Fernando Castrillón

Drugs/Capitalism/Psychoanalysis: An Interview with Benjamin Fong on His New Book "Quick Fixes: Drugs in America from Prohibition to the 21st Century Binge"

Quick Fixes: Drugs in America from Prohibition to the 21st Century Binge, by Benjamin Y. Fong, Verso, 2023, 272 pp.

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Fernando Castrillón: Thank you, Dr. Fong, for agreeing to this interview. I have a whole series of questions that attempt to bring what you write about in the new book, in alignment with some of the quandaries and issues within the larger field of psychoanalysis now. To begin with, I find that your book functions well as both a text with wide popular appeal and as a kind of primer for analytic clinicians. It lays bare the enormous social and political economic landscape of despair and decay that contributes to our compulsive stance vis-a-vis drugs; a sensibility directly in opposition to many contemporary psychoanalytic theories of the mind which simply don't take into account the obvious fact that most people are now plugged into one or another pharmacological or drug machine.

This theoretical oversight is odd when we consider how these drug relations, as it were, impact dreams, the capacity to remember them and then speak them in session, or how drugs in conjunction with other technologies like social media and easily available, highly tailored pornography combine to silence speech and give enormously powerful visual substance to repetitive fantasy scenes, thereby relegating the enunciative function to the body, a task the body is not set to take on. With all this in mind, why do you suppose that many clinicians and clinical theories, particularly in psychoanalysis, fail to take drugs and their associated clinical problematics into account?

Benjamin Fong: So, there's an obvious connection between drug consumption and the domain that psychoanalysts participate in. The government agency that has been tracking drug consumption in quite detailed form since 1979 is called SAMHSA, or the Substance Abuse and Mental Health Services Administration. Even bureaucratically we understand that the two go together.

As I point out in the book, drug consumption across the board is up in the 21st century (with the notable exception of cocaine). And that includes the well-known features like the opioid crisis, but you name it, its amphetamines, benzodiazepines, antidepressants, antipsychotics. One in six Americans is on a psychiatric medication. Given that prevalence, it seems obvious that a large proportion of analysands would be on different psychoactive substances when in analysis. And it seems incumbent upon analysts to better theorize how these different drugs play into analysis. How does Lexapro, for instance, present in a session, and what does it mean for the course of analysis? I don't have the answers, but it seems necessary to be asking the questions.

FC: But considering your wide reading in the field of psychoanalysis, why do you suppose there is this resistance on the part of analytic theory or analytic theorists? Why not include the fact of widespread use of both pharmaceutical and non-pharmaceutical drugs in the theories, especially when they have such important clinical repercussions in session? Like I was saying, there are certain drugs that make it really difficult to remember what your dreams were from the night before. People who smoke a lot of marijuana, for example, will report that they don't really remember their dreams, or they'll say they don't dream, which of course makes analytic practice quite difficult, for example.

BF: Well, I'm just guessing here, but I'm guessing there are generally just more professional reasons for this: clinicians are interested in talking, in what happens in talk therapy, in what develops in interpersonal relationships, whereas they see medication as a wholly different domain – the thing prescribed by psychiatrists in a very different paradigm of cure and personal transformation.

I'm not extremely well-versed here, but in the case of psychedelics, for instance, there has been some theoretical work done to conceptualize the role of the drug in the process of therapy. So in the 50s, at the same time that LSD is being used in macabre experiments in MK-ULTRA, therapists were trying out different psychedelics, LSD most notably, and noting how it lowered ego boundaries and defenses temporarily so that direct work could happen in a session.

