

# “Swallow Them All, and It’s Just Like Smack”

Comorbidity, Polypharmacy, and Imagining Moral Agency alongside Methadone and Antipsychotics

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## Abstract

This research article investigates moral agency in the spaces between the methadone clinic and the inpatient psychiatric ward by exploring the ways dually-diagnosed service users move through ever-more labyrinthine networks of care. I ask: how are patients’ own engagements with the ethical stakes of such care both made possible and delimited by virtue of their proximity to substances that are understood to affect their subjectivities, wills, and capacities for self-governance? Drawing on fieldwork in the community mental health network of Dublin, Ireland, and following my interlocutors’ own reflections, I analyse the moral dimensions of polypharmaceutical treatment for substance use disorder in the context of psychiatric dual diagnosis. I illustrate how various apparatuses of coercion and care apprehend and govern patients who are thought to be both addicted and mad, simultaneously enthralled by one form of the *pharmakon* and dangerously unreasonable when other medications are absent or neglected. In the space of such medicated subjectivities, a curious but ultimately revelatory claim to authority about the intended and unintended effects of polypharmaceutical treatment takes shape.

## Keywords

Psychosis, Addiction, Dual diagnosis, Moral agency, Ireland.

## Introduction

Sean began the day homeless—barred from the halfway house where he had been sleeping ever since his mother kicked him out—and driven by a mission to procure a length of rope. By the evening, he had lost his makeshift noose but gained a bed in the inpatient psychiatric unit of the hospital where I was conducting my fieldwork, just across the River Liffey from the centre of Dublin. When I asked what had moved him to attempt to take his own life, he simply said that he had reached the limits of his abilities to cope through the use of psychiatric medications and that even heroin could not anaesthetise his pain.

Sean would be discharged within a week, but in the intervening days I came to view his case as an important, if fragmentary, part of my ethnographic research on psychosis, antipsychotic drugs, and adherence to pharmacological treatment protocols in Ireland’s largest community mental health network. His words invite a deeper consideration of psychiatric comorbidity and polypharmaceutical treatment regimens, as well as the transience and precarity inherent to living with the dual diagnosis of opioid use disorder and persistent psychotic phenomena like paranoia, hallucinations, and delusions. On a deeper level, Sean’s thoughts on the imbrication of the psychiatric injunctions to adhere to prescribed medications and avoid opioids like heroin have helped me explore the daily, lived rhythms of pharmaceutical consumption and the ambiguities of a pharmacologically and institutionally mediated concept of will. I have previously called this ambiguous entanglement ‘medicated subjectivity’ (D’Arcy 2019), and thinking with Sean and his experiences has allowed me to see the impasse in which he found himself as a sort of paradigm case for understanding how moral agency can emerge *from* rather than in opposition to the vicissitudes of such a state.

The story of the events that precipitated Sean’s admission to the inpatient psychiatric unit that I call St. Dymphna’s Ward is a meandering one. Prior to our first meeting, the consultant psychiatrist who ran the ward—a man I refer to as Dr Domnhall Lynch—advised me to proceed with caution, as Sean had presented at the emergency room following a suicide attempt. When I opened our interview by asking him what had brought him to the hospital, however, Sean eschewed a straightforward narrative marking a discrete moment of crisis and instead told me, in spare, laconic fits and starts, about his life.

He began with the subject of drugs, both as a marker of pathology and an organising object within the scattered narrative of the preceding years. Even before being kicked out of his hostel, he had battled a heroin addiction for many years and had been working with a string of physicians to treat his substance use disorder with methadone for nearly as long. The doctor who prescribed Sean methadone functioned as his primary care provider, and prior to losing access to

stable housing he had made the trek south from his hostel and across the Liffey to the clinic nearly every morning, except on days when his depression kept him in bed. The threat of withdrawal was usually enough to keep him motivated, but with a nod toward an abscess and several other fresh injection sites in the crooks of his arms, Sean acknowledged that methadone was not always enough to deal with persistent feelings of hopelessness and despair. He relapsed when he was given a two-week suspension from his hostel for fighting, and he had continued to use intermittently until he was admitted to St. Dymphna’s. The space of the inpatient clinic was a strange sort of reprieve, he reported. He had a warm bed, he was given food and methadone and the other pharmaceuticals he had been prescribed, and it was impossible for him to procure any heroin while inside the locked ward.

## **A fragmentary ethnography**

This research article has grown out of a year and a half of ethnographic fieldwork in the community mental health system of Dublin, Ireland. Initially, I went to Dublin to investigate the meaningful relationships that develop between psychiatric patients and their medications as they move through community-based health networks. New forms of ‘medicated subjectivity’ have emerged in the aftermath of deinstitutionalization, most saliently through patient engagement with the logics of psychopharmaceutical adherence that govern extra-institutional care (D’Arcy 2019).<sup>1</sup> Over time, however, the breadth of my interlocutors’ relationships to both licit and illicit substances began to demand an equally broad consideration of what it means to live with, through, and in the shadow of powerful chemical agents. This realisation forced me to revise my definition of the field of the interpersonal, chemical, and institutional ties that define adherence as such. In this way, the research and findings that inform this article were neither planned nor expected.

The analysis that follows is guided by Sean’s reflections on his dual diagnosis and the polypharmaceutical nature of his treatment. He has helped me to articulate the double-bind of dually diagnosed mental health patients whose prescribed but potentially intoxicating psychotropic medications can threaten their recovery from addiction. Sean considered the risk of addiction posed by this treatment regimen to be a primary barrier to reconciliation with his family—a tragic paradox given the importance of this goal in motivating his recovery and the significance of his family as a source of moral agency.

1 In my work, I look to Paul Brodwin’s work to differentiate between adherence and ‘compliance’. Brodwin’s fascinating analysis of Assertive Community Treatment emphasises the directly observed nature of compliance and features near-daily contact between patients, psychiatric nurses and case managers who function as agents of institutional oversight (2013). I define adherence as part of a subjectivising psychiatric apparatus that emphasises patients’ self-directed, unsupervised fidelity to prescribed treatment plans (D’Arcy 2019).

