Labors of Recovery:
Superfluity and Livelihood in Puerto Rican Addiction Shelters

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Abstract:

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This dissertation examines Puerto Rican therapeutic communities – resource-poor mutual-aid collectives that have flourished over the past five decades, despite being heavily criticized by human rights groups for using unwaged labor as a method to treat addiction. The persistence of these communities, which are spreading rapidly across Latin America, is widely ascribed in international media to state neglect. I conducted a year of ethnographic research in Puerto Rico to understand why labor therapies thrive, and what these approaches are intended to achieve among those who practice them. Challenging the argument that labor therapies are the simple result of the state failing to provide alternatives, my research shows that during the last half century therapeutic communities have been successively recruited to serve a variety of distinct and sometimes competing interests. My examination of the multiple, contested, and sometimes-converging projects that inhere within this therapeutic regime shows that these organizations have variously served as entrepreneurial projects of informal enterprise, existential projects of redemption, state projects of containment, and shunt-valves for relieving burdens of dependency from straining kinship systems. Their endurance, therefore, not only reflects their capacity to patch the cracks of multiple faltering systems (including employment, corrections, family), but it also reflects their protean vulnerability to appropriation: that is, the ease with which they are co-opted by other actors for alternative utilities.

Based on eight months of intensive participant observation in one therapeutic community, *La Casita*, where I explored the cultural logics and meanings of labor therapies, I argue that “drug treatment” here is not centrally geared towards “treating addiction.” Instead, *La Casita’s* therapeutic practices of labor therapy, time-discipline, prayer, and internal work are more instructively read as social technologies through which men who are excluded from the labor market and estranged from kinship ties seek to cultivate an alternative masculinity that restores their sense of worth. The “socially useful” masculinity under construction here, based on a performance of work, responsibility, and duty, offers unemployed men an alternative way to claim the dignity and social membership of work.

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List of Abbreviations

ASSMCA (Spanish acronym)	Puerto Rican Mental Health and Anti Addiction Services Administration
CISLA (Spanish acronym)	Center for the Investigation of Addiction
DSCA (Spanish acronym)	Puerto Rican Department for Services Against Addiction
Hogar CREA (Spanish acronym)	Home for the Re-education of Addicts
NIAAA	US National Institute on Alcohol Abuse and Alcoholism
NIDA	US National Institute on Drug Abuse
NIMH	US National Institute of Mental Health
SAMHSA	US Substance Abuse and Mental Health Services Administration

Spanish Glossary

El aprendizaje	Apprenticeship, an informal form of professional training offered by residential drug treatment programs.
Ex adicto	Ex-addict, a term used by therapeutic community members to refer to someone who has completed a residential drug treatment program.
Ex-adicto honrado	Honored ex-addict, an honorary title bestowed on therapeutic community residents in a graduation ceremony upon program completion.
El honrado certificado	Honored certificated person, an honorary title bestowed on therapeutic community residents in a graduation ceremony upon program completion.
La práctica	Practicum, an informal form of professional accreditation offered by drug treatment programs.
Operación Manos a la Obra	Operation Bootstrap, an economic development program implemented between the 1940s-1960s that brought about industrialization in Puerto Rico.
Re-educado	Re-educated person, a term used by therapeutic communities to refer to someone who has completed a residential drug treatment program (the same meaning as “ex-addict”).
El terapista	Therapist
El trabajador de caso	Caseworker

Historical Timeline

Key events in Puerto Rican Drug Treatment History

1959 Commonwealth Narcotics Law 48 is passed and Puerto Rico assumes jurisdiction over narcotics control.

1961-1966 The Center for the Investigation of Addiction (CISLA), Puerto Rico's first therapeutic community, is established and operates for five years.

1968 The Home for the Re-Education of Addiction (*Hogar CREA*) is founded.

1968 The Permanent Commission for the Control of Narcomania is established. It consists of nine members and its remit is to evaluate all existing methods for combatting drug addiction.

1970 Methadone introduced on an experimental basis in Puerto Rico through the Department of Social Services.

1971 US President Richard Nixon declares a War on Drugs.

1971 Commonwealth Law of Controlled Substances is passed introducing mandatory minimum sentences for drug dealing, possession, and trafficking.

1973-1993 The Department for Services Against Addiction is founded and provides public drug treatment for 20 years.

1993 Puerto Rico's public healthcare system is privatized through a series of laws collectively known as *La Reforma*.

1993 Commonwealth Law 67 is introduced which establishes the Administration of Mental Health and Anti-Addiction Services (ASSMCA), to replace of DSCA. ASSMCA's role is to oversee rather than to provide drug treatment.

1996 Puerto Rico's Drug Court Program is established.

2000 Commonwealth Law 408, or the Mental Health Act, is passed.

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Introduction

What this dissertation is about

By December 2016, Antonio had been at the shelter for about a year and a half. He was among a shifting cohort of thirty male residents living at *La Casita*, a non-profit organization that provides drug treatment in a gender-segregated, male-only residential shelter. Founded in 2007 by a former heroin user and therapeutic community graduate, *La Casita* is one node in an extensive network of private non-profit agencies that are licensed by the Puerto Rican government to provide residential treatment for drug addiction. Like many of Puerto Rico's "therapeutic communities," as they are often referred to, *La Casita* is a self-help organization staffed by peers who self-identify as ex-addicts. Resources here are scarce: *La Casita's* chief tools for treating addiction are limited to "labor therapy" (a disciplined daily schedule of domestic chores and manual labor), prayer, and peer-led encounter groups, where people confront each other about their behavioral difficulties and failings.

Antonio was among a dozen or so men at *La Casita* who described themselves as volunteers. These men had typically resided at the shelter for several months to a year, had access to certain privileges (for example, a bedroom with fewer roommates), and were responsible for various pastoral and administrative tasks. These commonly included acquainting new recruits with the norms and rules of the shelter, supervising and

facilitating group activities, and taking messages on the office phone. Like most volunteers, Antonio was not paid a formal salary, but neither did he have to pay the $200 monthly residence fee. A small number of peer staff members at *La Casita* were paid formal salaries and lived off-site in their own private homes, but Antonio's situation was by far the more common.

A fifty-two year old former-construction worker, Antonio had been in and out of Puerto Rico's therapeutic community system since 1996, which was also the year he'd been shot in the spine by a gang member. Two bullets had injured five disks and marked the onset of a twenty-year relationship with opioids, first with prescribed pain relievers, then with heroin. Since then, Antonio had cycled in and out of residential treatment, spending years, on and off, as both a resident and peer counselor. During the months that Antonio would spend at *La Casita*, days were filled with a busy daily schedule of chores, therapies, and manual labor, all strictly regulated through a system of rules, rewards and punishments. Antonio worked hard, and soon the years he'd spent at other therapeutic communities began to shine through as he was recognized as a seasoned peer facilitator. Unlike the novices, he had little difficulty with the early mornings, which began with morning prayer at 5am. Nor did he have difficulty following the rules, which were numerous and enveloped many of the day's elements: from speaking ("new residents are not permitted to talk to each other without an older resident present"), to eating ("no talking during meal times") to smoking ("never light a cigarette that has already been put out by another person"). The last rule: "Always ask authorization for everything," which was plastered onto the wall outside the men's dormitories, was by now second nature to

Antonio. Perhaps surprisingly, however, Antonio would often tell me that *La Casita* was the most "relaxed" program he'd attended - during his last stint in residential drug treatment he'd been told to admit he was an immature child and ordered to wear shorts.

As low-cost therapies that grow, multiply, and transform, therapeutic communities have proven highly versatile and varied tremendously across the sixty-five countries to which they are estimated to have spread since their emergence in Los Angeles in 1958[1] (NIH 2015). Their polymorphism notwithstanding, they have often subscribed to a character-based theory of addiction that dominated North American psychiatry in the mid 20th century (Acker 2002). In line with characterological theories, most closely associated with American psychiatrist Lawrence Kolb (1911-2006), therapeutic communities have often considered addiction to be a symptom of an underlying personality disorder that requires "re-education" through "personality re-structuring," achieved through one-to-two years of residency in a controlled therapeutic environment.

In the 1960s and 1970s, therapeutic communities were a lead treatment for addiction in mainland United States, with the National Institute for Mental Health (NIMH) providing funding to dozens of centers (White 1998). Many mainland therapeutic communities closed down in the 1970s and 1980s, however, for a variety of political and economic reasons. One was governmental pressure to reform their methods, which were increasingly viewed as amateurish, overly confrontational and psychologically damaging (White and Miller 2007). For those that relied on public funding, many were forced to

[1] The first therapeutic community for addiction in the United States was Synanon, established in 1958 in Los Angeles (see Clark 2017).

significantly alter their methods, through, for example, the employment of professionally accredited staff, the abandonment of harsh punishments, and the introduction of a system for accrediting peer leaders (Deitch and Drago 2010; White 1998). Professionalization significantly raised operating costs, however, prompting many to close, others to relocate to private prisons, and those that remained to significantly reduce lengths of stay from 1-2 years to 3-6 months. 'Reformed therapeutic communities' as they are sometimes called, continue to be held in high esteem in the United States[2], but today they shoulder a much smaller fraction of the treatment burden relative to out-patient treatments and short-term residential detox (Deitch and Drago 2010).

In Puerto Rico, in contrast, therapeutic communities have continued to thrive since their establishment in 1961, mostly in the non-profit sector, and today they constitute the dominant form of treatment for addiction. Despite their ubiquity, these are highly contentious facilities. Analogously to the debates surrounding mainland therapeutic communities in the 1970s, drug treatment activists have decried their methods as "unscientific" and "exploitative" (OSF 2016; IPR 2015), taking issue with their use of unpaid labor as a technique to treat addiction, and also their reliance on unqualified peer staff. Once standard practice in mainland therapeutic communities, unpaid labor was gradually abandoned as tasks of construction, decorating, and cooking came to be increasingly performed by hired hands (Deitch and Drago 2010). In contrast, unpaid work continues to be a central therapy in the programmatic design of many of Puerto Rico's

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[2] Phoenix House, which is probably the largest single provider with over 120 programs across the U.S., is listed in Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices.

therapeutic communities. Backed by recent government and private-sector contracts, residents of Puerto Rican therapeutic communities are increasingly sent to weed waterways for the Department of Water and Sewage, to pick up garbage from town squares and public parks, or, the year I began fieldwork in 2016, to remove thousands of tires from residential areas as part of the commonwealth state's response to the Zika virus (McNeil 2016).

This dissertation explores how therapeutic communities and labor therapies came to constitute the lead treatment for addiction in Puerto Rico, and what these approaches can be said to mean for those who practice them. My examination of these therapies sets them within their historical, political, and cultural context, a situating that illuminates the multiple, contested, and sometimes converging projects that inhere in this therapeutic regime. Based on archival research, key informant interviews, and extended ethnographic fieldwork I argue that one important reason they persist is because of the role they play in allocating surrogate livelihoods to a group of men who would otherwise be unemployed. Complicating this political-economic reading, I also demonstrate that therapeutic communities have been supported and conscripted by local elites as well as numerous state, market and family actors for a variety of different reasons. Over the last half-century, therapeutic communities have variously (and sometimes simultaneously) served as entrepreneurial projects of informal enterprise, existential projects of redemption, state projects of containment, life projects of the poor to professionalize themselves, and shunt-valves for relieving burdens of dependency from straining kinship systems. Widening the ethnographic lens so as to consider therapeutic communities' local

relevance outside of 'therapeutic' or 'treatment' domains, I reveal therapeutic communities to be deeply embedded in a complex and interconnected collection of local political projects. I explore this historically, beginning with therapeutic communities emergence in the aftermath of 20th century industrialization and continuing through to the neoliberal present.

In addition to examining therapeutic communities historically and institutionally, this dissertation also provides an experience-near ethnographic account of life in a therapeutic community. The eight months that I spent conducting intensive participant observation in one therapeutic community, *La Casita*, where I examined the cultural logics and meanings of these therapies, leads me to a certain proposition about what these therapies mean and what they are intended to "treat." In its most abstract distillation, my argument here is that these therapies are not primarily geared towards "addiction treatment" *per se*. Instead, they can be read as techniques through which people who have been rendered superfluous to production cultivate a sense of personhood that embodies social utility. In other words, they are part of an entrepreneurial project of creating social utility and wresting meaning and purpose out of a state of superfluity. I base this argument on a close examination of residents' veneration of time-discipline, where a strong moral emphasis on regular work patterns and a therapeutic imperative to "keep busy" conflicts with an institutional milieu where there are not a lot of useful things to do, leading residents to resort to various futile tasks. I show that in these spaces, therapeutic labor is not primarily understood as a means to achieving sobriety or to moving towards better future. Instead, these therapies can be read as secular-spiritual practices through which

individuals reject redundancy by proving to themselves and to others that they can be useful.

It both is, and isn't, about addiction

When originally conceived, this project was about "addiction" and the way people who suffer from it devise ways to "treat" each other. I'd imagined that I would eventually write a book about an "embodied health movement" (Brown et al. 2004), or about how people who share an illness band together to take things into their own hands when the state doesn't do enough. I got this idea, I think, from reading about therapeutic communities in other places, especially in New York and Los Angeles, where an extensive popular and academic literature (as well as several museum collections) document the histories of specific therapeutic communities.[3]

But after I had been in Puerto Rico for a few of months, it occurred to me that this was not what my research was about, at least not exactly. By then I'd visited several therapeutic communities and gained a reasonable sense of their clientele, and I was starting to question how many of the residents I knew could actually be said to suffer from "addiction," and what exactly "treatment" could be said to mean in these spaces. Like most public health students in the United States, I'd been taught the American

[3] For a historical overview of therapetuic communities in the United States, see Clark 2017; White 1998; White 2010; Deitch and Drago 2010. For accounts of specific therapeutic communities, see Janzen 2005; Densen-Gerber 1973; Sugarman 1974, and for museum collections, see the Phoenix House Oral History Project at Columbia Center for Oral History Research; and the Therapeutic Communities Collection at the University of Kentucky.

Psychiatric Association's Diagnostic and Statistical Manual's model of addiction, the fifth edition of which (DSM-V) defines addiction as one disease –"substance use disorder" – that ranges from low to high severity (American Psychiatric Association 2013). I'd also been taught that severity of illness was a key consideration for determining the appropriate level of care. Generally, only patients whose substance use disorders are deemed "severe" are considered to require residential treatment because it is understood to be "restrictive" (see for example international guidelines, UNODC and WHO 2017), which is to say that I'd anticipated spending a year surrounded by people with severe substance use disorders.

Yet the profiles of the men I encountered at *La Casita* and at other therapeutic communities were actually very mixed. Certainly, some residents were like Antonio and described years of battling with debilitating addiction, sometimes to injectable drugs such as heroin, other times to crack or cocaine. Yet many of the men I got to know that year wound up in residential facilities for other reasons, and through routes other than a straightforward need or desire for treatment.

I think here of an interim findings report I tried to write early on in my fieldwork as a requirement of my funding from the National Science Foundation. In my abstract, I first wrote: "At therapeutic communities, where addicted and homeless men seek to treat each other." Then, remembering Héctor, a recently laid off nurse whose arrival at *La Casita* was precipitated by an eviction, and Rocky, whose schizophrenia precluded him from living independently, I realized I'd over-simplified, and tried again: "where men suffering

from addiction, homelessness, unemployment, and mental illness seek to treat each other." But then I remembered Nelson, who'd been court-mandated to attend *La Casita* on a drug trafficking charge, and Efren, who'd been committed into residential care via the civil courts on account of drunk driving.

My attempt to write these men into categories, which multiplied on just a moment's reflection, had failed. What these men shared could hardly be described as some assembly of personal or psychological traits or easily definable demographic characteristics. Rather, it occurred to me that what these men had in common was a shared, if temporary, uprootedness. These men were all suspended for the time being, for durations that ranged considerably, outside of the usual domains of kinship, economy, and community. Excluded from opportunities to earn a formal living, and exempt from conventional kinship obligations and social duties, they occupied a kind of isolated, satellite niche in the island's social and political landscape. To better demarcate who and what this dissertation is about, I use two related concepts, superfluity and abeyance, from philosophy and historical sociology, respectively. These help us to move away from surface appearances and health categories ("residents in a therapeutic community" or "substance users undergoing drug treatment") in favor of more instructive underlying processes.

Theoretical frameworks

I. Superfluity and abeyance

The first concept is “superfluity”, which is most closely associated with Hannah Arendt. In *The Origins of Totalitarianism* (1951, 1973), Arendt explores the elements of modern European history that led to the rise of Nazi Germany and Soviet Russia. In her account of 19th century European imperialism, Arendt observes that although capitalist expansionism was intended to resolve a crisis of capital accumulation and the limits of national production, all it actually achieved was the temporary deferral and subsequent reproduction of that crisis as the colonies became absorbed into capitalism. Echoing Marx’s early observations in *Capital* (1887), she argued that as part of its inherent dynamism (“constant revolutionizing of the means of production”), modern capitalism has a built-in tendency to generate “superfluity.” In her account of the South African gold rush, she construes the European migrants who settled in South Africa after the industrial revolution as an historically emergent category of socially “superfluous” people, themselves the victims and “inevitable residue” of the capitalist system, now “spat out” of Europe by a crisis of surplus capital (1974:189).

Superfluity provided Arendt with a continuum, from the state of being redundant to the state of being socially expendable, with which she was able to analyse the various antecedents to 20th century totalitarianism and its final culmination in the Holocaust (Bell 2012). Since then, scholars in other fields have drawn upon this idea, sometimes employing different language, to explore various dimensions of social exclusion in

capitalist, modern, liberal, and neoliberal states (see for example, Bell 2012; Hayden 2007; Lenz and Postl 2005; Mbembé 2004; Wacquant and Howe 2008). Zygmunt Bauman (2013), for example, argues that modernity, or what he calls "compulsive modernization," necessarily produces "human waste," with those who cannot be assimilated into modernization treated as unfit, surplus, and disposable. In the contemporary moment, he argues, "wasted lives" are erased from public consciousness, and left to rot in refugee camps and slums where they are stripped of dignity. Writing about the United States, Loïc Wacquant (2009) has argued that under neoliberalism, the superfluous "postindustrial proletariat" is treated as dangerous and as something that must be tranquilized and warehoused, through mass incarceration, in order to stem the social turmoil that neoliberalism creates at the "bottom of the urban order" (2009).

In its various iterations (Arendt 1951, 1973; Bauman 2013; Bell 2012; Hayden 2007; Lenz and Postl 2005; Mbembé 2004; Wacquant and Howe 2008) superfluity has figured in four distinct but related ways, which Boyd (2017) has characterized as: (1) "quantitative excess" (that which is overabundant), (2) "practical redundancy" (that which serves no useful purpose), (3) "noxious waste" (that which poses a threat because it is excess), and (4) "fungibility" (that which is replaceable, so expendable).
In this dissertation I draw primarily on the first and second of these meanings, approaching the men who live and reside in Puerto Rico's therapeutic communities as inhabiting a shared superfluous state in two senses: first, they share a structural location (that which is surplus to production), and second, they share an existential threat, that of being redundant. I emphasize redundancy as an *existential threat,* rather than as a *state of*

being, precisely because my argument is that therapeutic communities are apparatuses through which people create alternative kinds of 'work' that offer a variety of material and existential utilities to the bearer, as well as to various immediate and secondary beneficiaries. In departure from existing accounts that emphasize superfluity as an impersonal structural force, I offer an agentive examination of superfluity by focusing on the human experiences and efforts through which people seek to create purposeful social roles from within superfluous states. This active effort to avoid redundancy, which I analyze in this dissertation from a variety of different perspectives and levels, brings me to my second concept.

"Abeyance" (usually understood as suspension) is an idea originally developed by Ephraim Mizruchi (1983) in his often overlooked sociological study of the historically variable ways that societies have responded to the recurring problem of surplus. Unlike Arendt, Mizruchi was relatively un-preoccupied with the origins of surplus[4], which he equated with a quantitative mismatch between "societal roles" and their potential claimants. But abeyance was the name he gave to the holding process by which surplus populations are absorbed into a variety of surrogate occupations, such as breakaway religious orders in Medieval Europe, or compulsory apprenticeships in 19th century New England, or federal work programs in 20th United States. For Mizruchi, these institutions were all mechanisms for the "regulation of society," with abeyance construed in

[4] Though he does not deliberate extensively on the causes of surplus, Mizruchi notes that surplus is more likely to be generated in "liberal democracies" than under serfdom, slavery, or totalitarian regimes because under the latter, people can be more easily re-allocated to other societal positions, against their will, by the sovereign or ruler (1983:151). For Mizruchi then, surplus is related to freedom as much as to markets or capital, whereas for Arendt, superfluity is intrinsic to modern Capitalism.

(problematic) functionalist terms as something that maintains social order by placating "troublesome populations" through their sequestration "in abeyance," meaning outside of formal labor (Mizruchi 1983: 1-24).

In Hopper and Baumohl's (1994) resuscitation of the concept, they went a long way in disposing of much of this functionalist baggage by redefining abeyance as a state or predicament rather than as a magical institutional adjustment to the problem of surplus. This redefinition permitted them to analyze why past and present attempts to resolve homelessness in America have consistency failed (they address only housing, not labor or community integration), without simplistically attributing the emergence of any particular abeyance mechanism – whether the almshouse, the workhouse, or the modern day homeless shelter - to mere fluctuations in unemployment. That said, a continued emphasis on abeyance's conservative role in performing "the dirty work of system maintenance" (Hopper and Baumohl 1994: 543) means that abeyance continues to be equated with a single (often conservatively conceived) "regulatory" function (e.g., see DeVerteuil and Wilton 2009).

To transcend the idea that abeyance mechanisms inherently perform a particular function, in this dissertation I conceptualize abeyance not as a cohesive regulatory mechanism but instead as an adaptive niche, inhabited by actors who are surplus to labor, which offers a plurality of affordances to any number of potential beneficiaries. This permits me to reframe the issue of abeyance' nature – its purposes, sponsors, and effects - as a contingent historical and ethnographic question, something that both complicates its

"function" and permits a thicker ethnographic description of how it "works" on an everyday basis. This emphasis on plurality allows me to explore the multiple, contested, and sometimes converging projects that intersect with and inhere within this therapeutic regime. In the account that follows, these include (among others): entrepreneurial projects of informal enterprise, state projects of containment, life projects of the poor to professionalize themselves, and the attempts of straining kinship systems to relieve and redistribute burdens of dependency.

Running throughout this dissertation then is a concern with this generative relationship between superfluity, as a structural reality and existential threat, and the various abeyance mechanisms – including state, entrepreneurial, juridical, and civic – that arise in response to it. These two concepts together - superfluity and abeyance – provide the scaffold upon which I connect the arguments made in each of the four substantive chapters. As such, the theoretical arguments developed in each of the four chapters examine a different element of this relationship, and include: an historical account of therapeutic communities as "abeyance mechanisms" that arose in the post-war period in the aftermath of industrialization; a phenomenological exploration of how residents employ these therapeutics to carve out a meaningful sense of personhood; an ethnographic account of "vernacular professionalization," which is at once an entrepreneurial project through which criminalized men seek to professionalize themselves, and also a governing strategy through which the commonwealth state pursues cheap containment; and, finally, an analysis of the creation and implementation of a new but highly anachronistic abeyance

mechanism, which I analyze as "juridical care," and which uses civil commitment legislation to redistribute burdens of dependency between kin, the state, and the judiciary.

To support these arguments, each chapter draws on relevant focal literatures, from both within and outside the discipline of anthropology, that have to do with specific substantively connected topics, most importantly drug courts, the so-called war on drugs (more on this below), mass incarceration, peer care, homelessness, and of course, addiction. Yet, the arguments presented in each of the four chapters do not neatly slide into any of these topical areas. Instead, what unites this dissertation is a concern with superfluity, as an individual ordeal and social problem, and the ostensibly "therapeutic" project devised here in response to it.

By virtue of its disciplinary location, this examination of therapeutic communities and labor therapies in Puerto Rico is also informed by debates in medical anthropology, the anthropology of neoliberalism, the anthropology of addiction, and moral anthropology, as summarized below.

II. Medical anthropology

During the last 150 years, biomedicine has made increasingly powerful claims to define the conditions of human life and death, and exerted a profound influence on our conceptions of illness and health, normality and pathology (Lock and Nguyen 2018). Challenging the idea that biomedicine is devoid of moral values or ideology, a large body of work in the anthropology of medicine has shown how medical and therapeutic categories, knowledge, and practices are produced and shaped by social processes that we

may conceive in the broadest sense as culture, power, and political economy (Lock and Nguyen 2018; Petryna, Lakoff, and Kleinman 2006; Good et al. 2010; Baer, Singer, and Susser 2003).

One influential neo-Marxist strand of this work has drawn attention to the ways in which capitalist logics shape definitions of illness, as well as the organization and content of specific treatments (Baer, Singer, and Susser 2003; Singer and Page 2013; Singer 1994). For example, scholars have examined the political and ideological utility of defining problem drinking and drug use in medical terms, and emphasized how medical definitions, which can locate social problems within individual bodies, can obscure the political and economic drivers of social suffering (Singer et al. 1992; Singer 2007; Singer and Page 2013).

Other works have added greater nuance to understandings of how 'the social' can shape and produce particular therapeutic regimes. For example, in his investigation of treatment for alcoholism in Russia, Eugene Raikhel (2016) explores why placebo-based therapies continue to be widely prescribed by Russian psychiatrists, given that they are widely considered to be ineffective in Europe and the United States. His ethno-historical account traces certain particularities in Soviet psychiatry, and illuminates various epistemological differences in scientific understandings of the mind and brain between post-Soviet psychiatry and North American psychiatry. Similarly, Lakoff (2006) has contextualized the continued dominance of psychoanalysis within Argentinian psychiatry in relation to de-institutionalization and the developmentalist modernization that occurred in the wake

of Peronism.

This dissertation draws on this well-established tradition in the anthropology of medicine to explore the social, political, and economic factors that have contributed to the historical rise and persistence of this therapeutic regime. By identifying an unruly collection of locally enabling and constraining institutions and resources that have variously propped up this therapeutic regime, from faltering unemployment and correctional systems to overwhelmed kinship networks and community, it shows how multiple social contextual factors and interests – that often have very little to do with addiction, illness, and healing - are at play within this therapeutic regime.

III. Neoliberal transformations of care

The historical portion of this dissertation is grounded in work on the neoliberal extension of market-based governance across public institutions and health care settings in U.S. and Latin America (Abadía-Barrero 2015; Han 2012; Mulligan 2014; Mirowski and Plehwe 2009). The exercise of political power modeled on the principles of the market economy represents a transformation in the relationship between the state, the market, and the individual (Mirowski and Plehwe 2009), in which "the risks and costs of managing human frailties under capitalism once shouldered by government and corporations get displaced onto individual workers and vulnerable families" (Somers and Wright 2008:2). A great deal of work on neoliberalism has described contexts in which the dismantling of public services shifts the work of care to other social actors such as families (Han 2012), NGOs and volunteers (Adams 2013; Biehl 2007; Muehlebach 2007), informal self-help groups (Garcia 2015), and overstretched frontline workers (Hopper 2006). Yet fewer

works have explicitly foregrounded the question of 20th century historical change to examine how specific institutions of care have transformed and adapted over time (but for a good example of this, see Keshavjee 2014). This has left open a variety of questions about how institutions of care variously respond and adapt to neoliberalism.

Informed by recent works that highlight the regional specificities of neoliberalism (Ferguson 2006; Elyachar 2005), this project takes the rise of Puerto Rican therapeutic communities as a movement with its own local history and internal dynamics, but as inescapably entangled with neoliberalism (Ortner 2016). As scholars have noted, the most significant wave of neoliberal reforms occurred in Puerto Rico in the 1990s under the auspices of a newly elected pro-statehood governor, Pedro Rosselló. This time of political transition that was intimately related to Puerto Rico's future constitutional status in relation to the United States (Mulligan 2014). Governor Rosselló's reforms, which privatized Puerto Rico's public healthcare system, are widely considered to have been an attempt to demonstrate Puerto Rico's suitability for statehood, through assuring economic and ideological compatibility with the United States (Hansen 2018; Mulligan 2014).

By historically tracing therapeutic communities' development since their establishment in the 1960s, two decades before neoliberalism took shape in the United States (Harvey 2005) and three decades before the privatization of Puerto Rico's healthcare system (Mulligan 2014), this dissertation helps to deepen anthropological understanding of the genealogy of neoliberal transformations of care. The expanded historical portrait presented here begins with the post-War New Deal and the commonwealth state's

modernization projects, and continues through the war on drugs as initiated in the 1970s by the Nixon administration, through to the neoliberal present. Rather than attributing therapeutic communities' rise to neoliberalism in any simplistic sense, the historical portion of this dissertation documents the precise ways in which therapeutic communities have responded and adapted to neoliberal reforms. This includes an examination of how they have altered their methods and organization, and also an analysis of how their imbrication in a variety of local political projects continues to favorably position them to survive in the neoliberal era.

IV. The anthropology of addiction

This dissertation is also informed by the growing subfield of the anthropology of addiction (Garriott and Raikhel 2015). Perspectives from critical medical anthropology, science and technology studies and governmentality studies converge in this work, situating addiction and its treatment as an analytical site for exploring contemporary life (ibid:477). A central project within this work has been to examine how configurations of clinical and lay knowledge shape specific therapeutic techniques (Raikhel and Garriott 2013; Fraser, Moore, and Keane 2014; Moore 2007; Campbell 2007).

As evidenced in a recent review (Garriott and Raikhel 2015), however, anthropological investigations of addiction therapies have tended to pay much more attention to the governing strategies and techniques that operate within particular treatment regimes (e.g., Bourgois 2000; Keane 2009; Zigon 2010; O'Malley 2009; Kerwin Kaye 2010) than they have to the historical contexts, state actions, and policies that produce particular therapeutic regimes in specific places and historical moments. For example, drug

treatment has been theorized as a collection of techniques for cultivating "responsible" (Vrecko 2010b), or "moral" (Zigon 2010) subjects. Other scholars have pointed to how ideas about gender are filtered into therapeutic regimes, with drug treatment often characterized as disciplinary devices for producing, for example, women who are emotionally introspective but not "overly oriented toward children" (McKim 2008), or men who show "contentment with life" and abide by Islamic values (Al-Krenawi and Graham 1997).

It is also illuminating, however, to consider the historical and political contexts in which particular therapies take shape. Fairbanks' (2009) does this successfully in his analysis of how specific configurations of welfare legislation, labor policies and government agencies induce Philadelphia's recovery houses to employ coercive tactics, such as obtaining power of attorney over clients and confiscating clients' identity cards. Helena Hansen (2018) has also done pioneering work in her history of Evangelical drug ministries in Puerto Rico. By weaving together the histories and imageries of Pentecostalism and post-industrialism, and also the biographies of treatment leaders, she characterizes these ministries arising from an existential or spiritual need to reconcile Puerto Rico's dilemma as a liminal colonial state with long frustrated aspirations for U.S. standards of living. Through religious transcendence, she argues, these self-fashioned ministries provide an alternative social order of family, work, and gender to people who are economically and socially marginalized, allowing addicted men to "symbolically reverse their marginalization" through building spiritual power.

Like Hansen (2018), I am also interested in how therapeutic communities can operate as surrogate livelihoods, homes, and foundations of social membership in contexts of marginality. But in addition to examining what therapeutic communities offer to their practitioners – for example, a job, recognition, dignity, redemption and so on – this dissertation also explores how these projects of the poor have become entangled with other political interests. These include state projects of containment (Chapters 1 and 3), municipal governance (Chapter 1), electoral politics (Chapter 1), and familial projects of domestic order (Chapter 4). My examination of the structures and political interests that support this therapeutic regime leads me to emphasize that therapies thrive not simply because of the material or spiritual affordances they lend to their inhabitants, but also because of the way in which they are embedded in Puerto Rican political life.

IV. Moral anthropology

A fourth framework grounding this dissertation is recent works in moral anthropology (Fassin 2012; Mattingly 2014; Robbins 2013). A key insight from that work is that inequality and power limit but do not eclipse people's capacities to make meaning and to lead good lives (Ortner 2016; Robbins 2013). While human rights groups have decried therapeutic communities as "exploitative" (OSF 2016), there has been little consideration of what this therapeutic regime may offer to its practitioners. Across the fields of drug abuse, mental heath and HIV/AIDS, a substantial literature has described various aspects of the role of the "expert patient" or "wounded healer" (Kielmann and Cataldo 2010), often focusing on the advantages of subjective illness experience for quality of care (Austin, Ramakrishnan, and Hopper 2014). Taking a somewhat different tack, this

dissertation heeds recent warnings that anthropologists should not overlook the caring and ethical dimensions of human life in their analyses of structure and power (Lambek 2010; Keane 2015). Accordingly, it seeks to understand how residents and caregivers, who have experienced immense social suffering, endure, work through and make meaning in this therapeutic market (Kleinman, Das, and Lock 1997; Das et al. 2001).

Specifically, this dissertation positions therapeutic communities as a means to pursue several lines of inquiry relating to personhood, redemption, and moral experience. Specifically, through a phenomenological examination of labor therapies (Chapter 3), it explores an emergent notion of personhood and social morality that passes judgment on busyness and idleness as lived states. Bridging neo-Marxist and moral anthropological frameworks (Adams 2013; Muehlebach 2007), this dissertation examines the emergence of a distinct and alternative economy in which "lumpen subjects" (Bourgois and Schonberg 2009) may carve out a meaningful alternative livelihood and thus be converted into producers of economic, social and moral value (Adams 2013; Elyachar 2005; Zigon 2010). It explores a seemingly unlikely mutuality of interest whereby the neoliberal carceral state hands over obligations of care to disempowered peers, who not only embrace these responsibilities, but also create an entrepreneurial project of self-betterment within this paraprofessional market (Das et al. 2001; Kleinman, Das, and Lock 1997).

Ethnographic context

A brief history of Puerto Rico's constitutional status

The events described here take place in a particular time and place that could be conceptualized in a number of ways, but two contextual elements in particular warrant elaboration. First, Puerto Rico's status as a colonial territory of the United States is a vital element of the historical context in which therapeutic communities have thrived. In brief, Puerto Rico became a colonial territory of the United States when the US took possession of the island in 1898 during the Spanish American War. In 1901 the US Supreme Court ruled that Puerto Rico's legal status was that of an "unincorporated territory." That is, Puerto Rico "belonged to" but was not "part of" the United States (Burnett and Marshall 2001). Although Puerto Rico's residents were granted US citizenship in 1917, as an unincorporated territory Puerto Rico has remained subject to federal legislation at the discretion of Congress, has never had representation in US federal government, and its residents are still not permitted to vote for the US president (Burnett and Marshall 2001). Up until 1948, US congress appointed all of its Governors. In 1948, when the US granted Puerto Rico the right to elections, Luis Muñoz Marín of the Popular Democratic Party (Spanish acronym, PPD) became Puerto Rico's first democratically elected Governor, a position he retained until 1968, when he was eventually defeated by the pro-statehood opposition.

Governor Muñoz Marín, described by historian Michael Lapp as "the quintessential moderate" (1995:184), had abandoned his earlier ambitions of achieving independence

for Puerto Rico, something that had defined his pre-World War II political career. Instead, Muñoz Marín struck a compromise: eschewing the anti-colonial movements that were gaining strength in Latin America, and instead pursuing economic development through state-led modernization. The modernization projects of the 1950s were accompanied by a transformation of Puerto Rico's constitutional status. Puerto Rico became a 'commonwealth' in 1952, a status that provided it with a degree of local autonomy over local policies, but which is widely considered to have rendered its economy entirely dependent on American investment (Dietz 1986; Lapp 1995). Owing to its constitutional status as a commonwealth, a status that remains in place today, a complex policy climate has surrounded the historical evolution of Puerto Rico's therapeutic communities. For the present purposes, a pertinent upshot of Puerto Rico's commonwealth status is that many of the U.S. federal government's major policy projects of the 20th century were also implemented in Puerto Rico, albeit in locally specific ways. Because of this, various events in US narcotics history and policy are included and explored in this dissertation.

