UNIVERSITY OF CALIFORNIA SAN DIEGO

Investigating the Role of Cultural Environment in Addiction Treatment and Recovery in the United States-México Border Zone

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of Philosophy

in

Anthropology

by

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The Dissertation of Ellen Elizabeth Kozelka is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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ABSTRACT OF THE DISSERTATION

Investigating the Role of Cultural Environment in Addiction Treatment and Recovery in the United States-México Border Zone

by

Ellen Elizabeth Kozelka

Doctor of Philosophy in Anthropology

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Professor Thomas J. Csordas, Co-Chair
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This dissertation focuses on therapeutic experience in community-based (non-biomedical) drug addiction treatment in the United-States-Mexico border zone. Drawing on 18 months of ethnographic fieldwork in four residential rehabilitation centers (two faith-based and two 12-Step) in Tijuana, México, I analyze the therapeutic model and daily life in each center to understand how its distinct formulation of treatment guides inpatient efforts toward recovery. By

examining the complexities of social roles, stigma, and temporal experience, I devote careful attention to the convergences and divergences of community conceptualizations, institutional programming, and individual experience. I demonstrate that cultural conceptions of mental illness shape persons' self-identification as either healthy or ill, formatively influencing their engagement with the treatment process and efforts moving into recovery. My dissertation thus explores the range of therapeutic effects that occur within the same treatment model and their implications for anthropological theory and implementation science within global mental health practice.

INTRODUCTION

Fieldnotes- 12 July 2018
Alas de Esperanza[1]

I thought I saw a woman that looked exactly like Eva across the courtyard when I was washing paint off the steel table after an arts and crafts hour. I did not think much of this woman's resemblance to her, because I was too busy laughing at Aida's song choices. I had given her my phone (on airplane mode) so she could play whatever music she wanted while she helped me clean. Aida wasn't cleaning, but watching herself dance to Migos's "Walk it Like I Talk It" and Drake's "0 to 100/ The Catchup" in the reflection of the doctor's office door. She had just gotten a "fuckboy haircut" (buzzed on the sides with a few inches swooped in front of her eyes from the top) at the center's salon, and I could tell she was feeling her look. I went to put the box of paint in the supply closet, fumbling with my wallet as I tried to get my ID out to shimmy open the lock (the keys had been lost weeks ago); a woman walked up and removed the box of precariously balanced paints from my arms. It was Eva. "Don't say anything," she said. I didn't speak, but gave her a long hug, the box of paints between us. When we broke free, she said again, "Don't say anything. Yeah, I'm back." She then proceeded to sit in the supply closet and talk with me as I finished cleaning up. Eva had unexpectedly left the rehabilitation center with her parents in April, after her ex-boyfriend came to Alas with a police officer claiming they were married and she was being held against her will (she was never married to this man, and Eva suspected he had bribed the police officer). She told me she began drinking again and eventually using crystal[2] to cope with the latest traumatic events inflicted by her abusive ex-boyfriend. Her mother had tricked her into coming back to Alas by claiming they were going to Tijuana from San Diego to

[1] *Alas de Esperanza* (Wings of Hope) is a pseudonym, along with all other center and individual names, in accordance with UCSD IRB approval #140892.
[2] Crystal is a common way to refer to crystal methamphetamine in this ethnographic context.

visit a relative. While she told me this, her guilt and shame were palpable. I told her that I did not care she was back. She had had a tough year; it made sense that she would use again to try to cope. I told her I was just happy to see her[3]. Eva then told me she had been at the center since June 29th. When I asked why she had not come out to see me earlier, she said she was embarrassed. I told her she did not need to feel embarrassed with me, that it did not matter if she come to Alas 10 times. One time will be her last time; rehabilitation is a longer process for some people and she should not compare herself to others. She laughed and said, "You should tell them that," gesturing to the inpatient-guards milling around the courtyard. "But I want this to be my last time." There was a silence as I stuffed some extra paper into a box of miscellaneous craft supplies; then Eva said, "I love drinking. I don't think drinking itself is bad. But for me it is, because it opens the door to other drug use. I know that now...that I can't drink anymore."

This scene is indicative of life and therapy at Alas de Esperanza (Alas), a residential 12 Step rehabilitation center in Tijuana, México. The way Eva came to treatment and her subsequent interactions with other inpatients point to the ways moralized and stigmatizing conceptions of personhood from the broader cultural context shape community-based addiction treatment in the United States-México (US-MX) border zone. Further, despite spending many months living in Alas, Eva and many other women have divergent understandings of what drugs are, what constitutes addiction, the type of person who has it, and how it should be treated. Further, the center very much resembles a total institution, defined as "a place of residence and work where a large number of like-situated individuals, cut off from wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman 1961:xiii).

[3] Eva's ex-boyfriend had threatened her life several times; I was happy to see her alive, though I did not want to tell her that at the time.

However, everyday life there confounds this definition in many ways. Guards are also inpatients; people cannot be found despite the whole center existing in one house; rules are constantly broken, both with and without the knowledge of some staff; and the outside social world (including drugs) creeps in, even though the center is locked-door. Yet, the world inside Alas has a distinct logic. To not engage with total institutions as a defining element of experience there would not capture the institution's influence over daily life and therapeutic process. There are many moving parts to daily life and therapy at Alas, acting at times independently and others interdependently in ways that definitively shape the ways therapeutic process plays out for each individual.

This dissertation centers on the multiple and divergent, yet often overlapping framings of addiction, those who have it, how it should be treated, and what success looks like within community-based residential drug rehabilitation centers. As an interventionist total institution (Goffman 1961; Waldram 2012), community-based rehabilitation is characterized by various techniques of disciplining that shape the self and its healing transformations for individuals (Foucault 1977, 1978). Yet, attention to daily life in this setting reveals such techniques are not the sole determinant of either experience or self-transformation. Individual life histories, social support from outside the center, and social interactions within it further complicate life and therapy there. Inpatients play an active role in their treatment, questioning, accepting, altering, adapting, and resisting different elements, both during and after their time at Alas. My data suggest that each person's therapeutic process is diverse, shaped by their life before, during, and after inpatient treatment in ways that confound generalizations about any particular therapeutic model and reveal the co-constructed yet individualized nature of the healing experience in community-based addiction treatment.

DISSERTATION QUESTION AND GOAL:

In this dissertation, I ethnographically examine community-based, residential drug rehabilitation centers in Tijuana, México from both the institutional and inpatient perspective. My goal is two-pronged in that I seek to understand 1) the institutional conception of the problem "addiction," and its corresponding therapeutic model as well as 2) the first person experience of receiving community-based addiction treatment, particularly how the social organization and daily life within an interventionist total institution dynamically shape individuals' engagement with therapeutic process.

My driving question is simple, yet it reveals both the complexity and importance of understanding cultural ideas of health and illness, moral ideas of personhood, and the intersection of individual experience with structural forces. Throughout this dissertation, I explore the question: why are there such diverse experiences of treatment and recovery, even within the same community-based therapeutic model? By investigating the everyday interpersonal interactions in community-based rehabilitation centers, I examine the culturally shaped "give" in the structure of these total institutions (Rhodes 2004). I focus on the intersubjective nature of therapy, particularly the significant role that others play in any one person's treatment experience. I examine how the treatment model shapes not only therapeutic encounters in rehabilitation, but how shared experiences and interactions, both extraordinary and banal, in turn shape how treatment is experienced and interpreted for individuals. These interactions illuminate not only the human construction of these social establishments and their cultural environment, but also how they impact the subjectivity and self-transformations of those confined by them.

My dissertation's analysis focuses on the social categories incorporated into each center's

therapeutic model and how they mediate lived experience, often with drastic effects on individuals' understanding of, agreement with, and engagement in the therapeutic process. Thus, I aim to elucidate how healing occurs (or does not) in unexpected ways, especially when it challenges the prescribed narratives (Mattingly and Lawlor 2001) created by these interventionist total institutions. *I argue that in tandem with the biological components of addiction, inpatient experiences in treatment, shaped by their life histories and social support systems before entering and after leaving, influence their conceptions of addiction and recovery as well as their ability and desire to organize their lives in line with those conceptualizations.* Overall, my goal is to contribute to the claim that "addiction" is an individualized illness, as is the healing process of recovery. As such, available treatment options should be variable enough to match these flexible conceptions.

During my research, I focused my attention on daily life and therapy in community-based rehabilitation —in other words, I examined the complex, dynamic, and often indeterminant interactions of persons, therapeutic space, time in treatment, the border zone, and cultural conceptions of addiction that shape the nature of mental health interventions in context as well as how these are captured in global mental health (GMH) research and practice. These centers are in Tijuana, Mexico, and they provide services to persons throughout the US-MX border zone, making them a part of GMH practice. My work is not evaluative of the centers in which I conducted research; however, I aim for this dissertation to speak directly to those who do evaluate GMH interventions, making a case for both the necessity of including anthropology in GMH and implementation science as well as incorporating individual experience when attempting to understand, form, and evaluate community-based mental health treatment.

CRITICAL DEFINITIONS:

Before presenting my dissertation's theoretical triangulation, methodology, and analytical overview, I must provide a justification for the terms I will be using throughout this dissertation. There is considerable scholarly and popular debate as to their definitions, only emphasizing my argument that these terms are subjective and dynamic cultural framings, despite their structural and political power over people's lives. These terms relate to how to define the problem addiction, who has it, how it should be treated, and what counts as successful treatment.

To begin, the differing uses of the terms "drug" and "addiction" in popular culture and academic research foster ambiguity over their actual definition. For analytical clarity, I define drug as any psychoactive substance, both legal and illegal. This encompasses all manner of consumption, including oral ingestion, snorting, smoking, and intravenous injection. I use the term addiction, defined as a both treatable and chronic relapsing medical disease and biopsychosocial condition involving complex interactions among brain circuits, genetics, the environment, and an individual's life history. People who experience addiction may have physical and/or psychological dependence, and they use substances or engage in behaviors that become compulsive and often continue despite harmful social, economic, and personal consequences (this definition is an adapted version of the American Society for Addiction Medicine's 2019 definition). As Meyers (2013b:6) states, addiction "carr[ies] a tremendous moral and social weight, even in the aftermath of abuse." I follow Hammer et al (2012) in recognizing the unproductiveness and impossibility of creating a definition of addiction that will appease all perspectives (e.g. researchers, media, family members, policy makers, and care providers) on its nature (see Recke 2017 for a similar perspective on recovery). My definition maps onto Koob et al's (1998) neurobiological model of addiction and my participants'

understandings. Still, much of academia and the health sciences have moved away from using "addiction" in favor of "substance (ab)use" because of its stigmatizing nature. However, referring to the problem by a different name does not erase the stigma my participants experience in daily life, nor does it reflect their conceptualizations learned from experience and in treatment. They use the word addiction, even as they debate its meaning. Thus, I use addiction to reflect the nature of the treatment in which they are inundated. This debate is explored more thoroughly in Chapter One.

The term "drug addict" is also highly contested, not least because of its moralizing and stigmatizing connotations. Most public health researchers and harm reduction advocates have recommended using PWID (Persons Who Inject Drugs) or more generally persons who use drugs, as drug abusers tends to carry the same judgements as "addict." However, most of my participants refer to themselves as "addicts" and all of the centers as institutions refer to them as such (among other terms). I choose to use "addict" to reflect the reality of their sociocultural position.

Next, I must contextualize my use of "treatment." I understand treatment and therapy, following Csordas and Kleinman (1996:3), to be related to "the domain of active response to illness, disease, pain, suffering, and distress." This is an intentionally broad approach to understanding treatment. "Active response" encompasses everything from generalized experiences, like opening one's heart to a Higher Power in response to trying life conditions, to highly specific acts, like taking Advil to help mitigate a headache (Csordas and Kleinman 1996:3). Though the term "treatment" is most commonly associated with biomedical frameworks that apply evidence-based, "specific remed[ies] to a specific and limited problem," Csordas and Kleinman (1996:3-5) point out that this understanding is often paired with the assumption that

non-biomedical treatments are nonempirical. However, many anthropologists have outlined the systematic processes of observation and interpretation of symptoms that lead to non-biomedical forms of treatment (e.g. Ross et al 2012; Odgers Ortiz and Olivas Hernandez 2019; Csordas 1994b). Thus, community-based drug rehabilitation centers represent "treatment," because they outline a particular understanding of the problem addiction as well as formulate a method aimed at its solution. As such, I apply the term treatment to community-based forms of therapy in this dissertation. This allows me to develop a comparative framework of analysis for community-based therapies that exist alongside yet outside of biomedicine.

I also need to explain my use of the word "inpatient" in reference to my participants throughout this dissertation. The word commonly used in Spanish to refer to persons living in community-based treatment centers is *interno* or *interna*.[4] For this dissertation, inpatient is its closest English translation, but there is a significant difference in meaning. In English, inpatient has a strong connection to the biomedical world. In contrast, the word *interna* is not often used in medical contexts; but, it is used to generally refer to someone living in a closed environment, for example: a student in boarding school. The use of *interna* refers to the fact that persons in these community-based centers are in a locked/closed environment rather than their moral and medical identification as an addict. In other words, "inpatient" assumes a connection to a health issue, while this is not necessarily so for *interna*. The translational tension within the word *interna* represents and incapsulates the dynamic, competing cultural understandings of addiction as a biomedical health issue, a moral failing, or an element of an individual's essential nature that characterizes the cultural environment in this area of the US-MX border zone.

It is also important to note that no one term in English or in Spanish satisfactorily

[4] As the majority of my dissertation focuses on women, I will use the feminine form throughout this explanation.

encapsulates the variety of social categories applied to persons living in Tijuana's community-based rehabilitation centers. For example, women living at Alas de Esperanza are flexibly called *mariposa* (butterfly), *interna* (inpatient), and *adicta* (addict), by themselves and others, in both English and in Spanish. My participants also referred to themselves as "inmates" (only in English) at times. Each word is used in different contexts, and by different people (e.g. in 12 Step meetings women will refer to themselves and each other as addicts, the center psychologist will often refer to them as inpatients, and Valentina will refer to them as butterflies undergoing the healing process of recovery). These differences highlight the various social roles persons inhabit within therapy, even if they do not hold a service position. However, I choose to use inpatient throughout this dissertation for consistency and to highlight my participants' immersion in an interventionist total institution aimed at treating or addressing a particular problem. Further, because I focus on a particular population with cross-border experience (as will be discussed in the Sample section below), my participants understand themselves partially as patients who should be receiving treatment, not solely as sinners in need of redemption or addicts in need of insight about their nature in order to recognize their flaws, seek forgiveness, and transform into a productive member of their family and society. I recognize that inpatient is an imperfect term to encompass experience at Alas and other community-based centers in Tijuana. I use it in tandem with addict, *adicta*, *interna*, and *mariposa* (e.g. when those other terms represent the exact language of my participants) throughout my dissertation to highlight my participants' embeddedness in the treatment process as understood by each center.

"Recovery" is the final critical analytical concept for this dissertation. When its definition shifts, so do ideas of success in treatment. I follow White (2007:236) in defining recovery as "the experience (a process and a sustained status) through which individuals, families, and

communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life" (White 2007: 236). This definition recognizes the inherently biopsychosocial nature of addiction, as will be addressed in the following Theoretical Framing section. As such, my dissertation pays particular attention to when recovery starts, what it entails (e.g. its relation to full sobriety or only a person's drug of choice), and how it can be lost.

THEORETICAL FRAMINGS:

In this section, I provide an overview of the main theoretical framings that contextualize my analysis within this dissertation. It is intended as an synopsis that situates the theory presented more thoroughly in each analytical chapter. These framings are: 1) Global Mental Health: A Case for Sustained Incorporation of Anthropological Thought; 2) Moral Experience and Personhood within and beyond Total Institutions; and 3) Self, Subjectivity, and Healing Self-Transformations. To close, I briefly state how my dissertation both draws on and contributes to each theoretical domain.

Global Mental Health: A Case for Sustained Incorporation of Anthropological Thought

A Brief Overview of Global Health's Development and Commitment to Mental Health

Global health (GH) is a large interdisciplinary field, characterized by research and practice aimed at both improving health and access to care (Patel and Prince 2010). It emerged out of the fields of public and international health, representing a new philosophy of care focused

on the full scope of health issues, without limiting investigation and intervention to a particular geographic location. GH maintains the multi-disciplinary, population-based (as opposed to individual) and preventative care model of its predecessors, aimed at serving the structurally vulnerable and underserved populations by creating healthcare systems with the help of stakeholders (Koplan et al 2009:1993-4; Patel 2014). GH novelly marks the inclusion of curative and rehabilitative aspects of medicine and recognizes the formative influence of culture and structural forces for health in its serious inclusion of the social sciences (Napier et al 2014). Most importantly, use of the term "global health" marks a philosophical shift from paternalistic, hierarchical foreign aid to a collaborative engagement or "mutuality of real partnership, pooling of experience and knowledge, and a two-way flow between developed and developing countries" (Koplan et al 2009:1994-5). This inclusive expansion has also been applied to research and practice, including mental illness and other chronic noncommunicable diseases along with infectious diseases.

Global mental health (GMH) represents a newer subfield within GH, one in which research is rapidly proliferating, though not without controversy. It is the application of the principles of GH specifically to mental health (Patel and Prince 2010; Patel 2014). GMH has come to the forefront of GH in the twenty-first century (Sorel 2013; Becker and Kleinman 2013; Medina-Mora et al 2006) for which the declaration "no health without mental health" is increasingly recognized (Prince et al 2007). Such recognition stems from the global data citing mental disorders as the number one global burden of disease among non-communicable diseases, of which, addiction is considered one aspect of GMH (WHO 2014, 2005; Tol et al 2011). While healthcare systems typically separate mental, neurological, and substance (MNS) disorders, Patel et al (2015) have combined them because they all have a cyclical nature in relation to their

environment, they tend to manifest in areas of socioeconomic adversity and structural inequity, and when a person has an MNS disorder, they tend to fall in socioeconomic status (c.f. Wickam et al 2017). In this sense, interventions can be targeted at two different parts of this cycle: 1) the effect of poverty and precarious ecologies (Jenkins and Kozelka 2017) that create circumstances of higher risk as well as the social drift that occurs from stigma and discrimination or 2) the treatment of MNS conditions themselves, ranging from biomedical frameworks to religious and peer-based care. Because these disorders are so debilitating and chronic, Patel et al (2015) think that governments should commit to providing this care. Yet, one of the biggest reasons MNS packages of care have not been scaled up is poor political commitment and lack of mental health literacy.

Thus, the biggest push in the field of GMH is not just a financial commitment from governments, NGOs, community organizations, families, and individuals on issues of mental health, but a sustained effort to address all barriers to mental health and its care that set it apart from other aspects of health and well-being. As such, the goal and agenda for MNS disorders should be providing access to collaboratively understood, nondiscriminatory healthcare at all levels that can facilitate healing (Kleinman 1995) and positive social outcomes. GMH researchers and governments cannot expect mental health or any health intervention to consist of a singular, vertical format. They will differ depending on the area of MNS, the population, as well as the social, cultural, and historical context. As Bourgois notes, quantitative and qualitative researchers have much to offer each other theoretically and methodologically "to address how social power relations propagate illness in identifiable patterns across vulnerable populations" (2002:259). In this way, I position my research as a bridge between anthropological and GMH research in order to further both fields. By bringing together anthropological perspectives,

particularly the theoretical insights of psychological and medical anthropology, I hope to show how anthropological techniques can help researchers in a broader range of fields comprehend the multifarious complex of influences on GMH. The remainder of this section will focus on the need to include anthropological analysis in GMH research and practice, using addiction treatment as a case study.

Cultural Understandings of Health, Illness, Treatment, and Health-Seeking Behaviors

Anthropology represents a commitment to the study of culture and its importance to human life, despite the wide variety of methods anthropologists use to analyze it. I understand culture as a pervasive process at work in all aspects of human experience. It is "not a place or a people, not a fixed and coherent set of values, beliefs, or behaviors, but an orientation to being-in-the-world that is dynamically created and re-created in the process of social interaction and historical context" (Jenkins 2015: 9). As such, culture is a complex dynamic that is simultaneously experienced individually and upheld collectively.

Culture thus plays a significant role in our understanding of health and illness. For example, cultural conceptions of illness include ideas about nature, course, cause, treatment, moral status of the afflicted, illness-related stigma, and personal responsibility of the ill (Jenkins 2015: 254-5). In his foundational piece "How Medicine Constructs its Objects," Byron J. Good (1994) focuses on the "formative processes" of biomedicine, which are formulated, constituted and constructed, in a culturally distinct way. As he describes, the formative processes of culture include symbolic forms that are the content or objectified *things* of culture (like science, religion, and medicine), which act as functions of personal experience and sociocultural reality. These things, these formative processes, are only really understood "in action," or as they play out in

everyday life (c.f. Brodwin 2013). The diverse and culturally particular ways in which the body and knowledge of it are shaped, experienced, and understood are the focus of this anthropological analysis of community-based addiction treatment.

Cultural conceptions of addiction and the social category "drug addict," like other dimensions of health and mental health, are complex because they incorporate both biological and sociocultural processes (Good et al 2011; Hruschka et al 2005; Johansen and Johansen 2015; Jenkins 2015; Hammer et al 2012; Myers 2015; Barrett 1996; Good 2010; Kleinman 2010; Stack Sullivan 1953). Though the scientific community has sought to explain drug addiction as a medical problem since the 1960s (Garcia 2010:13; Jenkins 1991:155), the conception of addiction as a moral, individual problem persists (Gideonse 2015; Carr 2011; Harris 2015; Zigon 2011; Saris 2008; Garcia 2008). Culture shapes ideas of the problem addiction and what drugs are considered problematic. In other words, a drug's social history is what separates drug addiction from therapeutic application of psychopharmaceuticals. Yet, the line between legal and illegal is cultural and always arbitrary because it divides a continuum (Saris 2010:211). As Canguilhem (1991:34) notes, medical notions of "the normal" and "the pathological" are not unbiased; like social categories, they are based on dynamic, hegemonic forms of knowledge (Ralph 2014; Singer and Page 2014). This complex nature can be seen in the cultural formulation of social institutions dedicated to address social problems like addiction.

One key focus of anthropological research that has furthered medical theory is the element of care in the treatment process. Annemarie Mol's The Logic of Care interrogates the moralistic weight of the current biomedical/GH systems' Western-centric "logic of choice," unsettling its assumptions of the individual (and familial and communal) role in defining and guiding treatment as well as the healing processes. Biehl and Locke (2010) remind us that the

content of care is itself contextually shaped. Similarly, Jenkins's (1991:140) formative piece on the state construction of affect discusses the role of the state in constructing the political ethos, or "the culturally standardized organization of feeling and sentiment pertaining to the social domains of power and interest." She shows how institutions (political, religious, medical, etc.) shape culture and, in turn, the self. In this way, we must always pay attention to the structural and communal influences upon care, for instance, the state's role in defining who needs care, when they need care, and why they need care.

Sociocultural conceptions of illness and disease shape not only health seeking behaviors, treatment, and its subjective experience, but the social categories understood to have the problem. The social category "drug addict" is necessarily linked to the cultural definition of the disease drug addiction. Its general connotations are negative and moralistic, associating addicts with recklessness, selfishness, lack of self-control, and anti-social behavior—i.e. lying, stealing, and interpersonal violence (Bourgois and Schonberg 2009; Garcia 2010; Gideonse 2015; Glassner 2012; White 2014; Meyers 2013b; Singer and Page 2014). In the US-MX border zone, this social category takes a unique slant to also be associated with narco violence and illegal migration (Campbell 2005; Campos 2012). Culturally shaped communal conceptions of problems, like addiction, and their associated social category, like "drug addict," are part of the cultural environment. Thus, I investigate how the cultural environment in the US-MX border influences the various designs of interventionist total institutions created to address the social problem of addiction.

There are many models of drug rehabilitation within the US-MX border zone; perhaps the most well-known is the biomedical model, in which addiction is a chronic disease process with a treatment that is both long term and only partially effective (Garcia 2008). Another

frequently studied model of treatment is Narcotic Anonymous/Alcoholics Anonymous (NA/AA) (Kaskutas 2009; Brandes 2002). It incorporates the Twelve Steps, which emphasizes individual choice and personal power over addiction (Swora 2004; Alcoholics Anonymous Worldwide Services 1952). This uneasy balance between the notion that personal choices or will aid in overcoming addiction and the disease model is a tension within this model of treatment. A lesser studied model of treatment in the social sciences is the faith-based model (Hood 2011, 2012; Hansen 2005, 2018; O'Neill 2019), In this ethnographic context the faith-based model is evangelical, and it understands addiction as the consequence of being closed off to God. To begin this type of treatment, the drug addict must themselves open their heart to God/Jesus in order to allow Him to enter and change the addict (Kozelka 2015; Odgers-Ortiz and Campos-Delgado 2014; Galaviz 2016; Odgers Ortiz and Olivas Hernández 2018). This study examines the ways different models of community-based non-biomedical drug rehabilitation centers purposively organize treatment in their controlled environment (the rehabilitation center as interventionist total institution) around specific cultural conceptions of addiction and the social category "drug addict."

The role of the anthropologist is to contribute to the "polyphonic understandings of collective behavior and human suffering and to engage in the complex discourses that surround" them (Waldram 2012:ix). Thus, I engage seriously with the therapeutic models of community-based, nonbiomedical addiction treatment as understood by the institution and inpatients. This enables insight into the framework of illness; from there, one can comprehend its development into a myriad of healing pathways. These are based on the individual inpatient's interaction with the therapeutic framework (acceptance, refusal, or something in between). My goal is to "resist simple, reductive explanations" of the social problems associated with addiction and the personal

failings attributed to drug addicts as well as their potential for change (Hinton 2005: 4). I hope by providing the context of lives in treatment (Carpenter-Song et al 2007), my readers and I can better understand the often equally painful and hopeful struggle (Jenkins 2015) for recovery.

Moral Experience and Personhood within and beyond Total Institutions

Throughout this dissertation I use Goffman's (1961) conception of the total institution to frame my analysis of therapy within Tijuana's community-based rehabilitation centers. I choose this model, over others, such as Foucault's biopower (1978) or pastoral power (1980) primarily because of the conditions in the centers in which I work. Inpatients are "cut off from society for an appreciable period of time" (Goffman 1961:xiii) to accomplish the goal of rehabilitation. This specific goal of rehabilitation is also what makes these centers *interventionist* total institutions (Waldram 2012). Nevertheless, to analyze these centers through a Foucauldian lens would bring limited novel insight. Garcia (2010; 2015) has already thoroughly explored similar centers both in Mexico and the United States in this way. I seek to expand understanding of inpatient experience within such centers, specifically the co-construction of therapeutic process and its implications for recovery. To do so, I examine cultural ideas of personhood, stigma, and their influence on experience. Following Jenkins (2015:9), I understand experience as "the encounter with the real phenomena of self, others, and the world as this encounter is lived out in the actions and events of everyday life." In this way, I examine interactions in treatment to understand their connections to and influence on therapeutic experience in community based rehabilitation.

First Person Perspectives for Illness and Treatment Experience in Total Institutions

While it may seem obvious that total institutions as a particular type of social

establishment are directed beyond the individual level, my goal in engaging with total institutions is meant to throw into sharp relief how culturally shaped social conceptions form a feedback loop with structural forces to shape individual experience (Ralph 2014; Contreras 2013; Farmer 2003, 1990). I seek to understand what it is like to be in treatment for persons in Tijuana's community based drug rehabilitation centers, because "*how* they experience treatment very much affects what they gain from it" (Waldram 2012:x).

Including first person perspectives of compulsory addiction treatment is essential to understand therapeutic process, especially instances of compulsion or violence. This allows researchers to remain "experience near," documenting "what an individual might naturally and effortlessly use to define what he or his fellows see, feel, think, imagine" (Geertz 1984:28) instead of imposing "experience distant" analytic categories that obscure persons' own conceptualizations of the treatment and the healing process (Jenkins and Barrett 2004:7-8). Methodologically, then, experience near ethnography (Kleinman and Kleinman 1991) provides the method through which we can examine the first person perspectives of therapeutic process.

This is especially important in community-based addiction treatment in Tijuana (and globally), due to the ongoing legal and ethical debates on coerced, locked treatment (Tanguay et al 2015; UN Joint Statement 2012; Bergenstrom and Vumbaca 2017). Urbanoski (2010:1-2) calls for more research on the effects of coercion from the client's perspective; she argues that current policies and treatment practices have been directed by the "implicit assumption of the effectiveness of coercive treatment." Yet, the majority of GMH researchers have denounced compulsory treatment as unequivocally detrimental and a violation of human rights (Wegman et al. 2017; Werb et al. 2016a). There is considerable bleeding between the porous boundaries of voluntary and involuntary total institutions, and it stems from their social orientation (Hejtmanek

2015) as well as their legality (Garcia 2015). Like Bartlett (2018), I engage specifically with first person perspectives of treatment so as to understand from inpatients' points of view, whether or not particular treatment modalities are helpful (including compulsory treatment). This insight, I argue, is the best foundation for subsequently improving care provision for addiction.

Temporality and Healing: Connecting Treatment Experience with Recovery Experience

Time, as a socioculturally shaped dimension of human activity, provides organizational structure to life (Fabian 1983; Bakhtin 2006[1981]). Time becomes qualitatively different in interventionist total institutions. It is objectified into sentences or remaining treatment time (Reed 2003; Hejtmanek 2015). Past, present, and future are no longer seamlessly connected, they are discrete units marked as before, during, and after treatment, each of which is experienced differently (Read 2003:92-6). As such, understanding time in treatment is a particularly important, because, as I will explore, its experience formatively shapes subjectivity and self-transformations (Kuiper 2015; Cooper 2015; Jeffrey 2010; Fraser 2006; Meyers 2013a; McWade 2015; Kemp 2009; Klingemann 2000). In this dissertation, I investigate how different experiences of time in treatment may ultimately shape possible addiction and recovery trajectories.

Time and space are intimately and experientially linked, particularly in total institutions; however, space as a domain of subjectivity must be individually addressed. These rehabilitation centers, as total interventionist institutions are designed to control every aspect of daily life. Many researchers have studied interventionist total institutions as spaces of constraint that still have considerably fluid social interaction with the outside world (Hejtmanek 2015; Waldram 2012; Garcia 2010; Rhodes 2004). However, this focus must be extended to investigate how

culturally shaped social conceptions of problems like addiction enter into this type of space and direct action there, creating what Goffman calls a "natural experiment[5] on what can be done to the self" (1961:12). Locked rehabilitation is a liminal space (Turner 1967), between healing and healed, characterized by a focus on what a person is waiting to do as an indicator of who they have become. In this way, the imaginative process of what is possible (Parish 2008) will be a good indicator of how a particular inpatient understands themselves and their future prospects once their period of waiting has concluded. Understanding the variations of experience in these different centers requires a recognition of how various cultural conceptions of addiction and the social category "drug addict" influence treatment in each particular space.

An important goal of the time spent in treatment is to catalyze the healing process. Healing is an "elemental social function" and a "form of symbolic action" (Kleinman 2010:87). Analyzing it represents a different approach to conceptualizing medicine than those who focus on its biophysical aspects. Csordas (1988) outlines the need to approach studying healing via therapeutic process in order to include incremental effects. In various works, Csordas has outlined the distinction between therapeutic procedure (who does what to whom); process (the nature of participants' experience (changes/insights/of emotions, thoughts, behaviors), and outcome (final state of participants in terms of satisfaction, both positive and negative with healing and change in symptoms or functioning) as different analytical points at which one can study the phenomenological process of healing (Csordas 1988, 1994; Csordas and Kleinman 1996).

The study of therapeutic process necessarily includes the experience of persons, and there are many avenues through which one can investigate it. Many scholars have engaged with

[5] Goffman uses the phrase "natural experiment" as a foil to controlled experimental conditions.

therapeutic process by examining inpatient narratives of treatment (Mattingly and Garro 2000; Carr 2011; Kaiser et al 2019; Kleinman 1988). I do not explicitly engage with inpatient testimonies in relation to the evangelical or NA/AA therapeutic model; my Colef colleagues have already done this (Garcia Hernández 2018). I focus on examining the intersubjective nature of therapy, particularly the significant role others play in any one person's treatment experience and healing process. Because healing is so often studied and discussed as either successful or failing, scholars have not defined efficacy in a way that allows for partial, incremental, or inconclusive results (Csordas 1988, 1994). But when one attends to the interactions and experiences during the therapeutic process, this type of incremental healing comes up all the time. If understood as a healing process, deconstructing community-based rehabilitation's therapeutic procedure could reveal the aims of healing, both bodily and spiritually.

Understanding how conceptions of addiction and the social category drug addict are conceptualized, both within the center and outside it, during treatment and after it, will help contextualize the cultural environment in which inpatients are trying to heal. Though the experience of treatment and recovery may often be lonely and painful (as well as fatal for some), it is a deeply social process. In this way, Livingston (2012) argues that the anthropology of value conjoins the biopolitical, social, ethical, and human in medicine, further highlighting the ethics of healthcare systems. Her work illustrates "how care proceeds amid uncertainty in contexts of relative scarcity" (Livingston 2012:6). This is comparable to the political economic focus on anthropological research within GMH, which is paving the way to understand why addiction is so widespread in the US-MX border zone as well as how politics and the economy influence illness and treatment trajectories (Good 1997). Waldram terms studying this the anthropology of therapeutic intervention, referring to "health-related contexts in which there is a largely

unwelcome intrusion into the life world of the patient" typically because 1) they do not recognize or accept that they have a problem, 2) they recognize they have a problem but do not think they need treatment or the particular type of treatment offered, or 3) they are incapable of offering a viewpoint, either cognitively or legally (2012:235). There are social and legal power/authority structures that establish the right to intervene on the grounds of what is best for both the individual, their family, and society. I view an anthropology of therapeutic intervention as seeking to understand the cultural processes at all levels (structural, interpersonal, individual) of these dynamics. In combining the study of therapeutic procedure with therapeutic process (inpatient experience of treatment and recovery), I seek to gain insight into how the healing process becomes both the embodiment of cultural idea(l)s and the site of its (often painful) contestation.

This contestation comes to light most clearly outside the centers, in recovery. Recovery is a "polyvalent concept" (Pilgrim 2009:475 in McWade2015:244) that alludes to cultural ideas of cure, healing, social norms, and in the case of rehabilitation, who the 'drug addict' is and what their possibilities for the future are. The future can be conceived or conceptualized by the individual as a horizon, which is either opened or closed; the future either holds coherence, promise, and a life worth living, or it holds an arresting uncertainty (Csordas and Jenkins, in press). This dissertation seeks to contribute to the anthropology of therapeutic process by drawing out analytically the experience of healing through time, both in rehabilitation centers and outside of them. I seek to highlight the diversity of inpatient experience; in connecting this diversity with first person perspectives of success, failure, or something in between, this dissertation will speak to the dynamism and individualism of illness and healing experiences, despite their erasure by generalized and generalizing cultural framings.

