From Treatment to Containment to Enterprise:

An Ethno-history of Therapeutic Communities in Puerto Rico, 1961-1993

Abstract:

Unpaid work is now a central therapy in Puerto Rican therapeutic communities, where substance users reside and seek to rehabilitate each other, often for years at a time. Once a leading treatment for addiction in mainland United States, therapeutic communities were scaled back in the 1970s after they lost federal endorsement. They continue to flourish in Puerto Rico for reasons that have less to do with their curative powers than with their malleability as multi-purpose social enterprises and their historical co-option by state, market and family actors who have deployed them for a variety of purposes. Their endurance from the 1960s to the neoliberal present obliges us to recognize their capacities as what Mizruchi calls "abeyance mechanisms" whereby "surplus" populations, otherwise excluded from labor and home, are absorbed into substitute livelihoods. Having initially emerged as a low-cost treatment, in a context of mass unemployment and prison-overcrowding they now thrive as institutions of containment and informal enterprise.

Keywords: drug addiction, therapeutic communities, surplus, abeyance, Puerto Rico

According to a senior official of the World Federation of Therapeutic Communities, "real therapeutic communities, by which I mean addicts treating addicts [are] on the way out." In one sense, he is surely right. Once a lead treatment for addiction funded by the National Institute for Mental Health (NIMH), many mainland United States (U.S.) therapeutic communities closed down in the late 1970s in the face of widespread criticism of their methods (White and Miller 2007). Today they persist primarily in correctional settings (McCorkel 2013), but shoulder only a small fraction of the overall treatment burden relative to out-patient treatments and short-term residential detox (Deitch and Drago 2010). Therapeutic communities have continued to flourish in Puerto Rico, however, where they now constitute the dominant form of treatment for addiction.

As low-cost therapies that grow, multiply, and transform, therapeutic communities have proven highly versatile and varied tremendously across the sixty-five countries to which they are estimated to have spread since their emergence in Los Angeles in 1958[1]. Their polymorphism notwithstanding, they often subscribe to a character-based theory of addiction that dominated North American psychiatry in the post-war 20th century (Acker 2002). Addiction is taken to be a symptom of an underlying personality disorder that requires 're-education' through 'personality re-structuring', achieved through one-to-two years of residency in a controlled therapeutic environment.

[1] The first addict-led therapeutic community for addiction was Synanon established in 1958 in Los Angeles (Janzen 2005).

Though they thrive in Puerto Rico, these are highly contentious facilities. Human rights groups have decried their methods as "unscientific" and "exploitative" (OSF 2016; IPR 2015), taking issue with their reliance on unqualified staff and their use of unpaid labor as techniques to treat addiction. Once standard practice in mainland therapeutic communities, from the 1970s onwards unpaid labor was gradually abandoned as tasks of construction, decorating, cleaning, and cooking came to be increasingly performed by hired professionals (Deitch and Drago 2010). In contrast, backed by government and private-sector contracts, residents of Puerto Rican therapeutic communities are increasingly sent to weed waterways for the Department of Water and Sewage, to pick up garbage from town squares and public parks, or, during the Zika epidemic of 2016, to relocate thousands of tires from residential areas as part of the commonwealth state's public health response (McNeil 2016). Indeed, unpaid work is now a central therapy in the programmatic design of many of Puerto Rico's therapeutic communities.

In this article I explore how therapeutic communities and labor therapies came to constitute the lead treatment for addiction in Puerto Rico. That therapeutic movements flourish, wane, and assume particular formations in particular places is, on one level, a genealogical story that could be told and retold in numerous contexts, and might not be so anthropologically interesting. That therapeutic movements, practices, and formations are constantly evolving and becoming different things, however, speaks to a broader dynamic – of the unstable, mutable, and often "extra-therapeutic" concerns that animate therapeutic movements. Thus, while existing accounts of therapeutic communities have provided valuable historical knowledge on the origins and trajectories of particular institutions (Janzen 2005; Sugarman 1974;

Densen-Gerber 1973), these works do not necessarily help us to understand the larger structures, contexts, and socialities through which therapeutic movements unfold. In particular, they are insufficiently attentive to the role of therapeutic communities as social enterprises. To widen our angle of inquiry, this article examines therapeutic communities as "abeyance mechanisms" to analyze how multiple "extra-therapeutic" projects may find a home in contemporary drug treatment regimes.