My primary research sites included an inpatient psychiatric unit in a large, inner-city hospital, an affiliated outpatient clinic, and a community mental health group run by and for psychiatric service users in consultation with the New Lacanian School of Dublin. I observed and interviewed clinicians and patients in each of these settings, and I tracked the permutations of medicated subjectivity and its many guises through their respective institutional and communal registers. The larger fieldwork project out of which this text emerges is thus distributed across a network of care; though the data that informs my thinking on the comorbidity of psychotic mental illness and addiction comes almost exclusively from St. Dymphna’s Ward. Following the work of Eugene Raikhel and William Garriott (2013), especially in their dialogue with Anne Lovell on the notion of ‘trajectory’ (as cited by Raikhel and Garriot 2013), the acuteness of the suffering that was usually associated with these kinds of comorbidities continually led me back to St Dymphna’s. Despite the haunting power of the psychiatric hospital as a total institution in Irish history (Kelly 2016, 2022), and despite the concentration of psychiatric authority found in the inpatient unit, clinicians and patients often spoke of a shared desire for new and experimental practices and spaces for healing, reminiscent of Lisa Davis’s concept of the ‘counter-clinic’ (Davis 2018).

All of the patient-interlocutors whom I observed and interviewed were patients of Dr Lynch. While working in St. Dymphna’s, I shadowed Dr Lynch and his colleagues, both during their everyday activities and in the more formalised setting of rounds and patient intake sessions. Dr Lynch’s consultation team included two psychiatric residents, a social worker, an occupational therapist, a clinical psychologist, and two community nurses. The team also frequently consulted specialists in substance use disorders and resource managers for treatment programmes to complement their own considerable expertise.

I often engaged with the patients that appear in this article in the social spaces in St. Dymphna’s Ward, such as the day room, the smoking quarters, a sitting area near the entrance to the unit, and, more rarely, the hospital café. I doubled my usual prudence to avoid asking direct questions about treatment when speaking with a patient with a dual diagnosis that included substance use disorder, allowing the patient to speak first. Though some of the patients that I met in St. Dymphna’s Ward happily reported a relative freedom from stigma related to mental illness in the space of the hospital, it was clear that the tentative community and mutual recognition surrounding the experience of psychosis did not always extend to accommodate a history of addiction. It is difficult to say, for this reason, how many of the patients that I came to know during my fieldwork in the ward struggled with substance-use disorder in addition to a psychotic spectrum illness. But often, the patients who talked openly about their years battling alcoholism or benzodiazepine

misuse were quick to note the quasi-narcotic effects that sometimes accompanied their cocktails of antipsychotics and other psychotropic drugs.<sup>2</sup>

I never sought out patients who struggled with addiction,<sup>3</sup> but the rising prevalence of dual diagnosis for psychotic mental illness and substance use disorder in Dublin’s community mental health network—an outgrowth of the ongoing Irish opioid crisis—disrupted my attempts to isolate my study of adherence to how my interlocutors understood and related to *prescribed* medications. For some of the people I met over the course of my ethnographic work, after all, distinguishing between pharmacologically mediated notions of poison and cure was an increasingly murky endeavour, recalling the logic of Derrida’s *pharmakon*.<sup>4</sup>

Jamie Saris (2010) has noted the linguistic distinction between two types of ‘intoxication’ in Old Irish,<sup>5</sup> one from madness and the other from a substance such as alcohol. In his genealogy of contemporary addiction psychiatry, Saris (2013) also wrote that many clinicians and researchers hypothesise an underlying case of a mental illness like depression when charting the aetiology of addiction, sometimes suggesting that substance abuse can represent an attempt by a mentally ill person at self-medication gone awry. Such characterisations of comorbidity are especially important for ethnographic explorations of the psychopharmaceutical treatment of dual diagnoses because they underscore the ambivalence at the heart of recognising and treating simultaneous instances of serious mental illness and addiction; they reveal widespread conjecture about the possibility of a shared origin but also suggest the potential for clinical expectations of ‘unreason’ on the part of the patient. This ambivalence can guide compassionate care, but it can also further stigmatise and disempower patients with dual diagnoses, even compounding a commonly shared sense of helplessness and dislocation.

- 2 Jamie Saris and Fiona O’Reilly (2010) have documented the high frequency of polypharmaceutical drug abuse by urban Irish drug-users, including both illegal substances and widely available prescription medications, especially benzodiazepines and sleeping aids. In the same report, they note the highly stigmatised nature of addiction (especially to drugs like heroin) in Irish society, even among communities of drug users.
- 3 I draw upon work in psychiatry and addiction medicine to differentiate between ‘addiction’ and ‘dependency’ when writing about substance use disorder, as well as my interlocutors own words. Patients diagnosed with substance use disorder frequently referred to themselves as ‘addicts’ or to ‘struggles with addiction’, as did their doctors. Szalavitz, Rigg, and Wakeman (2021) define addiction as ‘continued drug use that persists in the face of negative experience’ and dependency as physical withdrawal stemming from ‘an ordinary biological consequence of taking certain medications for weeks or years’. While I am wary of drawing easy distinctions between patients’ psychological and physical relationships to addicting or dependency-inducing substances, I use Szalavitz, Rigg, and Wakeman’s definition when writing about medical care.
- 4 I refer to Derrida’s work (1981) to note the ambiguity in the Greek etymological root of the word ‘pharmaceutical’. ‘*Pharmakon*’ can designate poison or cure, as well as a magical and transformative substance. Context and dosage determine the specificity of the *pharmakon* in question.
- 5 Saris writes: ‘the Irish language possesses a very ancient word, *meisce* (drunkenness, frenzy, ecstasis) that generally requires a modifier to specify the vehicle that has taken one “out of one’s mind” (e.g., *meisce mearachta*, as against *meisce leanna*, meaning the intoxication of madness as opposed to the intoxication of ale)’ (Saris 2013, 264).

Neely Myers has offered the nurturance of ‘moral agency’—or a person’s capacity to shape their life story in such a way as to be recognised by others as ‘good’—as a possible strategy for confronting the experiential, structural, and narrative disruptions that frequently mark the lives of people living with psychosis (Myers 2015, 2016; Myers and Ziv 2016). While describing the many barriers to the psychiatric expectation of ‘recovery’ from psychotic mental illness, Myers (2016, 430) notes that her interlocutors’ life stories are often punctuated by moments of ‘Aristotelian *peripeteia*, or “breach” of life plan, followed by a subsequent erosion of moral agency and sense of connection to others’. People living with psychotic mental illness can counter these disturbances to straightforward narratives of value and belonging by drawing on the collective resources of the ‘social bases of self-respect’, an internal sense of autonomy that Myers (2016) calls ‘autobiographical power’, and the ‘peopled opportunities’ for recognition as a good person that emerge from the cultivation and maintenance of intimate relationships. As Myers and her interlocutors are quick to observe, however, this is frequently a challenging endeavour, given the degree to which psychosis can disrupt the kinds of relationships upon which moral agency often depends.