Moral Experience and Personhood

Just as all forms of medicine have culture, they also have a system of morals. One of the most important pieces on this topic is Georges Canguilhem's The Normal and the Pathological (1991). He describes how medical systems typically include culturally based and morally defined assumptions about who contracts certain diseases or falls ill, how one should interact with treatment, and what particular categories of people will (and will not) do well in treatment or with healing. This has a significant impact on the way care is provided and its relationship to therapeutic process and outcome. "Healing is not the outcome of diagnostic acts, but the healing function is active from the outset in the way illness is perceived and the experience of illness organized" (Kleinman 2010:86). Medical systems help shape the experience of illness by incorporating cultural conceptions of what counts as illness and disease, informing what can be expected for treatment and healing.

I chose to examine the polyphonic understandings of addiction, its treatment, and recovery based on my firm belief that as moral, social beings striving for "the good life," (Mattingly 2014) we must understand how individuals in community-based addiction treatment understand themselves and their experiences as well as how those experiences are shaped by their ever broadening spheres of influence. The intended "cumulative effect" of treatment is to create a new sense of morality and to make inpatients contributing members of society through an inherently ethical process of "habilitation," or the transformative (not restorative) process meant to "inculcate in others, through the overt use of power and control, that which we most admire or wish to emulate morally, ethically, and socially, and to do so by glossing over the complexities of human sociality to make being moral seem as unambiguous as possible" (Waldram 2012:225).

Persons exist in "moralized social worlds" (Waldram 2012:ix) in which we not only see ourselves as moral but question and evaluate the morality of others. I follow Taylor's definition of person as "a being who has a sense of self, has a notion of the future and the past, and can hold values and make choices" (1985:97). To be or count as a person, one must have both one's own point of view and the ability to communicate it intersubjectively (Parish 2014). This is especially important because social conceptions of addiction and "drug addicts" shapes who within a given society is understood as having value and personhood (Desjarlais 2000). Inpatients struggle not with the uncertainty of addiction, but with its fixity (Garcia 2010:18; Jackson 2005) and its aspersions to their moral personhood. As such, I study moral experience of treatment in relation to personhood.

The term experience, however, represents a problematic for anthropologists. Kleinman and Kleinman (1991) originally used the term experience because it had less discursive baggage than concepts like affect or self. Others (Desjarlais 1994; Jackson 1989) use it because it addresses something more immediate than discourse. Desjarlais wants to understand the essence of experience, while Good (1994) thinks that it conceptually exceeds symbolic form, or language. Yet, one must acknowledge the dynamism of experience; it changes and accrues, and it is more than its parts or a coherently structured narrative of events. "[E]xperience is too complex, too subtle, and too private to be understood through anything but phenomenological assessments" (Desjarlais 1994:888). I argue experience can be investigated by attending to the stories, metaphors, expressions, and social formations though which it manifests in everyday life. In directly examining how conceptions of addiction and those who have it shape ideas of personhood in community-based addiction treatment, I attend to its moral experience from the

first person perspective. This will provide insight into how therapeutic models shape self, subjectivity, and their transformations.

Self, Subjectivity, and Healing Self Transformations

Subjectivity is a broad category that, depending on its definition, leads to very different methodological and theoretical works. I understand subjectivity to be the "relatively durable structure of experience that is yet subject to transformation based on changing circumstances and modes of engaging the world" (Jenkins 2015: 9-10). Subjectivity thus represents the experience of thinking and feeling through one's existential condition (Biehl 2007:14). Jenkins (1991) explores, through her work with Salvadoran women, how subjectivity intersects with broader social processes. Her analysis of their sub-threshold distress, or as she describes, "extraordinary conditions" shows us how being or becoming in extraordinary conditions is "just like everyone else only more so" (Jenkins 2015:257). The enormous complexity of self, person, and subjectivity as well as their interrelation and interaction with the (human interactional) environment in community-based addiction treatment will be the focus of my analysis in this dissertation.

Though the self has been defined as practice (Ortner 1984) or a set of characteristics or elements (Quinn 2006), "it" is not an entity. The self is a series of culturally constituted orientations to 1) itself (self-awareness), 2) other objects (non-self), 3) spatiotemporal aspects, 4) motivational aspects, and 5) normative aspects of a society as they are discerned, classified, and conceptualized from within it (Hallowell 1955). Hollan uses "scapes" following Appaduri (1990) to acknowledge both the intra and inter-self terrain that the self-system must map and from which a dynamic, contingent self constantly emerges in the whole person. He defines selfscape

as “the self-system’s implicit moment by moment mapping of its own representations of its own past embodied experiences onto the space and time of the contemporary, culturally constituted world” (Hollan 2014:182). Individuals literally bring social categories to life through their unique time, place, and embodied experience. Thus, I understand the self to be “an indeterminate capacity to engage or become oriented in the world, characterized by effort and reflexivity” which emerges through a constant feedback loop of culturally constituted social worlds and “pre-reflexive bodily experience” (Csordas 1994:5). In other words, orientational self processes constitute the self. In this dissertation, I examine the ways in which community-based treatment institutions and the experience of treatment, along with the positions offered to inpatients within them, mediate lived experience and shape self-transformations (see Haas 2012; Hejtmanek 2015; Rhodes 1991, 2004 for similar explorations within different institutions).

METHODOLOGY:

Fieldwork for this dissertation was conducted over the course of two three-month pilot studies in 2014 and 2015 as well as an 18-month period from April 2017-September 2018. The pilot studies represented part of my graduate training as a member of the broader research team from El Colegio de la Frontera Notre (Colef) on the project “Religious Therapeutic Offerings: Evangelical Rehabilitation Centers for Drug Dependents” directed by Dr. Olga Odgers Ortiz in collaboration with UCSD faculty Dr. Thomas J. Csordas and Dr. Janis H. Jenkins.

I engaged in data collection at four rehabilitation centers: 1) Nueva Vida en Dios, an all-male evangelical rehabilitation center, 2) Nueva Vida en Dios para Mujeres, an all-female evangelical rehabilitation center, 3) Pasos para Recuperación, an all-male 12 Step rehabilitation center; and 4) Alas de Esperanza, an all-female 12 Step rehabilitation center. I established a

working relationship with each of these centers as a member of Dr. Odgers Ortiz's research team. Through these connections I was able to secure permission from each center's director to recruit participants over the age of 18 who had been in the center for at least two weeks (i.e. inpatients out of each center's detoxification stage). The majority of this dissertation will focus on the center Alas de Esperanza and the women there, as will be explained in the Data Analysis Justification section.

It is important to note how the centers for this study were selected as well as how they relate to the broader Colef project. When I joined the Colef project in 2014, the team was already in the second phase of the study. In the first phase, the research team conducted a comprehensive review of all treatment centers operating throughout Tijuana and Baja California Norte (this is detailed in Odgers and Olivas 2018). In this primary phase, study members identified systematic and ethical problems at many centers, akin to those outlined by other research teams in Tijuana (e.g. Lozano-Verduzco et al 2016a,b; Syvertsen et al 2010; Rafful et al 2019)). Dr. Odgers and the Colef team ultimately decided to focus analysis in phase two on examining the different models of community-based treatment; in so doing, the team narrowed research to centers that provided exemplary cases for how a particular therapeutic model could work (e.g. evangelical, 12 Step, etc.). As such, when I joined the project, the centers included in the study had already been narrowed down to exclude any highly problematic centers that engaged in human rights abuses. Further, all are registered with the Baja California Department of Health and meet minimum compliance regulations under Norma Oficial Mexicana-028 (NOM-028). I then chose to include these four centers in my study in order to have a comprehensive view of exemplary evangelical and 12 Step treatment for men and women.

In the pilot studies for this dissertation, research was conducted exclusively within the rehabilitation centers Nueva Vida, Nueva Vida Para Mujeres, and Pasos para Recuperación, though I made initial contact with Alas de Esperanza during the 2015 pilot study. For the 18-month period, research was conducted both in all four rehabilitation centers (described below) and inpatient home neighborhoods. I returned to all three centers from my pilot research and engaged in participant observation there as well as follow-up interviews with center workers. However, due to the recruitment criteria of my study (see below), many participants at the time I began my extended fieldwork were at Alas de Esperanza. Further, significant ethnographic and analytical attention had already been directed at treatment experience in Nueva Vida, Nueva Vida para Mujeres, and Pasos Para Recuperación by the Colef research team (Galaviz 2016; Odgers Ortiz and Galaviz 2016; García Hernández 2014). After consultation with my dissertation chairs, I decided to focus data collection at Alas de Esperanza. More details on this will be provided in the Data Analysis Justification section below.

Recruitment

Participants were recruited from all four centers in two main categories 1) inpatients and 2) center workers. Inpatients were recruited based on their internment at one of the study centers and international experience. I enrolled both voluntarily and involuntarily committed inpatients to examine if and how this difference reflected particular cultural conceptions of addiction and shaped the experience of treatment. I specifically wanted to focus on persons with cross-border experience and those whose substance use could not be treated biomedically (i.e. drugs for which there are no pharmacological substitutes or medically assisted treatments). As such, I recruited inpatient participants of both US and MX nationalities who had spent at least one year living

and/or working in the US who reported methamphetamine as either their drug of choice or one of their main drugs of choice. Center workers were recruited based on their knowledge of the center, its history, and treatment process.

I used purposive, multilevel, multistage sampling (Onwuegbuzie and Leech 2007), a form of non-probability sampling that allowed me to select, as a multilevel project, participants that "facilitate credible comparisons of two or more subgroups that are extracted from different levels of study," for example, inpatients and center workers (Onwuegbuzie and Leech 2007:240). As a purposive multi-stage project, I also selected individuals that represented multiple treatment stages (Onwuegbuzie and Collins 2007:285). Because the actual time in treatment varied for each inpatient and inpatients entered the center irregularly rather than in distinct cohorts, I recruited continuously and at difference stages of treatment (i.e. immediately after detox, after one month in the center, etc.) to ensure I could follow inpatients after their time at the center. Thus, my sampling methods allowed me to feasibly study a diverse group of participants intensively, despite them being at different stages of treatment.

I approached women at Alas de Esperanza through two main methods. The first was through the arts and crafts class that I ran at the center during my fieldwork. After the 1-2 hour long arts and crafts class, I often sat in the living areas of the house, as a means to both observe daily life and make myself available to those who had questions about the project. In talking with women during the art class, if they seemed to meet study criteria, I would invite them to listen to my IRB-approved recruitment materials. The second method I used to recruit new inpatients was the snowball sampling technique (Onwuegbuzie and Collins 2007). I asked already enrolled inpatient participants to recruit willing and eligible new inpatients, so potential participants could hear from a fellow inpatient about the project without me present, in order not to pressure

participation. Once they came to me, I then presented the study materials and explained the project, obtaining their consent before enrolling them in the study.

I was acutely aware of the power dynamics of conducting research as an affluent white woman in a locked, Mexican rehabilitation center. In order to not pressure participation, I never interviewed participants on the same day that I recruited them. Further, I never went to the sleeping areas of the house without being invited by a participant and I always asked other inpatients to ask participants if they wanted to be interviewed on any given day. In this way, I tried to create a system that reduced the pressure for inpatients to participate in interviews when they did not want to and a way in which they could decline interviews (e.g. telling a fellow inpatient to tell me they were asleep or could not be found within the house of roughly 80 women).

Sample

The total sample in this study included 90 participants. Of those, 57 met study criteria and are included in this dissertation. There were 39 female and 18 male participants. Their ages ranged from 19 to 64, based on IRB stipulations that all participants be over the age of 18. The sample is divided into two main categories: inpatients and center workers.

There are 47 inpatient participants[6]. There were 6 participants from Nueva Vida, 4 participants from Nueva Vida para Mujeres, and 7 participants from Pasos Para Recuperación. The largest subset of participants was 30 females from Alas de Esperanza. Their ages ranged from 19 to 48. The majority of analysis focuses on Alas de Esperanza participants, as will be discussed in the Data Analysis Justification section.

[6] Though all center inpatients in some way shaped participant observation, and the arts and crafts class I ran was not limited to study participants, they are not included in the overall participant count.

The total number of center worker participants was 10. These represent staff from each center that were in no way active inpatients in any of the centers, though most (N=9) identify as being in recovery. I interviewed every center's director as well as their assistant director. For some, I was able to interview another member of staff. However, the majority of center workers at each center were simultaneously inpatients, and are thus included under the inpatient participant sample. This phenomenon is given significant attention in Chapter Two. In this study, I recruited 2 center worker participants from Nueva Vida, 2 from Nueva Vida para Mujeres, 3 from Pasos Para Recuperación, and 3 from Alas de Esperanza. The first chapter of this dissertation draws on my interviews with center workers.

Methods of Data Collection

Semi-Structured Ethnographic Interviews with Center Workers

Semi-structured interviews which consisted of "predetermined questions related to domains of interest" were conducted with all center worker participants of the study (Schensul, Schensul, & LeCompte 1999:149). These interviews were aimed at collecting data on the cultural conceptions of addiction and the social category "drug addict," the understanding of the rehabilitation center's particular treatment model, and experiences working in that particular center. As such, the key points of reference in these interviews were: how their particular center understands the problem of addiction; who they see as generally using their services (i.e. the typical inpatient); conceptions of how treatment at the center operates; opinions on what type of person is successful with treatment; how they individually understand the underlying problem of addiction and the social category "drug addict"; as well as their perceptions and experiences of working in a rehabilitation center. They were only asked to provide information about their

opinion of and generalized experiences with the rehabilitation process. I did not solicit any information or opinions about specific inpatient study participants.

Center worker interviews were conducted one to two times with each participant, lasting from 30 minutes-2 hours. The analysis of these data with inpatient interview data allowed insight into the disjunctures between the institutional formation and understanding of treatment.

Semi-Structured Ethnographic Interviews with Inpatients

Semi-structured, thematic interviews were conducted with inpatients, ranging from 20 minutes to 2 hours in length. The key points of reference in these interviews were: how they feel they are perceived at the center; how they understand addiction and the social category "drug addict," including if and how they fit into it; how the center operates; their opinion on its policies, particularly if they aid or hinder the treatment process; their plans for after treatment; and transnational experience as it impacts treatment.

Regular follow-up interviews were conducted with each inpatient during their time at the center, for a total of 2-6 interviews for each inpatient at Alas de Esperanza, depending on their length of stay in treatment. This allowed me to get a sense of how inpatient treatment experience changed over time, particularly how different elements of social life or treatment gained or lost salience. These interviews contributed to analysis of how institutional life and broader social structures shape experience, therapeutic process, self, and self-transformation.

Person-Centered Interviews with Inpatients

Person-Centered Interviews represent a methodological attempt to collect experience near data of human behavior (LeVine 1982; Levy and Hollan 2014). Hollan describes this method as

offering “a powerful way of grounding social, psychological, and even biological theories of human behavior in lived experience of real people” (2001:62). Methodologically, it seeks to understand participants as both an informant of social conceptions and a respondent of personal perceptions and experiences to better understand the formation of person in sociocultural context (Levy and Hollan 2014:316).

After establishing sufficient rapport with inpatient participants (Briggs 1986), I asked them to participate in Person-Centered Interviews. These interviews were in depth, lasting 30 minutes-3 hours. They were open-ended, allowing participants to discuss whatever they felt contributed to their experience, before or during treatment. This methodology allowed the interviews to capture any important but unforeseen influence upon the experience of treatment from the first person perspective of inpatients.

Follow-up Semi-Structured Ethnographic Interviews with Inpatients

I also conducted follow-up semi-structured ethnographic interviews with inpatient participants after they completed treatment and left the center. These interviews were done only with participants from Alas de Esperanza. Of the 30 inpatients participants, I was able to establish contact post-treatment contact with 16 and interview 10.

These interviews focused on re-adjustment to life outside the center and their “in recovery” relationship to drugs. The post-treatment interviews were fit into the participants’ schedule. They were conducted in person in participants’ home neighborhoods (ranging from Tijuana and San Diego, to Orange County, Los Angeles and San Francisco), over the phone, via Facebook video chat, and in one case over Facebook Chat. These interviews lasted 1-2 hours.

Focus Groups with Inpatients

Focus groups are a type of semi-structured group interview that "capitalizes on communication between research participants" (Kitzinger 1995). They are commonly used in research studies examining conceptions of illness and disease as well as experiences with health services (Murray et al 1994). This method of interviewing is founded on the idea that in group settings, though participants will answer the questions individually, they interact with a group of their peers, exploring and clarifying their position in relation to social/group conceptions (Tong et al 2007:351).

I conducted focus group interviews with inpatients in groups of 2-6 participants. At Alas de Esperanza I conducted 39 focus groups, ranging from 45 minutes to 3 hours in length. The topics of the focus groups centered on cultural conceptions of addiction and the social category "drug addict," drug use, the rehabilitation process (including but not limited to detoxification and relapse), opinions of the center and its policies, and transnational experience as it impacts treatment. However, these were open-ended, and conversations were often directed to experiences of daily life, coping with loss and trauma (e.g. the end of romantic relationships, coming to terms with and healing from abuse prior to entering Alas), center gossip (e.g. who was in an illicit romantic relationship, drugs entering the center, etc.), center worker grievances (e.g. strained relationships with front-office workers), and family problems with treatment (e.g. frustration with having to stay in the center longer than planned).

Zimbardo Time Perception Inventory with Inpatients

The ZTPI is an accredited questionnaire created by Dr. Phillip Zimbardo and Dr. John Boyd at Stanford University (Zimbardo and Boyd 1999). It is not experimental; it is simply an

individual differences metric. It consists of 56 statements about time which participants rate their agreement by choosing a number 1 through 5. It takes approximately 20 minutes to administer. I recruited inpatients to complete this inventory during their first semi-structured interview. I will use this data, in combination with interview and EPO data to examine if and how variations in time perceptions are associated with certain conceptions of addiction and the social category "drug addict" as well as structure interpersonal interactions.[7]

Ethnographic Participant Observation

I used Ethnographic Participant Observation (EPO) to document how cultural conceptions entered into the flow of inpatients' daily lives in the space of the center and shape the nature of their engagement with the treatment process. I conducted EPO by spending 5-10 hours per week participating in work time, rest time, group therapy meetings, evangelical services, Bible studies, Zumba classes, watching TV with inpatients, etc. Though I took some notes during participant-observation, I did not want notetaking to distract me from observing. Therefore, at the end of each day of fieldwork, I audio-recorded each day's events.

Individual interviews were conducted in either English or Spanish, based on the preference of each participant. Focus group interviews were conducted primarily in English. However, in both individual interviews and focus group interviews, participants fluidly switched between languages, as is common along México's northern border. Interviews and were audio-recorded, reviewed, and transcribed. There were two instances in which participants declined to have certain interviews recorded. In these cases, I took detailed hand-written notes. Audio-recorded

[7] This data is not examined in this dissertation; it will be addressed in future, forthcoming works.

fieldnotes were reviewed and summarized in an excel sheet listing its main points. All files were kept on a UCSD-run encrypted, password-protected server. Any physical documents were kept in a locked filing cabinet without identifying participation information.

DATA ANALYSIS JUSTIFICATION:

Though data was collected at four rehabilitation centers over the course of my pilot and extended dissertation fieldwork, the majority of my analysis will focus on Alas de Esperanza, an all-female 12 step center. There are several reasons for this. First, due to US and MX cultural norms about inter-sex confiding, I was able to establish much better rapport with my female participants. Second, the Colef team (Odgers and Olivas 2018), including myself (Kozelka 2015), has devoted significant time and analytical attention to evangelical treatment. Finally, there is a dearth of research not only on women's experience in community-based, residential drug rehabilitation but even less of ethnically Mexican women (Baker and Carson 1999; Tuchman 2010; Weeks et al 2008; Valdez et al 2000; Campbell and Ettorre 2011). After consultation with my dissertation committee chairs, I chose to focus on my female participants from Alas de Esperanza to increase scholarly knowledge on the conceptions of addiction and treatment, health seeking behaviors, and treatment trajectories for ethnically Mexican women in 12 Step community-based centers.

The analyses in the following chapters draw from a mix of data sources, including individual interviews, focus groups, participant-observation, and discussion with Colef team members.

ETHNOGRAPHIC CONTEXT:

Two main contextual features shape the nature of this ethnographic project. The first is the US-MX border zone. Tijuana is the largest Mexican border city, and it has long been a destination for US residents seeking more affordable healthcare, from prescriptions and dental care to surgery and addiction treatment. Further, nearly one third of all US deportees are repatriated to MX through Baja California, with half of them passing through Tijuana. Deported persons and/or "returned migrants[8]" (Duncan 2015) on the Mexican side of the border have a high risk for certain mental health conditions, like depression, and an even higher risk for engaging in risky health practices, like injection (or other) drug use (Brouwer et al 2009; Strathdee et al 2008). Forsaken "drug addicts," (Singer and Page 2014), best exemplified by those living in El Bordo (the Tijuana River canal) (Woldenberg 2013) have recently been the focus of police action (Goldenberg et al 2010; Werb et al 2016b; see also NOM-028). This entails rounding up the homeless, the recently deported, the socially isolated, and the economically destitute living in El Bordo (only a fraction of whom are "drug addicts") and then forcibly taking them to jail or a drug rehabilitation center. Tijuanense officials have described the proliferation of community-based drug rehabilitation institutions as a public health effort to clean up the city, and they have been funding centers registered through the Department of Health (Syversten et al 2010).

The second contextual feature relevant to this dissertation is the local knowledge and implementation of Mexico's addiction treatment law Normal Oficial Mexicana-028-SSA2-2009 (NOM-028). According to Mexican law (NOM-028), it is possible for family members to commit other family members against their will. This requires some relatively easy paperwork.

[8] Returned migrants, following Duncan (2015), refers to migrants who have been "voluntarily" deported to Mexico from the United States or who have returned willingly.

Nearly 50% of all internments in all evangelical and NA/AA centers sampled in the proposed project's umbrella study were involuntarily committed (Odgers Ortíz 2015). Further, unlike the majority of rehabilitation centers in the US, rehabilitation centers in Tijuana (and MX more generally) are locked. Standard commitment periods last for a minimum of three months and range anywhere after that to a year or more, though persons can leave treatment early, with the consent of the family member who committed them.

Thus, the knowledge of community-based centers, their locked status, and their varying therapeutic models has created a cross-border health-seeking phenomenon, directed not from MX to the US, but from the US to MX. As a GMH phenomenon, this trend in health-seeking behaviors, I argue, provides insight in the necessity to understand cultural conceptions of health. This dissertation's focus on culturally-shaped conceptions of health, illness, and treatment, will illuminate the implications of this trend for community-based, residential addiction treatment.

CHAPTER ORGANIZATION AND OVERVIEW:

Chapter One gives further details of the ethnographic context in which this study was conducted. It provides an in-depth analysis of the cultural conceptions of addiction in the California-Baja California area of the US-MX border zone as well as their implications for the formation of therapeutic procedure at every center from my study. In presenting the institutional conceptions of inpatients, addiction, and treatment, I argue communal understandings of health and illness shape both health-seeking behaviors and available treatment options. These multivalent conceptions must be taken into account when evaluating the efficacy of all available treatment options, not just community-based methodologies. This chapter lays the groundwork for the following three chapters' specific analysis of inpatient treatment experience and recovery

trajectories at Alas de Esperanza.

Chapter Two explores the specific institutional position and therapeutic experience of inpatient-guards at Alas de Esperanza. By examining everyday interactions and extraordinary circumstances from an experience-near perspective, this chapter expands the theoretical conception of Goffman's total institution and engages with the broader GMH debates on compulsory, community-based addiction treatment. I argue that first-person perspectives of care within community-based treatment and beyond reveal the dynamic nature of therapeutic process, and the need to engage seriously in understanding a therapeutic model, before condemning it. This chapter has been formatted as an article, and it is currently under revisions with Medical Anthropology Quarterly.

Chapter Three focuses on the specific elements of stigma and moral experience to examine self-transformation within the treatment model at Alas de Esperanza. I explore how the center's therapeutic model draws on conceptions of moral personhood, thus incorporating stigma into therapeutic process. Despite inpatients' agentive work to heal in treatment, stigmatized conceptions of addiction follow them into treatment, weaving into the very fabric of therapeutic procedure. By focusing on the notion of "valuing" as a therapeutic goal, I examine the complex ways stigma and depersonalization affect self-transformations in treatment. Yet, by also exploring how inpatients negotiate whether or not they are ready to leave locked treatment, I discuss the agentive role they play in pushing back on the depersonalization associated with the category "drug addict."

Chapter Four represents a culmination of the previous three chapters. Using case studies of three women who spent time at Alas de Esperanza, I engage with the temporality of healing in compulsory community-based treatment, and how, like stigma, the experience of time plays a

significant role in shaping the self-transformations that occur through community-based addiction treatment. I specifically discuss the notion of hope and its relation to the horizons of possibility in the face of different familial, social, and structural forces. In presenting snapshots of each woman's addiction trajectory, I question whether recovery can or should have a singular definition. Thus, I make an argument for analytical attention to imperfect, ambiguous healing trajectories as a way to better understand the long-term experience of addiction treatment.

My dissertation ends with a concluding note on the individual nature of addiction, treatment experience, and recovery. I reflect on the contributions this dissertation makes to both anthropological theory and global mental health practice, specifically implementation science. Finally, I address this study's limitations and identify trajectories for future research.

CHAPTER 1
HOW CULTIVATED CULTURAL CONCEPTIONS ALONG THE UNITED STATES-MEXICO BORDER SHAPE TREATMENT PROCEDURE IN TIJUANA'S COMMUNITY-BASED DRUG REHABILITATION CENTERS

INTRODUCTION:

Tijuana's community-based, non-biomedical centers offer an alternative treatment modality to biomedical centers, similar to Ross, Timura, and Maupin's (2012) findings comparing Mexican popular[9] health conceptions and health-seeking behaviors for traditional medicine versus "western" treatments. In Mexico, other treatment models for addiction (alternative, mutual aid (*ayuda mutua*), and mixed methods) are legally recognized in national drug policy NOM-028-SSA2, monitored by state-level Departments of Health, and in some cases publicly funded. Galaviz and Odgers (2014) point out that the Mexican government tacitly prioritizes biomedical modes of treatment; yet, infrastructure to provide such treatment is currently insufficient (Duncan 2017). Persons throughout Mexico, and particularly along the California-Baja California (C-BC) area of the US-MX border zone, have recognized this need and responded to it with their own treatment institutions. These centers are very often religious or spiritual, reflecting the multiplicity of cultural conceptions surrounding the problem "addiction,"[10] those who have it, and how it should be treated within this cultural mixing zone of the US-MX border.

The Mexican State actively avoids confronting the intermingling of church and state in these types of centers, forestalling open dialogue about how differing conceptions of the problem and those afflicted with it shape the guiding therapeutic principles of these publicly funded centers. It also obscures how treatment within them is experienced (Galaviz and Odgers 2014;

[9] Here I use "popular" to mean "of the people," following the Spanish-language use of the word.
[10] In each chapter of this dissertation, "drug addict," "addiction," "addict," and "recovery" appear in quotes at their first use to signify their cultural construction and contested definitions.

Odgers Ortiz and Olivas Hernandez 2019). Openly engaging with cultural conceptions of health issues like addiction and its treatment, that traverse the "biomedicine-alternative medicine" divide, will allow researchers, practitioners, government officials, community members, and inpatients to understand the different forms of knowledge[11] that can either aid or harm treatment at the individual level. Otherwise, practitioners and policy makers risk allowing alternative modeled treatments to remain a black box, minus certain baseline human rights considerations. By presenting different perspectives of the problem drug addiction, its associated social category, "drug addict," and the proper method to treat both the condition and category as understood by four community-based treatment centers, I demonstrate the ways cultural environment[12] shapes health-seeking behaviors and therapeutic procedure in the Tijuana-San Diego border zone.

In this chapter, I investigate how community-based therapeutic models, which are shaped by broader conceptions from the cultural environment yet institutionally and individually interpreted, are enacted in therapeutic procedure and everyday discussions about treatment and inpatients in all four centers from my dissertation research. The effects of the therapeutic environment on inpatient subjectivity and personhood have implications for both individuals' treatment experience and "recovery" trajectories, as will be explored throughout this dissertation.

INVESTIGATING CULTURAL CONCEPTIONS OF ILLNESS AND THEIR RELATIONSHIP TO HEALTH SEEKING BEHAVIORS:

Psychological and Medical Anthropology have a long history of investigating cultural

[11] These different forms of knowledge range from the illness experience of the current and formerly addicted to religious experience and/or religious healing. These are particularly relevant for understanding treatment for substances that have no pharmacological replacement therapy, such as methamphetamine.
[12] I define the cultural environment as the specific and dynamic constellation of conceptions, morals, practices, and institutions that exist in particular times and spaces.

conceptions of mental health and illness as well as their relationship to health-seeking behaviors (Edgerton 1966; Jenkins 1988a,b). Cultural conceptions of health are the "common sense" knowledge used to interpret experience (White and Marsella 1982). Often referred to as "illness experience" (Kleinman 1988), idioms of distress (Nichter 1981; Kaiser et al 2015) or "explanatory models of illness," (Kleinman 1981) these conceptions shape both the types of treatment persons seek out and their diagnosis by practitioners. For example, Good (1994) discusses the culturally particular ways in which the body and knowledge of it are shaped, experienced, and understood through the lens of medical students in a teaching hospital in the United States. He shows how the standards enacted within this system, though arbitrary, are governed by a certain set of moral norms for action (c.f. Good 1995). This process of creating a culture of medicine, particularly what counts as sickness and how it should be treated, occurs within all medical systems and especially in areas and instances of medical pluralism, such as Mexico's northern border (Odgers Ortiz and Olivas Hernandez 2019).

As such, it is important to understand the multiple and competing sources of cultural knowledge that shape ideas of health, illness, necessary/appropriate treatment, and successful treatment. Chua's (2012:226) work on the "register of complaint" deftly outlines the "social processes, power relations, and material exigencies that shape the work of diagnosis" for psychiatric illness. Her case studies show that relationships of power emerge both in the way illness complaints are expressed as well as their interpretation into diagnosis. Both complaints and diagnoses come into being through creative improvisations of meaning that are hard to predict, yet draw on local, moral, and gendered concepts of person. Similarly, Duncan (2017) explores how cultural conceptions of mental illness and its treatment are often framed as a barrier to appropriate mental health care. Yet, Boonmongkon et al's (2010) analysis of

reproductive tract infections from patient and epidemiological perspectives demonstrates why ethno-models of illness and disease must be recognized for high-quality, specific health interventions as well as generally high-quality care systems. To meet the health needs of women or anyone seeking care, "both the 'demand' side (women's health concerns) and 'supply' side (effective medical treatment) of health care provision need to be addressed simultaneously" (Boonmongkon et al 2010:435). If, as Hansen (2013) describes, conceptions of the problem and who has it shapes societal response (particularly available treatment options) then, as I argue, it would follow that these conceptions also shape the therapeutic model within those available options.

Culture shapes ideas of the problem glossed as "addiction," which has always been a problematic social and scholarly concept, due to its moralistic connotations (White 2014). Its understanding typically includes assumptions about who contracts certain diseases or falls ill, how one should interact with treatment, and what particular categories of people will (and will not) do well in treatment or with healing (Singer and Page 2014; Knight 2015). Communal conceptions of addiction and drug addicts must be understood, because sociocultural conceptions of illness and disease shape health seeking behaviors, treatment options, treatment experience, and its "afterlife" (Meyers 2013b). Like other dimensions of health and mental health, cultural conceptions of etiology, those afflicted, and treatment processes are diverse because they incorporate both biological and sociocultural elements (Hruschka et al 2005; Johansen and Johansen 2015; Jenkins 2015; Hammer et al 2012; Lende 2005). This complex nature can be seen in the diverse cultural formulation of the social institutions dedicated to addressing the social problem of "addiction" in Tijuana. I analyze how the cultural environment coalesces to create particular therapeutic environments in Tijuana's drug rehabilitation centers, revealing the

power social conceptions and institutions have in shaping ideas of personhood, subjectivity, and self-transformation.[13]

CONTEXTUALIZING CONCEPTIONS OF ADDICTION AND ITS TREATMENT IN THE C-BC BORDER ZONE:

The US-MX border zone is a critical contextual feature to community-based addiction treatment in Tijuana that must be recognized in relation to the development of different therapeutic models. Duncan (2015:24) defines transnational disorders as "disorders that are experienced, produced, and sometimes treated within the national borders of more than one country." Addiction and its treatment in Tijuana will be treated as such in this chapter; understanding this cross-border phenomenon and its linkages to the cultural environment is imperative to comprehending and ultimately improving individual treatment experience and recovery trajectories.

Though intersected by the international border, San Diego, California and Tijuana, Baja California form a contiguous urban and cultural environment. Tijuana is the largest Mexican border city and has the busiest land border crossing in the Western Hemisphere (Brouwer et al 2009), with many people living and working on opposite sides of the political border. In spite of the increasingly racialized sociopolitical and economic tensions within the border zone's cultural environment (and within both countries in general), an estimated 10% of the Mexican population lives in the US, with the highest concentration in California (Alarcón et al 2016; Hernandez et al 2009). Although Mexican (im)migrants contribute immensely to California's work force through labor and taxes, they are more likely than any other ethnic group to live in poverty and have less

[13] This chapter lays the groundwork for the examinations of personhood, subjectivity, and self-transformation that comprise the remainder of this dissertation.

access to health care, including drug addiction treatment (Viruell-Fuentes et al 2012; Sabo et al 2014), despite the growing need for access. Tijuana is a major port of entry for illegal drugs into the United States, so drugs are omnipresent in this border zone (Medina-Mora and Real 2013). This affects persons on both sides of the border. Over the past ten years, illegal drug use has risen to nearly 10% among persons aged 18-34 in México, and the state of Baja California has the second highest percentage of reported illegal drug use in the past year (Instituto Nacional de Psiquiatría 2017:52; 68). In San Diego, heroin and methamphetamine use is on the rise; 377 persons died in methamphetamine-related incidents in 2016, compared to 311 in 2015 (Methamphetamine Strike Force 2017; Wagner 2014). In the city of San Diego, arrests and citations for methamphetamine use increased from 2,309 in 2015 to 3,409 in 2018 (Hargrove and Dorman 2019).

Contemporary and historical sociopolitical and economic concerns shape both the cultural environment and community understandings of issues like drug addiction and its treatment throughout the border zone. The health seeking behaviors of individuals and their families for addiction treatment options similarly transcend the political border. There have been 118 articles in San Diego Union-Tribune covering drug addicts, addiction, and its treatment in the US-MX border zone from January 2000-July 2017 and 202 in the Los Angeles Times in the same date range, signaling its omnipresent concern in the area. Various groups of people living in the San Diego-Tijuana region have overlapping, though dynamic and distinct cultural conceptions about drug addiction, persons considered drug addicts, and what treatment should entail. For instance, while 60% of the Mexican population surveyed in 2008 thought that persons who use drugs need help, 50% did not consider drug addiction to be a disease (Secretaría de Salud 2008: 71). Persons living in the US have similar negative attitudes towards addiction and

drug addicts. Barry et al (2014:1270) found persons surveyed across the US reported high acceptability for discrimination (for housing and jobs); desire for social distance (e.g. persons do not want addicts to marry into their family); high doubt that available treatment is effective; and high opposition to policies aimed to support medical and social services for addicts. Mexican and Usonian attitudes towards addiction reflect a cultural ambivalence to the framing of addiction as either a treatable disease or a moral failing. This is significantly influenced by the War on Drugs, race, and class differences of those affected (c.f. Hansen 2017). These competing conceptualizations of addiction may be contributing to the prolific spread of non-biomedical, community-based, alternative (evangelical) and mutual aid (12 Step) drug rehabilitation centers in Tijuana, with inpatients from both sides of the border.