"Abeyance" was a concept developed by sociologist Ephraim Mizruchi (1983) in his study of the historically variable ways that societies have responded to a recurring problem of "surplus"– that is, the quantitative mismatch between a society's "status vacancies" (social roles) and its potential claimants (1983: 1-24). Abeyance provided Mizruchi with a construct through which he was able to analyze the emergence of a variety of alternative economies, including monasticism and breakaway religious orders in Medieval Europe, and 19th compulsory apprenticeships in New England that provided stipend and training to the otherwise unemployed. In Mizruchi's initial functionalist formulation, abeyance mechanisms were considered to be institutions for the "regulation of society." Conceived as a magical adjustment to the problem of surplus guided by hidden intelligence of "organizational inter-dependency" (1983:20), these were said to provide redundant and potentially "troublesome" populations with a surrogate livelihood and home, while sequestering them non-competitively "in abeyance" outside the formal labor market (1983: 1-24).

Subsequent theorists reworked the concept as predicament (suspension) rather than a functionalist institutional adjustment (Hopper and Baumohl 1994). However, a continued emphasis on abeyance as something that performs "the dirty work of

system maintenance" (Hopper and Baumohl 1994: 543) means that abeyance continues to be understood in terms that can imply a unified and coherent function.

To transcend the idea that abeyance mechanisms inherently or necessarily fulfill a particular function (whether conceived in functionalist or neo-Marxist terms), I conceptualize abeyance mechanisms as versatile niches offering a plurality of "affordances" (Keane 2018) to a variety of different actors. Following Keane (2018), I use the term "affordance" rather than 'function' to emphasize the *potentiality* of abeyance's 'uses': that is, its 'purpose' or 'utility' is contingent on how particular actors perceive it and put it to work (2018: 31). Thus, while the occupants of abeyance niches are 'surplus' in the neo-Marxist sense of excluded from the labor market by virtue of modern capitalism's tendency to generate human superfluity (Arendt 1974), the affordances these niches offer to various distinct actors complicates a straightforward neo-Marxist reading. Rather than fulfilling some particular function determined by inherent qualities or historical conditions, abeyance's 'purposes' are contingent and inherently social (Keane 2018:31). This analytical emphasis on potentiality and plurality highlights the malleability of abeyance mechanisms, something that turns out to be crucial to understanding therapeutic communities' endurance in Puerto Rico.

If we consider therapeutic communities as abeyance mechanisms that absorb 'surplus' actors, it merits noting that most therapeutic communities in Puerto Rico cater to men. This gendered absorption of unemployed men is related to a multitude of factors spanning the organization of kinship, the labor market, criminal justice, public housing policies, and welfare entitlement regulations, among other things. As work on

labor and gender in Puerto Rico so plainly shows, unemployed men and women experience distinct opportunities and constraints for sustaining themselves financially (Safa 1995, 2011; Ramírez 1999; Hansen 2018). To a greater extent than women, unemployed men have been incorporated into informal and illicit economies (Flores 2015; Muehlmann 2017), rather than into kinship. In line with recent calls to recognize how drug addiction and its management are gendered (Campbell and Herzberg 2017), this article approaches therapeutic communities as gendered responses to the problem of male surplus.

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

Second, the rise of self-help and volunteer care networks has often been attributed to neoliberalism, neglect and state retreat (Garcia 2015; Biehl 2013), an anthropological narrative that coheres well with local media accounts of therapeutic communities that emphasize the commonwealth's failure to provide alternative treatments (Cabán

2016). Tracing therapeutic communities' historical ascendency as a treatment for addiction in Puerto Rico, however, reveals that what first appears to be an artifact of state neglect has in fact been championed, deployed and manipulated by various state actors for reasons that are distinct and often discordant.