Finally, in 2016 - the year fieldwork for this project began - Puerto Rico's relationship to the US underwent yet another evolution. In response to a decade-long recession and resultant debt crisis, the United States exercised its power under the Territorial Clause of the US constitution by introducing a financial oversight board through the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA). The powers bestowed on PROMESA now supersede those of both the Puerto Rican Governor and the Legislature. Puerto Rico's Governor was permitted to sit at the table only as a non-voting

member. The former US President, Barack Obama, appointed all seven members of the board. Lambasted in the press as a “blatant act of colonialism” (Rivera 2016) and, oddly, as “evidence” for Puerto Rico's colonial status (Delgado 2016), PROMESA has facilitated the imposition of a variety of fiscal austerity measures, including cuts to education and the closure of hundreds of public schools (Etehad 2017). The historical events described in this dissertation then, are largely set prior to this, but the ethnographic material extends into the cusp of the new austere era.

A very brief note on the war on drugs

A second element of the historical context that is important for understanding why therapeutic communities have thrived is the so-called “war on drugs.” As scholars in various disciplines have noted, the thing that is often referred to as the war on drugs is not reducible to a set of policies or a single coherent strategy (Zirnite 1998; Bagley 1988; Felbab-Brown 2013). While most can agree, more or less, that the policies, institutions, and human effects that are now known as the war on drugs began (or at least took a particular shape) in 1971 under US President Nixon (Bagley 1988; Felbab-Brown 2013; Zigon 2015; Zirnite 1998), from then on there is little in the way of agreement about what the term can be said to encompass. Because of this, some scholars have advocated abandoning the term altogether (e.g., see Mansfield 2016), and have focused instead on specific counter-narcotics policies in specific places, such as Mexico, Afghanistan, and the urban US. Yet as Zigon (2015) has noted, conceiving of the war on drugs only through its localized manifestations risks missing the fact that across geographically and socio-economically diffused locales, people and objects are connected – or “caught up in shared conditions (2015: 502)” - by complex structures (or according to Zigon’s

theoretical orientation, “assemblages”). These include, among other things, state-based surveillance and control, mass incarceration, militarized police violence, and global militarism, each of which has taken various forms over the last thirty to forty years.

In this dissertation, I use the term war on drugs in a similar manner to Zigon (2015). Like him I believe that isolating and dissecting the drug war into its constituent ‘pieces’ (if there are such things) risks missing the fact that therapeutic communities in Puerto Rico, mass incarceration in the United States, and federal experiments in addiction science are all connected. Thus, when I refer to the war on drugs in this dissertation, I acknowledge that this includes a globally diffuse collection[5] of institutions, policies, objects, and people, who are indeed connected, albeit in complicated ways. While using the term war on drugs does risk implying a more coherent and coordinated effort than exists, the connections and relationships between narcotics policies, mass incarceration, and localized treatment regimes are important to keep in mind, especially in a place like Puerto Rico, where as I show in Chapters 1 and 3, various US policy projects including mass incarceration, centralized addiction treatment, and therapeutic jurisprudence have been colonially imposed and administered over the last forty years.

Fieldwork in Puerto Rico before the Hurricane

This study began in July 2015 with a preliminary three-week visit to Puerto Rico as part of a Social Sciences Research Council dissertation improvement award. In July 2016 I

[5] I use the term “collection” rather than Zigon’s term “assemblage” because I do not explore ontology here. (For discussions of assmblage theory see: Collier and Ong 2005; Zigon 2015).

returned to the island, where I conducted thirteen consecutive months of ethnographic fieldwork originally conceived of as exploring residential drug treatment.

The month I began fieldwork was almost exactly a year before Hurricane Maria would pass through the island, devastating communities and eventually leading - at time of writing - to an estimated 3000 fatalities (Fink 2018). By mid-2016, Puerto Rico's public services were already under considerable strain. After ten consecutive years of economic decline, in June 2015 Puerto Rico's Governor, Alejandro Garcia Padilla, declared Puerto Rico's $72 billion debt "not payable" (Corkery and Walsh 2015). In the year that followed, public hospitals found their electricity supplies cut off for failing to pay their bills (Rappleye 2016), a fire in a power plant triggered a three-day island-wide electricity blackout (Toh 2016), thousands of public sector workers laid off (El Vocero 2016), and, in response to the news of a $450 million budget cut to the public university system, students of the University of Puerto Rico declared a one-week shutdown of the university, which quickly became an indefinite strike (Robles 2017).

Needless to say, Puerto Rico was already in chaos, with neither healthcare nor drug treatment being exceptions. In 2016, the commonwealth's recently privatized healthcare system was hemorrhaging medical professionals, with headlines running, "Puerto Rico Is Losing Doctors, Leaving Patients Stranded" (Allen 2016), and "Why it can take longer than a year to see a doctor in Puerto Rico." According to a 2016 investigation by *Reuters*, working physicians were down by 36% from the previous decade, and medical specialists for Puerto Rico's 3.5 million residents were in particularly short supply, with just one

pediatric allergist, four geneticists, and ten pediatric neurologists (Respaut 2016).

In the realm of drug treatment, things were especially bleak. In 2015 a podcast aired on National Public Radio's *This American Life* had prompted outcry when it ran a story about Puerto Rican state officials purchasing one-way plane tickets for drug users who were then sent to Chicago and abandoned in unlicensed flophouses[6] (This American Life 2015). The scale of these deportations subsequently came to light when journalist Alfred Lubrano wrote an article in the *Philadelphia Inquirer* that traced this government practice – known locally as "Air Bridge" - to seven sender cities in Puerto Rico and also to several named government officials (Lubrano 2016).

Back on the island, the situation in Puerto Rico's in-house drug treatment facilities was not much better. By the commonwealth government's own estimates (based on its periodic "household survey"), only 24% of people who met the clinical criteria for substance abuse, and 8.5% for substance dependence, were receiving any form of specialized drug services (ASSMCA 2008). Compared to the mainland, Puerto Rico's drug treatment services were known to be severely under-resourced (Deren et al. 2014). The results of one comparative study of drug users in Puerto Rico and New York City were particularly startling. Relative to New York-based Puerto Rican drug users, drug users in Puerto Rico were dying at three times the rate of their New York-based counterparts (Colon et al. 2006).

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[6] The deportation of drug users from Puerto Rico to the mainland had been happening since the 1990s. It was a local government practice administered primarily by city mayors and police and it had actually been documented at least five years earlier (Torruella 2010), though it had never made international news before.

In addition to problems of treatment scarcity, there were also signs of problems within drug treatment facilities themselves. In May 2015 Puerto Rico's residential drug treatment centers came under intense public scrutiny following a report from a local harm reduction agency (called *Intercambios Puerto Rico*) that decried their methods as "psychologically abusive" and "exploitative" (IPR 2015). The report, which circulated widely internationally, accused the island's residential drug treatment centers of using "abusive and […] dangerous practices," "many already dismissed by science," including "coerced committal," "punishment and humiliation as treatment," and "forced labor as treatment." This latter charge was leveled against one organization in particular, *Hogar CREA*, Puerto Rico's largest and most well-known residential provider and a long-time recipient of federal and commonwealth funding (mostly from US the Department of Housing and Urban Development, as well as various commonwealth agencies). The *Intercambios* report prompted public outcry and led to a federal investigation of Puerto Rico's residential facilities. It also provoked *Hogar CREA,* the organization that had received the most criticism in the report, to pursue a lawsuit for libel and defamation (which, two years later, proved ultimately unsuccessful).

Despite calls for greater regulation, the commonwealth state's capacity to make demands on residential treatment facilities was legally constrained by an exemption clause in a key piece of legislation – the Mental Health Act – initially introduced in 2000 (and amended 2008). As Hansen has described (2018), this bill of rights was supposed to establish minimum standards of care in mental health care facilities. When legislators drafted one version of the law that would have required all therapeutic communities to employ clinically trained staff and adhere to minimum standards of care, therapeutic community

leaders denounced the proposed law, with Evangelical leaders even threatening to mobilize voters against the Governor in the upcoming election. In the end, an additional article that exempted non-profit providers from the healthcare standards set out in the bill was added to the law (Ley 408 2000). Thus, during the time I conducted fieldwork, the commonwealth state's regulatory leverage over licensed therapeutic communities remained restricted to compliance with basic safety standards (fire escapes, occupancy limits), rather than to any clinically defined standards of care (this remains the case at time of writing).

Ethnographic methods and analysis

It was within this highly contentious political climate that this project took shape, which presented various methodological and ethical challenges. From the outset, I decided that I'd try to talk to staff and residents from as many centers as possible. My reasoning for this was two-fold. First, I wanted to gain a sense of the different kinds of institutional arrangements and political factors that supported this therapeutic regime as a whole, which required that I also gain a sense of institutional variability. Second, I figured that including accounts from representatives of multiple different organizations would make it easier for me to protect the identities of the institutions I worked with. Obtaining access to multiple different centers initially seemed like a major obstacle, but one thing I hadn't accounted for was how much movement there is (of staff and residents) between different centers. Because many of the people I interviewed have spent time as residents or staff members in multiple different centers, I have been able to learn a lot about the structure

and approaches of different centers without having to go, in every single instance, via institutional gatekeepers. This has been especially helpful for learning about *Hogar CREA,* an organization that features prominently in this dissertation, but that did not (and does not) welcome attention from researchers or journalists, largely because of the negative press coverage that it has received since the publication of the *Intercambio* report (IPR 2015).

Timeline		**Method of data collection**
2017	July	Archival and policy research
	August	
	September	
	October	
	November	
	December	Ethnographic visits to multiple centers
2018	January	Ethnographic research at *La Casita*
	February	
	March	
	April	
	May	
	June	
	July	
	August	

In July 2016 I began full-time fieldwork. For the entirety of the year, I also worked part-time as a graduate research assistant on a study of HIV care access among injection drug users in San Juan funded by the National Institutes on Drug Abuse (NIDA). This part-time position was crucial to the viability of my research, in the sense that it provided me with an income (I was awarded a federal grant roughly half way through fieldwork). But it was also relatively unrelated to my dissertation project, in the sense that most of my responsibilities on that project were desk-based (e.g., conducting literature reviews for

quantitatively-oriented research papers), and so the cross-pollination between the two projects was actually fairly minimal.

For my dissertation research, my most immediate problem was bureaucratic. By the time I began fieldwork, my proposal had been under review at the Institutional Review Board (IRB) of the University of Puerto Rico for four and a half months, and at that time I was expecting it to be approved within a matter of days. Figuring that I'd make a start on the historical portion of the project, I settled into an apartment in San Juan near the University of Puerto Rico, and began gathering sources from three archives (*el Archivo General de Puerto Rico, la Colección Puertorriqueña,* and *la Biblioteca Legislativa).* Though I initially intended to spend no more than six weeks or so on the archival research (in hindsight, hugely undervaluing it in favor of ethnography, about which I was much more excited), for a variety of reasons it took five more months to get my study approved, something that I think has greatly altered the scope and texture of this dissertation.

That summer, I made the acquaintance of a retired psychiatrist, Dr. Efren Ramirez, who turned out to be a pivotal contact that year. He was not only the founder of Puerto Rico's first therapeutic community (called CISLA, founded in 1961), but he was also the former therapist of one of Puerto Rico's most famous therapeutic community leaders (Chejuán, the founder of *Hogar CREA*), a family relation of Puerto Rico's former Governor Luiz Munoz Marin, and had also served as the first Commissioner of Addiction Services for New York City in the mid 1960s. He quickly became an invaluable accomplice as I pieced together whatever I could glean about therapeutic community history from the

archives. Enthused by the project, he rustled together whatever he could from his own personal collection– files of newspaper cuttings documenting his own professional life, in-house magazines and early publications from some of Puerto Rico's first therapeutic communities, and even unpublished drafts of his memoirs (which were the closest thing to a 'history' of Puerto Rico's therapeutic communities that I would ever find). He also put me in touch with dozens of individuals who'd been therapeutic community leaders in the 1960s and 1970s, some of who were also his former patients, and some of whom I was later able to interview.

In December 2016, after I had been in Puerto Rico for more than five months, stuck in the archive (as I felt at the time), now making my way through reels of photo-film on anything marginally related to my topic, my project was finally approved. Figuring I needed to get out of the capital, I bought a car and began by visiting and talking to directors at as many residential drug treatment centers as I could identify. At that time, and as still the case at time of writing, residential facilities were the most numerous among all kinds of licensed drug treatment facilities[7], and provided care to approximately 4500 people each year (ASSMCA 2014), out of the 57,000 adults who are estimated to need treatment because they meet criteria for last year substance dependence disorder (ASSMCA 2016). In terms of capacity (number of beds), 44% of that 4500 was provided by one single organization (*Hogar CREA*), a homegrown chain with 52 centers on the

[7] At that time, Puerto Rico had 160 government-licensed facilities in operation that provided specialty drug or alcohol services (SAMHSA 2014). These comprised: 11 detox centers (capacity 156 people), five outpatient mental health clinics, 6 state-run methadone clinics, 6 needle exchange programs, and 132 residential centers (ASSMCA 2008; ASSMCA 2014).

island; 19% was provided by other “community-based” organizations; 30% by “faith-based” organizations; and 7% was provided by the government, mostly in correctional facilities (IPR 2015). As is still the case, there was no generalized funding mechanism for residential treatment. Some centers received contributions from government (mostly from Puerto Rico’s Department of Corrections, but also from federal funders such as HOPWA[8] and Ryan White[9]), while others relied entirely on non-government sources. Centers also varied considerably in their capacity: some were single-branch units operated by a handful of people whereas others were large franchises operating across Latin America.

Using the government registry of licensed drug treatment providers,[10] and a few handy referrals I’d acquired along the way, I eventually succeeded in visiting thirteen different centers across five municipalities (San Juan, Arecibo, Juncos, Humacao, and Caguas), with most interviews arranged through an intermediary contact. On each of these visits I interviewed directors about their institutional history, structure, and therapeutic philosophy, and I gradually gained a sense of the institutional variability among residential programs. Roughly half of the centers I visited were bureaucratically categorized as “faith-based” and the other half as “community-based,” which is slightly higher than the 30% centers that are faith-based nationally (IPR 2015). Despite bureaucratic nomenclature, however, the prominence of religion in all of these centers

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[8] The Federal program - Housing Opportunities for Persons With AIDS.

[9] Ryan White is the largest federally funded program in the United States for people living with HIV/AIDS.

[10] And soon finding that many of the phone numbers were out of service, and many of the addresses out of date.

was quickly palpable, most visibly in the makeshift chapels, called *cultos,* that often littered the grounds, and also because of the significant amount of time people spent praying.

Over time, I noticed that the "faith-based" centers tended to be smaller operations than the "community-based" centers[11], with the latter being more likely to have large corrections contracts. A second and related difference was that the "community-based" centers tended to be more obviously carceral, in the sense of being surrounded by fences and gates covered in barbed wire. In contrast, the smaller faith-based programs were more likely to have open grounds and even to feel bucolic.

The permanent state of financial precarity that permeates all of Puerto Rico's residential programs was apparent early on. The directors I spoke to, many of who identified themselves as *productos del programa* ("products of the program"), invariably described a constant hustle to keep their organizations afloat. This generally involved seeking donations (from religious organizations, businesses and other donors), developing entrepreneurial side-projects to generate income, obtaining public contracts at the Department of Corrections, or submitting grant applications to various other governmental agencies.

Access to government funding was a challenge, however, not just for a lack of it, but also because most centers lacked the professional accreditation or resources that are required

[11] The major exception being Teen Challenge, an Evangelical chain with multiple programs in Puerto Rico and elsewhere in the United States and Latin America.

in order to receive government funding from federal or commonwealth health departments (most relevantly, the US Substance Abuse and Mental Health Services Administration, or the Puerto Rican Administration of Mental Health and Anti-Addiction Services). In order to access government funding, one common strategy employed by several of the centers I visited was to extend their institutional remit to include "shelter for the homeless." This enabled centers to access to public housing grants (most significantly from the US Department of Housing and Urban Development), which brought few demands regarding therapeutic content or staff credentials. For this and others reasons elaborated upon in Chapter 2, I began to think of these institutions as "addiction shelters."

The ninth organization I visited was *La Casita*, a "community-based" program. Initially envisaged as a therapeutic community for the treatment of addiction, owing to funding necessities *La Casita* had recently adjusted its remit to include residential shelter for the homeless. This bureaucratic makeover had facilitated access to more stable sources of funding. It had also brought with it shift in *La Casita's* intake, which in addition to substance users now also included people who'd lost their jobs and homes, people with mental health disorders, and a growing stream of court-mandated residents referred through the courts.

Founded in 2007 by a former heroin user and therapeutic community graduate, *La Casita* acquired its premises when its founder, Jorge Santiago, inherited a burnt-down property. Jorge's own heroin addiction had brought him into contact with twelve different

rehabilitation programs between the ages of eighteen and twenty-seven. After completing his last stint as a patient at a Pentecostal addiction ministry in Puerto Rico's interior, where he'd been taken on as a therapist and worked for several years, he decided in 2007 to found his own program in what was then still a burnt-down house.

Jorge and the other staff at *La Casita* were especially welcoming to me. Accustomed to hosting visitors, mostly Puerto Rican university students and therapeutic leaders from other parts of Latin America, they were enthused about having a researcher around and allowed me to base a portion of my study there. In theory, I could have based this portion of the study at any of the centers I'd visited. By that point I'd spent so many months in the archives, pouring over bureaucratic documents, government contracts, and decades of narcotics law, and I'd interviewed a sufficient number of center directors and government officials, that my grasp of the institutional and political factors sustaining these organizations was reasonably well developed. By contrast, my sense of what they are like if you actually have to live in one was minimal. For this specific purpose, *La Casita* appealed not because it was "typical" or "unique," or because it provided a theoretically interesting form of contrast to something else (Hirsch 2003). Instead, it worked as a site because it was not currently engaged in contentious public litigation, open to having a researcher around, and not so institutionally carceral that I'd have to be searched for weapons each time I entered the premises. Of course, this means that my in-depth exploration of what life is like in a therapeutic community is a particular account of *La Casita*, not a generalizable account of all therapeutic communities.

Owing to my decision to base this portion of the story in a "community-based" rather than a "faith-based program" program, the therapeutic practices that I describe here differ somewhat to the religious practices (e.g., conversion, fasting, and bible study) that have been described in faith-based programs (see Hansen 2018). That said, labor therapies are not exclusive to community-based organizations[12], just as religious practices are not exclusive to faith-based organizations. As described in Chapter 2, *La Casita* was actually saturated in Christian content. Although religious belief and worship were not obligatory, a vernacular Christianity prevailed, prayer was an organized daily practice, and even its most secular therapeutic teachings (grounded in characterological theory and North American psychiatry) were laden with Christian salvific content. Thus, the distinction between "faith-based" and "community-based" was primarily an indication of an organization's funding sources (church or state), and perhaps of its stance towards religious worship as obligatory or voluntary, than it was of everyday practice.

In terms of funding, *La Casita* had a couple of government contracts, neither long-term, but by the standards of Puerto Rico's residential facilities it wasn't doing too badly economically. That said, from the battered pine bureau that sat in the office corner with every drawer broken, to the sofa that oozed its stuffing, to the chain link fence that caged around a rusting office chair and was now serving as a hair salon, *La Casita* was manifestly makeshift. Much of its supplies – bunk beds, tin cups, hundreds of cans of condensed milk– were donated. Its therapeutic strategy also shared an ad-hoc quality that

[12] Teen Challenge, Puerto Rico's largest Evangelical residential treatment provider, is known to have several state and local government contracts through which it dispatches its residents to perform unpaid work. In this regard, it is organized in a similar manner to *Hogar CREA*.

I came to recognize as common among Puerto Rico's residential programs. For example, its most recent articulation of its therapeutic goal - "resocializing the homeless" – was itself a product of a recent change in funding, and its design was now a hodge-podge of 12-step techniques, traditional therapeutic community approaches, biblical or at least Christian-inflected teachings, and some from humanistic psychology. Its therapeutic objectives now numbered in the dozens and filled a full five pages of the newly written handbook, copies of which had been printed off an office computer and fastened together with staples.

Since *La Casita* was a men's center, and one which frequently experienced bed-shortages, we agreed I should continue to live off-site, but with the exception of nighttime hours I was pretty much permitted to come and go as I pleased. Over an eight-month period (January 2017-August 2017), I conducted intensive observations at *La Casita*. Four to five days a week, I'd arrive at 7am in time to join morning prayer. I'd participate in group therapies, and accompany residents as they completed their assigned tasks and duties. I often ate lunch or dinner there, sometimes with residents in the canteen, and other times with the directors in the staff room. Though not an official "volunteer," I would often help out with managing donations, mostly clothes, food, and furniture, and I accompanied residents to court and to off-site family visits and medical appointments. Though I conducted formal recorded interviews with residents and staff members at *La Casita* (see Table 1 and Table 2), I found unrecorded informal conversations to be far more informative, particularly those with residents. I think this had a lot to do with setting, in the sense that however green or bucolic, *La Casita* was

inescapably and palpably a "total institution" (Goffman 1961), I found that the presence of a tape recorder often put people on edge. My most interesting conversations with residents took place instead during chore-times and coffee breaks, in "public-private places," out of earshot but within sight, for example: on the laundry balcony, on the patio before or after group therapy, in the hair salon, or at the "gym" (actually just a jumble of weights and punching bags in the corner of a car park). I found this worked better than the dingy conference room at the back of the shelter, which I used primarily for recording interviews with staff members (with far fewer problems).

I gravitated towards those residents who showed an interest in talking to me, and I kept my distance from those I sensed would rather be left alone. Given the lack of entertainment on offer, and the institutional absence of female company, it really wasn't difficult to find people who wanted to talk. I sometimes introduced myself as an anthropologist, which tended to produce blank stares, and quickly shifted to introducing myself as a student of public health interested in learning about addiction, which people seemed to find more easily recognizable. (This, in turn, often led to pronouncements about the problem of drugs in Puerto Rico. The meta-narrative of drugs as a nationwide problem, one that "doesn't discriminate" and affects the rich and poor, was all around).

I usually carried a notebook, even after getting to know individual residents quite well, and even during some fairly personal conversations. The vast power differentials between me (a researcher, from England, with the institutional clout of Columbia University behind me), and them (institutionalized, usually poor, and often criminalized), and the

fact that we could chat for hours but at the end of the day I could go home, felt like something I needed to explicitly acknowledge, not try to diminish or hide. I also had to navigate being in a singularly masculine space, while trying to get to know people, and avoiding (and pre-emptively shutting down) unwanted sexual attention. In hindsight, I benefited a lot here from the oversight of a couple of individuals. There were two men in particular (a staff member, Rocky, and by his instruction a resident, Angel), who I think made things easier for me by being generally present, checking in with me regularly, and often dishing out quite comical warnings to other residents to "*trata a la jovencita con respecto*" ("treat the young girl with respect"), while publicly instructing me to let them know if I ran into problems.

In addition to this kind of 'chivalrous oversight,' another thing that helped, oddly, was carrying a notebook. This was probably because, at least to my mind, the notebook served as a visible reminder that our conversations, however friendly, were taking place in the context of research; it also rendered visible the radically unequal exchange that was taking place in these interactions. In this regard, it was a bit like when your professor ends your friendly conversation at exactly 3pm just as scheduled, or pointedly leaves the office door open when the two of you meet. It meant that I wasn't mistaken for an uncomplicated, uncompromised friend, or a date, however friendly the relationship. I didn't find this strategy to be a major hindrance to open conversation (unlike the recorder). In fact, I think some men appreciated the fact that they were being listened to carefully.

There are, of course, other ways of approaching ethnographic encounters, strategies that are much more immersive and that seek to reduce the power differentials and sociological distances between researchers and their informants. While immersive approaches are certainly valuable, in my view they tend to work best when researchers are actually sociologically close (or closer) to their informants. In my case, by virtue of me being not just privileged, white, and female, but more importantly, I think, *free to leave,* this was a "good enough" strategy (Scheper-Hughes 1993), and one that I could live with. Each evening, I'd drive back to San Juan against miles and miles of stationary rush-hour traffic, exhausted, and often glad to be alone.

On the days I wasn't at *La Casita*, I spent a lot of time returning to the residential programs I surveyed before settling at *La Casita,* to conduct follow-up interviews and short-term observations. Outside of these treatment settings, I spent as much time as possible in the company of other stakeholders. Each Wednesday I attended a social gathering and live radio recording of a group of drug treatment activists near the University of Puerto Rico. Several members of this group became important friends with who I was able to discuss my emerging findings and research ideas (and later, share preliminary chapter drafts). I attended government outreach initiatives to enroll homeless drug users into treatment, I followed harm reduction workers as they distributed clean syringes in shooting galleries, I attended debates and lectures at the Medical Center of the University of Puerto Rico, as well as the fundraiser events and graduation ceremonies of various treatment programs. I also spent a lot of time at the mall with mothers of residents, with whom I became friendly later in my fieldwork when I became interested

in civil commitment. Over the course of fieldwork, I got to know several of the families of residents at *La Casita*, but it was mostly the mothers I spent one-on-one time with. I also spent a lot of time in the municipal courts observing civil commitment procedures (I talk about this more in Chapter 4).

Table 1	
Recorded interviews	**N**
Oral history interviews with therapeutic community leaders	15
Key informant interviews	15
In-depth interviews with residents at *La Casita*	8
In-depth interviews with residents from other therapeutic communities	10
In-depth interviews with staff from other therapeutic communities	10
In-depth interviews with staff at *La Casita*	5
Total	**63**

To protect the confidentiality of participants, all interviewees have been given either pseudonyms or general appellations (e.g., therapist at a faith-based center). The people referred to by their actual names are public figures or published authors (e.g. Efren Ramirez, Juan José García Ríos) whose views have already been documented through popular media, academic publications, or public domain archival documents. No statements are ascribed to any of these individuals beyond those already substantively made in print or other public media. As an additional precaution, I also use the fictional name *La Casita* to refer to the residential center where I based a portion of this study, and where it does not compromise the significance of events I have modified other identifying details (e.g., location).

Table 2	
Sample characteristics of residents and staff	**N=33**
Age	42
21-39	18
40+	15
Education	
High school or less	26
Some university	5
Completed university	2
Incarceration	
Formerly incarcerated	28
Never incarcerated	5

Throughout fieldwork, I kept a written record of my observations, including first impressions, unexpected events, and descriptions of settings. As soon as possible, I typed-up hand written notes into more extensive and detailed desk notes, which I organized using various tables that compiled observations, questions and contradictions, emergent analytical themes, and methodological decisions. At the end of every formal interview I wrote a short interview summary, which I organized according to my initial theoretical framework. This helped me to track emerging findings, and to assess whether or not my interview guides were adequately addressing my theoretical questions (Burawoy 1998). Because data analysis was ongoing and commenced with data collection, I was able to adjust my interview guides as I went along, such that data collection and analysis guided each other in an iterative process (O'Reilly 2008).

On leaving the field, I analyzed the textual data, including fieldnotes, interview summaries and interview transcripts using Atlas TI. This software operated as an organizing tool, enabling me to compile, code and search documents during analysis and writing phases. My approach to data analysis was based on aspects of the extended-case

method (Burawoy 1998) for the interrogation and extension of existing theoretical frameworks in relation to addiction therapeutics, neoliberalism and care.

A note on language and some things I do not write about

For some readers, there will be a notable absence in this dissertation of any explicit discussion of women and female drug users. The reason for this is analytical. The vast majority of Puerto Rico's therapeutic communities, past and present, have been founded by men, for men – a fact that has a lot to do with their entanglement with criminal justice, something that I explore extensively in this dissertation. Women's therapeutic communities do exist in Puerto Rico; currently there are fifteen of them out of a total of 132 residential programs (Villafañe 2010), including two of the thirteen I visited.

Through that visit and various other means, I was able to interview and talk to a handful of women who lived or who had lived in therapeutic communities. This alerted me to how these institutional settings and the experiences of those who live in them are profoundly different from those of their male counterparts. There is increased attention to the experiences of women undergoing drug treatment, as well as to their experiences in carceral institutions more generally (McCorkel 2013; McKim 2014, 2008; Muehlmann 2018). But almost all of the women in this dissertation figure through their relation to male residents, usually as mothers. And as I have revised chapters, the experiences of female residents have receded as I've focused on male institutions, masculine spaces and men's experiences. Women's experiences are no less important or interesting, as I hope is obvious, and are worthy of a study of their own.

In addition, some readers might hope for greater discussion of whether these therapies are clinically effective. Since my research examines the social context in which these therapies thrive, and the experiences of the individual people who use them, this is not a question I attempt (or am able) to answer (but for on-going debates on this question see Malivert et al. 2011; Smith, Gates, and Foxcroft 2006). That said, in my attempt to think through what these therapies bring to individual people, I do reach certain conclusions about the social contexts in which these institutions, and the way of life they offer, can become desirable or at least preferable options to particular people (see especially Chapters 2 and 3). Following Mattingly's (2010) call that we avoid reducing personal lives to structural epiphenomena, this dissertation foregrounds the particular lives and experiences of individual people, rather than pursuing socio-demographic comparisons of different categories of people. In so doing, it seeks to present an alternative vision to the structural determinism that has characterized accounts of superfluity to date.

Some readers may also be puzzled by my use of the terms "addict" or "ex-addict," owing to legitimate concerns that these terms are stigmatizing and can reduce a person's identity down to their struggle with a substance use disorder. In the present context, using the current preferred term in clinical medicine ("people with substance use disorders"), would significantly compromise ethnographic events, however, by imposing a vocabulary that was not used by my interlocutors. My use of these terms "addicts" and "ex-addicts" here is thus intentional, but circumscribed to one of three scenarios: where informants explicitly identify as such (with exceptions to this mentioned in the text), where I am

referring to institutional nomenclature, where I am describing historical events in which these were the terms used.

Finally, it is also worth noting that the events described in this dissertation all took place prior to Hurricane Maria. While my on-going research suggests that therapeutic communities are taking on additional roles in disaster relief in the aftermath of the hurricane, this inquiry remains underway and I do not discuss the hurricane's repercussions here. Therefore, the ethnographic portrait of everyday life in a therapeutic community that is presented here is necessarily marked by a time-stamp that is unusually sharp.

Chapter 1

Abeyance Mechanisms

The best-known origin story for therapeutic communities begins in Los Angeles, California. Widely considered as the prototypical therapeutic community for addiction, Synanon was founded by Charles E. "Chuck" Dederich in 1958. A former oil salesman and long-standing member of Alcoholics Anonymous (AA), Chuck had fallen out with several of Los Angeles' AA groups owing to his doubts about their methods - in particular their emphasis on higher power rather than personal responsibility. An additional source of conflict was his tendency to dominate in group meetings, something that was ill-tolerated by his peers (Janzen 2005). In 1958, he pulled his discussion group out of AA and they began meeting three times a week at a beach storefront in Santa Monica beach (Casriel 1963).

Synanon's members soon devised a variety of methods for treating each other. All were required to kick their habit "cold turkey" on a "kicking couch" for between two and three days (Endore 1968). Pain medication was not permitted, because Chuck was said to believe that this could worsen addiction (Janzen 2005:25). Distrustful of the therapist-patient relationship in traditional psychotherapy, because only the patient was obliged to open up and be honest, Chuck and his early followers devised a therapeutic technique called "The Game", which later became known as the "encounter group" or "attack therapy." In sessions that lasted between two to four hours, between eight and fifteen

"players" would "run their stories," with members encouraged to criticize each other's conduct "with impunity" in a "public form of analytical and humorous gossip" (Janzen 2005: 13).

Between 1958 and 1991, Synanon grew from a small peer-led rehabilitation program into to a multi-millionaire dollar treatment franchise, and later into a contentious social movement (or many would say cult), that disbanded in 1991 after proclaiming itself a religion (Ofshe 1980). Its strange and contentious history, featuring head shaving, mass vasectomies, forced abortions (see Janzen 2005), and a famous attempted murder involving a rattlesnake (The Washington Post 1980), has made Synanon the object of a colorful and extensive popular and academic literature (Morantz 2015; Casriel 1963; Endore 1968; Yablonsky 1965), including several documentaries and a feature-length movie (Quine 1965).

In addition to its cultural legacy, Synanon sparked the development of hundreds of therapeutic communities across North America. Like their forebear, the histories of "second-generation" therapeutic communities such as Daytop Village, Odyssey House, and Phoenix House – all in New York City (see Sugarman 1974; Densen-Gerber 1973; Columbia Center for Oral History Research 2014), and Matrix House in Lexington (see Weppner 1983), are extensively documented. These show that many continued to follow Synanon's basic design - a programmatic structure based on "addict-led" mutual-aid, long-term communalist residence, encounter groups, and a hierarchical work-system in which rewards and punishment acted as vehicles for rehabilitation (Yablonsky 1965).

For a variety of historical reasons, these approaches began to fall out of favor in the late 1970s. Under government pressure to reform their methods, which were increasingly viewed as overly confrontational and psychologically damaging (White and Miller 2007; White 2010), many mainland therapeutic communities professionalized (Deitch 1999; White 2010). This significantly raised operating costs (Deitch and Drago 2010) and prompted many therapeutic communities to close down in the 1980s (White 1998: 318-325). While therapeutic communities continue to operate on the mainland, especially in correctional facilities (McCorkel 2013), today they shoulder a much smaller fraction of the treatment burden relative to out-patient treatments and short-term residential detox (Deitch and Drago 2010).

In Puerto Rico, in contrast, therapeutic communities have continued to thrive since their establishment the 1960s, mostly in the non-profit sector, and today they constitute the dominant form of treatment for addiction. Unlike their North American counterparts, unpaid work is now a central therapy in the programmatic design of many of Puerto Rico's therapeutic communities. These organizations often dispatch their residents to sell goods in the street, to clear scrap yards for private companies, and to cut grass on government and other public properties.

That therapeutic movements flourish, wane, and assume particular formations in particular places is, on one level, a genealogical story that could be told and retold in numerous contexts, and might not be so anthropologically interesting. That therapeutic movements, practices, and formations are constantly evolving and becoming different

things, however, speaks to a broader dynamic – of the unstable, mutable, and often "extra-therapeutic" concerns that animate therapeutic movements. Thus, while existing accounts of therapeutic communities have provided valuable historical knowledge on the origins and trajectories of particular institutions and approaches (Clark 2017; Janzen 2005; Sugarman 1974; Densen-Gerber 1973), these works do not necessarily help us to understand the larger structures, contexts, and socialities through which therapeutic movements unfold. In particular, they are insufficiently attentive to the role of therapeutic communities as social enterprises. To widen our angle of inquiry, in this chapter I examine therapeutic communities as "abeyance mechanisms," and use the anomalous ascendance of Puerto Rico's therapeutic communities to examine how multiple "extra-therapeutic" projects may find a home in contemporary drug treatment regimes.

"Abeyance" (usually understood as suspension) was a concept developed by sociologist Ephraim Mizruchi (1983) in his study of the historically variable ways that societies have responded to a recurring problem of "surplus" – that is, the quantitative mismatch between a society's "status vacancies" (social roles) and its potential claimants (1983: 1-24). Abeyance provided Mizruchi with a construct through which he was able to analyze the emergence of a variety of 'alternative economies,' including compulsory apprenticeships and federal work programs in 19th and 20th century United States, which provided income or training to the otherwise unemployed. He also analyzed more encompassing abeyance mechanisms including monasteries and breakaway religious orders in Medieval Europe.

In Mizruchi's initial functionalist formulation, abeyance mechanisms were considered to be institutions for the "regulation of society." Conceived as a magical adjustment to the problem of surplus guided by hidden intelligence of "organizational inter-dependency" (1983:20), these were said to provide redundant and potentially "troublesome" populations with a surrogate livelihood and home, while sequestering them non-competitively "in abeyance" outside the formal labor market (Mizruchi 1983: 1-24). Subsequent theorists reworked the concept as predicament (suspension) rather than a functionalist institutional adjustment (Hopper and Baumohl 1994). However, a continued emphasis on abeyance as something that manages "troublesome redundancy" (Hopper and Baumohl 1996:12) and thus performs "the dirty work of system maintenance" (Hopper and Baumohl 1994: 543) means that abeyance continues to be understood in terms that can imply a unified and coherent function.

Here, I define abeyance not as a coherent process for regulating surplus, but as a versatile niche that offers a plurality of affordances and is inhabited by actors who are surplus to labor. I say 'affordances' rather than 'functions' because I wish to emphasize a point made by Webb Keane (2018) about the potentiality of utility. That is, whatever 'purpose' or 'function' a thing can be said to perform is not determined by its inherent qualities or by historical conditions. Rather, an object's purpose is always contingent on how particular actors perceive it and act; thus, 'purpose' is contingent and inherently social rather than determined (2018:31). To transcend the idea that abeyance mechanisms inherently or necessarily fulfill a particular function (whether conceived in functionalist, Marxist, or neo-Marxist terms), I conceptualize abeyance as offering a plurality of

affordances[13] to a variety of different actors. This analytical emphasis on potentiality and plurality highlights the malleability of abeyance niches, something that turns out to be crucial to understanding therapeutic communities' endurance in Puerto Rico.