An interdisciplinary research team led by Olga Odgers Ortiz completed a telephone survey of 141 drug rehabilitation centers in Tijuana in 2013 (Odgers and Olivas 2018:14). This survey found 91% of the centers contacted identified themselves as either spiritual or religious, though this boundary was fluid. Based on their requirement to recognize a higher power, 64.5% of the centers identified as 12 Step, while 28% identified as explicitly religious, specifically evangelical (Odgers and Olivas 2018: 14). Only 8.55% identified as secular, clinical rehabilitation centers (Odgers and Olivas 2018: 14; Galaviz and Odgers 2014). While all treatment types are available in Tijuana, especially if one considers the vast number of unregistered centers outlined elsewhere (e.g. Lozano-Verduzco et al 2016a,b; Syvertsen et al 2010; Rafful et al 2019), the majority of treatment options are non-biomedical, community-based, and significantly incorporate spirituality or religiosity.

Persons or their families choose community-based drug rehabilitation centers in Tijuana for diverse reasons. Many ethnically Mexican people living in the US-MX border zone cannot

afford treatment in expensive biomedical centers for themselves or their family members.[14] Though socioeconomic reasons should not be discounted, persons and families may be seeking treatment at community-based centers for other reasons as well, including that they think community-based therapeutic models better match their or their loved one's "problem." For example, 50.2% (over 36 million) of Mexican persons surveyed thought "special farms for addicts far from the city" were the most effective form of rehabilitation while only 20% thought psychiatric care was most effective (Secretaría de Salud 2008:73). Further, inpatient drug rehabilitation centers in the US are for the most part open; inpatients in the US can leave even after they have checked in for care. In Mexico, however, addiction treatment is most often locked (Odgers and Olivas 2018). If a family member commits another family member to addiction treatment (with the approval of a physician), they cannot leave until the treatment period, typically three months, is complete or on the approval of the family member who committed them (see NOM-028-SSA2). As addiction typically manifests as chronically relapsing in course, families throughout California that are aware of Mexico's differing treatment laws very often consider Tijuana's community-based rehabilitation centers a more viable option. This decision is not taken lightly, as some families have mixed immigration status. Those deported through Tijuana may lack the social support to shelter themselves, let alone address any problematic drug use; they may also find themselves brought to community-based centers by police (Werb et al 2016b). Others may believe religious treatment offers a better solution to addiction, while biomedical models only replace one drug dependence with another. Still others may think that immersion in a community of support for their addiction is the best option for recovery. These

[14] A detailed account of the structural forces influencing their socioeconomic status is beyond the scope of this chapter.

diverse motivations are reflected in the therapeutic models at religious and spiritual centers in Tijuana that I worked with for this project.

EXPLORING THERAPEUTIC PROCEDURE IN FOUR COMMUNITY-BASED CENTERS:

Therapeutic models of community-based drug rehabilitation and their institutional organization of everyday life reveal salient cultural understandings of addiction, its treatment, and those who require it. Here, I present the institutional model for each center I collaborated with from the point of view of its high-level staff. These conversations outlining each center's therapeutic procedure provide insight into the cultural conceptions of drug addicts and addiction that shape both treatment there and ideas of recovery

Each center has a generally negative impression of the inpatient when they first enter rehabilitation. For them, new inpatients have a major flaw that has disrupted not only their lives but the lives of those in their social network enough that they needed to be committed (either voluntarily or involuntarily). The goal of treatment at each rehabilitation center is to rectify this main flaw. However, what this flaw is differs, changing the construction of treatment and its goal; in this way, I show that the particular formulations of therapy are not value-neutral, but laden with specific moralized meanings from the US-MX cultural environment.

Pasos Para Recuperación

Pasos Para Recuperación (Pasos) is an all-male, locked Narcotics Anonymous/ Alcoholics Anonymous (NA/AA) modeled rehabilitation center. Located in one of the oldest colonies in Tijuana, Pasos is self-contained within a building that covers roughly a Tijuana city

block. The director founded the center in 2000 after growing tired of visiting his three brothers in different rehabilitation centers. The building that Pasos now occupies used to be a shooting gallery[15]; during my fieldwork it was home to roughly 220 inpatients on any given day.

The philosophy of Pasos is modeled off of NA/AA, which recognizes all inpatients as drug addicts; this is a permanent condition that must be managed. Though therapy there has been modelled after the 12 Steps, it has a distinctly Mexican feel to it (Brandes 2002; Odgers and Olivas 2018; Kozelka 2018; Rodríguez Mascareño 2018). In the reception room, there is a model ship with the NA flag on a shelf right next to an altar to the Virgin Mary. Pasos is not directly affiliated with any one religious denomination; different religious groups (e.g. Jehovah's Witnesses, evangelical groups, and a Catholic nun) come to speak at the center, often during scheduled 12 Step meetings. Center workers recognize that religion can help inpatients achieve the goal of learning how to recognize, surrender to, and subsequently manage their addictive nature. However, religion is just an aid to the greater goal of rehabilitation: to restore inpatients' social and familial relationships. The object of care here is about more than the "drug addict" inpatient. At Pasos, the goal of rehabilitation is to help inpatients recognize and become the person they should be (or should have been) for their family and society.

Time spent at Pasos provides inpatients the opportunity to organize their lives accordingly. Marla, one of the administrators at Pasos, in discussing why the center invites different churches to come speak, said religion helps provide structure to inpatients' lives. However, she distinguished what Pasos did from evangelical centers. "Here we bring Christians, Catholics, Mormons, and Jehovah's Witnesses. We are open to whatever religion you want to

[15] A "shooting gallery" is a location where people can purchase, prepare, and consume drugs.

practice."[16] Indeed, there was an introductory book of religions sitting at the reception desk that I often flipped through while I sat there. It included Buddhism, Hinduism, and Sikhism, among other religions more commonly practiced in México, like Catholicism. The spirituality imbued in NA/AA combined with the implicit religiosity of its Mexican iteration does indeed create a unique environment for the incremental process of rehabilitation as healing at Pasos.

Focusing on familial, social ties as a means to catalyze recovery from addiction is meant to be a positive treatment method and is experienced as such for many inpatients at Pasos. However, the cultural conception of addicts behind this method may be less inviting. In the context of the involuntary intake procedure as it transitions into treatment, both Marla and Alejandro (a guard and office worker) illuminate how Pasos as an institution views incoming inpatients. Marla describes drug addicts as so selfishly engrossed in their own drug use that they will not listen to their families' attempts to help them. Thus, families must enlist the center's help to involuntarily commit their family member. Alejandro, a front office worker, describes this process as dangerous, "especially if they're with their homies, man. Five guys from the center [will] go to get him, and they've had guns pulled on them, or they've had to break down doors. One guy even got hit in the face with a bat and lost all his teeth." This violent intake procedure recalls not only what Garcia (2015) has outlined as a traumatic mirroring of the violence surrounding drug trafficking, but parallels Fraser's (2006) argument that the organization of treatment and its accompanying practices may actually reproduce the kinds of subjects that are considered undesirable (in this case stereotypically violent drug addicts). Intake procedures at Pasos not only reflect center workers' ideas about an incoming inpatient and how they should be treated, but intake also shapes how inpatients come to learn how the institution perceives them.

[16] Interviews for this project were conducted in both Spanish and English. When Spanish was spoken, I will provide it alongside the English translation.

As soon as a man arrives at Pasos, difficult though this process may be, he is immediately introduced to the institution's conception of him. For example, Pasos is not equipped to provide care to persons who have co-occurring serious mental illness along with their addiction. They only have a doctor and psychologist visit the center; a psychiatrist does not come to the house. Receptionists conduct an intake interview to determine what kind of drug the person used, for how long, how often, and why. When I asked Marla, the center's administrator what would happen if someone was admitted to Pasos and then it was discovered they had a serious psychiatric illness, her response reflects broader cultural conceptions of addicts.

> I'll call the doctor, and he'll tell us if the man—many times, with drugs, he will be very agitated or act like a person who, well, has a psychiatric issue. [Yo va llamar al medico, y nos va decir si el muchacho—muchas veces, por la droga, está muy agitado o está actuando como unas personas pues ya psiquiátricos.]

Drugs, in other words, make people act "crazy," to the point that they might be comparable to someone experiencing psychosis. She went on to explain that men will often act "crazy" in order to be released from the center. This conversation highlights both the cultural idea that drug addicts "act crazy" and that addicts are liars that cannot be trusted to truthfully describe their own mental state or their need for treatment.

Almost immediately, intake coordinators begin questioning why the new inpatient would put his family through this sort of ordeal. Further, Alejandro and Patricio (a former inpatient who now works as a receptionist at Pasos) both confirm that the two mandatory NA/AA model meetings a day usually revolve around family obligations, what inpatient drug use has done to their family, or how they will help their family when they leave Pasos. From the moment new inpatients arrive at the center, they are subjected to the institution's conception of who they are (a selfish "drug addict") and what they must learn to do in order to be cured (recognize their selfishness and continually work to maintain this change for their family). Accepting their

"addict" nature in perpetuity is the first step to changing for their families and society at Pasos. Daily life and therapy at Pasos are organized around this goal. They must work constantly towards their rehabilitation, and meetings with religious groups and 12 Step meetings are meant to help inpatients navigate this. Much of their free time is also dedicated to *servicios*, or house service that is also meant to help inpatients realize a way they can financially contribute to their families after they leave the center. The therapeutic procedure at Pasos represents one particular way that ideas about drug addicts and addiction from the cultural environment shape treatment procedure in community-based rehabilitation.

Nueva Vida en Dios

Nueva Vida en Dios (Nueva Vida) is a large, locked, all-male evangelical rehabilitation center located in the southern desert outskirts of Tijuana. The center's location makes it difficult to get electricity or water, but it is a sprawling complex that houses roughly 100 inpatients. It began in 1980 with the help of Pastor Roberto, a recovering alcoholic. Pastor Roberto is a transnational man; he attended University of California Los Angeles in the 1970s, earning a Bachelor's degree in Psychology. While there, he found Jesus, which allowed him to quit drinking "cold turkey." After serving in the United States Army, he experienced a calling from God to come back to Tijuana and help other addicts like himself. At first, Pastor Roberto joined an evangelical church in the process of setting up a rehabilitation center; but, when the church had financial difficulties, he took on the project himself. For the first four years he lived at the center alongside inpatients. Nueva Vida's therapeutic model has become so successful that according to Pastor Roberto, there are 16 other related centers in different Mexican states.

Pastor Roberto's main idea for treatment at the center is very similar to what he experienced in Los Angeles. It is a faith-based rehabilitation center, founded on the necessity that persons have a relationship with Jesus Christ and the Bible. "Here, we try not to emphasize religion. We just emphasize God, Jesus, and the Bible." He claims that his goal is just to share Jesus; people do not have to accept the message. He believes that at Nueva Vida, men have the opportunity to experience the power of God so they can overcome a bigger power: their addiction. Pastor Roberto has modeled his center around the image of the inpatient as sinner, whose sinfulness manifests itself through drug use. They inhabit the category drug addict as an indirect result of their sinful, worldly acts. To be successful in this particular treatment model, inpatients must be born again and form a personal relationship with Jesus.

Drug rehabilitation is, in fact, only an indirect result of time spent at Nueva Vida. Which is why, when asked, center workers refer to Nueva Vida as a spiritual regeneration center instead of a drug rehabilitation center, "regardless of what the sign outside the center says." As Nueva Vida's assistant director Benjamin stated in our very first interview: "secular programs can get you clean, but they do not change you. A relationship with God, fostered though a Christian rehab program like Nueva Vida, changes you completely and allows you to begin again." It is where inpatients come to know Jesus and change their sinful ways, as well as where they become persons of Christ who no longer need to do drugs. Once this happens, they will have realized their true nature, and no longer need to fill the hole in their heart that Jesus is meant to occupy with drugs. They will have returned to the righteous path of God from which they had strayed. In other words, time spent at Nueva Vida is not devoted to or understood by center workers as drug addiction treatment specifically nor is it understood as primarily meant to cure those in the social category "drug addict." It is a place for spiritual regeneration where sinners can find Jesus and

begin a new, good, and moral life with God. The cure to their addiction or sin, is a side effect of their spiritual rebirth.

However, getting sinners to begin their new life with God can be a difficult process. Pastor Roberto explained why involuntary commitments are sometimes necessary, revealing how Nueva Vida views inpatients.

> E: And can families petition people, or petition the center for men or women[17] to come involuntarily?
>
> PR: Yeah, some families bring their sons and daughters involuntarily. You know, they have a problem and they are alone, you know, they steal everything. If [their family] have ah, 10 dollars, they [the addict] steal it. And if they want a hamburger or something, they steal it.
>
> E: Yeah. Is there a difference do you think, between those people in the center and the people who come voluntarily?
>
> PR: Yeah. Sometimes at first, we have to kind of watch over 'em [involuntary inpatients], some of the guys we have to watch over them. They wanna take off, ya know. They wanna leave, they wanna leave. But eventually, they just, they just stop.

Here we see some of the stereotypes associated with drug addicts. They steal and have no qualms about it, because they are selfishly only thinking of themselves, not their families. To Pastor Roberto and Nueva Vida, this is a direct result of not knowing Jesus. They commit sins like stealing because they are selfishly trying to fill the hole in their heart that Jesus usually occupies with worldly things; since they do not know Jesus, they attempt to fill it with drugs or maybe fast food. According to Pastor Roberto, however, this does not work. Without Jesus, inpatients have a void that they attempt to fill at any cost, to the detriment of their families. Often, though, their families recognize their sins and the problems it causes them; so, they try to help their family member even if they do not want it.

[17] As mentioned in the introduction and in the following section, Pasto Roberto is also the director of an all-female evangelical center Nueva Vida en Dios para Mujeres.

These stereotypes also explain why inpatients try to leave at first as well as why the center is organized as a locked institution. Inpatients need to be watched over because they are not, at least in the beginning, committed to their own spiritual rebirth. They still do not know Jesus, and as long as they are locked into the center, they cannot get the drugs that temporarily and partially abate the feeling of incompleteness that comes from ignorance of Jesus. Until they come to know Him, inpatients will continue to attempt to "take off" and "fill the hole in their heart with drugs." Therefore, they must be watched, lest they attempt to escape.

What this therapeutic model entails is much different than what is offered at either biomedical or 12 Step centers. Benjamin outlines what constitutes therapy at Nueva Vida:

> "When [inpatients] understand the Word of God, they begin to [forget] drugs. We are not doctors, we are not therapists, we use Christ-therapy. It is the Word of God" ["Eh, cuando ellos entienden la Palabra de Dios, comienzan [olvidar] de las drogas. No somos medicamentos, no somos terapias, lo que usamos es christoterapía, es la Palabra de Díos."]

The treatment inpatients receive at Nueva Vida is not biomedical nor does it draw on any other form of mundane therapy. Nueva Vida uses Christ-therapy; it is based exclusively on repeatedly hearing the Word of God. Though inpatients may have heard it before, when they finally hear it and understand, they are changed. And it is through that change that inpatients forget drugs and embark on their new life with God.

Like inpatients at Pasos who must constantly work to stay "clean" in recovery, those at Nueva Vida must work constantly to maintain the results of their spiritual regeneration. Graduated inpatients are strongly encouraged to either begin an affiliated rehabilitation center in another state of Mexico or proselytize in Tijuana, particularly to the downtrodden sinners of El Bordo, passing along referrals to Nueva Vida when necessary. Sharing their story can spread hope for others' salvation as well as remind themselves of the dangers of straying from God's

Path. Thus, treatment at Nueva Vida teaches inpatients that their flaw is a sinful focus on the mundane world and the pleasures within it. Then, after the process of spiritual rebirth, therapy at Nueva Vida shows inpatients that they may contribute to society by saving other sinners afflicted with their same sinful focus on the worldly pleasure of drug use. The sinner-addicts at Nueva Vida represent a different crystallization of the cultural environment into therapeutic procedure for community-based drug rehabilitation in Tijuana.

Nueva Vida en Dios Para Mujeres

Nueva Vida en Dios Para Mujeres (Nueva Vida Mujeres) is the all-female, locked faith-based rehabilitation center associated with Nueva Vida en Dios. Located down the hill from Nueva Vida en Dios, the complex is much smaller, and there are considerably fewer inpatients. During my fieldwork there were 20-27 women living at the Nueva Vida Mujeres compound surrounded by a chain-link fence topped with barbed wire (they had also begun planting cacti along the fence to further deter inpatients trying to leave). Inside the complex, there are similar types of buildings as those at the men's center like a kitchen, cafeteria, and several dormitories. However, the guardhouse with its male guard is located outside the fence, while the reception building with its female reception workers is located inside the fenced complex. There are several other buildings outside the center that the women can live in after they have graduated from their treatment program, but they do not feel like they are ready to go back to Tijuana or the world outside the center. Their children are not allowed to come with them to the center, but they may come visit on Saturdays and Sundays.

Nueva Vida Mujeres was founded in 2000, much later than Nueva Vida en Dios. Though the nominal director is Pastor Roberto, it is in effect directed by his wife, Laura. This center is

run on a nearly identical philosophy to Nueva Vida en Dios, with slightly more attention paid to the inpatients' gendered roles as mothers (Gowan and Trevino 1998) and their need to return to caring for their children. Their overall conceptualization of treatment, specifically christoterapía, is the same. The difference is represented in the gendered role "good" women are meant to fill within their families (Lagarde 2003). In a focus group interview with the front office staff at Nueva Vida Mujeres, Ana Maria, the center director's daughter, described how treatment there compares to other centers:

> The Word of God is what helps here—Christ-therapy. We don't use bodily [treatment]. Though we have physical help for detox, we treat the soul, because we say here if—if we don't help or cure the soul, the soul will go back to the same thing. [Aquí es ayuda de la Palabra de Díos- la christoterapía. Pero no nos usamos [tratamiento] físico, ayuda física para detoxicarse, nosotros tratamos con el alma porque decimos aquí si el alma-- no se ayuda no se cura, alma vamos a volver a lo mismo.]

Here we see the mirroring of the focus on the Word of God as the main form of therapy, as well as the notion that if treatment does not focus on the soul, sinner-addicts will continue to try to fill the hole in their heart with mundane pleasures. In other words, they will go back to the very thing that is clouding their ability to from a relationship with Jesus —drugs.

As Velázquez Fernández (2018) has outlined, daily life and treatment at Nueva Vida Mujeres is completely organized through its religiosity. After inpatients pass through the early phases of treatment and are cleansed of all drugs (intake and detox), inpatients begin their reflection on their sinful ways through multiple daily bible studies that include memorizing biblical verses and singing hymns relevant to their redemptive rehabilitation process. Through these practices and reflections, women at Nueva Vida Mujeres are primed to open their hearts so that they may find and accept Jesus, as well as Jesus's teachings surrounding family and social life. The center focuses daily discussions on family, marriage, sacrifice, and service to others

(Velázquez Fernández 2018:192). In other words a main goal of treatment is for women to recognize their inherent connectedness with their families, and understand how their drug use has been harming not just themselves, but their children and other family members who depend on them. Successful treatment here is thus realized in a changed woman who has accepted God into her heart and who realizes that her role in life is to both be a mother and serve her family.

The therapeutic procedures at Nueva Vida Mujeres clearly outlines female gender roles, what women are meant to aspire to, and how female drug use specifically disrupts family life. As such, treatment here represents a specifically female-oriented version of the problem, its treatment, and a female-oriented definition of success.

Alas de Esperanza

Valentina, a recovering drug addict, founded Alas de Esperanza (Alas) in 2000 to provide treatment for women, by women, after her (mostly negative) experience in Tijuana's mixed-gender centers. Alas is well-known and respected from Tijuana to San Francisco. It has the reputation of being one of the biggest and best community-based centers for women, serving around 80 women at a time, ironically in a house seized by the Mexican authorities in connection to drug trafficking. It accepts both voluntary and family petitioned (involuntary) inpatients. Recently upgraded by the Department of Health from mutual aid to mixed methods in 2017 after their latest inspection, its treatment model remains heavily focused on the 12 Steps of the NA/AA program, though the center does provide psychological counseling for an additional fee.

Institutionally, treatment at Alas does not focus on any particular substance. Treatment is meant to prepare inpatients for the 'battle' against using their drug of choice (and eventually all drugs) as well as succumbing to negative thinking that contributes to their 'addict' nature. This

conception of treatment means recovery does not begin until after women leave the center; as such, throughout their time at Alas, women are merely 'in abstinence.' During this abstinence, they are meant to gain clarity on the unhealthy and spiritually corrupt aspects of their relationships, behaviors, and lives. Once they recognize the changes they need to make, they can begin to plan, one day at a time, for how they will initiate these plans outside the center, in recovery. For Valentina, recovery is a process achieved by living a life free of substances in a state of tranquility and being at peace with one's self due to one's spiritual awakening and self-forgiveness.

Alas' method of treatment is the 12 Steps; the spirituality and religiosity of her formulation of the 12 Steps matches recent studies of Mexican religiosity and health practices (Odgers Ortiz and Olivas Hernandez 2019).

> We are not a 100% religious institution; however, it is important. I can say it is 50% because [religion] is part of recovery. It is part of the person themselves to be believing in that higher power, that if they are here it is for a reason; not for herself, or for her family, but because God is giving her another opportunity to live. For us in this institution the spiritual is important. It gives them [inpatients] something to believe in. [No somos este, un 100% una institución religiosa, sin embargo, si es importante, puedo decir que un 50% y un 50% porque es parte de la recuperación, es parte de la persona en sí misma que vaya creyendo en ese poder superior, de que pues si está aquí es por algo, no por ella, ni por su familia, sino porque dios le está dando otra oportunidad de vivir, para nosotros si es importante, lo espiritual, dentro de aquí de la institución, como de ellas mismas de que vayan creyendo en algo.]

At Alas, inpatients are drug addicts in large part due to their spiritual void. According to Valentina, many women arrive spiritually dead; they do not believe in anything and life is worth nothing to them. They do not care if they harm themselves or others, because they do not hold anything dear. This interpretation results in a moral and societal problem: women who selfishly use drugs instead of contributing to society by taking care of their families. Therefore, with family and fellow inpatient support while in treatment, finding one's higher power is an

important element of treatment and recovery institutionally. Valentina is quick to clarify that Alas is not a 100% religious institution; however, it is an essential component of treatment. Mutual aid and family support is the other significant source of therapeutic support beyond spirituality at Alas.

Though the 12 Steps may be the backbone of Alas, without spirituality, Valentina believes women are more vulnerable to relapse. She outlined why relapse was common when asked what treatment is like for women who do not have a higher power.

> That is why we open up the center to Christians, Catholics, and Jehovah's Witnesses, because I know that they will come give their support. There have been people who fail, but a person who successively closes [themselves off] and does not believe in God relapses again. And [this] does not mean that the one who believes [in God] does not relapse, but it is more likely that [someone who does not] is very resentful of life, with God, with herself—because it is even with herself, and most likely, she is going to get confused. [Por eso nos abrimos lo que son con personas que ya sea que vengan a darnos su apoyo o tanto cristianos, como católicos y testigos de Jehová, porque sé que algo va a llegar, si ha habido personas negadas, pero una persona que sucesivamente se cierra y no cree en dios vuelve a recaer y no quiere decir que la que cree no recae, pero es más probable aquella que está muy resentida con la vida, con dios, con ella—porque es hasta con ella misma, y lo más probable, si se va confundir.]

Through a spiritual awakening brought on by any of the various religious groups who visit Alas, group counseling sessions, and/or NA meetings, inpatients learn to forgive themselves, recognize their self-worth, and understand the value they contribute to their family and community. She acknowledges that people who believe in God also relapse, but it is more likely among those who are closed off and resentful about their life. Most importantly, they are closed off to God and learning about themselves. If this is the case, it is more likely that the inpatient will be confused; she will not understand her place in the world, society, or her family. Valentina recognizes sustained rehabilitation is possible for those who do not believe in God and knows people that have maintained sobriety by attaching themselves to a group or a higher power other

than God. This, however, is not the treatment offered at Alas. The recovery process (brought on by rehabilitation at Alas) arises, "more than anything [through] tranquility, a peace with yourself." It is a peace that comes from inpatients forgiving themselves, not others forgiving them. It is a spiritual tranquility. The emblem of Alas is the butterfly; like a caterpillar in its cocoon, time spent in Alas is about a beautiful change towards this tranquil state of recovery.

Thus, the therapeutic focus constructed by Valentina is on rehabilitation and reintegration into their family and society, through a spiritual awakening. This is by no means an easy process, and Valentina believes it takes at least three months, particularly because so many women come to the center involuntarily. The therapeutic procedure at Alas reveals yet another formulation of the addict person, their problem, how it should be treated, and what success should look like.

SOCIAL ILLNESS, COMMUNITY-BASED TREATMENT:

The distinction between illness and disease as well as cure and healing are particularly salient for examining community-based addiction treatment models. Illness is the lived experience (both bodily and social) of symptoms associated with sickness (Kleinman 1988). It encompasses what individuals and families bring to treatment providers and describe as needing to be addressed. Disease refers to the medical practitioner's interpretation of illness experience through normative theories of disorder. Though practitioners must have some degree of cultural competency to accurately understand and interpret local idioms of distress, this translation as disease is always significantly narrower in frame than illness experience. Importantly, both illness experience and disease concept are culturally shaped, as can be seen through dynamic, "registers of complaint" and the ambiguous, social, dialogic diagnostic process (Chua 2012; Pinto 2012). As I have shown above, each center has its own distinct understanding of what the

problem of addiction is, who has it, and what is the most appropriate way to address it. Their therapeutic procedure represents only part of the cultural environment's conceptualization of the problem and its solution.

Though each center has its own specific understanding of the problem to be treated by its therapeutic procedures, there are similarities across them that highlight broader cultural ideas about addiction and its treatment. At Pasos and Alas, inpatients are drug addicts; this is a permanent condition that must be managed. Managing their addictive nature is what inpatients must learn in rehab in order to be a productive member of their family and society again. At Nueva Vida and Nueva Vida Mujeres, inpatients are sinners because they do not know Jesus. They inhabit the category drug addict as an indirect result of their sinful, mundane acts. First, inpatients must be born again and form a personal relationship with Jesus. Once this happens, they will have realized their true nature, no longer need to fill the hole in their heart with drugs, and begin to contribute to spreading the word of Jesus. While rhetorically different, these two main flaws result in the same societal problem (selfishly using drugs instead of contributing to society) and the same solution (changing the individual to become a moral and productive family and society member), albeit in different ways. Because these models have fundamentally different conceptions of the cause of the problem "drug addiction," their therapeutic models diverge on the appropriate way to treat it, as can be seen through their therapeutic procedure.

The object of healing, like addiction or sin, is evidenced by each center's therapeutic procedure. However, healing itself, or the transformation of person, "of the self that is bodily being" through such therapy is observed via attention to therapeutic process (Csordas 2002:3). Following Csordas's (1988) analysis of efficacy in religious healing, I further understand the healing process as incremental. So, while cure directly relates to pre-existing bodily norms and a

return to that condition, healing opens up to include past, present, and future experiences simultaneously. While illness is the sick person's experience as well as persons in their social networks, disease is primarily the perspective of the care provider, in this case the different community-based drug rehabilitation centers. These perspectives often parallel elements of illness experience, but any variations must be understood in order to assess their impact on the individual within treatment and its attempts to instigate healing for them. When aligned with inpatient and familial conceptions, any of these organizations of treatment can be beneficial to the incremental healing process for "addiction." When not aligned, the treatment model can be detrimental to inpatients' therapeutic progress as understood by the centers, whether they are reorienting the inpatient towards their (neglected) family obligations, finding Jesus, progressing through The Program, or experiencing serenity through self-forgiveness.

Different frameworks of illness as disease and appropriate treatment offer insight into cultural ideas of both the "good" or moral person and its opposite (Mattingly 2014; Myers 2015) As Good (1994:179) argues, illness plays a "significant role in the cultural understanding of a community or society precisely because of its negativity." It is through this absence of the norm that we can see clearly what about a person must be changed. Importantly, all four therapeutic models emphasize the necessity of the individual's desire to change. Any failures, like relapse are not attributed to the center's therapeutic model, but to the individual inpatient themselves. The 12 Steps and Christ-therapy remain constant, but a person's openness to either and commitment to changing themselves varies.

Not only is a person's individual experience of drug use and addiction highly specific, no one generalized model or case within it can satisfactorily account for the dynamic and subjective experience of therapy. Contemporary society, however, has a much different conception of

addiction treatment, which often includes expectations (or at least hopes) for cure. The common element for inpatients in Tijuana's community-based rehabilitation centers is not necessarily the therapeutic model they are exposed to, but the persistent idea, shaped by the cultural environment, that drug addiction treatment can and should have a singular trajectory. Though these models may be successful for some, what actions are involved in "recovery" or "working to get and stay clean" can be very different between inpatients and center workers, based on their conceptions of the problem and its solution. These can be either congruous or divergent, depending on each person, representing a tension between cure and healing within the same therapeutic model. As I will explore in the remainder of this dissertation, the paradoxical necessity for incremental healing in addiction treatment, when juxtaposed with the ideal trajectory of rehabilitation in the US-MX border zone, may help perpetuate the cycle of addiction for inpatients in Tijuana's rehabilitation centers.

Researchers still know very little about how community-based treatment operates, how it is experienced, and why the broader community understands it as valuable (Garcia and Anderson 2016; Syvertsen et al 2010). While Farmer (1990) asks how cultural consensus emerges around novel illness representation, in dynamic cultural environments communal consensus is rarely reached, influencing individual trajectories differently—even within the same treatment models. To understand this phenomenon, before any changes can be made, researchers must document the cultural environment (e.g. the political, economic, moral, social context and its influence on the formation of particular therapeutic models). From there, the lived experience of community-based therapeutic models, which include so much more than just ideas of the illness or disease, will become comprehensible. In understanding the lived experience of addiction treatment, scholars and activists can learn how the total institution of drug rehabilitation dynamically

shapes individual identity, subjectivity, and treatment trajectories. The following chapters demonstrate this by prioritizing/centering individual experience. In so doing, I caution against the idea that persons unthinkingly subscribe to a therapeutic model simply because they spend extended amounts of time within it or are forced into accepting it through coerced treatment.

CONCLUSION:

Though the US and Mexican governments may prioritize biomedical addiction treatment, the majority of people in treatment in Tijuana are in community-based rehabilitation centers. As has been shown, these centers formulate the therapy provided in them around particular, cultural ideas of the problem, who has it, and how it should be addressed for those individuals. Though some traditional medical practices have been integrated into the secular state healthcare system in Mexico, they are still considered "complementary" in comparison to biomedical treatments (Odgers Ortiz and Olivas Hernandez 2019). The state's refusal to recognize religion as the primary axis of treatment in a significant number of community-based drug rehabilitation centers, both in Tijuana and throughout Mexico, represents what Odgers Ortiz and Olivas Hernández term a "productive misunderstanding" in which public health officials do not have to engage with the sometimes problematic care options offered or forced upon individuals. Though the cultural environment of the border zone definitely shapes addiction and its treatment in Tijuana, the way available treatment models present the problem to be addressed in many ways obscure the social construction of this problem.

This chapter is not meant to endorse or denounce any particular community-based treatment method. Research on community-based addiction treatment throughout Mexico and the world, not just along the C-BC area of the US-MX border, has "underscored the thin border

between social and health problems, as well as the limits of either [public health or anthropology alone] to fully address their complex interactions" (Garcia and Anderson 2016:449). My goal has been to demonstrate why a stronger analytical focus on how conceptions of addiction and the "drug addict" shape therapeutic procedure will enhance scholarly understanding of inpatients' dynamic experiences within the same treatment model.

CHAPTER 2
THE GUARD'S DILEMMA: SOCIAL ROLES AND THERAPEUTIC AMBIGUITY FOR INPATIENT-GUARDS IN TIJUANA'S COMMUNITY-BASED ADDICTION TREATMENT

ABSTRACT:

Over the past 30 years, Tijuana has witnessed a proliferation of non-biomedical, community-based drug treatment centers. Research has focused primarily on documenting their spread and describing institutional practices, particularly human rights abuses. Experience-near ethnography attuned to inpatient perspectives shows that generalized responses to compulsory, community-based addiction treatment obscure its complicated experience. In this article, I explore the therapeutic process (Csordas 1988; Csordas and Kleinman 1996) of addiction treatment in one all-female 12 Step center along Mexico's northern border. I examine how each persons' treatment experience is shaped by their dynamic social roles within this interventionist total institution (Waldram 2012). I question the institutional notion that inpatients benefit therapeutically from acting simultaneously as guards (inpatient-guards), demonstrating how multiple treatment trajectories develop within the same overarching therapeutic model. This case study complicates the current scholarly literature on compulsory addiction treatment and refocuses scholarly attention to the ambiguities of efficacy through individual experience.

Keywords: Addiction; Treatment Experience; Total Institutions

INTRODUCTION:

Academic portrayals of compulsory, community-based 'addiction'[18] treatment are overwhelmingly negative; much of the literature deems it unequivocally detrimental and a violation of human rights (Wegman et al. 2017; Werb et al. 2016). Researchers and activists alike call for the immediate closure of these centers (or a halt to interning more people) and for laws that safeguard against such treatment (Bergenstrom and Vumbaca 2017; Gerra and Clark 2010; United Nations Joint Statement 2012). Yet, the number of centers offering this type of care has increased over the past 30 years in Tijuana and throughout Mexico (Odgers and Olivas 2018; Garcia 2015). When inpatient perspectives are taken into account (e.g. Olivas and Odgers 2015; Hejtmanek 2016), it becomes clear that compulsory treatment cannot be interpreted as unequivocally detrimental. Individual experience within community-based treatment models can be either salubrious or injurious, as well as situationally and temporally dynamic. In this article, I move beyond therapeutic procedure to critically examine the ambiguity of therapeutic process[19] (Csordas 1988; Csordas and Kleinman 1996) for inpatients in community-based addiction treatment.

I investigate how the paradoxically joined roles of inpatient and guard shape treatment experience in an all-female 12 Step center along Mexico's northern border, Alas de Esperanza[20] (Alas). By examining everyday interactions and extraordinary circumstances, I argue the potential hierarchies and power imbalances created by these simultaneously occupied and at times competing positions shape all inpatients' understandings of and commitment to the center's particular formulation of addiction and its therapeutic model for 'recovery' or healing.

[18] I chose to put the words addiction, (drug) addict, recovery, abstinence, and relapse in quotations at their first mention to signal their multiple and competing definitions within popular culture and among scholars.
[19] In this article, I use therapeutic process and treatment experience interchangeably.
[20] All center and individual names are pseudonyms in accordance with IRB approval.

My analytic focus on social roles serves to complicate the current scholarly literature on compulsory, community-based addiction treatment and offer a distinctive contribution to the anthropology of therapeutic process and intervention (Csordas 1988; Hejtmanek 2015) in total institutions (Goffman 1961).