Third, recent works in the anthropology and history of medicine offer persuasive accounts of how scientific knowledge and developments in the clinical sciences during the last century have transformed addiction therapeutics in various places (Fraser, Moore, and Keane 2014; Campbell 2007). But as recent works have shown, therapeutic movements are also embedded in other forms of political and social life (Hansen 2018; Garriott 2011). In line with these alternative readings, this article identifies an unruly collection of locally enabling and constraining institutions and resources that have variously propped up this therapeutic regime in Puerto Rico, from faltering unemployment and correctional systems to overwhelmed kinship networks and community fears. In so doing, it argues that these "other" political projects, with their largely "extra-therapeutic" concerns, are instrumental to the provenance and viability of this therapeutic regime.

The data for this article were collected during eighteen months of ethnographic and archival fieldwork between 2016-2017, prior to hurricane Maria. Fieldwork included twelve months in Puerto Rico and six months in New York City. This article draws specifically on the archival research and on the ethnographic interviews with therapeutic community actors (e.g., leaders, residents, steering-committee members, both in Puerto Rico and in New York City) and government officials (in Puerto Rico). The two activities overlapped and iteratively informed each other.

The following ethno-history begins with an examination of a heterodox strand of characterological theory that entered Puerto Rico's drug treatment landscape in the early 1960s. Next, it describes the uptake and routinization of characterological therapies by ex-addict entrepreneurs. It employs the concept of abeyance to analyze the ascendency of therapeutic communities from the 1960s to the 1990s neoliberal turn. It argues that one reason they propagated was the role they played in allocating surrogate livelihoods to a group of otherwise unemployed men. Complicating this political-economic reading, it also demonstrates that therapeutic communities have been supported and conscripted by local elites as well as numerous state, market and family actors for a variety of different reasons. By examining therapeutic communities' local relevance outside of 'therapeutic' domains, it reveals therapeutic communities to be deeply embedded in a complex and interconnected collection of local political projects.

Theoretical origins of characterological therapies

Prompted by an overcrowding crisis in Puerto Rico's prisons, the Center for the Investigation of Addiction (Spanish acronym, CISLA) was established in July 1961 as a division of Puerto Rico's Mental Health Program. Envisioned by its architects as a controlled therapeutic environment for the re-socialization of "sociopathic" addicts (CISLA 1964), its remit was to conduct research into the nature of addiction and to develop treatments. Until 1959, narcotics control had been administered not by the commonwealth but by the US federal government. Offenders (users and dealers) were tried in federal courts and, if convicted, sent to mainland federal prisons or to one of two federal hospitals, either the U.S. Public Health Service Hospital at Lexington, Kentucky, or in Fort Worth, Texas (Campbell 2007). With the passing of the

Commonwealth Narcotics Law No. 48 of 1959, Puerto Rico assumed jurisdiction of narcotics control and the state penitentiary rapidly exceeded capacity (Planas, Lopez, and Alvarez 1965). So in 1961, supported by a modest commonwealth grant, CISLA's first director, Efren Ramirez, then still a psychiatry resident at the University of Puerto Rico, took over an abandoned outbuilding on the grounds of the state psychiatric hospital in Río Piedras. There, equipped with only his education in general medicine and a personal predilection for psychoanalysis, he began experimenting with methods to treat addiction.

In the early 1960s, addiction was widely understood across North American psychiatry to be a problem of psychopathology. Particularly influential was psychiatrist Lawrence Kolb, who in the 1920s had popularized the idea that addiction resulted from inherent defects of personality (Acker 2002). Kolb had distinguished between 'innocent' and 'vicious' addicts, innocent being people with normal personalities who fell into addiction through accidental means, such as through prescribed painkillers. He reserved the term 'vicious' addicts for the illicit drug-using urban poor who, he argued, sought out narcotics and were vulnerable to develop addiction because of their pathological personalities (Acker 2002:142; Kolb 1925).