This is work that really ended in the 60s, with the prohibition of LSD. It's interesting today that the two tracks on which psychedelic legalization are happening really have nothing to do with this tradition. So there's the corporate synthetic route, which seems essentially to be about replacing the old SSRIs with new microdosed psychedelics. So same psychiatric paradigm, just new (and probably better) drugs. And then there's stuff like what's happening in Oregon and Colorado right now, a new form of adult, state-sanctioned use. You have to use psilocybin in the presence of a state-sanctioned facilitator, but they explicitly reject the idea of it as a therapeutic relationship. The idea here is that it's the mushroom that's doing the leading and the work, and any relationship developed should be wholly "non-directive." So in both cases, the idea that drugs could be used as some kind of adjunct to talk therapy is rejected, which is interesting again given the history.

But honestly, you would know better than me, Fernando, why analysts theorize some things and not others!

FC: Ha! I appreciate that. I think this might well serve as a lead into some of my other questions, but to your point, I don't know if analysts are exempt from being caught up in the madness having to do with drugs. Everybody's caught up in it, right? And I think one of the gifts of your book is it brings this kind of clearheaded sober thinking, as it were, to a subject that is exceedingly emotional and divisive, even though it might not seem it. The other thing, to be honest, is I don't think many analysts really know what to do with drug use on the part of their patients.

It is too large a thing to simply address via an addendum to the theory. And if you actually do deal with it in a wholesale manner, I think it challenges the theories enough that the theorists themselves are challenged.

So, I think that's part of it. It's like the gristle that you just can't chew through and for many a clinician, it's better to just pretend it's somehow not there or it doesn't impact the work. I think the old model of, well, we can't do analytic work with this person until they actually get off the drug, whatever it might be, which was an older model, I think you simply can't do that nowadays. Because then you would have few patients to work with. Most everyone is on something, of one sort or another. But I think it does connect to some of the questions that I was alluding to. So, if we go to those,

BF: It would be a funny exercise to think about matching drugs to the old analytic categories: amphetamines for obsessives, benzodiazepines for hysterics, etc. But more seriously, there was a relevant category in the early days of psychoanalysis that seems to apply here, that of the "non-analyzable subject." There were clear boundaries to psychoanalysis: if you couldn't develop the transference or if you surpassed neurosis, it wasn't for you. Those boundaries have broken down over time in interesting ways. But it does seem like patients using certain drugs might be thought of in this way, as bringing certain un-analyzable features to a session. Drugs could be an adjunct to analysis, but they could also obviously be a barrier, and again it does seem necessary to thematize that in some way.

FC: Agreed. Most certainly. Alright, so continuing, I want to focus on your chapter on cigarettes for a little bit. Because you quote Lord Henry from *The Picture of Dorian Gray* as saying the following: "A cigarette is the perfect type of a perfect pleasure. It is exquisite and it leaves one unsatisfied. What more can one want?" Could you speak more to this? Are we aiming to achieve dissatisfaction through our use of drugs, which might be somewhat akin to the arguments that people like Todd McGowan make? How does this relate to contemporary expressions of market and libidinal economies?

BF: Well, I think the cigarette is a privileged case. There is no ersatz satisfaction quite like the cigarette, and I think that its mild psychoactive properties have lent it a real malleability that you don't see in the cases of other drugs. Cigarettes have been masculine, they've been feminine, they've been dangerous, they've been health-promoting. Basically anything that advertisers wanted to attribute to cigarettes, they have been at some point in their history. In the cases of most drugs, the pharmacological effects don't exactly *determine* the cultural associations that are appended to them, but they certainly shape them in powerful ways. You couldn't imagine opium as a straight A student's drug.

But with the cigarette, there is something completely malleable about the experience. It's less about the experience and more what it does for our daily experience. It lends accents to the day, a ritual break. It's not satisfaction, but it partitions the day. It's also extremely destructive, and at a moment when we have full awareness of its dangers, I think this means there's a little bit of death drive in the smoking experience. Cigarettes are far and away the most dangerous psychoactive product ever brought to market.

There's other ways of seeking annihilation in drugs, of course. In the opiates chapter, I try to get to the phenomenology of the experience. What's notable about heroin memoirs or opium den descriptions is that there's very little said about the experience. It's nice, it's warm, it's comfortable. Opiates seem to lend themselves to an evisceration of experience. And that form of escape has always been the source of opium's appeal, and also the source of the scaremongering about it as well.