EXPERIENCE NEAR PERSPECTIVES OF THERAPEUTIC PROCESS WITHIN COMPULSORY, COMMUNITY-BASED ADDICTION TREATMENT:

Csordas (1988, 121-22) outlines therapeutic procedure, process, and outcome as the three approaches researchers use to study different forms of healing, from biomedical services to religious practices. There is value to focusing on procedure (form and content, e.g. Long 2018) and outcome (final state of participants in terms of satisfaction with healing and change in symptoms or functioning, e.g. Read 2012) when ethnographically examining the phenomenological process of healing. However, Csordas (1988) argues that without due attention to therapeutic process (the nature of participants' experience, e.g. changes or insights of emotions, thoughts, behaviors) we will never fully understand the range of efficacy within therapeutic models, beyond unequivocal success or stark failure. Just as Schlosser (2019) questions recovery's ambiguities, I examine the ambivalent therapeutic effect of social roles on lived experience in community-based addiction treatment to show their dynamic effect on individual subjectivities and "addiction trajectories" (c.f. Raikhel and Garriott 2013).

Anthropological researchers have argued for a more complex understanding of therapeutic process, including compulsion and coercive therapy. Similar to Pinto (2014), Garcia and Anderson (2016) explore the tension between coercion and care in compulsory addiction treatment, noting that Mexico City's *anexos* offer valuable health and social support; however,

they risk counteracting these benefits through their coercive tactics. Yet, by considering the unconventional possibility of a therapeutic aspect to physical violence, Garcia (2015) engages with an often-neglected aspect of treatment in Mexico City's *anexos* and other areas of entrenched violence. Many community-based treatment centers along Mexico's northern border employ similar coercive and sometimes violent treatment strategies (Syvertsen et al. 2010; Lozano-Verduzco et al. 2016a,b). However, Alas is registered with the Baja California Department of Health, meets minimum compliance regulations under Norma Oficial Mexicana-028 (NOM-028), and does not engage in violent therapeutic tactics like Garcia (2015) or Rafful et al (2019) describe. Coercion at Alas relates to the compulsory nature of treatment and the structure of daily life around social roles institutionally conceived as therapeutic. These different roles require labor (emotional and behavioral included) aimed at distinct aspects of life in an interventionist total institution (Waldram 2012). The perspectives that emerge from these different positions shape interactions and individual treatment experience positively and negatively, problematizing issues of consent, coercion, labor, and treatment ethics for community-based addiction centers beyond corporeal violence.

Including first person perspectives of compulsory addiction treatment is essential to understand therapeutic process, especially instances of compulsion or violence. This allows researchers to remain "experience near," documenting "what an individual might naturally and effortlessly use to define what he or his fellows see, feel, think, imagine" (Geertz 1984:28) instead of imposing "experience distant" analytic categories that obscure persons' own conceptualizations of the treatment and the healing process (Jenkins and Barrett 2004:7-8). For example, by speaking with former 'students' from China's labor camps for 'drug addicts,' Bartlett (2018) reevaluates the notion that compulsory labor as treatment is unequivocally bad

and offers nothing but harm to those forced into it. The ‘students’ both critique living conditions in these camps and defend compulsory labor’s basic tenet as therapeutic. In discussing their desire to contribute rather than idle on the margins of Chinese society, they echo the desire of many marginalized persons with mental illness to have value and to be recognized by others as having value (Myers 2015). Community-based treatment represents a technology (Hansen 2018) through which persons and families throughout Mexico attempt to both address addiction and (re)integrate those who have been marginalized. Experience near ethnography (Kleinman and Kleinman 1991) provides the method through which we can examine the abstruse ways aesthetics and social environments of care (Halliburton 2003) contribute to therapeutic process.

Generalized responses to compulsory addiction treatment obscure its complicated experience as well as its implications into recovery. By critically examining if inpatients benefit therapeutically from acting simultaneously as guards (inpatient-guards), I discuss how social roles influence individual treatment trajectories and the overall therapeutic environment at Alas. Many situations in which inpatient-guards act require them to interact with other inpatients in ways that run counter to one social role or the other. By analyzing these dilemmas, I demonstrate how multiple, treatment trajectories develop within the same overarching therapeutic model. However, I do not seek to offer a solution to the inpatient-guard’s dilemma. By illuminating how the institutional model is dynamically taken up by inpatient-guards and experienced by inpatients overall, I illustrate the individually ambiguous, partial, and inconclusive therapeutic elements within compulsory, community-based addiction treatment. I hope to redirect scholarly attention to the ambiguities of therapeutic process to understand and improve this contextually valued form of treatment, as persons and their families continue to utilize it, despite its denouncement by many Global Health scholars and practitioners.

ETHNOGRAPHIC METHODS AND SETTING:

Ethnographic fieldwork was conducted over 18 months in 2017 and 2018 at Alas de Esperanza, a women's 12 Step Narcotics Anonymous (NA), mixed-methods residential rehabilitation center. Analysis is drawn from participant observation, focus groups with inpatients, and individual interviews (both semi-structured and person-centered [Levy and Hollan 1998]) with 33 inpatient and center worker participants. Interview topics included: cultural conceptions of addiction, drug addicts, and recovery; opinions about daily life and the center's therapeutic model; family life before coming to the center; life narratives (focusing on initiation of drug use and how women came to the center); and future plans.

Valentina, a recovering drug addict, founded Alas in 2000 in one of Tijuana's working class neighborhoods. It serves 80-90 voluntary and petitioned (involuntary) women from both sides of the US-MX border from as far away as San Francisco and Mexico City. Institutionally, treatment at Alas does not focus on any particular substance. Treatment is meant to prepare them for the 'battle' against using their drug of choice (and eventually all drugs) as well as succumbing to negative thinking that contributes to their 'addict' nature. As one participant described, 'the war [with addiction] does not begin in the center, it begins when you leave.' This conception of treatment means recovery does not begin until after treatment; as such, throughout their time at Alas, women are merely 'in abstinence.' During this abstinence, they are meant to gain clarity on the unhealthy and spiritually corrupt aspects of their relationships, behaviors, and lives. Once they recognize the changes they need to make, they can begin to plan, one day at a time, for how they will initiate these plans outside the center, in recovery. For Valentina,

recovery is a process achieved by living a life free of substances[21] in a state of tranquility and being at peace with one's self due to one's spiritual awakening and self-forgiveness.

At Alas, inpatients are drug addicts in large part due to their spiritual void. According to Valentina, many women arrive spiritually dead; they do not believe in anything and life is worth nothing to them. They do not care if they harm themselves or others, because they do not hold anything dear. This interpretation results in a moral and societal problem: women who selfishly use drugs instead of contributing to society by taking care of their families. Therefore, finding one's higher power is an important element of treatment and recovery institutionally. Through a spiritual awakening brought on by any of the various religious groups who visit Alas, group counseling sessions, and/or NA meetings, inpatients learn to forgive themselves, recognize their self-worth, and understand the value they contribute to their family and community. The emblem of Alas is the butterfly; like a caterpillar in its cocoon, time spent in Alas is about a beautiful change towards recovery. Thus, the therapeutic focus constructed by Valentina is on rehabilitation and reintegration into their family and society. This is by no means an easy process, and Valentina believes it takes at least three months, particularly because so many women come to the center involuntarily (a process described below).

Treatment, according to center staff, occurs in three phases.[22] Valentina frames progression between stages as entirely up to the behavior and attitude of each individual woman, though center staff actually determine inpatients' preparedness to progress. The first stage is dedicated to rest. Inpatients have no responsibility or freedom of movement within the house.

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[21] These substances range from the mundane and legal (e.g. tobacco, alcohol, and coffee) to the stigmatized and illegal (e.g. heroin, marijuana, and methamphetamine). Though most center workers acknowledge many will use some legal substances both during and after treatment, some seek to reach a time in their own recovery when they no longer need any form of substance, including pharmaceuticals.

[22] The self-work of treatment, however, continues indefinitely or until a 'relapse' to using their drug of choice or some other halt of progress towards the ideal state of tranquil serenity occurs (e.g. resuming a relationship with an abusive boyfriend or addict friend).

Except for NA meetings and meals, they are confined to the detoxification room and under 24/7 surveillance by an inpatient-guard who has the authority to punish them for breaking center rules. However, this phase is framed as the beginning of mutual aid, following the 12 Step model; their time is dedicated to coming to terms with where they are and accepting that they need to work on themselves while at the center through the help of their fellow inpatients. It is this inpatient-guard monitoring new inpatients who observes this process and makes the recommendation for progression to the next stage (after 3 to 7 days). During the second stage, women gain more freedom and responsibility. They can access the living areas during free time, and they are expected to contribute to the upkeep of the house (e.g. wiping down tables after meals). If center staff (specifically inpatient-guards monitoring all inpatients) perceive inpatients are in despair, acting negative, or that they just want to leave without working towards self-forgiveness and personal growth, their progression will slow. There is no clear timeframe for entering the third phase, though many women reach it after about a month. It only occurs when center staff believe the women exhibit more self-confidence and have begun to forgive themselves; they are then given even more freedom and the possibility of increased responsibility. They can attend optional workshops or activities, and they may be appointed a service position such as inpatient-guard, cook, or maintenance worker. Increasing responsibilities and access to activities is meant to reflect their personal and spiritual growth. This stage is understood as the transition to life outside the center, with jobs and familial responsibilities. Inpatient services to the center are described by center staff as practice in a safe environment for managing the relationships, responsibilities, and stress women will need to balance once they move into recovery outside the center. While Valentina recognizes the risk of giving inpatients

such important responsibilities, she believes it is necessary; by showing confidence in the women, she hopes to teach them to have confidence in themselves.

Valentina is intimately involved in orchestrating center life beyond creating the institutional conception of treatment. However, her primary role is bureaucratic, and it takes her outside the center most of the time. She leaves day-to-day tasks to her daughter Daniela and a former inpatient Sara. So, while Valentina formulated the institutional conception of inpatients and treatment, it is the front office workers Sara and Daniela who orchestrate daily social life and treatment aimed at recovery.

'I GUESS WE ALL GOTTA BE BITCHES HERE!': EXTENDING TOTAL INSTITUTIONS THROUGH SOCIAL ROLES:

Goffman defines total institutions as places 'of residence and work where a large number of like-situated individuals, cut off from wider society for an appreciable period of time, together lead an enclosed, formally administered round of life' (1961, xiii). As a compulsory residential rehabilitation center for women, this accurately describes the overall social organization of Alas. Daily life is controlled by center staff, from the space women can inhabit to the activities they can participate in. Yet, the social organization within Goffman's total institutions, a fundamental operational element, also marks a point of departure for Alas. For Goffman, there is an impenetrable social divide between the small group of supervisory staff, or guards, and the large managed group, which he calls 'inmates'. Staff do not live in the total institution and they are socially integrated into the outside world, unlike inmates. These two groups are usually antagonistic to each other, and tend to only view each other through narrow, negative stereotypes. 'Staff often [see] inmates as bitter, secretive, and untrustworthy, while inmates often

see staff as condescending, highhanded, and mean' (Goffman 1961, 7). Social mobility between the groups is severely restricted, if not impossible, and a significant social distance is maintained between them. Thus, two distinct yet parallel social and cultural worlds develop among the staff and inmates within Goffman's model of total institutions.

While the institutionally controlled daily schedule equates Alas to an interventionist total institution, the fluidity of social positions within the center complicates this scholarly definition. The social roles of staff and inmate—at Alas, the center worker and inpatient or *mariposa* (butterfly)—intermingle, often confounding their distinction. There are three groups of staff at Alas: front office workers, therapeutic workers, and service workers. All three of these groups blur Goffman's boundary between guard and inmate.

Front office workers are primarily characterized by the fact that they spend the majority of the day in the front office, comprised of the two rooms immediately accessible from the main entrance that are closed off from the rest of the house by a lockable, sliding glass door. All of the front officer workers are either in recovery or have never been in treatment, and they live outside the house.[23] However, others are inpatients acting as assistants to these externally-based front office workers (to be described below). This group contributes to the bureaucratic and organizational needs of the house including: acting as gatekeepers to the locked house, managing inpatient files, coordinating and overseeing intake procedures, keeping inpatient files up to date, facilitating food deliveries, organizing daily therapeutic or recreational activities, facilitating off-schedule family visits, answering family requests for updates, screening phone calls for inpatients, monitoring the cameras placed strategically around the house from the monitor in the

[23] There is one exception to this rule; she is the *encargada de la noche* (night guard) and she remains at the house overnight to ensure there is a high level staff member on site, should anything happen. She, like other front office staff, is allowed to leave the center for personal reasons, without needing special permissions.

front office, running the convenience store, keeping track of inpatients' store credit, and organizing other daily administrative functioning. Front office workers are not confined to front office; some of their duties take them inside the confines of the house, like running the store or monitoring intake procedures in the doctor's office[24]. However, these spaces are separate from the everyday living spaces of the inpatients. The front office workers who do not live in the house rarely go into the living space of the house; most often, they send an inpatient-guard or inpatient-front office assistant into the house to get whatever or whoever they need. Though they are the highest ranking daily staff, they are not, the highest level, akin to the warden or the psychiatrist, as Goffman (1961) describes. The center director, Valentina, is the highest-ranking staff member at the center; the front office workers act as the gatekeepers to accessing her, distilling the center's day-to-day life for her.

The therapeutic staff are characterized by the type of work they contribute to Alas, though this group too straddles the inpatient-staff distinction. There is one center psychologist who lives outside the center, working at the center several days a week, depending on the number of current inpatients. She provides group therapy to everyone at Alas and individual therapy at an additional cost. There are also two peer counselors at Alas. One, a woman recently deported from the United States, started working at Alas in September 2017. She lives outside the center, but spends much of her day, four to five days a week at Alas, both providing therapy and participating in center activities, like the Zumba classes. The other peer counselor, began her certification training as an inpatient at Alas. She acted as a counselor for five months while living in the house; when she celebrated her one year sober anniversary in July 2018, she moved

[24] The doctor's office is another room off the main courtyard separated from the rest of the house by a lockable sliding glass door. This door, unlike the front office, is tinted for privacy.

out of the center. At the time of writing this chapter, it is unclear whether or not she will continue peer counselling at Alas, now that she is no longer living there full time.

The final category of workers at the center is service workers. Unlike front office workers and therapeutic workers, current inpatients entirely comprise the category of service workers. They act as live-in guards, NA meeting coordinators, room managers, cooks, maintenance workers, and front office assistants. Inpatients may receive a service role as soon as one month into their stay at Alas, but not all inpatients are given a service (there are only 20-25 positions in a house of 80-90 inpatients). Though inpatient-service workers are the lowest rank of center workers, they enjoy many privileges that their fellow inpatients without positions do not have. For example, inpatient-service workers can smoke cigarettes outside designated smoking times. In this chapter, I focus on service workers, particularly inpatient-guards.

Work or labor marks another fundamental difference between life in a total institution and outside it, in society. The essentials for everyday life (e.g. food, shelter, and daily activities) are planned and provided by the total institution, and its economic system is a semi-discrete entity. Thus, the incentive for labor, and inpatients' attitudes toward it, are necessarily different within total institutions (Goffman 1961, 10). For front office workers, their labor is compensated, though many say they find aiding inpatients move through treatment rewarding. Inpatient-service workers are not monetarily compensated for their work; any service position and its labor is understood as a reward for time well-spent in treatment. Those who receive a position are understood by themselves and their family to be taking their treatment and efforts toward recovery particularly seriously.

Inpatient-guards occupy an unusual social position, as they must devote themselves and their time both to preparing for their own recovery and to monitoring or punishing their fellow

inpatients. There is often a rough transition period, where many fledgling inpatient-guards feel uncomfortable exercising their new duties. They are now surveilling their friends (the women they spend all day, every day with) and reporting them to Daniela and Sara, whom they rarely interacted with before becoming a guard. Sara and Daniela's interactions with inpatients are mostly limited to doling out punishments or denying 'impossible' requests, like providing more coffee at meetings on their tight budget. They do not necessarily explain this to inpatients, though. To inpatients, it seems like 'the front office' thinks they would not need to worry about having coffee to sit through morning meetings if they had never used drugs, because Sara and Daniela often retort to requests or complaints with 'well you shouldn't have hit that pipe.'[25] Many women see the front office workers as lacking the necessary emotional support to create an environment conducive to self-forgiveness and personal growth. This perception is often the starting point for many new inpatient-guards' more direct relationship with Sara and Daniela. This dilemma new inpatient-guards face can have serious implications for inpatient-guards' understanding of their 'problem,' as well as how their thoughts and actions contribute to life at the center.

Some of the inpatient-guard's main responsibilities are to surveil daily life, enforce center rules, and report any problems to the front office. This includes conduct reports from the 3 daily *juntas* (12 Step Meeting). It is a guard's job to ensure that all the women are following the rules; she must often exercise authority over them. As an inpatient, she is her fellow inpatients' equal; they are all *mariposas* working together to forgive themselves and grow in the service of their recovery. These competing perspectives and directives can cause both internal and interpersonal conflicts.

[25] 'Pipe' is a reference to methamphetamine use; its most common ingestion method in this ethnographic context is smoking.

For example, I was at the center the day Yessica became a guard. She is a 24-year-old woman committed by her mother to Alas for the second time due to her methamphetamine use. When I came into the courtyard around noon, she was sitting at the store point,[26] looking extremely agitated. I asked how she was doing; she responded, 'Shitty.' I had been expecting her to say 'good' or 'happy,' because she had been wanting to be made a guard since she returned to the center. She thought it would show her mother she was committed to 'doing well' this time. When I asked her why she was upset, she explained that her friends called her a 'bitch' for telling them to be quiet in the morning *junta,* or NA meeting. Because they did not listen to her, she brought the problem to Sara, who called her *pendeja* (stupid, incompetent) for not being able to handle the problem on her own. When I asked Yessica how she was going to balance her new responsibilities with her existing relationships, she replied in English, 'Well, I guess we all gotta be bitches here!' Yessica's response reveals how difficult it can be to manage the competing directives of her two social roles. When she tried to exercise her authority, her friends accused her of being 'bitchy' and continued talking, perhaps in an attempt to re-establish the egalitarian nature of their relationship (Snyder and Fessler 2014). She reported this, but Sara—busy with the paperwork for 15 new inpatients—told Yessica to handle it on her own, albeit unprofessionally. This abrasive tone, unintentional or otherwise, shapes the way Yessica understands her role in the center and how she approaches her position.

Yessica's response after this conflict exemplifies one way the joint social roles of inpatient and guard can shape therapeutic process. After that interaction (Yessica was a guard for 11 months before her eventual escape), she rarely informed the front office workers of her dealings with other inpatients. She only reported to Sara or Daniela if women broke a major rule

[26] 'Point' refers to the strategic locations where inpatient-guards are positioned throughout the center to monitor inpatients.

like having a romantic relationship with another inpatient or planning an escape. She explained that to do otherwise would just make her angry and resentful, and she wanted to focus her energy on working toward her recovery, not harboring negative emotions that impede her 'process'. This was simultaneously positive for Yessica's individual therapeutic process and sometimes problematic for other inpatients. Exactly one month before she ran away from the center, we discussed her transition to inpatient-guard and how she now approached this position; her understanding had shifted from her original 'we all gotta be bitches' sentiment:

> You have to earn some sort of confidence in yourself, and be like, "you know what, I'm telling you [as inpatient-guard]." But not in a bossy way, or "just because I say so." There's a reason behind it. Like, "You're not gonna smoke because you were *told* [emphasis hers] three times in the meeting to stop talking."[27]

Yessica understands her new outlook on decision-making as growing her self-confidence. If she always interacted with her fellow inpatients as this benevolent authority, enforcing the rules while simultaneously exemplifying how focusing on one's own self-improvement helps one move forward in treatment towards recovery, then she would truly be the face of the mutual aid model that Valentina envisioned the guard position to be. However, Yessica, like Sara and Daniela, had many negative interactions with other inpatients. In some instances, inpatients she punished told me they thought it was simply because she did not like them. Yessica's decision-making and its relation to Alas' treatment model may be just as unclear and unsupportive to her fellow inpatients as Sara and Daniela's actions are to her.

The social distance between staff and inpatient and the relationship to labor at Alas encompasses a far wider range than Goffman describes. Yessica's paradoxically joined social roles have ambiguous potential for therapeutic process within this community-based model.

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[27] All interview segments were edited for clarity. When Spanish was spoken, I provide the original words and their translation. These translations, and any errors within them, are my own.

Despite the negative social interactions she had with the front office workers, she found a way to progress along a treatment trajectory that worked for her. Her increased self-confidence was not necessarily beneficial for everyday life or therapeutic process for other women at Alas; this is partly related to Yessica's understanding of the intersection between the labor for her service position and toward her recovery. Further, the therapeutic value of her dual positions is inconclusive, if not negative, as she ultimately ran away from the center and began using drugs again. The way the front office workers interact with inpatient-guards often pushes them to be more independent and self-confident in exercising their duties. It also discourages inpatient-guards from communicating with front office workers about their decision-making, to ensure that they are appropriately balancing their dual social roles of authority figure and sister in recovery.

A 'RUDE' MEETING: POSITIVE THERAPEUTIC IMPLICATIONS WITHIN A NEGATIVE CONTEXT:

The therapeutic significance of inpatient-guards' labor is inextricable from Alas's structural organization as an interventionist total institution. Inpatient-guards' impact on therapeutic process is observed most easily in the extraordinary circumstances that abound at Alas, such as inpatient fights, attempted escapes, and often violent intake procedures. These extraordinary circumstances exist because treatment can be involuntary and once admitted, is compulsory. It is in these instances that inpatient-guards' labor for the center can be seen as having direct impact on other inpatients' therapeutic process. Just as there is a fluid boundary between staff and inpatient, there is individual variability in adherence to center rules and Valentina's vision of the inpatient-guard. The co-existence of these different inpatient-guards and their dynamic ability to operate under or ignore the tenets of mutual aid meant to be captured

in their service work drastically alters the form and content of their interactions with other inpatients, the environment of the center, and all inpatients' treatment experience. Here, I examine a situation that, while extraordinary to many outside Alas, is part of daily functioning there: the involuntary intake procedure. It reveals how in extraordinary, sometimes negative, circumstances the inpatient-guard's multiple perspectives can ambiguously shape treatment experience for new inpatients.

Intake at Alas can be disorienting and terrifying for new inpatients. Often, they are unaware they are being checked into a drug rehabilitation center by their family members when they arrive; many have been told that they are helping a relative move or that they are just going to enjoy a day in Tijuana with family. Though some know they are on their way to treatment, if they are coming from the United States they are mostly unaware that the laws governing involuntary, compulsory treatment are different in Mexico. Most intake procedures occur within the center itself; the family drives their car into the center courtyard through the sliding corrugated steel door. While some women get out of the car willingly, many fight - kicking, screaming, and biting those who try to force them into the doctor's office for their intake examination and interview. As the courtyard is surrounded by the house, inpatients looking down from their rooms or the stairwell can watch the entire process. However, on Sundays, new inpatients come in through the front door or visitor's entrance, as the courtyard is filled with families visiting their inpatient relatives.

America, unlike many women, knew she was headed to Alas when she and her family set out from Oceanside, California on a Sunday. When they arrived, her mother told her to wait in the car while she went inside. America waited in the car with her son, Adrian, unaware of what was going on, how long she would have to wait, or if she would be able to enter the center that

day. Suddenly, a group of women came out of the center and surrounded her car. A short, stocky woman with a slicked back ponytail, wearing oversized clothes and a thick gold chain opened her car door, grabbed America's upper arm, and started pulling her from the car while Adrian was sitting on her lap. Frightened, but more worried about what her son might interpret as violence, America slipped him off her lap and allowed herself to be dragged from the car. At this point, she remembers changing her mind about wanting to enter treatment at Alas. 'I thought this can't be a good place if they would treat you like that.'

America tried to push the inpatient-guards (at the time she did not know their affiliation with Alas) away from her, so she could get away. As she did so, Linda (the woman who grabbed her arm) came up behind America and kicked her feet out from underneath her. Beth, another inpatient-guard, who was standing on the stairs into the center vestibule, caught America's head and shoulders as she fell, stopping her from smacking head-first onto the tile steps. Beth then moved around America, shielding her from the other inpatient-guards as well as blocking her from escaping down the street. As she did so, America bit her arm. Beth, however, just pulled America to her feet, so she could walk up the stairs herself into the center's front office. A few weeks later, during a focus group on intake experiences, America and Beth recounted this first interaction like this:

> America (A): The only guard I like is Beth. She's actually the one who welcomed me into the center. She saw how they had to get me out [of the car], because once I got here, I said no, I don't want to do this anymore. [Beth (B): yup!] So, they literally had to drag me in here.
>
> B: She fuckin' hurt my arm! [points to where America bit her] I won't lie to you.
>
> [all laugh]
>
> A: I even told her I was sorry!

B: [smiling] Rude! I was like, 'Yeah, thanks!' She's like [sarcastically] 'I'm sorry!' Haha sorry my ass!

A: It was hard for me, cause when they first got me here, you know, I'm the kind of person that I like knowing how the treatment—explain to me how it's gonna work. Break it down for me. You know, [say to me] "You're gonna stay three months." My mom, like, from the get-go, she told me to wait in the car, and I said, 'Why am I gonna wait in the car, if I'm coming by choice? Can I come in and know what's going on? I'm ok with staying, [smiling] I don't have a choice! But show me what's going on. I think that's something that as far as treatment, how it starts, I think that a lot of girls are scared. I know I was! Even for the first three days, I couldn't trust anybody. I felt like I couldn't trust anybody. I was like 'Oh my God, what are they going to do to me?' I wouldn't eat for the first three days. Well, she [gesturing towards Beth] did bring a couple things down to me and I would take a nibble—

B: You fuckin ate!

A: —Out of it. My daily activities in the first week I was here were eat, cry, go to sleep.

The levity in America and Beth's retelling of her intake and first week at Alas obscures the therapeutic significance and benefit of joining the social roles inpatient and guard within the mutual aid model of addiction treatment. Beth had been living at Alas for five months and acting as an inpatient-guard for two months when America arrived. Not only had she been forcibly dragged out of her family car and into the center, but she had participated in the involuntary intake of dozens of women with Linda. Linda was well known among inpatients for her aggression; some even think it was why she was given the inpatient-guard position. At the time of America's intake, Beth had purposely hung back; she had hated the feeling of being surrounded when she came in, and she knew swarming new inpatients usually provoked aggression to which Linda would react, further escalating the situation. When Beth herself had been brought into the center, also on a Sunday, she had fallen on the vestibule steps. So, Beth's 'welcome' for America was to shape her actions as guard through her personal experience as a new inpatient. Beth protected America as much as she could from the sometimes overly

aggressive nature of intake procedures. She even helped America regain some of her hurt or lost dignity from the mortification process of intake (Goffman 1961) by helping her walk into the center (almost) on her own.

Inpatient-guards can relate to the crisis of intake in a fundamental way. Hejtmanek (2015) discusses the divide between how workers and patients experience 'crazy shit' or behavior that halts regular activities at Havenwood, a youth psychiatric facility. However, workers at Havenwood and most total institutions have a fundamental distance from patients. They restrain patients, but they have never themselves been restrained. Hejtmanek describes restraint as an intersubjective, intimate form of touch. At Alas, intake is an intersubjective and intimate, yet ambiguous element of treatment experience because inpatient-guards restraining new inpatients during intake have undergone the same process. Beth specifically stood on the steps during America's intake because she knew the risk of falling there. When America bit her, she did not react violently; in fact, she exemplified the potential of the dual role that Valentina envisioned; Beth both enforced the center's rules by bringing America in to the treatment center and aided America as an equal in moving toward recovery by putting her in the position to walk into the center on her own. Compared to Linda, it is easy to see why America says, 'The only guard I like in the center is Beth.'

How inpatient-guards treat (extra)ordinary situations like intake procedures is fundamental to the center's operation and therapeutic process within it; yet, it is highly individual. Linda's aggressive enforcement of the center's rules negatively impacted America's transition to living at the center. America and most inpatients recall their intake procedure as setting off an antagonistic relationship with inpatient-guards; but, it also catalyzes certain relationships necessary for mutual aid addiction treatment. America respects Beth; she looks up

to her as a sponsor. During this focus group, she reiterated her apology for biting Beth. She did not forget the way Beth treated her during her intake, and it factored into her requesting Beth to motivate her during NA meetings, asking her for advice, and passing on *chisme* (gossip) that ultimately helped Beth with her inpatient-guard duties. The violence of involuntary intake does include the risk of triggering an antagonistic relationship towards treatment and those persons specifically meant to aid new inpatients working toward recovery. However, if inpatient-guards approach their duties as Beth did for America's intake, their dual perspectives can instigate intimate, egalitarian relationships, which Valentina understands as necessary for recovery through mutual aid.

'THAT'S SOME JERRY SPRINGER SHIT'[28]: THE DYNAMIC PERSPECTIVES OF INPATIENT-GUARDS:

All inpatient-guards' adherence to the center's vision of their role in treatment varies situationally. Their actions during extraordinary circumstances can foster reactions that do not benefit either the inpatient-guard or other inpatients. Beth's perspective while performing her duties during an escape demonstrates how the tasks of the inpatient-guard sometimes can come into direct conflict with Valentina's institutional conception of inpatients and inpatient-guards as butterfly sisters in recovery.

One afternoon, Beth and I sat at her point on a balcony overlooking the center's main courtyard. Just as we were discussing her simultaneously extreme desire to immediately leave the center to be with her family and her fear of doing so in case she 'messed up' (i.e. relapsed),

[28] The 'Jerry Springer Show' is a day-time United States talk show that aired from 1991-2018. It is most often associated with its tabloid-like content (e.g. 'Secret Mistresses Confronted') and on-air physical altercations between guests.

the courtyard exploded with a chorus of ¡*Fuga*! (Escape!). A new inpatient had used the bars on the staircase window like a ladder to climb onto the roof. Beth jumped up, leaped down the stairs and ran out of sight through the front office doors. For 40 minutes, the center was on lock-down; finally, Beth and a few other inpatient-guards come back into the courtyard with *la fugada* (the escapee). The center began to return to everyday operations, and Beth and I returned to her point with her friend and fellow inpatient-guard Carlotta.

> Beth (B): Oh my God my mouth is still like dry from all that!
>
> Carlotta (C): Did you guys run around the whole building?
>
> B: Yes! Dude I jumped like the Olympics right now!...I was right here and I heard everyone yelling "*¡Fuga! ¡Fuga! ¡Fuga!*" And I ran into the office. Sara's all like "*¡Está buscando,* go!" [Go look for her!] And I ran out the front, and they're like, "Go to the other side!" And I ran, Schoom! It felt good running.
>
> Author (A): Where'd you get the ladder? [Beth eventually got *la fugada* off the roof using a ladder]
>
> B: Oh the neighbors came out!
>
> C: The neighbors came out?!
>
> B: Yeah! They were right there helping and everything.
>
> C: She's [*la fugada*] like whoooaa!
>
> B: I was like woah haha…All the neighbors were yelling ¡*fuga*!... then one [neighbor] ran out with the ladder. Everyone was ready. It was awesome out there! That's some crazy Jerry Springer shit, you know? I don't know where she thought she was gonna go; we had her surrounded. She got paranoid. She was like "Now what's gonna happen to me?" I'm like, "Get down, stop asking for attention, you drama queen."
>
> A: Haha.
>
> B: She's like "I wanna go home." "You ain't going nowhere! We got you surrounded!" haha I can't believe I said that.

This 'Jerry Springer' action exemplifies the conflicting perspectives of inpatient-guards,

which shape their orientations toward themselves and behaviors toward their fellow inpatients in paradoxical ways. As an inpatient, Beth's feelings about daily life in the center and the front office workers (especially Sara) deeply resonate with Yessica's realization that the attitude of the front office workers can impede recovery. In her six months of treatment, she had come to see herself as an addict. But, partly because of interactions with the front office workers, Beth is nervous she will not be able to maintain her commitment to her family when she leaves the center for the second time. Defining herself as an addict, perpetually orienting herself to this fact in her daily life, scares her; she is afraid it will allow her to 'mess up'. Yet, Beth is a guard. She takes her duty seriously and understands her service as practice for having a job outside the center, particularly a job with a boss she does not like. This job produces a different orientation to herself and others within the center. When *la fugada* attempted to escape, Beth no longer oriented herself towards *la fugada* as a sister in recovery who may be experiencing her same self-doubt and pain. Beth occupies and enacts the role of the guard (Zimbardo et al. 1999). In this instance, Beth acted towards *la fugada* as callously as inpatients, even herself, interpret front office workers' and inpatient-guards' interactions with them. Beth refers to *la fugada* as a drama queen for voicing the very sentiment 'I wanna go home' that she had been articulating to me just seconds before the attempted escape. Though Beth expresses disbelief that she responded so callously, her reaction is not unexpected from someone in the guard position. Inpatient-guards are often punished for major events that disrupt the daily operations of the house, such as fights or attempted escapes. The social roles inpatient-guards inhabit shift their subjectivity and behavior toward others, though not always in the way intended by Valentina for rehabilitation and recovery.

The fundamental social divide between staff and inpatients in total institutions collapses at Alas, creating the potential for internal conflict in terms of the self-orientational processes and behaviors (Csordas 1994; Hallowell 1955; Lester 2017). For inpatients who straddle the distinction between staff and inpatient, as both rule enforcers and equals on the path to recovery, many situations arise in which they must consciously consider the perspectives of both of their social roles. According to Valentina, this self-reflection is essential to acting in ways that both stimulate their self-growth and aid their fellow inpatients move toward her understanding of recovery. However, the extraordinary circumstances that occur at Alas due to its organization as an interventionist total institution, often leave little time for such reflexivity. Unless inpatient-guards are constantly engaging in self-reflection or prepared for a particular scenario, as Beth was when she caught America, there is the risk they will act as Beth did toward *la fugada*. In this instance, Beth was reacting solely through her perspective as guard. Actions drawing on an imbalance of their dual social roles contribute to a sense of hierarchy in a center designed to be egalitarian, perpetuating antagonism between staff (including inpatient-guards) and inpatients. Because the social roles of inpatient and guard are blurred at Alas, inpatient-guards risk focusing on their service to the center, instead of Valentia's understanding of treatment in which all inpatients' labor is dedicated to self-forgiveness in the service of recovery. This has the potential to negatively shape treatment experience for inpatients like America, Yessica, and *la fugada*, as well as the life at the center as a whole.

DISCUSSION:

In environments designed to promote healing like Alas, the social structure influences treatment experience and catalyzes dynamic self-transformations that often resonate beyond the

center, into recovery. Social life undoubtedly contributed to Yessica's, America's, and Beth's engagement in center life and their treatment experience, though not in ways that could always or easily be categorized as positive or negative. Inpatient therapeutic process at Alas pushes scholars to consider a more flexible understanding of healing and efficacy in compulsory treatment.

Culture and biology are both integral to defining efficacy (Jenkins and Kozelka 2017); whether a particular treatment is considered efficacious is contextual and dynamic for individuals and communities over time (Read 2012). Hejtmanek (2016) argues that transformation or healing occurs within compulsory therapeutic settings; though adolescents at Havenwood experience change, they understand it outside the logic of the therapeutic system that produces it. Just as Poltorak (2013) challenges the singular consensus of efficacy's conceptualization, this Tijuanense case study highlights the necessity to engage with individuals' dynamic and ambiguous therapeutic process to understand its intersections with institutional treatment models, conceptions of efficacy and healing, as well as treatment trajectories.