Ramirez drew upon Kolb's notion of personality defect and on psychoanalytic theories of family origin to argue that addiction was caused by childhood developmental failures. In a series of publications, lectures and oral presentations in the 1960s (Ramirez 1966a, 1966b), he advanced a theory of addiction as a personality disorder caused by a failure of "epi-genesis," a concept that psychoanalyst Erik Erikson (1959) borrowed from embryology to describe the regulated development of

personality over the life course. According to Erikson, personality development progressed through a sequence of pre-determined stages, each of which was expressed at a certain time in the life course. The development of specific "human strengths" – fidelity, hope and care – was contingent upon the successful passage through the preceding stages. Applying the epigenetic principle to the problem of addiction, Ramirez argued that the addict's "scant capacity to feel anguish, guilt and sincere remorse" stemmed from a failure of epi-genesis during childhood, in which family breakdown had prevented the acquisition of "appropriate norms and values of society" (Ramirez 1966a:121).

Addicts were not "psychotic," he argued, but "have adopted a system of values and an outlook on life that make their behavior contrary to what most citizens consider normal" (Ramirez 1966b). They were more accurately classified, he argued, as "sociopathic", in the sense that their "distorted personalities have oriented them away from the attitudes and activities pursued by the normal productive citizen" (Ramirez 1966b). This psychopathic personality development was reversible, however. Through treatment, the addict could be rendered 'capable of functioning as a productive, nonparasitic member of society' (Ramirez 1966b).

The remedial project was clear. Ramirez set out to rectify psychopathic personality development through a program of intensive re-socialization. His vision of a therapeutic community involved a team of professionals and non-professional "ex-addicts" who acted as a bridge between clinicians and patients. CISLA's basic program was threefold. Induction described outreach efforts that "utilize[d] ex-addicts to establish contact with active addicts on the streets, to attempt to motivate them so

that they will enroll themselves" (Ramirez 1966a:118). Next was a "personality restructuring process" carried out through full-time residency (Ramirez 1966b). Finally, during the "re-socialization training process," addicts were expected to recruit other addicts into the program in order to "to pay back their debt to society" (Macro Systems 1972:26).

During its first three years, CISLA treated an estimated 1083 residents and claimed a relapse rate of just 5.6% (CISLA 1964). These remarkable results did not go unnoticed. In 1966, Ramirez was recruited by New York Mayor John Lindsay to serve as the first Commissioner of Addiction Services. Ramirez' arrival in New York coincided with a hyperactive period in government-funded addiction treatment in the urban US. As the heroin epidemic's death toll became known through popular media, and as stories about child heroin addicts induced moral panic across the city, local governments were jolted into action (Densen-Gerber 1973). New outreach clinics and residential therapeutic communities, modeled on CISLA and Synanon, sprung up across the city's five boroughs (Densen-Gerber 1973; Sugarman 1974), soon spreading to Miami, Philadelphia, Los Angeles and Chicago (Deitch and Drago 2010). In 1969, forty programs in mainland United States described themselves as therapeutic communities in a survey sponsored by the National Institute of Mental Health (NIMH) (Sugarman 1974: vii).

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

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

health department only reluctantly. Its demise was all but assured, some say, by the loss of Ramirez, who was not only highly energetic in his efforts to extract funds from the department, but was also extremely well connected (his wife was the daughter of Governor Luis Muñoz Marín). And so, as the 1960s drew to a close, an epidemic of unknown magnitude was being managed by a handful of small and chronically under-funded agencies: a nine-member Commission for the Control of Narcomania, a smattering of government-run clinics in San Juan. The only public treatment offered outside the capital was in the Addiction Rehabilitation Center in Ponce, modeled on CISLA (Macro Systems 1972, 36-41).