FC: So in this way it's analogous to ketamine; this idea of a pause of subjectivity, a way to get away from it all?

BF: Yeah, I think so. Ketamine's a very interesting drug, and it can be used in a lot of ways. Firefighters keep it on them because it can be, and is often, used as an anesthetic. The dose really makes the experience, but at certain doses, ketamine is like a quick subjective timeout. It's interesting that ketamine is almost the model drug in the contemporary psychedelic renaissance, being one of the only drugs that is legal at present.

But in a lot of ways it is a bad substitute for MDMA or psilocybin.

But I don't know, I'm hesitant to paint one picture about the forms of everyday dissatisfaction in contemporary society and drugs *as such*. Drugs do a lot of different things for us. Opiates help us escape; amphetamines help us adapt. There's no single use to which "drugs" in the abstract are put, and it's an oddity of the American discourse about drugs that we often imply that there is.

But I do think there are more generalizable features about the *form* in which drugs are taken today. If you look at human drug consumption throughout history, drugs have been used in various social settings, towards religious ends, sometimes to get through the doldrums of agricultural work. But today, most drugs fit pretty narrowly into the categories of uppers and downers, and even drugs that don't are manipulated to those ends. That's pretty interesting, that we've so *instrumentalized* drug use to serve the purpose of either getting up in the morning to complete our tasks, or else helping us unwind quickly in the evening to prepare for the next day of completing our tasks. That's a historically novel paradigm of drug use.

FC: On that, I want to return to the Lord Henry quote because I think there is, if one takes it super concretely, something that starts to show itself as a possibility. So, the quote again is: "A cigarette is the perfect type of a perfect pleasure. It is exquisite and it leaves one unsatisfied. What more can one want?" Clearly, it's a question about desire. But what I also hear is: what more can one want? I mean, it is a question that has no real answer except that, well, there's seemingly nothing else left to want. For the contemporary subject, this is almost as good as it gets. Take your little cigarette break, put an accent on the day, as you were noting, and then keep on producing and consuming. What want can one want after that? There's nothing else to want. One is left with dissatisfaction, right? But a dissatisfaction that's not premised on a future sort of granting of the thing that one wants. It's a dissatisfaction that would seem to be born out of a scenario in which there is nothing left to want anymore. That wanting itself is actually in question. It's more *that* that I was hearing in Lord Henry's quote and this possibility I've sketched out.

BF: I think that that's right, but again, I'm hesitant to generalize here. Heroin, for instance, absolutely gives you what you want. Every opiate user throughout history has understood this. The thing is given, and quite efficiently! And many drugs satisfy our desires quite directly like this.

So again, I think cigarettes are a fairly unusual case. They're not immediately satisfying. They're often intensely disgusting to people who don't smoke. And of course we know now that they are death sticks (the only consumer product that kills when used as directed, according to historian Robert Proctor).

But lest we psychologize this case too greatly, let me say a word about cigarettes: the reason that cigarette consumption continues at high rates today is because cigarette companies are tremendously good at marketing their product, and they're tremendously good at skirting regulations and finding new markets for their products. That is the reason, and I think that any kind of individual blame on cigarette smokers, vape users, etc. is just participating in the project of the cigarette companies. They have very carefully crafted the argument, in courts and in the media, that we individual consumers are ultimately to blame.

That being said, I do think it's difficult to make sense of continued cigarette smoking today without processing something of the dire nature of contemporary reality. Something about this straightforwardly destructive act reflects how people see contemporary society, contemporary politics, the contemporary climate crisis. There are a lot of anxiety-producing things happening all around us. And I end the cigarette chapter by saying, there's something quasi-mimetic about smoking today. You're participating in the destruction that you see all around you. It's also a perfectly subversive act in a world that blames individuals for social ills.