Scholars using anthropological methods have long argued for a more complex understanding of therapeutic process, which necessitates considering first person perspectives. Because treatments are often only described as successful or failing, good or bad, researchers and clinicians may hesitate to discuss efficacy in ways that allow for inconclusive results. Yet, when one attends to individual experiences in therapeutic process, conflicting results readily emerge (Csordas 1988; Csordas and Kleinman 1996). Inpatient-guards like Yessica and Beth, articulated that their treatment experience and decision-making in relation to other inpatients was often shaped, though imperfectly, by their shared experience in compulsory treatment. Inpatient-guards receive directives from the front office workers on their duties; but, ultimately, they

choose when to act, how they respond, and what they report to the front office. Their role is one of the most influential elements of therapeutic process at Alas precisely because of their liminal, betwixt and between status (Turner 1967) as both authoritative guard and equal fellow inpatient. Examining this liminality is essential to understanding this contextually valued, compulsory form of addiction treatment. Without attention to the therapeutic ambiguities social roles produce, it is difficult to understand the full range of effects within a given treatment model.

CONCLUSIONS:

Here, I examined how social roles at Alas smudge stark dichotomies in the theory of interventionist total institutions and unambiguous conceptions of efficacy through attention to therapeutic process. This extends beyond community-based rehabilitation centers in northern Mexico or even community-based residential treatment centers. The current incorporation of 'user experts,' 'peer counselors,' and 'former patients' into treatment (Recke 2017) mirrors the inpatient-guard disciplining other inpatients. These models may face similar challenges, as 12 Step, mutual aid treatment programs have always had concerns about prestige-based hierarchies, despite their egalitarian rhetoric (Snyder and Fessler 2014). First person perspectives will aid scholarly and clinical attempts to scrutinize the full range of experience and necessary changes in all treatment models, without pitting one against another.

The organization of daily life at Alas exerts a similar amount of control over inpatient experience as Goffman's total institutions. Yet, the labor inpatient-guards provide can come into direct conflict with their dual social roles (i.e. service work versus inpatient self-work dedicated to recovery). Myers (2015) argues that to even consider recovery as possible for persons with serious mental illness, they must have intimate, reciprocal relationships through which they learn

and are held accountable for their actions, producing moral agency. At Alas, the great power and danger of the inpatient-guard's dual perspectives lies in their ability to both recognize and ignore the moral agency of their fellow inpatients, shaping therapeutic process toward or away from recovery. Understanding the context of these experiences both extraordinary and banal (Jenkins 2015), will help scholars and activists understand why communities and former inpatients in the US-MX border zone find this form of treatment valuable and challenging at the same time as well as work towards shared decision-making for best care practices.

I must acknowledge that Chapter Two has been submitted in part for publication and may appear in Medical Anthropology Quarterly. I, Ellen Kozelka, was the sole author of this chapter, though I received crucial feedback from my committee members as it was drafted.

CHAPTER 3
READY OR NOT...: STIGMATIZED MORAL EXPERIENCE AND SELF-TRANSFORMATION IN COMMUNITY-BASED DRUG TREATMENT

INTRODUCTION:

Alma, a 19-year-old inpatient-guard sat with me in the audiovisual room at Alas de Esperanza, (Alas) crunching on Hot Cheetos as we discussed her upcoming "release" (as she called it) in May 2017. This was her fourth stint in rehabilitation for methamphetamine use, though she also used other drugs like alcohol, marijuana, and cocaine. Despite describing how far along she thought she had come in her "process" over the past year, specifically that she felt ready to leave Alas and enter recovery, Alma still harbored resentment towards her parents. Her attempts to understand her parents' decision to send her to rehabilitation against her will and its effect on her therapeutic process exemplifies the complicated moral experience of rehabilitation at Alas.

> Ellen: What do you think has changed [from coming to Alas] to now that you feel like you're ready [to begin recovery]?
>
> Alma [A]: Um…you know it's really hard, because in a way I am still resentful of my parents for sending me here involuntarily.
>
> E: Well for sure. They definitely tricked you.
>
> A: Yeah they definitely tricked me, then lied to me, and even though they tell me that it's for my own good, I still feel like 'What the fuck?' you know? Like, why would you do that? That's fucked up, definitely fucked up. And I'm just like okay. I'll try to bear with this for as long as I can, but I feel like it's [being in the center involuntarily] just getting to me, you know?
>
> E: For sure. I mean, how could it not? Have you talked to them about that?
>
> A: Um, at first I did talk to them about that and I was like "I don't want to be here anymore, you know, you sent me here involuntarily." And they were like, "You know what, you're just going to have to pull through because we sent you there for your own good and because we love you." And so I'm just like "okay..." I try to understand them, but I wish they could understand me too.

Alma's parents tricked her into going to rehabilitation by bringing her to Tijuana from San Francisco to "visit family." Instead, they brought her to Alas. Once in the center, they told her she would only be there for three months; at the time of this conversation, Alma had been at Alas for 10 months. While linked to her involuntary commitment, Alma's resentment stems from her moral experience of personhood. Though she tries to understand her parents' decision, their lack of engagement with her perspective exemplifies the problematic of personhood in the enactment of treatment at Alas. Alma's moral experience of stigma illustrates how the behavioral environment (Hallowell 1955) in treatment centered around "valuing" shapes inpatients' orientations toward themselves and fellow inpatients in ways that may not always be anticipated within the center's therapeutic model. As I will show, these self-transformations have serious implications for individual therapeutic process and addiction trajectories.

In this chapter, I focus on stigma's intersection with personhood and moral experience in context to examine the co-construction of self processes and transformations in one community-based rehabilitation center, Alas. Scholars have outlined the co-construction of the self by social networks (Kleinman 1999), sociopolitical condition (Haas 2017), and illness experience (Parish 2008) including therapeutic contexts (Good 1994; Kaiser et al 2019; Lester 2017; Jenkins and Carpenter-Song 2008; Jenkins 2010; Schlosser and Hoffer 2012). Psychological anthropology has long been a resource for research at the existential nexus of social, cultural, and experiential processes (e.g. Parish 1991; Csordas 1990; Jenkins 1991; Kapferer 1997; Levy 1973; Throop 2010), including morality. Morality is another major focus of psychological anthropology. Examined as laboratory (Mattingly 2014); agency (Myers 2015, 2016); experience (Garcia 2014); striving (Carpenter-Song 2019); moods (Throop 2014); struggle (Jenkins 2015); breakdown (Zigon 2009); and discourse (Carr 2006; Desjarlais 1996; Brodwin 2008),

psychological anthropologists have attempted to capture how morality factors into self processes and personhood in everyday life and extraordinary conditions. My approach in this chapter thus combines these two major areas of psychological anthropology to focus on inpatients' moral experience and its role in shaping their therapeutic process.

The treatment model at Alas is taken up by both workers and inpatients in dynamic ways that alter therapeutic process as well as healing self-transformations. Understandings of treatment and its goal at Alas reinforce stigmatizing cultural tropes of addiction, addicts, their behavior, and treatment possibilities. Here, I explore how stigma shapes conceptions of personhood and moral experience to understand its role in individual therapeutic process. What does the moral experience of stigma tell us about the intersubjective nature of person and therapeutic process? Does addiction in this ethnographic setting lay the groundwork for depersonalization, rendering third person perspectives of needs and choice more authoritative than first person perspectives of self-transformation? What does the negotiation of stigma in treatment reveal about the "work of self" (Parish 2008) aimed at recovery? I specifically examine the element of stigma to identify the ways moral processes mutually shape community-based treatment and therapeutic process. Building on Chapter One, I demonstrate how Alas's treatment model incorporates and produces stigma, self-stigma, and particular treatment expectations for and among inpatients, including conceptions of who is ready (or not) to begin recovery.

STUDYING THE SELF AND ITS TRANSFORMATIONS IN THE BEHAVIORAL ENVIRONMENT OF COMMUNITY-BASED ADDICTION TREATMENT:

There has been a rigorous, decades-long debate in anthropology on the utility of investigating and theorizing the self (Lester 2017; Jenkins 2010; Csordas 1994a,b). Questions

surrounding the nature of self and how it can (not) be studied represent most arguments against giving it analytical attention (Geertz 1984). Depending on the structure of the self (i.e. singular vs. plural, egocentric vs. sociocentric—see Csordas (1994a) for a useful outline of the different theoretical positions—some have questioned whether or not it is a construct specific to industrialized Western societies (Geertz 1984:126). Though the self has been defined as practice (Ortner 1984) or a set of characteristics or elements (Quinn 2006), "it" is not an entity. The self is a series of culturally constituted orientations to 1) itself (self-awareness), 2) other objects (non-self), 3) spatiotemporal aspects, 4) motivational aspects, and 5) normative aspects of a society as they are discerned, classified, and conceptualized from within it (c.f. Hallowell 1955). Thus, I consider the self to be the "indeterminate capacity to engage or become oriented in the world, characterized by effort and reflexivity" emerging through a constant feedback loop of culturally constituted social worlds and "pre-reflexive bodily experience" (Csordas 1994b:5). These orientations are shaped by the cultural environment and can be directly observed in the behavioral environment. They are not singular, universal, or static; it is through these variables that the self and its transformations become perceptible objects of study. In this chapter, I explore how the cultural environment "enters in" (Lester 2005) to the behavioral environment in this rehabilitation center, contributing to lasting transformations to the self's orientational processes for inpatients.

The distinction between the cultural and behavioral environment must be parsed out prior to understanding their interrelated influences on the orientations and transformations of the self in relation to stigma and personhood. The cultural environment is the specific and dynamic constellation of conceptions, morals, practices, and institutions that exist in particular times and spaces. In relation to drug addiction, these can be observed, for example, in media

representations of drugs and "drug addicts" or laws governing treatment. The behavioral environment describes the parameters to which the self orients, laying the groundwork for action (Hallowell 1955:85-7). It is the taken-for-granted organizational features of the cultural environment that are dynamically and situationally interpreted and enacted in both brief interactions and extended social relationships (Hallowell 1955:88). So, for example, the US and MX media representations of "drug addicts" as morally bereft, selfish criminals who represent a danger to good, law-abiding society are part of the cultural environment. A person's repulsion to a perceived drug addict peddling at the Tijuana-San Ysidro border crossing and their subsequent refusal to give money to the "addict," and its potential impact on that person's subjective experience is part of the behavioral environment. The cultural environment's formulation and the behavioral environment's enactment by individuals or groups is fundamentally culturally constituted within a given society and a particular context. Different people have access to different elements of the cultural environment, altering their orientational processes, and thus, their behavioral environment. For instance, a volunteer in a migrant shelter in Tijuana might have received training on the biomedical understanding of drug addiction as a chronic brain disease, and a former drug user would have intimate knowledge of the physical and psychological compulsion to use. Their behavioral environment encapsulates different elements of the cultural environment, shaping diverse self-orientations toward the "drug addict" peddling at the border.

One can examine the interaction between the cultural and behavioral environment by analyzing subjective experience in context. The experience of self (subjectivity) and personhood are affected by relationships of power in drug treatment (Foucault 1980). Subjective experience is the dynamic process, both conscious and unconscious, of a person working through their

thoughts and feelings, their circumstances and their contradictions (Biehl et al 2007:14). It is the phenomenological process of subjectivity, or, as Jenkins describes, the "relatively durable structure of experience that is yet subject to transformation based on changing circumstances and modes of engaging the world" (2015:9-10). In the context of community-based drug rehabilitation in the border zone, I provide examples of how women at Alas come to understand the institutional conception of treatment as a particular type of self-transformation that is linked to an institutional understanding of their personhood as well as how they negotiate it through tactical responses of the self (Desjarlais 2000) in order to complete treatment.

STIGMA, PERSONHOOD, AND MORAL EXPERIENCE IN COMMUNITY-BASED ADDICTION TREATMENT:

Stigma is an ideal method to study the interaction between self and culture, experience and context. The self's orientational processes are never complete, thus, "it" eludes objectification (Csordas 1994b:276). Yet, stigma attempts to reify the self as person in culturally specific ways. A focus on the continuum between normal and pathological has been a long-time emphasis in mental health stigma research (Benedict 1934; Canguilhem 1991; Harris 2015; Jenkins and Carpenter-Song 2008) because "normal tends to be considered moral" (Gideonse 2015:334). Other foci have included its experience (Yang et al 2007; Jenkins and Carpenter Song 2005); its social uses (Singer and Page 2014); its cultural variation (Abdullah and Brown 2011); its underlying psychological mechanisms (Teachman et al 2006; Major and O'Brien 2005); its effects on treatment (Earnsahw 2013; Luoma et al 2007; Corrigan et al 2005; Luoma et al 2007; Metzel and Hansen 2014); and its implications for global health research and interventions (Link and Phelan 2006; Birbeck et al 2019; Rao et al 2019). In this section, I examine stigma's

relationship to cultural ideas of personhood and moral experience to help inform how stigma may shape the self-transformations which constitute therapeutic process in community-based rehabilitation.

Stigma, or "bodily signs [or disgrace] designed to expose something unusual and bad about the moral status of the signifier" (Goffman 1963: 1) is a powerful social phenomenon with a myriad of effects on those who experience it. It is a product of the historical, political, and cultural sentiments, ideas and memories of a group of people who find its distinction salient. Yet, "stigma involves not so much a set of concrete individuals who can be separated into two piles, the stigmatized and the normal, as a pervasive two role social process in which every individual participates in both roles, at least in some connections and in some phases of life" (Goffman 1963:137-8). It is part of a social complex, and persons exist at some point on a continuum between stigmatized and unstigmatized. While a stigmatized—unstigmatized continuum is the appropriate description to understand a single trait or aspect, I argue that the whole person (Parish 2008) is a combination of these trait/aspect continua (including normal-abnormal), whose indeterminate thresholds (Csordas 1990) intermingle, interact, and contradict, forming a whole person as "busy intersection" (Rosaldo 1989:17). As such, I understand stigma to be an intersubjective, relational process produced and experienced in culturally specific social interactions that occur between individuals (Jenkins and Carpenter-Song 2008). The specific organization of this persistent social category (continually influenced by political and economic forces) directly impacts how treatment is understood at Alas.

To understand how stigmatizing cultural conceptions in treatment shape moral experience and self-transformations in community-based treatment, we must understand stigma's relationship to cultural conceptions of personhood. I use Taylor's definition of person,

understood as "a being who has a sense of self, has a notion of the future and the past, and can hold values and make choices" (1985:97). Importantly, a person must have both their own point of view and the ability to communicate it intersubjectively (Parish 2014). However, an individual's ability to communicate or be recognized as a person is affected by stigma. Goffman (1959) effectively explains how people categorize others into social categories to facilitate interactions with them; however, this process is almost never explicit. The "in effect" character attributed to people relies on implicit assumptions drawn from what we perceive to be their nature, based on our understandings of the implicit and shifting social categories in a given social setting (Goffman 1963:2). Goffman refers to this as the "virtual social identity;" any negative "in effect" characterization that lessens a person's "virtual social identity" is a stigma (1963:2). These categories are based on culturally shaped stereotypic thinking, which assumes all persons within the given category, in this case drug addicts, have the same inherent set of devalued traits (Singer and Page 2014:16). These stereotypic categories tend to be overly simplistic, unchanging, rigid and in many ways inaccurate, because they do not take into account individual variation (Lee 1989:10). So, stigma contributes to cultural concepts of person in that it primes persons to relate to those labelled as drug addicts in stereotypic ways, rather than through intersubjective engagement with them as persons.

Parish (2014) argues that like the self, morality is a process, part of both sociocultural context and experience. He demonstrates this by presenting cases of moral experience, located it in the space "between persons," or the "existential nexus of subjectivity and intersubjectivity" (2014:32). Yang et al similarly argue that stigma occurs "between persons at the level of words, gestures, meanings, feelings, etc. during engagement with what matters most" (2007:1532). Moral experience is thus related to the local processes of enacting values in everyday life

(Kleinman 1999). It is the capacity to explore the relationship between the self, society, and others as well as our first person obligations to each, in context. Yet, moral experience only occurs if cultural conceptions of the person "make people present to each other in particular ways" (Parish 2014:33). In other words, cultural ideas of personhood create or deny the possibility for moral co-presence (Csordas 2014). This moral co-presence of persons shapes our ability to communicate intersubjectively as well as our sense of obligation to others. Through the cultural constructions that make persons be seen as having value or not (Myers 2015), we can examine the ways stigma's moral experience shapes both ideas of the person and, in this ethnographic case, inpatients' therapeutic process.

Yang et al (2007) argue that focusing on moral experience of the stigmatized and stigmatizers allows researchers to reconceptualize how others in our social world constitute and contribute to stigma's experience. Brodwin (2008) discusses how higher order ethical concepts in combination with the details of everyday clinical work produce moral discourses. He understands moral discourses as the "conceptual bridge between moral experience and systemic ethical reflection" (Brodwin 2008:143). Moral discourses, or the way actors engage with ethical issues between persons, shape the enactment of Alas's treatment model and individual experience of it. While Chapter One examined each center's understanding of addiction, treatment, and inpatients, here I present how the stigma that imbues therapeutic procedure at Alas lays the groundwork for inpatient understanding of personhood (their own and their fellow inpatients), shaping self-transformations.

RELEVANT CENTER OVERVIEW:

Founded in 2000 in one of Tijuana's working class neighborhoods, Alas is a 12 Step

mixed-methods center that serves 80-90 voluntary and petitioned (involuntary) women from both sides of the US-MX border. Institutionally, treatment at Alas does not focus on any particular substance. Treatment is meant to prepare inpatients for the 'battle' against using their drug of choice (and eventually all drugs) as well as succumbing to negative thinking that contributes to their 'addict' nature. This conception of treatment means recovery does not begin until after treatment; as such, throughout their time at Alas, women are merely 'in abstinence.' During this abstinence, they are meant to gain clarity on the unhealthy and spiritually corrupt aspects of their relationships, behaviors, and lives. Valentina works extremely hard to form institutional connections across Tijuana and San Diego that bring volunteers, researchers, and public programs to the women at the center, so that inpatients might be able to find an alternate path during their time of reflection and repentance at Alas. She invites these groups to provide educational programs (e.g. sexual education), services (a beauty school comes once a month to practice on the women's hair, giving them free haircuts), and activities (Zumba and art classes) for the times the women are not in meetings. For Valentina, recovery is a process achieved by living a life free of substances in a state of tranquility and being at peace with one's self through one's spiritual awakening and self-forgiveness.

At Alas, inpatients are considered drug addicts in large part due to their spiritual void. According to Valentina, many women arrive spiritually dead. They do not care if they harm themselves or others, because they do not hold anything dear. This interpretation results in a moral and societal problem: women who selfishly use drugs instead of contributing to society by taking care of their families. Therefore, finding one's higher power is an important element of treatment and recovery institutionally. Through a spiritual awakening brought on by any of the various religious groups who visit Alas, group counseling sessions, and/or NA meetings,

inpatients learn to forgive themselves, recognize their self-worth, and understand the value they contribute to their family and community. The emblem of Alas is the butterfly; like a caterpillar in its cocoon, time spent in Alas is about a beautiful change towards recovery. Thus, the therapeutic focus constructed by Valentina is on rehabilitation and reintegration into their family and society. This is by no means an easy process, and Valentina believes it takes at least three months, particularly because so many women come to the center involuntarily.

Valentina is intimately involved in orchestrating center life. It is not uncommon to see her strutting through the center in stilettos, cigarette in hand, to personally solve any number of major problems, like the broken septic tank. The inpatients respect her for this; she is not afraid to get her hands dirty in service of the center and the women. However, her primary role is bureaucratic, and it takes her outside the center much of the time. She leaves day-to-day center tasks to her daughter Daniela and a former inpatient Sara. These two share the role and responsibilities of assistant director, for example: fielding inpatient family members, listening to inpatient complaints, appointing inpatients to services (jobs) within the house, chastising inpatients for neglecting the duties of their service, and punishing inpatients for breaking the rules. While Valentia has formulated the institutional conception of inpatients and treatment drawing on aspects from the cultural environment, it is the center workers and inpatients who enact the behavioral environment on a daily basis. Their interactions with each other reflect the everyday construction of treatment, shifting its experience and producing the self-transformations in ways unintended by Valentina's vision of her community institution aimed at self-forgiveness and spiritual growth.

"LEARNING TO VALUE": STIGMATIZING CONCEPTIONS OF PERSON THAT SHAPE TREATMENT AT ALAS:

Though Alas formally recognizes that addiction is a family disease, requiring self-work from both inpatients and their family members, it does not always feel as such to inpatients. There is a NarAnon meeting[29] every Wednesday at Alas, but not many people come. When I asked Sara, an assistant director at Alas, why this might be, she said it was probably because family members have to work or they come on Sunday and do not have time to come more than once a week. Importantly, her answer also highlights cultural conceptions of the locus of the "problem" in addiction. "Many times [families] do not—they think the problem is the person in rehab only." The cultural conception of addiction is that "it" lies solely in the individual, and only they must change. Sara describes that though families make a sacrifice for their daughter, sister, wife, or mother to pay for treatment, they also need to work on themselves. Yet, families often understand treatment at Alas as meant to focus solely on the inpatient. Alas as a rehabilitation center, aims to create self-transformation for persons and their families to live in a state of tranquility; often for families, it is to reorient the inpatient away from just themselves and back toward their families, becoming a "good" member of society. This stigmatizing conception of treatment and goal exemplifies stereotypic thinking that can give rise to depersonalization in community-based treatment.

Similarly, moralized and stigmatized conceptions of person factor heavily into the Alas's therapeutic model. Mapping on to the broader Mexican conceptions of drug addicts as "weak" or "delinquent" (Secretario de Salud 2008:71), treatment often feels like a punishment to inpatients. Many family members tell inpatients they are in treatment to learn to value their life, their

[29] NarAnon, or Nar-Anon Family Groups, is a 12 Step Program for family members and friends affected by someone else's addiction (Nar-Anon 2019).

family, and/or their children. Many women, like Alma, are told the decision to enter treatment was made for them for their own good, regardless of their feelings about it. Some women even describe rehabilitation in the same terms as prison; "I'll do my time to show my family I can change." However, they often do not know how long they will be in treatment, as families often change their minds, citing inpatients' attitude and lack of perceived change.

To understand what type of change family members were looking for in treatment, I asked Sara why some women do well at Alas and others do not. In responding, she acknowledged that Alas's treatment program does not work for everyone. Though it has a good therapeutic program, inpatients have to want to change, otherwise the treatment offered cannot function for them. Sara told me that will, or the desire to change, is the key to successful treatment.

> The majority of people here are here against their will because their family needs help; they [inpatients] don't want to change. But as they work through the process, and as time goes on, they start to change, and work on themselves. But if they don't start to work on themselves, no program, no place, no doctor, no psychologist will be able to help them. when they leave they will be the same.

According to Sara, rehabilitation necessitates self-transformation; however, it cannot occur without active engagement. Many inpatients' will is not directed at self-transformation away from addiction. So, when they leave Alas they go back to the same places, the same friends, and the same romantic partners that played a role in their addiction. Thus, people relapse after treatment at Alas because they did not want to change or make an effort to do so.

The nature of choice in rehabilitation at Alas reveals an interesting tension in the moral experience of therapy. The first person framing of self-transformation in rehabilitation is taken away to some extent for everyone. Even if inpatients enter treatment willingly, they cannot leave without outside (i.e. familial) approval, indicating that to them, it seems like their inpatient

relative has transformed into a person who will or is centering their life around their familial obligations. Yet, recovery is a choice that can only be made by the individual. The stigma associated with drug addicts' behaviors and personalities changes the relationship "between persons;" in this case, it removes the obligations that families and center workers have toward considering inpatients' first person perspectives about their subjective experience of the therapeutic process.

The stereotypes family members use to justify involuntary treatment and that Alas employs to frame necessary inpatient therapeutic engagement also enters into how inpatients are primed to understand Alas's organization, as can be seen in the concept of "valuing." For example, in one focus group about everyday life in the center, our conversation revealed how many of the women understand their time at Alas through a moralizing and stigmatizing lens. Even the most mundane aspects of life in the center differ from their life outside it; inpatients consider these changes, trying to understand how they might be therapeutic.

> Eva: I like being by myself and all of a sudden, you know, I'm down there [in detox[30]], and it's like the craziest girls or just, no sé [I don't know], well I guess everywhere you know? You just got here and everyone is like [makes hissing noise to indicate cattiness and craziness].
>
> Ellen [E]: Is it easy or is it hard to find space for yourself here?
>
> All: It's hard!
>
> Beth [B]: It's difficult. Like there's no such thing here as alone time.
>
> America: You don't have privacy.
>
> Carlotta: None.

[30] Detox is located in the basement of Alas, a physical reminder of the building's connection to the drug trade, as very few homes in Tijuana have basements except for those found in connection to the drug trade. Inpatients' emergence from the basement after detox is the first symbolic transition of treatment. Their movement out of detox, represents each woman's shedding of her connections to the moral underground of drug use and a re-emergence into the moral light of familial and societal contributions and obligations. This highlights yet another way the cultural environment shapes the therapeutic organization at Alas in moralizing ways.

E: Wow.

B: Hey, but that's even better, you know?

E: Why?

B: Out there, we'll value that, like being able to just to be in the bathroom taking a shit without everyone telling you like [America: Knocking on the door] ¡*Sobres animo*! You know, like hurry the fuck up! You haven't even like wiped your whole cheek yet, and they're already yelling at you like you know?

[All laugh]

B: I feel like for me, it's going to help me value everything. Just even my alone time, everything. It's the whole value, like we already had talked about this, like if everything was smooth, I wouldn't get shit out of this, you know?

Myers (2015:430) argues that cultivating the social basis of self-respect entails meeting local definitions of what a person should do to be respected." Families appreciate that the object of care at Alas is about more than the "drug addict" inpatient; rehabilitation is about becoming who a person should be (or in their case should have been) for their family and society. Locked treatment, regardless of its intent, incorporates the idea that addicts care only about themselves. Taking away their choice to seek or leave treatment and within treatment their access to creature comforts, like privacy, definitively shapes treatment experience for inpatients. In trying to teach addicts to value their life and their families, Alas's treatment contributes to inpatients' stigmatizing moral experience making them feel their past actions make them deserve to be treated as such. Inpatients then internalize these stigmatized stereotypes, often both accepting that these terms apply to them and thinking that they need to be treated as such in order to catalyze the self-transformations in line with how the center frames rehabilitation. Beth says, "if everything was smooth, I wouldn't get shit out of this, you know?" In this statement she accepts

that she did not value the life she had outside the center and that she needs to be punished in order to catalyze her ability to value it.

Framing treatment, however directly or indirectly as about reorienting oneself away from drugs and onto the family, a cultural conception of the "good" (Myers 2015), reveals local conceptions of personhood and how inpatients at Alas do not meet it. Despite the center's official therapeutic model recognizing that addiction is a family disease, stigmatized conceptions of addiction and drug addicts filter into treatment at Alas, often limiting the practical locus of responsibility and action onto the inpatient alone. This change can be seen in Sara's as well as many family members' evaluation that involuntary inpatients (like Beth and Alma) often do not want to change, so the decision to change must be made for them. For these families, certain center workers, and even some inpatients like Beth, it is "the process," including punishments[31] along with 12 Step meetings, that incites inpatient self-realization and self-transformations toward the moral good. In other words, the cultural environment enters into the behavioral environment at Alas, allowing for time at the center to be framed by family members, staff, and inpatients themselves through stereotypic thinking about drug addicts and their desire to change, without necessarily incorporating specific information about individuals as persons. This has the potential to give rise to inpatients' depersonalization, which can be seen in attempts to catalyze healing through punishments rather than self-forgiveness.

READY OR NOT?: DISCERNING MOTIVATION AND MORALITY IN TREATMENT:

Simply spending time in treatment and learning to value what inpatients have while

[31] Family members often specifically create punishments during treatment to catalyze valuing. For example, Carlotta received a large amount of store credit during her first stay at Alas. However, during her second stay (when my research was conducted) her family did not provide any store credit, so she would "value" her access to her favorite snacks and foods while outside the center.

healing from a first person perspective, however, is not enough to leave the center. Women must also prove to center workers and their family that they are using their time for positive self-transformation toward "the good." Yessica, a 24-year-old woman at Alas involuntarily for the second time, questions this conundrum when we discussed why she was so upset after her family failed to take her out of treatment or even call on the day marking three months at Alas[32]:

> Y: My grandpa says [referring to an earlier conversation] that I have to prove to them that I'm going to do the things that I say I'm going to do. But I'm like well, to be honest, I'm just locked inside. I'm doing, [but] I can't prove I'm doing in here.
>
> E: I was going to say, how would you prove it?
>
> Y: In here? I can't… I just do what I'm told to do, and that's it. Because I don't want to stay to live here. So if I don't do what they ask me to do, I'm going to pay the consequences, not anybody else. And I'm pretty sure my mom [Rosa] is losing no sleep over me or the way I'm feeling. And it, it bothers me, it irks me, it hurts my feelings.
>
> E: Do you think your mom knows how you're feeling?
>
> Y: No.
>
> E: And she doesn't care how you're feeling?
>
> Y: I think she cares that I was worse out there, which it might—it's true. But, it still doesn't change how I feel.
>
> E: You don't think she'd be upset to know that you– how do you feel in here?
>
> Y: I just feel like I'm, like she hates me. And she just wants [me] to learn my lesson or something.
>
> E: Yea. But how do you feel in here that makes you want to get out so bad? What is it about here?
>
> Y: It's not here, or the people, it's myself. I want to go on with my life.

[32] Three months is the typical treatment timeframe at Alas. Most inpatients expect to leave at this point, unless conversations with their families indicate otherwise.

Yessica is weighed down emotionally by the involuntary, punitive approach her family takes for her addiction treatment. They paradoxically want her to prove that she will "do well," which she believes is an impossible task while in treatment. If the existential nexus "between persons" is where moral experience occurs, Yessica's pain comes from Rosa's denial of her moral presence (Parish 2014). Without this acknowledgement, Rosa applies her third person perspective to Yessica's progress that does not incorporate Yessica's moral experience of her therapeutic process. Yessica recognizes this, so she just does what she is told, not necessarily because she buys into the center's logic of care (Mol 2008) or treatment model, but because she knows that without acquiescing to the center's rules, they will not tell her mother she is doing well. And Rosa is "losing no sleep over me or the way I'm feeling," so she will keep Yessica in treatment, potentially indefinitely, a consequence that Yessica acknowledges only she will have to pay. Yessica recognizes that Rosa believes she is doing what's best for Yessica, even if it does not align with her own beliefs. In fact, she feels Rosa is trying to punish her, so she "learns her lesson" to stop using drugs.

In outlining the strategies for managing stigma for mental illness among their participants, Jenkins and Carpenter-Song (2008) demonstrate the complexity of stigma experience for mentally ill persons and show the keen socio-emotional awareness of their participants in recognizing and responding to stigma. The subtle, stigmatizing interactional discrimination from others, like Yessica's grandfather and mother, shape therapeutic process for those who are stigmatized. Yet, women at Alas do not passively accept their stigmatization. Yessica is most concerned with "going on with her life," not changing to the way Rosa wants her to be, despite mirroring those values in order to leave. She does not passively accept the depersonalization from her mother, but acts in the way she believes will help her leave Alas.

The ways in which the self-transformations associated with healing in rehabilitation are evaluated by center workers and fellow inpatients can also be stigmatizing. In a focus group with three inpatient-guards, Beth, Carlotta, and Alma, we discussed what inpatients get in trouble for and how they are punished. Punishable offenses range from stealing center materials that could harm others (e.g. a kitchen knife) and writing letters to other inpatients (the implication is that they are romantic) to falling asleep in meetings or trying to escape. Punishments include "being stood up" in front of one of the cameras for easy surveillance by office workers for one day to a whole week, having visits or *permisos*[33] taken away, having smoke breaks taken away, and having family members informed of inpatient behavior. In discussing the various punishments inpatients receive, I asked about a woman who had tried to escape earlier that month. Alma and Carlotta told me that her punishment was to be sent back to detox, starting her treatment process over. However, her family came and took her out of the center a few days later (so she was in treatment less than a month). Their responses to her leaving demonstrate how inpatients themselves often take up the stigmatizing conceptions of who they are that become integrated into Alas's treatment model:

> E: What do you guys think of that [the lady leaving early]?
>
> Alma [A]: I don't think she was ready. She'd been using since she was 15 and she's 30.
>
> E: What do you think about people who leave treatment early?
>
> A: I think everyone is different in their process. Like I think it has a lot to do with your mentality. And the way you—it also depends a lot on how many rehabs you've been to.
>
> E: Why?

[33] *Permisos* (permissions) are approved, supervised trips outside the center. These are discussed in more detail in Chapter 4.

A: Like I think if it's like barely your first one, I think you deserve to be here for only 3-6 months, you know?

E: Ok.

A: But if like you keep relapsing and relapsing, then I think they deserve to stay a little bit more. Like up to a year.

E: Why?

A: Because maybe you aren't, maybe you need more [12 Step] Program in your life. You just need to learn more about yourself. And maybe that time that you were doing before just wasn't enough.

E: Ohhh, ok. Do you think you can tell when someone leaves, if they're ready or not?

A: Yea, cause you can tell if they're just playing the part, you know? Or you can tell when they're being actually serious about their recovery.

E: True. Ok. And what's like a red flag for people who are just going through the motions or faking it?

A: Ok, when we're in the meetings, and they talk about wanting to get better and all this stuff, but outside of the meeting, in the house when we have free time, their actions show completely different.

Carlotta [C]: Like they talk about how they used to use.

A: Like the drugs they used to use.

C: And how they want to go back to it.

A: Like making it sound like it's really fun you know?

Mirroring the concept of valuing, Alma outlines the amount of time persons "deserve" to spend in treatment based on how long a woman has used drugs, how many times they have relapsed, or the "number of rehabs you've been to." Again mirroring language associated with prisons, Alma says that "maybe the time you were doing before just wasn't enough," insinuating that a certain amount of punishment, i.e. internment in a locked rehabilitation center, is necessary to catalyze "learning more about yourself." Though Alma acknowledges that the healing self-

transformations that occur in rehabilitation are individualized and occur on different timelines, she, like Sara, links recovery or relapse to a person's will to be clean. Those who continue to relapse and use drugs do not match the concept of a good person in this context. As such, they deserve to spend more time in treatment. This extra time in treatment will allow them to get "more Program in [their] life;" in other words, extended locked treatment provides the environment for them to understand the ideas of who they are, who they ought to be, and how they need to change. This contradicts Alma's own sentiment from our individual interview about having to stay in treatment longer. "I'll try to bear with this for as long as I can, but I feel like it's [being in the center involuntarily] just getting to me, you know?" Despite disagreeing with the notion of long-term involuntary treatment from the first person perspective, from the third person perspective it seems she is quick to apply the same cultural logic that perpetuates involuntary rehabilitation.