The additional complication of substance use disorder would seem to double the potential for disruption that psychosis produces for both inner experience and external relationships. In his striking ethnography of addiction in East London, Joshua Burraway (2018) explores the complex interplay between traumatic memories, self-medication with dangerously addicting substances, and medico-judicial surveillance by institutions (both caring and carceral). For Burraway’s interlocutors, ‘memory offers not synthesis but crisis’, and the multiple ruptures produced by personal tragedy and the habitual use of alcohol and other drugs to blunt both consciousness and a sense of mnemonic continuity produces a phenomenological fragmentation—a life that is frequently defined by experiential discontinuity rather than coherence, wherein pursuing a blackout can be understood as the pursuit of a *kind* of ‘good’. Likewise, Angela Garcia (2010) has argued that heroin use in the Española Valley, in New Mexico, allows addicts to bear witness to a collective loss that hovers at the threshold of memory, forgetting, and an unmournable dispossession. It is significant that both of these scholars have allowed for the possibility that their interlocutors might strive for something like Myers’s sense of moral agency *through* alcohol and drugs, but a conceptual and methodological tension remains between the fundamentally intersubjective nature of moral agency and the doubled rupture of psychotic mental illness and addiction.

Such a doubling of discontinuity is logistically and methodologically challenging, but this aspect of my larger ethnographic project has brought me into a deeper dialogue with anthropologists that centre on the work by people with substance

use disorders to manage their own relationships to potentially addicting drugs in ways that are frequently harmful but occasionally, and idiosyncratically, therapeutic (Bourgois and Schonberg 2009; Garcia 2010; Hansen 2019; Schlosser and Hoffer 2012; Saris 2011, 2013; Zigon 2019). I follow a tradition of thinkers in medical anthropology, the history of medicine, and philosophy who conceive of mad subjectivities, and the forms of care that engage them, as fundamentally marked by internal heterogeneity, giving rise to creativity and loss in equal measure (Pandolfo 2017; Giordano 2014; Corin 2007; Good, Subandi, and DelVecchio Good 2007; Jenkins 2015, 2010; Biehl 2005; Myers 2015, 2016). At the same time, the multiple orders of institutional intervention that often compose my dually diagnosed interlocutors’ care made it difficult to maintain the kinds of sustained ethnographic relationships that remain my standard of data collection. Instead, I have taken inspiration from Gunel, Varma, and Watanabe’s (2020) theorisation of ‘patchwork ethnography’ when writing about my time with people who experienced comorbid psychosis and addiction—emergent from data and analysis that were both ‘fragmentary’ *and* ‘rigorous’. Theory and method became entangled in my growing appreciation for the extent to which comorbidity can unsettle stable definitions of ethnography, psychiatric care, and easy distinctions between licit and illicit substances.

Allowing the intersection of multiple orders of rupture to teach me about comorbidity has also led me to reconsider the kinds of subjectivities that emerge from dual diagnosis. While I continue to look to psychological anthropologists who argue that psychosis ‘resists incorporation into social order’ (Corin 2007) and who invoke the discourse of psychoanalysis to claim that the other can be ‘recognized but never known’ (Pandolfo 2017), I have also begun to draw upon R.D. Laing’s concept of ‘ontological insecurity’ to think through the subjective and experiential dimensions of dual diagnosis. When brought into conversation with Cheryl Mattingly’s work (2014) on the ontological debates that characterise the ‘moral laboratories’ of clinical encounters, this fragmenting of a stable sense of self, other, and shared reality has become a useful heuristic when thinking through the strategies that patients, clinicians, and even social scientists employ when struggling, together, to define a commensurate and mutually intelligible world.

Though psychotic mental illness and substance use disorder are often identified as chronic illnesses that demand pharmacological management by biomedical institutions of care, cases of dual diagnosis like Sean’s can easily be reframed as existential and ethical crises. Such a reframing can help to rethink the institutional politics inherent to treating such comorbidities, as well as the meaningful stakes of dual diagnosis for the people who engage with and sometimes withdraw from psychiatric care. Specifically, Sean’s case has helped me to think through the doubling of these aforementioned experiences of rupture and marginality in the

clinical, conceptual, and lived space of comorbidity; the concomitant doubling of the demands imposed by the psychiatric injunction to adhere to one category of medications and strenuously avoid another; and the degree to which my interlocutors’ relationships to the nested assumptions *about* and clinical projections *regarding* the potential for transformations in my interlocutors’ subjectivities were influenced by their respective proximities to an array of distinct but deeply interrelated substances. The ethical questions that remain—how to live in relation to these experiences and these substances—have given me further reason to return to considering the place of moral agency in the methadone clinic, the inpatient ward, and all of the spaces in between.

### **Comorbidity, cascade, and the double injunction to adhere/avoid**

Sean’s case was a curious one. He had presented to St. Dymphna’s Ward because of an unsuccessful suicide attempt, yet his most immediate and easily remedied medical need upon admission was the resumption of methadone maintenance therapy. The clinicians who treated him in the inpatient unit were able to appreciate the necessity of attending to both psychological and chemico-physiological forms of suffering with counselling, conducting a review of his psychopharmaceutical regimen, and offering supervision to prevent further suicide attempts. Both Sean and the ward staff tactfully made it clear that this was not the normal standard of care that he usually received when receiving care from the underfunded and overworked staff of Dublin’s public addiction treatment programmes, however. The complexities of this particular psychiatric emergency were, in a sense, easily subsumed by the treatment paradigm that gave shape to Sean’s everyday routines. The ritual adherence to the methadone clinic rose to meet the chronic misuse of heroin—a longer, slower form of suicide in the eyes of many of the clinicians who cared for Sean.