So that's my line on cigarettes, but again, I don't think there's something necessarily generalizable to all drugs here. Opiates just hit the spot. If Satan exists, the morphine molecule is the evidence for his existence.

There we don't need a very sophisticated theory of human desire as refracted through a degrading society. The problem with opiates is not that they leave us unsatisfied, it's that they satisfy so damn efficiently.

FC: And perhaps in that way they actually kill desire.

BF: For sure, and I think that's why they have been so irrationally demonized too over the years. From the very beginning of the drug war in America, opium and its derivatives have been the target. The problem is that they eliminate desire, the kind of desire that would allow for normal, productive subjectivity. They grate against the category "recreational." And because they make people unproductive, because they cause them to lose desire, that's why they've been seen as so dangerous.

That it was the Chinese who were smoking it played into this. In the late nineteenth century, the Chinese opium smoker was seen as embodying the exact opposite of the ideal of male productivity: lazy, effeminate, underground. Everything about opium chafed against the demands of industrial capitalism.

FC: You say people today smoke because they're nervous and they smoke to lend sense to the day, but they also smoke because they're hastening an end, which connects to what you were talking about with opiates. If we turn to that chapter, you make an interesting remark about pain. To quote you: "We often call it boredom or 'dissatisfaction', but when it really makes itself felt, we sometimes call it 'pain' — an attractive descriptor because it frames all of our many complex problems in the simple terms of needing *relief* rather than work or communication." What are you saying with that?

BF: The story of the opioid crisis today is, at root, a story of pharmaceutical company malpractice. But the way in which they pursued that malpractice was through a transformation of the paradigm through which we understand the management of pain. Before the 1980s, doctors were pretty reticent to prescribe opiates across the board because they knew that they were very addictive. They had the stigmas associated with opiates. And doctors didn't necessarily think they *had* to relieve people from pain. Pain is part of the human experience. Pain is sometimes necessary to recovery. The point of medicine was to heal you, and while the relief of pain might be part of that process, it just as well might not be.

Around the 1980s, there was a kind of revolution in pain management. This is when you get the genesis of palliative care, the idea that there should be some kind of end-of-life treatment. The category of chronic pain also emerges around this time, and these are pretty loose conceptual vehicles. Who is to say when pain should and shouldn't be treated? This is also when you get the introduction of the Wong-Baker Pain Scale. The faces that go from sad face to happy face on an intake form. If the patient circles the happiest face, they're not in pain. If they circle the saddest face, they're in the most pain they could be in. But this is all subjective, of course. A kind of happy face to you might be a kind of sad face to me. But once this is in a medical record, and say, a patient sues a doctor, they could bring that to court and say, "Hey, I was reporting this level of pain, and it wasn't adequately addressed." So, it introduced a new source of liability. With all of these changes, doctors become much more open to the idea of prescribing various painkillers. This was a whole conceptual transformation really, that allowed us to see pain as something that ought to be treated by doctors. And it's what paved the way for the opioid crisis.

One thing that is very appealing about pain as a category is that it frames a variety of often complicated issues as in need first and foremost of *relief*. The idea is that the problem should be *eliminated*. Well, sometimes problems need work. Sometimes they need working-through. Sometimes they need confrontation. Especially in the contemporary neurobiological paradigm, this idea is very attractive. There's some specific problem happening in my brain, and the drug is going to fix it. Well, it's the same thing with pain. Pain, as a category, provides explanatory relief in getting us to see sometimes complicated problems in our life as in need of relief. But again, pain comes from many different sources. Sometimes you need

physical therapy, which can itself be painful. Sometimes you need analysis, which can also be painful.

FC: Your response brings us to my next question, regarding your chapter on psychotropics. As you state, "We all want to know what's wrong with us. And when the word 'capitalism' is illegible as an explanation for our generally uncomfortable state of being, easy substitutes must be ready to hand Drugs provide pharmacological relief, but perhaps more importantly, they provide explanatory relief." Could you expand on this?