Moral ideas of the person shape conceptions of true self-transformations in treatment; inpatients are subject to the evaluation of their progress by family and center workers, often in contradictory ways. Though inpatients are meant to talk about their past drug use, they must do it in a particular way. In keeping with the moral understanding of addiction, drug use is harmful and should never be described as fun, despite Carlotta, Beth, and Alma all discussing their use as fun in the same focus group interview. In talking about their past drug use (during 12 Step meetings or daily life at Alas) inpatients open themselves to the moral evaluations of center workers, who, as was shown in the previous chapter, have a significant impact on therapeutic process for other inpatients. Despite any and all efforts to positively heal and move towards self-forgiveness and recovery from the first person perspective, any third person perspective evaluation that an inpatient does not have the will to change can have a significant impact on the

way center workers treat them and how long they must stay at Alas.

The effects of these sorts of moralizing evaluations of inpatients by front office workers and inpatient-guards can be significant for inpatients' therapeutic process. Verónica is a 22-year-old brought to the center voluntarily by her uncles for 5 months. She has a long history of drug use, starting with alcohol at age 13 and methamphetamine (meth) by age 14; however, she describes the first few years of her use as social or to cope with her loneliness. It was not until she moved in with her boyfriend and father of her child after time apart from him that her meth use became problematic to the point of causing her panic attacks. This was why she sought help from her uncles. A few weeks before she left treatment, while discussing her transition out of the center, Verónica mentioned that she wants to truly be open with her family about her continued struggles with the urge to use. She particularly wants to be open with her uncles and family, because she has experienced "jail-talk" first-hand from the abusive father of her child and she does not want to do the same thing to her family. She describes jail talk as what people say while they are "locked up" but they have no plan or intention to live up to their promises.

> While he's in jail he gives you like the "jail talk" you know? Kind of like when we're in here, like—like they'll be like "Oh I'm going to do good," [they're] like all about God and all this and that. And you believe it because you love them and you want to believe it, you know? Then all of a sudden they just—AGAIN [emphasis hers] like stray off and starts doing drugs again.

Jail talk is what selfish, unchanged persons do in order to get what they want. At Alas, women engage in "jail talk" in order to be able to leave the center, regardless of whether they have engaged in the process of self-transformation and forgiveness that Valentina understands rehabilitation to be. To combat this, Verónica wants to be open with her uncles about her struggles to change and heal, but she is worried her honesty will be perceived as an *unwillingness* to change, rather than a positive self-transformation towards open communication.

Carlotta experiences the same problem; in a focus group a month before her anticipated departure from Alas, Carlotta lamented that she needed to work on being more open with her father, as "keeping everything to herself" had in her view heavily contributed to her relapse (this is her second time at Alas).

> I need to be more open with him. He comes on [every] 10 days, and he asks me stuff and I answer him. And then we talk for a little bit but then later on he's just on his phone, or I'm with the kids [her children] and we don't, I don't know it's like quiet visit now. I don't know what to tell him! I've been here *so long*! [emphasis hers] I don't know what to tell him! I don't want to tell him I want to go home [and] I'm ready to go home, because then he's gonna be like "No, you're not ready." So I don't know what to say.

Carlotta feels as if she is ready to leave treatment and begin recovery; she had been at Alas for nine months at the time of this interview. Yet her first person perspective does not in this context match the authority of her father's perspective. The space "between persons" is fraught with stigmatized conceptions of who addicts are and how they are meant to exemplify their positive self-transformations. This makes open, honest communication about the therapeutic process for drug rehabilitation difficult.

Alas's treatment model posits that persons in rehabilitation need self-springing will or motivation to change as well as family support to move towards recovery. Without family support inpatients may lose motivation, with improper family support inpatients can become resentful, and with no family support inpatients can become despondent. However, inpatients/addicts can also take advantage of their family and their willingness to provide support. In order to have the type of self-transformation toward self-forgiveness and personal growth that Valentina intended, inpatients describe needing to be able to communicate clearly about how they are moving through "the Program," including when they feel like they are ready to begin recovery. However, the stigmatizing cultural conceptions of addiction in this context

predispose family members and center workers to frame certain conversations about past drug use, urges, or preparedness to begin recovery as signs of "not being ready," instead of positive self-transformation. The stereotypes of addicts alter the ability to have true, intersubjective moral presence between inpatients and family members as well as between inpatients and center workers, which is necessary for community-based, mutual aid addiction treatment. This fundamentally shapes therapeutic process away from first person understandings of healing towards external, third person cues, that may or may not reflect the type of positive change intended to indicate self-forgiveness and preparedness to enter recovery outside Alas.

ADDICT DOES NOT MEAN CRIMINAL OR CRAZY: STIGMA DESPITE (WORKING TOWARD) RECOVERY:

Focusing on familial ties and obligations as a means to catalyze recovery may seem like a positive treatment method for both the institution and many inpatients. As Christensen (2017) argues, Narcotics Anonymous's recovery model necessitates its members re-shape their self and subjectivity around its understanding of addiction (an abiding aspect of self) and recovery (a recognition in their powerlessness over addiction and constant self-vigilance). Similarly, to be considered "successful," "in recovery," or "clean" by the standards of Alas, inpatients must strategically position themselves in relation to the recovery trajectory outlined by the institution. However, its enactment may be less inviting in the ways it shapes inpatient conceptions of self and subsequent transformations as they attempt to move towards recovery.

The organization of treatment at Alas incorporates moralized and stigmatizing conceptions of who inpatients are (addicts) and how they need to change. Alas, like most 12 Step centers, understands every addict to be the same and they organize treatment as such.

Despite cultural conceptions of drug addicts in the border zone as selfish, criminal, and weak, relatively few women match the stigmatized stereotypes completely. They all vary in the amount of time they have used, what they have used, where they used, and what their "rock bottom" looked like. For example, Ivanna a 45-year-old woman petitioned by her mother after nine months of crystal[34] use, has a hard time accepting that everyone at the center is "all the same addict," even though she often uses that rhetoric herself. She recounted her feelings when the police brought 13 new inpatients to the center that shows this:

> Last night, I stood in the window and I saw that they had these police people come in and I felt like I was in jail, like what the fuck? And you just start seeing those [women], like did you see them? Does that look like me? That affects me! Because it makes me feel like.. a van of 13 girls, ladies, that I used to give money to people on the street [like them a] donation, whatever, and I'm in the middle. Like you come in the category where I don't belong! You know what I'm saying? It makes me feel like the buckets of shit that's [thrown in the courtyard]…

Being in the same center as women like those she used to provide charity to deeply shakes Ivanna's conception of self. "At the moment, we're at different levels, we're all at different levels in our mind. We're all the same, but we all have different conditions, Ok?" Even as she references their sameness, Ivanna creates distance between herself and these new "worse" inpatients at a different level. In accepting that stigmatizing cultural conceptions apply to these "other" inpatients, Ivanna contributes to the depersonalization of her fellow inpatients. Despite these new women's work towards healing self-transformations, Ivanna and others at the center still classify them as "at different levels" with "different conditions." In other words, regardless of these women's attempts to change, Ivanna and others still view them as "street people" who do not want to change.

The persistence of moralizing, stigmatized conceptions of addicts in the behavioral

[34] Crystal is a common way to refer to methamphetamine in this ethnographic context.

environment at Alas shapes the way all persons within Alas relate to each other and understand themselves. For example, Ivanna, criticized the office workers' lack of emotional support as reflective of their negative conceptions of inpatients.

> Ivanna (I): So the way I was feeling I, I learned here that the people from the front of the house [front office workers] could start with a little bit more moral support.
>
> E: Yeah.
>
> I: Not treating [their job] as [only] authority, because, yes, we are bad people. Yes, we were bad for consuming that drug, but it doesn't make us like a criminal and we shouldn't be treated like that. Nobody should. Because like I said, there is always a why to how we consume it. If we are here in rehab, it's because we are here to recuperate. If you're put in jail, it's because you are being punished. And I think some of these people are mixing these things... And so what I learned here is that…I don't want to be that person. I don't want to run a service [work for the center while an inpatient] the way they run it here because I can't do that.
>
> E: Yeah.
>
> I: I cannot come in here and treat you like a number or treat you like because you consume it, oh well, you shouldn't have consumed. Because that's not helping you. Because you're supposed to be in rehab. So, when somebody says "I don't want to be here. I'm sick and tired of going to meetings" [office workers] shouldn't respond "Oh well you guys shouldn't have done hit the pipe." That's negative, that like makes them feel worse.

Ivanna interprets this behavior as due to the office workers' understanding of inpatients as "criminals." Ivanna specifically discusses the fine line between having inpatients reflect on how their drug use has affected their families, and simply punishing them. "If we are in rehab, it's because we are here to recuperate." She resents being treated as if she is a criminal in the very place she has come to change the behavior that associates her with the criminal. Instead of making her reflect on how she can learn from her past actions to make a better future or value what she now has, Ivanna insinuates that her interactions with the office workers make her and

most inpatients, “just feel worse.” Her time at the center has shown her that this harsh treatment often causes inpatients to slip in their recovery, making them no longer want to change.

Yet, even as she criticizes the main office workers for creating a behavioral environment that blames inpatient “drug addicts” for their problem, Ivanna questions whether or not it is, in fact, the “drug addicts” that at times make Alas a very difficult place to live, rehabilitate, and recover:

> Do you think it’s the people here? Cause that’s a question I have. Do you think it’s the girls here or do you think it’s the people who run the place, or is it the addicts? I understand that Valentina, God bless her for having a place, and like I get happy when we have new people, because that’s more people out of drugs right? My respect to that. I know Valentina is doing good. But the people that run it. Do you think that maybe they should change that a little bit? Or do you think it’s the addict that’s just, already an addict and has a different way of thinking that it makes everybody contaminated, like when you have a bowl of apples and one addict just contaminates everybody? I mean what is it?

Ivanna has begun to orient to her fellow inpatients (and herself) based on the way main office workers interact with herself and others. Many women see office workers as lacking the necessary emotional support to create a treatment climate conducive to recovery. The perceived lack of support and the reasoning behind it reveals one way, from an inpatient’s perspective, how stigmatized cultural conceptions enter into the behavioral environment at Alas, shaping both everyday action and self processes oriented towards (or away from) recovery.

This model for interaction, intentional or not, filters down, and, over time, can shift someone like Ivanna from empathetically engaging with her fellow inpatients’ struggles toward recovery, to viewing herself and her fellow inpatients as rotten apples, contaminating everyone around them. It creates an environment in which inpatients relate to each other as equals on a journey of self-forgiveness and healing while simultaneously viewing others as “the same but with different conditions.” This shifting moral superiority can lead to the depersonalization of

these morally inferior inpatients, allowing center workers and other inpatients to engage in or condone interactions with fellow inpatients that they believe is unhelpful for themselves. In this way, inpatients often participate in the denial of each other's moral presence even as they together work toward recovery and denounce this very type of occurrence from first person perspectives.

Inpatients worry this stigmatizing conception and treatment of them will not stop when the leave the center. Alma, discussed this fear with me as she prepared to leave Alas after 1 year in treatment:

> But whatever I do for myself you know like, I don't know I just–it's kind of hard because I feel like...to…to society, I feel like to society I'm considered crazy because I've been in rehab so many times, I've been to outpatient so many times, I've been to a mental hospital three times already. [E: Yeah.] Like this one time I was at my house and all the neighbors came outside because they, they took me out on a stretcher from my house.

Stigma shapes not only therapeutic process, but inpatients' conceptions of their moral personhood. Alma and Carlotta worry that they might not be seen as changed, despite their efforts to move through treatment at Alas in the ways center workers or family members frame as positive. Persons like Beth come to view the stigmatized notion of "valuing" embedded in treatment as necessary for her healing self-transformation. While Ivanna works toward her own healing and self-forgiveness, the way center workers frame readiness can lead her and others to create a hierarchy of moral personhood despite the center's 12 Step framework of egalitarian mutual aid. Further, even if each woman moves through therapy in the way Alas outlines, it may not alter their family members' or friends' conceptions of them. These fears can play a large role in inpatients' understandings of self and the self-transformations they are working towards while at Alas.

CONTEXT IS KEY: UNDERSTANDING MORAL EXPERIENCE AND SELF PROCESSES IN CULTURAL AND BEHAVIORAL ENVIRONMENTS

Cultural conceptions of person shape ideas of who inpatients are and how they should be treated during rehabilitation. At Alas, stigma is a main component of the moral underpinnings of personhood as well as how treatment is meant to elicit self-transformations in line with this cultural idea of "the good person" (Myers 2015). Further, despite community-based drug rehabilitation's failure to permanently cure the majority of persons who enter into their treatment, it does not often induce doubt among communities in the US-MX border zone in this form of therapy's ability to do so. Individuals and families continually intern themselves or their loved ones in these facilities. Blame for failure is often placed upon the "drug addict" who "didn't want to get clean" or who "didn't try hard enough." As has been shown, inpatients are keenly aware of how these concepts apply to them. Thus, this chapter provides evidence for how the self and moral experience are mutually shaped by contextual, cultural understandings of personhood.

In his work on Usonian Narcotics Anonymous (NA), Christensen shows that NA's narrow interpretation of addiction "legitimates wider behaviors and norms that are neglectful of addiction's contextual influences" (2017:26). Though helpful for many, the 12 Step model's dismissal of trauma, structural violence, and other socioeconomic and political inequities in lieu of individual responsibility exemplifies a callous neoliberal moral system in which only self-reliance and economic productivity are valued. When it places all failure upon the individual, this limits the effectiveness of the model on an individual level and its wider reach. Further, it limits open communication between care providers and receivers (c.f. Carpenter-Song et al 2007). While I agree with Christensen's critique of NA, I think it neglects the dynamism of the

particular cultures that spring up in different NA/AA communities and the creativity and resourcefulness of persons who participate in it (c.f. Jenkins and Carpenter-Song 2008) as well as in their own self making efforts (Parish 2008) and healing (Kleinman 1988). Inpatients seriously engage with Alas's treatment model, questioning its relevance and effectiveness for their lives. Therapeutic models may espouse singular, narrow recovery paths, drawing on specific aspects of the broader cultural milieu. Though they present clean narratives of treatment and recovery, its lived experience is not necessarily so; individuals who pass through them experience a much wider range of therapeutic trajectories due to a myriad of contextual influences. Family support, agreement with the center model, stigma, center worker interactions, individual ideas of self and illness (among many others) shape these varied trajectories.

As I have shown, inpatients do not passively accept these stigmatizing conceptions for themselves. Yet their resistance itself reveals the contextually specific forms of personhood enacted at Alas. Fox (2001) examines the ways institutional discourses "coercively construct new selves for inmates" and inmates' responses to this construction. She examines how the cognitive Self Change Program conceives of inmates as essentially violent criminals, yet paradoxically asks them to be rational independent agents of their own rehabilitation. The program insinuates self-change, self-knowledge, and self-regulation, but the conditions of possibility for this self-driven action are set by the institution. Importantly, the program does not necessitate change, just the knowledge of how to change. So, it forces inmates to see themselves as essentially criminal, but leaves them to come up with how they will rehabilitate themselves (Fox 2001:179). She summarizes Foucault, saying, "power dynamics are characterized by the coercion that prompts resistance" (Fox 2001:191). As I have demonstrated through this case study of stigma's moral experience at Alas, though individuals may resist the changes the

program calls for, the possible type and form of their resistance is shaped, if incompletely, by institutional parameters, by the behavioral environment interwoven with elements from the cultural environment. Resistance and that which is resisted must in some way speak to each other, just as self processes exist in and are of culture. The moral experience of stigma at Alas exemplifies how the behavioral environment, often in complex ways, alters the orientations of inpatients toward themselves and their fellow inpatients, in ways that may not always be anticipated within a community-based therapeutic model.

CONCLUSION:

Here, I have demonstrated that understanding stigma's moral experience is a key element to understanding the self processes that occur in community-based addiction treatment. Specifically, having a better understanding of the way self-transformations aimed at healing are catalyzed through concepts of person will further scholarly understanding of efficacy in community-based treatment contexts. As Csordas (1994b:3) has argued, "the locus of efficacy is not in symptoms, psychiatric disorders, symbolic meaning or social relationships, but the self in which all of these are encompassed." Efficacy is visible through the phenomenological experience of self-transformation. Therefore, understanding the elements that factor into subjective experience and self-transformation, like stigma, is essential to comprehending the efficacy of community-based drug rehabilitation programs like Alas from first person perspectives.

CHAPTER 4
GONE...AND BACK AGAIN?: TEMPORALITY, HEALING, AND REAL LIFE AFTER COMMUNITY-BASED ADDICTION TREATMENT

"Vladimir: So there you are again.
Estragón: am I?
V: I'm glad to see you back. I thought you were gone forever.
E: Me too.
V: Together again at last! We'll have to celebrate this. But how? Get up till I embrace you.
E: (Irritably) Not now, not now."
- Waiting for Godot

Fieldnotes - 14 December 2017
Alas Christmas Party

I picked my way through the plastic folding tables, decidedly avoiding the dance floor covered in strobing lights where the steel table usually stood in the courtyard. I made my way to the corner by the *tiendita* [store] where Jaime was leaning up against the wall next to a table laden with bowls of horchata and two-liters of Coca-Cola. "How are you doing? Having fun?" I asked. "I'm good; it's weird. I leave tomorrow morning." I had forgotten this, so I asked if she felt ready and if she was happy to go home and be with her family so close to Christmas. Jaime responded, "Yeah, but I won't be with them for too long. Like I said, I want to get a job with Border Patrol. So I'll probably have to go to, like, Texas or something, because they usually send people away from where they know people, to stop corruption and stuff." I asked if she was comfortable going so far from her support system (her family, friends, and the people at Alas). She said, "Yeah, I think it will be good to get away from my friends back in SD. I used with them. And I have no idea how to use in Texas so it will be way easier to stay clean." As we talked, A man starting screaming for Jaime to help serve dinner; laughing, she said, "I'll see you later Ellen!" I left the center at 11:30pm (though the party was by no means over) to get to the Otay Mesa border crossing before it closed. I did not see Jaime for the rest of the party.

Fieldnotes - 7 June 2018
Alas de Esperanza

I burst into the courtyard, surprised to find it empty as I was 10 minutes late for the arts and crafts hour I ran during my fieldwork. I threw the craft floss on the glowing steel table (it was already hot and getting hotter) and looked around for a guard. There should be at least three in the courtyard, but at the moment it was deserted. I turned towards the metal screen door into the main house, thinking the heat might be keeping everyone inside. Just as I moved toward the door, it opened and Jaime walked out. Surprised, I screamed, "Jaime! It's good to see you!" "Yea, I'm back," she said quietly. There is a small moment of awkwardness when she went to shake my hand as I went to hug her; but, we shook hands while I bombarded her with questions "When did you come back? Where is everyone? Do you want to make bracelets? It's *so* good to see you!" She smiled ruefully, saying "Yea, I got here a couple days ago. Everyone is in with the priest, but he's almost done... Man, I forgot the details of being here. Art class on Thursdays, the *flaquito* [skinny priest] stays for three hours on Friday but the *gordito* [fat priest] only stays for two....do you want me to call everyone [for the art class]?" "That would be great, thanks, Jaime!" I said. With that, she walked back into the house, leaving me alone at the steel table, hearing the scrape of chairs on the tile floor and the swell of voices coming from the main room that signal the end of the priest's session. Jaime did not come to art class.

INTRODUCTION:

Jaime's experience is familiar for those who have studied or experienced mental health recovery; it reveals the complexity of addiction, its treatment, and healing when one follows an individual through time. Though there is a standardized pathway for rehabilitation at Alas, the way each woman progresses through treatment is much more dynamic. While living at Alas, women are inundated by the institutional model of what it means to be an "addict," what they

should do in treatment, and what they should do after it to be "clean" or heal. Treatment is a reckoning of who each woman *is* and what possible futures and selves exist for them. Importantly, though, recovery trajectories are not black and white. Earlier chapters have outlined Alas's institutional model of treatment and its distinct path for recovery; yet when one follows the actual trajectories of women who move through the center, the institutional model for success is taken up and interpreted in a variety of ways, resulting in a multitude of actual addiction trajectories (Raikhel and Garriott 2013). In this way, the experience of treatment is a profound and fundamentally individual yet intersubjective attempt at self-(re)making that cannot easily be predicted by simply examining the therapeutic procedure at a given rehabilitation center.

If rehabilitation is itself an example of self-work, so too is the transition to recovery, or life outside the structure of residential treatment. As these women re-enter their social networks, they begin to assert their own understandings of their addiction, recovery, and plans for the future. The return to their life outside the center and the attempt to enter recovery is a new reckoning; their horizons of possibility shift. In those shifts, the desire for or the attainability of their plans, hopes, and dreams may change. The reasons for which they cannot enact their plans or move towards their goals range from structural and economic to social and personal. Some women manage the anticipated and unanticipated challenges that accompany this transition. Others cannot, and they watch the sun set on their horizon of ideal possible, often with personally devastating consequences, like relapse. As others have argued, it is important that the macro theoretical concepts used to understand the struggles of mental illness, addiction treatment and recovery, such as structural violence, are not divorced from their lived experience (e.g. Ralph 2014; Jenkins 2015). By connecting the different stages of treatment, I seek to recognize and highlight the effects of uneven social systems (Whyte 2009) that shape self and subjectivity.

In this chapter, I trace the trajectories of three women as they came to Alas, moved through treatment, and transitioned out into their social world. These women granted me the privilege of learning the complex biopsychosocial nature of their drug use; we candidly discussed whether the 12 Step model espoused by Alas was helping them direct themselves towards the life they wanted. Then, after they left treatment, we reconnected in various ways and to varying degrees to discuss how they were managing the transition back into their social lives. Each woman represents (though not exhaustively) one of the multitude of trajectories that emerge from the same center.

In presenting their various pathways and experiences, I investigate the idea of "successful recovery." Who gets to define it? How should I make sense of competing definitions of positive transformation/ healing in coerced therapeutic settings divorced from persons' actual life context? What do persons' failures, successes, and attempts at "having a life" (Csordas and Jenkins, in press) reveal about the nature of community-based addiction treatment and recovery? How does the self interact with the lived experience of recovery? How do hopes, dreams, failures, and setbacks factor into our conceptions of self? In this chapter, I draw only from my dissertation fieldwork; therefore it represents a snapshot of each woman's addiction trajectory. Though partial, I argue considering life histories and the movement between points in the healing process are essential for understanding individual recovery trajectories, even within the same treatment model.

CONNECTING THE DOTS: TEMPORAL EXPERIENCE AND HEALING DURING AND AFTER RESIDENTIAL ADDICTION TREATMENT:

Time and its experience hold particular significance for therapeutic process in locked-

door, residential community-based addiction treatment. As an interventionist total institution (Waldram 2012), rehabilitation is a fundamentally different temporal experience than recovery or active drug use. It is a period of abstinence, often outside of the individual's control (in this ethnographic context), in which they are consciously directed to consider their drug use, its effects on their lives and those of their social networks, as well as their goals or plans for change or healing. It is a period of in-betweenness dedicated to acknowledgement of the past, needed change, and re-orientation towards a "better" future life.

Since Turner's (2017[1969]) work on liminality, much research attention has been devoted to the temporal experience of in-betweenness. Framed as waiting (Crapanzano 1985; Chua 2011; Little et al 1998; Jeffrey 2008), becoming (Biehl and Locke 2010), existential limbo (Haas 2012, 2017), timepass (Jeffrey 2010), reveries (Varma 2016), and constraint in place (Reed 2003), anthropological researchers have examined how the phenomenological process of waiting can be experienced as a punishment. Others have demonstrated that multiple temporal registers exist and impact subjectivity for persons in addiction (Knight 2015; Odgers Ortiz and Galaviz Granado 2016). Still others have explored temporality and spatiality's relationship with mental health treatment (Kemp 2009; McWade 2015, Meyers 2013a), revealing how "transnational disorders" (Duncan 2015), "improvement without cure" (Jenkins and Carpenter-Song 2005), the "chronotope of the queue" (Fraser 2006) or "the loss of self" (Carpenter-Song 2019) may ultimately lead to what Lurhmann (2007) has termed "social defeat." As discussed in Chapter 2, this relates to the moral conceptions of addicts (Gideonse 2015; Singer and Page 2014) and how they must rework themselves in order to re-enter society.

Csordas has called for researchers to develop a theory of healing (or the healing process) by modeling "how therapeutic process effects transformation in existential states" (1988: 139).

Still, researchers have focused heavily on understanding the constructed and institutional nature of healing (Mattingly and Garro 2000; Mattingly and Lawlor 2001; Quesada et al 2011) as well as its relationship with conceptions of illness and cure (Kleinman 1988). Others have focused on the often tenuous intersection of hope and healing (Mattingly 2010; Good et al 1990; Odgers Ortiz and Galaviz Granados 2016). Halliburton (2003) emphasizes the taken for granted nature of cure and people's search for cure and healing inducing environments, within a range of therapeutic systems. I seek to pull apart these assumptions by examining several stages of addiction trajectories to better understand the both individual and intersubjective nature of therapeutic process as well as its connections to horizons of possibility.

Continuing the focus on therapeutic process as seen in Chapter Two, this chapter specifically focuses on the phenomenological process and individual, often ambiguous or contested experience of healing through time. The horizon is a common phenomenological metaphor used to capture conceptions of the future possible. This can be examined through persons' hopes, fears, and future plans. By exploring inpatients' hopes and future plans through time and specifically in the context of their life history and treatment experience, I investigate the relationship between healing, self, and self-transformation (Csordas 1994a), what Csordas and Jenkins (in press:28) call temporal subjectivity or the "system or matrix of possible horizons situated at the boundary between mediate and immediate future (Csordas and Jenkins, in press: 28). Hope as possibility can be intersubjectively managed (Crapanzano 2003, c.f. Good et al 1990) and may affect not only therapeutic process, but horizons of possibility for individual addiction recovery, particularly those in locked, residential treatment.

Following Csordas and Kleinman (1996), Hejtmanek (2016) explores the healing and self-transformations that occur in coerced settings, highlighting that they may look very different

from the institutional framework for "success." While Carr's (2011) "script flipping" highlights an agentive action to work within such "helping institutions," Varma's (2016) analysis of intoxication and reveries highlights how persons in addiction treatment reconstruct themselves and use multiple temporal registers (i.e. past, present, and future) to understand their future possible. As I will show, this is the work of self that occurs in rehabilitation and recovery; depending on a person's life history and what strategies or definitions of addiction and recovery they draw on, they may move through treatment in ways not necessarily intended by the center, though it is nevertheless a success for that person.

Parish (2008) argues that the self is made through our experiences, just as we are persons made through our meaningful relationships. Self-making is processual (Csordas 1994a), and often under-determined. Yet, in moments of crisis or breakdown (Zigon 2007), persons must consciously rework or transform the self to accommodate our changing circumstances. This work of self occurs at Alas; from the first person perspective, women try to grapple with addiction, understand its relationship to their self, and reframe it in relation to their future outside the center and in recovery.

Recovery, like addiction itself is a murky biopsychosocial concept shaped by individuals' self-transformation processes and socio-structural forces. While Deegan (2002:6) describes recovery as "a transformative process" of the self, Myers (2015) frames recovery as a process of rebuilding moral agency. By presenting case studies from around the world, Kaiser et al (2019) show how recovery narratives are co-constructed in both clinical and research settings, in both positive and negative ways. Recovery is a "polyvalent concept" (Pilgrim 2009:475 in McWade2015:244) that alludes to cultural ideas of cure, healing, social norms, and in the case of

rehabilitation, who the 'drug addict' is and what their possibilities for the future are. As such I understand recovery as:

> the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (White 2007: 236).

In tracing the trajectories of these women through time, I engage with each woman's therapeutic process as they engage with their own ideas of addiction and recovery, its convergence with institutional life, and their transition into life outside the center. In this way, I explicitly analyze their experience of self-transformation to hone in on the ambiguities of the phenomenological process of healing in addiction treatment and recovery.

Below, I present the cases of three women with diverse ages, substance use histories, and social life experiences at the center. Through discussing what brought them to Alas, their hopes and plans while in the residential center, as well as their transition back into their social lives and responsibilities outside the center, I examine the temporal experience of opening and foreclosing future horizons. I understand this temporal link as a critical element for understanding the healing process (Csordas 1988; Csordas and Kleinman 1996) and possible selves (Parish 2008). I investigate how our human ability to hope and plan for the future possible is shaped by our social world, both its structures and the human relationships in which we find ourselves enmeshed. I examine the temporal experiences of opening and foreclosing futures to understand the simultaneously personal and social process of addiction trajectories (Raikhel and Garriott 2013) to highlight the intersection of culture and self (Csordas 1994a,b).

AMERICA: CYCLICAL SUCCESS AND DIVERGENT UNDERSTANDINGS OF ADDICTION AND RECOVERY

When we met, America was a 25 year-old woman from San Diego County. She had two children, a 12 year-old daughter Camila and a two year-old son Adrian. Her drug use was entirely US-based; she came to the center voluntarily with her mother Ana and father Angel, though she had a negative intake experience (discussed extensively in Chapter Two). She started drinking at age 20, smoking pot and cocaine when she was 22 and first used crystal when she was 23. It was her crystal use that ultimately led her to Alas.

Before Treatment

America's path to the center was convoluted, and directly linked to the biopsychosocial process of "coming down" from her high. It took America's parents two attempts to get her into Alas. Ana and Angel first tried to bring America in February 2017, after she realized she was exposing Adrian to drugs. She had been out smoking crystal with friends one night in February, and she returned to her apartment where her son Adrian was (Camila was with her paternal grandparents). At the time, Pedro, her boyfriend, was in jail, and she was cheating on him with another man. This man showed up in her apartment with a group of people and they started smoking crystal in the bathroom. America's realization of what was going on caused her to seek help:

> They went to the bathroom and they got high. I mean, all that smoke, regardless whether you want to put the fans, you want to turn the AC on, whatever – I still think it's contact. My son's in the room, you know? I'm not okay with that. It really got me heated and it got to the point where I was like so sad, I was super – this is where the comedown comes. I wasn't high anymore. I was coming down so I was feeling guilt coming from all places. I grabbed my son, I tell my mom, "You know what mom? I'm not okay. I'm not doing okay. I've lied to you these past couple of weeks. I'm still getting high. I need help."

The combination of coming down off crystal and recognizing the exposure to drugs that her son had experienced left America feeling guilty; so, she sought help from her mother, who knew about Alas because America's cousin Leti had stayed there the previous year. Ana said she would pay for America to go to the center, but America had to give her custody of Adrian. America agreed. However, the next day when she, her mother, and father were on their way to Alas, America began to regret her decision. She started to make requests to stop to get food at a gas station, but she was just stalling. After they stopped in San Ysidro, she brought up that Pedro had her papers, and she did not want to cross to Tijuana without them. Her father protested, saying it would be fine, they could bring them to her later. So, she dropped all pretenses, and said:

> 'I don't want to go, and when we get to the border I'm going to tell them you guys are taking me against my will.' That scared them off, so we went back home and my dad said 'You know what? Do whatever you want. I don't want you getting high anymore. And if that's what you're going to do, I don't want you around.'

Despite her father's admonitions, America's use escalated; she began smoking crystal every day with her boyfriend Pedro, when he returned from jail. She reported that she knew there was a problem, but she could not stop. Her spiraling use and behavior culminated in her arrest alongside her friends for grand theft auto. This was her first arrest, and though it rocked her, it was not the impetus for her seeking help, nor was her worsening performance at work as a teacher's aide. She called out sick frequently because using "wasn't even a choice anymore," but she did not want to go to work high. In the last week of April 2017, she was laying on the ground, feeling extremely lethargic in her high from smoking marijuana. Pedro came over to her and sprinkled heroin in her eyes. This was not the first time that he had tried to trick her into using heroin; he had also previously inserted heroin into her anus while they were having sex.

Pedro wanted America to use heroin with him, not just smoke crystal, but she had been refusing. However, she had been considering it. After he put the heroin in her eyes, she felt a burning sensation then a high, but she did not like it. She described the come-down as "even worse." She felt weak, nauseous, and got terrible diarrhea along with a headache. On top of this awful physical experience, Pedro was pressuring her to smoke heroin and telling her how no one would love her as much as he did. Even though she felt awful, she grabbed Adrian, ran out of the apartment, and walked to her aunt's house.

When her cousin Leti answered the door, she looked frightened by America's appearance. America then told her aunt and cousin everything that had been going on. Leti then said something that inspired America to go to rehab, "What are you going to do different than you haven't done already?" America responded "I'm leaving, I want to go to TJ. I really want this change." "So what are you going to *do*?" "I'm going to call my mom." She took the phone Leti handed her and called her mom, asking Ana to come get her so she could go to rehab. Though skeptical of America's commitment, Ana sent Angel to pick America up. On the way home, Angel stopped at Walmart to pick something up, leaving America in the car with Adrian. While alone, she kept thinking she could still run away; Pedro was calling her non-stop. She describes ignoring his calls as her first test of her commitment to changing her life. Angel was surprised she was still in the car when he came back. They briefly stopped at home to pick up America's mother and brother, then they headed to Tijuana.

> Finally, we're on our way and my mom keeps [mimics looking into the backseat of a car], you can tell she's nervous, and that's what held me back. Looking at my parents, I'm tired of disappointing everyone who loves me. Who truly loves me, and I just tell myself, I'm gonna stay in the car. I really wanted to jump out. And I told my brother, "Look, hold me to you. I really need to feel your guys' support, because I'm really wanting to jump out the car right now."

Her family's support in combination with her recognition of her worsening use while coming down from crystal meth brought America to Alas in May 2017.

During Treatment

America came to treatment "voluntarily." As described in Chapter Two, her intake procedure was negative and affected her desire to stay at Alas. Though she thought she was only going to be at the center for roughly 15 days to one month, she stayed the full three-month treatment period. In some ways she resented this, as the decision was not up to her; but, America appreciated the extra time at the center. She acknowledged that she would not have reached the point in her healing process that she had by July[35] if she had not stayed.

When America first came the center, she described being disappointed in herself, specifically because she did not like people knowing she was in rehab, especially her work. Even though she came by choice, the stigma she associated with needing help for managing substance use was very painful for her. By the end of July 2017, America was proud of herself for acknowledging that she had a problem and taking time to focus on herself and her needs. What helped her most in treatment was hearing other people's stories during the meetings and knowing that other people were going through the same process. She realized that her biggest problems were lack of healthy personal boundaries and her need to please other people. She believed her biggest challenges for healing would be getting to know herself and learning how to set boundaries— to "say no" even to people she cares about—because doing so can be an act of self-care. While in rehabilitation, America realized that the majority of her romantic relationships had been toxic, revolving around codependency. She connects the fact that she does not fully know

[35] America left treatment in July 2017.

herself or how to approach personal/romantic relationships in a healthy way due to her early pregnancy with Camila at age 13. Since that young age, she had been focused on caring for other people (her daughter, her boyfriends, etc.) instead of herself. Being at Alas allowed her to begin to get to know herself and shift her priorities to include self-care.

