The clinic is a house: small, brown, made of straw bale and mud plaster. It sits at the end of an unpaved road ten miles from the nearest town. Fifteen acres of dirt dotted with desert sage surround it and, here and there, clusters of cottonwood trees, dilapidated outbuildings, rusted metal chairs. A netless basketball hoop leans precariously. It looks as though it is about to collapse with the next gust of strong, summer wind. We watch it from our perch by a coffee-can ashtray and wonder when it will finally fall.

John smokes a cigarette and stares blankly at the cloudless blue sky. Though it’s 85 degrees, Lupita’s thin body is wrapped in layers of sweat-shirts and blankets. She nods off in her chair, her head rhythmically
falling and rising, falling and rising. Bernadette complains that her legs hurt, feel knotted and twisted up. “How much longer,” she asks me, “till the next dose?”

The three are heroin addicts living at a drug detoxification clinic in northern New Mexico’s Española Valley. Since the early 1990s the Española Valley has had the highest per capita rate of heroin-induced deaths in the United States. In a region of just over 30,000 residents, nearly 70 people died from heroin overdose in little over a year—which is to say that within this close network of rural towns and villages, everybody knows somebody who is addicted to heroin or has died because of it.

John, Bernadette, and Lupita are in varying stages of heroin detox, a month-long process that uses medications to ease the pain of withdrawal. Like the majority of patients at the clinic, they are court appointed—or sentenced—to detoxification, the first official step in a longer process of drug recovery and, in their cases, punitive rulings. This is not the first time they have undergone treatment, or sentencing, for their heroin addiction.

I had recently been hired to work at the clinic as a detoxification attendant—a job I took as a means to get closer to subjects in my area of ethnographic study. Like all the other attendants, I received no formal training for the position, although I was required to take an examination that certified my ability to properly distribute prescription medications used in the clinic, especially the narcotic-based relajantes (relaxants) that many patients used on the “streets.” At the clinic, use of these medications was “legitimate,” and patients asked for them with desperation. They were unable, it seemed, to adjust their bodies’ addictive demands to the clinical indications of las pildoras—capsules such as Darvon and Librium—which on the street are commonly crushed and injected like heroin.

On my own I quickly learned to keep the patients occupied and briefly distracted before their next scheduled dose. On this afternoon, as Bernadette grew increasingly restless, I suggested a walk to the Rio Grande, which formed the western boundary of the clinic grounds. John and Bernadette reluctantly agreed. We left Lupita and headed toward the river.
We walked slowly, the sun hot on our dark heads. I watched John and Bernadette concentrate on their legs and feet as they moved. Their steps were uncertain and deliberate, like the very young or the very old. They stopped for a cigarette break, during which they considered turning back. But by that point we were closer to the river than to the clinic. With my urging, we pushed on, our socks shot through with prickly thorns.

The walk to the river brought forth memories: of apple orchards and dirt bike trails, trout fishing and twelve-packs. John said the river was fuller back then and the crops that drank from the irrigation ditches it fed more abundant. We wondered about the coming monsoon, whether the rains would finally be strong and lasting; the region had been in a severe drought for the better part of a decade. Then, for several minutes, we walked in silence.

“I can smell the water,” Bernadette said, her face glistening with sweat.

The edge of the river was lined with a thick tangle of brush. I led the way through it, pushing back angry branches and locating dry footholds along the muddy perimeter. Bernadette followed close behind me, and John followed her. We cleared the brush and then, suddenly, were standing on the east bank of the Rio Grande.

The river was brown and shallow, its surface pebbled. We stared at the muddy water and remembered summer swims.

And then, Bernadette: “This sucks.”

Not wanting to admit defeat, I suggested walking upstream where the river widened before heading back. Bernadette lit another cigarette—she’d had it—and fell behind while John and I walked ahead without her. I imagined as we walked that we were looking for something to call forth our memories—perhaps schools of flickering minnows or deep pools of clear water. We walked quietly. After a few minutes, John stopped. “Mira [Look],” he said, pointing. Caught in a cluster of rocks lay a heroin cooker made of an old soda can, along with two discarded syringes.

“Este río está muerto [This river is dead],” John said.

