

## ONE Graveyard

### PAST AS PROLOGUE

The heroin detoxification clinic lies at the end of a typical road in the Española Valley. Little more than a path, the road is unpaved, deeply rutted, and strewn with shards of broken glass. Pack dogs roam along it and are prepared to chase—for a few moments at least—the occasional passing car or three-wheeled ATV. Crumbling adobe houses line the road, abandoned for newer trailer homes. The adobes and the trailers sit adjacent to one another, marking a transition between generations. Both are set on small plots of land once used for cultivating squash, chile, and corn. Like the adobe, artifacts of a prior agricultural life remain: there is the ubiquitous tractor, broken down and stripped of its tires; the empty storage shed, once brimming with apples. Both

appear to be sinking into the land from the force of years, sun, and neglect.

The road to the clinic is like any other. Except for a small hand-painted sign that reads "Nuevo Día," there is no obvious indication of institutional presence or, for that matter, of heroin.

The clinic spans several buildings. First, there is the cluster of small adobe houses, whose curved, earth-colored walls closely resemble the traditional architecture of the region. These surround a much larger, central building, whose gray-painted exterior and crisp lines suggest an institutional aesthetic. Like the adobe and the trailer, the juxtaposition of the clinic's structures suggests a transition from tradition to modernity, intimacy to order. During the early stage of its operation, the detox program was fully located in one of the adobe houses and was affectionately referred to as "la casita," the little house. However, as the program expanded to accommodate an increased patient load, it was moved into the larger building, and the term *la casita* fell out of use.

In the past the clinic was a state-run residence for mentally ill adolescents named Juniper Hills. Its patients were primarily from the Española Valley, and they suffered a range of afflictions—bipolar disorder, depression and schizophrenia, physical and learning disabilities, substance abuse. Many had a history of physical or sexual abuse, and some had had run-ins with the law. Despite its idyllic name, Juniper Hills led a troubled existence. It was underfunded, short-staffed, and overcrowded. The structure displayed scars wrought by its previous inhabitants: fist-sized holes in plaster walls, obscenities etched into windowsills. By the time I arrived, it was hard to tell to which institutional generation the scars belonged.

According to a former patient attendant at Juniper Hills, the sheriff's department was frequently called in to settle fights, or to take away the most unruly or the suicidal. Most of the kids would return after a few nights in juvenile detention, or "5150," the code for involuntary psychiatric evaluation. The sickest patients, the attendant said, "stayed inside like chickens," pecking at themselves and at each other, while the health-

ier patient  
facility's ex

The att  
Hills—the  
since grad  
he was "go  
unsettling

western bo  
stowaways  
within a fe  
off again, u  
along the p

It is said  
of the Juni  
fire and the  
similar ord

The girl  
and star  
room. Bu  
burned.  
Eventual  
late . . . r

I consul  
dence" of  
still scorch  
the buildin  
at its blacke  
inside was

Over tim  
herself as a  
means to si  
ent.<sup>1</sup> Flowin  
sorrow, help  
cals to talk

ier patients sought refuge outside, spending long hours wandering the facility's expansive grounds.

The attendant was eighteen years old when he worked at Juniper Hills—the same age as many of its patients, some of whom he'd known since grade school. During his period of employment, he said he felt that he was "going crazy" himself, a feeling he attributed to the institution's unsettling environment. He recalled the lure of the Rio Grande, on the western boundary of the facility. Patients often escaped to the river like stowaways, wandering upstream or down. Most of them would return within a few hours; they had nowhere else to go. Usually, they would set off again, until a tall chain-link fence topped with barbed wire was erected along the perimeter of the grounds.

It is said that a young girl diagnosed with schizophrenia set fire to one of the Juniper Hills buildings. According to the stories, she died in the fire and the facility closed. Numerous people recounted the story to me in similar order and detail, which went something like this:

The girl was depressed, crazy. One night she locked herself into a room and started lighting matches. Her clothes caught fire and so did the room. But the girl didn't make a sound. She stayed quiet, even while she burned. Clearly, the girl just wanted to die, you know what I mean? Eventually, the other patients smelled the smoke, but by then it was too late . . . no, I don't remember her name.

I consulted police reports and newspaper archives looking for "evidence" of the story. There was only the building itself; its walls were still scorched from the long-extinguished flames. For months, I visited the building as if I were visiting the grave of an estranged friend. Staring at its blackened walls, I imagined that the fire was still raging, that the girl inside was burning, and that the flames she started had spread to me.

Over time I began to understand the story of the girl who immolated herself as an allegory for the precariousness of Hispano life and as a means to situate the multiple and overwhelming wounds of past and present.<sup>1</sup> Flowing through locals' recounting of the fire were sentiments of sorrow, helplessness, and rage. The story of the girl seemed to enable locals to talk about their deep ambivalence toward the very presence of the

institution along the Rio Grande and their collective failure to have cared for such a girl, whatever her name may have been, or will ever be. Like the Mexican folktale of *La Llorona*, the Weeping Woman, the story's continued circulation seemed to insist that *we* must all be more careful next time—that we must listen more closely for the girl's silent cry.<sup>2</sup>

After its closure Juniper Hills was again transformed, this time into a *picadero*, or shooting gallery. Several addicts described it to me as a perfect setting for heroin binges. Parts of the facility were relatively intact, providing shelter from sun, rain, or snow. There were beds, forgotten medical supplies, and bathroom mirrors, the latter of which enabled addicts to inject heroin into areas of the body that were otherwise impossible to see. Juniper Hills remained a popular *picadero* even after the rodents, mold, and asbestos set in. Eventually, county officials considered condemning the building, but a 1999 special congressional hearing on the region's heroin problem identified it as a potential site for a much-needed drug treatment center.<sup>3</sup>

Five years later Nuevo Día's detoxification clinic opened its doors.

The opening of the clinic was celebrated with much fanfare. Musicians performed traditional *rancheras* as journalists and state politicians toured the facility, carrying with them paper plates heavy with tamales. County representatives spoke movingly about the opportunity to stem the endless tide of heroin overdose, and many recounted their own struggles with alcohol and drug addiction. A prayer for healing was murmured. With the cutting of the yellow ribbon, the troubled memory of Juniper Hills was laid to rest and Nuevo Día was born.

The year Nuevo Día opened there were forty fatal heroin overdoses in the Española Valley, testament, in part, to the inadequacy of addiction services in the region. At the time those services included two residential recovery programs with a length of stay ranging from two years to less than thirty days, several outpatient programs that rely on Twelve Step Fellowship principles, and a harm reduction program specializing in needle exchange and methadone maintenance. At one point there was

one residential program that experienced several deaths, and a program that was permanently in violation of the safety of patient care.

Despite the problems broached in the program, a major component of the rehabilitation services is initially for drug addiction, with parts of the stay lasting up to six months. They were made possible by funding stemming from the state's "patients" who were necessary in order to run the program.

Given such a situation, the clinic was the first detoxification clinic focused on heroin addiction, a medical model that it considered significant. Certain events were celebrated as Behavioral Health developments as a result, and seemed healed.

The timing of the clinic's opening to New Mexico was significant. It was a work as a detoxification program in the evening, and the opening at the clinic was significant for addiction, re-derstanding

one residential alcohol detoxification facility in the valley. The center experienced several temporary closures between 2003 and 2006. It was closed permanently in 2007 as a result of conditions that placed the health and safety of patients at risk.

Despite the many psychological and emotional issues that are often broached in the context of drug addiction, mental health was not an integral component of these programs.<sup>4</sup> Nor were educational or vocational rehabilitation services. Also lacking were detoxification facilities explicitly for drug addicts; heroin addicts were referred to facilities in other parts of the state, many of which had waiting lists ranging from three to six months. Significantly, these referrals were court ordered—that is, they were made in the context of an addict's legal troubles, most often stemming from a drug-related offense. In many instances prospective "patients" were forced to remain incarcerated for a longer time than necessary in order to facilitate their entry into a residential recovery program.

Given such dire circumstances, the opening of Nuevo Día's detoxification clinic was significant on both practical and symbolic registers. It was the first detox facility in the region specifically for drug addicts that focused on heroin addiction. It was also the first to promote and use a medical model for detoxification by offering anti-opioid medications and what it considered a "clinical setting." The clinic's "modern sensibility" signified certain cultural, economic, and medical advancements that were celebrated in a historically impoverished and drug-weary region. Behavioral health workers and locals in general embraced these developments as a major step forward. The wound of Juniper Hills finally seemed healed.