If abeyance niches are inhabited by actors surplus to the labor market, it merits noting that "surplus" states are often gendered, not simply empirically - through gender disparities in unemployment, but also culturally - in how they are socially perceived and acted on. The fact that most of the therapeutic communities described in this chapter are geared exclusively towards men is a reflection of the quite distinct ways that being "surplus" to the labor market tends to play out in the lives of men and women. In Puerto Rico, men have faced higher rates of unemployment than women since the 1960s (Dietz 1986; Safa 1995, 2011). Owing to a combination of factors relating to criminal justice policies (see Muehlmann 2018), the organization of public housing policies, government regulations on welfare entitlements, and crucially the organization of kinship systems (Safa 1995, 2011), men and women who are unemployed face a different collection of opportunities and constraints for sustaining themselves financially. Ethnographies of Latin American gangs and the drug trade have depicted illicit and informal economies as alternative routes to income for men excluded from the labor market (Muehlmann 2013; Flores 2014; O'Neill 2015). In this chapter, I focus on therapeutic communities as an additional alternative economy and response to the problem of male unemployment.

[13] Following Keane, I employ Gibson's relational definition of affordance: "the affordance of anything is a specific combination of [its] properties in light of what it offers, provides, or furnishes for the animal that perceives it" (Gibson 1977: 67-68, cited in Keane 2018:31).

Examining therapeutic communities in Puerto Rico as abeyance mechanisms speaks to two anthropological debates. First, while addiction therapeutics have often been considered as appendages of particular political projects, for example as the new penology (McCorkel 2013), or as technologies of biopower (Bourgois 2000) or subjectivization (Zigon 2010), conceiving them as abeyance niches formulates the question of their "nature"– their logics, techniques, and relation to state power -- as a contingent, historical question. As this chapter shows, during the last half-century therapeutic communities have actually been conscripted and deployed by a variety of distinct political projects to perform widely different 'roles,' which have variously included (among others) state containment, entrepreneurial informal enterprise, family respite, and electoral governance.

Second, the rise of self-help, mutual-aid, and volunteer care networks has often been attributed to neoliberalism, neglect and state retreat (Garcia 2015; Biehl 2013a), an anthropological narrative that coheres well with local media accounts of therapeutic communities that emphasize the commonwealth's failure to provide alternative treatments (Gotay 2017; Cabán 2016). Tracing therapeutic communities' historical ascendency as a treatment for addiction in Puerto Rico, however, reveals that what first appears to be an artifact of state neglect is in fact a therapeutic regime that has been championed, deployed and manipulated by various state actors for reasons that are distinct and often discordant.

Third, in their thought-provoking anthology, Veena Das and Clara Han and others (2015) have taken issue, quite rightly, with the analytical privileging of the biological sciences within the anthropology of medicine, which has seen the emergence of a troubling disconnect between questions about life, meaning, and experience (the classic questions of cultural anthropology) and the so-called 'new' questions of biosociality, bioscience, and biological citizenship (Das and Han 2015:2). This privileging of the biological also extends to anthropological work on addiction and mental health, where analyses of psychiatry, addiction science, and global pharmaceutical markets have generated impressive insights into the emergence of pharmaceutical and therapeutic forms of citizenship and sociality (Lakoff 2006; Rose and Novas 2005; Vrecko 2010b; Raikhel 2015; Petryna, Lakoff, and Kleinman 2006).

But as recent works have shown, therapeutic movements are also embedded in other forms of political and social life (Garcia 2010; Hansen 2018; Garriott 2011). In line with these alternative works, this chapter identifies an unruly collection of locally enabling and constraining institutions and resources that have variously propped up this therapeutic regime in Puerto Rico, from faltering unemployment and correctional systems to overwhelmed kinship networks and community fears. In so doing, it argues that these "other" political projects, with their largely "extra-therapeutic" concerns, are instrumental to the provenance and viability of this therapeutic movement.

Theoretical origins of characterological therapies

Prompted by an overcrowding crisis in Puerto Rico's prisons, the Center for the Investigation of Addiction (Spanish acronym, CISLA) was established in July 1961 as a

division of Puerto Rico's Mental Health Program. Envisioned by its architects as a controlled therapeutic environment for the re-socialization of "sociopathic" addicts (CISLA 1964), its remit was to conduct research into the nature of addiction and to develop treatments. Until 1959, narcotics control had been administered not by the commonwealth but by the US federal government. Offenders (users and dealers) were tried in federal courts and, if convicted, sent to mainland federal prisons or to one of two federal hospitals, either the U.S. Public Health Service Hospital at Lexington, Kentucky, or in Fort Worth, Texas (see Campbell, Olsen, and Walden 2008). With the passing of the Commonwealth Narcotics Law No. 48 of 1959, Puerto Rico assumed jurisdiction of narcotics control and the state penitentiary rapidly exceeded capacity (Planas, Lopez, and Alvarez 1965). So in 1961, supported by a modest commonwealth grant, CISLA's first director, Efren Ramirez, then still a psychiatry resident at the University of Puerto Rico, took over an abandoned outbuilding on the grounds of the state psychiatric hospital in Río Piedras. There, equipped with only his education in general medicine and a personal predilection for psychoanalysis, he began experimenting with methods to treat addiction.

In the early 1960s, addiction was widely understood across North American psychiatry to be a problem of psychopathology. Particularly influential was psychiatrist Lawrence Kolb, who in the 1920s had popularized the idea that addiction resulted from inherent defects of personality (Acker 2002). Kolb had distinguished between 'innocent' and 'vicious' addicts, innocent being people with normal personalities who fell into addiction through accidental means, such as through prescribed painkillers. He reserved the term 'vicious' addicts for the illicit drug-using urban poor who, he argued, sought out narcotics

and were vulnerable to develop addiction because of their pathological personalities (Acker 2002:142; Kolb 1925). Kolb's theorizing on addiction dominated North American addiction science up until the 1960s (White, Kurtz, and Acker, 2001). By the time CISLA was founded in 1961, portrayals of addicts as psychopathic and constitutionally inferior were commonplace in both scientific and popular discourse (White 2009).

Ramirez drew upon Kolb's notion of personality defect and on psychoanalytic theories of family origin to argue that addiction was caused by childhood developmental failures. In a series of publications, lectures and oral presentations in the 1960s (Ramirez 1966a, 1966b), he advanced a theory of addiction as a personality disorder caused by a failure of "epi-genesis," a concept that psychoanalyst Erik Erikson borrowed from embryology to describe the regulated development of personality over the life course (Erikson 1959). According to Erikson, personality development progressed through a sequence of pre-determined stages, each of which was expressed at a certain time in the life course. The development of specific "human strengths" – fidelity, hope and care – was contingent upon the successful passage through the preceding stages (Erikson and Erikson 1998:58). Applying the epigenetic principle to the problem of addiction, Ramirez argued that the addict's "scant capacity to feel anguish, guilt and sincere remorse" stemmed from a failure of epi-genesis during childhood, in which family breakdown had prevented the acquisition of "appropriate norms and values of society" (Ramirez 1966a:121).

Addicts were not "psychotic," he argued, but "have adopted a system of values and an outlook on life that make their behavior contrary to what most citizens consider normal"

(Ramirez 1966b). They were more accurately classified, he argued, as “sociopathic”, in the sense that their “distorted personalities have oriented them away from the attitudes and activities pursued by the normal productive citizen” (Ramirez 1966b). This psychopathic personality development was reversible, however. Through treatment, the addict could be rendered ‘capable of functioning as a productive, nonparasitic member of society’ (Ramirez 1966).

The remedial project was clear. Ramirez set out to rectify psychopathic personality development through a program of intensive re-socialization. His vision of a therapeutic community involved a team of professionals and non-professional “ex-addicts” who acted as a bridge between clinicians and patients. CISLA’s basic program was threefold. Induction described outreach efforts that “utilize[d] ex-addicts to establish contact with active addicts on the streets, to attempt to motivate them so that they will enroll themselves” (Ramirez 1966a:118). Next was intensive treatment, a “personality restructuring process” carried out through full-time residency (Ramirez 1966b). Finally, during re-entry the addict continued the “re-socialization training process” on an outpatient basis. During this phase addicts were expected to recruit other addicts into the program and thus “to pay back their debt to society” (Macro Systems 1972:26).
During its first three years, CISLA treated an estimated 1083 residents (CISLA 1964) and claimed to have a relapse rate of just 5.6% (Jaffe 1966:125). In 1964 alone there were 86 lectures across Puerto Rico about the CISLA method. CISLA graduates, who referred to themselves as *La Nueva Raza* (the new breed), had their own weekly Sunday radio program called ‘The Voice of the New Breed’ (Jaffe 1966). Soon CISLA was making

international news, if not always with the hoped-for seriousness of coverage. 'Junkie Cure Junkie' was the headline at *The Guardian*, a British newspaper (Fiddick 1967).

In 1966, Ramirez was recruited by New York Mayor John Lindsay to serve as the first Commissioner of Addiction Services. Ramirez' arrival in New York coincided with a hyperactive period in government-funded addiction treatment on the mainland. As the heroin epidemic's death toll became known through popular media, and as stories about child heroin addicts (some reportedly as young as eleven) induced moral panic across the city, local governments were jolted into action (Densen-Gerber 1973). Pre-existing therapeutic communities, of which there were a handful, mostly modeled on Synanon (see Deitch and Drago 2010), found their financial stability strengthened by a variety of city and federal grants, having previously scraped by through donations from charities or through pooling the welfare checks of residents. New outreach clinics and residential therapeutic communities, modeled on both CISLA and Synanon, sprung up across the city's five boroughs (Densen-Gerber 1973; Sugarman 1974), soon spreading to Miami, Philadelphia, Los Angeles and Chicago (Deitch and Drago 2010). In 1969, forty programs in mainland United States described themselves as therapeutic communities in a survey sponsored by the National Institute of Mental Health (NIMH) (Sugarman 1974: vii).

Hogar CREA, the Home for the Re-education of Addicts

Puerto Rico's therapeutic communities followed a different line of development. Though widely considered to have shown promise, CISLA was closed down in 1966 when its commonwealth funding terminated after just five years of operation (Ríos 1983). As an

unknown and untested method, it had received funding from the mental health department only reluctantly. Its demise was all but assured, some say, by the loss of Ramirez, who was not only highly energetic in his efforts to extract funds from the department, but was also extremely well connected (his wife was the daughter of Governor Luis Muñoz Marín). And so, as the 1960s drew to a close, an epidemic of unknown magnitude[14] was being managed by a handful of small and chronically under-funded agencies: the Permanent Commission for the Control of Narcomania, established in 1968, consisted of just nine members, who were charged with evaluating all of the existing methods for combatting drug addiction (Estado Libre Asociado de Puerto Rico 1970). In Puerto Rico's capital, San Juan, there was a handful of government-run intake units and outpatient clinics, while the only public institution providing addiction treatment outside the capital was the Addiction Rehabilitation Center in Ponce, also modeled on CISLA (Macro Systems 1972:36-41).

It was in this context of state inaction that the Home for the Re-education of Addicts[15] (*Hogar CREA*) was founded in 1968. *Hogar CREA* was founded by Juan José García Ríos ('Chejuán') with the assistance of three fellow CISLA graduates. A "star patient" at CISLA, affectionately nicknamed "el semántico" by fellow residents for both his intellect and argumentativeness, Chejuán had stood out among CISLA staff members as a natural

[14] At this time there were no accurate studies measuring the prevalence of addiction in Puerto Rico. CISLA, which conducted its own in-house research, estimated that there were 10,000 addicts in 1964 (CISLA 1964). This figure should be treated with caution, however, because the investigators simply asked current residents how many addicts they knew.

[15] *Hogar* literally means home or hearth, and the acronym *CREA* stands for Center for the Re-education of Addicts.

leader and "outstanding member of the group." As one of his therapists recalled: "He was sharp, a fast learner. He had charisma and a following. I noticed that many addicts listened to what he said". Though his adolescence and early twenties had been marked by heroin addiction and periods of incarceration, Chejuán was atypical of CISLA's clientele. He had been raised in a middle class household, was the son of a successful businessman, and had been educated in business administration (Velez 1986).

Politically savvy and well-connected, Chejuán immediately set about generating support from industry, commerce, banks and associations (Velez 1986). His tactics combined political lobbying with street theater. Chejuán once brought a group of teenage addicts, some as young as twelve, to a private meeting with members of the Legislative Assembly whom they persuaded to commit half a million dollars in funding (Cappa 1972). Equally impassioned were *CREA's* graduates, who commonly gave testimony to the press about how the organization had turned their lives around (El Mundo 1969). At a press conference at *CREA* headquarters about a year after it was founded, the baby-faced Carlos Pinto, aged 22, smartly turned out in a shirt and tie with hair neatly combed to one side, spoke of his desire to save others like him: "I've got involved in the program because it is effective. I'm sure I'll never go back, not just because of what this would mean for me, but because I have an interest in saving others from this vice and destruction" (Cabrera 1969).

In a few months, Chejuán and his associates had acquired not just financial donations, but also vehicles, furniture, land, and their first building in Trujillo Alto. To drum up

community support, *CREA* would send representatives into the towns to give talks to interested citizens. Crowds would flock to public gatherings, press conferences and public speeches where Chejuán would not only exhort citizens to get actively involved in tackling the drug problem, but would also offer concrete means of doing so: financially self-sustaining residential communities, managed by local citizens through steering committees (Babb 1969).

In the late 1960s and early 1970s, ignored by the state and shouldering a burden few knew how to manage, affected families pressed their mayors and communities to welcome *Hogar CREA* with open arms (El Mundo 1970b). As one steering committee member recalls: "When *CREA* started, all these parents who'd been worried about their kids, who were stealing, having run-ins with police, all of a sudden they had this option." This was also echoed by parents: "At least now I could get him out of the house for a few weeks, a few weeks when I didn't have to worry. Will he be arrested? Will he die?" Within a few years, *CREA* achieved broad civic participation across the community – from parents and families, yes, but also from pastors, priests, police, teachers, social workers, sororities and a host of civic groups, from the Lions' Club to the Wives Club of the College of Engineers (El Mundo 1973, 1970b). Throughout the 1960s and 1970s, it was widely commended by the press and by politicians (Cabrera 1969; El Mundo 1969, 1970a, 1970c), who praised the organization's capacity to produce "conscientious and responsible citizens… capable of getting along with life in accordance with the established norms of the community" (Babb 1969).

As this ethno-history attests – the emergence of this therapeutic regime was not an automatic consequence of state neglect. To be sure, the lack of alternative available treatments was an important element of the context in which Chejuán and his followers felt compelled to act. And unmet need for treatment was also probably a factor behind communities' embrace of the organization. Yet a consideration of the individual actors involved in this therapeutic institution's early genesis reveals the fundamental contingency and sociality behind this care regime. In addition to state neglect, human action and interest were crucial here. Most striking was how Chejuán and his followers seized the opportunities available to them (and through their own efforts, created new ones), and also in the gratitude and relief felt in the towns and broader community - something that was crucial to the organization's civic support base. Historical particularity is also relevant to understanding the particular turn taken by *Hogar CREA's* therapeutic practices.

Reflecting the direct influence of the Eriksonian theory of addiction, as adapted by Dr. Ramirez at CISLA (Ramirez 1966b, 1966a), *CREA's* therapeutic techniques sought to correct for a childhood 'stunting' of character development. Through 're-education,' residents were taught to return to a childhood state to retroactively cultivate moral character. This entailed movement through successive therapeutic stages, each corresponding to phases of the psychoanalytic life-course (e.g., 'newborn,' 'crawling,' and 'walking'). Until at least the 2000's, male residents were required to wear shorts; trousers and watches were privileges reserved for residents who had proven their maturity by reaching the final 'adult' stage. For their part, 'newborn' women were expected to

wear dresses and take afternoon baths with fictive mother figures. As one female graduate recalls: "It was their way of letting you know… you are still a child, and you have to wear what we tell you." Misbehavior was disciplined through a variety of punishments, ranging from the benign (unpleasant cleaning chores), to the more extreme (group humiliation). Recalled by some as tough but necessary: "I used everything as an excuse… But *CREA* helped me a lot, because I finally started facing my issues," others look back with less sanguine memories:

> Everyone would point at you, they'd call you *barraco*[16], say you were dirty, a failure, a pig… I've come to realize … most of these folks, man, they came here humiliated, homeless… hungry … their family don't want nothing to do with them... They come into my door, and I'm gonna humiliate them? No! I never liked it. I never liked the way they [were] treated.

Over the course of the 1970s, while *Hogar CREA* and its leaders were busy rallying community support, therapeutic communities in mainland US were obtaining city and federal grants and contracts, awarded through various city governments and also through the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (Deitch and Drago 2010). Their Puerto Rican counterparts, by contrast, had lost funding, political sway, and all official endorsement. It was in this mixed context of formal disinvestment coupled with popular clamoring for more programs that *CREA* recognized and capitalized on a

[16] A creole insult meaning fat, literally referring to a kind of wild boar.

thus far un-tapped resource: the value-generating capacity of its residents. Unpaid labor, which had only rarely generated revenue in New York's therapeutic communities[17], was reconfigured as the economic backbone of Puerto Rico's therapeutic communities. In other words, the constituent elements of an economically viable alternative economy were in place.

'Operation Bootstrap' and the problem of surplus

Hogar CREA's rapid expansion, from three residents living in one *hogar* in 1968 to 1200 residents spread across a decentralized federation of 22 separately managed centers in 1972 (Macro Systems 1972:88), reflected not only the growing demand for treatment, but also mass unemployment. During the 1940s and 1950s, a series of state-led modernization projects, first initiated under the US-appointed Governor Rexford Tugwell in the 1940s, but later extended under the popularly elected Governor Luis Muñoz Marín, had brought about rapid industrialization (Lapp 1995).

As the sugarcane mills and home needle industries withered, Puerto Rico's largely rural population flocked to the towns in search of work in the rapidly expanding factories. By the mid 1960s, consumer products such as garments, textiles, and electrical goods had become Puerto Rico's the biggest industries (Wells 1971). State-led modernization, or 'Operation Bootstrap' as it became known (*Manos a la Obra*, in Spanish), had rested on a dual strategy: direct state investment in industry, modeled on the US New Deal Programs of the 1930s, combined with enticing American investment through tax deductions and

[17] A notable exception being the Delancey Street Foundation in San Francisco, see Wallace 1999.

other financial incentives (Lapp 1995:184-185). Key was the Industrial Incentives Act of 1947 (amended in 1948), which granted private companies a ten-year exemption from a host of distinct taxes and trade fees.

But owing to the vast tax exemptions awarded to American companies, the new manufacturing wealth flowed straight back to American investors, rather than remaining in Puerto Rico (Dietz 1986). While Puerto Ricans experienced a one-time leap in per capita income, from $121 per year in 1940 to $900 per year in 1965 (Hansen 2018:78), employment actually shrank from 603,000 in 1951 to 543,000 in 1960 (Planning Board of Puerto Rico 1964). The labor force participation rate dropped from 55.5% in 1950 to 45.4% in 1965 (Planning Board of Puerto Rico 1984) and unemployment soared (Dietz 1986). By the late 1960s, tens of thousands were emigrating each year in search of work on the mainland, something that was actively encouraged by the Muñoz Marín administration (Lapp 1995).

It was in this context of widespread joblessness that *Hogar CREA* assumed the recognizable formation of a Mizruchian abeyance mechanism (1983): in addition to providing treatment, it had now adopted an additional role in creating and allocating alternative 'work' opportunities to men who were otherwise superfluous. Its microenterprises included a bread company, a car repairs shop, a car wash, and a furniture moving company. It also dispatched its residents to walk the streets, clad in brightly colored *CREA* T-shirts, where members would spend hours every day selling goods, mostly cakes, bread, bottles of water, and garbage bags to passing cars and to

members of the public[18]. The organization also entered into a variety of informal agreements with mayors, city governments, and private landlords. For a very low fee, local governments and private companies could hire *CREA* residents to perform such tasks as cleaning the streets and mowing the lawns. Its thrift and industriousness impressed local government officials, who appreciated having a cheap labor pool of "respectful" and "well-behaved" addicts to pick up garbage, de-weed the town *plazas* and landscape government property. As one long-standing *CREA* affiliate who helped set up several branches in the Dominican Republic in the 1980s, recalled: "they were well behaved, they were courteous, and for a very low fee they could be called upon to [help]."

While some ex-residents remember it as being useful work experience: "it was an education. I'd sold drugs before, but now I was mowing lawns, cutting down trees, selling something actually useful for the *hogar,*" others recall feeling exploited: "I didn't agree that the patient was selling in the street all the time. I didn't like … being out in the sun all day." Regardless, these income-generating activities – which *CREA* would later call 'representation and sales therapy' – came to constitute defining elements of *CREA's* programmatic design.

CREA graduates, who often had limited employment options, often jumped at the chance to stay on as volunteers after their treatment finished, where they were generally paid not

[18] Specific sales were determined by the steering committee. For example, the garbage bag initiative was the brainchild of a steering committee member who also owned a garbage bag business.

formal wages but rather in kind – shelter, sustenance, and sometimes a stipend. With a characteristic passion, they widely credit these opportunities with saving their lives (I was often told, "I'd be dead by now"). Many describe their decisions to volunteer as "obvious" choices. One program director, who entered *CREA* in the 1990s and stayed for twenty years, recalled in an interview: "It was an easy decision. I'd just graduated and my mindset had changed in the extreme. The fact that I could really give myself to something, have a purpose, and it would benefit others too."

Throughout the 1970s and 1980s, *CREA* absorbed hundreds of graduates into ex-addict caregiving positions (DSCA 1986). *CREA* graduates were not the only people to recognize the benefits of this arrangement. "It was a great option for a lot of people," recalled a government official. "At the graduation ceremonies there'd be all these addicts there. The families could see them there in good clothes, looking smart... as re-educated ex-addicts. Now they had a purpose."

This organizational structure proved highly successful. By 1972, *CREA* was providing roughly 40% of the island's 3000 rehabilitation vacancies (Macro Systems 1972:76). By 1986, it had 65 centers in Puerto Rico, with satellite programs in the Dominican Republic, Colombia, Venezuela, Costa Rica, and Pennsylvania (Velez 1986). In addition, several new Puerto Rican therapeutic communities were founded. Modeled on *CREA, Hogar Nueva Vida* was founded in 1973 and *Hogar Nuevo Pacto* was founded in 1982. This rapid propagation of therapeutic communities, with their swelling pool of unwaged and underwaged laborers was a reflection not just of state neglect or straightforward

unmet need for treatment. Not solely or even primarily propelled by concerns with illness and healing, much of the community support that gave early impetus to this movement derived instead from a concern with giving surplus men "a purpose." What began as a 'treatment' venture had quickly morphed into an abeyance niche, one who's chief affordance at this time was informal enterprise: that is, supplying alternative work, a sense of purpose, and civic recognition to a group of surplus men otherwise easily scorned and excluded. Thus, this therapeutic regime was at once therapeutic, redemptive and remunerative.

The commonwealth addiction program

Were it not for the events of the 1970s, the rise of therapeutic communities might be reasonably interpreted as an innovative response to the state's failure to provide alternatives. Indeed, state neglect is a commonly invoked local explanation (Cabán 2016), which resonates with anthropological accounts of mutual-aid therapies in Latin America (O'Neill 2015; Garcia 2015; Biehl 2013a). Though perhaps explaining their emergence, such accounts do not necessarily help us understand their persistence. The 1970s in fact saw the most comprehensive effort to expand addiction treatment in US narcotics history, with Puerto Rico actually making a *more* concerted effort than mainland United States to bring addiction treatment under the domain of government. So why did these alternatives to therapeutic community care fail to gain traction in Puerto Rico between 1973-1993?

CREA's first decade coincided with a mass overhaul of addiction treatment across the United States. President Nixon, elected in 1968 on a 'law and order' campaign promising to crack down on crime in the inner city and to bring treatment to addicted Vietnam

Veterans, formally declared a ‘War on Drugs’ in 1971. Throughout the early 1970s, through a host of administrative and legislative actions, federal addiction efforts mushroomed. New institutions were created to provide and to oversee addiction treatment: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971 and the National Institute of Drug Abuse (NIDA) in 1973. Federally funded addiction treatment programs, which had numbered 135 in 1971, spread across 54 mainland cities, numbered 394 by 1973, spread across 214 cities. Patients enrolled in federal treatment rose from 20,000 in October 1971 to over 60,000 in 1972 (Goldberg 1980).

Federal and commonwealth funds to support centralization were also made available in Puerto Rico, where the Department for Services Against Addiction (Spanish acronym, DSCA) was established in 1973. Modeled on NIDA, DSCA’s structure consisted of centralized intake units where people were diagnosed and then referred outwards to various treatment services. Taking its lead from on-going drug treatment initiatives in US cities, in particular the pioneering work of Jerome Jaffe in Chicago, DSCA elected to circumvent what was then a highly contentious debate about the ethics of methadone maintenance and committed itself to providing all of the major existing treatment methods (methadone maintenance, abstinence-based counseling, and abstinence-based residential treatment), its capacity to do so assured through public financial investment. DSCA also provided emergency detox and had a host of educational programs, prevention initiatives, evaluation units, clinical and toxicology laboratories, justice divisions and various research and training centers (DSCA 1983a). By the late 1980s, DSCA was providing approximately 5000 people with outpatient counseling, 4000 with

abstinence-based residential treatment, and 2400 with methadone maintenance (DSCA 1990:4).

Centralization of addiction treatment in Puerto Rico was actually *more* comprehensive than that on the mainland. In mainland United States, federal organizations such as NIDA or NIAAA rarely provided their own direct services; instead they gave individual states and private organizations contracts or grants to provide treatments (Besteman 1992). In contrast, the newly inaugurated DSCA assumed a more central role as a public provider of addiction treatment. At that time, Puerto Rico boasted a public healthcare system known as the Arbona system, which had provided free healthcare since the 1950s (Mulligan 2014). Accustomed to socialized health care, the newly inaugurated DSCA was envisaged, above all else, as a service provider. Thus, most of its budget funded DSCA-operated services, not community or private programs[19] (DSCA 1986). Unlike NIDA, DSCA-operated programs were highly centralized, administered according to standardized procedures and staffed by employees who wore standardized uniforms and who drove government vehicles.

Such comprehensive centralization was not always welcomed by therapeutic community leaders, who, in contrast to their North American peers, found themselves barred from government contracts and unable to tap these newly available resources. During the run up to DSCA's creation, senior leaders from *Hogar CREA* and CISLA actually attempted

[19] In 1985 the agencies total annual budget was $16,113,483. Of this, 88% of the total budget was dedicated to the services and operational costs of the agency itself, with just 8.8% spent on community-based or private programs (DSCA 1986).

(unsuccessfully) to block the legislation that was then being drafted to facilitate centralization. Through private letters to Governor Hernández Colon and through written testimonies submitted to the Legislative Assembly (Ramirez and Ríos 1985), leaders argued in favor of a US-style contracting system in which the government's role would be to distribute funds to private providers rather than to provide services itself (Cabrera 1973). When this did not happen, *Hogar CREA's* relationship with DSCA became highly acrimonious. In June of 1978, *CREA* actually obstructed DSCA's efforts to conduct a census by refusing to share its records (Rodriguez 1978). Despite this animosity, *Hogar CREA* would go on to have a profound influence on the commonwealth government's response to addiction throughout DSCA's twenty-year existence (1973-1993).

Within four years of its existence, DSCA became the lead provider of addiction treatments in Puerto Rico, accounting for 47% of a total treatment capacity of 7300 in 1977 (DSCA 1977a). Close behind was *Hogar CREA*, accounting for 44% of those enrolled in treatment. Small percentages were also treated through state correction and other therapeutic community or private programs (DSCA 1977a).

Far from signaling a challenge to the ideology of therapeutic communities, the commonwealth addiction program in fact presented a fresh opportunity to proponents of characterological therapies. In the early 1970s, there were few professionals with addiction expertise, and fewer still willing to assume frontline positions in service delivery. To meet this professional scarcity, DSCA elected to employ, *en masse*, hundreds of ex-addict paraprofessionals, most of who were graduates of either *CREA* or

CISLA (DSCA 1975). This mass employment of ex-addicts by government actually required careful legislation to exempt them from the minimum credential requirements that then operated across all other government departments[20] (Estado Libre Asociado de Puerto Rico 1973:8-9). While it was the caring professions (social workers, occupational therapists, psychologists) that constituted the bulk of the workforce in DSCA-operated treatment programs, by 1974 DSCA-operated treatment programs employed three times more para-professionals than physicians, and twice as many para-professionals as nurses[21] (DSCA 1975a:132).

Reflecting the presence of CISLA and *Hogar CREA* graduates within its workforce, characterological therapies were taken up by DSCA-operated residential programs in the 1970s and 1980s (DSCA 1983b:73). This incorporation of Eriksonian theory into government residential programs was greatly facilitated by support from DSCA's senior leadership, in particular by Isabel Suliveres, who served as DSCA's second secretary between 1985-1992, and who was a vocal advocate of the Eriksonian theory. Like therapeutic communities, DSCA's residential programs sought to instill "socialization skills," to develop "adaptive behavior," and to help the resident to "gradually abandon old habits like obscene language, fighting, and lack of respect for others" DSCA 1983b:73).

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[20] This was achieved through an amendment to Law 60 of 1973, the law that created DSCA. The amendment restricted the minimum education requirements to the department's clerical and administrative staff.

[21] In 1974 the ratio of staff to patients in DSCA-operated residential treatment facilities was: 1/8 for para-professionals, 1/34 for doctors and 1/3 for non-clinical professionals. Across its treatment modalities (including residential, outpatient and methadone), the ratio of staff to patients was: 1/13 for para-professionals, 1/42 for doctors, 1/26 for nurses, 1/5 for non-clinical professionals (DSCA 1975a).

Discharge criteria at DSCA-operated programs demanded that participants not only achieve abstinence, but also that they adopt "acceptable attitudes and values" and responsibly perform assigned duties and chores (DSCA 1983b:73).

Though it employed paraprofessionals, compared to *Hogar CREA,* DSCA offered far fewer occupational positions for ex-addicts. In September 1982, DSCA was providing care to twice as many patients (across all treatment modalities) as all private programs combined[22]. *Hogar CREA,* however, boasted a considerably larger workforce (685 staff members, compared to DSCA's 420). This relatively bloated workforce was a reflection of the fact that 71% of *CREA's* 814 staff was unpaid graduates[23] (DSCA 1986:30-31). Since DSCA paid all of its employees with formal wages, it was much less effective than *Hogar CREA* at providing positions to ex-addicts.

Between 1973-1993, therapeutic communities co-existed alongside the commonwealth program. The persistence and extension of labor-based therapies, when a range of publicly funded alternative treatments was also available, obliges us to consider two additional historical developments: the challenges that engulfed DSCA's methadone program, but more importantly, the adaptability of therapeutic communities as abeyance niches and the manner in which they were hi-jacked by various beneficiaries to serve various other political interests.

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[22] In September 1982, DSCA was attending 7,383 clients in 48 centers, compared to 3414 clients attended in 69 private programs (DSCA 1986:30-31).

[23] This was also the case in Puerto Rico's smaller private programs, where most staff members were unpaid volunteers (DSCA 1986:30-31).

Extra-therapeutic metamorphosis

From its inception, the commonwealth methadone program was the object of intense public controversy. Deeply unpopular within the towns, where it was widely considered to be "swapping one drug for another," methadone was also publicly and vocally denounced by therapeutic community leaders and Evangelical ministers (El Reportero 1981). Practical challenges arose within the methadone clinics themselves. Former employees recall that methadone was routinely under-prescribed to levels below the recommended dose leading to poor clinical outcomes. A lack of security led to high staff turnover, and the appearance of homeless encampments around methadone clinics prompted fierce community resistance (Lebrón 1976). Faced with rising community opposition, DSCA's methadone clinics were scaled back from 1976 onwards. At their peak in 1976 there had been 15 clinics serving 1893 patients (Lebrón 1976:72). By 1997, just four methadone clinics provided care to 1078 patients (SAMHSA 1997).

While DSCA struggled to maintain its methadone program, therapeutic communities not only grew in number (Macro Systems 1972; DSCA 1990), but extended their institutional charter, taking on various 'extra-therapeutic' affordances and cultivating new political allies. At the community level, they assumed many of the risks and costs of managing drug violence, which by the mid 1980s was wreaking havoc across Puerto Rico's towns (Navarro 1995). Throughout the 1980s, newspapers abounded with stories of armed robberies, gun violence, and not infrequently homicide (El Vocero 1984b). In one instance, a "death squad" of six shooters armed with AK-47s broke in to a *CREA* center Trujillo Alto, killing two residents and injuring three (El Vocero 1984b). At another

hogar, a director and two residents were taken hostage when a group of intruders, armed with machine guns, broke in to steal $3500, having been tipped off by a current *CREA* resident about a recent car sale (El Vocero 1984a). Though such attacks prompted outcry about the inadequacy of the existing security (El Vocero 1984b), they also indirectly attest to the limited capabilities of existing social structures to contain the violence of the drug economy. Families, who were sometimes caught in the crossfire of drug-related violence, appreciated the protection from violence that came with having their relative out of the house.

An additional affordance offered by *Hogar CREA's* was the role it assumed as a safety valve for the Department of Correction. Exchanging, Mizruchi (1983) might remark, one abeyance assignment for another, *CREA* absorbed hundreds of prison inmates each year from the mid-1970s onwards, as did several other therapeutic communities (Department of Correction and Rehabilitation 1994). Prison overcrowding, which had been an enduring problem in Puerto Rico since at least the 1950s (Planas, Lopez, and Alvarez 1965), had reached crisis point in the late 1970s when inmates filed a class-action lawsuit against the Puerto Rican government, who subsequently were forced to pay $250 million in federal fines (The Seattle Times 2014). Following outbreaks of infectious diseases including tuberculosis and mange, several of Puerto Rico's prisons were under orders from federal judges to make improvements (Wright 1982). Faced with a budget deficit, chronic overcrowding, and mounting federal fines, corrections found a ready way out in therapeutic communities, which presented both an expedient safety valve and a cost-

shifting maneuver (the modest *per diem* that corrections awarded for court-ordered residents was significantly lower than the equivalent cost of incarceration[24]).

Now squarely integrated into state projects of security, and financially bolstered by a variety of criminal justice contracts, *CREA* was also courted by various local elites including mayors, police chiefs, and senators. Politicians found *Hogar CREA's* canvassing troops particularly useful. In 1988, *CREA* residents in Santurce distributed leaflets for Senator Marco Rigau; the same year its residents went knocking door to door seeking signatures to put Senator Rolando Silva on the ballot (Ross 1995b). Governor Hernández Colón himself, who served two terms (1973 to 1977 and 1985 to 1993), benefitted from Chejuán's vocal support during his election campaign, and subsequently dispatched his senators to visit *CREA* programs to gather information that would help draft legislation to support the organization (El Mundo 1970a).

Avoiding allegiance to any single political party, *CREA* gained support among both the Popular Democratic and the New Progressive parties, a feat delivered chiefly by way of the mayors, for whom *CREA* provided a handy pool of cheap labor for home improvements, construction work, and moving furniture (Gutiérrez 1996). *CREA's* extensive municipal coverage, popularity among the mayors, and widespread community support soon invited attention from central government. The words of one public official highlight the extent to which *CREA* succeeded in bursting its therapeutic banks:

[24] At the time of writing, the *per diem* is $25 per court-ordered patient per day. In the 1980s, it was likely much lower.

> What you have to understand about Puerto Rico is that come election time, the governors need the mayors. Without the mayors, the governors can't do anything. [...] Chejuán was able to establish very good relationships with most of the mayors. In Puerto Rico there are seventy-eight mayors, one for every municipality. That's how they maintained alliances on both sides. That's what was genius.

Cross-party support eased access to fresh funding. The commonwealth legislative assembly supplied the organization with a steady stream of donations throughout the 1970s and 1980s (Ross 1995a), as did individual donors from industry and commerce (Velez 1986). In 1974, the Industrialists Association named Chejuán citizen of the year, as did the Chamber of commerce in 1976. Now public hero and "pride of Puerto Rico" (El Vocero 1987). Chejuán ratcheted up *CREA's* community mobilization efforts in the late 1980s, initiating what became hugely popular annual "crusades of faith and hope," orchestrated to expand community participation and to raise funds for the organization (El Mundo 1989). On campaign trails that snaked through each of the island's 78 municipalities, Chejuán led public demonstrations that drew thousands of people, including interested citizens, civic groups, politicians, police chiefs, religious leaders, and trade union leaders (El Mundo 1989, 1990; Ross 1995b).