John lit another cigarette, and we turned back toward the clinic in silence—our shoes heavy with water and mud. When we met up with Bernadette, John again announced that the river was dead. Bernadette
looked at him blankly, and the three of us continued without speaking. When we arrived we found Lupita exactly where we had left her—bundled up and nodding off in the sun.

Later that evening, just before midnight, John disappeared from the clinic after eight days of heroin detoxification. He left behind his few belongings (muddy shoes, a weathered Bible, and a portable CD player) and walked a series of dirt roads that led to the main highway. From there he hitchhiked to Española, the nearest town, ten miles away. Because his departure placed him in violation of his probation, the attendant on duty was directed to notify the police. John’s patient file was labeled “self-discharge against staff advice,” although it is unclear whether any of the staff advised him to stay.

The next morning police found John in his pickup truck, parked beside the garbage bins at the Española Dairy Queen. When they approached the driver’s window, they found John in a drug-induced sleep—in the passenger seat beside him an empty syringe. John was arrested. Three months later he was sentenced to return to the New Mexico State Penitentiary in Santa Fe, where he was to serve a two-year sentence for drug possession and outstanding warrants. In the eyes of the detox clinic, John was just another patient who had relapsed and failed treatment.

Since his arrest I have often wondered if John’s so-called self-discharge was precipitated by our encounter at the river. By all accounts he was doing well with his recovery program and was, in his words, “committed to kicking it this time.” Indeed, he seemed to have gotten over the hardest stretch of heroin detox—the first few days when the physical pain is at its worst. And the threat of prison was, he said, “enough to keep me straight.” What happened? Did John’s intimate recognition of the heroin cooker and syringes we stumbled upon awaken an overwhelming desire to get high? Or were there other, perhaps deeper dynamics of loss and longing during our walk that contributed to his relapse? How would I be able to begin to understand the motivations, force, and meaning of his “self-discharge”? 
Shortly after John’s arrest, I sat beside a different stretch of the Rio Grande near my house. A discarded Budweiser can, caught between fallen branches, shone brightly, like a medallion in the murky water. I poked at the can with an old wooden crutch that had been abandoned by the river’s edge. And everywhere, in the branches of the cottonwoods, among the black-billed magpies, in the weed-choked irrigation ditches, caught on barbed-wire fences, were discarded plastic bags emblazoned with the Walmart logo. *Low Prices. Always.* I recalled John’s words about the *ríó muerto* and wondered if it had ever been alive.

When I returned to northern New Mexico in January 2004 to begin researching heroin addiction, hypodermic needles seemed to be everywhere. They were discarded along the tortuous county roads connecting the tiny, ancient, Spanish-speaking villages—Santa Cruz to Chimayó, Córdova to Truchas, La Canova to El Guique. They were tossed in the acequias—the centuries-old labyrinth of irrigation ditches that feed the valley’s crops. They were reportedly found in restaurants, schoolyards, and cemeteries. To my surprise, there were syringes hiding under the leaking sink of the house I rented, unused and forgotten.

For weeks, I surveyed my property, looking for sharp objects. I wore thick-soled shoes and moved across my acre of dry land methodically, in square-foot parcels. I didn’t find any syringes (except for those inside my house), but I collected dozens of broken beer bottles and other wasted objects. I also soon discovered that my next-door neighbor was a heroin dealer and, along with her boyfriend, operated her business out of her home. After witnessing a series of violent incidents at her house, I stopped wandering around my property and took to sitting in my attic window. For months, I watched cars spitting up dust as they drove up and down our shared dirt road. I watched her customers duck into her darkened adobe house and quickly reappear at all hours of the day and night. I listened for the desperate sound of late-night knocking and the other sounds that often accompanied it: screams and blows and, sometimes, the shattering of glass. And I watched my neighbor’s eight-year-old son running out
of the house as though it were on fire and taking refuge in the tiny pump house, which sat just below my office window.