The timing of the clinic's opening was fortuitous. I had just returned to New Mexico to begin ethnographic fieldwork on the region's epidemic of heroin addiction and felt lucky to be among the first people hired to work as a detox attendant. My shift was the "graveyard"—six o'clock in the evening to seven o'clock in the morning—and I hoped that by working at the clinic I would be afforded an "insider" view of the intimacies of addiction, recovery, and institutional life. I wanted to gain a deeper understanding of the acute physical and psychic aspects of heroin addiction

and recovery, especially as they are experienced in an institutional setting. Given how deeply entrenched heroin had become in the valley, I wondered if the workings of institutional life reflected or differed from the world "outside." Could the clinic provide enough of a counterpoint to the pressures of addiction and everyday hardship to enable addicts to begin the process of recovery? What might such a process look like? Or was the very idea of an alternative to the harsh realities of addiction naive, even counterproductive?

The night before my first shift a heroin addict named James advised me that I should quit before I even started, that "detox attendant" wasn't the kind of job that afforded the luxury of time to "think," which is how he understood my role as an anthropologist.<sup>5</sup> I met James at a Narcotics Anonymous meeting. He was a "*veterano*," or longtime heroin user, a respected status that implied he'd witnessed and experienced the harsh realities that accompany addicted life. Over the course of my research, I often turned to James for advice with my project. He was a practical and protective man and discouraged me from working the graveyard shift. What are you going to do, James asked, when an addict from the village of Chimayó gets in a fight with another addict from the village of Hernández? Or, what are you going to do when you're the only "authority" in the middle of the night, and someone breaks into the clinic in a desperate attempt to deliver a heroin-filled syringe to a detoxing lover? Or, what are you going to do when someone jimmyes the lock to the medicine cabinet, swallows a bunch of pills, and starts convulsing? The scenarios James offered (which were, he said, based on years of "experience") were endless, and with each he warned: There's no time to *think*, Angela. *What are you going to do?*

It turns out that James was both right and wrong. He was right that urgent situations arose requiring immediate and unconsidered responses. But these situations, and how I responded to them, would form the basis of my thought. In what follows I sketch the first emergency that I encountered, one that James did not anticipate but that nevertheless offers an entry for considering the structures and fractures of clinic life.

PRIM

There  
tonwo  
sun. I  
Dr. Bu  
store  
tomec

I a  
attenc  
beans  
four v  
wash  
her sh

I s  
tailed  
I was  
Copy  
A. G.  
port.

M  
ing n  
detox  
Two  
medi

Resic  
Libri  
patie  
Hald  
respe  
both

M  
Patie  
tion,  
ligra

## PRIMAL SCENE

There was no indication of turbulence that afternoon. At home, the cottonwood leaves shivered in the breeze and the dogs lay belly-up in the sun. Reluctantly, I drew the shades to shut out the bright June light. Dr. Bustos, the clinic's medical director, had suggested a midday nap to store up energy for the long night ahead, but my body was unaccustomed to these new hours, and I found it impossible to sleep.

I arrived at the drug detox clinic at 5:30—just as Maria, the day-shift attendant, put away the evening meal. She offered me a bowl of pinto beans and warmed a tortilla. The beds were full, she said. There were four women and six men, eight heroin addicts and two alcoholics. As she washed dishes, Maria reported that nothing unusual had happened on her shift and that the patients had retired to their rooms.

I signed into the Daily Log—a wide-ruled spiral notebook that detailed the events of the day. It was my first shift, and I didn't know what I was supposed to write, so I flipped through previous entries for clues. Copying the language of earlier entries, I wrote, "June 9, 2004. 5:45 P.M. A.G. assumes shift from M.G. M.G. says there is nothing unusual to report. Patients resting. Facilities secure."

Maria led me into the nurse's station—although at the time and during much of my employment there was no nurse, only minimally trained detox attendants such as myself. We reviewed the medication schedule. Two tablets of the muscle relaxant Robaxin and four tablets of Vistaril, a medication for panic disorder, were to be given at midnight and 6:00 A.M. Residents in Dorm One were to receive fifty milligrams of the sedative Librium at 10:00 P.M., followed by doses at 2:00 and 6:00 A.M. Five patients were to receive three milligrams of the antipsychotic medication Haldol at 9:00 P.M. and 6:00 A.M., and all patients were to be given their respective SSRIs, prescribed for the treatment of depression, anxiety, or both.

Maria showed me a corresponding graph of the medication schedule. Patients' names and ages were in one column, and in another, medication, dosage, and dosing hours. Some indications were notated in milligrams, others descriptively—by the color and shape of pills. The graph

was incomprehensible and sent me into a panic. What if I incorrectly dosed patients? Maria told me not to worry, that the patients knew exactly what they needed; they were experts in their own treatment.

"Just don't let them fool you," she said.

The night attendant's station was an L-shaped desk located where two hallways met—one led to the men's dormitory, the other to the women's. Beneath harsh fluorescent lights, the hallways glowed like highway tunnels. I instinctively felt the need to shield my eyes when I walked to and from the rooms.

The hallway lights washed over the attendant's desk, where I was to remain throughout the night, monitoring the patients and recording events in the Daily Log. During my orientation, I was warned that sleeping was grounds for termination. I wondered how an attendant could possibly sleep with the shock of those lights, especially after hearing the famous "graveyard stories" and their gruesome details: patients jumping out of dormitory windows; rival gang members stabbing each other in bed; desperate addicts overdosing on stolen bottles of rubbing alcohol. I wasn't worried about falling asleep.

Within seconds of Maria's departure, closed doors opened, and patients emerged from their rooms. From my station I watched men and women shuffle down the hallway in slippers. They moved toward me unsteadily and met my greetings with silence or high-pitched requests for "algo," "something"—something to take the pain out of legs, arms, and backs contorted by the absence of a fix. Even before introductions were made, I could tell the heroin addicts from the alcoholics by the way clothes hung from bodies. My initial assessments were confirmed on closer inspection—by the fresh track marks and swollen abscesses on arms, hands, ankles, and necks.

For the next three hours I deflected growing demands for *something* by filling bowls with vanilla ice cream and permitting the use of a boom box. Soon, the sounds of Tejano and hip-hop music filled the clinic. Though the volume was turned up high, the music inspired no movement, no

recognition.  
fixed on a cl  
named Yvet  
Together, w  
plane.

By 12:30 i  
ication to br  
mon room, I  
ing chair. A  
by time and  
grab his thi  
his limbs w  
and apolog

"I can't h

"It's oka

We both  
sedative. In  
scribed the  
coursing th

"I can't

I went in  
into a curre  
the clinic's  
tant to tak  
rooms, of c

Sitting  
vomit and  
lay crump  
a strong c  
bathing, I

Sudden

Blacko  
but there  
the hallw  
too, and t

recognition. The patients sat motionless on tattered couches, their eyes fixed on a clock hanging high on the wall. At one point a young addict named Yvette said that she felt like we were stuck on a deserted island. Together, we waited for the dosing hour like the arrival of a rescue plane.

By 12:30 in the morning everyone but Peter had received enough medication to bring about a thick veil of sleep. Peter sat with me in the common room, nervously extending and closing the leg rest of an old reclining chair. Although he was only twenty-nine, his body looked shrunken by time and pale against the chair's rough orange fabric. I watched him grab his thighs and punch his arms with shrunken fists. The spasms in his limbs were clearly worsening. Peter cried out in pain, cursed God, and apologized for the vulgarities.

"I can't help it," he said.

"It's okay," I answered.

We both knew it would be hours before he could get another dose of a sedative. In any event, the last dose hadn't offered any relief. Peter described the pain as razor blades ripping through his legs, electric bolts coursing through his spine.

"I can't take it anymore," he cried.

I went into the men's bathroom and drew a bath, sprinkling Epsom salts into a current of warm water. In the absence of more effective anti-opioids, the clinic's part-time doctor encouraged salt baths. But patients were reluctant to take them, dreading the sting of stripping naked in brightly lit rooms, of cold porcelain against burning skin.

Sitting on the edge of the tub, I watched the water level rise. Dried vomit and diarrhea caked the rim of the toilet. A pair of soiled underwear lay crumpled in the corner of the room. Windowless, the bathroom had a strong odor of feces and cheap air freshener. Another deterrent from bathing, I thought.

Suddenly, the lights went out.