BF: In that chapter, which is a history of transformations in psychiatric practice, I focus a good deal of time on what's often called the biological revolution in psychiatry. This was part of what marginalized psychoanalysis from psychiatric practice, but it also introduced new diagnostic categories tied very directly in the DSM-III and after to different drug treatments. Today, the psychiatric paradigm is completely brain-based. You've got some problem of norepinephrine re-uptake, and this drug is going to fix the problem. It's very mechanistic, objective. It's not about delving into one's personal life or economic stresses or social situation, and in that sense, it's very easy. You can say, "I don't need to spend countless hours in talk therapy, I can just take this drug that's going to do the thing for me." The biological revolution in psychiatry offered the opportunity to deal with subjective problems as if they were objective ones.

So most immediately, the issue is that after this transformation, lost is a relationship to oneself, but there's also an occlusion of the social reference. If you look at pharmaceutical advertisements from the post-war period, they're terrifying in themselves, but they do very directly relate to social imperatives. There's references to politics, there's references to how much people hate their work, there's references to how isolating the domestic cell was. There's all sorts of references to people's actual social situations involved in drug advertisements. Beginning around the 1980s, you see the justifications for psychopharmaceutical advertising switch away from those social references and towards claims about different neurotransmitters and re-uptake mechanisms and whatnot. And once we start talking about human subjectivity as if it's just a series of brain states, it makes it really difficult to have an honest conversation about why precisely we're taking drugs.

FC: Excellent. By way of concluding, I want to take us to the end of your book. In the conclusion, you insist that good jobs, widely available healthcare along with other large scale social measures would do a lot to alleviate the compulsiveness of drug use and its repression. And while I certainly would agree with that, the use of drugs seems inextricably tied to the question of human subjectivity more generally. In other words, drugs are here to stay regardless of any future political economy or social arrangement. How would you respond to this point?

BF: Oh, I'd absolutely agree. I think it's really difficult to imagine any human society where drug use is completely off the table. This is one of the things that defines human beings. We take drugs, it's an existential feature of human being itself. We are drug-taking animals.

In the conclusion of the book, I argue that what we need today is a *free relationship* to drugs. Right now we not only suffer under a variety of forms of scaremongering around drugs, but we also have to deal with a variety of stresses and anxieties that *compel* drug use. If you eliminated those stresses and anxieties, and also provided safe routes of administration, accurate medical knowledge, etc. about drugs, people would still probably use drugs, but not in the ways they're using them today. I think in that kind of situation, we'd have a totally different relationship to psychoactive substances.

The intense contradiction between peddling and prohibition is what Americans have been caught in for well over a century. To overcome this, I think we need improved material conditions: more affordable housing, better jobs, healthcare for all. By relieving the material stressors on the American populace, I think both the

compulsions to excessively medicate and also excessively moralize about the problems of other people will be lessened.

FC: But the idea of a free, non-compulsive drug relation would seem to be nowhere on the horizon at this point.

BF: Well, let me say this: the book is a kind of materialist challenge. If you're going to be a materialist about the drug problem, insomuch as it's a problem, you can't stay too focused on the drugs. This is about underlying material conditions, and until you deal with them, whatever neat policy fixes liberals want to trot out are just not going to work.

So, one of the things that I deal with in the conclusion is movements toward decriminalization and harm reduction. These are very nice in theory, but they haven't worked largely because they are carried out without the social provisioning needed for them to work. This is one of those cases where the harder work of rebuilding society in the United States is avoided.

I'd love it if there were simply policy fixes to the issues of drug abuse and addiction in America, but there aren't. These are very expensive problems we're dealing with. Problems we can only address with the adequate political will to do so. From one perspective, this seems almost impossible today, given the gridlock of our political situation. But things can change, and quickly. In the depths of the Depression in the 1930s, it didn't seem very likely that a revolution in working-class living standards was on the table, but it was. It happened quickly.

FC: Fair enough. Thank you.

Bio:

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