The ubiquitous and troubling presence of the syringes highlighted the extent to which heroin had become enmeshed in every aspect of physical space and everyday life. They were everywhere in the landscape, on public land and private, tiny but dense sites in which history and subjectivity merged and, ultimately, disappeared. Anecdotes to a local reality, the syringes were imbued with alienation, desperation, and longing. They appeared to me as a kind of ghostly sign, like the handmade memorials called descansos (resting places) that line the highway, marking the site where someone died or was killed in an automobile accident. I understood my task as an anthropologist to conjure up the social life that produced these signs, to give it flesh and depth. Indeed, that is why I went to New Mexico to study heroin—to try to give purpose and meaning to an aspect of American life that had become dangerously ordinary, even cliché.

I grew up in New Mexico, leaving at the age of seventeen for the West Coast and later the East Coast. For years I would speak of New Mexico’s distinctive beauty, never of the deep suffering that I knew existed there. I kept memories of New Mexico separate in my mind—maintaining a firm boundary between what could be rendered (its celebrated landscape) and what could not (the uncertain and secreted experience of addiction). But from my moment with John at the Rio Grande, I recognized that the two were inextricably linked. New Mexico’s landscape makes visible the existence of addiction, and addiction shapes and is shaped by New Mexico’s landscape. Each has its own processes of sedimentation, which are entangled in ways that this book tries to understand.

GEOGRAPHIES OF ADDICTION

John’s moment at the river and subsequent relapse provide a powerful introduction to several themes that I explore in this book. First, there is the material and symbolic nature of finding the used syringe during our walk. I had suggested the walk to the Rio Grande precisely because I thought it would provide a respite from the many challenges of clinic
life—from the physical pain of detox to the boredom and discomfort that accompany the clinic’s slow tempo. My plan seemed to work, at least before we got to the river itself. John’s and Bernadette’s memories of events that had occurred along the river harkened back to a time before heroin and its personal devastation. But seeing that even the river was, in a sense, contaminated by heroin pointed to just how deeply entrenched the region’s addiction problem was and would push me to address how there is ultimately no space—physical or experiential—external to it. Our discovery along the river would force me to address the way in which heroin haunts so many aspects of everyday life in this region, from the most public to the most intimate.

“Our landscape is everywhere spotted with ruins,” J. B. Jackson (1994: 15) wrote of northern New Mexico. This book starts from the idea that this particular geography of addiction encloses multiple forms of spatial and existential ruin, sedimented and entangled through time.

As I learned the contours of John’s personal history, I came to understand that his declaration that the river was dead expressed a feeling of loss that was intimately connected to the social and political history of the region. This feeling, and the language used to describe it, resonated powerfully with many addicts I interviewed, especially as they spoke of memories of dispossession and loss of land. Indeed, addicts’ narratives of heroin use were often related to mourning a lost sense of place. The presence of heroin here is closely connected to the multiple and changing ways that this land has been inhabited, labored on, “suffered for,” and lost (Moore 2006). A central theme in this book is how loss and mourning provide more than a metaphor for heroin addiction: they trace a kind of chronology, a temporality, of it. They even provide a constitutive power for it.

An important part of this geography of addiction is the growing presence of the public health and legal apparatus. What I want to describe now are the high stakes involved in how these institutions classify and respond to events such as John’s relapse and how these classifications shape addicts’ understandings of their addiction and, by extension, themselves. In defining John’s departure from the clinic as a “self-discharge,” certain claims were made regarding his capacity and will to be a “good patient” and “good citizen”—that is, within the realm of the law or, in this case, his
inability to be such. John’s “relapse” or “treatment failure”—purportedly neutral terms in a medical sense—would become morally charged by his subsequent arrest and imprisonment. The effects of these competing institutional claims are a central concern of this book. I argue that such claims and the structures of authority in which they are embedded extend into the addict, presenting him or her with a new life script, such as “the patient” or “the prisoner.”

By attending to the politics of what I call the patient-prisoner, I explore how the local phenomenon of heroin addiction and addicts themselves are constituted not only through hardship and loss but also through the logic, routines, and practices of medical and juridical regimes (Bourgois 2000; Lovell 2006; Rhodes 2004). Such an inquiry extends Michel Foucault’s (1979, 1998, 1990) inquiry into how forms of governance become forces for the creation of new forms of subjectivity. I work with a somewhat similar set of concerns in trying to describe how institutional structures and claims are absorbed by the addict, exacerbating a sense of personal failure that
contributes to a collective sense of hopelessness and, in turn, the regional heroin problem itself.