Blackouts in the northern villages were fairly common during storms, but there were no rains that night. I shut off the faucet and turned toward the hallway. The emergency lights and the outdoor floodlights were out, too, and the clinic was encased in darkness. Staggering around furniture,

I opened the blinds in the common room and the nurse's office to let in the glow of the receding moon. A swath of milky light cut across Peter's legs. I was relieved to see that he was still sitting on the reclining chair because, for a moment, I wondered if he had intentionally cut the power.

At night the villages of the Española Valley are dark enough, even with electricity. There are only a handful of streetlamps, and these are a dim yellow—like the streetlights I'd seen in Mexican barrios or South African shantytowns. And these village lights illuminated only the most dangerous intersections—State Route 582 and County Road 1040, for instance—a junction marked by shattered glass and handmade memorials, *descansos*, that plead, "Rest in Peace." Even with electricity, one is guided by the memory of curves and ruts, by the glow of car headlights, by the wash of moon.

That night, the entire village had lost power. There were no candles or flashlights—I quickly discovered that the clinic had no emergency supplies whatever—and it would be at least five hours till morning.

"I can't take this anymore," Peter cried. "I can't fucking take the pain in my legs no more."

The bath was now out of the question. I approached Peter and lightly touched his calf. He grew still. Tentatively, I pressed the palms of my hands against his thigh, wrapped my fingers around his legs and squeezed. I had seen strung-out addicts touch each other in the same way.

Peter's thighs felt brittle beneath his thick sweatpants. His knees were swollen and stiff. Peter wept as I massaged his legs. He apologized for his weeping. He asked me to squeeze his feet and hands, and he apologized for those requests, too. He apologized for his pain.

The darkness obscured the wall clock, and I couldn't tell what time it was. I told Peter this. "Take me outside," he said. I helped Peter from the recliner, careful not to pull his arms too strongly. The stars and the moon

gave off a hazy  
wood trees tha  
during the day  
ments of silenc  
dered if he rea  
o'clock was th

"You can te  
"The one usefu  
like a firefly b  
heroin fifteen

I looked up  
should go bac

"Let me sm

We stood t  
tered quiet ob

Fortunately

before the bl  
solute, and I

room. I open  
*Pauline, Lupe,*

across the da

Yvette asked  
sleep. When

fours, groani

"It's all my

"Come ou

"It's all my

I touched

"Would yo

"Come ou

Peter craw

other, facing  
for warmth.

the time. We

across the sk

gave off a hazy light. We could see the blackened outline of the cottonwood trees that lined the Rio Grande and the chairs that patients sat in during the day, shivering in the sun. Peter looked up and, after a few moments of silence, announced that it was about two in the morning. I wondered if he really knew this or if he said so because he knew that two o'clock was the dosing hour.

"You can tell by the stars," he said, pointing upward with his hand. "The one useful thing my father taught me." The tip of a cigarette glowed like a firefly between his fingers. Peter's father had introduced him to heroin fifteen years ago, when Peter was fourteen years old.

I looked up, but I was unable to make sense of the night sky. "We should go back in," I said.

"Let me smoke my *frajo* [cigarette] first."

We stood together in the predawn light. I listened to Peter as he muttered quiet obscenities between drags on his cigarette.

Fortunately, I had measured out the 2:00 A.M. doses in tiny paper cups before the blackout occurred. Still, the darkness of the clinic was absolute, and I struggled to carry the medication and water from room to room. I opened doors, shook shoulders, and called out names. *Yvette, Pauline, Lupe, Marcos, Andrés, Mikey, Arnold*. The patient's hands reached across the darkness for their small cup of pills. "Where the fuck is it?" Yvette asked as she grabbed at the air. Everyone but Peter returned to sleep. When I returned to the common room, he was squatting on all fours, groaning.

"It's all my fault," Peter cried. "It's all my fault. It's all my fault."

"Come outside with me," I said.

"It's all my fault."

I touched Peter's back. His shirt was drenched in sweat.

"Would you do it again?" he asked. He wanted me to touch him.

"Come outside with me." I didn't want to touch him anymore.

Peter crawled to the door. Outside, I placed two chairs alongside each other, facing the river. It was cold, and we huddled beneath a bedspread for warmth. Every once in a while I asked Peter to look up and tell me the time. We did this until dawn, when the first light streaked orange-red across the sky.

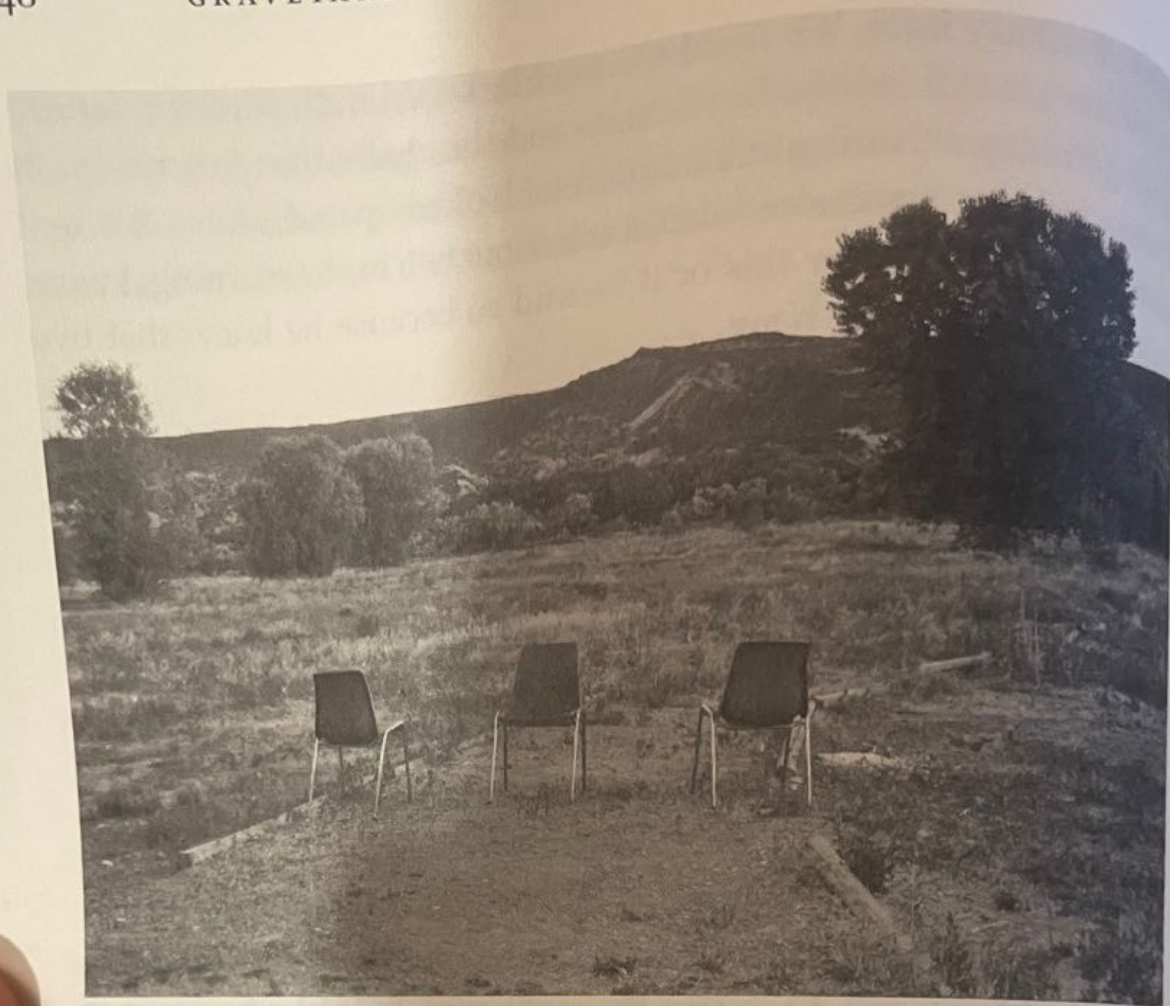


Figure 2. Waiting room. Photo by the author.

#### QUESTIONS OF COMMENSURABILITY

The incommensurable relation of one to the other is the outside drawing near in its separateness and inaccessibility. Desire, this pure impure desire, is the call to bridge the distance, to die in common through separation.