CREA also cultivated close relationships with several mayors, senators and other political leaders (El Mundo 1970a; Beardsley 1993). Its success in winning over the Puerto Rican political class is revealed by its attendance lists at graduation ceremonies, which in 1988 included Governor Hernández Colón, the President of the Chamber (José Ronaldo

Jarabo) and the President of Association of the Mayors (Pedro Padilla), as well as a host of senators, judges, and businessmen and various Catholic and Evangelical religious leaders (El Mundo 1988).

Such broad political support should not be interpreted, however, simply as the result of the direct favors the organization conferred upon individual politicians. *CREA* was unquestionably an enormous boon for several distinct sectors of the Puerto Rican polity, serving simultaneously as a source of relief for over-burdened families, a cost-cutting device for the corrections department, a cheap labor supply for mayors and municipal governments, and a campaign resource for political leaders. In this respect, the commonwealth addiction program was a hopelessly under-equipped competitor: its remit restricted to treatment, its methadone program widely reviled and, by virtue of the fact that paid its staff formal wages, it did not perform the work of abeyance in absorbing surplus people.

Therapeutic communities, in contrast, allocated substitute work to hundreds of volunteer graduates across dozens of segregated communities. Seen thus, *CREA's* persistence and invigoration throughout the twenty-year period of the commonwealth addiction program is best explained not so much by the failure of the state to offer alternative treatments, as by the adaptability of therapeutic communities as abeyance mechanisms. They were repeatedly and routinely co-opted by diverse interests to serve a variety of purposes. The trajectory of therapeutic communities in mainland United States during this same period offers a contrasting case.

Professionalization of mainland therapeutic communities

Two distinct regulatory histories are evident in the fate of therapeutic communities in Puerto Rico and the mainland. An unintended and overlooked consequence of the comprehensive centralization that took place in Puerto Rico was the regulatory freedom it actually afforded to organizations operating outside the commonwealth system. Unable to obtain DSCA contracts, therapeutic communities turned to the mayors, local government, the department of corrections, and the commonwealth legislative assembly, none of whom had, within their formal institutional remit, any responsibility for providing or overseeing healthcare. Inadvertently then, comprehensive centralization positioned Puerto Rico's therapeutic communities outside of the commonwealth regulatory systems governing healthcare, effectively immunizing them from the various pressures to reform that swept through mainland US therapeutic communities during the 1970s and 1980s.

On the mainland, the sub-contracting model provided therapeutic communities with a steady stream of public contracts. In the 1960s and 1970s, this was done through the NIMH (Sugarman 1974). When federal programs were phased out by the Reagan administration in the 1980s, they obtained contracts from city and state governments (Besteman 1992:78). But public contracts entailed heavy regulatory demands, many of which were broadly similar to those made on hospitals and other medical institutions.

Though complex historical reasons underlie the changes that were instituted across mainland therapeutic communities between the 1970-1990s (see White and Miller 2007), the regulatory reach of the mainland sub-contracting model was crucial in facilitating

such reforms as the abandonment of harsh punishments, the introduction of a 40-hour working week, and the employment of professionally trained staff including psychologists, social workers, cooks, cleaners and mechanics (Deitch and Drago 2010). Ballooning operating costs associated with mandated professionalization[25] prompted many therapeutic communities to close down in the late 1970s and 1980s (White 1998: 318-325). To sustain financial viability, those that remained either relocated to prisons, or privatized and significantly reduced lengths of stay from 1-2 years to 3-6 months. Today, long-term residential therapeutic communities occupy an increasingly marginal role within the US addiction field relative to outpatient programs and short-term residential detox (SAMHSA 2013), which are deemed to be more cost-effective (Mojtabai and Graff 2003).

Neoliberal reform

Therapeutic communities' independence from DSCA proved crucial to their survival of a series of health care reforms known as *La Reforma*. Between 1993 and 2001, the public health care system that had operated in Puerto Rico since the 1950s was dismantled and a private managed care system installed (Mulligan 2014). In 1993 DSCA was closed down altogether and replaced by a new department that unified addiction and mental health services (ASSMCA), a change modeled on similar consolidations on the mainland. Through a series of administrative and legislative actions, the state's role shifted from provider of addiction treatment to that of administrator.

[25] When therapeutic communities reduced their length of residency they lost many of their senior residents or 'elders'. This meant that staff needs increased. Whereas in the 1960s, there was a ratio of one counsellor for 20 or 30 residents, by the 1970s regulations called for ratios closer to 1:15, which further increased running costs (Deitch and Drago (2010:919).

Under *La Reforma,* many government-operated residential programs were closed down and counseling services transferred to managed care companies (Hansen 2005). Methadone clinics, whose capacity had been in decline since the late 1970s, managed to remain in the public sector, but by 1997 they were treating 40% fewer patients than they had in 1976 (SAMHSA 1997; Lebrón 1976). The number of people attending government-operated programs of any kind dropped by 73%, from 33,975 in 1993 to 8,935 in 2003 (DSCA 1993; ASSMCA 2004), with intake at residential programs dropping from 6,117 to 450 (DSCA 1993; ASSMCA 2004). By 2014, residential care was almost exclusively the preserve of private non-profit organizations. Out of total of 4,500 bed spaces in residential care, 93% were provided by private non-profits; nearly half (44%) just by *Hogar CREA*, 30% by faith-based organizations and 19% by other community-based entities (IPR 2015). A small proportion (7%) of residential care was provided by government, mostly in correctional facilities.

Though therapeutic communities remained dominant, *La Reforma* also spawned a network of managed behavioral health organizations (MBHOs), which, though still relatively small in capacity (SAMHSA 2013), now offered a range of biomedical therapies (e.g., motivational interviewing, buprenorphine therapy). In departure from its predecessor (DSCA), the current administrative body responsible for overseeing addiction treatment (ASSMCA) eliminated all references to Eriksonian personality theory from government protocols. It pointedly aligned itself, via the 2000 Mental Health Act, with the DSM-IV model of addiction as a 'substance use disorder' (DoH PR 2000).

While proponents of *La Reforma* anticipated it would increase access to biomedical addiction services, utilization actually remained low (Alegría et al. 2001), partly because MBHOs began to funnel drug users away from expensive treatments (e.g., with psychologists or psychiatrists) and towards cheaper support groups (Jordán et al. 2016). To date, *La Reforma* has not induced the swing towards biomedical therapies that its architects anticipated. Instead, healthcare privatization has further entrenched the divides of what was already a highly fragmented landscape, leaving a stark disjuncture between the new department's ambitions for a "modern" biomedical treatment system (Hansen 2018) and the realities of Puerto Rico's therapeutic landscape. The bulk of licensed treatment facilities in Puerto Rico continues to be provided in the private non-profit sector,[26] mostly by therapeutic communities, who for the most part have been wholly unaffected by the new department's endorsement of biomedical therapies. This is not least because, along with the majority of non-profit providers, therapeutic communities are legally exempt from the new department's regulations on mental healthcare standards (see Hansen 2018). All of which is to say, whatever their aspirations and doctrinal commitments, public health officials in Puerto Rico continue to operate in an environment shaped by historically entrenched political, institutional, and legal-regulatory mechanisms that are highly conducive to the persistence of therapeutic communities and unpaid labor therapies.

[26] In 2013 Puerto had 161 facilities in operation providing drug or alcohol services to 15,169 individuals. Most facilities were run by private non-profits (67.7%), followed by state government (16.8%), private for-profit (14.3%) and the rest local government (0.6%) or federal government (0.6%) (SAMHSA 2014).

Conclusion

After an impassioned riff on the lack of scientific evidence to substantiate therapeutic communities' claims of efficacy, a long-standing critic of *Hogar CREA* concluded that, however uncharted their clinical success, "therapeutic communities provide a highly structured environment that keeps addicts off the street and largely out of trouble" (Ross 1995b:12). This chapter has highlighted precisely this containment affordance -- as well as abeyance's adaptive versatility -- as key to the therapeutic community's viability in Puerto Rico. Having initially emerged as a low-cost treatment at a time when there were few alternatives, *Hogar CREA* soon morphed into an island-wide federation of financially independent work colonies animated by the redemptive power of labor, its financial needs met primarily through entrepreneurial activities of its own design and industry.

Conceiving of therapeutic communities as versatile niches that offer a plurality of affordances helps us to comprehend their endurance. Throughout the second half of the 20th century, Puerto Rico's therapeutic communities have been successively recruited to serve a variety of alternative, varied and even, at times, competing interests. For an overwhelmed corrections department, they have provided a highly convenient safety valve and cost-shifting device. For local governments, private businesses, and individual politicians, they have supplied a cheap workforce; for families, a way out of desperation; and for mayors, they have variously been mobilized as election allies and as levers of community approval. Their endurance, therefore, not only reflects their capacity to patch the cracks of multiple faltering systems (including employment, corrections, family), but it also reflects their protean capacity for appropriation: that is, the ease with which they

are co-opted by other actors for alternative utilities. All this suggests that the criticisms they draw from treatment activists - as “unscientific” and “not evidence based” (IPR 2015; OSF 2016) - may, in the final analysis, be beside the point. These programs will likely persist owing to the plurality of affordances that these institutions present.

There are, of course, alternative readings. Therapeutic communities could be parceled into one of several existing frames: as stations within biopolitical circuits of clinic, jail, and prison (McKim 2008; Gowan 2010; Hopper et al. 1997), as appendages of a particular political project, such as the penal state (Wacquant 2009), the new penology (McCorkel 2013), or narcopolitics (Garriott 2011), or as technologies of liberal or illiberal governing styles (Bourgois 2000; Kaye 2013; Zigon 2010). But framing therapeutic communities as abeyance mechanisms offers distinct affordances of its own. Instead of suggesting the emergence of some “new” political project, the present account has emphasized how a versatile niche can lend itself to a variety of different productive ends. As a habitat that arises from a tendency of modern capitalism to generate surplus, it represents a *potential* resource that may be seized upon by any number of *potential* beneficiaries, each characterized by its own context-driven interests and ideologies. Thus, abeyance mechanisms do not coalesce around any unified logic. They consist of multiple projects that may be constantly changing.

This chapter challenges the argument that therapeutic communities are the simple result of the state failing to invest in alternative treatments. The commonwealth addiction program, as instituted through the Department of Services Against Addiction (DSCA)

between 1973 and 1993, in fact constituted one of the most comprehensive efforts (in design, not scale) to provide centralized publicly funded addiction treatment in US narcotics history. Yet in the end, characterological therapies found in the commonwealth program a certain symbiosis. Endorsed by DSCA's senior leadership and promoted by therapeutic community paraprofessionals, characterological therapies were taken up by the commonwealth's own residential centers, and were never seriously challenged by its widely unpopular methadone maintenance program.

In contrast to other Latin American accounts of self-help (Garcia 2015; O'Neill 2015) or 'zones of abandonment' (Biehl 2013a) - residual dumps left behind by an uninvolved and retreating state – Puerto Rico's therapeutic communities have arguably been both supported and manipulated by various state actors (municipal governments, mayors, senators, and governors) for reasons that are multiple, distinct and shifting. Evidencing the now familiar observation that a single unified 'state' has never existed (Sharma and Gupta 2009), therapeutic communties continue to find champions within a complex state infrastructure composed of legislative assembly donations, corrections contracts, informal labor agreements, and legal-regulatory mechanisms. Unlike the commonwealth addiction program, their imbrication into a complex and deeply reticulated collection of political projects has favorably positioned them to weather the neoliberal turn.

An additional implication of this chapter is that the direction of addiction therapeutics in the neoliberal era may be less assured than is typically depicted. Scholars writing of the United States, Canada, and other Global North contexts have spoken of a late 20th century

‘remaking’ of addiction (Fraser, Moore, and Keane 2014; D. Moore 2007), emphasizing a gradual coalescence of a neuropolitics of addiction (Vrecko 2010a), characterized by the emergence of new “neurochemical selves” (Rose 2017). The continued prevalence of characterological therapies in Puerto Rico – also documented in carceral settings on the mainland (Kaye 2013; McCorkel 2013) – suggests, however, that the neuropolitical turn may be highly circumscribed. Instead of a linear movement towards profitable, neuro-technological and pharmaceutical therapies, as would be consistent with trends towards the “pharmaceuticalization” of mental disorders and HIV/AIDS (Esposito and Perez 2014; Abraham 2010; Bell and Figert 2012; Biehl 2013b), the trajectory of addiction therapeutics might be better characterized as one of ever-greater fragmentation, with therapeutic communities, mutual-aid, and other abeyance niches remaining largely untouched by the sea-changes that are sweeping across addiction science (see Campbell 2007). Like Philadelphia’s recovery house movement (Fairbanks 2009), these therapeutic movements may increasingly derive their institutional power through synergistic articulation with other political projects – from public works and criminal justice (in Philadelphia) to municipal governance, electoral politics, and civic mobilization in Puerto Rico.

The Puerto Rican therapeutic community story also serves as a reminder, therefore, that in our efforts to comprehend the care or management of any illness or disorder, we must also be attuned to the wide variety of interests and concerns that drive and channel therapeutic regimes. These extend far beyond “therapeutic” matters of sickness and healing (Lock and Nguyen 2018), and also extend beyond the clinical sciences, biopower,

and the regulation of populations (Das and Han 2015). By widening our ethnographic angle of inquiry to include these "extra-therapeutic" developments, the anthropology of care can illuminate the congeries of local interests, socialities, and political projects that may, at a given time and place, animate and give shape to therapeutic movements (Hansen 2018; Garcia 2010).

In the wake of Puerto Rico's recent economic and environmental crises, abeyance's future incarnations are perhaps difficult to predict. As Puerto Rico embarks on re-construction, therapeutic communities may well take on additional roles. This should come as no surprise. As we have seen, this exchange of one abeyance assignment for another has been an enduring, if not defining, characteristic of Puerto Rico's therapeutic community movement.

Chapter 2

The Theater of Work

Thirty men stood in a circle on a wooden terrace. It was 6.30am. Mountain air pressed moisture onto the windows of the men's dormitories. Each clasping his neighbor's hand in prayer, their voices rang out and filled the valley.

> I give you my hand,
> set my heart in rhythm with yours
> and I pledge us both before God—
> bringing myself and you
> to honor life.[27]

When the prayer was over, metal scratched tile as each man took his seat. For a few moments there was silence. Rocky, a formerly homeless heroin user and US army veteran, was leading this morning's therapy. Because there had been eight new arrivals this week he began with a re-cap of the rules. Confidently, as he had done this many times, he rattled through them. Men were to get up at 6am and have thirty minutes to shower and make their beds. "Why get up at six?" he asked. Then, answering his own question, he continued: "To teach independence. The early mornings prepare you for

[27] Te doy mi mano, pongo a latir mi Corazón al compas del tuyo y por ti por mi, me comprometo frente de Dios. Me comprometo y te comprometo a honrar la vida.

work." Pausing, he eyed the men in the circle. "At 6.30am, we pray. After we pray, we eat breakfast." Residents were to wear proper clothes in the canteen, he instructed, "that means no flip-flops, no tank tops, and no talking. Is that clear?" Thirty voices shot back in unison, "*si hermano*." Straightening his posture, Rocky continued, "At 8am, we do labor therapy. That means you clean the toilet, you do the laundry, you prepare lunch, or, for those with relevant experience," he said, nodding towards a jumbled pile of grates and scaffolding that lay in the dust beside the terrace, "you help with the construction of the new roof patio." "Why do we do labor therapy?" he asked. "By learning how to work we are learning independence and breaking our dependencies, all of our dependencies."

Rocky continued in this declamatory manner for the next half hour, stopping to take the occasional question. When the short stream of questions had dried up he turned to introduce the other staff members: Rafi, Tito, and Jorge. "We are all from the streets here. We know what it is like to eat from a trashcan. Trust me, we all know what you've been through". As the session drew to a close, he turned to face the new recruits, who stood side-by-side forming a dazed throng. "Here you are going to work. You will work in construction. You will work in the canteen. You are going to work with your problems and work with yourself." "Some of you may need to see a psychologist," he said, "But what most of you need is time. Time is the best psychologist."

I draw this scene from the eight months I spent observing daily life at *La Casita*, a privately-owned non-profit organization that is licensed to provide residential treatment for drug addiction. Group therapy took place every morning and was one of several daily

practices, along with domestic chores and manual labor, through which *La Casita* sought to create "independent," and "hard-working" men, who would be capable, as the handbook put it, of "returning to society." Over the course of a year, which could turn into several, days were filled with a busy daily schedule of therapies, chores and tasks, all strictly regulated through a system of rules, rewards and punishments. Through hard work, treatment leaders said, residents would break the dependencies that had brought them there in the first place. In time, the center's letterhead said, men would gain the necessary skills and dispositions to become "useful members of society."

This chapter considers this attempt to be "useful" among a group of male residents who live at *La Casita*. My intention is to make clear that the organizations considered to be providing "residential drug treatment" in Puerto Rico are actually in another line of work. In the first place, their clientele is not uniformly (or even largely) defined by addiction. In the second, even for those who are, what these organizations is largely uninvested in the arc of reparative care that is implied in modern notions of "recovery" (Braslow 2013). Instead, *La Casita's* practices of labor therapy, time-discipline, prayer, and internal work are more instructively read as social technologies through which men who are excluded from the labor market and estranged from kinship ties seek to cultivate an alternative masculinity that restores their sense of worth.

Through an experience-near account of daily life at *La Casita*, I describe how residents learn to draw on the language and imagery of work to convert a stigmatized "dependent" and "redundant" masculinity into a "socially useful" masculinity based on a performance

of work, responsibility, and duty. I also hope to make clear, however, that the investment of the stigmatized "superfluous" self in this alternative masculinity is difficult and fraught. It is not just the (sometimes achingly apparent) artificiality and repetitiveness of the exercise, but the engineering of work itself that is unsound. These men confront a daily contradiction between a therapeutic imperative to be "useful" and an institutional milieu that cannot ensure a steady supply of useful things to do. When socially useful tasks are lacking, futile tasks are often substituted as therapies of last resort. Even in this outpost of surrogate employment, redundancy remains an abiding possibility.

Again, though "addiction" figures prominently in the life histories of many of the men described here, it was not a universally shared condition. Many of the men I got to know at *La Casita* had enrolled for other reasons, such as homelessness, job loss, mental illness, or court-mandate. As members of a self-help collective, what they share is a structural state of "superfluity" (Arendt 1951, 1973): not only are they excluded from the labor market, but they also share a durable "uprootedness" from home, kinship, and ordinary foundations of social belonging. Accordingly, this chapter seeks to explore the forms of life that are possible in this nominal "drug treatment" program. A key question driving this chapter is how do the routines and rituals of "rehab" fare as an alternative foundation for belonging, when wage labor, kinship and other conventional foundations of social membership are not available?

Wage labor and drug treatment: Two sites for the cultivation of masculinity

This chapter seeks to stich together two strands of anthropological thought that deal broadly with questions of personhood, gender, and labor but have thus far unfurled

separately. The first considers the relationship between labor and masculinity. Among the major achievements of this work has been the historical documentation of 19th and 20th century transformations in the life course in Euro-America. Increased formalization of distinct "life stages" saw the gendered mapping of adult development onto wage labor, such that being a man became enshrined in being a breadwinner (Greenberg 2009; Tosh 2005), while womanhood became synonymous with the domestic sphere and labor there devalued as "unproductive" (Folbre 1991). In the now familiar narrative, though 20th century industrialization and two world wars saw increasing numbers of women absorbed into the labor market, they continued to be dismissed as "supplementary earners" (Safa 1995; Summerfield 2013). Despite structural changes in the gender make-up of the workforce, many labor and social welfare systems continued to be geared towards a "wage earner" that was constructed on the basis of an able-bodied adult male (Safa 1995).

Mass male unemployment is often considered as a challenge to liberal conceptions of manhood (Ferguson 2013). Unable to achieve culturally valued markers of manhood, unemployed men have been said to experience a "temporal hardship" (Jeffrey 2010:466) of being stuck in a "permanent male adolescence" (Hansen 2018:105). Ethnographies of male unemployment have described how it can inflict shame, symbolic violence, and other kinds of social suffering (Jeffrey 2010; Mains 2007; O'Neill 2014).

It is worth remembering however that in Puerto Rico, mass male unemployment is by no means a new state of affairs. Whatever brief (and by most accounts, grueling) 'heyday' Puerto Rico's sugar-cane workers may have experienced following US occupation in

1898 and the growth of the corporate sugar plantation system (Mintz 1951, 1956), sizable seasonable fluctuations in agricultural production meant that regular periods of idleness continued to be the norm throughout the early 20th century. Post-war industrialization did little to help. The closure of the sugar plantations disproportionately displaced men from the labor market (Dietz 1986; Safa 1995). Between 1950 and 1965, the labor force participation rate (men and women) dropped from 55.5% to 45.4% (Planning Board of Puerto Rico 1984). Among men specifically, it fell by 20% between 1950-1980 (Safa 2011). So severe was unemployment during the postwar period (widely considered the zenith of US-style modernization) that the commonwealth state had to promote mass emigration as part of its economic development strategy (Dietz 1986). The consensus among analysts of Puerto Rico's labor history is that whatever its ascribed status as a "showcase" for American capitalism, modernization roundly failed to deliver full employment (Dietz 1986; Safa 2011; Lapp 1995). Moreover, the long valorized ideal of the "male breadwinner" has in fact constituted an ephemeral modernization "myth" that has never materialized in Puerto Rico (Safa 1995).

So what are we to make of the relationship between wage labor and manhood in the "local moral world" of the present? When men are widely denied work membership, where else might they turn? Ethnographies of the drug trade, gangs, and other illicit and informal economies in Latin America and the urban United States have provided various kinds of answers to this question (Muehlmann 2013; Bourgois 2003; Flores 2014; O'Neill 2015). Here, I want to suggest that an additional partial answer can be found in

the theaters of labor that are staged in the putative "drug treatment" organizations like *La Casita*.

The second literature I draw on considers the cultivation of personhood in drug treatment regimes. As the anthropology of addiction so plainly shows, drug rehabilitation is always doing "something more" than treating (or trying to treat) addiction (Garriott and Raikhel 2015). Broadly speaking, drug treatment has been theorized as a collection of techniques for cultivating (with varying degrees of success and intentionality) "responsible" (Vrecko 2010b), or "moral" (Zigon 2010) or "melancholic" (Garcia 2010) subjects. Others have pointed out that however we read its disciplinary logic, rehabilitation is often distinctively gendered: its rituals and routines geared towards creating and disciplining specific kinds of women and men. These ideal men and women can be colored by existing inequalities, ideologies and discourses and constructed according to quite specific (and frequently revealing) criteria. This can be found, for example in the figure of the woman who is emotionally introspective and liberated but not "overly oriented toward children…[or] men" (McKim 2008), or the man who shows "contentment with life" and abides by Islamic norms and values (Al-Krenawi and Graham 1997), or the woman who has high self-esteem but is not "too sexy" (McKim 2014).

In tandem then, these two literatures invite a hybrid reading of residential "drug treatment" in contemporary Puerto Rico as a surrogate for wage labor and alternative foundation of manhood. Unlike the transient encounters of the clinic or Alcohol Anonymous meeting (Brandes 2010; Raikhel 2016), and in obvious departure from the

'revolving door' of detox (Garcia 2010), *La Casita* positions itself as a durable and encompassing alternative way of life. Though not advertised as a permanent dwelling, residents would often settle at *La Casita* for two or three years at a time, with peer staff often staying for much longer periods. Engaging, then, with a small number of works that have begun to interrogate mutual-aid drug treatment regimes as substitute care systems and survival strategies (Fairbanks 2009; Garcia 2015) and as surrogate homes and families (Hansen 2018), this chapter approaches *La Casita* as a citizenship of last resort for men without other options.

Building on these works, I seek to go beyond conceptions of drug treatment as a corrective mechanism designed to instill socially valued attributes in subjects otherwise embedded in "thick" social lives, with a view, so the story often goes, to restoring liberal membership (Zigon 2010; Vrecko 2010b; Bourgois 2000). Instead, what I am asking is how this thing called "drug treatment" holds up as an alternative footing for masculinity for men displaced from the usual domains of labor market, kinship, and community. My analysis of *La Casita's* therapeutic practices – and its staged theater of work that simulates the aesthetics and time-discipline of waged labor – leads me to argue that "addiction treatment" in Puerto Rico currently works to provide the dignity and belonging otherwise missing in the lives of men superfluous to the market economy.

Addiction shelters

La Casita is one node in an extensive archipelago of private non-profit agencies licensed by the Puerto Rican government to provide residential treatment for drug addiction. Like most of Puerto Rico's "addiction shelters," as I came to recognize them, it blends long-

term communalist residence and peer-led mutual-aid. When I conducted fieldwork in 2016-2017, there were 132 such shelters collectively providing care to roughly 4,500 people, overwhelmingly men[28] (IPR 2015). Other drug treatment options were limited, and comprised: 11 detox centers (capacity 156 people), five outpatient mental health clinics, six state-run methadone clinics, and a handful of private buprenorphine clinics (ASSMCA 2014). The 132 residential centers differed in terms of their size, funding structure, and religious orientation. About a third of them were registered as "faith-based," with most of the remainder registered as "community-based" (IPR 2015).

Most "faith-based" organizations are Pentecostal "addiction ministries" (Hansen 2018) that have taken hold since the onset of the 20th century Latin American Pentecostal revival. Reflecting their Pentecostal orientation, they employ bible study, fasting, religious conversion, and transcendence as techniques to treat addiction. The addiction shelter I refer to here as *La Casita* belongs to a different lineage. As a "community-based" rather than a "faith-based" organization, its design is indebted to the therapeutic community approach, in particular that of to *Hogar CREA* (*La Casita's* founder was a *CREA* graduate). Though these "community-based" organizations cannot be accurately characterized as "secular" (for reasons I explore in this chapter), and though they have a lot in common with the Evangelical drug ministries, "faith-based" and "community-based" programs have distinct histories, and here I focus on the latter.

[28] In 2016, there were just fifteen women's residential treatment programs out of a total of 132 residential programs (Villafañe 2010).

La Casita was founded in 2007 by Jorge Santiago, a former heroin addict and therapeutic community graduate. Jorge had spent ten years living and volunteering as an *ex-adicto* in Puerto Rico's addiction shelter system, but split off to establish his own program after inheriting a burnt-down property. Initially envisaged as a therapeutic community for the treatment of addiction, owing to funding necessities it had recently been rebranded as a "shelter for the re-socialization of the homeless." This bureaucratic makeover facilitated access to more stable sources of funding. It also expanded *La Casita's* clientele, which now also included formerly homeless men and a growing stream of probation referrals.

By the time I first visited in late 2016, *La Casita* had been converted into a brightly painted two-story home. Surrounding the main building were a tiled and spacious terrace where group therapies were held, a stone table and seating area littered with cigarette butts, and an improvised out-door gym in the corner of a gravel car-park. The orange and yellow house was flanked on both sides by neatly tended infant palm trees, each encircled by painted rocks. The view of the valley gave the place a healthful, bucolic feeling.

Working hard, keeping busy

Angel was one of the people I came to know well. His first day at *La Casita* had coincided with mine and as apprehensive newcomers we'd sought each other out. Highly committed to what he saw as his "last chance" to prove himself, Angel was a former drug trafficker who'd spent the last ten years in and out of prison. His heroin addiction began about five years ago, and he'd been cajoled into treatment by his terminally ill mother, who had threatened that unless he entered treatment, he would not inherit a thing, including the house they both lived in. On his first day he was assigned laundry duty, a

role he held onto for several months until being re-allocated, to his annoyance, to toilet duty. The laundry room (in fact, a balcony) was usually much quieter than the other communal areas and became a place where we could talk. One afternoon in February, about a month into Angel's time at *La Casita*, we sat chatting by the washing machine as he hung up pair after pair of boxer shorts, with a dozen or so laundry baskets lined up waiting their turn.

That day, Angel seemed to radiate energy. Having just finished hanging out a round of laundry, he now jumped up, tiptoed, onto a stool. Grasping a pole with a sock wrapped around the end, he stretched both arms upwards and began scrubbing the exterior walls of the dormitory as if they were windows. Though the walls were not obviously dirty (in fact, another resident had already cleaned them earlier that same day), Angel committed himself to the task, his concentration interrupted only by my repetitive questioning. "Why are you doing that?" I asked for the third time. "It's important to keep busy," he eventually answered, "it's important to use my time productively." After several more energetic strokes with the handmade sock-mop, each carefully executed to extend all the way from the top of the wall to the bottom, he stopped. "I didn't used to do any of these things," he said, now turning to me, "getting up early, doing my chores, working up a sweat of my own brow." After several more minutes of intense scouring, he finally got down from the stool and gazed upwards to admire his handiwork.

During the eight months that Angel came to spend at *La Casita,* he took the idea of "keeping busy" seriously. In the eyes of senior leadership, and as explicitly set out in *La*

Casita's handbook, one of the shelter's primary goals was "To help the participant develop a disposition to work." To this end, idleness was frowned upon and hard work was woven into the choreography of the day. Time was strictly regulated according to a repetitive series of discreet units of activity. Each unit was therapeutically repurposed so that prayer time was "spiritual therapy," chore time was "labor therapy," and, for one hour a day only, free time was "recreation therapy." Each of these units formed part of a larger temporal ordering of shelter life in which keeping busy was therapy.

This probably feels familiar. Writing about England during the 18th and 19th centuries, Thompson (1967) argued that the advent of industrial capitalism entailed a "re-structuring of man's social nature and working habits," where it ceased to be morally acceptable for workers to merely pass the time. Instead, time became a valued currency, every last bit of which had to be "consumed, marketed and put to *use*" (1967:91). In an analogous manner, when residents spoke of their adaptation to *La Casita,* they described a similar moralization of regular work patterns and vilification of time that is not used. Adaptation to life at *La Casita* was described as a process of "learning to work" and "using time productively." It involved cultivating habits such as getting up early, being punctual, conducting one's assigned tasks and duties properly, and avoiding wasting time. "Before, I didn't do anything with my time," one resident explained to me. "I would sleep until noon, then hang out with *mis panas* (my friends). But now I get up early. I keep busy. I've learned to use my time productively."

Though *La Casita* was registered as a secular "community-based" organization, a vernacular Christianity prevailed. Prayer, though explicitly "non-obligatory", was an organized daily practice that most residents participated in and that took place several times each day to mark the morning's beginning, the onset of every meal, and the day's end. It was usually held in group spaces, canteens and dormitories, rather than a chapel or *culto* (worship service), there being no designated place of worship onsite (though on Sundays men had the option of attending either Pentecostal or Catholic services in nearby churches). Though a small minority of residents chose to remain silent during prayer, most would join the circle to stand hand-in-hand, where prayers were spoken out loud and in unison.

As was the case in medieval monasteries (Asad 1987; Landes 2000), residents lived, worked, and prayed to bells. From the 6am hand bells that signaled the day's onset, to the 10pm bells that sent men walking to their dormitories, bells set the time for eating and sleeping, and also for praying and for working. By calling residents to attention, and by signaling the onset of a new activity, the bells functioned as goads to therapeutic labor. More totalizing in its reach than the clocks driving capitalist production (Thompson 1967), this was a "total institution" schedule (Goffman 1961), more akin to an army barracks, asylum, monastery or convent than to the factory floor. The importance placed on therapeutic labor in particular bore a striking resemblance to the Benedictine and Cistercian Orders, where *laborare est orare* ("to work is to pray") is the basis of spiritual life (Benedict 1906).

Summons to labor, often blending Christian invocations of exertion as spiritual toil with neoliberal notions of personal responsibility, were impossible to escape at *La Casita*. They were plastered on the walls, where posters advised: 'Work dignifies my person,' 'Food is not free,' and 'Responsibility is liberation in action.' They echoed in the hand bells. They even seemed to be drawn out, tightly, across the immaculately made bunk beds.

That tasks of necessity - cooking, cleaning and other in-house chores - were rarely plentiful enough to occupy the hands of all residents on any given day did not afford license to relaxation. Instead, when contingencies of group living failed to generate enough tasks to keep all members busy, Sisyphean assignments were at hand. Washing a car that had already been cleaned, scouring the floor tiles with a toothbrush, or mopping the kitchen ceiling, were commonly prescribed last-resort therapies to keep residents busy when there was nothing else to do. Laborious and futile tasks were also prescribed as punishments for lateness or rule breaking: staying up through the night to scrub walls and floors, or being sent out, in the midday heat, to cut the grass with scissors. Work then could take on a demonic resonance.

Exertion. Endless work. A compulsion to labor that has lost its grounding in the satisfaction of human need – or in the reassurance of salvific favor. These are all features of what Max Weber famously called the Spirit of Capitalism in his classic thesis that Protestant asceticism provided the psychological impetus for the development of capitalism, only to later be abandoned by modern capitalism's stewards. Weber warned

that modern capitalism had become an "iron cage," its subjects driven by mechanical compulsion ("specialists without spirit, sensualists without heart"), blindly pursuing profit for profit's sake (Weber 2015:105). Underlying this surface resemblance of factory and shelter, however, are distinct moral economies.

Unlike Weber's entrepreneurs, for whom the central duty of work was economic productivity and accumulation of wealth, *La Casita* derived little in the way of income from its residents' labor. Opportunities for marketing residents' labor outside the compound were rare, limited to the odd occasion when private landlords hired residents as day laborers in exchange for nominal financial compensation. Nor was therapeutic labor obviously configured as a stepping-stone to formal employment. *La Casita* was actually exceedingly ill equipped to assist residents with finding or maintaining paid work. Residents were not generally permitted to leave the premises without special permission (granted for medical appointments, court hearings, and the like). The only "occupational therapy" that I witnessed consisted of a single occasion when a visiting student from the University of Puerto Rico held a workshop on writing resumes. That considerable time was expended on futile tasks highlights an important characteristic of *La Casita's* therapeutic project: time spent *doing something* is as important as time spent *producing something*. Thus what looks like, and is often spoken about, as "productivity" is not primarily geared towards production.

As St. Benedict might have foreseen, *La Casita* was more centrally geared towards the inculcation of certain moral and bodily dispositions. Self-discipline, responsibility,

independence. These are all qualities that addiction research has described in terms of neoliberal governance. One prominent strand of this work has interpreted specific therapeutic practices, from pharmaceutical treatments to talk therapies, as disciplinary tools for the cultivation of "responsible subjects" (Zigon 2010) and "better citizens" (Vrecko 2010b). The implicit premise, of course, is that this renders its subjects better able to "adhere to the duties, expectations and obligations of their families and societies" (Vrecko 2010b:45), or more capable of "living a normal life" (Zigon 2010).

But what interested me most was not this correspondence in disciplinary logic between the governing projects of *La Casita* and neoliberalism. Rather, what intrigued me was *La Casita's* extraordinary capacity to harness the language and imagery of work, blending Christian suggestions of work as salvation and neoliberal discourses of personal responsibility, in a mimetic simulation of labor. The effect was theatrical, melodramatic even. But over time I came to recognize this theatre of labor as a social technology through which residents could begin to convert a socially maligned 'dependent' status into a "socially useful" masculinity, based on a performance of work, ceaseless exertion, and an effortful avoidance of idleness. The "useful member of society" under construction here, the man who gets up early because he has responsibilities and duties to fulfill, represents an almost photonegative of the welfare dependent, unemployed, redundant male that was so clearly in Rocky's mind as he welcomed *La Casita's* new recruits at the beginning of this chapter. Oddly, this performance of work found its most theatrical expression in a secular-therapeutic practice, widely discounted in addiction science, which casts treatment as a process of re-constructing a flawed personality.

"Work on your personality"

It was my first day back at *La Casita* following two weeks of non-stop interviewing at other shelters. I made my way up the driveway and saw Israel, doubled over and bathed in sunlight. The handlebars of a large wheelbarrow, loaded with cement, were resting on his knees and he stood panting. As I approached, he gestured up the trail towards to the stone table where a group of residents stood smoking amid the construction. Slowly, we made our way up there.