In this work, I approach heroin addiction as a human and ethical phenomenon that urgently requires understanding, especially as it can be illuminated through ethnography. I also approach heroin addiction as an analytic in which culture, politics, and history coexist as a site of struggle and whose examination requires close attention to the personal and collective histories that form subjects and their drug use. By viewing addiction as phenomenon and analytic, I hope to show how Hispanic addictive experience is closely related to history and not merely cultural or personal pathology, as it is so often described. In doing so, I call attention to both the personal and political stakes of heroin addiction—its phenomenology and its political economy, its intimate and institutional forms.

Anthropologists and others have established that the addict cannot be disconnected from the broader “moral world.” My analysis extends this insight by showing how specific geographies of addiction intersect with institutional and historical formations to shape the lives of addicts. In thinking about the connectedness of the heroin addict to the broader moral world, I have attended to the many spaces, roles, and identities “the addict” inhabits. This approach stands as a critique of popular representations of addicts as separated from “traditional” social and intimate bonds, or as isolated from parents, children, and community. Though many addicts do experience isolation, I question the notion of the “isolated addict” and insist on the persistence of intimate and genealogical ties in addicts’ lives. I demonstrate how these ties are maintained through everyday modes of care within addicted families and between neighbors—from the family household acting as a proxy clinic for the state, to practices of “gifting” heroin in times of physical need and economic scarcity, to funerary rituals for fatal heroin overdoses, such as “shooting up” the graves of the recently departed.

On the one hand, these practices of care can be interpreted as criminal, perverse, or self-defeating, and they have been incorporated in the “crackdown” strategies of local and state police. Several police officers I interviewed mentioned that drug possession cases can most effectively be “rounded up” at local cemeteries, where heroin addicts frequently
mourn loved ones lost to the drug while getting high themselves. On the other hand, these practices can be described as the “burden of care” families and communities must shoulder in the context of poverty and institutional neglect. Both framings risk missing the dynamics of connectedness and longing from which these practices emerge. My goal here is to restore the embodied, economic, and moral dynamics of addiction as they play out in domestic and community relations and to show how these relations enhance, remake, and sometimes reduce the life possibilities of the addicted (Bourgois 2002; Lovell 2002).

This book’s orientation to tracing the connectedness of the addict to the broader moral world extends to its consideration of how personal history is interwoven with cultural and political history. Northern New Mexico has always been depicted as a remote and insular region. In reality, it has been the site of colonial exploitation and transformation for more than four centuries. Today, locals passionately express the material and cultural losses that resulted from the region’s embattled past—in particular, the loss of Spanish and Mexican land grants—and they are likely to understand its heroin problem as a contemporary consequence. The memory of locals and their personal encounters with heroin (and the international trafficking circuits on which it depends) made it clear to me that northern New Mexico is anything but isolated. It thus became essential to resist taking an isolationist stance in which personal histories of addiction are reduced to individual soma or psyche. Instead, I understand individual histories of addiction as a historical formation and as embedded in an immanent social context. Put differently, I explore heroin addiction as a contemporary modality of Hispano life based in the longue durée of Hispano dispossession. This geographic, or pastoral, vision of addiction grounds my analysis of how the historical and continuous processes of dispossession of Hispano property and personhood emerge as a condition of possibility for the contemporary phenomenon of heroin use.

At the same time that I foreground the inseparability of addictive experience from history and the broader world, I recognize that I am exploring
forms of experience—getting high, overdose, suicide—that insist, to a degree, on the singularity of the subject. These forms of experience exclude me, and yet they concern me; heroin overdose is endemic to the region (and may thus be considered “collective experience”) and yet, in the end, is a solitary act. Such quandaries that this research encounters raise epistemological problems that center on the question of how to think and write an account of experience that is fundamentally foreclosed to the ethnographer, sometimes even to language itself. These are dimensions of experience that often escape clinical and critical analysis and that necessitate working on the margins of knowing and acknowledgment (Cavell 1976).