Blanchot, *The Writing of Disaster*

I spent the better part of my first graveyard shift in absolute darkness. The blackout had a dramaturgical effect, amplifying the precariousness of the life of the addict, the vulnerability of institutional life, and the instabilities and anxieties of subjects caught within. It also amplified the precariousness of my relation to Peter and the uncertain nature of our responsiveness to each other. The tempo and feeling of our subjective posi-

tionings c  
were thro  
can be pro

Thirteen  
cause of th  
Daily Log  
hours una  
record kee

June 10,  
power u  
toms. A  
as indic

While suc  
keeping, i  
of that nig  
and anxie  
night's un  
thing," I w  
pass the ti  
ached non  
sentments

What d  
main in ea  
of experie  
again, ber  
light by w

Though  
serted isla  
aloneness.  
haps most  
bodily exp  
who are  
consuming  
ous system

tionings could not have been more different. Yet the situation that we were thrown into made me question whether singularity and difference can be productive of care, even commensuration.

Thirteen hours after I began my shift, I finally prepared to leave. Because of the blackout, I had not recorded the details of the night in the Daily Log. When the day-shift attendant came on duty she noticed the hours unaccounted for and asked me to "fill in the blanks" for the sake of record keeping. I wrote:

June 10, 2004. At approximately one A.M., the clinic lost power. No power until morning. Peter D. experienced severe withdrawal symptoms. All other clients appeared to sleep comfortably and were treated as indicated.

While such a summary was sufficient for the purpose of clinical record keeping, it was a woefully inadequate representation of the complexity of that night. It did not mention the cries or the touching, the confusions and anxieties. Instead, I struggled in my field journal to reconstruct the night's unfolding of events and emotions. "They all cried for *something*," I wrote. "*Some thing* to take the pain away, some thing to help pass the time." And: "I did not ache the way I imagined they did, but I ached nonetheless. The ache was caused by their stares, spasms, and resentments. By time itself."

What does it mean for a patient and attendant-anthropologist to remain in each other's presence from within such radically different sites of experience? And what does it mean for the institution to find itself, again, bereft of the power to provide one of our most basic needs—the light by which to see?

Though we were all together—stuck, as Yvette suggested, on a deserted island—what I think we shared most was a terrible feeling of aloneness. This aloneness, or singularity, operated on many levels. Perhaps most significantly, for patients, it is most powerful in terms of the bodily experience of detoxification itself. Science has shown that addicts who are physically addicted experience detoxification as an "all-consuming pain"—one of the consequences of the changes in the nervous system induced by long-term heroin use.<sup>6</sup> This "hyperalgesic state"

has both physical and mental effects, including violent abdominal cramping (often leading to uncontrollable diarrhea), the sensation of burning in the arms and legs, severe headaches, physical agitation, and feelings of anger and depression. In the early stages of withdrawal, patients experience uncontrollable physical and vocal disturbances that closely resemble the symptoms of Tourette's syndrome. They may hit themselves, pull their hair, and scream vulgarities. An addict I spoke with who emerged from this state described those first days as "the worst possible hell, especially since you know you can just *fix it*." Perhaps that is why the request for *something* has such an urgent appeal; it represents the possibility of something else, something beyond the pain.

Although patients may collectively feel pain, they do not share it. The pain forms a kind of inconsolable solitude. Jean Cocteau's diary of opium addiction, composed while he was undergoing "the cure" in a Paris clinic, contains drawings that come close to expressing the inferno of pain that detoxification entails. There are images of screaming mouths, contorted limbs, and decapitated bodies. "I am describing a wound in slow motion," Cocteau (2001: 18) writes of his detox experience. In his images and words, he is entirely alone.

Within the clinic the question of shared pain was more than physical. It concerned the possibility of an ethics of commensuration among dispossessed and singular subjects who are consigned together under the sign of "recovery." Can singularity and dispossession produce commensuration and healing? Or are these states best interpreted as irresolvable symptoms that are produced, in part, by the institutional contexts in which subjects are made to live?

I was first confronted with the need to imagine a sociality based on incommensurate experience and subjects the night of the blackout, when Peter and I sat beneath a blanket, waiting for morning. The separateness of Peter to myself, the darkness of each hour, the tension in his limbs versus the tension in mine—all of it was, for lack of a better word, utterly *human*. In the clinic I would also witness such expressions in the fleeting moments between patients—in the way addicts touched each other's aching limbs or the way they regarded each other's tattoos. I witnessed it when a group of women gathered around a mother who

had ju  
overdo  
These  
of care

A P U

I have  
dant b  
of my  
clinic  
strateg  
us—bu  
cesses  
"prima  
trative  
tional  
the clin  
prevail  
mensur  
and th  
peutic

I vie  
visory  
during  
has res  
place a  
must e  
tion an  
experie  
courage

had just learned that her daughter, also a heroin addict, had died of an overdose. They were moments of rupture and of shared singularity. These were moments when I could imagine the possibility of a new kind of care.

#### A PURGATORIAL ZONE

Have I been here before? Oh God, I've been here before.

Lucretia Martinez, on her first day of heroin detox

I have provided a detailed recounting of my first night as a detox attendant because it stands out as an early and formative event in the course of my fieldwork that operates as a sustained reflection on the terms of clinic life. My use of the Freudian notion borrows from its interpretive strategies wherein events or memories that have made certain claims on us—but that are not entirely clear—are rendered visible through processes of recollection and elaboration.<sup>8</sup> I work with the idea that the “primal scene” described above—its staging and its subjects—is illustrative of the many material and personal vulnerabilities of institutional life. Of particular interest to me in this regard are the effects of the clinic’s technical instability vis-à-vis an enduring pastoral setting, the prevailing sense of uncertainty that pervades the everyday, the commensurability and incommensurability of experience between subjects, and the ways these features structure the interpersonal and the therapeutic domain.<sup>9</sup>

I view the clinic as a kind of purgatorial zone—an interstitial and provisional place where patients are made to wait and reflect on life before, during, and beyond their institutionalized present. My use of the term has resonance with Roman Catholic doctrine, where *Purgatory* denotes a place and condition of suffering inhabited by the souls of sinners who must expiate their sins before going to heaven. The idea here of redemption and salvation provides a powerful metaphor for clinical life: patients experience an anguished state of “waiting” during which they are encouraged to look back at their past. This process of looking back is not

for purposes of interpretation, in a psychoanalytic sense; rather, it is to make amends and to break with one's past life in order live a more healthful, and moral, future.

I saw patients protest against the purgatorial zone in which they were placed. In words and gestures, they insisted that the past was forever in their present and always already embedded in their future. How can one imagine a "future life" that depends on a radical break from these infinite temporal flows (Bergson 2000)?<sup>10</sup> Could the clinic's attempts to dis-aggregate time make possible a "temporality of second chances" (Das 2006: 101)? How might the *other* spaces and conditions in which patients were entangled, such as those on intimate and juridical registers, affect such a possibility? Finally, how do the needs of the physical body, which is a central part of both Catholic and therapeutic modes of redemption, disrupt the possibility of "salvation," or in this case, recovery.

To think of the clinic as a kind of purgatorial zone, it is important to examine life beyond clinic walls, to integrate previous social contexts and events through which the institutionalized present takes form. The analytic and ethnographic mode I use here is therefore dynamic. It moves in and out of different temporal and physical settings and introduces different patients that I came to know during my work at the clinic. The point of this movement is to map the multiple and intersecting forms of vulnerability in everyday life and to show how these forms reflect and mediate the experience of vulnerability within the clinic itself.

What contributed to the clinic's purgatorial sensibility is that it was a part of a larger governmental apparatus, one that bridged psychiatric and penal systems, and was thus structured by the concerns of these sometimes conflicting, sometimes parallel domains. Although most of the addicts receiving treatment were court appointed and referred to as "patients," they often identified themselves as "prisoners." They were aware of mental and behavioral health's symbiotic relationship with the law, just as they were aware that their addiction was linked to the ways that "gatekeepers" in both fields imagined addicted lives and which

influenced their exceptionally high pending on whether could either be termination, or another treatment. The informal co its attendant involve a precipit or death. Signi completed" the one program a heroin use with of these indivi tional treatment

The clinic pr live in purgato and openly by want to take a return to the cl come to incorp as a means to f

#### A DIFFICULT

One summer at home to as specifics, he sa Within minute clinic, which v

When I arri rette. Lucretia told me matte been through

influenced their futures. The stakes, then, for the patient-prisoner were exceptionally high, and there was an implicit understanding that, depending on what happened during the course of one's "program," life could either be made or unmade. The formal consequences for treatment termination, or self-discharge, included prison, institutionalization in another treatment or psychiatric facility, and the loss of child custody. The informal consequences generally included a return to drug life (and its attendant intimate, economic, and social wreckage), which might involve a precipitous increase in drug use, sometimes leading to overdose or death. Significantly, the outcome for patients who had "successfully completed" their treatment programs was similarly grim. According to one program analysis, nearly 90 percent of so-called successes resumed heroin use within two years of program completion, and more than half of these individuals returned to the clinic one or more times for additional treatment.<sup>11</sup>

The clinic provides fertile ground for exploring the question of how to live in purgatorial spaces, as well as the question—expressed frequently and openly by patients—of whether a "future life" was worth living. I want to take a detour now and introduce Lucretia, a woman whose failed return to the clinic after "losing everything" suggests how some patients come to incorporate the very idea of purgatory into their drug narratives as a means to forever suffer that which was lost.

