# Demystifying 'Deaths of Despair': An Interview with Medical Anthropologist Dr. Jennifer J. Carroll

*Interview conducted by Kaitlin Ugolik Phillips*

**Healthy North Carolina 2030 aims to increase life expectancy in the state from 77.6 to 82.0 by the end of the current decade. Among the most influential barriers are overdose deaths and suicide rates, which are often referred to as "deaths of despair." In this interview, Managing Editor Kaitlin Ugolik Phillips talks with Jennifer J. Carroll, PhD, MPH, about the evolution of the concept and potential levers for change.**

## Introduction

Even as life expectancy improves in other countries, the United States lags behind, and North Carolina is no exception [1]. Researchers attribute some of this trend to increasing "deaths of despair," or those that happen as a result of suicide or drug or alcohol use [2]. COVID-19 has led to increased deaths nationally and statewide since 2020, while drug- and suicide-related deaths have also continued to escalate [3].

*Jennifer J. Carroll*

**Jennifer J. Carroll, PhD, MPH**, is a medical anthropologist with appointments as assistant professor in the Department of Sociology and Anthropology at North Carolina State University and adjunct assistant professor of medicine at Brown University. She specializes in substance use behaviors, overdose, and drug policy, and refers to herself as "a harm reductionist first and an academic second." Carroll has worked in harm reduction programs, including syringe services programs, since 2004, later moving into academia in an effort to use the tools of the social sciences to better understand how to support the health of people who use drugs and foster innovative harm-reduction and prevention strategies.

Dialogue around deaths of despair has often centered on the demographics of the trend: many headlines, including in this journal, have noted the concentration of death rate increases among White, middle-aged people, especially men [4]. As Carroll discusses, however, deaths of despair are not a new phenomenon, and have been experienced by many communities in the United States and around the world for decades.

In this interview, Carroll illuminates the history of the term "deaths of despair," as well as the way our understanding of it has oscillated alongside political and cultural trends.

"Deaths of despair, as it circulates as a concept in my communities, is not new," Carroll says. "We have a lot to learn from the ways in which it has manifested over and over again."

**Kaitlin Ugolik Phillips: As a medical anthropologist, how would you define the concept of "deaths of despair?"**

**Dr. Jennifer Carroll:** *I'm familiar with the concept especially as it was put forward by Anne Case and Angus Deaton, the Princeton economists who first externalized this idea and used that term to describe it [5]. They refer back to work by Emile Durkheim, a French sociologist who many people consider the founder of the social sciences, who developed this term "anomie" that Case and Deaton refer to, and connect that to the idea of deaths of despair [6]. It's this concept of being disconnected, not feeling like you're integrated, not feeling like you have a purpose.*

**Phillips: Is this a concept you've encountered a lot in your research?**

**Carroll:** *There's a very similar phenomenon that we've seen in Russia. We saw huge drops in life expectancy among middle-class men in Russia following the dissolution of the Soviet Union. The very narrow, specific, gendered role [of men in that society] is less available now, and yet men are still raised in a culture that tells them they're supposed to fill it. So, you end up with a combination of more depression, more alcohol consumption—you know, anomie.*

*The* way *in which we notice things like deaths of despair tells us as much as the content of what we notice. Angela Garcia*

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*published a book in 2010 called* The Pastoral Clinic *about opioid use and overdose, and people cycling through bouts of treatment, depression, and return to use in the Hispano community in Española, New Mexico [7]. The way she describes what was happening in that community in the early 2000s fits the definition of deaths of despair; these are individuals who, through US policy and through US expansion, have been dispossessed of land, dispossessed of culture—a profoundly marginalized and oppressed group of people. Garcia very pointedly made this critique at a conference—she was very rightfully angry, saying, "My community was in crisis decades ago. Where was the moral outrage with that?"*

**Phillips: It sounds like people have been suffering from what we now call "deaths of despair" for a long time. Why do you think we seem to be repeating history with this?**

**Carroll:** *Our current mainstream medical and psychological institutions have sort of discovered and forgotten, and rediscovered and forgotten, PTSD [post-traumatic stress disorder] multiple times. Deaths of despair, as it circulates as a concept in my communities, is similarly not new, and we have a lot to learn from the ways in which it has manifested over and over again. There are very, very clear patterns. It is a common, normal, repeated, and frequently observed response to the oppressive structures that we set up acting as intended. We have a long and steady history of not taking care of each other in capitalist society.*

**Phillips: To put this in the health policy context, when we're looking at the death data and the life expectancy impact, is what's different now just the frame, the willingness to talk about it and to address actual experiences?**

**Carroll:** *I think that's absolutely correct, and I think there's a lot of misrecognition happening that makes things worse. I am on the advisory board for the [self-described drug users' union] North Carolina Survivors Union, and at their behest I undertook some interviews with a women's hepatitis C mutual aid group. What stood out to me was that their access to health care was so precarious that they were almost afraid to move. They were developing these incredible strategies [to avoid medical stigma in their interactions with clinicians], and every now and then—not often, but every now and then—one of these women would experience a successful health care interaction. Someone would actually treat the slipped disc or take their life-threatening spinal abscess seriously, or they were screened and diagnosed with and treated for hepatitis C with no stigma, with no negative interactions. If you asked them how to go out and reproduce that positive interaction, they couldn't tell you, because the way they are treated is so unpredictable and so typically negative. I think that we have a lot of policies that are creating this need for people to scramble and develop strategies for helping themselves that are way more complex than they need to be.*

*I also think our drug policy tends to go after the* symptoms *of people not being taken care of, as opposed to the* fact *that people aren't being taken care of. One example is the fact that we're having conversations in our state House about "death by distribution," about enhancing criminalization of fentanyl distribution [8], while we still do not have accessible health care—like Medicaid for all—which is what folks actually need. When death by distribution was being debated, I testified before the judicial committee and told them that if they passed this law, the prevalence of fentanyl in the drug market in North Carolina was going to skyrocket. We have a mountain of evidence that tells us that criminalization does not change* whether *people engage in criminal behavior, it changes* how *they engage in criminal behavior [9].*

**Phillips: Do you have any recommendations for policies that you believe will work to reduce deaths related to substance use and overdose?**

**Carroll:** *We need to expand Medicaid, we need more money in schools, we need child care, we need paid parental leave. But housing is the biggest issue. I have talked to recovery coaches, treatment providers, and harm reductionists across the state, and the biggest thing that people say is, "How are you supposed to think about going to detox and starting medication if you're living on your friend's couch? How are you supposed to go through your court-ordered treatment if you don't know where you're going to put your head?" That's not being addressed meaningfully, but we're spending a ton of time making sure that people know we're going to take their kids away if they smoke pot. When we go after the symptoms of the crisis that people are experiencing with those punitive drug policies, we are totally missing the point.*

*I also really, really hope that we are able to build up some meaningful things that do not require, endorse, or facilitate connection with the criminal justice system. I think we need to get out of our mindset that people will quote-unquote "straighten up" if we create an environment in which they experience negative consequences for not doing so. We also need to come to terms with the fact that incarceration drives overdose. We're not helping anyone by prosecuting them or making them spend a night in jail "for their own good."*

*The solution is being able to connect people with strategies that are more effective for meeting their own needs than what they're doing. Fortunately, we live in a society where more doors are opening up every day into better strategies, and we know that harm reduction programs are the most trafficked pathway into behavior change [10]. Harm reduction is where I put my money—literally and figuratively—and the state should absolutely do the same.* NCMJ

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