Rather than bracket these questions, I attend to them as moments of incomprehensibility. I do so with the intent that they be understood as moments that raise fundamental questions for anthropology and for an ethics of care. Where to look, for example, when one wants to understand the experience of losing oneself, as getting high and overdosing is so often described? What does this form of self-exile communicate in terms of the (broken) interdependencies of self and other? In foregrounding those moments that appear unknowable, I seek to demonstrate the significance, and sometimes penetrability, of certain limits: the limits of experience, understanding, and ethnography, especially as they form the basis from which we constitute others and ourselves.

On a methodological register, considering the historicity, interconnectivity, and incommensurability of addictive experience has meant attending to seemingly different fields. For example, after John’s “self-discharge,” I realized that it would be important to follow his movement through the penal system in order to understand what happens to addicts that “fail” forms of medical intervention. And I did follow John and other addicts as they cycled through arrest, hospitalization, and incarceration. While examining these institutional realms, I came into contact with more intimate details of addicts’ lives.

In fact, it was at John’s drug court hearing that I began to piece together details of his personal life: an estranged father living in a mountain village, a younger brother fighting in the war in Iraq, a five-year-old daughter living with John’s mother in Chimayó. I would move accordingly
across these different sites—from the clinic to the courthouse to the mountain village to the prison—following the contours of John’s life across space and time. As I did, I recognized that these sites were not disparate but a part of the same process of formation: the formation of an addiction and of a life.

Sometimes following the story means hitting dead ends, and I encountered many of them. These included states that I could not access given the nature of my research (such as understanding what it feels like to overdose) or situations that I turned away from for fear of reprisal (such as the offer to observe the buying and selling of heroin along a secluded stretch of river). There were also subjects who were lost to “the streets,” imprisonment, and death. I argue that it is in these moments where the connections end that the vulnerabilities of drug life—and life itself—are most powerfully visible. Such dead ends provide us with clues to what is most at stake for the subject, a family, and a community.

Although my interest in rethinking addiction is situated in understanding the entanglements of history, sociality, and subjectivity, it is vital, too, to understand the standard approaches to understanding addiction, in particular, in the medical and juridical domains. Each chapter of this book considers how selective institutional interventions (in this case, state-regulated treatment and criminalization) lead to an internalization of new moral codes, which must be negotiated between addicts and within families and communities.

In the section that follows I briefly examine some of the prevailing models for understanding heroin addiction and for “rehabilitating” heroin addicts, commenting on how these models have their own adverse effects, such as “fixing” addicts in certain life scripts whereby they continually return to the system meant to rehabilitate them. This cycle of failure, I argue, is as much a human failing as an epistemological one. It is my hope that this book upsets the acceptability of these standard approaches and the kinds of claims that operate through them, and that it points toward a more critical—and ethical—approach to thinking about and treating heroin addiction.
ADDICTION’S CYCLES

From the point at which heroin enters the bloodstream, the physiological effect—the rush—occurs very quickly, usually within twenty seconds to a minute. The central nervous system and the cardiovascular, respiratory, endocrine, gastrointestinal, and genitourinary systems, as well as the skin, are affected. Morphine, the psychoactive ingredient in heroin, causes the state of euphoria, analgesia, and sedation associated with a heroin high. Over time, increasingly larger and more frequent doses of heroin are needed to achieve this state. Using becomes less about achieving a high and more about staving off withdrawal. Heroin is medicine; it relieves the pain its use creates.15

There is a complex, even geometrical relationship between the physiological experience of heroin addiction and the explanatory model of “chronicity”—established by scientists and caregivers to understand and treat addiction. Briefly, the model of chronicity likens addiction to a life-long disease, such as diabetes, asthma, or hypertension (Appel and Kott 2000; Cami 2001; Heymann and Brownsberger 2001). The notion that addiction is a disease—chronic, subject to relapse, rooted in the subject’s neurobiology and beyond his or her rational control—corresponds to developments in the technosciences of addiction (such as neuro-imagery) and a distancing from older lexicons of moral failure, stigma, and social causality. With addiction thus viewed as a chronic disease process, or, more specifically, a chronic relapsing brain disorder, its treatment is now conceived as long term and partially effective. Relapse is an expected occurrence during or after treatment episodes, especially where there are underlying physical, psychological, or “environmental” factors (Appel et al. 2000; Volkow 2005).