#### A DIFFICULT PATIENT

One summer afternoon, one of the clinic's counselors, Beto, called me at home to ask for help admitting a "difficult patient." Without giving specifics, he said that the presence of a female attendant was necessary. Within minutes I was driving down the stretch of dirt road that led to the clinic, which was a mere mile from my house.

When I arrived at the clinic, Beto was waiting outside, smoking a cigarette. Lucretia hadn't arrived yet. Between drags on his cigarette, Beto told me matter-of-factly that Lucretia was his half sister and that he had been through this routine with her too many times. Inside the clinic,

patients talked about Lucretia's imminent arrival. They all seemed to know who she was, and they all anticipated that she would be in terrible shape. She was.

Lucretia was escorted into the clinic by a police officer. She was without shoes, and her feet were coated with dirt. A terrible odor surrounded her. "She shit her pants," the officer said.

A solicitous female patient named Marcy quickly offered a pair of her extra sweatpants. As she ran off to the women's dorm, the circle of spectators that had gathered around Lucretia began to break away. Beto stood there for a moment and stared wearily at his sister. Then he asked me to take her to the bathroom and prepare her a bath. I extended one of my arms around Lucretia's narrow shoulders and guided her down the hallway. "Who are you?" she asked me, a mess of black hair covering her eyes.

As we walked to the bathroom, Lucretia began to violently cry out, "It won't work, it won't work." She said she knew where she was, and, no, it just wouldn't work. I sat her on the toilet seat, turned my back to her protests, and prepared a bath. To my relief, Marcy joined us and helped me remove Lucretia's soiled clothes. We eased her trembling body into the bath. The water quickly turned brown, as if colored with drops of dye. Marcy poured water over her back and head. All the while, Lucretia shivered and repeated her cry of hopelessness.

I stayed at the clinic that night, checking in on Lucretia every few hours. She stayed in bed the whole time and refused conversation, meals, and medication. The following morning, as I prepared to leave, I wrote in the Daily Log, "Concerned about L. M." When I returned for my next shift, Lucretia was gone. Her patient file contained a note that she left beneath her pillow. Written in uneasy block letters and presented here verbatim, the note read:

same room same bed it dont work  
 i no what I need. just let me go.  
 i miss angel and my daughter but they are gone  
 4-ever dont you get it?  
 i dont want to go thru this no more.  
 life is hell just let me go.

I tried to  
 tranged and  
 tient at the c

It was thr  
 sentenced to  
 sent to jail fo  
 that correspo  
 refused food  
 group couns  
 In these clin  
 characterize  
 "refusals" sh

Several ho  
 I recognized  
 I would ever  
 aware of my  
 brief, and she  
 tia in Español  
 she did not r  
 I give her a ri

We drove t  
 with two othe  
 working with  
 heroin. She a  
 swered "No,"  
 tell me a thing  
 things.

When we ar  
 Then she aske  
 ing that she di  
 room for an in  
 Lucretia was r  
 ready to talk. I  
 scribed as *the b*  
 the loss of her c

I tried to talk to Beto about his sister, but he said that they were estranged and that his contact with her was limited to her stretches as a patient at the clinic. "You know as much as I do," he said.

It was through her patient file that I learned Lucretia had twice been sentenced to the clinic for drug detox in 2004, both times in lieu of being sent to jail for drug possession. I consulted the Daily Log during the dates that corresponded to her residence. One entry noted that she had again refused food and medication, another that she refused to take part in group counseling sessions and demonstrated a deepening "pessimism." In these clinical accounts the language of failure and refusal seemed to characterize Lucretia. I wondered about the multitude of "failures" and "refusals" she had suffered outside of the clinic.

Several home addresses were listed in Lucretia's patient file, and I recognized the street names and the villages. I did not imagine that I would ever visit her in these homes and doubted that she was even aware of my presence at the clinic that night; our encounter had been so brief, and she was so distraught. However, months later I ran into Lucretia in Española, and I took the risk of reintroducing myself. As expected, she did not remember me, but she invited me to her home, provided I give her a ride.

We drove to an address that I did not recognize, to a trailer she shared with two other women. During our ride, I told her that, in addition to working with Beto as a patient attendant, I was a "researcher," studying heroin. She asked me if I could write her a prescription. When I answered "No," she grew quiet. Then she chuckled and said that she could tell me a thing or two about heroin, if I was interested in her version of things.

When we arrived at her trailer, Lucretia asked if I wanted to get high. Then she asked if I cared if *she* got high, and then she laughed, announcing that she didn't care if I cared. I excused myself and went to the bathroom for an interval of time that would allow her to fix. When I returned Lucretia was relaxed. We sat quietly for several minutes, until she was ready to talk. In a slow, muted tone, she began to unravel what she described as *the beginning of the end*, the death of her husband, Ángel, and the loss of her daughter.

We both fixed that night, after Angelita [her daughter] was sleeping. We tried to be good about that, you know, for her not to see. Well, we fixed, we watched a little TV and fell asleep. I always fell asleep first. Ángel used to say I slept like a baby when I was high. It was the only time I really could sleep, you know? *Pero cuando me levanté, Ángel se murió* [But when I woke up, Ángel died]. He was dead.<sup>12</sup>

Lucretia turned her back to me and with great effort lifted her long black hair, revealing her husband's name, tattooed in vertical letters along her upper spine. Then she let her hair fall like a curtain. She stood unsteadily and walked into the living room, which seemed to serve as her makeshift bedroom. When she returned she carried a wallet-sized school portrait of her daughter, Angelita, who was named after her husband. She handed me the image, which I held in the palm of my hand. Angelita wore black-rimmed glasses and smiled purposefully. "She's a good girl," Lucretia said.

After Ángel's death came a series of events that led Lucretia to the detox clinic and, eventually, to prison. The first event was losing the subsidized one-bedroom apartment she shared with her husband and daughter as a result of her inability to pay the rent. At that time she was "trying to make it straight," and there was no one who could take her in who was not using heroin. I asked her about her brother, Beto. He was clean, wouldn't he help? Lucretia simply shook her head.

In the days that preceded her eviction, Lucretia resorted to selling the majority of her belongings, including her husband's beat-up car and, when times got really tough, the apartment's stove, for which she was arrested. With her few earnings and belongings, she and her daughter moved into a room at the Western Scene Hotel, located on the outskirts of Española. Lucretia remembered the room's bowed mattresses and stained carpet. "I paid \$25 a night for that shitty room. Some days I didn't eat."

At that time Lucretia said she wanted to get help for her addiction, but she didn't have the \$50 addicts who admit themselves are required to pay. If she had been arrested she would have been admitted to the clinic free of charge. She actually *wanted* treatment but didn't have money then. Nor does she now. "It makes no sense," she said.<sup>13</sup>

Lucretia recalled a small window in the hotel room that offered a view of the Jemez Mountains—a place she fondly remembered as a

child. The view of the hotel was designed for living there day after day on heroin.

A friend of Ángel's asked. He was a doctor. We had a good relationship for me, I guess [at a restaurant]. He was there in the cafeteria and eat nothing. I missed Ángel.

He didn't want to see me. I didn't want to see either. He told me about heroin]. He gave me Ángel died. I

Lucretia shot herself before, she fell on her daughter crying. Her mother's drug protective services of heroin detox on her own but could

Lucretia's relationship was a consequence of technical was turned away from registration fees, all fees reimbursed offender, Lucretia to her. She no longer had hope.

That afternoon "failures" and to recover was arrangements

child. The view of the mountains helped, she said. Plus, her stay at the hotel was designed to be temporary, until she got back on her feet. But living there day to day, hungry and unable to sleep, Lucretia returned to heroin.