Fittingly, anthropologists working at the intersection of medicine, disability, and care have recently analysed the conceptual and practical overlap between comorbidity and chronicity as organising principles of contemporary biomedical treatment paradigms (Manderson and Warren 2016; Nichter 2016; Weaver, Barrett, and Nichter 2016). This work is useful for better understanding the dual diagnosis of psychotic mental illness and substance use disorder for a number of reasons. Perhaps most importantly, it allows for an analysis of the entangled and sometimes synergistic relationship between two sets of symptoms and the attendant classes of medications that are used to treat them without drawing an oversimplifying equivalency between the two, or positing that the contents of one diagnostic category are aetiologically prior to the other as a primary condition. By this I mean that when a clinician, social scientist, or philosopher takes the

meaningful content of psychotic symptoms seriously, these phenomena are not reducible to being side effects of the presence or absence of the drugs that produce addiction; nor is such addiction reducible to a by-product of psychotic mental illness. These two categories of diagnostic criteria—or, alternatively, orders of experiential disruption to daily life and social integration—do nevertheless seem to have an amplifying effect on one another.

Following Weaver, Barrett, and Nichter (2016), early interventions into the study and treatment of comorbidity have long critiqued what scholar René Dubos (as cited in Weaver, Barrett, and Nichter 2016) calls the ‘doctrine of singular etiology’, or an approach to treating disease processes that emphasises the isolation and individuation of both the causes for and treatment of a patient’s general state of ill-health. Historically, they note, cases of comorbidity or multi-morbidity have been framed with reference to an ‘index disease’, or the disease that is first detected and diagnosed, and then a collection of ‘secondary’ conditions, which can ‘confound what would otherwise be a clear treatment path’ for the index affliction. The treatment that Sean received in St Dymphna’s Ward—as well as that which he said he was receiving at his methadone clinic and as a patient in Dublin’s broader community mental health network—attempted to address the complexity of his experiences and multiple diagnoses, but his care was guided by the logic of a sort of psychobiological triage when he was outside of the state of exception represented by the inpatient unit. Opioid maintenance therapy represented the everyday emergency of substance use disorder as an index condition while Sean’s psychiatric diagnoses seemed to be treated as equally chronic but nonetheless secondary conditions; these did not become a primary focus of treatment until they were acute enough to warrant hospitalisation, usually also in relation to a relapse in heroin use.

Practically speaking, Sean’s day-to-day treatment seemed to mirror this divide. Though his doctors at the inpatient ward were actively treating his depression, persistent psychotic phenomena, and the sleeplessness that plagued him, the medications meant to address his psychological problems were usually managed by the doctor who oversaw his daily visits to the methadone clinic. Opportunities to pursue psychotherapy and other forms of socially engaged treatment were also comparatively limited, winnowed down by the slow creep of austerity in post-deinstitutionalisation Ireland and what João Biehl (2007) has called the ‘pharmaceuticalization’ of clinical infrastructures. The clinical response to Sean’s substance-use disorder, depression, and psychotic experiences was more medication, sometimes without a long-term consideration of the interactions of the drugs themselves or their effects upon Sean’s sense of personhood and self. Comorbidity was treated with polypharmacy even with the risk of a heroin relapse hovering always at the periphery in the clinic.

As might be expected, this proliferation of pharmaceutical interventions presented its own risks, only some of which could be productively engaged in the space of the inpatient unit. It was rare that patients entered St. Dymphna’s Ward in the full, furious grip of withdrawal, though there were stories that circulated about previous tenants who tore out ceiling tiles and ripped apart couch cushions while searching for a real or imagined stash of drugs. More concretely, Dr Lynch and his colleagues had recently been forced to scale back their relatively liberal policy of leaving the door to the ward unlocked as often as possible. The gesture was equally symbolic and pragmatic; it was meant to encourage patients to take day trips when the clinical staff allowed them leave and to discourage the sense of claustrophobia and demoralisation that can accompany involuntary commitment. Unfortunately, the policy was largely abandoned when the growing epidemic of heroin use in Dublin penetrated even the security of the ward itself; local dealers were discovered to have attended visiting hours under the guise of seeing friends and family while actually attempting to sell drugs to patients who could not come to them in person.

From a psychopharmacological perspective, the presence of addiction was a subtle constant—both the object of therapeutic intervention and, in some cases, an outgrowth of previous programmes of care. Patients who struggled with alcohol withdrawal were frequently treated with chlordiazepoxide, a benzodiazepine marketed under the cheerfully promising trade name of Librium. Patients who had become dependent on or addicted to benzodiazepines also sometimes sought out the safe space of St. Dymphna’s Ward to detox from a previous therapeutic regimen run out of control. Dr Lynch was generally interested in taking advantage of the direct observation afforded to patients staying in the ward—a rarity in the broader context of community mental health in Dublin and elsewhere—as an opportunity to experiment with lowering the dosages of his patients’ psychotropic drugs. This allowed him to try to work with the patient to find the threshold of clinical efficacy and blunt some of the sedative or potentially intoxicating effects of higher dosages. He was particularly interested in this kind of experimentation in the context of benzodiazepine usage, as this was a class of medication that posed an especially acute risk of addiction.

For some patients, the line between poison and cure could blur beyond all recognition. A woman named Orla offered deeper insights into the dangerous entanglement of treatment and addiction when, following an involuntary admission to the ward after a suicide attempt, she asked to remain as a voluntary patient for a ‘respite’ from the stresses of everyday life. She was making progress in her recovery, she claimed, but when Dr Lynch cut back on her daily regimen of benzodiazepines she was discovered with contraband sedatives and hurriedly discharged herself after admitting that she had resorted to asking her family to

smuggle her some ‘sleepers’ when they visited. This sort of response to Dr Lynch’s programmatic attempts to lower his patients’ dosages on the ward was not uncommon, underscoring the addicting potential of commonly prescribed medications and recalling Angela Garcia’s *The Pastoral Clinic* (2010) with its accounts of loving if counterproductive gestures by opioid addicts’ family members who suffered to see their loved ones going through withdrawal. Orla’s struggle with negotiating the dosages of her more dangerous (but still legal) medications emerged again when she revealed to me that she had used her psychotropics—a formidable cocktail consisting of an antidepressant, an antipsychotic, a benzodiazepine, and a non-benzodiazepine sleeping aid—to induce the overdose that had brought her to St. Dymphna’s Ward. From a clinical perspective, her doctors found themselves in a double-bind; she seemed to be in danger of becoming dependent on if not outright addicted to some of her medications, but taking her off these drugs was nearly unthinkable given the severity of her depression and the likelihood of another suicide attempt. At the agonizing intersection of mental illness and substance use disorder, Orla was in a similar double-bind as she strove to endure the profundity of her pain.