It was in this context of state inaction that the Home for the Re-education of Addicts[2] (*Hogar CREA*) was founded in 1968. *Hogar CREA* was founded by Juan José García Ríos ('Chejuán') with the assistance of three fellow CISLA graduates. A "star patient" at CISLA, affectionately nicknamed "el semántico" by fellow residents for both his intellect and argumentativeness, Chejuán had stood out among CISLA staff members as a natural leader and "outstanding member of the group." As one of his therapists recalled: "He was sharp, a fast learner. He had charisma and a following. I noticed that many addicts listened to what he said". Though his adolescence and early twenties had been marked by heroin addiction and periods of incarceration, Chejuán was atypical of CISLA's clientele. He had been raised in a middle class household, was the son of a successful businessman, and had been educated in business administration (Velez 1986).

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

Politically savvy and well-connected, Chejuán immediately set about generating support from industry, commerce, banks and associations (Velez 1986). In a few months, Chejuán and his associates had acquired not just financial donations, but also vehicles, furniture, land, and their first building in Trujillo Alto. To drum up community support, *CREA* would send representatives into the towns to give talks to interested citizens. Crowds would flock to public gatherings, press conferences and public speeches where Chejuán would not only exhort citizens to get actively involved in tackling the drug problem, but would also offer concrete means of doing so: financially self-sustaining residential communities, managed by local citizens through steering committees (Babb 1969).

In the late 1960s and early 1970s, ignored by the state and shouldering a burden few knew how to manage, affected families pressed their mayors and communities to welcome *Hogar CREA* with open arms (El Mundo 1970b). As one steering committee member recalls: "When *CREA* started, all these parents who'd been worried about their kids, who were stealing, having run-ins with police, all of a sudden they had this option." This was also echoed by parents: "At least now I could get him out of the house for a few weeks, a few weeks when I didn't have to worry. Will he be arrested? Will he die?" Within a few years, *CREA* achieved broad civic participation across the community – from parents and families, yes, but also from pastors, priests, police, teachers, social workers, sororities and a host of civic groups (El Mundo 1970b).

As even this abbreviated history attests, the emergence of this therapeutic regime was not some automatic consequence of state neglect. Particularly important to *CREA's* early genesis was the manner in which Chejuán and his followers were able to seize

and shape the opportunities and resources available to them. An overburdened, financially strapped state set the stage for therapeutic community's ascendency, yes, but human action and converging interests were crucial in the design and realization of this response, revealing the fundamental contingency and sociality of this care regime.

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

Over the course of the 1970s, while *Hogar CREA* and its leaders were busy rallying community support, therapeutic communities in mainland US were obtaining city and federal grants and contracts, awarded through various city governments and federal institutes (Deitch and Drago 2010). Their Puerto Rican counterparts, by contrast, had lost funding, political sway, and all official endorsement. It was in this mixed context of formal disinvestment coupled with popular clamoring for more programs that *CREA* recognized and capitalized on a thus far un-tapped resource: the value-

generating capacity of its residents. Unpaid labor, which had only rarely generated revenue in New York's therapeutic communities[3], was reconfigured as the economic backbone of Puerto Rico's therapeutic communities. In other words, an economically viable abeyance mechanism was born.

'Operation Bootstrap' and the problem of surplus

Hogar CREA's rapid expansion, from three residents living in one *hogar* in 1968 to 1200 residents spread across a decentralized federation of 22 separately managed centers in 1972 (Macro Systems 1972:88), reflects not only the growing demand for treatment, but also the burden of mass unemployment and post-industrial dislocation – two widely recognized casualties of Puerto Rico's status as a colonial experiment capitalist development (Hansen 2018; Dietz 1986; Lapp 1995).