A friend of Ángel's found me at the hotel. "What are you doing here?" he asked. He was like, shocked, because he knew me before, with Ángel. We had a good life. It was a hard life, but it was good. Well, he felt sorry for me, I guess, and he took me and my girl to Sonic [a fast-food drive-in restaurant]. He asked me if I needed anything, and I started crying right there in the car. I told him I hadn't slept in like a month, that I couldn't eat nothing. I missed Ángel. He was being all caring-like. He told me he missed Ángel, too.

He didn't want to take us back to the hotel, but I made sure he did. I didn't want no funny stuff with him. I didn't want him in my room either. He told me I looked tired, and he offered me a *gorrita* [measure of heroin]. He gave me the works [syringe]. I hadn't touched the stuff since Ángel died. I didn't want to take it, *pero* I took it.

Lucretia shot up alone that night after putting Angelita to bed. As before, she fell asleep. And as before, she awoke to the sounds of her daughter crying—this time at the sight of police officers standing before her mother's drugged body. Angelita was promptly taken away by child protective services and Lucretia arrested. She was sentenced to thirty days of heroin detox at Nuevo Día—which she had previously sought out on her own but could not afford. Lucretia didn't have to pay this time around.

Lucretia's relapse and loss of her daughter were thus, in part, a consequence of technical procedures: as a self-referring addicted mother, she was turned away from treatment because of her inability to pay a \$50 registration fee; as an "offender," she was sentenced to treatment, with all fees reimbursed by the state. But in her transformation from addict to offender, Lucretia had lost the roles and loves that were most meaningful to her. She no longer had a reason to undergo treatment. She no longer had hope.

That afternoon in her trailer, I began to understand the nature of her "failures" and "refusals"—why she was a difficult patient. Her desire to recover was gone. She felt betrayed by the various institutional arrangements that had initially caused her to be turned away from

treatment, then demanded it. Recalling her last stint at the clinic, she said, "I didn't want to sit through no bullshit and to pretend like it was gonna get better. Ángel was gone. Angelita is now, too. I knew it wouldn't ever get better."

### THORNS

The blackout that occurred during my first shift at the clinic lasted for nearly seven hours. By 6:30 in the morning, the electricity had been restored, and the clinic was flooded with the light of sunrise. And yet the darkness—its prevailing sense of uncertainty—persisted. Peter returned to the orange chair, his body still contorted with pain. The other patients began to emerge from their rooms and resumed their requests for pills, coffee, sugar—all the *somethings* that provide temporary relief from the pain of withdrawal. I took refuge in the nurse's station and arranged the morning pills in small paper cups. At seven o'clock I announced it was "medication time." The dispensations were ritualistic. The patients lined up quietly just beyond the door of the nurse's station and, one by one, swallowed their pills, an action I recorded in the medication log.

Before breakfast, a group of patients assembled for an informal Bible study. I prepared breakfast—scrambled eggs and tortillas—while Yvette read awkwardly from the Gospel of Matthew: "And some fell among thorns; and the thorns sprung up, and choked them."

"What?" someone asked.

"Thorns are sin," Pauline said gently. Pauline was forty-two years old and had recently found God.

"Check out *these* thorns." Marcos lifted his shirt above his head. Spread across his back was a tattoo of a Jesus. Blood dripped from where the spiny crown pierced Jesus' temples.

"Jesus got my back," Marcos said. "Otherwise, I couldn't take this shit."

The five days and four nights Marcos had spent at the clinic were little different from the years he spent on the "outside," a childhood of foster families and a recent five-year stint in prison for drug trafficking. A dirty urine analysis sent the recently paroled Marcos to the clinic, where, in his mind, everything resembled something else—a prior time, a prior place.

"The clinic  
ing about  
restrictions  
frustration  
narrative,  
deepen his  
hood. About  
on watch a  
you know  
kid, same  
en la mañana

Accord  
He was a  
gloss for a  
Marcos's  
was taken  
tributed i  
dence tha

At nig  
slept sou  
name "*el*  
clinic, Ma  
face in a p  
Marcos w  
was emp  
eight year  
the days  
continue  
gan a se  
across th  
be just r  
know, t  
house]. I  
Towa  
cho" (A  
cracks"

"The clinic is just like *la pinta* [jail]," Marcos invariably said when talking about conditions of everyday life there—the food, arguments, and restrictions on movement or telephone use, feelings of boredom and frustration. Prison was Marcos's constant reference. Eschewing a linear narrative, he applied the feelings and experiences of his incarceration to deepen his portrayal of his life before prison, especially his early childhood. About that time he said it was "like being behind bars. Everybody on watch and nowhere to go." Or, "In *la pinta*, you gotta have a game-face, you know, don't let nobody know what you're thinking. When I was a kid, same thing. You don't want people to know nothin' about you, 'cause *en la mañana*, someone come to take you away. Game-face."

According to his patient file, Marcos had bipolar disorder and dyslexia. He was also described as having "trust issues"—a frequently uttered gloss for any kind of behavior or attitude deemed suspicious or reserved. Marcos's adamant refusal to sleep in a dorm with other male patients was taken as a symptom of his "trust issues." (Some staff members attributed it to possible rival gang affiliation, although there was no evidence that he was in a gang.)

At night a mattress was placed in a utility closet for Marcos, where he slept soundly among mops and brooms, thus earning himself the nickname "*el portero*" [the janitor]. Months after our first encounter at the clinic, Marcos told me why he slept in the closet. We were sitting face-to-face in a plastic dining booth at the fast-food restaurant in Española where Marcos worked. It was three o'clock in the afternoon and the restaurant was empty. Marcos told me that a male relative raped him when he was eight years old. In hushed tones, he described a terrifying childhood—the days and nights spent hiding from his perpetrator. The sexual abuse continued until the age of ten, when he was sent to a foster home. So began a series of temporary living situations with unfamiliar families across the state. "The first time, you don't know if its gonna save you or be just more of the same," he told me. "You hope it's gonna last, you know, that you got *una nueva familia, nueva casa* [a new family, new house]. But it don't."

Toward the end of the interview, Marcos expertly assumed a "*gaba-cho*" (Anglo) accent and said that he managed to "slip through the cracks" when he was sixteen. After years of being tracked by the state, he

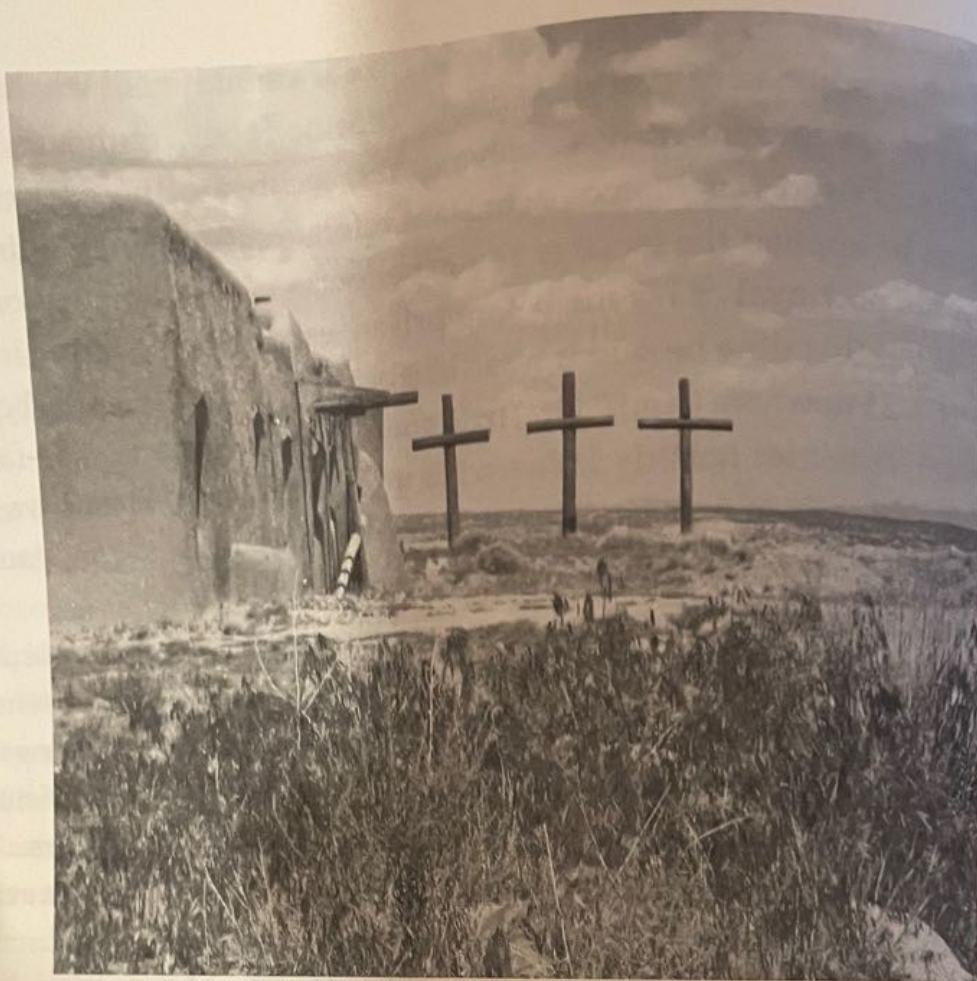


Figure 3. Trinity. Photo by the author.

said, "I was on my own, with nobody following me." At twenty he was arrested for possession of heroin with intent to sell.