Israel, a fifty-five year old former truck driver, was approaching the end of his third stay at *La Casita*. Since the 1990s, he had cycled in and out of addiction shelters spending years, on-and-off, as both resident and live-in *terapista*. That day he had just returned from court, where the judge at his hearing had inquired about his 'exit strategy' (a transitional plan written by a caseworker in negotiation with a resident). As yet, Israel had none, nor did he seem thrilled by the prospect of leaving.

> I try not to think too much about it. I'm very cautious about making plans for getting out. Of course, I want to have a house, a car, a job, I want to be able to call my daughter in Florida that I haven't seen since she was two - now she's twelve. I want to say, 'come, visit papa.' But I can't. Because when these plans don't work out, that's where the frustration comes, and maybe a relapse.

During the various conversations I had with Israel in the eight months that we overlapped at *La Casita*, he would often veer between a peaceful calm over the prospect that he

might well be here for a while, and a frustrated panic that so much of his life had been spent in shelters. I recall one occasion, after Rocky floated the idea that he stay on as a *terapista*, Israel had seemed troubled, even alarmed: "I've already been doing this for many years," he exclaimed. "Next year I'll be fifty-six." "That's way too old to be living in *hogares*." He'd visibly shuddered at the prospect.

But today, as he stood finishing his cigarette, his stance towards peer care work as a future career seemed more positive. "I'd like to stay on here, if I can," he said. "It's a good option for me." "I already have a lot of experience working in addiction." He told me about the two years he'd spent working as a volunteer at a Pentecostal addiction ministry. "It was a mistake to leave that place," he said. "That was how I ended up back on the street." Seeming to collect his thoughts, he continued: "Right now, I'm just focusing on working, focusing on myself. And I'm making a lot of progress. I'm keeping busy, working on my personality, working with myself."

This idea of personality re-construction was an explicit therapeutic teaching at *La Casita*. Caregivers often characterized recovery as a process of "re-education" which involved "rebuilding" or "reorienting" personality. Consider one of several similar statements I catalogued that year, this one made by Rafi, a self-described *re-educado*:

> When you start consuming [drugs], the whole personality changes. Your temperament gets more aggressive, irritable, you become impulsive, you get violent. A person who is addicted is a person who has lost all their morals…and lost

> the value of life. And so for the people that arrive here …you have to start rebuilding personality, through changing their temperaments, attitudes and customs.

During my conversations at *La Casita* and at other shelters, I encountered many ideas about what addiction was and whether and how it could be treated. One competing framework was the chronicity model (see Garcia 2010), which likens addiction to a chronic disease. A third cast addiction as a brain disease. It was actually not uncommon for my interlocutors to juggle and switch between these theories, often within one single conversation.

Much can be said about how people in therapeutic settings take up and internalize scientific theories, which is why institutional scripting has proven such a fruitful area of inquiry within the anthropology of medicine and linguistics (Campbell and Shaw 2008; Carr 2009; Gowan 2010). In addition to examining how institutional power colors the way that therapeutic subjects speak, however, it is also worth considering what scripted ways of speaking can be seen to accomplish. Carr (2009) addresses this question in her work on rehab in the United States, where she shows that learning to speak "like an addict" can be a way for women to achieve their personal goals.

Similarly, the intriguing thing here about residents' claims to be working on their personalities was not that their speech was scripted, which it undoubtedly was, but that it seemed to be meaningfully implicated in their sense of worth. Over time, as I paid more attention to what residents were trying to accomplish when they said they were working

on their personalities, I noticed that it often seemed to take the form of a prayer. It was something that residents claimed, or even clung to, especially in moments of doubt about the usefulness of their time at the shelter.

Consider another conversation I had with Israel, mentioned above, as he contemplated leaving. Shaking his head, he said:

> No, it's important to know oneself. I'm not ready. Besides, I'm changing a lot here. I'm developing my maturity, yes, according to my age. I'm developing in terms of being responsible, being tolerant and patient. Here, I'm developing a true personality and way of being.

In one sense, Israel's words denote social suffering. Scholars might reach for circulating concepts of "symbolic violence" or "stigma" in order to grasp how men like Israel, who are unable to obtain liberal markers of male adulthood, come to label themselves as "immature," "failures" or "useless" (Bourgois and Schonberg 2009; Jeffrey 2010). These concepts can be useful, particularly for drawing attention to how men like Israel come to locate their suffering internally, thus occluding the social conditions that cause their pain.

But in another sense, which any account of manhood cannot afford to ignore, Israel's words were also prayerful. Prayer, as Mauss' reminds us, is rarely just the outcry of an individual in anguish. More commonly, it is a socialized language that brings people into relationships with one and other, and through which they seek to bring about changes in

their life circumstances (Mauss 2003; Bandak 2017). The contrast matters. Whereas co-circulating theories of addiction ("it's like diabetes") tended to be articulated expositively – as a way of packaging a complicated condition into something recognizable - *working on my personality* was said aspirationally, especially when contemplating one's present predicament. Operating as a kind of mantra, its meaning lay not in its lexical connotation (psycho-pathology), but in its claim to group membership as a hard-working, busy, "useful member of society." By sculpting what could look and sometimes feel like being stuck in a state of dependency into the language of internal growth, *working on my personality* tore open a window of possibility for advancement in a context where alternative opportunities were lacking. Signing salvation rather than cure, it operated as a kind of pledge that gave meaning to a passage of time whose purpose or value was not always obviously apparent.

Consider another conversation, this one with Angel. It was a Monday morning in February and the electricity was down again. I'd joined him on the terrace where he was drinking coffee and watching the rain. He seemed down. Yesterday, it transpired, had been family visiting day and his parents hadn't shown. "It was a punishment," he said. "I know it." "It's because they are trying to test me." Angel glared into space for a while, seeming to wrestle with himself. I asked him if he'd requested permission to call them when something like a resolution seemed to click in his mind. "No." he said. "I won't call." "I know that wouldn't be the right way." *Sigo trabajando con mi personalidad" (*I keep working on my personality). Staring into the clouds, he recounted his parents' last visit two weeks prior. At some point, when he and his father were alone, his father had

told Angel that he loved him. “He’s never said that before,” said Angel. “I had to go to bathroom and cry.” In tears, he continued:

> I’m thirty-eight years old. That’s too old to be learning the difference between right and wrong. At first when I arrived, I was in such a rush, like, I can’t be here when I’m forty. But now I’m here and I see there are lots of older people. I know I shouldn’t rush because I’m not ready yet. I’ve been learning who I am here.

Angel’s torment seemed to index several feelings: discomfort with place, regret for a misspent past, a desire for something better, and the early seeds of recognition that his best option might be to stay put. That last feeling might also be read as the early stages of an acceptance of a manhood based not on return to labor market or family, but instead on a pledge to persist in the knowledge that return might not be the best option.

Mattingly has characterized hope as an invented moral project that “most centrally involves the practice of creating, or trying to create, lives worth living even in the midst of suffering, even with no happy ending in sight” (Mattingly 2010:6). Here, the invented moral project is not so much hope, but persistence in the face of little to hope for. Not primarily concerned with healing, *working on my personality* can be read as a narrative strand within a larger philosophy of endurance borne out of a structural state of superfluity. From this “superfluous” state emerges an alternative vision of manhood based on remaking the redundant self into a “useful member of society” that embodies social utility, and manifests that utility through the constant avoidance of idleness. This

conception of manhood is based not on wage labor, fatherhood, or even living independently. Instead it is based on busyness and self-work as a compromise location between a labor market in which there is no place for you, and the feelings of worthlessness that can arise from not working. This alternative masculinity involves keeping busy, even when there's nothing to do, and working as hard as you possibly can, without expecting evidence of material advancement. It involves getting up early like you have responsibilities and duties to fulfill, and dressing properly as if those duties required it. By inventing ways to be useful even in the most useless of places, these men are proving to themselves that they can be, in Angel's words, "a useful person." And yet, as we might expect, this can also be tiring, especially when facing the inconvenient fact that there are not enough useful things to do.

Spiritual boredom

Despite continual injunctions to work hard, "busy" was often an impossible state to maintain. As a disciplinary device for regulating time, the daily schedule was actually only marginally effective. Time-discipline was regularly disrupted by electricity blackouts (there were many), material scarcities, or, most commonly, by a lack of basic supervision. The latter had to do with *La Casita's* patchwork of funding sources, which brought with it hefty administrative obligations. Just ensuring that residents made it to their court appointments – which on any day might be held at several different municipal courts - was frequently enough to overtax *La Casita's* modest workforce. This meant that group therapies, labor therapies, and other structured activities were often cancelled because there was no one around to facilitate.

Residents' everyday talk was often saturated with a bored frustration about *not being able to do anything*. Instead of feeling that they were advancing towards independence and self-sufficiency, many worried they were "wasting time" and "falling behind." With lengthy sentences to complete, and with so much time to fill, being stuck (*estanquado*) was a major source of anguish. Take Angel, by mid-December he was just two months down and had an anticipated sixteen more to go. It was a dreary day. The sky was cloudy and the rain threw spots on the gravel car park. I found him behind *La Casita's* van where he was lifting weights. He was visibly irritated. Upon finishing each round of short, rushed arm curls he tossed the dumbbells to the ground, allowing them to clang as they knocked into the other equipment. He was sick of it, he said. "It's not easy being stuck up here when you are used to being free." Though he was doing all his assigned chores - "putting in the effort" as he stated it, it was hard to imagine sixteen more months of this. "I'm thirty-eight," he said, his voice beginning to crack. "It can't take me till I'm forty to get over this." Wiping off the raindrops that had settled on his forehead, he resumed another round of arm exercises. "I know I can be a useful person, but it's the boredom. Boredom is bad for us addicts."

When the two o-clock bell rang, we trudged up the driveway expecting to attend group therapy, but it turned out to be cancelled. Though the chairs had already been set out in a circle, there was no one around to facilitate. Chores complete, we wondered what to do. Taking advantage of a temporary lack of supervision, we sat on the sofa on the terrace and watched Animal Planet. I brushed away the flies that kept landing on me. Afterwards, we ate pasta and drank ice tea in silence in the windowless kitchen.

Bored frustration. A willful effort to keep bodies and minds in motion that was constantly frustrated by a lack of necessary tasks. When busyness was interrupted, either because socially necessary tasks were scarce, or because planned activities had been cancelled, questions arose. The prickling of doubt could settle in. Rather than feeling improving, productive, *useful,* life at *La Casita* could materialize as pointless, mocking, and even unbearable.

Boredom has figured as an illuminating analytic within recent work on unemployment. In Bucharest and India, vivid depictions of daily life among unemployed men have analyzed boredom as a form of social suffering caused by an "over accumulation" of time (Mains 2007; B. O'Neill 2014). In these accounts, boredom is often attributed to the forced idleness that comes with the excess time of being "cast aside" (O'Neill 2014) or "left behind" (Jeffrey 2010). At *La Casita* boredom was also related to time: *time that stretched ahead, time that had to be filled*. But as a form of affective hardship, I found that it wasn't confined to periods of inactivity. Complaints of boredom were also commonplace during organized activities, suggesting that even when residents succeeded in making themselves "useful" - things could still be boring.

I recall one hot afternoon in April. That afternoon's session was led by Nelson, an *avanzado*, since the entirety of *La Casita's* staff had been called to a district meeting. That day, the group was restless and the heat uncomfortable. Some of the younger residents broke into muffled protest as the session began, tutting their way through the prayer half-heartedly. Within minutes of Nelson beginning his sermon ("hard-working

habits”), he was cut short by the realization that a resident had fallen asleep. This was not an uncommon occurrence, though it was usually taken to be of great moral impertinence. “You!” Nelson shouted out, berating the dazed man and instructing him to go and put water on his face. As the elderly resident obligingly retreated, Nelson shook his head in indignation, calling out, “I’ve been up since 4am. Do you think I’m not tired?” Taking advantage of the momentary distraction, Luis, a younger resident, leant towards me, whispering: “There is way too much therapy here.” “It’s just therapy-therapy every day.” The men sitting within earshot murmured in agreement.

Later that evening, I sat in the kitchen talking to Angel as he scrubbed down the kitchen floor. He seemed down and I asked him if he wanted to watch the TV show that was blaring out on the terrace for ‘recreation-therapy.’ “I just don’t understand how people can live here for years and years,” he said. “It’s the same thing every day.” “It’s just like, let’s do chores and more chores, then prayer and more prayer, then chores and chores again until night time. How do they just live here for years and years?”

Residents’ distress as they contemplated the prospect of months or years of the same repetitive daily routine was striking in its uniformity and also in its resemblance to *acedia,* a form of spiritual suffering often considered a distinctively monastic affliction. While English renditions of *acedia* include sloth, repulsion, and lassitude, scholars of Christianity usually understand it as a spiritual kind of boredom induced by the rigidities and repetitiveness of ascetic life (Crislip 2005). In *The Praktikos,* fourth-century Christian monk *Evagrius Ponticus* emphasized *acedia’s* temporal dimensions, notably its

tendency to slow down time: “[to make] it seem that the sun barely moves, if at all, and that the day is fifty hours long” (Bamberger 1970:18). In her memoir Kathleen Norris has described *acedia* as an “intense and comfortless awareness of time,” in which the future looms as an “an appalling, interminable progression of empty days to fill” (Norris 2008:6-7).

For *Evagrius Ponticus, acedia* was threatening because it seemed to mock monks’ good intentions by recalling the worldly life they had left behind and tempting them to abandon ascetic life. It installed “in the heart of the monk a hatred for the place, a hatred for his very life itself, [and] a hatred for manual labor” (Bamberger 1970:19). To me, this seemed to encapsulate Angel’s anguish, as he stood there in the kitchen, scrubbing the floor, panicking about how much time lay ahead and wondering whether it all might be pointless.

If left unchecked, *acedia* could escalate into an outright loss of faith. Something like this happened one weekend in March. It was a Wednesday afternoon and I was chatting with Diego, a Bronx-born resident. Though he had now completed his 18-months of drug court, he said he was “stuck treading water,” with no home to return to and no way of supporting himself.

We chatted in English as he cleaned the car with a sponge. He gestured over to a group of residents who were pouring cement outside the main building where there would soon be a new laundry room. “I’m so tired of this bullshit,” he said, looking angrily at the bucket

of soapy water. He'd spent the whole morning cleaning and he was exhausted, he said, explaining to me what this had involved. Scrubbing all of the floors, moving the fridge, sweeping all of the cockroaches out from underneath, washing all of the walls inside and outside. "I could be working," he said, shaking his head and taking a drag of his cigarette. "I have a resume, a bank account. I could be working now. Instead I'm stuck here washing walls and floors and not being paid anything." Flicking his cigarette onto the ground, he kicked over the bucket of water sending slimy liquid gushing around our feet. "I can't stand it here," he said. "I'm just wasting my life."

Trying to be useful, while superfluous to the labor market, uprooted from kinship and community, and relying in large measure on a series of repetitive and not infrequently futile tasks, is a precarious foundation for manhood. In their efforts to be "useful members of society", men constantly cut their teeth on the sheer tedium of empty hours to fill. Despite the constant summons to labor: the early mornings, the bells, the plethora of domestic and manual tasks - idleness was sometimes inevitable. The boredom of idleness that settled in during these moments, which was actually a lot like that described in work on homelessness and unemployment among men in other, non-institutionalized places (Jeffrey 2010; O'Neill 2014), speaks volumes about the engineering faults of this theater of work. It is simply unable to assure a steady supply of useful things to do.

But perhaps the more serious problem here is the spiritual boredom, which I've compared here to *acedia,* that settles in even when residents succeeded in manifesting busyness. Even as these men 'drank their medicine,' so to speak, and duly and piously kept busy, as

instructed, the painfully apparent futility of the tasks at hand could be difficult to ignore. We might recognize this problem as lying in the 'shoestring' nature of this makeshift effort to give work to idle hands. With so little in the way of resources, this theater of work amounts to a poor, hollowed-out substitute – even for a substitute. After all, the medieval monks at least had carpentry, winemaking, and agriculture to contend with (Landes 2000). That the substitute work performed in the monasteries required skill, craft, and creativity and resulted in products of value may have lent it greater credibility. In any case, such privileges all feel a far cry from the invented work of washing walls and bleaching bathrooms. Considering the meagerness of the production and the minimalism of the set, it is perhaps impressive that residents were sometimes able to genuinely feel and publicly manifest a clear commitment to this project. But like the monks of Benedict's abbey, many struggled to maintain their faith in this repetitive way of life; many questioned their commitments to a daily routine that "mirrors eternity in its changelessness" (Norris 2008:5). Thinking back to Angel and Diego's torment, we might read Angel's spiritual boredom as the beginning of a crisis of faith that emerges from the incomplete investment of the "redundant" self in the available alternative manhood. And bubbling beneath Diego's crisis of faith comes, I suspect, a sense of having been betrayed, of having placed one's faith in a restoration project that turns out to be exile.

Conclusion

In his essay on mass male unemployment in South Africa, James Ferguson (2013) asks how, during the "demise of work membership," are social recognition and economic support to be given in ways that are not tied to wage labor. In this chapter, I have sketched one particular setup that I believe attempts to do just that. As this ethnographic

examination of daily life at *La Casita* has shown, the thing called "drug treatment" here turns out to be geared not towards treating addiction, but instead towards providing a surrogate job and alternative foundation for manhood for men who have no place in the contemporary labor market.

In this theater of work, men sought dignity, worth, work and belonging – things they were otherwise missing on account of their exclusion from wage labor. Denied the full social personhood provided by work membership, these men learned to resort to therapeutic labor and self-work as a way to repurpose a devalued "dependent" and "redundant" masculinity into something dignified, something useful, and something they could live with. By embodying "usefulness" through the performance of busyness, responsibility, and duty, these men were proving to themselves and to each other that they were, as *La Casita* formally described it, "useful members of society." But these performances were by no means easy undertakings, as I have shown. Residents' efforts to restate their claim to social worth were regularly bedeviled by the scarcity of necessary tasks, the repetitiveness of communal rituals, and the sheer futility of the work at hand.

So what can this ethnography of life at in a "residential drug treatment" center say about the relationship between labor and masculinity in the present? By trying to convey a sense of what life at *La Casita* looks and feels like, I have tried to show that for all its ancient echoes of *acedia* and monastic discipline, the addiction shelter is a quintessentially contemporary, and flawed, solution to the problem of male superfluity. Consider, first of all, its fragile patchwork of funding, its "community-based" veneer, and

desperate need to appeal to multiple, increasingly disengaged factions of the social welfare state. Then consider its imbrication into state projects of containment, its dependency on corrections funding, and the ensuing carceral obligations that it constantly struggles to fulfill. Treatment. Mutual-aid. Shelter. Penitentiary. Monastery. Job. None of these institutional identifiers is completely accurate, but the difficulty of categorization does suggest one thing. It is through its capacity to stretch "drug treatment" to capture some aspects of all of these things that the addiction shelter has become, in the contemporary moment, one of Puerto Rico's few secure and growing legal male industries.

While the addiction shelter is built on a pledge – of honoring the life you have now, of persisting in the fact of little to hope for, and of wresting dignity and worth from a superfluous state - this pledge proves an unreliable foundation on which to build a life. Boredom, idleness, a feeling of futility, and a weariness of soul created by the addiction shelter's inability to make work that feels useful leave many men questioning their commitment to this alternative way of life. The orchestrated "useful" masculinity that shelters cultivate as a base of worth and dignity for men without jobs is undermined by its own destitution. It may aspire but it cannot live up to these men's desires for the real thing.

Chapter 3

Vernacular Professionalization

Jorge and I make our way down Muñoz Rivera street to the municipal sports arena, a bastion of an older order of public recreation that can be refitted, needs depending, for school tournaments, government conventions, and private celebrations. On this hot, cloudless Sunday, the parking lot is filling fast. Cars and limousines line up to snake the corner. Puerto Rico's elected officials – the chief justice, the town mayor, and scores of representatives of the legislative assembly – have come together with over eighty families to pay tribute to this year's graduating class of *Hogar CREA*. The attendees mingle in the entrance hall, making an unusual crowd if ever there was one. Jorge and I join the throng as it moves rapidly through the lobby and trickles its way around the tables that fan out from the stage. Parents, grandparents, children, and partners, all turned out in their best attire, are assembling into groups and taking their seats. We find our name cards on a gold table in the middle. It is decked out with plastic flowers and helium balloons that stream up from the backs of pink plastic chairs. Jorge starts looking around, scanning the faces table by table. Through the crowd, his seven-year-old daughter Beatrice has just spotted him. She runs over and hurls herself up around his neck. The force of her small body crashing into his chest causes her sparkly tutu to splay out, spraying sequins onto the floor. Jorge's wife, Belinda, ushers their tuxedoed nine-year-old son into his seat.

A few minutes before *CREA*'s leader breaks out with the opening speech, Jorge's friend and former therapist finds him. They embrace and he guides Jorge to a coterie of polished

directors, introducing him as they each shake his hand. They are the district leaders, each responsible for coordinating activities across dozens of *CREA* centers. A waiter in a black suit and white gloves offers them cups of Coca-Cola from a tray. I recognize him as a resident from Juncos. A wave of quiet signals the service is about to begin. Jorge and I rejoin his family at the table.

Among the scores of public officials up on that stage, when it comes to community recognition Héctor Figueroa holds the upper rung. A household name, only his predecessor, the deceased Chejuán García Ríos, can claim greater community standing. For Figueroa, the presence of the town-mayor and the chief of justice, along with the full house of more than two hundred and fifty citizens, lends proof and authority to the continued eminence of his organization in the Puerto Rican township.

> Honorable ladies and gentlemen. Today is a special afternoon. We are here to award certificates to this year's *re-educados* and *re-educadas*, the graduating class of 2017 who have demonstrated, yet again, that *sí, se puede* ("yes, it can be done"). Like all of you graduating re-educados here today, I am here too as a product of the *CREA* program. Like many of you, I am also here as a product of the justice system. And I'd like to thank every member of the *CREA* family – our colleagues who have supported us, the volunteers and steering committees, without whom we couldn't survive, and of course our friends here in the Department of Justice who have got us to where we are today. I can tell you all that it's a beautiful privilege to be here.

> To our honorable directors, we are also here to thank you for the tireless work and sacrifices you have made on behalf of *CREA*. Today is a proud day for you too. You have all spent years as interns, you have all made enormous sacrifices, and you all know how much effort it takes make the journey to become re-educados. Graduates, now that you have all put in the effort, after all that work and sacrifice, you can now start to enjoy the success. You can return to your community as qualified men and women, as leaders in your communities, and together we can work to recreate and re-educate the Puerto Rican personality, to create a future for our island, a future free of substances.

Today is not a typical rehab festivity, at least not the low-key Narcotics Anonymous kind where members warmly applaud each other for achieving a month of sobriety, before politely settling down back to business as usual. Today, Figueroa can address a class of soon-to-be graduated ex-addicts under the gaze of Puerto Rico's high and mighty, in an embodied display of leadership and professional achievement. Today, he is able to hail his fellow ex-addicts as graduates and certified professionals, with all the fanfare and grandeur of an American commencement.

This is not lost on the next speaker, the town mayor, who composes his eulogy as a commencement address: "Today you can all be proud of your immense achievement," he delivers to uproarious applause. "Now is the time to think about where you want to be in five or ten years. You've already proven you can do anything you set your mind to."

Figueroa reclaims the mike and beckons the audience to rise to sing the American national anthem, a chorus that ends with a trio of flag bearers, tall and proud, making their way slowly down a red carpet that connects the graduates and their families to high table. As the flags of the United States, Puerto Rico, and *Hogar CREA* glide steadily down the red carpet, the crowd rises again, this time to sing the Puerto Rican national anthem, in an equally impassioned performance. Afterwards, the guests are invited to take their seats as *CREA's* graduating members and directors stand side-by-side, fists clenched on heart, and serenade the audience with *Hogar CREA*'s signature hymn. It's a relief when the pre-recorded music chimes in - a Spanish string piece that blares out through the speakers.

Then one by one, the graduates, who are nearly all men, are called to walk down the red carpet to high table where, after shaking the hands of Figueroa, the town mayor, and the chief justice they are each awarded a medal and trophy. Prizes in hand, one by one the *certificados* assume their seats in a row of golden chairs that face the stage.
In a time-honored tradition, the next two hours are a whirlwind of tributes and testimonies. A *re-educada* from the Bronx gives thanks to *CREA* for saving her life. "Thank you to God, thank you to *CREA*. I am proof the program works." "I believe in *CREA*." A wife gives testimony to her husband, clean for fourteen years and now a much beloved director in Trujillo Alto. Tears streaming down her face, she recounts the story of one of her husband's former *internados,* who'd just made him godfather of his new-born son, a testament – she says - to what it means to be part of the *CREA* family. "My husband," she finishes, wiping tears from her eyes, "a symbol of recuperation." The

audience roars in applause. After the ebbs and crests of speeches, it is Figueroa who closes out the ceremony. He chooses his final homage to pay tribute to Chejuán, "*el padre* in the fight against addiction," and to give thanks to the executive table, "for their support in the fight for the wellbeing of our beautiful island." With the fury and undulation of a soccer commentator before a goal, he reaches his final crescendo: "May you never fall back, may you never regress, your honored certificated *re-educado*."[29]

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Watching the graduation, I felt that a drama was unfolding before my eyes. On the stage, addicted and criminalized men were applauded by the powerful in recognition of their hard-earned sobriety, and in celebration of the opportunity that surely lay ahead. Shirts starched and shoes shined, these men stood proud as they shook the hand of the town mayor and received their certificates under the gaze of family and town. Center of stage for all to see was the embodied best-case scenario that therapeutic community treatment can offer: ex-addicts and ex-criminals, now reformed and remade as honorable leaders in Puerto Rico's fight against addiction - catapulted to equivalence, for today, with the governing class, the professions, and the whole of working Puerto Rico that stands apart from the street. Aspiration filled the air.

The graduation ceremony dramatizes an increasingly common strategy in post-industrial Puerto Rico: the improvisation of livelihood by way of "vernacular professionalization."

[29] In Spanish, "*Para que no vuelvas atrás. Para que nunca regresas, su honrado certificado*."

By this, I am referring to the fashioning of an abeyance mechanism, in this case a hybrid therapeutic market, labor niche, and domain of expertise, which simulates the professions in symbol, insignia, and representation, but that is explicitly "extra-professional" in the sense of originating from without.

The notion of the vernacular has often figured in accounts of knowledge struggles between local communities and scientific authorities in domains such as environmental justice and HIV activism (Escoffier 1998; Bartel 2014). In these accounts, vernacular knowledge is often is juxtaposed with scientific knowledge, as something that emerges at the local level rather than from authoritative scientific institutions. An alternative conceptualization of the vernacular is presented by studies of the global movement of human rights discourses. Levitt and Merry (2009, 2011), for example, use the term "the vernacularization of human rights" to refer to how global ideas about human rights are appropriated and customized in diverse local communities. Unlike other accounts of "vernacular knowledge" (Escoffier 1998; Martos 2016; Bartel 2014), Levitt and Merry's formulation emphasizes how externally derived ideas are imported, adapted, and changed in local settings (2009, 2011).

In line with this work, I use term "vernacular professionalization" to refer to how ideas and discourses about professionalization - including pedagogies, certification systems, hierarchies, and symbols - are appropriated, customized, and adapted in communities that are located specifically *outside of* the formal professions. In other words, vernacular professionalization is a mimetic process by which actors appropriate and modify globally

circulating ideas about professionalization from an explicitly “extra-professional” positionality. I use the term “vernacular” rather than “local” or “lay” or “traditional” to describe this entrepreneurial strategy because I want to emphasize the transfer and blending elements of this process: like the vernacular languages that derived from Latin in Europe, the local systems of professionalization that are improvised and created here are influenced by a template, in this case global ideas of “the professions,” which are then adapted and modified according to local conditions.

In contemporary Puerto Rico, this entrepreneurial strategy through which poor and criminalized men seek livelihood, honor, and upward mobility has become entangled with a variety of counter-narcotics and biopolitical projects that are all part of the war on drugs.[30]

As a colonial territory of the United States, Puerto Rico has been subject to federal counter-narcotics efforts since the early 20th century, though most forcefully since the 1971 when President Nixon declared a “war on drugs.” To date, scholarship on the war on drugs in Puerto Rico (Ferrería 2012; O’Neill and Gumbrewicz 2005; Santiago-Negrón and Albizu-García 2003), as in other Latin American contexts (Bagley 1988; Carpenter

[30] See the introduction for a discussion of the contested meanings of the “war on drugs”. For now, it suffices to repeat that I follow Zigon’s (2015) conceptualization of the war on drugs not as a single strategy or collection of policies but as an assemblage of institutions, people, and objects. These are diffused across a variety of geographically and socio-economically distinct locales, but that are connected by complex structures that include, among other things: state-based surveillance, mass incarceration, militarized police violence, and global militarism. These have each taken various forms over the last thirty to forty years, beginning with President Nixon’s declaration of a “war on drugs” in 1971. An historical account of this is provided in Chapter 1.

2014), has often focused on enumerating its casualties, often through quantitative assessments of government expenditures, public health outcomes, and incarceration and law enforcement-related measures, and sometimes through qualitative examination of the various social vulnerabilities afflicting populations directly impacted by it (see, for example, Padilla et al. 2018; Brotherton and Martin 2009; Brotherton and Barrios 2011). Missing from these accounts, however, is a consideration of regionally specific responses – at the level of the state, civil society, and other social institutions – to the US-led war on drugs.

Here, I foreground local history and regional specificity to provide an ethnographic account of how criminalized and drug-using men in Puerto Rico have responded to, and harnessed, the unlikely opportunities that the war on drugs presents. I do this through ethnographic examination of a paraprofessional group of men who refer to themselves as "re-educated ex-addicts" or *re-educados exadictos*[31], who operate non-profit residential drug treatment centers across the commonwealth.

[31] Through "re-educated ex-addicts" are legally recognised under the Mental Health Act as a professional category ("specialist guides in community treatment"), there is no standardized criteria for what constitutes being an "ex-addict." In practice, it is an internally conferred status that is usually understood to refer to a person who has completed a residential drug treatment program, with 'completion' typically predicated on between twelve and eighteen consecutive months of residency, abstinence, and conformity with the particular institution's rules.

Puerto Rico's war on drugs[32] is now approaching the end of its fifth decade, and the commonwealth state is estimated to have spent over $5 billion on drug-related law enforcement and incarceration, or an estimated $600 million per year (Ferrería 2012). Under federal mandate to enforce narcotics control, the commonwealth state has experimented with a variety of cost-saving measures over the years, one of which has been to use the courts to divert those convicted of drug-related offenses away from prisons and into lower-cost institutions of treatment. For decades, non-profit peer-run residential drug treatment facilities have been the largest recipients of diverted offenders. As Puerto Rico's Drug War is increasingly waged through the courts, efforts to lower containment costs have found a fortuitous affinity in criminalized men's efforts to better themselves, linking the colonial politics of the drug war to the dreams and ambitions of Puerto Rico's poor.

Scholarship on neoliberalism has often noted a tendency for the caring professions to be replaced by less qualified, lower-cost professional categories, for example, nurses by nursing aides, teachers by teaching assistants, or social workers by social welfare assistants (Boehm 2005; Wacquant 2010). But as I show in this chapter, in Puerto Rico this fissuring of the professions in the interest of cost-effectiveness has a much older history. Across what is now a deregulated, carceralized, non-profit "archipelago" (Foucault 1977) of residential drug treatment centers – sites of central importance in

[32] Like my definition of "war on drugs," when I refer to "the Puerto Rican war on drugs" I am referring to a complicated collection of objects and people that are "caught up in shared conditions"(Zigon 2015: 502). The 'Puerto Ricanness' here refers only to field site and ethnographic focus. It does not imply that the war on drugs in Puerto Rico is disconnected or distinct from the war on drugs in other places.

Puerto Rico's war on drugs – this systematic bifurcation of role has reached its radical conclusion in the ascendance of the "self-certified professional," an oxymoronic subject whose lack of educational capital and alternative employment options makes him an ideal candidate for state projects of containment.

In this chapter, I consider the work of *re-educados* as a project of "vernacular professionalization," which is one sense is an entrepreneurial life project through which criminalized men seek to create a labor niche that simulates the professions, appropriating and adapting globally circulating ideas about professionalization. In a second sense it is a governing strategy through which the commonwealth state pursues cheap containment. I explore vernacular professionalization ethnographically- considering its performance, history, and tactics - and I examine the ways these improvised channels of certification and qualification mimic existing educational structures. While many consider these credentials to be "fake" and the bearers to be "pseudo-professionals" (see for example, IPR 2015), I employ Baudrillard's notion of simulation (1983, 1994) to argue that the "self-certified professional" is now a foundational labor niche whose occupants are responsible for fulfilling vital roles as social workers, case workers, and therapists in post-industrial Puerto Rico. The tendency of self-certified professionals to short-circuit all credentialing requirements that typically restrict and qualify entrance to these professional categories is tolerated because of the utility these subjects represent to various state actors.

To better understand the dynamics of this strategy, this chapter first situates the formation of this labor niche within its historical context of the war on drugs. Next, it ethnographically examines the improvised channels through which this labor market seeks to transmit status, respect, and honor to its subjects, attending in particular to cultural and symbolic dimensions of its training and credentialing systems, and to the Christian-inflected American ideologies of success that circulate through its reward ceremonies. It then explores the entanglements of these entrepreneurial projects of self-betterment with state projects of containment, and argues that vernacular professionalization flourishes as a collective collusion only because of this unlikely convergence of interests, not because it opens a viable route to social standing outside of this circumscribed therapeutic market.

Drug convictions, and becoming a "therapeutic adjunct"

Like many *re-educados,* Salvador describes himself as a "product of the justice system," a reference to the fact that his arrival at *La Casita* was precipitated by a drug charge, and his first four years there were spent under court order. His first interaction with criminal justice had occurred in New York City, when at the age of fourteen he'd been involved in a fight that ended with him spending a night in jail. Soon after the incident he'd been sent back to his birthplace, Bayamon, to live with his maternal grandparents. According to Salvador, this was among several of his mother's attempts to protect him from the gangs and violence that surrounded their home in the Bronx.

As a spatial fix to city fears, it proved only partially successful. Salvador completed fifth grade in high school and went on to obtain various kinds of employment. At eighteen, he

worked as a cashier in a fast-food chain restaurant; later, he served as a janitor in a large apartment complex. He used cocaine on and off, however, throughout his late teens, and from his mid-twenties onwards he also began dealing the drug on the side. This venture ultimately led him to acquire seven drug-related charges between 1975 and 1985, during which time he spent a total of six years in prison. In 1985, he was diverted into a residential drug treatment program called *Hogar CREA*, whose representatives were conducting recruitment in the courts, and where he went on to spend four years as an *internado*. In 1989, he completed his mandatory treatment period as required by court order and graduated as a "certified re-educated ex-addict." Looking back, he attributes his life trajectory since then directly to his court order.

> Before this, I hadn't done a thing with my life. Not a thing. When I first went to *CREA* in 1985, all I knew was drugs and the street. But soon, I was noticed as a good leader. And the program, it helped me to discover talents in me that I never knew I possessed. And so after I graduated, I decided to stay. I professionalized myself, as they say. And after a few years, I followed my dreams and started my own program. And thanks to God, I'm still here today, as the founder and director of a program, sixteen years and counting. Me, a director… even though I don't have sixth grade.

Like Salvador, the work histories of *re-educados* often spanned illicit economies and low-waged sectors of licit economies, sometimes traversing Puerto Rico and the mainland. Prior to enrolling in *La Casita*, for example, Luis had been a deliveryman for

Pizza Hut in San Juan; Carlos had been a cleaner in a local branch of *Chili's*, an American chain restaurant, while Ivan had a slightly more lucrative job in the military back in Florida. For each of them, their involvement in the illicit drug economy had been interspersed, and sometimes overlapping, with low-wage licit employment. Each had wound up in a residential facility via a drug charge.

Though *re-educados* are often quick to identify as "drug addicts" or "ex-addicts," and readily testify to their misspent histories of addiction in narratives that are strikingly formulaic, when I began to compile the substance use histories of dozens of *re-educados*, they turned out to vary widely. While some recounted years of battling with severe and debilitating addiction, for example, Humberto had injected heroin on a nearly daily basis for over thirty years (including the twenty he spent in prison), many described a range of more moderate drug use. Nelson, for example, had smoked and sold synthetic marijuana for a year or so before being arrested for dealing. Ernesto had used marijuana and cocaine periodically throughout his twenties, though said he'd never considered it a serious problem. In contrast, Salvador's heavy cocaine use ultimately lost him his job as a janitor when he forged a check to sustain his habit.