Forty years after invading Puerto Rico in 1898, the U.S. set its colonial government to a series of modernization projects. These were first initiated in the 1940s under the US-appointed Governor Rexford Tugwell, but later extended under the popularly elected Governor Luis Muñoz Marín. To bring about rapid industrialization, *Manos a la Obra* ("Operation Bootstrap") combined investment in industry with cheap labor and generous tax incentives, attracting eager entrepreneurs from the mainland (Lapp 1995, 184-185). Between the 1940s and 1960s, consumer goods (textiles, footwear, and electrical) replaced sugar as Puerto Rico's signature industries. But owing to the vast tax exemptions awarded to American companies, profits flowed straight back to American investors, with little remaining in Puerto Rico (Dietz 1986). While Puerto

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

Ricans experienced a one-time leap in per capita income, from $121 per year in 1940 to $900 per year in 1965 (Hansen 2018:78), the labor force participation rate actually dropped from 55.5% in 1950 to 45.4% in 1965 (PBPR 1984).Industrialization disproportionately displaced men from the labor market (Dietz 1986; Safa 1995), with the male labor force participation rate declining by 19% between 1950-1980, from 80% to 61% (Safa 2011). Capital- rather than labor-intensive technologies were partly to blame. They allowed Bootstrap firms to reduce the size of their workforces, from 80 workers per factory in 1962 to just 55 in 1967 (Dietz 1976). By the late 1960s, tens of thousands of Puerto Ricans were emigrating each year in search of work on the mainland (Lapp 1995). Among analysts of Puerto Rico's labor history, the consensus is that whatever its status as a "showcase" for American capitalism, Operation Bootstrap left behind a growing class of surplus workers and left the economy entirely dependent on American investment (Dietz 1986; Safa 2011; Lapp 1995).

It was in this context of colonially-induced structural dislocation and widespread joblessness that *Hogar CREA* assumed the recognizable form of a Mizruchian abeyance mechanism. Under the guise of providing treatment, it created and allocated alternative 'work' opportunities for surplus men. Its microenterprises included a bread company, an auto repair shop, a car wash, and a furniture moving company. It dispatched its residents to the streets, clad in brightly colored *CREA* T-shirts, where members would spend hours every day selling goods, mostly cakes, bottles of water, and garbage bags to passing motorists. The organization also entered into a variety of informal agreements with mayors, city governments, and private landlords. For a very low fee, local governments and private companies could hire *CREA* residents to perform such tasks as cleaning streets and mowing lawns.

Its thrift and industriousness impressed local government officials, who appreciated having a cheap labor pool of "respectful" and "well-behaved" addicts to pick up garbage, de-weed the town *plazas* and landscape government property. As one long-standing *CREA* affiliate who helped set up several branches in the Dominican Republic in the 1980s, recalled: "they were well behaved, they were courteous, and for a very low fee they could be called upon to [help]."

CREA graduates, who had limited employment alternatives, often jumped at the chance to stay on as volunteers after their treatment finished, where they were usually provided shelter, sustenance, and sometimes a stipend rather than formal wages. With a characteristic passion, they widely credit these opportunities with saving their lives. "It was an easy decision [to stay]," recalled one program director, who entered *CREA* in the early 1990s and stayed for twenty years. "The fact that I could really give myself to something, have a purpose, and it would benefit others too."

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

This organizational structure proved highly successful. By 1972, *CREA* was providing roughly 40% of the island's 3000 rehabilitation vacancies (Macro Systems 1972:76).

By 1986, it had 65 centers in Puerto Rico, with satellite programs in the Dominican Republic, Colombia, Venezuela, Costa Rica, and Pennsylvania (Velez 1986). In addition, several new Puerto Rican therapeutic communities were founded. Modeled on *CREA, Hogar Nueva Vida* was founded in 1973 and *Hogar Nuevo Pacto* was founded in 1982.

This rapid propagation of therapeutic communities, with their swelling pool of unwaged and underwaged laborers was a reflection not just of state neglect or straightforward unmet need for treatment. What began as a 'treatment' venture had quickly morphed into an abeyance mechanism, one who's chief affordance at that time was informal enterprise: that is, allocating an alternative job and sense of purpose to a group of surplus men jolted to the margins by capitalist development and empire.