"I'll tell you what. Being in prison is the worstest thing in the world for someone like me," he said. That's why he tattooed Jesus on his back—not as an act of bravado, as it was so often assumed, but as a desperate attempt to protect his body. "I didn't want no one touching me," Marcos said.

Over breakfast Marcos congratulated me on surviving my first night. You have no idea, I thought. But of course he did. There would be more of the same on my graveyard shift. Perhaps it wasn't a power shortage

(although  
a shortage  
the patient  
rate of pat  
out or wal  
casion ove

The cli  
tion strug  
tients com  
day, mom  
the clinic  
cheted be  
of life at t  
side, at h  
that they

The tur  
shift, and  
when it v  
grounds.  
with hirin  
trained; it  
of drug a  
habilitatio  
munities  
hoods and  
despite th  
tendant's  
cabinets—  
ity of inst  
the heroin

"Blood  
to say. Th  
essarily e  
poused. F  
of family

(although during the monsoon rains the clinic lost power repeatedly) but a shortage of beds, medication, staff, money, food, and activities to keep the patients engaged. This shortfall led to an increase in the already high rate of patient discharges. Some were sent to jail, and others were kicked out or walked out, only to begin using again—and on more than one occasion overdose and die.

The clinic operated in a constant state of instability. The administration struggled to make ends meet, the attendants struggled to keep patients comfortable and in line, and the patients struggled to stay. Day to day, moment to moment, there was little continuity, little security. Life at the clinic vacillated between chaos and boredom, just as patients ricocheted between states of agony and relief. Indeed, the quality and tempo of life at the clinic mirrored that which patients lived *afuera*, on the outside, at home or on the streets. Many patients left the clinic, reasoning that they were no better there than they were anywhere else.

The turnover also applied to detox attendants. Most quit after a single shift, and during the course of my employment, at least one was fired when it was discovered that he was dealing and using drugs on clinic grounds. The administration reported that one of the greatest challenges with hiring attendants was not that they were undereducated or undertrained; it was that often they were relatives of patients and had a history of drug addiction themselves. Like many rural mental health or drug rehabilitation centers, the pool of clinic employees came from the very communities and families of addicts they served. They shared neighborhoods and homes and knew intimate details of one another's lives. Hence, despite the few symbols and rituals of technical distance—such as the attendant's log, our thick ring of keys, and access to locked medicine cabinets—there was little personal or professional distance. The proximity of institutional and intimate life reflected just how deeply entrenched the heroin epidemic was.

"Blood is thicker than bureaucracy," the clinic's executive director liked to say. This "thickness" of relation between staff and patients did not necessarily encourage trust or understanding—principles that the clinic espoused. Family favors were as common as family feuds, and the presence of family members at the clinic, as in Lucretia's case, added to the sense of

the inexorable familiarity of family life and drug life. Within the clinic, various social, familial, and medical identifications and relations intertwined.

Whereas many ethnographies of institutions foreground the deliberate division of these areas (e.g., Desjarlais 1997; Rhodes 2005), in this setting institutional life was an extension of a broader realm of sociality, especially of family. The incorporation of these forms of social life into the structure and social realities—produced a very different configuration of “institutional power,” as well as different possibilities and challenges for “rehabilitation” or “recovery.” While patients in the clinic talked frequently about “*la vida afuera*” [life outside], there really was no such place. Life outside thrived *within* the clinic’s walls. It established the tempo of the clinic and played a large part in determining the futures of its patients.

As an institution, the clinic operated not rationally or coherently but symptomatically—always as a response to unforeseen or unmanageable events. This symptomatic structure contributed to the clinic’s overwhelming feeling of instability, the most obvious contributing factor of which was its financial constraints. The telephones located in the nurse’s and attendant’s stations rang ceaselessly. Yet a receptionist was out of the question; there was no money for administrative support, or for a designated cook, or for “real nurses,” or for “first-line therapies” such as the highly effective anti-opioid medication buprenorphine, popularly known as the “magic bullet.”<sup>14</sup> Even with the lack of financial, administrative, and medical support, there was an endless waiting list of patients—often reaching as far back as five months. Attendants were told to tell them to call back, knowing that the likelihood someone would actually answer their calls was slim.

The instability involved more than just money and staffing. Though this was a medically monitored treatment program, there was little consistency in the treatment itself. Detox patients were regularly given (or unknowingly took) the wrong type or amount of medication, at least twice with near-fatal consequences. With no apparent justification, medications were abruptly stopped, replaced, or newly assigned to patients. These changes were noted in the medication log lightly if at all. And evidence of mishaps was sometimes erased from the log altogether.

Adding to the transferred from psychosis, depression. Newly admitted patients, a professional staff to assist

Indeed, patients the use of illicit substances, attention with newer, oxone, asked that drug was choosers,” a held as a form was not a ne

The requirements attendants called dealers, the drug

#### LA VIDA

Before admission to prison or program the patient years, Peter Marcos, haloperidol rigidity, a period of heroin he maintain.

Adding to the irregularity was the fact that many of the patients were transferred from mental health facilities or jails. Medications for psychosis, depression, diabetes, and HIV were often "lost" in the transfer. Newly admitted addicts frequently experienced weeklong drug interruptions, a problem exacerbated by the rural location of the detox clinic, its distance from well-stocked pharmacies, and the lack of trained medical staff to assess and follow up on a variety of critical prescriptions.

Indeed, patterns of "legitimate" medication use in the clinic mirrored the use of illicit street drugs. With a limited supply of second-class therapies, attendants "made do," treating not so much as needed but as able. Treatment was intermittent, even experimental. Patients familiar with newer, more effective therapies for heroin withdrawal, such as Suboxone, asked for the medications by name and complained that this or that drug was not available to them. They were told, "Beggars can't be choosers," and, according to patients, medication was sometimes withheld as a form of reprimand. In this setting, the provision of medication was not a neutral act (Biehl 2005).

The request for medication at nondosing times was constant, and the attendants who dispensed medications, including me, were sometimes called dealers. Although the clinic was presented as a rehabilitation center, the drug economy of the streets persisted within it.

#### LA VIDA AFUERA: LIFE OUTSIDE

Before admission to the clinic many of the patients had moved between prison or psychiatric hospitalization or from one failed drug rehabilitation program to another. This erratic movement between institutions followed the patients' movements across diagnoses and drug regimens. For three years, Peter received methadone at another drug treatment program. Like Marcos, he was diagnosed as bipolar and prescribed the antipsychotic haloperidol, as well as numerous medications for depression, muscular rigidity, and insomnia (all side effects of haloperidol). Throughout this period of "licit" drug use, Peter also used heroin. When he could not get heroin he took "benzos" or drank excessively—anything, he said, "to maintain."

By the time I met Peter at the detox clinic, he had been incarcerated twice and court appointed to drug rehab three times. In 2003 he was admitted to the University of New Mexico Psychiatric Center for "crisis stabilization," the result of multiple overdoses and emergency treatments with injections of naloxone, a medication that fights the life-threatening depression of the central nervous and respiratory systems during heroin overdose. "Everyone thought I had a death wish," he later explained. "Maybe I did."

Peter's father died six months before Peter was admitted to the Psychiatric Center. "The thing is," he said, "I didn't ever really know him. We never lived together or nothing. The only way I knew him was *chiva* [heroin]. The way he came to be my father, it was *chiva*."