That drug conviction more so than drug addiction emerged as the more consistent unifying experience in residents' early career paths[33] complicates our view of *re-educados* as straightforward "peer counselors," and points to the entanglement of this labor class with corrections projects.

The transition from *internado* to *re-educado,* or from resident to staff member, often begins under court order. Héctor, for example, was appointed as a "case worker" after eighteen months of residential treatment, two and half years prior to completing his compulsory treatment order. While Salvador, who'd been court-ordered into treatment for a minimum of four years, was appointed as a "tribunal coordinator" after one year, as an "assistant director" after two years, and as a "director" after four years. Similarly, Luis was taken on as a "therapist" after just eleven months of treatment, which was seven months prior to completing his court order.

In these shelter settings, professional titles such as caseworker, social worker, therapist, and leader are highly coveted designations that carry significant social capital, but map only loosely onto professional responsibilities. Depending on the organizational specifics, the duties of a caseworker or therapist may differ significantly, but over time I came to

[33] This ethnographic finding is also supported by independent evaluations of Puerto Rican drug courts that have documented very low prevalence of substance-use related diagnoses among people diverted into drug treatment. One qualitative study of over four hundred drug court participants found that 60% did not meet the criteria for drug dependence at their time of their compulsory treatment (Colon, Matos, and Garcia 2005a). A second independent evaluation that analysed 1000 client files between 2000-2003 found that just 7.3% of active drug court participants had a formal drug diagnosis (of any kind) on record, though 52% were diverted to a residential facility within six months following sentencing (Colon, Matos, and Garcia 2005b).

recognize a spectrum of work that varied in terms of status, responsibilities, income arrangements, and basic freedom.

At the bottom-end were *re-educados* who, to my eyes, resembled 'expert' residents. These *re-educados* had typically resided at the shelter for several months to a year, had access to certain privileges (for example, a bedroom with fewer roommates, a key to the office) and were responsible for various pastoral or administrative tasks. These commonly included guiding new recruits, supervising and facilitating group activities (including therapies), and taking messages on the office phone line. These men were usually unpaid and referred to as "volunteers" as a way to distinguish them from residents without these responsibilities. Considering that many "volunteers" were still under court order, however, and thus legally prohibited from leaving the premises, this title is at best misleading.

In the middle were "staff" who received some form of income, ranging from a sub-minimum wage stipend to a minimum wage salary[34], and who, depending on income arrangements, might live on- or offsite. The responsibilities of these "case workers," "social workers," and "therapists" encompassed both the on-site tasks of the volunteer (enforcing order, delivering group therapies, mentoring new recruits), and additional off-site administrative duties, such as representing residents in hearings, writing case reports, and sometimes liaising with courts and families. These subsidized roles were generally performed by men with several years of living and volunteering in addiction shelters.

[34] Stipends were typically in the range of $7000-$9000 per year, with salaries ranging from $18,000 and $26,000.

At the top were the “directors” or “leaders,” such as Héctor, who were sometimes little better off than the staff they supervised. Depending on organizational specifics, directors might live on- or off-site. Some directors received formal incomes – usually through corrections grants, while others were paid only a stipend, typically by the Pentecostal church. Carlos, for example, a forty-two year old director of a secular addiction shelter, was paid $26,000 via a government corrections contract and lived offsite in a privately-owned house (though as the founder of the program, he’d spent five years living in the *hogar’s* basement along with his wife and newborn child before succeeding in obtaining a government contract and thus being able to afford to live off-site). In contrast, Javier, who was a seventy-two year-old director of an Evangelical program, a position he’d enjoyed for two decades when I interviewed him in 2016, received a stipend rather than a formal income and lived nearby in private lodgings provided and owned by the church. In general, directors employed at larger organizations (Teen Challenge, *Hogar CREA, Hogar Nueva Vida, Hogar Nuevo Pacto*) were more likely to be paid a formal, if modest, salary.

Such breadth of income, status, and responsibility – not to mention freedom - within the *re-educado* labor niche defies a straightforward “poverty survival” reading - a concept commonly employed in studies of peer-led addiction treatment to date (Fairbanks 2009; Garcia 2015). For example, in his study of Philadelphia’s recovery houses, abandoned row houses where “street-level entrepreneurs” set up unlicensed self-help groups and survive through pooling their participants’ welfare checks, Fairbanks argues that these are “informal poverty survival strategies” produced by welfare restructuring and urban

neglect. Angela Garcia (2015) offers a similar argument in her study of *anexos* in Mexico, where unregulated and unlicensed self-help groups thrive in a context of medical scarcity and state abandonment.

But such a reading is inadequate for understanding the work of *re-educados* in Puerto Rico. In contrast to these accounts of peer care as marginal fly-by-night operations that flourish off-radar and unlicensed, beyond and uninteresting to state scrutiny, the work of *re-educados* unfurls squarely under the gaze of the commonwealth state. Licensed by the Mental Services Administration Health and Addiction (Spanish acronym, ASSMCA) as providers of residential drug treatment, and often bolstered financially by corrections contracts, the work of *re-educados* in Puerto Rico is inseparable from the state and is deeply entangled with state projects of containment. A more informative interpretation of this work, as I came to understand it, is not that of "informal survival" but instead "government adjuncting." In other words, the *re-educado* is essentially a low-skilled and low-cost worker who has been converted and repackaged, through carceral intervention, from a criminalized subject and (from the state's perspective) a financial burden, into an inexpensive agent or adjunct, providing a way to substantially lower containment costs. As we shall see, the creation of this work force is directly tied to the US-sponsored war on drugs.

The war on drugs in Puerto Rico

The drug conviction-to-adjunct pipeline common in the labor histories of many *re-educados* is a trend that stems directly from Puerto Rico's dovetailing of mainland drug policies. First initiated under President Richard Nixon in 1971 and ongoing since then

(for history, see Acker 2002), the war on drugs in Puerto Rico has closely mirrored that on the mainland. As mainland incarceration rates exploded during the last decades of the 20th century, parallel developments occurred across the commonwealth, with the number of people incarcerated in Puerto Rico rising from 4,221 to 14,691 between 1981 and 2000 (World Prison Brief 2016), and the incarceration rate rising from 130/100,000 to 582/100,000 between 1981 and 2003 (World Prison Brief 2016; Santiago-Negron 2003:1420). By the early 2000s, Puerto Rico had the third highest incarceration rate in the world, surpassed only by mainland United States and Russia (Santiago-Negron 2003:1425). By 2011, it had one of the most bloated police forces (relative to population) in the United States[35], employing an estimated 510 officers per 100,000 inhabitants (Ferrería 2012:1151), compared to 423 in New York City (GOVERNING 2018).

Carceral expansion in Puerto Rico was driven both by legislative change and by stricter enforcement of existing laws. Particularly important was the introduction of the Commonwealth Law of Controlled Substances in 1971, which soon became the most common conviction among Puerto Rico's prison inmates, and which applied to 33.94% of the total prison population in 2003 (Santiago-Negron 2003:1422). Federal laws and courts also played a role. Key was the Federal Anti-Drug Abuse Act of 1986, which increased penalties and instituted mandatory minimum sentences for most drug offenses (O'Neill and Gumbrewicz 2005), and the Federal District Court of Puerto Rico, which convicted thousands of Puerto Ricans of drug-related offenses (over two thirds of

[35] Surpassed only by the District of Columbia, Louisiana, which is a high-crime jurisdiction, and Wyoming which is a low population state (Ferrería 2012:1151).

sentences in Federal court in Puerto Rico in 2001 were passed specifically for drug-offenses) (O'Neill and Gumbrewicz 2005:37).

Mass incarceration was facilitated by large increases in spending, with Puerto Rico's budget for the Department for Justice rising from $25 million in 1984 to $62 million in 1992 (Departamento de Justicia 1992; Departamento de Justicia 1986), and that of the Department for Corrections rising by 262%, from $147 million in 1992 to $532 million in 1998 (Departamento de Justicia 1992:53-3).

In 1993, Governor Rosselló launched the infamous *Mano Dura* (or Strong Hand), in which he dispatched the National Guard to stage mass arrests through approximately eighty police and military raids in public housing projects between 1993 and 1999, all under intensive news coverage (LeBrón 2018). By 2011, the pooled annual budget for Puerto Rico's Police Department, the Correctional Administration and the Judicial Branch was $1.5 billion (Ferrería 2012). To put that into perspective, that same year the annual budget for the Mental Health and Anti Addiction Services Administration (ASSMCA), the department responsible for overseeing all addiction prevention and treatment on the island, was just $96 million (Ferrería 2012).

In the face of exploding incarceration costs, Puerto Rico has experimented with a variety of prison-diversion schemes, starting with the Treatment Alternatives to Street Crime program (TASC), a federal initiative introduced in the 1970s, but also through various

other legislative mechanisms.[36] In the commonwealth, therapeutic community leaders have played an historically proactive role in the development of prison-diversion schemes through, for example, submitting invited policy responses to the Legislature to inform various pieces of legislation, and through establishing several ex-addict led organizations to oversee treatment among court-ordered residents. *Hogar CREA's* director, Chejuán Garcia Rios founded two such organizations during the 1980s, the Social Association for Rehabilitated Ex-Addicts (Spanish acronym, ASEAR), and the Association for the Services of Rehabilitated Ex-addicts and Ex-convicts' (Spanish acronym, ASEER).

From the 1970s onwards, Puerto Rico's Department of Correction (later, the Department of Correction and Rehabilitation) diverted hundreds of inmates in each year to various therapeutic communities, who in exchange received a *per diem* for each court-ordered resident. Similar arrangements were made between therapeutic communities and the Juvenile Institutions Administration, facilitated by federal funding (Departamento de Justicia 1992). By the early 1990s, the Department of Corrections was diverting over 1800 people each year into residential facilities (Department of Correction and Rehabilitation 1994:30). Prison diversion was subsequently expanded again in 1996 through the establishment of the Drug Court Program (DCP), which was modeled on similar initiatives on the mainland. Historically, the biggest recipient organizations of diverted offenders, by a large margin, have been *Hogar CREA, Hogar Nueva Vida* and *Hogar Nuevo Pacto* (both modelled on *CREA*), and Teen Challenge (a large multi-national Evangelical treatment franchise). Each of these organizations now operates

[36] Such as rule 247.1 of the Puerto Rico Rules of Criminal Prosecution, and various amendments to the 1971 Law of Controlled Substances.

several programs on the island, each receives significant financial backing through corrections contracts, and each has been known to recruit participants directly from drug courts.

Anthropologists and others have observed similar trends towards prison-diversion in North America and Canada (Kaye 2010; Tiger 2013; Hannah-Moffat, Maurutto, and Turnbull 2009; Feeley and Simon 1992) and through them, have begun to elaborate changing philosophies, rationales, and governing strategies of the juridical system. Many have noted a late 20th century shift towards "therapeutic jurisprudence" (Wexler 1990), an approach to the law that seeks to maximize the therapeutic benefits of the legal system, through reconfiguring judicial processes to channel people into institutions of treatment. Studies of therapeutic jurisprudence have analyzed how, during the late 20th century, the courts have ceased to be sites primarily devoted to the establishment of truth beyond so-called reasonable doubt, and have increasingly begun as well to apply "psychic truths" in efforts to rehabilitate (Kaye 2010:9). Scholars have situated these changes within earlier transformations of rehabilitative philosophy, fiscal policy, and penal governance (Kerwin Kaye 2010; Tiger 2013; Feeley and Simon 1992). But as *re-educado* Salvador's words suggest, what stands out about Puerto Rico's war on drugs and its particular conviction-to-adjunct pipeline is the extent to which the targets of these carceral interventions have seized upon (and creatively melded) the opportunities that these corrections projects have presented. This opportunity-seizing element of Puerto Rico's war on drugs challenges us to ask what more, besides efforts at cheap containment, underwrites this labor regime.

Vernacular professionalization by way of simulation

"I certified myself," ex-trafficker Héctor Vayaz announced early in an interview. We were sat in a dilapidated office where water dripped loudly into a trashcan from a peeling ceiling, and the shelves of an ageing bookcase drooped tiredly, struggling under a weight attributable not to books but to an extensive collection of trophies. The assortment of goblets and shields came in various shapes and sizes: plastic figurines of painted gold, small embossed silver cups, and large black-diamond plaques. Following Héctor's gesture, my eyes floated upwards to a black and white framed photograph that was hanging on the wall. At the center of the photograph was Héctor, flanked on both sides by a dozen residents. "In Recognition for Services to the Free State of Puerto Rico," read the inscription. They stood smiling in rows with medals around their necks like a high school soccer team. Héctor was the founder (and also in-house pastor) of a faith-based residential drug treatment program in Mayagüez, where we settled into an interview.

> "I passed through a program. I saw the hurt. I saw what was happening with the youth in Puerto Rico, [and] I'm not gonna be hanging around on the corner, watching. So I did something. I graduated the program, and I got certified in addiction."
>
> "Oh cool," I said. "Where did you get certified?"
>
> "I got certified at my old program," he said. "That's how it is here."

In its most basic sense, vernacular professionalization is an improvised and entrepreneurial strategy through which poor and criminalized men seek to improve their

lot – to gain livelihood and honor – through the concoction of a therapeutic market and domain of expertise that simulates the professions – in symbol, insignia, and representation – but that is "extra-professional" in the sense of originating from without.

In terms of symbolism, it covets modern discourses about skilled work, middle class aspirations, and the value of education. In this respect, it presents a striking contrast to accounts of male subsistence strategies in Latin America and also among Latinos in North America. A rich ethnographic literature conducted in illicit and informal economies has described marginalized men's efforts to seek honor and respect outside of formal labor (e.g., see Bourgois 2003; Flores 2014; Penglase 2010; Muehlmann's 2013). Quite strikingly, these accounts have often employed constructs such as "hyper-masculinity" (Gilmore and Gilmore 1979) or "oppositional identity" (Bourgois 2003) when describing the strategies through which men respond to their marginalization. These depictions of 'oppositional sub-cultures' have often emphasized interpersonal violence and sexual domination, as is the case among Puerto Rican crack dealers in East Harlem (Bourgois 2003), or male strength and sexual prowess, as we see in Muehlmann's (2013) account of the drug mules in Mexico. Hansen (2018) has provided a compelling counter-example in her work on Puerto Rican drug ministries, where the "alternative masculinity" aspired to is one that explicitly rejects the violence of the drug trade, and instead is grounded on domesticity, masculine self-reliance, and a re-invented image of the male breadwinner as an Evangelical "spiritual patriarch."

In contrast to these accounts, the images underpinning vernacular professionalization draw on a collection of discourses – the qualified professional, education, qualifications – that are neither "oppositional" nor so obviously gendered. In fact, they are perhaps better thought of as values associated with modernity. These specifically modern values are apparent in *re-educados* valorisation of accreditation.

Contrary to popular conceptions of *re-educados* as revering "experiential expertise" over and above all other forms of professional preparation (people in public health repeatedly told me this, "they think only addicts can treat addicts"), professional accreditation is actually upheld by *re-educados* as a sign of honor and a fetishized social status. Honor, as Herzfeld (1980), reminds us, is rarely merely a question of beliefs. More commonly, it refers to an "evaluative description of public behavior" (1980:341) - in this case, a self-conscious performance of a decidedly modern conception of honor. One based not on "hyper-masculinity" or "machismo," as work on honor in Latin America has sometimes suggested (Gilmore and Gilmore 1979; Blok 1981), but on modern, middle class notions of respectability that center most centrally here on education and the acquisition of a skilled, steady job (for further discussion of honor and modernity, see Caulfield, Chambers, and Putnam 2005).

This helps to explain, in part, why addiction shelters go to great lengths to devise a parallel world of titles, trophies, rewards, and ceremonies that mimic, albeit through a frequently flashy theatricality, a coveted and valorized image of "the professions," one that is palpably indebted to American ideals and images of "success." This rather potent

mix adds some context to some of addiction shelters' more curious rituals: the elaborate reward ceremonies, the sometimes-grandiose titles (*ex-adicto honrado*[37], *re-educado certificado*[38]*),* and the appropriated professional designations (*terapista, trabajador de caso, trabajador social*[39]*).*

Some addiction shelters – particularly the larger ones – actually operate internal training schemes known as *aprendizaje* (apprenticeship) and *la práctica* (practicum) for graduated *re-educados*, which confer informal forms of accreditation. These programs vary in form and content from place to place, and tend not to follow any specified curriculum, at least not one that I could find written down.

In 2017, I attended six training sessions for *re-educados* at two different addiction shelters. I found myself watching Manuel, a long-standing and evidently much beloved director of a residential program in Guayama. His official title was "district training official," and he was responsible for coordinating and delivering training across several different shelters. In a previous life, Manuel had been a shop assistant, then a drug trafficker, but in 1991 he'd been court-mandated to a residential program – where we were now all gathered – and he'd stayed there ever since.

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[37] Honored ex-addict.

[38] Honored certificated re-educated ex-addict.

[39] Respectively, therapist, caseworker, and social worker.

I watched Manuel teach four classes. He was charismatic and often paced up and down the room as he talked. He always wore a suit and tie and would start each session by inviting the group to give a round of applause and a welcoming cheer to each attendee. Following lively introductions, he'd invite the group to hold hands in prayer: "Being here together, *profesionales entre profesionales,* this is what we strive for. We are happy, we are motivated, we are grateful. *Gracias a Dios*."

In format, practicums had a hybrid structure and atmosphere that lay somewhere between seminar and office party. Between ten and fifteen of us would sit around a table stacked with worksheets and refreshments. The facilitator would introduce the topic, and for the next few hours we'd listen to a lecture, complete various exercises, and watch online videos. In terms of content, it was a hodgepodge of lessons determined by the presenter's choice. The six trainings I attended (four led by Manuel, two by visitors) covered a mixture of topics, some based on scientific research (e.g., "substance use and DSM-V" and "domestic violence") others on pop-science ("managing stress" and "achieving your potential"), and others on bible-based thoughts for the day ("the power of prayer") or on recent news items.

For example, in a session dedicated to "leadership and authority," Manuel talked us through the ideas of John Maxwell, an Evangelical American author whose pop-psychology books on leadership have sold millions of copies across the United States (Kruse 2019) After the presentation, we watched several online videos and performed role-plays exercises. In another session, we watched a TED talk delivered by an academic

researcher about the long-term health consequences of childhood trauma. In another, we discussed how the Christian notion of sacrifice applied to *re-educados*' work, with attendees asked to enumerate specific sacrifices they'd made ("sleeping on the floor when there aren't enough beds" and "working hard for little pay").

The hodge-podge content of these training sessions – pop-science, Christianity, and public health doctrine – highlights the mimetic manner in which vernacular professionalization operates in Puerto Rico. Lacking any stable curriculum and unrestricted by theoretical allegiance, this improvised education system mimics and borrows its structure, content and discourses from its surroundings, mixing and melding Christianity, medicine, and popular culture into an improvised project of self-betterment.

Consider a session I attended on "substance use and DSM-V," led not by Manuel but by a visiting graduate student with a BSc in psychology from the University of Puerto Rico. The student began the session by reminding attendees that "addiction" was just a lay term, and that "as professionals talking among professionals, we should all be trying to use the correct DSM-V term, 'substance use disorder'." Before giving his presentation, he asked the class to enumerate some of the characteristics that someone with a substance use disorder might display. "Being manipulative!" shouted one attendee. "A loss of social values!" suggested Manuel. Consistent with the characterological approaches that had defined their own therapeutic careers, "aggressiveness," "irritability," and "conflict with authority" were among the other suggested responses. After noting the responses, the lecturer then turned to his next slide, which listed "eleven reportable or observable

symptoms of substance use disorders according to DSM-V." Unlike the characterological explanations offered up by the *re-educados* in attendance, these symptoms were mostly behavioral, and included such things as: consuming more substances than originally intended, continued use in spite of harm to personal relationships, spending large amounts of time consuming or obtaining substances. After the presentation, we completed a quiz in groups about observable symptoms of substance use disorders. Once Manuel had thanked the speaker, he delivered an off the cuff recap: "Today's addicts are complicated. It's not like before, when addicts were just addicts. Now, they have trauma, mental health, dual-diagnosis, domestic violence. Addicts have changed," he said, "and we have to change too."

To me, this session stood out as a striking dramatization of how vernacular professionalization operates as a kind of *bricolage* (Lévi-Strauss 1966) for the cultivation of social capital – in this case, a highly coveted and valorized professional kind of cladding. At play is this session was an encounter between two seemingly distinct therapeutic epistemologies: a clinical epistemology grounded in the norms of biomedicine and the diagnostic criteria of DSM, and then a therapeutic community system, grounded in Eriksonian psycho-analytical theory and character-building therapies. Yet, the extremely accommodating orientation of *re-educados* to what (to outsiders) might seem like high-stakes framing tensions reflects the fact that 'theory' here (whether of the scientific, popular, or spiritual variety) functions not primarily as a guide for therapeutic practice, or as a tribal allegiance within a contested landscape of addiction treatment. Instead, vernacular professionalization draws on whatever is around, blending

diffuse kinds of theory and knowledge that self-improving subjects can appropriate and meld, via self-certification, into a kind of honor based on modern notions of middle-class success, skilled work, and education.

For the day's trainees, attendance was rewarded with the bestowal of small prizes: an embossed certificate for each attendant, a plastic medal for newcomers, and for the person deemed "most promising leader," a plastic shield. The ceremonial conferral of these prizes was marked by a round of applause, one for each member, with absent members calling in to deliver their congratulations on loudspeaker. Afterwards, we tucked into the refreshments; there was a large spread with a cake. These were joyous occasions. At the end of each session, we'd pray, and Manuel's energy never dropped. "We are so grateful for these opportunities we have been given."

"Remember to have your certificates in a safe place," he called out to the exiting throng. "That way, if anyone says you aren't qualified, you can show that you are." Outside after the workshop, a *re-educado* redelivered to me an enthusiastic rendition of a lecture that he has recently given a novitiate about the harms of drug use. "Me, a therapist! When I came here, I didn't know at that moment there were many things I didn't believe I could do… That I could get certified, that I could professionalize myself." We chatted for a while as we ate cake, while some of the others launched into a game of basketball.

For some, the trainings on offer here might read like a glorified imitation of a higher education, a fanciful counterfeit and a flashy kind of group theater whose artificiality is

apparent, and, for those to whom the status value of educational qualifications matter, problematic. Certainly, this was the view of many Puerto Rican public health officials, for whom "self-certification" was often dismissed as fraudulent, opportunistically, and even immoral.

But dismissing vernacular professionalization as phony or as a mere "economy of appearances" (O'Neill 2011) misses the point that however staged the performance, and whatever its short-comings, for the actors involved here (not to mention those entrusted into their care) these are indisputably "serious games" (Ortner 1984). To me, the picture here is actually closer to Baudrillard's (1983) discussion of the power of simulation in post-modern societies. The thing about simulation, he tells us, is not that something pretends to be real, or even that something masks or distorts what is real, but rather that it "threatens the difference" between what is real and imaginary (1983: 454). This point seems apposite here, where vernacular professionalization is not just tolerated, but is widely treated by others (more on this soon) as perfectly equivalent to other forms of professional preparation. Via corporate simulation, *re-educados* have successfully curated not a secondary copy, but as Baudrillard describes it, "a programmatic, metastable, perfectly descriptive machine," one "that offers all the signs of the real" but "short-circuits all its vicissitudes" (1983: 454).

As I explore in the remainder of this chapter, the success of vernacular professionalization in Puerto Rico has a lot do with the alliance of interests between *re-educados* desires for opportunity and recognition, and the state's interest in keeping down

containment costs. In Puerto Rico, this alliance is threaded together by Christian ideas of debt and sacrifice and a moral economy that has proven exceptionally effective in delivering cheap containment.

Salvific value and the pathway to honor restoration

"Congratulations – you're rehabilitated," writes a journalist in *Primera Hora*, on observing a graduation ceremony in San Juan in 2000. "Today, twelve women and eighteen men achieve a new kind of freedom," she writes, as "thirty souls free of drugs," now "accredited as rehabilitated" (Primera Hora 2000).

Carving out a livelihood in a formerly majority Roman Catholic country with a burgeoning Pentecostal and Evangelical populace, the work of *re-educados* unfurls in a space that is saturated in Christian content. As such, the vernacular professionalization that underpins addiction treatment throughout Puerto Rico advances a deeply embedded set of Christian assumptions about salvation and redemption that have become increasingly interwoven into Puerto Rico's war on drugs.

One powerful metanarrative that has figured prominently in debates about addiction in Puerto Rico during the last half century is that of the "ex-addict crusader." This narrative positions *re-educados* as not just saved souls but also as crusaders, who, by virtue of their own salvation, carry an ethical duty to rescue others from the peril of addiction.

"They were lost in the underworld of drugs," writes a journalist in *El Vocero* (2000), "they succeeded in rehabilitating themselves and were reunited with family and friends."

"These men deserve our congratulations and recognition for their courage, [for] leaving a world of indignity engulfed in degrading demands of vice… [and] returning to this world as crusaders in the fight against addiction."

As I scour through old newsreels of media coverage of therapeutic community graduation ceremonies since the late sixties (e.g., Cabrera 1969; El Mundo 1989, 1969; El Vocero 1987), the unruly moral economy that surrounds the work of *re-educados* in Puerto Rico is rendered visible to me through chronicles that are as unvarying as they are grandiloquent. On the one hand, by virtue of their tainted record as former addicts, *re-educados* are discursively saddled with a moral debt to make up for past sins (with that debt sometimes written explicitly into program design[40]). Yet at the same time, *re-educados* are also hailed and celebrated as crusaders who are dedicating their lives to a national battle against addiction.

The language employed here, which draws on patriotic images of soldiers and war, bears striking resemblance to ideologies of military sacrifice documented elsewhere (for example, see Wool 2015), a key difference being how quickly and easily the *re-educado*'s moral standing can reverse, from hero to villain, or from savior to the highly stigmatized figure of the addict. In the supremely publicized spectacle of graduation, logics of sin, sacrifice, and debt run uncomfortably together here, but one thing all can

[40] In Puerto Rico's first therapeutic community, CISLA, which operated between 1961-1966 (see Chapter 1), drug addicts who had completed treatment had to complete a post-treatment phase in which they recruited other addicts into the program. This was explicitly construed as a way for them to "pay back their debt to society" (Macro Systems 1972:26).

agree upon is that everyone wins when the *re-educado* joins the fight. “The best thing of all,” a reporter from *El Vocero* notes, is the “double triumph to CREA” – “that it not only rehabilitates its clients, but also succeeds in creating crusaders” (El Vocero 2000).

Graduation ceremonies typically draw large crowds and are attended by Puerto Rico’s governing elite - senators, mayors, police chiefs, and frequently senior judges from the local municipalities. At a *CREA* graduation ceremony in 1988, for example, attended by none other than the standing Governor Hernández Colón, a joyful reporter congratulated the cohort of “new men” as they shook the hands of Puerto Rico’s government officials. Attendees include José Ronaldo Jarabo (the president of the chamber), Pedro Padilla (the president of association of the mayors), a host of businessmen, a bishop, several senators, an Evangelical leader, and a Catholic priest (El Mundo 1988). Fervently, the journalist described how Governor Hernández Colón “shook hands and hugged many of the hundreds of interns who had smiles on their faces, reflecting the alleviation of having woken up from the nightmare of drugs.” Governor Colón gave an impassioned testimony: “while other countries are known for exporting drugs, we can be proud that an organization born in Puerto Rico is exporting a message so hopeful and positive.”

In what are now durable institutions of public theatre, graduation ceremonies operate as staging grounds where *re-educados* are discursively imbued with a national “salvific” value: salvific in the sense that the font of their moral value and virtue lies in the *condition* of them becoming crusaders who dedicate their lives to the cause, and national in the sense that addiction figures as a threat to an imagined “national character” that is

explicitly Puerto Rican. Héctor Figueroa, the current director of *Hogar CREA*, encapsulates this idea in a commencement speech he delivered in 2016, when he implored *CREA* graduates to "return to their communities as leaders in the fight for the Puerto Rican personality." On this stage of national theater, salvific value is heaped upon the *re-educado*, ritually and publicly. Under the gaze of family and town, their unfinished pathway to restored honor is laid out ahead of them: to repay the debt, so the story goes, the *re-educado* must take up the fight and join the national crusade. "As they collect their certificates that accredit them [as] beings who have had the willpower to seize the opportunities society gave them, " writes a journalist in *El Vocero*, "they can return to their homelands as people of means" (2000).

The practices of recognition at play here are not altogether unique. Christian redemption as a pathway to restored social honor is a theme that figures heavily in the literature on rehabilitation (Zigon 2010; Flores 2014), especially in Pentecostal and charismatic Latin America (Garcia, Muñoz-Laboy, and Parker 2011; Sharp 2009). Helena Hansen (2018), for example, develops the notion of "spiritual capital" to describe how recovering drug users in Puerto Rican Evangelical street ministries redeem and reinvent themselves through cultivating spiritual knowledge and social ties within the church.

A contrasting account is offered by Kevin O'Neill (2011) in his research on gang prevention in Central America, where he has examined how Christian notions of salvation and redemption have become entangled with the geopolitics of American security. In his account of *Desafio 10*, a US-sponsored reality TV show in Guatemala that

rehabilitates gang members through instilling "good Christian living," he shows how the poor's desire to better themselves is harnessed for the purposes of security in a process he calls "security through sanctification."

There are obvious continuities here, but also some notable particularities. In the Puerto Rican context, the convergence of *re-educados*' efforts to professionalize themselves with the state's interest in keeping down containment costs has seen the wholesale concoction of a parallel therapeutic market and professional opportunity structure that has endured for over half a century and that has secured both state and widespread popular endorsement as a legitimate drug treatment enterprise (without ever being regulated).

More important, however, has been the way in which this alliance of state and self-certified professional, by virtue of its own success, has actually begun to undermine and de-stabilize the very labor and care arrangements that these entrepreneurial projects have long valorized and sought to emulate. A brief historical excursion into how vernacular professionalization was harnessed by the state during the neoliberal reforms of the 1990s is helpful here.

In brief, prior to the 1990s and the onset of healthcare privatization in Puerto Rico, a publicly-funded healthcare system had operated in Puerto Rico since the 1950s (see Chapter 1). That public system included the Department of Services Against Addiction (Spanish acronym, DSCA), which was established in 1973 to provide and oversee various forms of drug treatment services across the island. Among the services provided and

operated by the commonwealth state were DSCA's residential drug treatment programs, which were in some ways similar to therapeutic communities (they employed characterological therapies), but differed specifically with respect to its labor practices: it employed professionally-accredited staff to supervise paraprofessional peers, with all staff members (professional and paraprofessional) paid a formal salary.[41]

With the onset of Puerto Rico's neoliberal turn in the 1990s, and with the passing of a series reforms collectively now known as *La Reforma* (Mulligan 2014), DSCA's residential programs (as well as various other publicly-funded treatment modalities) were closed down. What remained in terms of residential drug treatment were the peer-run non-profit centers, run primarily by unwaged and under-waged paraprofessional peers.[42] Shortly after healthcare privatization, legislators soon passed the Mental Health Act of 2000, which was a bill of rights intended to impose minimum healthcare standards across Puerto Rico's (mostly now private) mental health care facilities. As Hansen has described (2018), rather than applying these minimum care standards to non-profit residential drug treatment centers, however – standards that pertained to minimum credential requirements for staff members, and the use of evidence-based methods, among other things – the commonwealth instead opted to permit non-profit drug treatment centers to provide "their community services according to their historic, traditional and customary

[41] An additional and important difference between DSCA's residential centers and non-profit therapeutic communities was that DSCA residents did not participate in labor therapies.

[42] After *La Reforma*, in terms of bed capacity, 93% were provided by private non-profits and 7% of residential care was provided by the state, mostly in correctional facilities (IPR 2015).

practices," unencumbered by (exempt from) the government regulations introduced in the bill.

What this act of deregulation achieved, in effect, was to enable the state to continue to divert hundreds of drug-offenders into cheap non-profit institutions, while avoiding the substantially higher operating costs that would have come with mandatory professionalization. Raising its hat to (now jubilant) therapeutic community leaders, in the same bill the state also granted *re-educados* legal recognition as "specialist guides in community treatment," a legal promotion that was accompanied not with any formal stipulation of required training, but instead with praise and recognition through a special statement that commended the "monumental labor of rehabilitated and re-educated ex-addicts." That both the exemption clause and the special recognition were both directly lobbied for by therapeutic communities[43] highlights just how easily this alliance of interests, by then over three decades in the making, was co-opted into neoliberal governing projects.

What began as an imitative market – a mimetic alternative economy that ran parallel to and alongside state systems of care – was ultimately repurposed in a manner that

[43] Therapeutic community leaders had lobbied directly for both the exemption clause and the special recognition. In letters to the Senate, a congress of community organizations including representatives from *Hogar CREA*, Teen Challenge, and the Assembly of God argued that forcing communities to employ clinicians would be a "death sentence" to the non-profit sector. In the letter, they explicitly recommended an article be added that would exempt them. They also implored the government to make greater effort to recognize the contribution of ex-addicts to handling the drug problem, and they called on the state to extend its support beyond "medical psychiatric approaches," to include diverse "spiritual" and "traditional" approaches.

facilitated (however unintentionally on the part of *re-educados*) the dismantling of long-standing labor and care arrangements. Through a neoliberal co-option of entrepreneurial projects of self-improvement, professional waged labor has gradually been eclipsed by unwaged and under-waged paraprofessional labor across the residential (and now mostly non-profit) carceral archipelago, while Christian-inflected practices of recognition have assured the persistence of an animated and grateful workforce.

This neoliberal dismantling of the professional labor contract in the domain of residential drug treatment has occurred amid a durable national fanfare which imbues *re-educados* with national salvific value, and which has continued, relatively unchangingly throughout the decades, theatrically to embrace the prodigal *re-educado* as a budding, card-carrying professional, while adroitly reminding him to be grateful for the (second) chance he's been given, and saddling him with a debt that can only be repaid through continued under-waged work in the place he just came from.

"The legitimate aspiration of every human being is to succeed," announces judge Carmen Dolores Ruiz, who delivered a powerful pep talk at a graduation in 2000, "but you have to fight for success." "The certificate that you receive today is proof that you have the potential to achieve success. But with that success," she warns, "comes the responsibility to be an example [for others]" (Primera Hora 2000).

Layered onto Christian ideas of salvation and debt is the intoxicating promise of success, upward mobility, and opportunity - in short, the American dream. It is this heady cocktail

of unpaid debt, and the promises of restored honor and American-style success and mobility that makes this theater of recognition so very expedient for the purposes of cheap containment.

> I feel grateful for what the program has done with me. I keep learning and working every day, this is the best work. I feel fulfilled, honestly, from not having a roof over my head, to having a job that I like. So I work eight hours that they pay me, and sixteen they don't pay me. They are donated hours. Why do I do it? When I was in treatment there were people who did it for me, so why am I not going to do it for others? I love it. I feel alive. I feel useful. There is nothing more gratifying than this.

So this middle-aged man stays and works at *La Casita*. He works not just hard, but gratefully, because at last, after eight years in prison and after partially losing his eyesight in a prison riot, he has finally landed on the best possible option available to him. "I have a house, I have food, I have my colleagues and participants. And I can be a useful person. That's my second pay. And I do it with love."

Conclusion

Men of honor, homecoming kings, crusaders in a national battle against addiction: these are the Christian-inflected American ideals that *re-educados* chase, and that the commonwealth state has stoked for the sake of cheap containment, preparing them for careers as unwaged and under-waged adjuncts across Puerto Rico's non-profit carceral

archipelago. Take your medal and your trophy, shake hands with the powerful, and be grateful you've been given a second chance. This is how this national ritual works. And the end result of this unlikely alliance is the repurposing of a colonial drug war into an entrepreneurial honor restoration project.

For the sake of cheap containment, the commonwealth state has facilitated and constructed a legal environment (and been cheered along by *re-educados*' own legislative lobbying) where criminalized men, who frequently have significant health vulnerabilities of their own, are repackaged and catapulted into adjunct *de facto* social workers, therapists, and caregivers. Pursuing promises of restored honor, recognition, and livelihood, it is precisely those most likely to be victims of the war on drugs who rush to seize these openings: men from low-waged and insecure ends of the licit economy, handlers and distributers in illicit markets, and men whose drug use or addiction has seen them stripped of their liberty.