In many of our conversations, interviews, and focus groups during her time at Alas, America discussed what counts as a drug, what addiction means, how it is experienced, and what counts as recovery or relapse. Her conceptualizations vary drastically from the center model. America understands addiction to take shape based on the particular substance. For instance, she understood her problem with legal substances to be not knowing how to limit herself. With illegal drugs, "it's about an emotional need, a physical and mental need and all that." Overall, she understands addiction to be a mindset; you can see addiction taking hold in a person through their behavior, particularly "dropping your responsibility to your family." For America, a person must be actively using to be an addict and in addiction. Though others at the center think that using drugs and being an addict make you a "not good person," America vehemently disagrees. As such, she does not think using the term "addict" to describe herself is either appropriate or helpful. "It's whatever you think of yourself; that's what you'll do." In other words, America thinks referring to herself as a perpetual addict would set her up for failure. In order to move through treatment at Alas, then she does not unconditionally accept everything they tell her about herself, her addiction, and its treatment. "I pick up only what works for me." She got into several fights with Ivanna and other inpatient-guards running 12 Step meetings, because she would refer to herself as "America in recovery," instead of "America *adicta*." She would not do that because, to her it "sounds like you're still even giving it [using] a thought." She also doesn't like talking to new inpatients, because "they're still in that same [addict] mindset." She acknowledges the

center's version of relapse—any use of any substance—but for her relapse relates only to her drug of choice.

> That night[36] I smoked pot. I still don't consider that a drug. I probably should change that Ivanna says, so when I get back I stay completely sober, you know? Until I know exactly—even alcohol. That's something I wasn't going to stay away from cause my whole family does that. But I really want to straighten myself.

This exchange reveals how differing conceptualizations of drugs can alter ideas of sobriety, relapse, and recovery. In turn, this shapes the way America moves through treatment, relates to her fellow inpatients, and understands her self.

Throughout her time at the center, America's framing of her "problem," to herself and others (including me), fluctuated drastically. America oscillated between recognizing how serious her use was getting and downplaying it, saying it wasn't that bad and that she had already stopped using all "real" drugs. In a focus group in May 2017, she stated that she was not an addict because she only used meth for five months[37]. In an interview in July 2017, I asked America if being at the center had changed her idea of addiction. Though she did not explicitly confirm this, she told me about a woman at Alas who is "5150[38]." This woman's life story scared her, it made her think about how close she was to that before coming to Alas. She told me that by April 2017 she would speak nonsense when she was high (people noticed) and she started to get paranoid, thinking people were following her or trying to kidnap her. In this same interview, she said "You know, you want to think your whole life or when you're active you want to think that it's not going to happen to me. That's not going to happen to me, but we don't choose that

[36] This is in reference to the night Pedro put heroin in her eyes, as described above.
[37] This contradicted the timeline she gave me in individual interviews; in that context she said she started using meth at age 23.
[38] This is a colloquial way to say "crazy." It is a reference to the California Welfare and Institutions legal code, Section 5150 that outlines the temporary and involuntary commitment of individuals to psychiatric custody if they, due to a mental health disorder, pose a danger to themselves or others.

[addiction] obviously." Even though earlier in the interview she said that "when you're really tired of using drugs, you find a way to stop." These fluctuations illuminate America's attempts to understand her self and her condition while reconciling these conceptions with Alas's institutional model.

In discussing what she wanted for her life after rehabilitation, America was very clear she wanted to maintain her dedication to herself. "I just want to focus on myself 100%." She wanted to be "selfish" and do only what she wanted: spend time with her family and her kids, develop healthy hobbies, return to her old job, and get to know herself. Though she still had feelings for Pedro, she knew their relationship was toxic and could not continue. She was also clear that she does not want to be with a past or present drug user in any future relationship, because she had done that in her past relationships, and during each of them, she used drugs. However she did not want to focus on finding a relationship. Her parents were supportive and recognized that going back into the world of social responsibility would be hard. "My mom told me, 'Look. You did a shit load of stuff in a short time. You have a lot of things to fix when you get out there. So you're going to have to start slow.'" Though her parents supported a slow start, America wanted to "jump in," despite her apprehension that she might "over-do it." Specifically, she was very nervous she would forget the value of putting herself first:

> "I really hope it doesn't change, like I don't want to get out of here and be out there and forget about…how I was thinking here. I want to continue doing it and I'm going to cut a lot of people off. Everyone as a matter of fact cause I know that being out there I still want to be able to focus on myself."

She planned to "cut people off." Beyond this, however, America did not make a plan for how she would cope with any potential stressors. When we spoke on her last day, on 31 July 2017, she did not have a plan for what she would do if she ran into Pedro or if she heard a song that triggered her desire to use. She just knew she won't be looking for him or the going to the places

where she used, because she had grown past it. Though she had clear future goals to frame her horizon of future possible, she actively avoided considering or planning for possible setbacks.

After Treatment

Fieldnotes - 26 August 2017

I got a text from America at 10:46pm as I was lying in bed, about to fall asleep. "Can I call you? It's important." "Of course!!" I responded, feeling both happy that America felt she could contact me, and a little sad that I had been so excited to go to bed on a Saturday night. I found out that she had just left a family party, because she felt weird; though she had "had a few sips of beer," everyone around her was drunk and it gave her "weird vibes." As she walked home, we discussed her transition to her life outside the center. She had been thinking of Pedro, because his sister kept texting her. She felt guilty she had been avoiding him, but she thought it was best for her. Other people she used with had been reaching out to her as well. She told me she was not avoiding them, though. "When they hit me up, I just tell them I'm clean now and they push themselves away." She had not been going to 12 Step meetings, because she wanted to save them as "a last resort." She does read the Solo Por Hoy on Mariposas[39] and send it to Verónica. She put me on hold for a few minutes, as her mom called while we were talking; when she came back to my call, America told me that was scared about disappointing her family or herself as she tried to figure out her life. We said our goodbyes when she got home, so she could get ready for bed.

Fieldnotes – 27 August 2017

America called this afternoon; she had been drunk the night before, and does not want to do it

[39] Mariposas is the name of a WhatsApp group run by former inpatients still working at Alas. Though more detail is given below, the intersection of technology and addiction recovery is outside the scope of this chapter. I plan to dedicate future research to mental health technology's application and effectiveness for addiction among Latinx women.

again. “I don’t feel that urge for alcohol anymore.” She also had a cigarette, even though she doesn’t smoke. She assured me that she didn’t smoke anything else. She also thinks she was thinking of Pedro last night because she wants to make amends, though she’s not sure is she is ready. America also thinks that Ana does not believe she is still clean; “you remember how she called me last night!” A friend told her taking a urine test might make her mom feel better, but America does not want to do that; she thinks it would show her parents that they are right to not trust her. We discussed the hardships of recovery and life outside the center, particularly how her attitude affects her interactions and relationships. She’s glad she had a slow start after leaving the center. She is not sure she would have been able to cope and maintain her commitment to her recovery with the return of all her family responsibilities and drama with her exes if she had to immediately get a job as well. Our conversation ended with her reiterating that she is sticking to her goals. She got a part time job at AT&T, and if she keeps it up she’s going to treat herself to a new car in December.

Fieldnotes - February 2018

America Facebook messaged me on February 1st saying we needed to catch up. I responded several hours later asking how she was. “I'm not doing so good I'm living in Pedro’s car when I can I stay in hotels. But I did get a job and I start Monday. So I hope it gets better.” Two weeks later she told me she had an abortion and that Pedro is in jail again for his fourth sales charge. We discussed her pain in making the decision to get an abortion without her family’s knowledge and her visit to Pedro in jail to break up with him. "I’m cutting him [out] by the root. I'm tired of him and everything that revolves him. In order to heal the way I deserve to he needs to go.” A week later she asked me for help with a scholarship and FAFSA form to go back to school.

Fieldnotes - 5 April 2018

Monica[40] introduced me to Maria today to enroll her in my dissertation study. Monica cryptically introduced me by saying I might be interested to talk with Maria about her friends. After discussing the project with her, and receiving her consent to be included in the study, I asked Maria what Monica had meant. She said conspiratorially, "Oh I know America; we grew up together. She's doing really bad right now." According to Maria, America was using meth again—and frequently. I called America from the car on the way home, but she didn't answer. I sent her a Facebook message asking if everything was going well, and she responded that everything was going great, and she was taking classes at Palomar College.

IVANNA: THIS YEAR IS REALLY ABOUT REALIZING THINGS...AT ALAS:

Ivanna is a 47-year-old woman who came to Alas involuntarily in April 2017 after nine months of continuous methamphetamine use in Tijuana. She is a US permanent resident; she has spent the majority of her life (over 30 years) living in San Diego County. Though she regularly drank wine after finishing up her shift as a manager of IHOP or had a beer at a family party, she did not experiment with other drugs prior to her period of heavy use. Ivanna spent one year at Alas, though that was not the original plan her mother, Teresa, had when she committed Ivanna. She has six siblings, three older and three younger. She also has three adult children, two sons who live in San Diego and one daughter who lives in Los Angeles.

Before Treatment

Ivanna had a very difficult upbringing. Though Teresa did not use heroin or any other drug, she spent over 15 years married to and caring for a man addicted to heroin—Ivanna's step-

[40] Monica is a study participant who lived at Alas from July 2017 to July 2018.

father. This relationship caused significant trauma for Ivanna and her three younger siblings, who were ultimately given up to foster care when Ivanna was 12 years old. Teresa did not even show up to the custody hearing, leaving no doubt in Ivanna's mind that her mother had chosen her abusive step-father over her and her younger siblings. For the next six years, she moved between foster homes and group homes. She had no communication with her mother during that time, but she remained in contact with one of her older siblings, Giselle. When she was 18, Giselle offered to have Ivanna come live with her; Ivanna thus emancipated herself from the state and moved in with Giselle. This was when Ivanna's mother re-entered her life, though to Ivanna they were never able to reestablish a good relationship. With the help of a social worker whom she considers to be a life-saver, Ivanna finished high school, secured her immigration status, and got a good job. They remained in contact even after Ivanna left the foster system; this social worker even helped Ivanna through the process of becoming a foster mother herself.

Ivanna's romantic life contributed to her sense of abandonment and betrayal as well. Though she was married to the father of her three children for 15 years, they divorced after she discovered he had been cheating on her. She remains happy with her decision to get a divorce despite her family questioning it, because thinking about her husband's infidelity made her depressed. For a while, she found meaning in fostering children; she served as the foster mother to five children after her divorce. Several years after her divorce, she ended up falling in love with a man that she helped pull from addiction. Though they did not get married, they were in a committed relationship and lived together for 11 years. During their relationship, she helped him stop using heroin and crystal, get his daughter out of the foster system, and reinstate his parental rights. However, she believes now that he was just using her to get his daughter back, as he

"walked out of her life" shortly after regaining custody of his daughter. This man introduced Ivanna to crystal; after he left her, she came to Tijuana to use.

During her nine months of use, Ivanna had no contact with her family. She described this period as cathartic; it was her first attempt to do something for herself, after organizing her life around her husband, boyfriend, children, and foster children. Using also brought up Ivanna's repressed pain from her childhood and failed relationships. She believes she was too busy throughout her life to recognize her feelings; using crystal allowed her to slow down and realize her emotional needs. She wanted to forgive her cheating husband, understand her mother, forgive her sexually abusive stepfather, and forget the man who introduced her to drugs then left her. Like many other women in the center, Ivanna's use stemmed from traumatic experiences, representing both an attempt to escape and address these traumas. She recounted filling several diaries with her thoughts and emotions about her life during her period of use. In this way, it was actually a lesson, though a complicated one. She understands her addiction as bringing to the surface the "years of hurt" she suffered; though painful, she began to address this pain through using and writing. She is unsure how long she would have continued using drugs and living in Tijuana if her mother had not intervened. Her ability to frame her use positively may be influenced by the briefness of her use, though others at Alas with more extended use histories also discuss similar positive elements to using for emotional traumas.

During Treatment

Teresa committed Ivanna to Alas for nine months, mirroring the amount of time she used crystal. Over the course of her time there, Ivanna's conception of self, her problem, and therapeutic process changed drastically, ultimately leading to her decision to remain in treatment

for a full year.

While at Alas, Ivanna wrote diaries about her life at the center, her struggles with her mother and treatment, her life before coming to the center, and what she hoped for in the future. She often mentioned a desire to retrieve the diaries she wrote while using (she left them in the home of the man she used with) in order to gain a clearer perspective on what she was thinking about during her use. She felt this would both give her guidance in writing her book on addiction recovery and closure in terms of removing herself and her things from this abusive man's life. Writing was helpful for her, and revealed how contentious and dynamic Ivanna's relationship with herself and her therapeutic process was.

Many external and internal factors shaped Ivanna's understanding of her therapeutic process and labor towards healing. The first was her immigration status. She is a US permanent resident with plans to become a citizen like her children, many of her siblings, and mother. However, during the nine months she used crystal in TJ, her wallet with her permanent resident card and driver's license was stolen. Ivanna's inability to act on paperwork problems that arose from the center forced her to rely on her mother, as Ivanna had no access to a phone or internet. Ivanna thought Teresa did not understand the magnitude of the potential consequences for Ivanna if Teresa did not comply with immigration requests. As a very action-oriented person, this period of forced inaction, especially when the stakes were so high, made it difficult for Ivanna to focus on her healing. It made her focus more on her immediate needs (e.g. going to the immigration office) rather than long term needs (e.g. extended time to heal and make plans for recovery).

Ivanna's relationship with her mother was another significant influence on her treatment experience. Teresa's apathy toward working on Ivanna's immigration status as well as

participating in Ivanna's therapeutic process brought up many of her unresolved emotions towards Teresa. This forced Ivanna to seriously consider her mother's role in her addiction trajectory and how she needed to move forward in order to heal. Ivanna did not feel it was her responsibility to tell Teresa what she did wrong in their relationship. She felt hurt by her mother's treatment of her as a child, but Ivanna recognized that Teresa is also in pain. For her first few months living at Alas, Ivanna thought Teresa put her in rehabilitation as her attempt to "do right" and to learn from past mistakes. After being in the center for several months, it began to feel as if Teresa just wanted to "lock her up;" she was not putting in the "50-50 work" or mutual aid and support necessary for recovery. She only came to Alas for 15 minutes to drop off food or clothes; she did not stay for meetings or to catch up with Ivanna. Further, Ivanna's brother Jesus, a long-time crystal user, had never been committed to residential treatment by Teresa. This significantly contributed to Ivanna's therapeutic process as she attempted to understand why she was in locked treatment in Tijuana (i.e. whether she belonged in a center like this with people who have "more severe" addictions than her), how long she had to stay in treatment, and how Teresa made decisions about Ivanna's treatment without asking for or including her first person perspective.

Finally, the center's behavioral environment played a large role in both her own and others' therapeutic process (as was shown in Chapter Two and Three). The environment that affects her ranges from creature comforts to the attitudes of the other inpatients' operationalization of "success" through service work. She filled many service roles, often at the same time. While this may have benefitted Alas significantly, (particularly her role as ward mother for the minors, due to her expertise as a foster mother) it cost her dearly in terms of her mental and physical condition. She developed severely high blood pressure and twice came

under the nurse's supervision for risk of stroke.

Each of these factors contributed to Ivanna's shifting understanding of her use as well as her self-identification with the social category "addict." When she first entered, she considered addiction to be a disease she did not have. She understood her use as brief and recreational, especially since she did not experience severe symptoms like hallucinating, commit desperate acts to get high like robbery, or form criminal connections like trafficker boyfriends that other women at Alas described. She often referred to herself as "normal," claiming that many women told her that her use of two 50 peso balloons of crystal every day was trivial. For the first six months, Ivanna was deeply concerned with her family's perception of her as an addict. She knew her ability to shape their opinion of her was limited while at Alas, so she was eager to leave, return to her family, and prove her commitment to recovery. Gradually, though, she came to view her time in treatment as dedicated to understanding herself, coming to terms with her traumas, and learning what she wants to do and be for herself.

This change was prompted by a *permiso* she was granted for her birthday. *Permisos*, or permissions, are day-trips granted to inpatients with family members who have visiting privileges[41]. Twelve members of her family, including some of her siblings, her mother, and several of her aunts from Fresno came to Tijuana to celebrate her birthday at Italian restaurant. Overall, she described her *permiso* as a positive experience; it confirmed much of her feelings that she is doing the right thing by committing to her own healing and recovery, including her decision to stay at the center for one year.

At the restaurant, everyone ordered wine and beer, while she ordered an iced tea. This particular scenario was one Ivanna had been "looking forward to;" she wanted to know how it

[41] *Permisos* are rarely granted for persons staying only three months and they are typically granted for major events.

would feel being around her family while they drank. She felt completely comfortable around them drinking and had no urge to drink herself. However, her brother Jesus introduced a different scenario that she had not considered would occur after treatment and emotionally shook her: he came to dinner high on crystal.

> The only thing that messed me up, it wasn't that I got the urge [to drink], it's that I got pissed off. One of my brothers, Jesus, the one that's been in the hospital that finally came out, remember I told you he's been consuming? [E: Mhm (affirmative)] Well he was high as fuck. And he sat next to me. At first I didn't realize it, but when he sat next to me, it's like I could smell it. I could see his reactions, and it really hurt me. I looked at him, his eyes, [and I could tell] he wasn't high on weed, he was high on crystal. And all he wanted to talk about was the past. Just things that I don't care about no more [E: Yea] Things that I've buried already. So my brother's [doing] this in front of my aunts from Fresno, and I keep saying 'Chuy, Chuy, I don't want to talk about it, I don't care, I'm ok!' [E: "I don't want to talk about this right now!"] I don't want to talk about it! So finally my sister Giselle's like, "We clearly told you guys that when you see Ivanna we don't want you to talk about her past, to ask her what she's been doing [at Alas], or to say how different she looks. We want you to respect her." Because I started getting nervous [E: Yea!] I didn't want to think about him [the man who abused her]. So my brother just goes "Ok, I'm sorry." And then we started having dinner.

Her plan had always been to go directly back to San Diego. Since she only used crystal in Tijuana, like Jaime, she was planning to create a scenario for life after rehabilitation in which she would never be confronted by crystal and its use again. She mentioned several times that he sat next to her, highlighting her proximity to his use. She tried to tell her mother that it affected her seeing her brother in this condition, but she did not think Teresa understood the severity of the situation for Ivanna. Jesus's use not only shattered Ivanna's vision for her future, drug-free life, but embodied a threat to her healing process. Her anger was in many ways an attempt to protect the fragile progress she had made.

I asked why Jesus's use particularly bothered her, when the rest of her family was also using in front of her. Ivanna highlighted the social normalization of alcohol versus crystal. Her

family always had wine with Italian food; they did not regularly attend family functions high on crystal. It was not a scenario that she had envisioned in her life after treatment. Therefore, she did not have a plan to deal with it, which solidified her decision to stay committed to staying for a year to work on herself even when confronted with the opportunity to leave that night. As dinner was wrapping up, Ivanna reminded Teresa she needed to return to the center by eight o'clock. This caused both Jesus and her aunts to offer to take Ivanna home with them instead. Teresa told Ivanna they could go get all her things and take her out of Alas. She responded:

> 'Mom it's not about what they want, it's about what I want. And I committed to myself to do a year here. I want to finish my process. It's time for me to do something for myself, and finish something for myself.' And my brother's like 'A year, you look fine! You don't need a year!" They don't understand that I'm not ready Ellen. Because the moment that the opportunity that I went out, and felt my brother next to me consuming, it wasn't a sensation, it's just that I was pissed. I was trying to control my emotions, I wanted to tell him off, 'why are you consuming when mom just spent I don't know how much money on the hospital for you?' So I need to learn how not to carry those feelings with me.

She felt angry with her brother for using and disrespecting their mother. This stems directly from what she has been learning at the center about valuing her family's commitment to and sacrifices for her. But she was also angry because she wanted Jesus to respect her decision to stay at Alas. His conception that she "looks fine" is exactly what Ivanna has been struggling with while at the center. Ivanna believes she has not mastered the ability to regulate her emotions, a key indicator that she can exist in the complex, outside world in a state of serenity, as Alas and Valentina understand recovery. Through her anger, she realized this journey to recovery is hers. *She* decides when she is ready, though she cannot ignore her social relationships (like her mother's security and her brother's opinions) because they will continue to shape her life and recovery trajectory. Standing her ground in this case, revealed Ivanna's burgeoning self-confidence in determining and acting in a way that is best for her.

She took immense comfort in this realization that stemmed both from her confrontation with her brother and from listening to her family's quotidian troubles.

> When I was sitting [at dinner], everyone was talking about this and that, their problems with work or family. The conversations they were having were like a totally different world than the arguments I have here [at Alas]. Then my brother-in-law, he's in the military, he just looks at me and he goes 'nothing has changed, huh Ivanna?' I go 'No!' he goes 'This is what I do when I'm with your family, I just sit there [she imitates him nodding his head] Believe me, I just don't get involved with your family!' I go, 'I hear you!'...Once you go out for permission...outside, the cops, the streets, the bums, and all that? Nothing's changed. The only thing that's changing is me, my mentality, the way I look at things. Before I used to get involved in everything [with my family]. But at this dinner, just listening, I learned everything gets resolved in life, one way or another. God is not going to give you a package that you can't handle.

Though she initially felt lost, adrift in the sea of new information about life outside the center, her brother-in-law helped Ivanna realize that everything is the same as always. His military career creates a similar experience to Ivanna's time in rehabilitation (i.e. being part of the family yet separated from them physically, knowing generally what is going on with everyone, but being removed from the everyday details). This provides a great comfort to Ivanna. Though the details may be different, the family is working through them; most importantly, they are working through them without Ivanna. Previously, she had taken it upon herself to try to fix all her family's issues. She now sees this was not only unnecessary, but detrimental to her own wellbeing. Listening instead of immediately getting involved helped Ivanna recognize her personal and emotional growth, a journey that she wanted to continue by extending her time at Alas.

Ivanna came to understand the time she spends in the center as full of learning opportunities about herself and her recovery. She likened this dinner to one of those situations. She recognized her emotions were "everywhere" listening to her family discuss their problems, which showed her that she really did need to continue working on her emotions. Though she

knew that she had committed to sobriety, she had not prepared herself for confronting an active user. While her brother's use bothered her, it was also an important emotional lesson as well as a sign of her strength and growing self-confidence. She also realized she does not need to solve everyone's problems. In realizing her own emotional limits, Ivanna exclaimed, "I think I'm growing in here, Ellen!"

Ivanna used her additional time at the center to work on her weakest points: her codependency and pressing desire to take action for others. Alas is the perfect environment to test these weak points and grow, as people constantly ask each other for food, clothing, and cigarettes. She excitedly told me that the other women in the center started calling her a bitch, which helped her realize doing things to please others will not necessarily make them like her, but it may put a strain on her ability to take care of herself. The center's environment does wear on her though; she mentioned how the attitude of the other women often make her wonder why she is still there, when she could probably find these same lessons outside the center. However, she reiterated her commitment to spend a year at Alas. She wants to spend her time constantly learning lessons to prepare for life outside the center, not growing comfortable and becoming codependent on the routine at Alas.

As it came closer for Ivanna to leave the center, she shifted from focusing on learning lessons more to preparing for life outside the center. She became consumed with worry over where and with whom she would live, how she would get back across the border, and how she would get a job. This was made even more stressful by the fact that she was not sure of the exact date that her mother would to take her from the center. Though her one year date was 20 April 2018, Teresa would not confirm that would be her last day. Giselle added considerably to her anxiety when she, according to Ivanna, began to express doubts about whether she wanted

Ivanna to move in with her. She felt, once again, that her family was not equally committed to her recovery. When we spoke on 19 April 2018, Ivanna's vulnerability was palpable; she had no home she felt she could go to and she was certain staying in Tijuana would be dangerous for her recovery. I told her to call me or Facebook message me when she got out if she needed anything; I would do all I could to help. I did not hear from her; but, I got a Facebook message on 27 April 2018 that she was out, in San Diego, and staying with her sister Giselle.

After Treatment

Fieldnotes- 27 July 2018

Today I picked up Ivanna from her sister's home in Chula Vista to go to lunch at Olive Garden. It's been three months since she left Alas, but we spent a significant amount of time at lunch catching up on all the drama from Alas.

Ivanna is struggling to adjust to her family's expectations and her role in her children's lives. She believes Giselle is anxious for her to get a job so she can move out. Ivanna also believes her daughter is avoiding her, since she has left her two children with her husband. Ivanna is having a hard time understanding this decision, as she took her children with her when she left her husband. However, her eldest son helped Ivanna embrace that people will do things she does not always agree with and "fresh into her recovery" is not the time for her to get involved. She is focusing on moving forward by cultivating a virtual support system through Alas. She maintains contact via a WhatsApp group "Mariposas" where they hold virtual *tribunas* about the *Solo Por Hoy*, what it means to them, and how they will work it into their day. This seems to be a significant comfort to her; she is extremely active in it, and people still call her "mom" in the messages, as they did at Alas. She also friends everyone from Alas on Facebook once they get out, because seeing their daily intentions or motivational posts help her. When she sees several

posts that indicate to her that they are not doing well (e.g. they post a meme about smoking marijuana) she hides them from her timeline, so she only receives positive affirmations. She also refuses to accept people who she knows are not good for her recovery, like people she used with in Tijuana. Ivanna is also starting to write her book about her experience with addiction, with the hope that it can be helpful to other people in her same situation.

After lunch, I took her to her immigration appointment to receive a new copy of her permanent resident card at a nondescript office building in Mission Valley. We waited in the reception room for about 20 minutes until a man came out to see her. The conversation that ensued was very confusing; he said her file had lapsed, so she needed to resubmit it. This required that she re-submit a copy of her birth certificate, along with several other documents. As she did not have those with her, she had to schedule another appointment. Once we got in the car, she said her mother couldn't find her birth certificate. When I asked how she could get a new one, she said she needed to go to the Mexican Consulate in Little Italy. I was going that way anyway, so we got back in the car and headed north. After searching for parking, we walked into the consulate where we were required to completely turn off all electronics. It was relatively busy, so we waited about 30 minutes before her name was called. I was not allowed to accompany her to the desk. She came back after only five minutes with an exacerbated look on her face. She could not get a new copy of her birth certificate without proof of identification (e.g. a government license), which she also could not replace without proof of identity (e.g. a birth certificate).

We got a coffee at the Starbucks down the street; as we drank she voiced her frustrations about her immigration paperwork. She had secured a job at a restaurant in Old Town, but she could not officially start until she provided her paperwork. She discussed her anxieties about having been out for months already, but not having her life "back together again." I tried to comfort her,

saying that it would take time, though it seemed to have little effect. I left her at the trolley station after we committed to getting lunch again in the next few weeks.

YESSICA: "THE MAN SAID 'WHY DO YOU THINK YOU'RE HERE?' // I SAID 'I HAVE NO IDEA'"[42]

Yessica was a 24-year old woman committed to Alas involuntarily for the second time by her mother, Rosa, when we first met in May 2017. Though a polydrug user, at the time of enrollment, her drugs of choice were methamphetamine and heroin. She is a US citizen, though she has been living in Tijuana since she left home at the age of 16. She has a five-year-old daughter, Luz, who has lived with Rosa, since Yessica went to Alas for the first time in 2015.

Before Treatment

Yessica grew up in San Ysidro, though her family moved around San Diego County a lot when she was younger, as her mother is undocumented. She has one younger brother and one younger step brother. Though she is on good terms with both, her use and her behavior towards her family has placed a strain on her relationship with both of them. She describes herself as a problem child, spending time in juvenile detention on eight different occasions. Yessica first started using drugs at 13 by smoking marijuana. At 14 she started taking prescription pills and by 15 she was using cocaine, pills, marijuana, and "partying" (drinking alcohol). She first tried crystal on her 16th birthday. Shortly after, she ran away from home to live in Tijuana, because she "just wanted to take care of herself." She met Luz's father, Martín, during this time, and the pair travelled around Mexico and the US southwest, working odd jobs. She became pregnant

[42] These lyrics are from Amy Winehouse's 2006 song "Rehab."

with Luz during this time, and for the first three years of Luz's life, they travelled around as a family. However, Yessica and Martín's relationship ultimately ended poorly, with threats against Yessica's life and Mexican child services intervening to take custody of Luz at the end of 2014. This was the impetus for Yessica going to treatment the first time.

She stayed at Alas for nine months. On a *permiso* in April 2016, Yessica told Rosa she appreciated everything she was doing to help her, but Rosa could not keep her locked up at Alas forever. Eventually Yessica would leave, and if she wanted to use again, she would. This upset Rosa, and she took Yessica out of the center the next day. Yessica acknowledged she hurt her mother, but she was feeling hurt herself for having been left at Alas for so long. Nevertheless, she moved back to California, went to NA meetings, got full custody of her daughter, and started working and making money. Yessica says she was clean for nine months, but felt empty. During this time, she met a border patrol agent who asked her out. Rosa was very excited by this, but Yessica was not. She thought he was a nice guy, but he was too sweet for her and she had to "pretend to not be an addict." They went on a few dates, though, and Yessica even started drinking with him. Yessica said Rosa didn't care about this, though, because she was so excited about the potential relationship. "It kind of bugs me cause it's like, my mom, she didn't care if I used or not. She just wanted me to be [a certain way]." Yessica had so many responsibilities at home and she had worked so hard to change and better herself in treatment, but Rosa had the same negative attitude. Though things ended rather quickly with the border patrol agent, Yessica started partying again. On New Year's Eve 2016, Yessica used heroin for the first time, because she wanted to try it after hearing everyone's stories about it while at Alas.

Rosa tricked Yessica into coming to Alas the second time after five months of extensive heroin and crystal use while living on the streets of Tijuana. In May 2017, Yessica had been

taken to jail in Tijuana; she was in a holding cell for 12 hours, feeling strong withdrawal symptoms. She called Rosa, asking if she would bail her out then Yessica would start methadone treatment. A few hours later, they released her. Yessica called Rosa from a payphone outside the station to let her know she had been released. Because she was feeling "dopesick," Yessica started walking along El Bordo, looking for someone who could help her "get well."[43] While she was searching for a rig,[44] Linda (though she did not know her at the time) came up to Yessica and asked her name. As soon as Yessica confirmed her identity, Linda grabbed her and threw her in a van. Linda and several other inpatient-guards had been walking along the riverbed looking for Yessica, upon Rosa's request. Yessica deeply regrets asking Rosa for help, "When I arrived [at Alas] I resented my mom for that. Because I trusted her. She said she wasn't going to put me away if I didn't want to, because she knows it doesn't work."

During Treatment

Yessica recounted working diligently toward recovery during her first stay at Alas. "I started working on a relationship with my higher power. I put everything in me [into it]; I wanted this." She described feeling guilty for not dedicating herself fully to her recovery while she was out, as she had "put 100% into [drug] use." She expressed a desire to learn what is best for her during this stay at Alas.

Yessica's conception of addiction is fluid and intersects with several different ideological/theoretical frameworks. Her conception of addiction places it on a continuum with obsessions. She thinks there can be good or neutral addictions, like to playing or watching soccer, but it becomes an negative addiction when a person starts doing something compulsively

[43] "Getting well" is a common euphemism used to reference drug use intended to address withdrawal symptoms.
[44] A rig refers to the materials needed for intravenous injection.

or when their body asks for it. “When in your mind you think ‘I don’t want to be doing this,’ but you do, that’s when your body don’t give you a choice anymore.” Yet, she also considers addiction to be a choice. She recounts that it was her choice to start using drugs, and then after that it was her mindset to keep using. She does not believe addiction is the same for everyone. She also voices the 12 Step program’s logic, saying a person is an addict forever, even if they are clean 40 years, because they could go back to using. “The Program tells you ‘es un enfermedad crónica y progresiva’ [it is a chronic and progressive disease].” This progressive nature, which comes from the way you need more and more of a drug to the point that you need it to function is also related to a moral change for Yessica. In addiction, persons might start feeling like they’ve lost their morals: “I might let somebody be with me just so I can get that dose, or I might witness something that maybe if I was ok, I would not let happen.” Yessica’s fluctuant conception of addiction causes significant strife with her mother, grandfather, and center workers.

Her time in treatment was shaped by the attitudes and expectations of her family members. She felt very resentful towards her mother, whom she felt was trying to punish her. Though her mother and grandfather were economically and materially supportive, Yessica never felt emotionally supported by them whatsoever. As Yessica aptly stated, “this [addiction] is not just a problem for me, it’s a problem for the whole family.” Yet, the little comments throughout her life about her being pathetic and the fact that Rosa would not provide her treatment timeframe made Yessica feel like her mother did not care about her, only appearances. Her mother rarely called during her second stay at Alas;[45] though she went to Nar-Anon meetings during Yessica’s first stay in treatment, Yessica did not think Rosa has continued going. Further, her grandfather, who lives in Tijuana, visited three times during her first three months in

[45] Without legal status, it was impossible for Rosa to visit Yessica in Tijuana.

treatment, and his last visit was only to tell her she was a *pendeja*. He told her she was not sick, the problem was *her* and "el exceso" [her excesses]. "They think their way of thinking is the right way. They're never going to understand this disease. My mom thinks I'm going to leave here and not want to use drugs and I told her, you're not going to get a paper that says 'oh your daughter will never use drugs again if she stays this amount of time.'" Her family members' attitudes and actions hurt Yessica and shook her own expectations for her future life, causing her severe psychic distress.

In many ways, Yessica was met with this same unsupportive attitude from front office workers and the center psychologist that she feels from her family. Yessica's mental health was dismissed throughout her time at Alas, in ways that mirror her familial struggles with understanding her addiction. Yessica mentioned having suicidal thoughts while in treatment; she discussed "wanting to go to sleep and just not wake up." When I asked if she had talked to her psychologist about this, she said she had, but "they just think I have to get over it." The psychologist dismissed her requests to talk to the psychiatrist that comes to the center, because "they think I just want medication to make time go faster." I asked if she could talk to anyone else about it, and she admitted she had been thinking about telling her grandfather, but ultimately decided to "stay quiet," due to her fears it might extend treatment. Sara actually said "Ella va a regresar dos o tres veces [She's going to go and come back two or three times]" about Yessica, while she was in the room. Despite Raquel, the peer counselor, standing up for Yessica, telling Sara nobody knows for sure what anyone else's recovery will look like, it is not difficult to see why Yessica felt a strong resentment toward many of the center workers. As explored previously, Sara's attitude can be rather callous towards inpatients, particularly those who have been in treatment more than once.

> Y: I hate it cause I think that they already label me as if I have no opportunity to improve myself. Like I'm just like what they think I am and that's it.
>
> E; Well, what do they think you are?
>
> Y: Well, that I'm always feeling sorry for myself.
>
> E: Who says that?
>
> Y: Everybody. I know sometimes they might be playing, but I think everyone has – in my life, even from my family, little comments you know? Like my mom always calls me pathetic.
>
> E: Well that's not very nice.
>
> Y: So, that's like – that kills me and labelling hurts me... I don't necessarily think that I deserve the type of therapy, you can say, that my family tries to give me. I don't appreciate the fact that they don't tell me how long I'm going to be here. Or that the answer is like well if you don't want this, why did you use drugs? Oh, hello, I didn't want to be an addict. I didn't plan this. I didn't sign up for this in elementary, you know?

Though Yessica felt supported by many of the inpatients at Alas and Valentina herself, she struggles to understand why Sara or others might say this about her. Yessica constantly told herself she might use again, but this was not simply because she wanted to use. The "labelling" and expectations of others when paired with the long history of her family's unsupportive behavior significantly influenced her horizon of possibility.