The chronicity model emerged in the early 1960s, in part as a response to the high incidence of repeated relapse seen among addicts who entered publicly funded treatment programs. It was intended to dispel the long-held assumption that heroin addicts were innately psychopathic and irredeemable (see Acker 2002).16

Underpinning this rescripting of addiction was the explosion of drug use in new economic and social settings—out of the “shadows” and into

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the white, middle-class mainstream. New constellations of disciplinary interests emerged that reexamined the etiological and clinical aspects of addiction. This turn culminated with the introduction of methadone maintenance in the 1960s. The idea was that methadone, a longer-acting drug than heroin, could be administered to prevent withdrawal and stabilize the addict’s physiology so that he or she could legitimately engage in life.

The tropes of chronicity and maintenance have become key organizing principles for the kinds of therapeutic work that take place in clinical settings. They have also ushered in a new agenda for addiction research in the behavioral and biological sciences. Recent developments point to the neurological basis of addiction, whereby repeated use of addictive substances, such as heroin, alter the neurological circuitry for dopamine, which triggers pleasure. According to this model, such changes in the dopamine system (described as “adaptive changes” or “habituation”) involve states of dopamine deprivation, which produce, among other things, feelings of pain, depression, and a persistent, worsening, and chronic need for more of the drug.

One wonders, what assumptions go into the making, interpretation, and circulation of such explanations? How do older discourses about addiction and recovery converge with and contradict those of the neurosciences?

I do not deal extensively here with brains or genes, or how popular discourses of addiction causality and relapse haunt addiction science (Campbell 2007; Courtwright 2001, 2009). I am interested, however, in how the scientific understanding of addiction shapes—or to be more precise, does not shape—local understandings and experiences of addiction. In this sense, this work is quite different from Emily Martin’s (2007) insightful analysis of bipolar disorder, in which her interlocutors assume, often in expert fashion, narratives of neurons and neurotransmitters when describing their experiences of mental illness. Such scientific discourse was largely absent in Hispano addicts’ narratives, although local community-based treatment programs, such as the one I worked for, adopted the “chronic illness-care model,” accepting and even anticipating that addicts who complete the program will eventually return.
According to Nuevo Día’s executive director, “We always want recovery to be a onetime thing. But it isn’t. It’s every day of your life. It’s hard to structure a treatment program based on that. So you do what you can all the while knowing . . . yeah, its unfortunate, but ‘I’ll be seeing you again.’”

Before brain scans could render the recircuitry of the addict’s dopamine system, Gilles Deleuze described the recircuitry that takes place in the context of addiction but in slightly different terms. In his essay “Two Questions on Drugs” (2007), he considers the “turning point” that takes place in drug use—that threshold where the “vital experimentation” of drugs crosses into a deadly one. Deleuze imagines vital experimentation as taking the drug user to new lines of flight. Over time, these lines roll up, start to turn into black holes, and the drug user finds herself “dug in instead of spaced out” (2007: 153). He asks, is this transformation from vital experimentation into deadly dependence inevitable? Is there a point at which pleasure and relations erode and everything is reduced to a “dismal suicide line” (154)? What causes deadly drug experimentation, and is there a certain point when intervention can and should occur?

I argue that is important to consider how certain circuits of experience are rewired, in part, by scientific translations of addiction and the medical and behavioral interventions that are informed by them. For now, let me say that the current vision of addiction as a chronic disease bears contradictions that are both enabling and disabling. It can indeed counter old, reductionist explanations of behavior or culture and potentially relieve the moral repercussions of “relapse,” the term preferred to describe the recurrence of drug use after a period of abstinence.

Etymologically, relapse denotes one who “slips again” and thus still carries the moral residue of other morally charged terms, such as regress or recidivism. Like drugs themselves, the framework of chronicity risks altering its own causality by insisting on a schema of return and repetition, whereby each return recapitulates a sense of inevitable demise. In addition, such a framing risks obfuscating other, perhaps more vital