Graduation ceremonies, and the vernacular professionalization they dramatize, promise *re-educados* opportunity, honor, and success. They are staging grounds for a world in which those who've lost everything can shoot up the social ladder and come out on top to stand shoulder-to-shoulder – for a brief moment - with the governing class. It may seem theatrical for a corrections official or police chief to promise an audience of criminalized men that a bright future lays ahead of them, in the style of an American commencement address. Yet these ceremonials prove constructive on at least two counts.

First, they conceal the fact that vernacular professionalization is rarely a one-way ticket. By the time I attended Jorge's graduation ceremony in 2016, he'd actually already graduated from three other residential programs, and racked up several years of unwaged and under-waged work as a peer therapist and caseworker, mostly while still under court order. But after two years of sobriety, to his great distress, in 2012 he relapsed on heroin. "I thought I was ready. I wasn't expecting it at all." On walking out after the relapse, he found himself stripped not just of his income and housing, but also of his honor and dignity. Unwelcome in the parental home of his wife's family, where she lived with their two children, he returned to his childhood town of Caguas and resumed a life he'd hoped he'd left behind. He begged for money at traffic lights, he squatted in abandoned buildings. "It was really hard to make sense of what was happening." After several months of homelessness and injecting drug use, he was eventually brought back to a residential treatment program by a police outreach team,[44] where he re-reenrolled in 2014. As is standard practice in residential treatment centers, on induction his *graduado* status counted for nothing, so in 2014 he re-initiated an eighteen-month residential treatment program for the fourth time.

Luis' story was not dissimilar. By the time we met in 2017, where he was the director of an Evangelical center (at that time for eight years and standing), he'd already graduated from two other programs, one in 1992, another in 1998. Upon his first graduation he'd worked for twenty months as a live-in social worker at a small program in Dorado, for

[44] The police outreach program is called *Vuelta a la Vida* and is a law enforcement effort to bring homeless drug users straight to treatment programs, without initiating criminal proceedings.

which he'd received a modest stipend ($8,000). Figuring it was time to try something else, he rented an apartment in San Juan and took a job as a cleaner in a mall, a position he lost soon after he started using crack again. "I ended up on the street, I was sleeping on cardboard boxes. I remember I used to sleep where the Catholic Church is, in the Plaza de Recreo in Rio Piedras. I slept on the stairs on cardboard."

"Your honored certificated *re-educados*, after all your work and sacrifice you can start to enjoy the success and return to your communities as qualified and certified people of means," seems like a cruel tribute given the personal catastrophes that have awaited these graduates. For his part, Luis would be arrested again, incarcerated again, and eventually court-mandated back into residential treatment again. Instead of "returning," he'd stay at that center for the next eight years. When I met him in 2016, he was still living on-site, though now as a director with his own separate living quarters courtesy of the church.

Through vernacular professionalization, *re-educados* work cultivate status, honor, and an alternative livelihood, but it consistently does so through a flashy theatricality whose staged nature and over-blown promises have got to be ignored in order for actors to take their roles seriously. It goes without saying that there is a mismatch between the futures that are anticipated and celebrated here, and the employment options that are available to these men. While there's a pumped up expectation that opportunity and success lie just around the corner, it is safe to say that very few of these men will ever become "middle class." While it is true that there are a handful of high-profile therapeutic community leaders who are firmly within the middle class, and who are even well connected in

government, this is decidedly far from the norm. For those who choose to leave the shelter system, they might find work in gas stations, fast-food restaurants, and malls. But their celebrated professional skills and expertise can hardly be called transferable.

In this respect there is an obvious and fundamental lie here, that simply passing through a treatment program can open doors and even catapult you into the middle-class professions. This improvised education system prepares its students for one thing and one thing only: the thing they just came from. Whatever honor and recognition may have been gained on the inside is legal tender only within a highly circumscribed economy. Outside this therapeutic market, these alternative credentials count for very little, often to the great peril of the individual whose viability was dependent on it. And unlike other forms of educational credentials, which, barring exceptional professional foul play are retained by the bearer whatever life's eventualities, the "certified honored and accredited *re-educado*" is a title constantly at risk of forfeiture. It can be revoked at any moment, and it is substance use, relapse, or drug charge – precisely the trigger events that kick-start this labor cycle – that are most likely to exact such a penalty.

The question remains, of course, how well can this alternative livelihood be said to serve *re-educados*? The answer is not easily quantified. My own notes and life histories of dozens of *re-educados* show that they routinely oscillate, over the course of many years, between a resident and a *re-educado* position, with the interim period often being one of extreme vulnerability. Outside the shelter, many *re-educados* find themselves in very similar conditions of vulnerability to those that preceded their arrival at the shelter. Yet

there were notable success stories: men who'd retained the job for years, sometimes decades. Men who'd acquired a stable salary that permitted them to live off-site. Manuel (the trainer) was one of these men. Never much of a drug user himself, he'd gone from drug trafficking to therapeutic adjuncting and had worked at the same shelter for upwards of twenty years. His salary was relatively high ($24,000) compared to the sub-minimum wage income of many of his colleagues, and he lived in a house in the suburbs with his wife and two children. That said, with both of them high school age, he told me he also worked night shifts at a private security firm to make ends meet. In contrast to this "success" story was Antonio, who'd been cycling in and out of therapeutic communities since the mid-1990s (about as long as Manual had been working). He was nursing a severe and relapsing heroin addiction that precluded him from retaining a staff position and frequently led to him becoming homeless. Is this simply a matter of therapeutic market that works better for those do not actually suffer from addiction? Not straightforwardly. The question of whether this 'works' as an alternative livelihood or not seems to largely depend, in the final analysis, on the available alternatives.

So I end with the story of Humberto, whose heroin addiction was a persistent problem, but despite this, for whom this system can probably be said to be working. We met some time in my second week at *La Casita*, and he spoke quickly and with such a thick accent that three transcriptionists refused to transcribe our interviews. When we first met, he told me he'd spent twenty years in prison; he went in when he was nineteen and came out aged thirty-nine, which was earlier than expected – his initial sentence was 147 years for trafficking, kidnapping, assault, armed robbery, and possession of firearms. He'd been a

heroin addict for thirty-five years, including the twenty he spent in prison. But when he finally came to *La Casita* in 2015, after a series of failed attempts at other programs, he said he finally knew he was ready: "I made it through the first year and was noticed as a hard worker. They told me, "if you keep this up, you will go very far here.'"

After eighteen months, he graduated. After graduation, he met with the director and asked for a job. The director said, "let's see how you manage for a few more months." So he stuck it out. Two months later, he was hired. His official title is "therapist." He's paid $325 a fortnight "as an incentive," which works out at about $8450 a year. He shares *La Casita's* best bedroom, the one with just two bunk beds in it. He remains onsite fulltime, seven days a week, and says, "I'm always working really, except when I'm asleep." Though he doesn't have a car or driving license, when he wants to go into town, someone can usually give him a ride. "But I don't really like being out of the *hogar*," he says.

> I'm really weak (*blandito*) when it comes to heroin, I took it for thirty-five years, non-stop. And now I've done, what is it, two years? So on Saturdays I'll leave in the morning, get into town around 9am, and in like two hours, I'm back here. I know if I leave I can relapse. So I stay here. I prefer it here. I have my family here. This is my first legal job. And I do it with all my heart. And I love what I do. I'm fifty-three years old and before this, I hadn't done a thing with my life. When I was prison, I never, never, would have imagined I could do this. I come from a life of suffering. I was one of those, they say, whose eyes don't see, whose heart doesn't feel. But God put me here.

In one of our interviews, I asked him if there are any aspects of living or working at *La Casita* that he didn't like, or would like to change, if it were possible. "No," he said. "I have nothing to say here. There is nothing I don't like. I love it all. This place is perfect." "What does this work mean to you?" I ask. "This means life.

Chapter 4

Judicializing Domestic Order

Eric leaned hard into his hospital cane. The security van exited the parking lot, and his frantically waving hand dropped in exhaustion. He steadied himself, adjusting swollen legs that bulged uncomfortably through aluminum knee braces. The sight of his son's departure – now safely on route to a residential drug treatment facility – had come as a relief. A Bronx-born veteran and father of four, Eric had spent the last seven years caring for his mentally ill and addicted son. Héctor had battled with depression since his early teens, and had first attempted suicide when he was just sixteen years old. By Eric's estimates, Héctor was using cocaine almost daily by his early twenties, and his most recent attempts at drug dealing had presented Eric and his partner Maria with fresh problems. They began finding weapons in their family home in Caguas, a cache, as they'd later learn, that Héctor had agreed to store on behalf of his new associates. One evening, Eric and Maria recall, Héctor had been involved in a shoot-out on their block. They described hiding in their bedroom, avoiding the windows, as they listened to the shower of bullets.

After several failed attempts at persuading Héctor to enter treatment, one of which had culminated in Héctor jumping out of Eric's moving car while they were on route to hospital, Eric and Maria decided to seek a Law 67, a compulsory treatment order that would legally impel their son to enter treatment for drug addiction. Petitioning the court had been a relatively simple process. After completing the requisite paperwork a hearing

had been scheduled. At that initial hearing, Eric and Maria had given a history of their son's cocaine addiction and described his increasingly unmanageable behavior to a judge. As Eric later recalled, he'd actually gone as far as begging the judge to intervene. Gesticulating in a mock re-enactment, he held his hands in prayer: "Look, you are a judge. You are the highest person in the land. If you can't do anything, who can?"

Héctor had not denied his drug problem. On questioning, he admitted to using both amphetamines and synthetic marijuana in the past week, and cocaine the day before the hearing. Upon hearing the testimonies of all parties, the judge had deemed that there was "reason to believe" that Héctor was "a drug addict," something which, under this particular law, meant that further evaluation was merited. To assess Héctor's addiction, the judge had requested not a clinical diagnosis but a urine test, and Héctor had been detained in jail for forty-eight hours so that this might be conducted. The results of the urine test, which were presented to the courts by a state official two days later, indicated that Héctor had recently consumed cocaine and marijuana. On the basis of Eric and Maria's plea for help, along with this "clear evidence" of their son's addiction, the judge ordered that Héctor enroll in residential treatment within twenty-four hours, warning that failure to do so would result in his immediate arrest.

A vehicle from a nearby residential facility had shortly been dispatched to collect Héctor. I happened to be in that vehicle. By now, I'd done several court pickups as part of my research into civil commitment. After fifteen minutes of friendly conversation between Eric and the driver, who had assured Eric that his son would be in safe hands (and

suggested that he talk to a visiting researcher), the van had departed leaving Eric and me in the parking lot. We continued chatting for the next hour, eventually relocating to the air-conditioned foyer of the municipal court. "That judge," Eric had said, kissing his fingers and thrusting them into the air. "That judge has really helped us a lot."

Though Eric exuded gratitude, the commitment of his son to a residential facility was only a brief chapter in the care chronicles of his life as the parent of an addicted and mentally ill child. While it certainly got Héctor out of the house for a time, something of no small consequence for Eric and Maria, Héctor's involuntary commitment fell short of ensuring his access to professional health or social care services. In fact, during the eighteen months that Héctor eventually spent at *La Casita*, he never received a clinical diagnosis, his addiction was never monitored or re-assessed by a clinician, and he never received the attention of a psychologist, psycho-therapist, or other certified health professional, for either his addiction or his depression.

Instead, in what turned out to be a protracted and labyrinth-like negotiation over when Héctor ought to be released, Héctor remained legally stuck for a year and a half at *La Casita*, a residential drug treatment center operated by ex-addict paraprofessionals. Throughout this time, he was never made aware of exactly how long he would be there, and he remained in the dark as to the precise legal criteria by which he might be granted release. What was clear, however, was that if he were to walk out without authorization, he would face criminal charges for being in contempt of court and could well face incarceration.

In the United States, there are two sets of legal channels through which citizens may be court-ordered to attend drug treatment: therapeutic jurisprudence which is overseen by the criminal court, and civil commitment which is overseen by the civil court. Whereas therapeutic jurisprudence is designed to divert substance users *who have been convicted of crimes* into drug treatment institutions as an alternative to incarceration (examples of this include drug courts), civil commitment permits the involuntary institutionalization of citizens who have not been convicted of crimes into treatment facilities. These civil commitment procedures are the focus of this chapter.

Currently, thirty-seven US states have statutes in place that allow for the civil commitment (also referred to here as "involuntary treatment") of people diagnosed with substance use disorders or alcoholism (NAMSDL 2016). Civil commitment usually occurs at the request of a petitioner who asks the court to legally impel a substance user to enter treatment. In mainland United States, individuals permitted to petition the courts typically include guardians, spouses, or other family members, or healthcare professionals. In most states, civil commitment is limited to emergency hospitalization lasting between twenty-four hours and five days, though a minority of states also permit longer periods (NAMSDL 2016). In Puerto Rico, extended compulsory treatment durations, commonly in the realm of twelve to eighteen *months,* have been permitted since 1993 when the "Law of the Administration of Mental Health and Anti-Addiction Services" (from hereon, "Law 67") was passed. Law 67 permits individual citizens (anyone over 21 years old) to petition courts to order "drug addicts" – specifically, those

who have not committed crimes – into treatment at a government licensed drug treatment facility.

Law 67 stands out among contemporary civil commitment legislation for both its long duration and its remarkably loose criteria. This is best illuminated by comparison with the United Nations Declaration of Rights Resolution 46/119 "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" (United Nations 1991). This resolution has served as a model and blueprint for civil commitment legislation across the United States and other United Nations (UN) member states, both in the realm of mental health (excluding addiction) and specifically in relation to substance use disorders, both of which I examine in turn below.

Under the UN Declaration of Human Rights, psychiatric patients are accorded the same civil and political rights as all other people, and thus cannot be compelled to undergo treatment without their consent, unless they are declared "legally incapacitated." As Davis (2012) describes, principles 11 and 16 of the UN resolution explain that "legal incapacity" can be declared in one of two circumstances: 1) If a medical expert determines that the patient has a mental illness <u>and</u> poses harm to themselves or others; 2) If a medical expert determines that the condition of a person with severe mental illness is such that not committing them will likely lead to a serious deterioration of their condition (2012:198-199). These principles –diagnosis, harm, and threat of deterioration – have guided the drafting of civil commitment legislation for mental health across UN member states.

In the United States, civil commitment for drug addiction operates in a similar way to civil commitment for mental illness, with some key differences. In a broadly analogous manner to the UN declaration, civil commitment laws in the US typically stipulate that one of the following requirements must be fulfilled in order to justify involuntary treatment for drug addiction: 1) the individual must have a clinically diagnosed substance use disorder, *and* pose a threat to themselves or others, or 2) the individual must have a clinically diagnosed substance use disorder, *and* be unable to meet their own basic needs (NAMSDL 2016). Across US states then, civil commitment laws for drug addiction typically follow three principles we can summarize as diagnosis, harm, and need.[45]

In departure from both the UN resolution governing involuntary psychiatric treatment, and from most US laws governing involuntary drug treatment, Law 67 contains no explicit stipulations regarding diagnosis, harm, need, or threat of deterioration. Instead, it permits long-term involuntary institutionalization in the absence of a clinical diagnosis of a substance use disorder, in the absence of any assessment of the individual's capacity for meeting their own basic needs, in the absence of demonstration that the individual poses a threat to themselves or others, and in the absence of any evidence that without treatment their condition will likely deteriorate.

Under Law 67, the *sole* requirement for involuntary treatment is that it be demonstrated in a court of law (not necessarily by a medical professional) that an individual is

[45] These are slightly different to the three principles of diagnosis, harm, and *threat of deterioration,* which operate in civil commitment legislation for mental illness in UN member states.

“addicted to drugs or alcohol” (Legislative Assembly of Puerto Rico 1993). Under successful petitions, usually based on the assessment of a *socio-penal* (“probation officer”), and sometimes based solely only on the testimony of a relative, the recipient will find him- or herself legally impelled to remain in treatment, usually (but not always) in a residential facility, typically for between one year and eighteen months. Interviews with government officials indicate that only a tiny minority of Law 67 recipients are mandated to attend clinical treatment such as outpatient biomedical treatment, medication-assisted treatment, or biomedical detox. Instead, the vast majority of Law 67 recipients are channelled to peer-operated residential drug treatment centers[46], where failure to comply or unauthorized leaving may lead to incarceration.

The long-term involuntary institutionalization of citizens in the absence of a clinically diagnosed substance use disorder, and in the absence of evidence that the citizen present a risk of harm to him- or herself and/or is unable to meet his or her own basic needs, represents a departure from international and local movements for the protection of patient rights. Although the law was introduced in 1993, in design and structure Law 67 is similar to the early 20th century “mental hygiene” or so-called “inebriety” laws that operated across many mainland US states and Puerto Rico in between the 1920s and

[46] As discussed below, there is no centralized government surveillance system for monitoring Law 67 cases. Instead, individual treatment facilities submit this information to ASSMCA. Clinical institutions tend to submit this data more reliably than residential centers, making it hard to make definitive comparisons. But since clinical institutions report very low numbers of Law 67 cases, most government officials infer that the remaining Law 67 cases are directed into peer-operated residential drug treatment centers.

1940s (Baumohl and Room 1987; Baumohl 1990; Baumohl and Tracy 1994; Havlena 1987).

In Puerto Rico specifically, asylum-era “mental hygiene” laws modeled on similar legislation in the mainland facilitated the mass-institutionalization of thousands of “inebriates” and “persons showing antisocial behavior” in Puerto Rico’s psychiatric institutions throughout the early 20th century (Havlena 1987)[47], just as similar processes occurred across mainland United States and Europe (Scull 1977). From about the 1960s, when the death toll and conditions at psychiatric institutions became known,[48] and when reports of conditions in asylums induced public outcry, a movement for the protection and expansion of patient rights achieved various legal and administrative changes (Scull 1977). In terms of legislation, Puerto Rico was subject to several new federal laws, the most important of which was the Community Mental Health Act of 1963, which replaced or annulled the earlier mental hygiene and inebriety laws. Similar to many US states, Puerto Rico also introduced various commonwealth laws to facilitate de-institutionalization (Rivera et al. 2005).

Despite legislative change, historical accounts suggest that the community mental health laws were only poor enforced in Puerto Rico (Havlena 1987; Rivera et al. 2005). Two

[47] By 1940 an estimated 1200 people were institutionalized in Puerto Rico’s state psychiatric hospital (Havlena 1987).

[48] In 1940, an estimated 200 patients who were institutionalized in Puerto Rico’s state psychiatric hospital died, mostly from chronic enteritis, dysentery, and tuberculosis. In 1945 there were a reported 170 deaths at the state psychiatric hospital. Though the official capacity was just 400, it is estimated that over 1000 patients were contained there (Havlena 1987:31).

major hindrances to their implementation were the inadequate budget and scarcity of skilled staff. According to a report by the secretary of mental health, across all Puerto Rico mental health services in 1977, 59% of the general practitioner and psychiatrist positions were vacant, while 37% of social worker positions and 41% of psychologist positions were vacant (report cited in Havlena 1987:63). Most historians agree that deinstitutionalization was slower and less complete in Puerto Rico than on the mainland (Havlena 1987; Rivera et al. 2005).

Despite differences in implementation, Puerto Rico continued to broadly conform with mainland policies and legislation. The Puerto Rican Mental Health Code was introduced in 1980, which was modeled on the recommendations of President Jimmy Carter's Presidential Commission on Mental Health. This law clarified the constitutional rights of patients, including requiring the provision of adequate care and custody, and defined alternatives to hospitalization for patients whose condition required psychiatric intervention.

It was in 1993 that Puerto Rico's legislative trajectory took a radical departure from mainland civil commitment legislation. With the introduction of Law 67 in 1993 a new civil commitment mechanism was established. Anachronistically, it was very similar in structure to the early 20th century inebriety and mental hygiene laws that had been abandoned since the community mental health movement of the 1960s. In departure from existing movements for patient rights both locally and internationally, Law 67 loosened

the criteria and widened the valve through which citizens could be channeled into and retained in treatment facilities involuntarily.

Though Law 67 has not been studied academically, local public health officials are highly critical of a statute they often describe as "punitive," and "arbitrary." In a manner that resonates with existing critiques of drug courts in the United States (see for example Tiger 2013), such criticisms often stem from a sense that in assuming authority over "health problems" the judiciary has overstepped its role.[49] Among deplored consequences are the confinement of patients in restrictive residential facilities, the denial of patient rights, and the violation of existing legal codes, including Puerto Rico's own Mental Health Act.[50]

For my purposes, Law 67 is important not simply because it is a punitive response to addiction. In fact, scholars have long noted addiction's incomplete medicalization (Campbell 2012), a circumstance variously attributed to a failure to find effective pharmaceutical treatments (Kushner 2010), to overreaching "therapeutic jurisprudence" (Kaye 2010), and to countervailing political projects aimed at "criminalizing" addiction (Bourgois 2003; Singer and Page 2013; Singer et al. 1992). Furthermore, historical

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[49] Drug treatment stakeholder repeatedly expressed sentiments such as: "Judges do not understand the science," or "Judges are professionals in courts in law. So why are they practicing health? It makes no sense."

[50] Under section 15.03 ("Institutionalization Prohibited") of Puerto Rico's Mental Health Act, the law states that any institution "which is found to have institutionalized a person" whose illness severity does not "warrants his/her placement at the level of care where he/she has been kept" is guilty of a crime under Article 168 of the Puerto Rico Penal Code (Legislative Assembly of Puerto Rico 2000:102).

genealogies conducted in Anglophone contexts have often demonstrated that addiction has long been a “hybrid entity,” governed and constituted by a collection of institutions and structures that span multiple (and often competing) clinical, carceral, and market domains (Baumohl 1990; Baumohl and Tracy 1994; Campbell 2007; Valverde 1998). As such, addiction’s straddling (and troubling) of criminal and civil juridical regimes is perhaps not so remarkable or surprising.

Instead, what is interesting about Law 67 proceedings is the window they provide onto the judiciary as a critical site where families, non-governmental organizations, and the state negotiate burdens of dependency and responsibilities of care. The emergence of this juridical mechanism in 1993 suggests a new set of relations between family, state and mutual-aid care, in which configurations of power and authority are being redrawn. By examining these proceedings ethnographically, and by tracing the kinds of knowledge that function to instantiate ‘need’ for treatment, and conversely the kinds of evidence that operate to justify release, this chapter uses civil commitment proceedings to explore power, knowledge, kinship, and freedom in contemporary Puerto Rico.

Juridical care

A wave of studies across the globe has pointed to an accelerating reliance on the judiciary for resolving fundamental moral predicaments, public policy questions, and political controversies (Dressel and Mietzner 2012; Flaherty 2006; Domingo 2005; Hirschl 2008b, 2008a). This has spawned the development of multiple literatures spanning several disciplines, with focal areas including the “judicialization of politics,” the “judicialization of mega-politics,” and the “judicialization of biopolitics” (Biehl 2015; Biehl 2013b;

Hirschl 2008b, 2008a; Abadía-Barrero 2015). Recent medical anthropological studies of right-to-health litigation, for example, have proposed the concept of the "judicialization of health" (Abadía-Barrero 2015; Biehl 2013b, 2015, 2016) to highlight the increasing relevance of the judiciary as a site where citizens and governments negotiate responsibilities of care.

Through his work on right-to-health litigation in Brazil, João Biehl (2013b) has described a "return of the juridical subject," which he characterizes as a "patient-citizen-consumer" who is able to harness the judiciary to claim the right-to-health within an increasingly profit-driven healthcare landscape. In his account of the juridical processes through which citizens make claims on governments to provide life-saving HIV medications, he argues that global pharmaceutical markets have transformed the "right to health" into a "right to pharmaceuticals," leading to broader changes in the nature and meaning of citizenship and political subjectivity in liberal states (Biehl 2013b).

I am also interested in the role of the judiciary in contemporary life. Yet in Puerto Rican involuntary treatment proceedings the judiciary performs the task of suspending citizens' right to freedom, rather than enforce citizens' right to health. A second difference between right-to-health litigation and involuntary treatment proceedings is that rather than channeling people into biomedical treatment, involuntary treatment proceedings tend to channel citizens away from the clinic and instead towards un-professionalized mutual-aid shelters where the traditional technologies of modern biomedicine are often absent.

As I show in this chapter, while Law 67 is sometimes understood as designed to ensure that people who need but refuse drug treatment will obtain the services they require, it is much more centrally geared towards alleviating families that are in crises provoked by the burdens of care than it is towards addressing the health needs of those under court order. At stake here, then, is an extension of juridical power into the jurisdiction and province of kinship. Through ethnographic observation of multiple active Law 67 cases, as well as case histories conducted with former Law 67 recipients, this chapter explores the kind of work that the judiciary is performing in Puerto Rican involuntary treatment proceedings, and argues the judiciary has re-adopted an important and anachronistic role as an extension of parental power and as a guardian of domestic order. Rather than approaching the courts as an uncomplicated tool of modern biopolitics (Keane 2009; Bourgois 2000; Vrecko 2010b; Fraser and Valentine 2008), I conceptualize Law 67 as a low-cost abeyance mechanism that operates to divert subjects who are deemed "troublesome" away from families and onto unprofessional mutual-aid networks. In other words, involuntary treatment can be read as a low-cost technique through which the state relieves the family during a time of domestic crisis.

Methods and (lack of) existing literature

When I began fieldwork, I had not planned to examine Law 67. Although I had come across the law in conversations with drug treatment activists, I was only dimly aware of how it worked and I did not initially intend to pay it much attention. Over the course fieldwork, however, Law 67's prevalence and peculiarities caught my attention. At *La Casita*, my primary field site, I came across seven residents (out of a total of twenty-eight) who said that they'd enrolled at the institution under court order via Law 67, and

many more who described receiving Law 67 court orders at some point in the past. What struck me most immediately was that none of the Law 67 recipients seemed to know how long they would be obliged to remain at *La Casita*. Though they were often anxious to be released (with the exception of one resident[51]), none was aware of any precise criteria or requirements that must be fulfilled in order for a judge to order their release. There were also stories circulating of residents who'd walked out in violation of their court orders and subsequently been incarcerated. One of these men was Gustavo, who was seventy-two years old and who I spoke to briefly before he left. My entrance into this then was circumstantial. "My sister totally fucked me over," Alex confided to me one day in January. "But you're a researcher. Help me find out how I can get out."

I began by searching for published academic research, reports, or government statistics on the topic. With the exception of two brief mentions in reports by treatment activists (IPR 2015; OSF 2016), and a short lay summary published online (and pro-bono) by a Puerto Rican law school (LawHelp 2019), however, I found that very little had been published about Law 67, in either the English or Spanish-speaking literature. Nor were there any publicly available government statistics, or any mention of the law in the online archive of government statistics from the Administration of Mental Services Administration Health and Addiction (ASSMCA), which was the place I'd gone to previously (and usefully) when doing research on drug courts.

[51] I met one resident, Israel, who was not just grateful to his family for seeking the Law 67, but also was adamant that he would prefer to be living in a residential treatment center than anywhere else. This resident had a twenty-year long history of heroin addiction and had experienced years of period homelessness and incarceration.

After four separate meetings with government officials at ASSMCA, as well as multiple phone calls and e-mail exchanges, all I had unearthed in terms of government statistical data on Law 67 was the absence of it. Because there is no specialized surveillance system monitoring Law 67 cases, the only data ASSMCA has access to come from an annual government survey that is distributed to all licensed drug treatment providers. In that survey, which focuses primarily on socio-demographic information of drug treatment participants, individual providers are supposed to report how many Law 67 cases they have admitted that year. However, due to widespread problems of under-reporting (which is a problem across the survey more generally), state officials confirmed that there was no reliable data on the prevalence of Law 67 cases.

So as to better understand how the law worked, I began by interviewing activists and caseworkers, but soon came across numerous inconsistencies between accounts of how the law worked. In my efforts to clarify these discrepancies, I reached out to several lawyers, who'd been recommended as having experience representing substance users and mental health patients. It quickly became clear, however, that very few lawyers have any direct experience dealing with Law 67 cases, which I later learnt was because Law 67 recipients rarely receive legal advice or representation.

Having rapidly exhausted the expertise of my contacts, I resorted to compiling case histories of residents who were, or who had ever been, Law 67 recipients. Over the course of fieldwork, I was able to trace the case histories of twenty-one current Law 67 recipients, recruited through participant observation from four different residential drug

treatment centers. For some of these residents, I was also able to meet and interview their family members – those usually responsible for petitioning the courts. I was also able to attend the hearings of five on-going cases (fifteen hearings in total). To reduce the risk of data collection posing harm to participants who were engaged in on-going Law 67 proceedings (e.g., through being used in court as evidence for their continued need for involuntary treatment), I used observations and informal conversations rather than one-on-one recorded interviews with these participants to learn about their experiences, and conferred pseudonyms in all of my fieldnotes.

In addition to the twenty-one Law 67 recipients who were enrolled in residential drug treatment, I also made contact with ten individuals who had undergone Law 67 proceedings in the past, but who were no longer in residential treatment and no longer required to be in treatment by a court of law. With these 10 individuals, I was able to conduct recorded interviews.

Juridical care "on the books" and in practice

Today, Law 67 of 1993 is one of two pieces of civil legislation, along with Law 408 of 2000 (amended in 2008, from here on referred to as "the Mental Health Act"), governing civil commitment for drug addiction in Puerto Rico. Together, these two laws allow individual citizens to petition the courts to order "substance users" or "drug addicts" (depending on wording) -- specifically those who have not committed crimes – into treatment.

A lack of effective surveillance systems renders the prevalence of Law 67 cases in Puerto Rico unquantifiable, but I was able to gather some prevalence information from individual courts. Nine municipal courts are responsible for processing civil commitment cases in Puerto Rico. Through visiting individual courts, I was able to gather data on the number of involuntary treatment cases from four of the nine municipal courts (two other courts declined the share this information, and three courts were not open when I tried to visit). This information is depicted in Table 1 (note, these figures were simply read from a hand-written log kept by reception staff and should be treated as suggestive).

As shown by Table 1, between 2014-2016 four municipal courts reported to have processed a total of 12,190 civil commitment orders, 9.5% of which were via Law 67, with the remainder (90.5%) through via the Mental Health Act. From these data, it is difficult to assess which of the two laws is used more frequently *specifically* in relation to drug addiction, because Law 408 governs civil commitment for *both* mental illness and drug addiction, unlike Law 67, which pertains only to drug addiction.

Table 1								
	2014		2015		2016		2014-16 No. of civil commitment cases	2014-16 % of civil commitment cases
Municipality	**Law 408**	**Law 67**	**Law 408**	**Law 67**	**Law 408**	**Law 67**		
San Juan	2356	65	2505	52	2164	56		
Carolina	513	39	678	42	522	31		
Bayamon	550	204	478	252	589	178		
Caguas	224	86	227	72	228	79		
Total by year	3643	394	3888	418	3503	344		
Total Law 408							**11034**	**90.50%**
Total Law 67							**1156**	**9.50%**
Total civil commitment cases							12190	100%

Though widely considered to be similar, the two laws have distinct institutional histories and operate in different ways. Though commonly known as an “involuntary treatment” law, the “Law of the Administration of Mental Health and Anti-Addiction Services” (“Law 67”) is what lawyers call an “organic” law (USLegal 2019): its primary purpose was the establishment of a new government agency. Part of a series of laws introduced in 1993 under a broader project of healthcare privatization, Law 67 unified addiction and mental health services into a single new administration whose remit, unlike its predecessors, was to oversee drug treatment and mental health services, rather than to provide direct health services (see Chapter 1). Unlike the drafting of other civil commitment laws in Puerto Rico (presently, the Mental Health Act 2000, amended 2008, and previously, the Mental Health Code of 1980), each of which was written in the form of a “bill of rights” and overseen by various professional medical societies and human rights organizations, Law 67 was written by government administrators in the absence of

input from medical professionals or treatment activists[52]. As such, Law 67 is not grounded in the tradition of mental health rights and aligns much more closely with the bureaucratic organs of the commonwealth state than it does with the institutions of psychiatry or medicine.

Given that citizens' right to freedom is at stake, one might expect the institutional procedures of Law 67 compulsory treatment orders to be definitively laid out, "on the books" (Peters 2013), if not in action. But the precise procedures that recipients are subject to are surprisingly difficult to pin down. The law itself, which few of those impacted by the law will ever come across in written form, lays out various "judicial procedures for the involuntary treatment of addicts" (Legislative Assembly of Puerto Rico 1993). Anyone over twenty-one who is deemed to be "addicted to drugs or alcohol" may be made subject to the law, and anyone over eighteen may act as the petitioner (they need not be a relative). But even here, details are sparse. With the entire section just one and a half pages long (1,040 words), Law 67 has several idiosyncrasies. These are best illuminated through comparison with Puerto Rico's Mental Health Act.

Most striking, perhaps, is Law 67's non-specificity. Whereas Puerto Rico's Mental Health Act employs the nosological framework of the American Psychiatric Association's DSM-IV-TR manual for diagnosis, explicitly using the terms "substance

[52] Government officials are generally quick to acknowledge this lack of external input, which is also suggested by Law 67's sparse paper trail in the legislative archive. While the legislative archive contains documentation of the invited policy responses from stakeholder groups for many health and mental health laws, Law 67's folder contains no policy responses.

abuse" and "substance dependence[53]," Law 67 uses the lay term "drug addict" and – remarkably – provides no further elaboration or definition. Divorced from the technical specificity provided by psychiatric nosology, this vernacular formulation displaces medical authority as a warrant for legal action, and operates as a marker designating rights that are usually accorded to citizens – specifically the right to liberty[54] - may be suspended.

The conditions under which this right may be suspended are then outlined in two short paragraphs. The law states that an "evaluation" must be conducted to assess whether there is "evidence" to support the petitioner's claim that the individual is a "drug addict." Like the term "drug addict," the process of evaluation is also under-specified. Whereas the Mental Health Act requires that an analogous "clinical diagnosis" must be conducted "by a psychiatrist in consultation with a multidisciplinary team" (Legislative Assembly of Puerto Rico 2000), thereby entrusting clinicians with the power to protect or abrogate this right, Law 67 fragments this authority. By stating that the "evaluation" must be conducted by "any person/entity that the Administration of Mental Health and Anti-Addiction Services delegates to," it permits this authority to be assumed by any number of unspecified agents.

[53] Since Law 408 was passed in 2000, DSM IV was replaced (in 2013) with DSM V, which replaced the two categories of substance abuse and substance dependence with one diagnostic category, substance use disorders.

[54] The right to liberty, which we can also understand as the right to not be institutionalized without consent, is codified in one way or anther by various pieces of Puerto Rican, US, and international law, including the Puerto Rican Mental Health Act, the US constitution, and the UN Declaration on Human Rights.

In practice, what counts as "evidence" for being legally marked as a "drug addict" varies enormously. Permissible evidence of addiction observed in my research included: a clinical diagnosis of a substance use disorder from a psychiatrist, a positive urine test of recent cocaine-use administered by a police officer, an accusation from a sibling of reckless drunk-driving, physical signs of injection-related scarring on the arms, a parental complaint of heroin addiction, and a personal confession of alcoholism. The statutorily unspecified agents who performed these "evaluations" were also variable and included police, probation officers, state and local government officials, treatment counsellors, and sometimes parents or even patients themselves.

Under Law 67, involuntary treatment duration is *not* established at the onset of the residents' internment, as it would be in most criminal proceedings. Instead, duration is negotiated in court hearings that are held "periodically" – usually bi-monthly (though Law 67 does not specify a precise time frame). These means that Law 67 recipients often enter residential facilities with no idea how long they will be there, often with great anxieties about their futures.

While the Mental Health Act has a similarly open time frame in this regard, it specifically stipulates that the individual must be placed in the least restrictive level of care according to the severity of their substance use disorder, and that a person who is ordered to enter residential care must be clinically evaluated regularly by a psychiatrist and relocated to a less restrictive form of care should their condition improve (Legislative Assembly of Puerto Rico 2000). In contrast, Law 67 contains no mention of illness severity,

appropriate level of care, or requirements on monitoring, and the criteria according to which a patient ought to be released from treatment are extremely poorly articulated. Orwell might have drafted them.

In one section, the law states that the patient should remain in the institution until such time as they have received "all the treatment [that the institution] can offer." When making this assessment in practice, judges usually deem residents to have met this criterion only when they have completed the entirety of the host organization's "recommended" duration, which in most Puerto Rican residential facilities is between twelve and eighteen months. Yet, in a later section it states that a "report" providing "recommendations" as to whether a person "should continue with involuntary treatment" must be presented at hearings throughout the resident's internment. Since no elaboration is provided as to the basis on which "recommendations" ought to be made, and because the professional credentials of the person writing the report are also left unspecified, the task of developing – or rather improvising - a justification for involuntary treatment usually falls onto individual treatment centers, and, by extension, onto front-line workers.