Other patients also wrestled with balancing the task of daily adherence to psychotropic medications with abstinence from similarly addicting substances like alcohol and opioids. One such patient, a woman I call Theresa, had received treatment from Dr Lynch and his colleagues for bipolar disorder, major depressive disorder, and alcoholism for years. Like Orla and Sean, Theresa had most recently been admitted to St. Dymphna’s Ward because of a suicide attempt, which she attributed to a relapse in alcoholism and an accompanying failure to adhere to a cocktail of antipsychotics, antidepressants, and non-benzodiazepine sleeping pills. Following Manderson and Warren (2016), the comorbidity of Theresa’s bipolar disorder and alcoholism produced a ‘cascading’ effect rather than indicating an ‘index’ condition, each of the respective symptomatology amplifying the other until she was nearly suffering from alcohol poisoning while ignoring her medications entirely. That is until she, too, used them to attempt a fatal overdose.

The inverse relationship between Theresa’s adherence to psychotropic medications and abstinence from alcohol was striking. Not only did this inversion mark the complexity of her and other patients’ subjective experiences of suffering, but it also revealed the polyvalent nature of pharmaceuticals and other drugs as the site of a doubled psychiatric injunction: a demand for fidelity on the one hand and abstinence on the other. This doubling played out along a familiar set of thematic refrains. Patients who struggled with substance use disorder, either with illegal drugs or prescribed pharmaceuticals, claimed they were attempting to drown out traumatic memories of difficult childhoods or recent violence and tragedy, all of which resurfaced when Dr Lynch and his colleagues precipitously lowered their

daily dosages of medications in the ward. Some staff members, on the other hand, routinely characterised this kind of behaviour as evidence of addiction and a desperate attempt to stave off the effects of withdrawal once drug consumption began to take place in a directly supervised environment. The cycle often seemed to begin again upon discharge.

Writing as a practicing psychiatrist and anthropologist of addiction, Helena Hansen has also centred the extensive overlap between patient populations who receive care for both psychosis and substance use disorders in her work on dual diagnosis. Hansen notes that during her psychiatric training she was ‘repeatedly informed that the majority of people with psychosis and severe mood disorders use nonprescribed psychoactive substances, and the majority of people who use nonprescribed psychoactive substances also have symptoms of psychosis and/or mood disorders’ (Hansen 2019, 76). Prior to patients receiving a diagnosis that would orient them toward a specific strategy of care, however, Hansen also observed a continuing commitment by clinicians to determine what Dubos (as cited in Weaver, Barrett, and Nichter 2016) would call an ‘index’—a primary diagnostic position that could have lasting effects upon the care for whichever aspect of the comorbidity was deemed secondary and even more profound affects upon the perceived character of the patient. The diagnosis of psychosis, for example, carries a ‘political and moral valence’ that ‘renders diagnosed people blameless even if marginal’, while a diagnosis of addiction with psychotic features can render patients psychologically and morally irredeemable in the eyes of their caretakers (Hansen 2019, 77).<sup>6</sup>

Dr Lynch was sympathetic but pragmatic when speaking to the intricacies of treating patients living with both psychosis and addiction, acknowledging the addicting effects of psychotropic drugs on patient’s lives, agencies, and subjectivities, as well as the necessarily dual nature of the psychiatric approach to pharmacologically mediated care. ‘Consider Theresa’, he tells me,

She’s presented to the emergency department with acute alcohol withdrawal, but her psychiatric comorbidities make treating her substance abuse much, much more complicated than a simple case of delirium tremens. Her most recent admission, of course, was also for an overdose of the medications we want her to take in well-regulated, daily doses [...] Theresa doesn’t simply

6 Hansen’s (2019) analysis of the ‘moral reckoning’ inherent to such diagnostic practices—wherein labels like schizophrenia and addiction carry bleaker prognoses and fewer treatment options than mood disorders with psychotic features—reveals that poorer patients and patients of colour are more likely to receive disempowering diagnoses that limit treatment, access to care, and opportunities to cultivate moral agency. I read Hansen’s work on dual diagnosis as an essential part of scholarship about race, racial disparities in healthcare, and structural competency, but I will not address how psychiatric care for psychosis and addiction can shape patients’ ‘racialised subjectivities’ here (though for demographic purposes, all of my interlocutors who struggled with addiction were Caucasian and ethnically Irish). Hansen’s writing is essential to another project in which I address the psychiatric complexities of Ireland’s increasing demographic diversity.

wake up one day and decide to forego her antipsychotics and pick up a bottle. Nor does she suddenly arrive at a breaking point and swallow all of her medications. Difficult circumstances define her living situation. She also makes innumerable, tiny decisions over the days, weeks, and months of her life, and ultimately—together—they may lead to her death if we are unable to intervene and prevent it. But it seems to be a cumulative process when we examine it with respect to the substances she abuses and the substances we prescribe. It is never black and white.

Also striking, and echoing the political and moral dimensions of stigmatic diagnoses and their treatment protocols per Hansen’s (2019) analysis, was the rhetorical and conceptual continuity between how clinicians evaluated their patients’ capacities for antipsychotic adherence when treating schizophrenia or bipolar disorder and their attendant worries about whether patients with substance use disorders could stay away from stereotypically dangerous chemicals.

In these cases, the truth of Derrida’s *pharmakon* and Hansen’s critique of the politics of diagnosis lay bare and uncontested. These two seemingly separate classes of patients often overlap extensively and the curative substances used to treat the former category are frequently the same ones that addict the latter. Both categories of substance have the capacity to soothe and blot out pain, as well as the potential for intoxication and addiction. The question remains: how to live in relation to such substances when one needs them to live well but through their use one’s life can be compromised by potential addiction?

## **Adherence, addiction, and double potentiality**

When I asked Sean at what point he developed a sense that his heroin use had got out of control, his face darkened, and he returned to the days before he stayed in the hostel. He was still living with his mother in the comparatively wealthy, suburban township of Tallaght, and they were both grieving the recent death of his father after a long illness. Though their respective relationships with Sean’s father were marred by his bouts of violent alcoholism, they mourned him nonetheless. Like a steadily increasing number of other Dubliners, Sean turned to heroin, an addiction which had begun during his father’s illness. The drug provided a brief respite from his bereavement, albeit at the expense of damaging his relationship with his mother and his own young children. Soon, however, Sean’s father returned.