He described his introduction to heroin as we sat together on the clinic grounds:

The first time, I said no. I was in his house, over in Chimayó, right there by the Sacred Heart [Catholic church]. We talked about when he was young, and all this family on his side that I didn't know. He told me he was sorry for not being in my life. It was making me kinda upset. He kept saying he was sorry, and he pulled out a joint. It tasted funny, and my dad laughed [and] said it was laced with heroin. I started freaking out. *I've got heroin in my system?* He told me to relax. It was okay. It felt good, *no?* I relaxed into it, and we just chilled.

In a little while, he pulls out like an ounce [of heroin.] He puts it on the kitchen table and says, *Wanna do a shot with me?* I told him no thanks. He loads it anyway. He cooked it in a spoon and was cooking it right in front of me and telling me he was sorry and we should go fishing. He liked to fish trout. I told him yeah, that would be nice, and he's cooking it nice and slow right in front of me. He asked if I'd ever seen this [preparing heroin]. I said sure, but I lied. He smiled and loaded it.

He told me to lie down on the couch. Close my eyes and give him my arm. Honestly, I didn't want to do it, but I figured I already got it [heroin] in me. He shot me up. That was the first time, and I was like, wow! It took all the feelings away, you know? He did it, too, and we stayed there together.

It was a long time ago.

Peter's memory of his introduction to heroin is one of the few he has of his father. Soon after he introduced his son to the drug, he moved to

Los Angeles  
there were o  
can barely re  
it occurred,  
it was heroin

This patte  
Española Va  
heroin addic  
ological fam  
primary sou  
"handled at  
workers.<sup>15</sup> F  
for their lov  
panies hero  
even been g  
thing for m

This rew  
ogy or bad  
use as a co  
lates and er  
and embod  
now I wan  
"intensified  
The paucity  
ist, and the  
perform a  
as substitut  
such as na  
not. They  
an attempt  
about a str  
dosed.

Among  
ment is a  
such traini  
people atte

Los Angeles. Peter never saw him again. Over the course of ten years, there were only a handful of telephone calls, the content of which Peter can barely recall. Peter learned of his father's death several months after it occurred, and though he was never told the official cause, he suspects it was heroin related.

This pattern of familial, intergenerational heroin use—common in the Española Valley—stands in sharp contrast to the mainstream notion of heroin addicts as isolated from family or community. In this milieu the biological family is often the primary domain of heroin use, as well as the primary source of support and care. Most cases of heroin overdose are “handled at home” by relatives, never coming to the attention of health workers.<sup>15</sup> Family members, especially parents, are known to buy heroin for their loved ones who are undergoing *las malias*, the pain that accompanies heroin withdrawal. This characteristic of the heroin problem has even been given a name, or symptom, “*m'ijto-itis*”—as in, “I’ll do anything for *m'ijo* [my child].”

This rewriting of domestic norms should not be read as pure pathology or bad parenting. In a later chapter I explore intergenerational heroin use as a contemporary modality of kinship that simultaneously articulates and enables the fragmentation of Hispano social and domestic life and embodies a distinctive sense of one's being in relation to another. For now I want to mark this issue as a practical response to a pattern of “intensified disengagement” of social and medical services (Biehl 2005). The paucity of local services, the endless waiting lists for the few that exist, and the provision of blatantly suboptimal care have forced families to perform a kind of social and medical triage. Parents and children work as substitute psychiatrists and first responders. They obtain medications, such as narcotics and psychopharmaceuticals, through means legal and not. They adjust prescriptions as they see fit, often decreasing doses in an attempt to make medications last longer or increasing doses to bring about a stronger effect. They attempt to revive loved ones who have overdosed.

Among the free monthly trainings offered by the local police department is a naloxone injection class. One winter evening I observed one such training, held in the parish hall of a local church. A dozen or so people attended, all of whom identified as parents, children, or spouses

of heroin addicts. A police officer opened the training with the painful acknowledgment, "It is you who will be in the position to save a life. More than likely, by the time we get there, it will be too late." Most of the attendees already knew this. They had already felt the devastating sense of helplessness that accompanies an overdose. Using adult-sized dummies, we practiced administering naloxone, an opioid antidote that if administered in time revives the body's respiratory and central nervous systems.

This monthly training does more than symbolize the gravity of the region's heroin phenomenon. It also demonstrates how practices of care become reconfigured through heroin, intensified at the kinship level. This intensification of kin relations is concurrent with processes of intensified disengagement at the state level. The expansion of these types of "consumer-centered" or "community" trainings occur precisely at the moment when public funding for mental and behavioral health programs are being drastically cut and when publicly funded clinics are being privatized or closed.

One of the obvious problems with the family shouldering the burden of care is that it, too, is unstable. The narratives of Peter, Mikey, and Lucretia point to the fact that the family, like the clinic, is marked by vulnerability. This wasn't always the case, as many valley addicts like to point out. More than once, I heard addicts insist, "There was a time . . ."—a time when families didn't use, when they "kept it together."

Ironically, the practice of family members using together, of trying to keep the problem of addiction close to home, arises in part from the profound significance family has in Hispano culture. The phenomenon of heroin use *within* the family attests to the endurance of these ties, as distorted as that may seem.

#### WHAT REMAINS

On day 23 of his program, Peter and I sat in the very spot that we had huddled together the morning of my first graveyard shift. There was color in his face, and his body had filled out slightly, in proportion to his

growing appetite  
going to complet  
ing." He wanted  
that he was goin  
was going to ma  
nothing else to c

That's what yo  
gonna do when  
like it stops he  
the same plac  
not. As soon  
with it [hero

I asked Pete  
inside:

What do you  
like outside  
out, you wo  
look of it . .  
gotta do is  
Otherwise

Peter's res  
while filling  
ices, would  
opening cer  
addiction se  
self. Indeed,  
clinic woul  
that addicts

Ultimate  
ings of inst  
presence of  
us with the  
commensur

growing appetite. He told me he was going to make it—that he was going to complete all thirty days. But it wasn't because he was "recovering." He wanted heroin just as badly as before, and he had no illusions that he was going to remain off the drug once he left the clinic. But he was going to make it, he said, because he had nowhere else to go. He had nothing else to do.

That's what you never think about. You don't think, *what's this person gonna do when they get outta here?* It's stupid. You guys are stupid. It's not like it stops here. It never stops. You get out and it's the same. You go to the same place, even if you have this idea that it'll be something else. It's not. As soon as you get there, someone starts knocking on your door with it [heroin]. You don't have to go to it. It comes to you.

I asked Peter to comment on the relation between life *afuera* and life inside:

What do you think! Look around you. It's all addicts here, no? It's just like outside. I mean, if you guys were really serious about helping me out, you wouldn't put us in a room with someone who is strung out. The look of it . . . it makes you want to get fucked up. No. The first thing you gotta do is get rid of all the *tecatos* [heroin addicts] in order to save one. Otherwise we're all just reminding each other of what we need.

Peter's response was a challenge on many levels. The detox clinic, while filling an important void in the Española Valley's addiction services, would not be the force for healing it had been celebrated as at the opening ceremony. Given their insufficiency and the lack of continuity, addiction services were to remain decidedly unstable—just like life itself. Indeed, without the radical transformation of *la vida afuera* the detox clinic would be just another rung in a repetitive institutional machine that addicts like Peter would ceaselessly move in and out of.

Ultimately, the bigger challenge Peter posited was not about the failings of institutional life but about an ethics of care. His comment on the presence of other addicts as being a crippling reminder of his *need* presents us with the opportunity to consider an ethics of care based on the idea of commensurability. Within the clinic the idea that the other's suffering is

our own is not abstract; it is visceral. How might those in the throes of pain help to heal each other? How might the suffering of others and the painful forms of recognition it evokes be a force for care and not a crippling force, as Peter suggests? In other words, how might the recognition of shared pain transform the nature of our need?

I thought of Peter and the night of the blackout—the uncomfortable intimacy forged between us that would remain unfathomable. I would never fully understand the nature of Peter's pain or of his need. And although I could not understand it, I still endured something alongside him; and Peter allowed me—perhaps even needed me—to be by his side.

That night represents to me the tremendously difficult process of commensurability—of remaining in the face of one another's unshared vulnerabilities. These vulnerabilities cannot be resolved any other way but by remaining close to one another. I write *commensurability* and not *incommensurability* because, over the course of those dark hours, what emerged between Peter and me was a *common* vulnerability. And it is through this common vulnerability that we can begin to understand the possibilities for a kind of care, one in which the parameters of the clinic and of the patient are not so easily defined. Perhaps *we* are the patient, and the clinic—intended as a space for healing—is all around us.