Across the thirty-one case histories documented in this research, there were two main scenarios in which residents were released. By far the most common was when the resident had completed the full program duration[55] (usually eighteen months). A less common route to release was when a professional representative (e.g., a psychologist)

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[55] Only after one full year are facilities required to provide a justification to not discharge the patient. A sufficient reason, accepted by judges during this research, was that the resident had not yet completed the recommended program length of eighteen months.

explicitly recommended release. It bears mentioning, however, that throughout my time observing hearings, interviewing caseworkers, and following residents and families through the shelter system and the courts, the legal criteria according to which residents might be released from treatment were never explicitly discussed. Nor were they ever explained to me when I asked; instead, I was usually told some version of "it's all up the judge."

Compounding confusion, individual municipalities sometimes create their own protocols for managing Law 67 cases. These differ from place to place, but the most striking developments have been in a handful of municipalities that have created their own agencies for overseeing Law 67 proceedings. In these municipalities, it is not just families, but also local government bodies, who petition the courts. In these cases, it is standard practice for hearings to go ahead without the participation of the resident or a representative from the treatment center. Instead, treatment centers fax a case report to the municipal government agency, which dispatches a government officials to represent the resident, despite the fact that they have had little or no contact with the resident (and even here, centers sometimes failed to fax the case report over prior to hearings[56]). Though still localized to a handful of municipalities, among the six cases I documented where a municipal government agency (rather than a family member) acted as the petitioner (curiously, these cases exclusively involved residents who were formerly

[56] On one occasion, after I asked a director whether I could attend the hearing of a municipal government-initiated case, the director replied, "You aren't going to learn anything from those cases." "There won't be much talking." The caseworker had nodded in agreement, before adding, "anyway, we don't always know when they are. The ones managed by the municipality don't give us much notice. Sometimes we are notified after the fact."

homeless), these residents often believed it was their homelessness, rather than their addiction, which had prompted local government to seek the court order ("it's illegal to be homeless," "they get you just for being homeless").

Even among cases initiated by family members, it is hard to overemphasize the lack of clarity with which residents and their families commonly enter into this process. For parents, siblings and partners – those most likely to act as petitioners to the court - the most consistent information they receive comes in the form of a one-page information sheet, issued by ASSMCA and available in court waiting rooms. These documents offer a practical guide for initiating Law 67 proceedings, including whom family members need contact and required documentation. They say relatively little, however, about the legal processes that will follow a petition. Thus, though most families are relatively well versed on how to seek a Law 67, and for instance can readily explain how to obtain a *carta de hogar,*[57] they tend to be much fuzzier on the question of what comes next.

Reminiscent of what Erving Goffman famously termed the "collusive net" to refer to the "emergency guardianship" that emerges between kin and professionals (Goffman 1961), Law 67 recipients are often misled during the initial phase of civil commitment procedures. For example Angel, an eighteen-year-old heroin user with a history of multiple suicide attempts, was led to believe by his mother that the hearing pertained to an ongoing financial settlement as part of her divorce. While Jose, a thirty year-old heroin

[57] A certificate issued from a treatment center that confirms availability (bed space) in the event that the petition is approved by a judge. This must be presented to the courts prior to initiating a Law 67 petition.

user, was told by his father and girlfriend that the hearing pertained to an accusation of domestic violence[58].

Law 67's brevity and official ambiguities leave vital procedural questions unanswered. For example, under what circumstances are people deemed to be "drug addicts" released? What kinds of knowledge function to instantiate 'need' for treatment, and conversely what kinds of evidence operate to justify release? To explore these issues in greater depth, I now turn to one case study of one family- Camila and Juan and their son Carlos. Though not a representative or average case, Carlos' particular story nonetheless conveys several things about the logics and dynamics of involuntary treatment under Law 67 in Puerto Rico.

Family case study

Camila bashed on the vending machine with her fist. Indifferent to the dollar bill it had just swallowed, it belched back a mechanical groan, yielding nothing. Giving up, we made our way to the cafeteria, taking seats at the quieter end of a bench at a long communal table, avoiding the worn-out shoppers. The week before, Camila had requested that we conduct our meeting at the mall, a choice venue among the mothers I interviewed, all of whom had sought Law 67 compulsory treatment orders to legally oblige their adult sons into residential treatment for addiction.

[58] In fairness, though stories such as these were quite common, there were other Law 67 recipients who recall being informed about the law by family members before the petition. Some also received court summons prior to their initial hearing, delivered by mail or a municipal official.

Today Camila looked tired. Her dyed brown hair, which she had straightened, hovered in stiff angles at her neck. After shuffling a few feet further away from a family who were sat at the other end of the table, tucking into hamburgers and paying us no attention, Camila was finally ready to start talking. “Let me tell you,” she breathed, before I had the chance to really frame a question. “My son was given *every* opportunity,” she said. “His father and I,” she said, closing her eyes and clasping her fingers together, “we provided him with *everything* he could have needed.”

Carlos, now thirty-seven, had been a barber. For the last few years, he’d done all his barber work right there in the kitchen of their family home in *Aguabuena*. She and her husband Juan, she said, had provided him with everything he could have needed. A bed to sleep in, a roof over his head, food, a car, a place to do his barber work. But he’d had an experience, she said, that had marked him. His three year old, who Carlos and his girlfriend (the child’s mother) had raised together, had turned out to not be Carlos’ biological son. There’d been a legal battle and eventually she’d left, taking the child with her. Carlos had been left devastated. “The whole experience,” she said, “it really left a mark.”

She gazed into space momentarily, before seeming to re-awaken from her thoughts. Then, skipping forward in time, she moved on to recall the various incidents that had taken place during the height of Carlos’ opiate addiction. “He was stealing,” she said. “From us, from the neighbors, from the cousin of a neighbor.” Once, they’d been at the beach, a small beach where everyone knew each other. One of the parents there had had a blow-up mattress for the beach. But when they went to blow it up, it was gone. He’d sold it for

$10." Another time, she'd noticed that a check had been cashed but it wasn't something she remembered. So she went to the bank and they looked back through the CCTV. "And there was my son," she said. Later that day, she'd called the bank and had spoken to the fraud department. She'd told them, "my son is sick, this is what happened." They'd said that they could get the $300 back, but if they did, they would also be obliged to inform the police about Carlos. Camila hadn't wanted that. So they'd lost the $300.

Then there'd been the photo incident. Camila shuddered. Her husband, Alejandro Snr, had been out in his car. "He's a well dressed man," she said, tensing her arms at her sides, insinuating masculine strength and respectability. Alejandro saw Carlos, begging for money at a traffic light (*"pidiendo en la luz"*). Carlos, obviously drunk, had with him a spread of photos. They had been Camila's photographs of Carlos' son. "The son that wasn't his." He'd been telling people he needed money for his sick son. "And my husband saw him. Not just my husband, my sisters, the family, even my boss saw him. I had people calling me up. He lost so much weight. People were coming up to us asking us if he had AIDS." "And it was a double pain", she said. Both for the drinking and the fact he was using those photographs. "And my husband has blood pressure problems, he doesn't need this. As with all these incidents, when she confronted him, he'd deny it. He'd shout a lot. Once he'd even thrown a plate at her. "And I'm alone at night with him," Camila said, referring to the fact that Alejandro Snr worked night shifts at a restaurant).

Raising her head, which had been clasped for the last ten minutes, her hair clasped in her

hands, she skipped back. “This whole thing is a mess. Now I’m on medication, I have emotional problems. I’ve been seeing a psychiatrist for them. That’s costing money. It’s not fair that I have to be on prescription mental health drugs because my son is an addict. And his medication, the Xanax is costing money too.” She gathered herself. “I live off my own salary, Caroline, I don’t live off the government.” “I work, and his father works too. We have given him so many opportunities.”

***

For his part, Carlos recalls coming home one day to find a police officer who duly issued him a citation summoning him to attend a hearing. At that hearing, he was ordered to receive a psychiatric evaluation at the state hospital (which was actually unusual, most Law 67 recipients I came across were never clinically evaluated) and detained for three days. The psychiatric report, delivered and presented to court by a government official, indicated that Carlos suffered from opioid use disorder. At the hearing, Camila and Juan recounted how they had found Carlos begging for money, and explained how his behavior was undermining stability of their family and the wellbeing of their other two children. On hearing these testimonies, the judge ordered that Carlos enter a residential facility. I first met Carlos at *La Casita* in January of 2017 on the day he enrolled.

Day 1: *As we sit outside the office waiting for Carlos to undergo an entrance assessment (required of all new residents), I ask Carlos how long he has to be here. “I have no idea,” he says. “My Dad has really fucked me over with this.” There’s another guy in the waiting room who says he’s a Law 67 too. It’s his second time at La Casita. He quit the*

program two months ago in violation of the order. He just got out of prison and is waiting to reenroll. "It's much better to be here," he tells Carlos. "Prison is much worse."

Day 30: *Today is Carlos' first hearing since enrolling. Accompanying him to court is Héctor, another resident who is acting as a peer-representative. The three of us find Carlos' parents in the waiting room. We exchange ten minutes of friendly conversation. When Carlos' case number is called, the five of us file into the small courtroom. The judge asks everyone to swear to tell the truth. We do so in union. Héctor-the-peer is asked to comment on Carlos' integration into the program. He gives a ringing endorsement: "He's participating well," "getting used to the routines," and "working really hard." The judge inquires as to how Carlos is getting on with the other residents. Héctor looks at Carlos, who has his hands folded behind his back and is staring calmly up at the judge's bench. Héctor says, "He never has any problems with anyone, your honor, he's showing through his behavior that he is a responsible person."*

Satisfied, the judge takes out an envelope. Inside it is a case report signed by the director of La Casita. The report is one page long and the judge reads it out loud. It is a good report. "Carlos complies satisfactorily with the norms and processes of the shelter." "Overall, Carlos has shown positive adjustment." The report concludes with a recommendation that Carlos "continue to commit himself to achieving positive change." Placing the report back into the envelope, the judge says she is thrilled the treatment "is working." Then, turning to Carlos, "That is exactly what we and your family want from

you." She looks at Camila and Juan who nod, then says, "What we all want is for this to be over as quickly as possible." "The best way to get out is to keep doing what you are doing. Keep up the good behavior." The judge asks Camila and Juan if they have anything to add. They chat for five minutes about how his physical appearance has improved. Camila is visibly joyful as she explains that he has gained weight and describes the 37th birthday party they'd thrown for him the week before, which he'd been able to attend on a visiting-pass. At the end of the brief conversation, the judge is smiling. She wishes Carlos a happy birthday and indicates that we will reconvene in two months.

Day 94: *Carlos, Héctor-the-peer and I sit in the waiting room drinking coffee from a vending machine. Today is Carlos' second hearing and marks the beginning of his third month as a resident. Today Carlos is cheerfully optimistic. "Today, I'll be out of here," he keeps saying. "My behavior is always good, my report will be great, the judge is going to hear it, and I'll be gone." Héctor -the-peer shakes his head. "You need to not focus on the date," he says. "Who knows what might happen." Carlos' lets out a laugh in protest. "No, amigo. You'll see." Soon we are joined by Carlos' parents and caseworker-J from La Casita.*

At 11.30am on the dot the five of us enter the courtroom. Today it is a different judge. He asks Carlos if he could please comment on his experience in treatment so far. Carlos says, "I'm doing well, Gracias a Dios." Standing straight and confident, he methodically elucidates all the activities, therapies, and responsibilities that he has undertaken in the last five months. Twice he mentions that La Casita have now entrusted him with being a

peer-mentor for the new recruits, a responsibility which involves shepherding new residents through the program. "Gracias a Dios," he says again, "It's a big job, ensuring they don't get lost." Next up is caseworker-R, who says he's "behaving well" and "settled in nicely." The judge now asks caseworker-R, "Do you think he's been there long enough?" Caseworker-R replies, "Generally, we recommend that residents complete the entire program, which is eighteen months. But with Law 67 cases, we respect what the court decides."

The judge ponders silently for about a minute, then asks Carlos: "Have you seen a psychologist?" Carlos indicates that he has not. Caseworker-R confirms that he has not seen a psychologist. The judge deliberates with himself for a few seconds, then says, "Without the services of a psychologist, he won't be psychologically strengthened and could relapse." Caseworker-R explains that this service is available for residents "who request it," and promises she can see this arranged. Looking at Camila and Juan, the judge says he wants to be sure that Carlos get the "total benefit" of the program. "It would be a mistake to let him out too early," he says. Turning to Carlos. "Without that inner strength, you could relapse." He indicates that we will convene in two months.

After court, I chat with Camila and Juan. "Of course I'd like him to come home," says Camila. "But it's not up to me. After all, it's the judge's decision." I glance at Carlos, expecting anger, but he doesn't speak. He puts his arm around his mother and kisses her on the cheek, then leaves us to go and smoke outside. Camila says, "he got it into his head he'd be allowed out. Now he's not, he's traumatized."

Juridical labyrinths

By October 2017, ten months after his admission, Carlos remained in involuntary treatment. By that time, I'd attended two more hearings and had a third recounted to me by phone. Like the preceding hearings, each was presided over by a different judge, each of whom concluded that Carlos should complete an additional two months, after which his "progress" would be reassessed. The specific rationales for his continued internment varied. After the third judge, mentioned above, requested that he see a psychologist so as to ensure he receive "all available services," an appointment was duly arranged. This was not an easy feat. In fact it took several weeks of phone calls and tireless advocating on the part of Camila, because at the time the waiting list for psychological care among publicly insured (mostly Medicaid) patients stood at six months across Puerto Rico's managed behavioral health organizations (MBHOs) (Respaut 2016).

At the next hearing, however, Camila's valiant advocacy proved irrelevant. The judge in attendance, upon hearings Camila's concerns about Carlos' continued dependency on Xanax, which she worried was " just another drug," concluded that he was "not confident" that Carlos had "got the most" out of treatment. After advising Carlos to "keep up the good behavior," it was agreed that we would reconvene two months later. Carlos kept up the good behavior, so much so that at his next hearing the judge (again, a different one) was so impressed by Carlos' positive case report – which praised his "hard work" and "commitment to his treatment" - that he concluded it would be a "mistake to remove him prematurely" from an environment in which he was "so clearly thriving." "We don't want you going back to old friends, bad places, old habits," he said.

Afterwards, Carlos and I stood in the smoking area. "What shit luck I've had," he said. "Every time a different judge. Every time, two months more." "I'm going to explode," he said. *"Soy mecha corta, sabes que significa mecha corta?"*

Carlos' feeling that he was a "short fuse," run down to a dangerous point and on the verge, he said, of doing something he might regret came out of (what was then) ten months of frustrated effort. Where initially he had been confident – and led to believe - that compliance with the rules and routines of the shelter was his best ticket to freedom, and had duly performed his chores and participated in group activities with zealous dedication, for the last ten months he'd been circling around in juridical labyrinth where the pathway to release was elusive. Suspended and powerlessness, Carlos was in the unfortunate position of attempting to regain his freedom as a citizen within a juridical regime where the criteria for doing so were ambiguous and constantly changing.

While it is difficult to say confidently why a judge adopts a particular position in any specific hearing, in these proceedings, "evidence" that was taken into account included Camila's concern that Carlos was dependent on Xanax, the judge's concern that he had not yet seen a psychologist, and the caseworker's statement that the "recommended program duration" is eighteen months. Interestingly, in other hearings it was evidence that treatment "was working" – in that Carlos was showing good "progress" and "commitment"- that seemed to serve as grounds for his continued treatment. Finally, at another hearing a few months later, Carlos' father, Juan, raised a concern that although his son's behavior had improved, he was unsure that his son would be able to remain

abstinent if he were to return home, especially given that Carlos did not have a job to go back to. This concern seemed to be taken into account, and the judge ruled that Carlos needed at least two months more treatment.

The shifting and elusive grounds for justification for release were apparent in other hearings, most of which (thirteen out of the fifteen I observed) took place without any qualified health professional present (more on this below). Specific rationales vocalized by judges included problems of poverty, for example, that the resident lacked a stable address, or did not yet have an exit strategy for finding employment, and also concerns about the residents' continued vulnerability to drug addiction. For example, one judge recommended further treatment for a resident on the basis that he "had a history of relapse." Similarly, another judge ruled that the resident should remain in treatment because "last time I let you out you went straight back to using drugs."

Within these juridical negotiations of residents' freedom, the task of providing a justification for release (or continued treatment) did not obviously lie within any particular domain of expertise. Divorced from any specified profession, instead it was free-floating and seemed to fall –fleetingly and haphazardly - onto courtroom attendees: caseworkers, peers, and family members (I observed two hearings where psychiatrists were present, out of fifteen). In the absence of professional representation, family members assumed quite powerful roles in shaping judge's opinions, and thus in determining residents' right to freedom.

In one hearing I observed, attended by Héctor and his father Eric (who figured in the beginning of this chapter), Eric explained to the judge that unlike his five other children, who were "all professionals," Eric has never been "right in the head." Leaning into his hospital cane, he recounted the various times in which he had tried to get Eric into care, for both his mental health issues and drug problems. The last time Eric had got Héctor to enroll in detox, he explained, Eric had run away in under six hours. "The other programs just won't do," Eric explained to the judge. "He can easily just escape again." "He needs to be in a place like this where is surrounded by people who can help him." "A place where he is safe." The judge had concurred, and ruled that Eric should remain in treatment for two more months, after which point his would be re-assessed.

While the opinions of family members were usually taken into account, I did observe some instances in which parents' requests were over-ruled. For example, one judge declined a mother's request that her son's court order be lifted. In that hearing, the judge reminded the mother that this was the second time she had taken out a court order within the space of one year, and the second time she had requested it be lifted. Since the second request that the order be imposed had come nearly immediately after a request that a previous order be lifted, that judge ruled that he needed to see more evidence that the resident was ready for release.

In addition to family members, the other actors whose testimonies mattered for the purposes of helping a judge to determine whether a resident should be released were the caseworkers. Recall that for residents, the case report may be said to represent their most

promising lever for persuading a judge order their release. It is on the basis of the case report that the law, in effect, anticipates and expects judges to make decisions about the necessity of further treatment. Across Puerto Rico's addiction shelter system, the caseworkers responsible for writing the case reports are far from a homogenous group, however. While a minority of caseworkers are university graduates, for the most part it is paraprofessional peers who perform this work. And in my efforts to better understand the legal procedures that govern release, as I ratcheted up caseworker interviews and returned to ten of fifteen centers to interview staff, two things became apparent. First, if a written recommendation for release is a key lever for lifting a court order prior to program completion, it was not one that caseworkers were widely aware of. Second, caseworkers often consider recommendations of release to be professionally, and even morally, dubious.

Caseworker Ernesto, who has spent the last ten years in Puerto Rico's addiction shelter system and who graduated from *La Casita* three years ago, is in charge of all Law 67 cases at *La Casita*. When I interviewed him in *La Casita's* main office, he explained that when writing a report it was crucial to "be objective." As Ernesto saw it, being objective meant limiting oneself to describing only what one has personally observed "with your own eyes." It meant avoiding interpretation or theorizing about a resident's current circumstances, and avoiding hypothesizing about a resident's future. "It's not for us to say how long a person needs," he explained. "We cannot predict what will happen. That would be a fallacy." Ernesto's conviction that it was irresponsible to recommend release was echoed by many of the shelter staff I interviewed. In another interview, a shelter

director explained to me: "We only say if the resident is adapting well or badly; following or breaking the rules. Good or bad behavior." "Practically, we cannot give a total recommendation – that person is ready [for release]."

As I probed this further, this was explained to me in a variety of ways. In response to a question I posed about whether a resident (a cocaine user) "needed" to remain in involuntary residential care, his caseworker exclaimed, "Look, can we ever really know the future? Of course not!" To me, this seemed to reveal an implicit and unacknowledged conflation of the justification for release, on the one hand, and the issue of therapeutic efficacy, on the other. Over time, I came to sense that one reason caseworkers are so loath to recommend release is because they often interpret this as taking or assuming responsibility for relapse. This was pragmatically explained to me in an interview with a paraprofessional peer and recent graduate. In response to my question as to why he would not recommend a resident's release, explained: "Because we can never know if someone might relapse. And if we recommend they leave, and if they subsequently relapse, it would harm the credibility of the program." I followed this idea up with several other staff members, including the director, who said: "Imagine if something happened, which it could happen, it would be our responsibility." "We cannot bear this weight."

Rather than providing concrete recommendations, caseworkers instead acquired a vocabulary for "being objective" (describing what they saw), and tended not to bother with diagnostics (analyzing their observations). So for example, a report might praise a resident when they showed "receptiveness," "commitment" or "a positive attitude"

towards treatment. It might also note that the resident was "adapting well," "showing positive adjustment," or "complying satisfactorily with the norms and processes of the shelter." Caseworkers also learnt to make note of negative behaviors, which like their positive counterparts, were often related to the contingencies of institutional living. Residents were criticized if they "displayed disrespect towards authority," or "consistently broke the rules," or "failed to show positive change in his interpersonal relationships," or even "made derogatory comments about the program." The kinds of information that judges received then, tended to be limited to behavioral descriptions of "adjustment" and "adaptation" to institutional life. And since the law does not have any clearly articulated release criteria,[59] adaptation to institutional life itself sometimes seemed to operate simultaneously as evidence for 'treatment' efficacy, justification for involuntary treatment, and even the goal of involuntary treatment.[60]

A direct recommendation for release was provided in just two of the cases I observed (both were granted). Interestingly, in neither instance did the release recommendation come from a caseworker. In both cases, it was a psychologist – with whom the resident had a pre-established relationship *prior to* the court order – who advocated for their removal in court using a mechanism called "juridical deference." In both cases, the

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[59] For example, that the individual must have a clinically diagnosed substance use disorder, *and* pose a threat to themselves or others, *and/or* be unable to meet their own basic needs, as is more commonly specified in contemporary US civil commitment legislation.

[60] To the extent that caseworkers made 'recommendations,' these generally pertained to characterological goals, for example: "We recommended that he work on strengthening his self-esteem, his decision-making skills, and that he evaluates his intrinsic values," or "We recommend that he manages his compulsive behavior and recognizes his internal and external strengths."

psychologists emphasized that the client did not meet the clinical criteria for substance use disorder and in both cases they were successful in persuading the judge to lift the court order (much to the annoyance of the one of the resident's parents). Aside from these two cases, I did not encounter any examples of professionals (psychiatrists, psychologists, caseworkers, social workers or others) advocating for residents' release.

Power, knowledge and authority in involuntary treatment

Within the anthropology of medicine and psychiatry, there is a long and established tradition of examining how scientific and "expert" bodies of knowledge – medicine, psychiatry, and criminology – create diagnostic categories that regulate and subjugate populations (see, for example, Martin 2009; Lakoff 2006; Garriott 2011). What is striking about the configuration of power and knowledge in involuntary treatment proceedings however is the scarcity or even absence of clinical expertise or specialist knowledge. In this regard, the epistemic milieu of juridical care in Puerto Rico is defined by a lay, or even 'vernacular' informality. Here, the power to diagnose "drug addicts," and the authority to recommend release or continued institutionalization, lies not in psychiatry but instead tends to fall onto a variety of social actors whom one might think of as traditionally "disempowered" (e.g., low income parents, peer caseworkers).

Within these proceedings, "vernacular knowledge" - everyday knowledge based on "social interactions, skills, practices, social networks and institutions" (Escoffier 1998:4)

assumes significant power and authority.[61] And within this particular blending of parental, civic, and legal power, the disempowered can become situationally powerful as vernacular knowledge displaces medical authority as the grounds for protecting or revoking the right to freedom.

The elevated authority of vernacular knowledge in Puerto Rican civil commitment proceedings represents a departure from existing accounts of civil commitment in other parts of the world, such as in mainland United States and Europe (Davis 2012; Testa and West 2010; NAMSDL 2016). In these accounts, the power to protect or abrogate patients right to freedom is usually entrusted to psychiatry (in the contemporary moment). That is, whatever specific stipulations any particular country has for involuntary treatment, it is usually clinicians who are entrusted with the power to protect or abrogate patients right to freedom according to their professional discretion (Davis 2012; Testa and West 2010; NAMSDL 2016). In the case of Law 67 proceedings in Puerto Rico, an alternative set of developments has taken place. In an historically anomalous short-circuiting of psychiatric power, this juridical care regime works to disperse forms of power and authority that are traditionally confined to the clinic onto and across families, mutual-aid networks, and the body politic.

[61] In Escoffier's (1998) account of HIV activism, as well as in more recent accounts of sexual health education and environmental movements (Martos 2016; Bartel 2014), vernacular knowledge is construed as emerging from the local level, and is juxtaposed with "scientific knowledge," which is emerges from authoritative institutions such as science and medicine.

This temporary and conditional empowering of the citizenry in civil commitment proceedings also represents a departure from existing accounts of therapeutic jurisprudence in North America, Canada, and Europe (Kaye 2010; Tiger 2013; Farole and Cissner 2005). In studies of drug courts and various other domains of criminal justice, scholars have noted that adjudication has become more statistical, more actuarial, more concerned with aggregate groups and populations rather than individuals and clinical cases (Hannah-Moffat, Maurutto, and Turnbull 2009; O'Malley 2009; Feeley and Simon 1992). The ascending authority of familial testimony, emotive appeals, and things that are, at bottom, just desperate pleas for help, thus seems to fly in the face of broader trends in juridical institutions towards "actuarial justice" (Hannah-Moffat, Maurutto, and Turnbull 2009).

In what may be plainly interpreted as the contingent recourse of a fiscally-strained state to help and assist a family in crisis, the commonwealth state has created and routinized an oddly archaic, low-cost juridical care mechanism. Through this juridical care mechanism, low-waged and underwaged paraprofessional caregivers (and to some extent, family members) are enlisted to perform work ordinarily undertaken by clinicians and other trained health professionals. This out-sourcing of labor has entailed a re-arrangement of established configurations of power and authority, by removing civil commitment from the realm of psychiatry and placing it in the hands of the citizenry. In this subversion of psychiatric power, lay knowledge becomes elevated as a basis for removing the right to freedom.

Conclusion

As this analysis of civil commitment in Puerto Rico has demonstrated, more is at stake in involuntary treatment than a straightforward "criminalization" reading would suggest. Here, the judiciary is not an uncomplicated extension of the "penal arm" of the state (Wacquant 2009; Alexander 2012). Instead, what is at stake is a much broader negotiation of responsibilities of dependency and entitlements to citizenship. Within this particular blending of the law, kinship, and mutual-aid, the citizen who is marked as "addict" represents neither a "criminalized" subject (Moore 2007) nor a "diseased" citizen (Biehl 2013b). In the context of Puerto Rican civil commitment, the "addict" is a subject whose 'threat' to domestic or public order, however weakly substantiated, serves as a legal warrant to revoke their claims to citizenship. It also serves to reallocate the responsibility of meeting their basic needs – obligations ordinarily met by kin - onto unprofessional networks of self-help and mutual aid. In this juridical regime "addiction" acts as a marker (like race, or language, see Hansen and Stepputat 2006) for excluding someone from a political community, at the same time as it acts as a shunt-valve for redistributing burdens of care.

In this juridical care regime, we do not see a straightforward bio-political mode of governance with the welfare and prosperity of population as its primary concern (Foucault 2009:107-108). Instead we see individual citizens and families harnessing the judiciary to restore domestic order and to redistribute burdens of dependency. In a context of fiscal scarcity, the Puerto Rican state has dispatched the judiciary as a family ally and as an extension of parental power. Though undoubtedly an object of gratitude for

over-burdened kin systems, this care regime woefully fails to meet the needs of its subjects.

Conclusion

For the men in this dissertation (because they are mostly men), living and working in a therapeutic community is rarely chosen freely. Nevertheless it is a time when many do their best to knuckle down, make the most, and take advantage of whatever chances and opportunities may be available. For those who do not have another place to call home, either because of familial bridges long burned, poverty, or often both, the addiction shelter can provide a welcome surrogate home. Among those for whom prison is the alternative, which it is for many of therapeutic community residents, the safety and freedom of the shelter – even allowing for institutional restrictions – can make it the preferable choice. For many of these men then, making the most can often mean settling down for the long haul in the knowledge that staying put is probably, for now, the best option.

As I have tried to show, making the most is usually a question of rejecting a devalued "redundant" status and converting it into a "socially useful" status. It is about building a sense of worth through finding and inventing ways to be useful, even if there are not a lot of useful things to do. This endeavor to be "useful," as we have seen, has proven highly generative. Among its more impressive outcomes has been the creation of a fully-fledged parallel livelihood and alternative career path, one that is clothed with kinds of dignity, honor and recognition, which, however precarious and forfeitable, can be deeply meaningful to the wearer.

These prized possibilities for personal and professional advancement notwithstanding, this effort to be useful also has its limits. Residents struggle to maintain their faith in the repetitive available alternative way of life. Aside from not always being satisfying, this effort to be useful also lends itself to various kinds of exploitation. From the unwaged and underwaged *re-educados*, repackaged from criminalized subjects into "self-certified" adjuncts, and now performing the work of cheap containment on behalf of the carceral state; to the indentured residents, who, regardless of personal faith (or skepticism) in the method, are sent to pick up trash for the city, to cut grass for the mayor, and to clear scrapyards for private developers, without remuneration. This improvised project for avoiding redundancy, it seems, is a precarious ground on which to base social membership.

From European imperial capitalism to global neoliberalism, theorists have characterized the conditions of production as a series of recurring crises of accumulation and a resultant tendency to generate human superfluity, with whatever is not absorbed necessarily treated as unfit, undesirable, and disposable. This assessment has been repeated in various iterations by leading theorists from Hannah Arendt (1951) and Achille Mbembé (2004), to David Harvey (2005), Loïc Wacquant (2009) and Zygmund Bauman (2013). For Arendt (1951), these were the European immigrants who settled in South Africa; superfluous in the societies they came from and so sent to mine the most superfluous material of all, gold. For Bauman (2013), these are the migrants and refugees from the global south, "wandering the routes once trodden by the 'surplus population' (…) – only in a reverse direction." (2013:73). For Wacquant (2009), these are the millions of African

Americans stuck behind bars in the United States, the insecure factions of the postindustrial proletariat. All can agree with the basic premise put forward by Marx, that capitalism is characterized by a constant shedding of "surplus populations" in the interest of ever more efficient accumulation (Marx 1977).

And yet, I think of a phrase I came across a few years ago in a book by Cheryl Mattingly. She used the phrase "writing against structure" (2010) to describe her approach to ethnography, and at first it both perplexed and troubled me. What she was criticizing was a tendency in anthropology to perceive our informants as walking exemplars of theory, and, when it comes to writing, to move our characters around like pawns in a theoretical board game. At first it perplexed me, because how else was I supposed to make sense of the lives of the people I encountered in Puerto Rico's addiction shelters, if not through theory? It also troubled me, because I wondered whether that was what I'd really been doing all along, moving characters around to tell theoretical stories. There was one passage in particular, which I will quote here, that has greatly influenced the shape and writing of this dissertation.

> In social theories where the scene is overwhelmingly dictatorial, the agents contained within it can only mirror its characteristics in their actions and dispositions, or, as we say in anthropology, "internalize" and "reproduce" the external social conditions in their own docile bodies. It is precisely this problem of docility that needs to be redressed in our social theories, even while we foreground the oppressive qualities of social structures (2010:46).

How then, she asks, do we write “characters we can care about, ones who are not merely puppets or victims of social conditions?” (2010:46). Mattingly’s method was narrative phenomenology[62]. My own effort here has been a little different, so I shall try to spell it out.

In thinking through these men’s lives, I have sought to make use of the concept of superfluity, by binding it to what I see as its livelier counterpart, abeyance, to examine the creation of an ostensibly “therapeutic” project that turns out to ‘treat’ not addiction, but redundancy. In exploring the efforts of these men to build an alternative way of life outside the domains of wage labor and kinship, and outside the drug trade, I have been forced to think about superfluity and abeyance not just as structural processes or bureaucratic rationalities, but also as things that are human. By paying attention to what this predicament feels like, including what the stakes are for the individuals who are stuck in this situation, I hope that I have been able to thicken up, or more precisely to humanize, these concepts. In a manner that by now seems oddly familiar, I’ve come to think of this approach to ethnography in terms of “character restoration.”

By character restoration, I am talking about an approach to writing that is attuned to structure, but that uses theory to foreground characters, and specifically what Mattingly (2010) calls “non-docile” characters. Methodologically, this has meant making room for,

[62] For Mattingly (2010), this is an approach to writing that “recognizes the macro structural dimensions of our existence” but “foregrounds personal, intimate, singular and eventful qualities of social life” (ibid:7) though offering portraits of “bits of lives” (ibid:235) that are not smoothly or easily subsumed into theoretical generalizations or cultural categories.

and caring about, individual people, by taking seriously their desires, intentions, actions, options, and predicaments. Here this attention to the efforts, goals and life projects of multiple differentially situated parties has helped to illuminate a highly synchronous collection of aligning interests, something that has turned out to be crucial to the success of this therapeutic regime.

As I showed in Chapter 1, the ascendance of Puerto Rico's therapeutic community movement was not some "natural outcome" of state neglect. In fact, the actions and behaviors of a handful of individual people were critical to this movement's early genesis. Since then, the sphere of relevant actors has expanded to include the overwhelmed corrections department, for whom therapeutic communities have provided a convenient safety valve through which to ease the burden of prison overcrowding. Also important are the local governments and private businesses, which have benefited from therapeutic communities' laborers, who they have been able to recruit at very little cost to perform unpaid work. The mayors have also played a role in this, supporting therapeutic communities in exchange for free labor and campaigning assistance during elections. Their endurance, then, must be considered within the context of therapeutic communities' imbrication within a wide variety of local political projects, each with their largely "extra-therapeutic" concerns.

In Chapter 2, I examined what these therapeutics mean for the people who practice them. Through an experience-near account of daily life at *La Casita*, I showed that the therapeutic practices of labor therapy, time-discipline, prayer, and internal work are not

centrally geared towards "treating addiction." Instead, they are social technologies through which men seek to convert a stigmatized "redundant" masculinity into a "socially useful" masculinity based on a performance of work, responsibility, and duty. I also showed, however, that this process is difficult and often fraught. These men are forced to contend on a daily basis with a contradiction between a moral imperative to be "useful" and an institutional environment that is unable to assure a steady supply of useful things to do. Thus, even in this improvised surrogate employment system, redundancy is a continual existential threat.

In Chapter 3, I considered what this paraprofessional opportunity structure brings to the people who work in it. I analyzed the work of re-educados as a project of "vernacular professionalization," which I theorized in dual terms as an entrepreneurial life project through which criminalized men seek to better themselves, and also a governing strategy through which the commonwealth state pursues cheap containment. Ultimately, I showed that the ability of self-certified professionals to short-circuit all credentialing requirements that typically restrict and qualify entrance to these professional categories is tolerated because of this unlikely convergence of interest.

In Chapter 4, I explored another dimension of therapeutic communities' local relevance. Charting the journey of residents and families' journeys through the courts, I examined the role of these organizations in relieving families of burdens of dependency. Focusing on civil commitment proceedings, I showed how the courts operate to divert subjects who

are deemed "troublesome" away from families and onto unprofessional mutual-aid networks.

Returning to Arendt's reflections on the "superfluous men… who came rushing down to the Cape", one point upon which she is uncompromising is that these men were "nothing of their own making." For Arendt, these men were "living symbols" and "living abstractions," not individuals – just "shadows of events with which they had nothing to do" (1974:189). By foregrounding characters that I hope we can now care about, this dissertation has tried to counter such a reading.

Across these four chapters, what I hope to have made clear is the fundamental sociality of this care regime, which is made up of and intersects with multiple, contested, and sometimes converging projects. In this dissertation, these have included: entrepreneurial projects of informal enterprise (Chapter 1), existential projects of redemption (Chapter 2), life projects of the poor to professionalize themselves (Chapter 3), state projects of containment (Chapters 1 and 3), and juridical interventions into domestic order (Chapter 4). Note, the structural exigencies surrounding this therapeutic regime are historically changing and not static. This is precisely why, for the purposes of ethnographic writing, such constructs as post-industrialism, the war on drugs, and neoliberalism can only ever be part of the story. As I hope is now clear, the individuals that make up and live in this therapeutic regime also matter, and by extension, what people do *in* structure, and what people *make of* structure, is important anthropologically.

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