‘Sometimes, when I’m on the drugs, I hear him. Sometimes I even see him’, Sean told me, his words intermittently interrupted by a fit of coughing. ‘It started after he died’, he continued, ‘when even the heroin couldn’t blot it all out. He would come

to me and say terrible things. Tell me to kill myself, slash my throat. He looked like he did just before he died, thin and yellow with drink. With cancer’.

Sean’s doctor prescribed him Seroquel and Effexor in addition to methadone—an attempt at a biopsychiatric solution to the problem of his father’s visitations that gripped him existentially and metaphysically. I asked Sean if the combination of antipsychotics and antidepressants (known as Serotonin and Norepinephrine Reuptake Inhibitors or SNRIs) prescribed helped to lift his mood and blunt the intensity of these encounters with his father. ‘I don’t rightly know’, Sean admitted. ‘I think they might be working because my mood is a little better, but I still see him sometimes when I’m really low. I guess the difference is that I used to think it was really him—now I know it’s not’.

Stumbling, I wondered aloud: if the ambiguous diagnosis of persistent psychotic phenomena and the prescription of multiple drugs failed to curtail the reappearance of Sean’s father, by turns spectral and hallucinatory, did anything *really* help? Sean answered that he found his trips to the methadone clinic comforting, especially on the days when he was able to speak with the staff psychotherapist, but that when he left the clinic for the world outside he continued to find himself unemployed, supported by only a modest disability allowance, and unless he sought out the company of friends who were in recovery or actively using he remained largely alone. To further manage daytime anxiety and help him sleep at night, the doctors at the methadone clinic had also prescribed him a low dose of the benzodiazepine diazepam (or Valium) to be taken at midday and a larger dose of zopiclone, a nonbenzodiazepine sleep aid, for the evenings.

Unable to contain my surprise, I asked him for clarification: was Sean really taking a daily dose of four different classes of psychotropic medications in addition to methadone? He laughed ruefully. This was why his mother had eventually kicked him out. His treatment, then, had begun to resemble his affliction, as he explained:

I keep asking the doctors to lower the doses of my tablets, but they’re worried that I’ll start on heroin again, so they keep them at the same level. In the morning, I pick all the pills up at once, you see, and it’s almost always too much for me once I leave, once I’m alone again. Swallow them all—swallow them all at once—and it’s just like smack.

As I have argued elsewhere, injunctions to antipsychotic adherence function as technologies of psychiatric deinstitutionalisation (D’Arcy 2019). Drawing on the work of Michel Foucault (1978, 1986) and Giorgio Agamben’s reading of Foucault’s *dispositif* (2009), I conceive of adherence as an apparatus upon which community mental health ostensibly depends. Crucial to the ideological underpinnings and nested philosophical assumptions of this deinstitutionalised care—as crucial, I

argue, as the widely touted psychopharmacological opinion that the development of atypical antipsychotics allows for a more sophisticated treatment of psychosis with fewer side effects—is the production of what psychiatrists call patient ‘insight’. So-called insight is loosely defined as the understanding that one’s reasonable faculties are at least partially impaired, that one may be seeing and hearing things that defy the consensus of what is or is not really there, and that one must relinquish at least part of one’s care—and indeed ability to engage in reality testing—to the intermittently scheduled oversight of a clinical authority. If the psychiatric definition of insight hinges on a patient’s capacity to recognise themselves as mentally ill and in need of medication, adherence represents a practical and *practiced* extension of this form of psychiatric self-knowledge and a moral obligation to self-care. The production of insight is notoriously difficult, however, and it does little to contend with the world-shaking potential of a delirious encounter with the fantastic, the supernatural, and the dead.

Adding the addictive potential of psychotropic medications and the menace of heroin and alcohol to this already heady concoction further complicates the possibility of adherence-as-subjectivising apparatus when dealing with psychiatric comorbidities. As Ian Whitmarsh (2013) observes, global health discourse about chronic conditions like diabetes and obesity deploys the language of adherence/compliance as part of a larger rhetorical strategy centering the production of informed populations of health consumers rather than ‘volitional subjects’. In Saris’s meditation on the relationship between addiction and the concept of ‘appetite’, however, he notes that the medical and legal institutions that frequently take custody of his addicted interlocutors only seem to conceive of them as subjects emergent from ‘the play of uncontrolled appetites’ driving their pursuit of intoxication (2021, 104). Though these approaches to theorising the presence/absence of a ‘subject’ within their respective health discourses may seem diametrically opposed, both frame the legibility of subjectivity in relation to specific categories of drugs; furthermore, both frame the medical understanding of the twin concepts of adherence and abstinence as a site of ‘crisis’ in the informed, ascetic management of appetites, rather than the many possible causes of chronic ailments themselves (Whitmarsh 2013). Sean seems to sit squarely between these two approaches in that he articulates the double-bind of dual diagnosis and medicated subjectivity—he is beset by the demand for adherence/compliance and the management of the dangerous hunger that such a command can counterintuitively inspire.

Another of Agamben’s texts is helpful when navigating the relationship between adherence, addiction, and the problem of subjectivity. In ‘On Potentiality’, Agamben turns to Aristotle’s writings on potential in *De Anima*. Agamben writes that children possess a ‘generic potential’ to grow and mature, but he is more

interested in the expressive potential inherent to human faculties. He notes that a faculty differs from a quality such as intelligence or insight in Aristotle’s estimation in that it is fundamentally oriented toward action, skill, or power—or a bringing into being from the potential to the actual. He gives the example of a poet who embodies potential because they can exercise their faculties in such a way as to write poetry, and so the faculties of the poet, he goes on to say, can be activated via a practice or an engagement with the *work* of poetry. Alternatively, faculties can remain un-activated and in a state of privation. Agamben writes:

To be potential means: to be one’s own lack, *to be in relation to one’s own incapacity*. Beings that exist in the mode of potentiality *are capable of their own impotentiality*; and only in this way do they become potential. They *can be* because they are in relation to their own non-Being. In potentiality, sensation is in relation to anesthesia, knowledge to ignorance, vision to darkness (Agamben 1999, 182, emphasis in original).

Thinking about my interlocutors’ relationships to antipsychotics and methadone via Agamben’s ‘apparatus’ helps to frame adherence as the psychiatric production of a medicated subject. Thinking with Agamben’s writings on potentiality helps explore the relationship between antipsychosis and addiction because it opens the possibility of the being or non-being of the medicated subject qua the expectations of institutions of care.