Yessica's uncertainty with her ability to heal or change came up when she tried to think about what she would do when she left Alas. From early on in this second stay, she discussed unresolved feelings for Noah, her most recent boyfriend, and its effect on her therapeutic process. They had been dating (though he lived with another woman) and using together, just before she came to Alas. She had broken up with him the day before she was brought back to Alas, because she realized she did not want to share him anymore. The next day when she went to apologize, she was picked up by the police and ultimately ended up back at Alas. Though she

thought of him all the time at the center, she did not talk about him much, because to do so felt like "squeezing lemon on a wound." Her unresolved feelings for Noah and her hope for clarity on their relationship was the reason she wants to get out of the center as soon as possible. Though he was still actively using, she wanted to go look for him no matter what.

We discussed in October 2017 whether or not finding Noah would be feasible or good for her overall mental health and recovery; in doing so, the conversation turned toward her desire to use drugs. She described wanting to use again, "because of the feeling. And it's easier, especially during this time when I don't want to be thinking about anything or feeling anything. It just makes everything go away." The lure of using drugs to escape her emotions and the uncertainty of her romantic relationship was strong for Yessica. Drugs not only make the pain go away for a time, focusing on finding drugs would give her something to occupy her mind and time rather than missing Noah. Yet, she also did not want to use again because she knew what it did to her body. She was scared that she did not know what would happen in terms of her using; even if he would not give her drugs, someone else might. She might even buy drugs on her own, instead of having them offered to her. In order to have the conversation and gain the closure she needed, Yessica felt she must risk having a potentially use-triggering conversation in the very context (under the bridge) in which her use is best facilitated.

Several months later, in March 2018, Yessica informed me she had spoken to Noah. He came to the center under the pretense of visiting an inpatient who had recently come to Alas.

> Y: I just feel like a great relief was taken off my shoulders. [Talking to him] it was something that I really wanted to do. And then that week I was like happy but at the same time sad because I was like oh, I don't want to be here anymore. But now I know that it's only excuses that I allow myself to have. That they're not really real.
>
> E: What do you mean?

> Y: It's just an excuse – or maybe I like to think that "oh I don't even know what to think anymore" because it's what I want, or what my heart wants, or what I want in life. But then it's this program that's telling me that "no everything that I've always had has been wrong" and then just so much bullshit. But at the end of the day I just try to do things right even if others aren't doing things right, you know?
>
> E: You have to do what's right for you.
>
> Y: I don't know, I don't think I'm doing right for me.

Seeing Noah made Yessica simultaneously happy and sad. After seeing him, she was no longer sure that she what she wants is right for her. Our entire conversation was marked by Yessica's uncertainty. We discussed the likelihood that Rosa would not allow her to leave the following Monday (her nine month anniversary), the possibility of going to beauty school, and her clandestine conversation with Noah. She told Noah she was glad to be at Alas; even though it had been difficult, it was worth it. Most importantly, she told Noah that she loved him and that would never change; but, their relationship would change if he chose to continue using instead of moving towards recovery. This certainty was immediately lost as we discussed her future. Though we had previously discussed her desire to join the military (I brought my computer to the center and we chatted with a navy recruiter online about the possibility of her joining), she had recently taken up the service of running the house salon. Valentina had been impressed with her work and offered to pay for some of her beauty school education, a two year certification process. Rosa was very excited about this possibility; Yessica, however, was unsure if she wanted to pursue this career. When I ask her what she wanted to do, she poignantly responded:

> I know if I stay clean, maybe 5 years from now I'll probably have what I really want. To you know, in some way be successful. Or be doing what I actually want to do. Or like living on my own. I'm talking 5 years, so like future plans. But for now, all I know is that going to that beauty school is something good that I have my doubts [about] because it's a 2-year career, but it doesn't mean that I have to do the whole 2 years. It just means you know, it's something that I'm doing right here so that I can get better at it.

For Yessica, a life that she wants to live is at least 5 years in the future, and she does not know with any certainty or clarity what it looks like. What that future is, what could even be possible is limited by her mother's trust issues, center workers' blatant lack of confidence in her attempts to heal, Yessica's own financial vulnerability, and the difficulties of planning for life outside the center without knowing when she will leave or where she will go. She no longer even felt certain that she wanted to leave:

> E: How long do you think you'll stay?
>
> Y: I don't care about the time. I just care about what I'm going to do with my life, and I know myself. I'll probably be okay for a while, or—I don't know why I keep telling you this, Ellen, like I keep telling myself—I'm probably going to be okay for a while but then eventually, once I have money and whatever, I'm probably going to go back to use. But I don't know...
>
> E: What makes you think that?
>
> Y: I guess because everybody else does.

For Yessica, "the present did not recede into the background but rather was hyperrealized" (Haas 2017:82) due to the unresolved nature of her relationship with Noah, the seemingly intractable disagreements over her condition with her family, the wildly varying support she received at the center, and her uncertainty about her future. Despite not knowing exactly what is best for her, she struggled to do it. Though she did not want to risk losing touch with Luz again, she feels a much stronger connection to the people living "under the bridges" who took care of her at her worst, rather than her mother, other family members, and people like Sara from whom she only feels judgement. Her indecisiveness towards who she should cut out of her life and who she should keep in it once she finished treatment caused her a significant amount of anguish, yet at the center Yessica was met with dismissiveness when she tried to work through these feelings.

Through her turmoil, Yessica changed drastically over the year I knew her. Her experiences have given her a lot of knowledge. “I don’t just know this process because I’m so smart, and I just know. It took me *years* [emphasis hers] of life screwing me over for me to get to this point for me to be able to-- I don’t know.” She was even made a front office worker herself during her last months at Alas (see discussion in Chapter Two). She learned, mostly through negative example how to approach her service roles in the center and her therapeutic process. Though her relationship with her family remained contentious, when we talked in May 2018, she framed her lack of support from her family as an opportunity to grow and heal, in ways women with familial support could not. She committed to pursuing a career as a beautician and even began an apprenticeship at the salon that partners with Alas to give free haircuts to those at the center. She became very busy, taking on many responsibilities for the daily upkeep of the house while pursuing her apprenticeship. She described being in a good place with herself, moving however tenuously towards the life she wanted for herself.

After Treatment

Fieldnotes- 5 July 2018

I arrived at the center with two large chunks of tres leches cake. I had missed Yessica’s one-year anniversary the week before, so I had promised I would bring her the cake of her choosing, so we could have our own mini-party. She was not sitting behind the front desk to check me in, so I signed myself in and started the arts and crafts hour. I chatted with Monica about her preparations for her own one-year anniversary (also her last day at Alas) while I refilled people’s paint palettes. Near the end of the hour, I asked Monica if she knew where Yessica was, so I could give her her cake. Her face fell as she said, “Oh my God, you don’t know.” Confused, I said, “Know what?” According to Monica, it had be “a dramatic week.” Yessica and Valentina’s

daughter-in-law had gone to pick up tacos for the front office workers to eat during a meeting. While they waited for the tacos, Yessica had said she needed to run into the grocery store across the street. She never came back. This happened on June 30th 2018; we had our conversation about celebrating her one-year anniversary on June 28th. I sent her a Facebook message that said "Hi Lady! I missed you today at the center! But I have a tres leches cake with your name on it! ☺" I am still waiting for a response.

Fieldnotes- 15 July 2018
Yessica posted a picture of herself smoking from a pipe with another former inpatient on Facebook today. The picture is full of comments from women at the Alas, ranging from kind words offering help her to rude and hurtful remarks.

DISCUSSION:

Studying community-based addiction treatment in a naturalistic setting like Alas provides a very realistic window to the complexity of therapeutic process over time. In presenting each woman's trajectory, I have shown how their addiction trajectories are distinct, due to their life histories, drug use, and family situation, among other things. In what follows, I discuss how hope and future plans can be used to understand persons' healing self-transformations over time from first person perspectives.

The Intersection of Healing and Preparation for Life after Alas

At Alas, women are told during their time in treatment not to worry about the outside world, but to focus on themselves and their self-improvement. As has been shown, this was often a bittersweet experience for many women; they had never had the opportunity to focus purely on

themselves due to childcare, work, and other familial obligations, often starting in their early teen years. Time in treatment allowed them to begin to address their past traumas or focus on building healthy relationships with their family members that were often constrained due to socioeconomic necessity. Yet, the outside world penetrated their existence in the center and those within rehabilitation reached out to connect with the world outside the walls of the center (Hansen 2013). Just as Garcia (2010:62) demonstrated, "life outside thrived within the clinic walls." This intersects with therapeutic process in multiple ways. Noah's intrusion into Alas's therapeutic space was simultaneously a relief and source of great confusion for Yessica, muddling her idea of what is best for her and what is possible. Ivanna's inability to contact her family about her immigration paperwork was at times a significant source of stresss and at others welcomed, so she could focus on her own healing. Further, despite all the self-work the women engaged in at the center, the decision about when they could leave came from outside it. As Csordas and Jenkins (in press) discuss, the convergence of familial and inpatient conceptions of either healing or the future are not guaranteed. These conceptions can change over time, changing the way families interact with their inpatient family members, and in turn affect the therapeutic process for that inpatient. Thus, treatment experience at Alas cannot be segregated from the social world outside it.

Despite the connections between social life in and outside the center, certain preparations are necessary for re-entry into a world not so strictly controlled as the interventionist total institution of Alas. Twelve Step therapeutic models formulate recovery in such a way they many women's plan for life after rehabilitation explicitly states they will never use drugs again. So, very often they do not prepare themselves for what would happen if they did encounter their drug of choice or any other drug again. In January 2018, Ivanna and I revisited what moving toward

recovery meant for her. She highlighted her earlier realization that the center has the majority of the raw elements needed, save one major element: "We've got the tools, we've got the rules, we have all the support here. If you go out, you might bump into the connect, a friend. But we don't get that [here]." Most women spend their time in treatment learning how to please their family, so they can leave. And while they may pick up on some elements of treatment specifically related to coping with potential future use, for the most part they are not ready or did not want to prepare for such an eventuality. In other words, it can be difficult for family members who do not spend the majority of their time with inpatients to discern whether or not they are "ready" to leave drugs behind, as this has often not been addressed fully. It can also be difficult for inpatients to recognize these signs in themselves, as Ivanna learned over the course of her year at Alas.

Others' tests were not as successful as Ivanna's *permiso*, as America learned when she tried to attend a family party at which alcohol is omnipresent. She engages outside the center in the learning process Ivanna did while in the center; however, being outside it allowed greater access to America's personal triggers for drug use. Yessica explicitly acknowledged that she would probably come into contact with crystal and heroin, persons she used with, and thus the opportunity to use again. In fact, she wanted to as a means to gain clarity and closure with Noah. Based on the circumstances of her leaving, many at the center claimed that Yessica had not "really changed" during her second stint at Alas. How much of Yessica's transformation at the center was script flipping (Carr 2011) in order to make life worth living, I do not know. But I choose to take her words as meaningful, since so much of her therapeutic process was shaped by front office workers, the psychologist, and other inpatients being openly skeptical of her motivation and intentions. This without question shaped her recovery trajectory, even as she tried

to plan a life for herself and her daughter (for similar processes see Jenkins and Carpenter-Song 2008; Jenkins and Carpenter-Song 2005). Closure with romantic partners represented a necessary aspect of healing for all three women. It also presented dangers for all three in their recovery; yet, it affected each person's addiction trajectory differently, based on their access to *permisos* and family support as well as their differing conceptions of sobriety and relapse.

A significant fear many women at Alas express, including America, Ivanna and Yessica, is the continuation of life outside the center—without them. America worried the longer she was in treatment, the harder it would be for her to return to her previous job and life. The realization that life and persons outside had not changed was a relief. Ivanna found on her *permiso* that life and her family outside were the same, it was just her that was changing. This gave her a sense of control and reaffirmed her commitment to taking the time to heal. For Yessica, however, this continuity was a source of frustration; her mother and grandfather's attitude completely ignored the 50/50 nature of mutual aid addiction treatment. It directly shaped her choice to go back to partying after her first stay at Alas, even though she had worked so hard to be the person her mother wanted her to be. The continuity of social life was dynamically positive or negative for inpatients, altering their healing process and recovery trajectories in distinct, individualized ways.

Hope, Healing, and Self through Time at Alas and Beyond

The experience of time and healing at Alas is dynamic. Time spent is experienced both as a productive period of healing and like a stagnant, punitive period imposed upon inpatients without any real connection to their healing self-transformations. Women at Alas are both waiting and healing (Odgers Ortiz and Galaviz Granados 2016), suffering and growing. As

Haas's (2017) asylum seekers, they are engaging in therapeutic work of self in an environment that in many ways exemplifies stigmatizing cultural conceptions of who inpatients are and who they can be as persons.

Further, inpatients' healing processes are often minimized, if not overlooked entirely by their family members and center workers, drastically shaping their self-conceptions as well as their ideas of the future possible. Carpenter-Song's (2019) longitudinal ethnography on mental health, homelessness, and family separation mirrors the changing nature of self, hope, and future possibility that I witnessed among women at Alas. Despite good faith efforts of engaging with the therapeutic process, family and institutional interactions often focused on inadequacies, still necessary changes, or reparations ("lessons to be learned"), rather than on the positive healing work being done. Just as the possibility of denial marked the future of Haas's (2017) participants, the possibility of relapse, of "not being strong enough" colored women's future possibilities in and outside the center. This paradox is similar to the "chronotope of the queue" (Fraser 2006) in that the organization of the therapeutic system contributes to some of the problems these families face, in a vicious cycle, that ultimately may result in the "loss of self" (Carpenter-Song 2019) for persons like Yessica.

Zigon (2009) discusses the temporal structure of hope as two-fold and inseparable. First it is a background orientation toward being-in-the-world that unconsciously sustains an already had social life. Second and simultaneously, hope is an "orientation of intentional ethical action" during the context of a moral breakdown (Zigon 2009:254). This simultaneity of hope does indeed complicate our understanding of hope beyond singularly passive or always conscious conceptualizations. However, Zigon hesitates to frame hope towards an ideal or "better' because his participants hope for "continuity, stability, or 'living sanely'" (2009: 257). To me, this misses

the reality of living in or under conditions of institutional, structural, and economic vulnerability. It is through the mundaneness of what persons hope for, that we can see just how much their lives are shaped by broader social forces. This is why the dreams of Ralph's (2014) participants to make it home after school without getting shot are so poignant. This is why Yessica's dream to maybe know what she wants in five years feels like an almost impossible idealization. Persons' ability to hope and to heal, in all its "vagaries, vulnerabilities, and paradoxes [are shaped by their] personal and family lives" through time (Mattingly 2010:233).

Hope is an orientation or attitude that is created, maintained, and acted upon within a particular social world. It is an orientational process of the self. As Csordas and Jenkins (in press: 27) note, there is an association between "how articulate, aspirational, and optimistic [interlocutors] are" about their future possibilities and "the socioeconomic plateau from which they began." This is not to say that hopes cannot exist outside the realm of possibility for a given person's life and the structural forces at work in their lives; they can, and when they do it can be psychically destructive (e.g. Duncan 2017). Hope and hopelessness are difficult to completely parse out either temporally or experientially, and their meaning is always culturally specific (Crapanzano 2003). Each is tinged with the possibility of the other, which may relate to their dynamism for individuals as their social relationships and life circumstances change over time. In this way, hope as possibility can be intersubjectively managed, shaping not only therapeutic process but a person's future horizon and self processes (c.f. Csordas and Jenkins, in press; Good et al 1990).

The idea of (or possibility of) recovery should necessarily be linked to treatment experience and life history. Therapeutic process is dynamic and individual, because people are stigmatized to differing extents and they have different levels of social support over time. On top

of the dynamic expectations they have for themselves, their shifting illness narratives, self-conceptions, life histories, traumas, and particular biological susceptibilities to drug dependence shape persons' ability through time to hope and heal in individual ways. To acknowledge this allows for a clearer understanding of the biopsychosocial process (Lende and Fishleder 2015; Lende 2005) of mental illness and its dynamic, ambiguous experience—from the context in which it emerges for individuals, to its treatment, and their reintegration or return into their families, communities, and social responsibilities. Treatment experience draws not only on the subjective experience of individual persons, but the cultural conceptions of illness, disease, and recovery that exist in their social circles and therapeutic environment. If recovery is linked to treatment experience, and we understand treatment experience as having multiple possible trajectories within the same therapeutic model,[46] then the conceptualization of recovery should necessarily also be multiple. Therefore, in order to design recovery-oriented institutions, their therapeutic models must seriously consider the varying types of support persons who use their services will need, from emotional and psychological to legal and economic (e.g. Carpenter-Song et al 2012; Jenkins 2015; Jenkins 1991).

CONCLUSION:

Alas has a clear conception of what drug addiction is, how it should be treated, and what the life of a successful former inpatient will look like in relation to substance use and personal relationships (including individuals' relationship with themselves). Families have their own conceptions of what addiction is, how it should be treated, and what would constitute successful

[46] Everyone theoretically moves through the same model, though there is practical fluidity, as we have seen (e.g. inpatient-guards can skip meetings, inpatients can have different levels of familial support, they can agree with the institutional model to differing degrees, etc.).

recovery or relapse. Further, inpatients experience what their time living in Alas is meant to do for them therapeutically, what is expected of them once they leave, how they must work towards recovery while in the center, and how they should avoid relapse outside it. These expectations often coexist alongside their own conceptions of addiction, self, and need for self-transformation. While these understandings many times overlap, there are often significant differences between them. These variances along with individual life histories shapes persons' therapeutic process, sense of self, and horizons of future possibility in dynamic ways that cannot always be predicted simply by knowing the particular treatment model they enter.

The aim of this chapter was not to present neat or complete case studies representing different recovery trajectories. Each of these case studies is incomplete, because America, Ivanna, and Yessica are still living and making sense of their lives, responsibilities, and recovery trajectories. However, these snapshots linking their life, treatment, and recovery trajectories illustrate how individual life history and communal treatment environment plays a strong role in both individual and collective therapeutic processes. As Carpenter-Song highlights, imperfect or incomplete trajectories are necessary to truly (re)consider current care options and restructure them in ways that recognize structural inequities and reformulate them around inclusive and humane care in line with social justice and health equity (Kaiser et al 2019: 5). As I have argued here, temporality (Haas personal communication) and experience Csordas (1994) must be used as a frame to understand long-term therapeutic processes. Only then and when coupled with attention to subjective experience (Jenkins 2010) can we see the simultaneous benefits and pitfalls woven into the systems of care persons navigate for addiction.

CONCLUSION

SUMMARY:

This dissertation centered on inpatients' first person perspectives as they attempted to understand their social position and move through community-based addiction treatment. The overall goal was to represent inpatient experience as well as to examine their point of view's tension with institutional conceptions of treatment in order to gain insight into the individual yet co-constructed nature of healing. I have demonstrated how different community-based rehabilitation centers understand the problem "addiction," those who have it, how it should be treated, and what "success" or "recovery" looks like (Chapter One). After presenting this broad perspective, I narrowed my analysis to focus on how social roles and interpersonal interactions shape both individual therapeutic process as well as one center's therapeutic environment (Chapter Two). I then explored how that same center's therapeutic model draws on conceptions of moral personhood, thus incorporating stigma into therapeutic process. (Chapter Three). Finally, I used three case studies to examine multiple points along individual addiction trajectories, to emphasize the individualized yet intersubjective nature of treatment and healing (Chapter Four).

All inpatients at Alas or at any other community-based rehabilitation center (as with any interventionist total institution) are subject to institutional oversight, conceptualizations of treatment, and ideas about recovery. While all total institutions can be categorized by their particular goal, Alas's therapeutic intent places it in the particular subset dedicated to the care of persons who are "both incapable of looking after themselves and a threat to the community" (Goffman 1962:4-5). This can be seen in the cultural conceptions of addiction and drug addicts that result in involuntary, locked treatment as the appropriate way to provide care. However,

inpatients' acceptance and uptake of Alas's therapeutic model is not guaranteed, despite its organization as an interventionist total institution. Their agreement with the center's therapeutic model is shaped by their individual life history, their own ideas of health and illness in relation to addiction, their interactions with others in the institution, their social support network, and the overall therapeutic environment. Whether read individually or as a whole, each chapter of this dissertation has highlighted the individual, dynamic, situational, and intersubjective process of rehabilitation in context.

As such, the culminating argument of my dissertation is that context and lived experience must be placed at the center of global mental health research, practice, and intervention. Many GMH researchers are indeed incorporating cultural context (Carpenter-Song 2015; Csordas and Jenkins 2018; Good 1997; Kaiser et al 2015; Kohrt et al 2014; Miller et al 2008). This dissertation illustrates just how complex context is as well as how ambiguous and dynamic experience within it is. I caution against the broader global health paradigm that context has "the same value for everyone involved in an intervention [or therapeutic model], as emphasis is placed on the production of evidence that is measurable, definable, and can be easily standardized" (D'souza 2019:166). In flattening context to a static variable, GMH studies risk missing which specific elements of context impact therapeutic experience and how they do so. Especially for addiction services, the context of a person's life and use history (as well as any relapses) are essential for understanding their individual illness experience and risk factors. As Carpenter-Song (2015) suggests, knowing what matters to a patient will allow both the care provider and the patient to be participants in treatment, as well as not be blindsided or overwhelmed by the recovery process, including any set-backs or difficulties. Addiction treatment cannot be separated from an individual's life trajectory nor the cultural context in

which the illness addiction and its proper treatment are understood. In this way, phenomenology of treatment experience provides a methodology through which we can understand the problem of addiction by mapping it onto larger questions of what it means to be human (Schalow 2017).

CONTRIBUTIONS TO SCIENCE AND BROADER SIGNIFICANCE:

This dissertation represents several key contributions to science that reflect its broader significance. Most broadly, I contribute to the fields of Anthropology and GMH through my analytical attention to community-based forms of treatment. I systematically outline the differing understandings of the "problem" of addiction at each center, and their particular institutional method designed to address it. I then examine the experience of that treatment, extending even beyond time spent in the therapeutic context by presenting women's attempts at reintegration into their social lives and communities. As I have shown, my participants have individual, yet co-constructed experiences of healing that are shaped by their cross-border experience, their understanding of addiction, and their exposure to the multiplex frameworks for successful treatment (from their families, different center models, and other addicts). Throughout their therapeutic process, they draw on multiple elements of the cultural environment that are often contradictory, creating paradoxes in how treatment should be understood, experienced and evaluated. This, I argue, plays a formative role in both individual and communal, cultural understandings of the problem addiction as well as the continual debates about acceptable forms of treatment. As such, my research expands scholarly and practical understandings of healing and efficacy through attention to the diverse and individual experience of treatment.

There is a discussion in GMH about whether the care community-based, non-biomedical centers provide should be referred to as treatment or involuntary intervention (c.f. Bazazi 2018).

This stems from the human rights abuses that have been documented to take place in such centers (e.g. Wegman et al 2017; Rafful et al 2018; Rafful et al 2019). To focus analytical attention on community-based treatment models as treatment does not deny the possibility (and in some instances likelihood) that human rights abuses may take place. But to ignore community-based models entirely or dismiss examining the potential "merits of involuntary interventions until voluntary, evidence-based treatment is widely available, accessible and responsive to the needs of PWUD" (Bazazi 2018:1064) engages in the same stereotypic thinking that stigmatizes drug addicts themselves (as argued in Chapter Three). Further, it ignores the immediate plight of a population in need of care, considering the structural nature of evidence-based care's severely limited availability, e.g. lack of trained professionals and prohibitive costs for care-seekers. It will take years of significant socio-political will and action to strengthen health systems in order to provide evidence-based treatment to all who need it (as discussed in Chapter Two). Finally, this argument paternalistically prioritizes biomedical understandings of the problem addiction and its solution while discounting the fact that community-based treatment models are often aimed at addressing a different problem (e.g. sin or lack of self-insight). As such, increasing evidence-based forms of treatment will not address the biopsychosocial nature of addiction, as it is does not relate to broadly held cultural conceptions of illness and their relationship to health seeking behaviors (as argued in Chapter One). By focusing intentionally on community-based therapy, this dissertation provides the foundation for future analyses aimed at developing a comparative framework for healing across all forms of treatment.

Attention to first person perspectives of treatment experience in all its forms could reshape scholarly and practical understanding of the cultural paradigms underlying addiction treatment frameworks. Schalow (2017) argues that phenomenology can be a counterpoint to the

medico-technical frameworks used to treat addiction. The biomedical system, while unquestionably helpful in improving quality of life, reflects the worldview of modern technology, summarized through the presumption that as technology advances, so too does the quality of human life (Schalow 2017). This has been explored by anthropologists under terms such as a the "biotechnical embrace" (Good 2001). Yet this medico-technical understanding and temporality of treatment in many ways mirrors the conundrum addicts face in their entrapment in the biopsychosocial need for quick gratification through use (Schalow 2017:162). Similarly, community-based frameworks often draw on local, cultural conceptions of illness and proper treatment, that may incorporate stigmatizing conceptions of person into their therapeutic models. Currently available treatments, both biomedical and community-based, problematically oscillate between opposite ends of the spectrum of mind-body dualism and the prioritization of individual versus communal needs/responsibilities. This is becoming even more relevant in addiction studies, as new research points to potential pharmacological treatments for methamphetamine (Coffin et al 2019), which were non-existent during my dissertation fieldwork. While such advancements will make great contributions to the provision of care for addiction, it also increases the urgency of this dissertation's call for first person perspectives of use, treatment, and recovery. Focusing research on the phenomenological experience of treatment and recovery will expand knowledge on the incremental and ambiguous temporalities of healing within all therapeutic models. In this way, research and practice will examine the full biopsychosocial context of healing in order to best shape best care practices in line with both individual persons' and the broader community's needs.

The next significant contribution of this dissertation is that it provides an in-depth presentation and analysis of ethnically Mexican women's longitudinal experience of community-

based treatment. Cultural context matters for addiction treatment, thus research must take into account ethnicity, race, and gender when examining addiction and its treatment. While there is a growing body of literature examining ethnically Mexican persons' experience of addiction and treatment (e.g. Medina-Mora et al 2006; Odgers and Olivas 2018; Strathdee et al 2008; Syversten et al 2010; Rafful et al 2019), it tends to focus on discrete periods of time within addiction trajectories. This study, however, examines the cultural context for ethnically Mexican persons in the border zone and how it shapes multiple stages of individual addiction trajectories. I explore local conceptions of illness and proper treatment, therapeutic experience, and the transition to recovery, which contribute to scholarly and practical understandings of communal conceptions of addiction and treatment offerings. This information will be vital for any GMH effort seeking to partner with local communities in order to provide long-term care for addiction.

Though this dissertation addresses the particular formulation of community-based treatment for both men and women, the majority focuses on women's experience. Several researchers have focused on the particularities of ethnically Mexican men's experience in treatment (e.g. Lozano-Verduzco et al 2016a; Garcia 2015). However, the health and social consequences of addiction are more severe for women than men (Lozano-Verduzco et al 2016b). Yet because women only represent .4% of the world prevalence for substance use (WHO 2010), they tend to be underrepresented in addiction studies. As I have shown throughout this dissertation, community-based addiction treatment for women in the US-MX border zone is understood differently than it is for men, and women at Alas move through treatment differently than men at other community-based centers (Kozelka 2015). They experience time and healing in sometimes similar and often unique ways based on their past experiences, future conceptions, familial support, as well as their (and the center's and their social networks') conceptions of

addiction, appropriate treatment, and recovery. Thus, this dissertation expands knowledge of the conceptions of addiction held by ethnically Mexican women in the US-MX border zone, presents novel evidence of the particularities of stigma for ethnically Mexican women in addiction treatment, and demonstrates the complexities of ethnically Mexican women's addiction trajectories by presenting case studies of women through the stages of treatment and recovery. The data from this dissertation could be used to inform and improve the healthcare for a systematically underrepresented population in GMH.

The final, major contribution to science is this study's ability to inform the field of implementation science within GMH. Implementation science aims to understand how, in what ways, and for whom interventions work (Betancourt and Chambers 2016; De Silva and Ryan 2016). This is especially important for psychosocial interventions, as their "modality of function is based on intersubjective phenomena and likely to be experienced differently across participants" (D'Souza 2019:2). By seriously attending to inpatient experience, this dissertation establishes the necessity to both understand and include first person perspectives of treatment in the shaping and evaluation of addiction treatment interventions. Similar studies could be conducted in other regions to inform best care practices for women throughout the world. I believe this logically extends beyond community-based addiction treatment models to incorporate all manner of treatment, including evidence-based therapies. In my future work, I plan to examine this specifically, as well as contribute to the individualization of care through implementation science within GMH (see below section Future Directions).

LIMITATIONS:

A limitation to this study is its generalizability. It was conducted in four rehabilitation centers in which, as we have seen, there are different therapeutic models. The majority of the analysis focuses on one women's center, and Chapters Two, Three, and Four specifically outline the wide variety of individual therapeutic trajectories within it. These data represent the experience of women as they move through a particular form of community-based treatment; it is not representative of all women undergoing addiction treatment in Tijuana. Further, as I chose to focus on women with cross-border experience, these women's experiences are also not meant to represent treatment experience at Alas exhaustively. It also does not address the differences in experience that may come from living exclusively on either side of the border. However, generalizability was not a goal of this study; representing and highlighting the heterogeneity of treatment experience represents an important contribution to GMH research.

Moreover, this dissertation does not engage in direct ethnographic comparison of inpatient experience in community-based rehabilitation centers with inpatient experience in evidence-based, biomedical or psychosocial-based residential centers located in Tijuana. There is a tendency in GMH to focus on evidence-based treatments, and for good reason. Many studies have outlined the institutional and human rights abuses that occur in compulsory, non-evidence-based treatments around the world (Wegman et al 2017; Bergenstrom and Vumbaca 2017). However, the majority of people in Tijuana are not in evidence-based therapeutic models, but community-based ones. I chose to focus this research on community-based care, as outlined in Chapter One, precisely because it is so widely used yet tends to be a "black box" in Mexican public health policy (Odgers Ortiz and Olivas Hernandez 2019). As discussed in Chapter Two, academic communities' condemning of such models without fully understanding their

complicated experience and links to cultural context has limited effect on societal acceptance and utilization of this form of care. Throughout this dissertation, I have analyzed it critically, while recognizing my limits as an anthropologist in evaluating its effectiveness. I do not, however, intend this dissertation to be used as a means to justify the human rights abuses that occur in Mexico and throughout the world in both unregulated (Rafful et al 2019) and state-sanctioned (Amon et al 2013) addiction and mental health (Werb et al 2016) treatment facilities. Cultural conceptions of health and illness are not justifiable reasons for the abuse of our fellow human beings. By understanding the reasons why persons believe such forms of care are necessary and co-educating both ourselves (e.g. researchers, policy makers) and stakeholders (e.g. family members, care recipients), we can work together to find humane, effective, and culturally sensitive care. Without doing this, persons in Tijuana and around the world will continue to find themselves in addiction treatment models that do not address their biopsychosocial healthcare needs.

Further, the goal of this research was to center the voices and experiences of ethnically Mexican women as they moved through community-based treatment. This was done at the expense of incorporating other voices, such as their family members. I also did not collect data on substance use severity or possible co-morbidities with other mental illnesses. While ethnographic methods provide critical information that inform GMH research, treatment implementation, and its evaluation, it should be integrated with other methods to provide a holistic representation of a treatment and its experience. Additionally, as follow-up contact was not established for all participants, it is not possible for this study to make claims on the full variety of recovery trajectories that emerge from Alas. However, the inclusion of mental health technologies could potentially mitigate this problem in future studies.

Finally, this dissertation represents my analysis and understanding of inpatients' experience. Though I consulted with my participants regularly throughout the writing process and incorporated their feedback into drafts of the chapters, its final form represents my analysis. This could be mitigated by using a participatory model for analysis and write-up, which actively acknowledges and incorporates the voices, perspectives, and suggestions of stake-holders and participants (Palinkas et al 2008; Wallerstein and Duran 2010; Bunce et al 2014). Ultimately, the "far messier tangle of poverty, displacement, trauma, and loss, of which mental illness and substances abuse are only a part" (Carpenter-Song 2019:56) exceeded in many ways what I could represent in this dissertation. Yet, I hope the experiences recounted here contribute to the growing ethnographic evidence of the consequential and reciprocal shaping of social structures, social networks, and subjective experience (Jenkins 2015) relevant for addiction treatment.

FUTURE DIRECTIONS:

The findings of this dissertation point to several directions for future research. Expanding the methods and populations included in future studies would present a more comprehensive view of community-based addiction treatment and its experience in context. Consistent with the study limitations, in further investigations of the experience of treatment I plan to better integrate inpatient experience into its context by including family perspectives alongside inpatient experience and institutional perspectives. This would enhance analysis of the ways interpersonal interactions influence individual therapeutic process. Similarly, future research will also incorporate more standardized methods of data collection (e.g. PHQ-9 [Kroenke et al 2001], GAD-7 [Spitzer et al 2006], and DUD scales [Scherer et al 2013]) regularly throughout the different phases of treatment and recovery. This would allow future research to more directly

assess the efficacy of community-based treatment at multiple levels: experiential, biomedical, and scholarly. In this way, future iterations of the study could more broadly contribute to the field of implementation science within GMH.

The theoretical expansion of this project in future works could contribute to the advancement of both anthropology and GMH. Specific and critical attention to the dynamic and individual experience of women in evidence-based therapies over time could further support Csordas's (1988) claim that efficacy is a continuum and often incremental in nature. Investigations of this sort would allow researchers and practitioners to then better respond to the individual needs of patients. Further, in future studies, directly and critically comparing the experience of women undergoing evidence-based treatments with women undergoing community-based treatments would enhance scholarship and practice of addiction treatment and its experience. These comparisons could provide fruitful understanding of how cultural conceptions of health and illness shape health seeking behaviors.

Finally, this study revealed the serious potential for the inclusion of mental health technologies as a tool for implementation science to both aid and track recovery trajectories among a highly mobile population among which follow-up is difficult. During my follow-up interviews with participants after they left treatment, I witnessed their efforts to create to create a virtual support community transcending the US-MX border, evidencing their desire for technology-based support and the need for further research in this domain. As of 2017, there were over 318,000 mobile health applications available for download in the iTunes and Google Play stores (Byambasuren et al 2018), yet very few of these have been evaluated for efficacy or even information accuracy (Carpenter-Song et al 2018). As technological advances become ever more intertwined into our cultural system, particularly in healthcare, it is fundamental that

scholars, care providers, and stakeholders understand the underlying conceptions framing the goals presented in such technologies, as well as how their design dynamically shapes individual engagement and therapeutic processes. I did not have enough data to thoroughly explore my participants use of mental health technology (MHTech) for this dissertation; however, incorporating MHTech in future studies could create a more robust set of treatment options for addiction recovery as well as broaden scholarly knowledge of MHTech and its impact on persons' subjective experience, identity, and efforts in recovery. In this way, future studies could be extended to engage directly with the growing field of implementation science within GMH by providing data on the experience and efficacy of treatment over time.

In sum, in this dissertation I have outlined the complexity and importance of cultural ideas of health and illness, moral ideas of personhood, and the intersection of individual experience with structural forces using community-based addiction treatment as a case study. I have shown that "addiction" is an individualized, yet intersubjective illness, as is the healing process of recovery. Finally, research points to promising areas of future study for understanding ethnically Mexican women's addiction treatment experience, and I have outlined the methods through which I will continue to study women's addiction treatment experience in context in ways that will both extend scholarly knowledge and improve GMH practice.

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