This is not to suggest that my interlocutors make conscious and active choices to participate in or actively resist programmes of psychiatric subjectivation via fidelity to or abstinence from psychotropic drugs and addictive substances. Rather, through the lens of intermittent psychosis and the chronicity of struggle inherent to substance use disorder, they contend daily with the potential of both existence and its opposite. Through their evolving and sometimes experimental relationships to the transformative substances in question, these men and women reveal the existentiality of this doubled potential for transformation. One order of subjectivity may come into being, while another may alleviate psychotic symptoms but obliterate the forms of knowledge and experience that they represent for the patient. One form of institutionally enforced abstinence may force a reckoning with a personal history or a remembered source of pain while other substances may blot them out altogether. By negotiating the fraught relationship between the two, my interlocutors frequently revealed the extent to which they were engaged in an ‘ordeal’ of ethical and even spiritual dimensions. Their daily choices determined their access to specific forms of community and care, and the struggle of this ‘ordeal’ determined their participation in the collective practice of imagining, building, and inhabiting a shared world (Pandolfo 2018). In Sean’s case, this began

with a request for an experiment—a simple decrease in dosage, a scandalous proximity to risk, and a multitude of possible futures.

## **Medicated subjectivity, moral agency, and imagining the institution to come**

In the long stretches of silence between Sean’s words, in the lacunae that paradoxically structured the account of his life, I began to perceive the extent to which the very act of living through each day involved negotiating the limits of Agamben’s ‘privation’. I wanted to know more about Sean’s life, but I was reluctant to press him for further information about his time in Dublin’s community mental health network for fear of producing a sense of invasion or the reopening of a wound. As Franco Basaglia writes in ‘Silence in the Dialogue with the Psychotic’, his seminal ode to quietude:

If words, as the extension of ourself in the other, are born of the presence of the other before us, my body, in order to live with others, needs distance, an interval to preserve its intimacy and to defend it from the invasion of the other. The possibility of communicating, of making a modality of otherness, of having a dialogue, is strictly dependent on a spacing, on the violence of which the word is born (Basaglia 1965, 99).

Implicit in this therapeutic technique, and following the majority of Basaglia’s writings on the necessary democratisation of ‘community psychiatry’,<sup>7</sup> is an invitation to experiment with new forms of care as well as with the formal structure of the institution itself. This exploration is oriented toward the kinds of clinical spaces and relationships that allow patients to work toward ‘self-mastery’ and the possibility of someone like Sean ‘possessing his own reality, his own body, his own illness’ (Basaglia 1987b, 122). Like Basaglia, Sean seemed to imagine such experimentation taking place *within* the clinic and in dialogue with his doctors. Like so many of his fellow patients, he also seemed to be asking for a place to rest. In the hollows of the afternoon we spent in conversation, I hoped to offer Sean some of the silent recognition Basaglia describes—a recognition that allows for an ‘internal suspension, a pause’ in which a contested and uncertain existence is allowed to settle into place and gain a firmer ground (Basaglia 1965, 99).

7 I am indebted to Naomar Almeida-Filho and Nancy Scheper-Hughes’s work on Basaglia’s writings about deinstitutionalisation, as well as Cristiana Giordano’s analysis of Basaglia’s de-colonial potential. They note Basaglia’s warning that community psychiatry can ‘legitimize norms that are directly linked to productivity in advanced capitalist societies’ while also absolving the state and newer forms of institutional care of the responsibility to provide spaces of refuge for those labelled ‘mentally ill,’ ‘deviant,’ or ‘mad’ (Almeida-Filho and Scheper-Hughes 1987, 97). This analysis is integral to my thinking about how psychiatric comorbidities are treated inside the hospital and in the community.

Such a grounding was difficult to assure given that Sean’s attempts at reclaiming some control over his distinctly medicated subjectivity were troubled by the absent-presence of the dead, the overwhelming pull of heroin, and the ‘toxi-philic’ remedy promised by a daily cocktail of methadone and psychopharmaceuticals. As Saris (2013) writes on the ‘dilemma’ posed by addiction when framed as a question of will in relation to dangerous and alluring substances—and as indicated by Sean’s struggles with the narcotic pleasure that his daily treatments could produce—sometimes ‘choice leads to a lack of choice’. It was clear, moreover, that neither the patient nor the institutions of care that structured his life were interested in debating the ambiguities of the *pharmakon*. Rather, following Mattingly (2014), it was in the ‘ontological murkiness’ of the patient’s *relationship* to the substances in question and the worlds they variously opened and foreclosed, that a real deliberation began. Writing about the ontological indeterminacy at the heart of a conflict between the parents of a terminally ill child and the child’s physicians, Mattingly notes that ‘the terms of disagreement rest upon such profoundly different assumptions that a kind of moral incommensurability or, at the least a deep mutual misunderstanding, characterises it’, ultimately undercutting the possibility for recognising the very ‘terms of their difference’ (2014, 155). In asking for a diminished daily pharmaceutical regimen, Sean was also arguing that his potential for lucidity and for enduring human relationships was worth the risk that he could relapse. This simple act offered a radical challenge to his caretakers at the methadone clinic.

The doubled and redoubled existentiality of these questions must be noted. Indeed, the very nature of Sean’s encounters with narcotic oblivion and the dead who return evince questions of being itself. The murkiness of the world or worlds in which Sean’s treatment takes place, and the possibilities and impossibilities of accessing this space of experience and care, recall the disruptions to a stable sense of identity, temporality, and differentiation from external reality that distinguish R.D. Laing’s concept of ‘ontological insecurity’. I would like to think with Laing on the shattering experience of losing hold of one’s identity in the aftermath of trauma, addiction, and other calamities that can precipitate a break with a shared sense of reality. Such an experiential state can be described by the sense that:

The individual in the ordinary circumstances of living may feel more unreal than real; in a literal sense, more dead than alive; precariously differentiated from the rest of the world, so that his identity and autonomy are always in question. He may lack the experience of his own temporal continuity. He may not possess an over-riding sense of personal consistency or cohesiveness. He may feel more insubstantial than substantial, and unable to assume that the stuff he is made of is genuine, good, valuable (Laing 1965, 42).

Here Laing provides us with a phenomenological model for understanding the crumbling of a world—one that mirrors both Sean’s descriptions of the nepenthe provided by polypharmacy and the untimely returns of the dead. In the aftermath of this ontological insecurity, his request for care and his pursuit of moral agency remained suspended between two conflicting clinical demands: adhere and abstain.

When I asked Sean what he wanted most from his treatment, he answered quickly and without hesitation: to go home and see his mother and his children. He also doubted the likelihood of this reunion given the degree to which his current treatment regimen allowed ostensibly ‘licit’ medications to be used in an ‘illicit’ fashion. The methadone clinic’s polypharmaceutical care plan, and his caregivers’ refusal to acknowledge his self-professed incapacity to resist the temptation offered by his medications, were a clear affront to Sean’s ability to cultivate a sense of moral agency, a network of family support, and hope for a good life that could yet come to be. In fact, this treatment paradigm served as a daily reminder of his struggle with nonexistence. Put plainly, Sean’s capacity to be recognised as a person with agency, much less as a *good* person, was drawn into stark relief in absence of the ‘peopled opportunities’ that distinguish his understanding of a fulfilling life (Myers 2016).

Somewhat surprisingly, Sean was largely happy in St. Dymphna’s Ward, a space of exception all but defined by the stakes of psychiatric emergency and granted sweeping powers to discipline and corral patients. Under nearly continuous observation by ward staff, and without access to heroin, Sean’s request for a lower dose of psychopharmaceuticals could be honoured. In short, he could continue his experimentation with his own personal polypharmacy, but this time with something like a safety net. Strikingly, he was almost never alone in the ward.

Outside the locked ward, Sean seemed to oscillate between perennial relapse and perpetual recovery. He frequented various clinics and received near daily treatment, but the care that he received often seemed to be an invitation to a curiously specific form of self-harm. Under the auspices of the psychiatric injunction to adhere to both methadone and psychotropics, and without direct supervision, there was no space for experimentation with dosages or for building the kinds of casual, goal-oriented, and therapeutic relationships that emerge from the regular appointments that typify the treatment protocols for drugs like clozapine (Brown 2022; Jenkins 2015). Most significantly, Sean’s impasse seemed to articulate the limits of the polypharmaceutical maintenance therapy favoured by Ireland’s Health Service Executive when combatting the national heroin epidemic and psychiatric comorbidities. In the space of Sean’s life, this standard of care began to resemble chemical restraint.

Here, I want to continue interrogating the ambit of adherence by returning to questions of ontology, experimental indeterminacy, and the ethics of care. Following work by Cheryl Mattingly, Neely Myers, Elizabeth Bromley, and Jarrett Zigon—and in dialogue with Sean’s attempts at a modest experiment with the dosages of his psychotropics—I suggest that enumerating the ‘onto-ethical’ claims (Zigon 2019) that undergird the apparatus of Sean’s treatment allows us to consider this system of care as inherently political by virtue of its capacity to produce a specific kind of world. Indeed, Sean’s predicament echoes the insights of this body of work by revealing how the political stakes of this world are oriented toward the production of an equally specific kind of subjectivity and the maintenance of a concomitant definition of personhood.

As Bromley (2012) observes in her ethnography of psychiatric research on the neurocognitive processes of schizophrenia, the ostensibly epistemological work of biomedical experimentation frequently involves profound, if implicit, ontological presuppositions about the subjectivities and life trajectories of people diagnosed with schizophrenia. In Bromley’s findings, these presuppositions frequently discount the complexity of research subjects’ lives and inner worlds, at times to the point of dehumanising them, betraying an expectation that psychotic mental illnesses can produce a ‘diminished self’ through impaired cognitive capacity (2012, 168). Drawing on her work, I have begun to understand Sean’s attempts to preserve the fullness of his own cognitive capacities and family relationships—to activate a kind of relational and internal ‘potentiality’ via abstinence from opioids *and* a reduction in psychotropic medications—as an aspect of his broader interrogation of the category of the ‘patient’. In essence, I see Sean’s request as an engagement with the same kinds of experimentally mediated personhood in which Bromley’s interlocutors also traffic, revealing the onto-ethical claims that inform, emerge from, and reproduce the intersection of community psychiatry and addiction medicine. What would it mean for Sean to be less anesthetised? What forms of family and community could be cultivated or even repaired? What would be risked, and according to whom? Which forms of life could be possible?

Such experimental requests for care necessarily index experiments in institutional form. Sean never voiced a desire for directly observed therapy or a safe injection site, nor did he petition for anything so anodyne as a needle exchange. Rather, I have come to believe he was requesting a space of ‘safe emergency’ which could allow the freedom to risk non-being in the pursuit of flourishing. In so doing, he gestures toward a theory of the subject from beyond a position of ontological security; such a model of the subject is inherently oriented toward reimagining clinical space as one which operates via the logic of Basaglia’s ‘internal suspension’. As Basaglia writes of his own extended dialogue with Laing:

Laing tries to shake the individual out of his inertia from within; we try to shake the society out of its inertia through working in a particular field. Concentrating on something does not mean reifying it, and these two aspects, the subjective and the social are two sides of a single reality (Basaglia 1987a, 194).

At the convergence of Laing’s and Basaglia’s approaches to institutional reform, Sean opens such a space of critical speculation, a space where I am trying to join him. His case challenges clinicians and social scientists alike to conceive of new forms of care that can balance the epistemological and administrative commitments of biopsychiatry and addiction medicine with an openness to the existential stakes of suffering and healing. As Sean says of the times when his adherence to his medication wanes: he does not know that his father is not really there—he is simply with him—and heroin is one of the only ways out. When he does adhere, however, he frequently slips dangerously close to another sort of annihilation, namely the blotting out of consciousness and meaningful relationships. Both routes are perilous.

I cannot close with a prediction of Sean’s success or failure in weaning himself off his medications upon discharge from St. Dymphna’s Ward, much less in reconnecting with his family. The transience and precarity of his affliction and the care afforded to him—his movement from a hostel to the streets, his lack of a fixed phone number—made him nearly impossible to track down, and I worried that it would be an affront to his privacy to try to find him at the methadone clinic. As such, I never saw Sean again.

Instead, I sit with the memories of our conversation, and hope to honour his attempts to imagine the potential for another life while frankly appraising the limits of the one he was living. Far from a person incapable of discipline and a prisoner to addiction, I saw him as someone deeply capable of articulating the horizon of his capacity for self-discipline surrounding specific subjects, substances, and circumstances. In doing so, Sean was uniquely able to both request help from the institutions of care that shape his life and subjectivity, medicated or otherwise, while also looking beyond them and toward new forms of risk, relation, and possibility altogether.

## Authorship statement

Michael D’Arcy is the sole author of this article.

## Ethics statement

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