The commonwealth addiction program

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

CREA's first decade coincided with a mass overhaul of addiction treatment across the United States. President Nixon, elected in 1968 on a 'law and order' campaign promising to crack down on inner-city crime and bring treatment to addicted Vietnam Vets, formally declared a 'War on Drugs' in 1971. Throughout the early 1970s, through a host of administrative and legislative actions, federal addiction efforts mushroomed. New institutions were created to provide and to oversee addiction treatment: the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971 and the National Institute of Drug Abuse (NIDA) in 1973. Federally funded addiction treatment programs, which had numbered 135 in 1971 across 54 mainland cities, grew to 394 by 1973, across 214 cities (Goldberg 1980).

Federal and commonwealth funds were used to create the *Departamento de Servicios Contra la Adicción* (DSCA) in 1973. Modeled on NIDA, DSCA's structure consisted of centralized intake units where people were diagnosed and then referred outwards to various treatment services. Taking its lead from on-going drug treatment initiatives in US cities, in particular the pioneering work of Jerome Jaffe in Chicago, DSCA elected to circumvent what was then a highly contentious debate about the ethics of methadone maintenance. It pledged to provide all of the major existing treatment methods (methadone maintenance, abstinence-based counseling, and abstinence-based residential treatment), relying upon generous public financial investment. By the late 1980s, DSCA was providing approximately 5000 people with outpatient counseling, 4000 with abstinence-based residential treatment, and 2400 with methadone maintenance (DSCA 1990:4).

[Insert figure 1]

Centralization of addiction treatment in Puerto Rico was actually *more* comprehensive than that on the mainland. NIDA and NIAAA rarely provided their own direct services; instead they gave individual states and private organizations contracts or grants to provide treatment (Besteman 1992). In contrast, the newly inaugurated DSCA assumed a more central role as a public provider of addiction treatment. At that time, Puerto Rico boasted a public healthcare system known as the Arbona system, which had provided free healthcare since the 1950s (Mulligan 2014). Accustomed to socialized health care, DSCA was envisaged, above all else, as a service provider. This strong centralization predictably infuriated therapeutic community leaders, who, in contrast to their North American peers, found themselves unable to tap the newly available resources. Within four years, DSCA became the lead provider of addiction treatments in Puerto Rico, accounting for nearly half of all total treatment capacity in 1977 (DSCA 1977). Close behind was *Hogar CREA*, accounting for 44% of those enrolled in treatment. Small proportions were also treated through state correction and other therapeutic community or private programs (DSCA 1977).

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

hundreds of ex-addict paraprofessionals, most of whom were graduates of either *CREA* or CISLA (DSCA 1975).

Reflecting the presence of CISLA and *Hogar CREA* graduates within its workforce, characterological therapies were taken up by DSCA-operated residential programs in the 1970s and 1980s. This incorporation of Eriksonian theory into government residential programs was facilitated by DSCA's senior leadership, in particular by Isabel Suliveres, who served as DSCA's second secretary between 1985-1992 and was a vocal advocate of Eriksonian theory. Like therapeutic communities, DSCA's residential programs sought to instill "socialization skills," and to help the resident to "gradually abandon old habits like obscene language, fighting, and lack of respect for others" (DSCA 1983). Discharge criteria at DSCA-operated programs demanded that participants not only achieve abstinence, but also that they adopt "acceptable attitudes and values" (DSCA 1983).

In September 1982, DSCA was providing care to twice as many patients (across all treatment modalities) as all private programs combined[4]. *Hogar CREA,* however, boasted a considerably larger workforce (approximately 800 staff members, compared to DSCA's 400). This relatively bloated workforce was a reflection of *Hogar CREA's* role as an abeyance mechanism: it was able to absorb hundreds of unemployed men

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

such that 71% of its staff was unpaid graduates[5] (DSCA 1986). Since DSCA paid all of its employees with formal wages, it was much less effective than *Hogar CREA* at providing positions to ex-addicts.

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

Extra-therapeutic metamorphosis

From its inception, the commonwealth methadone program was the object of intense public controversy. Deeply unpopular within the towns, where it was widely considered to be "swapping one drug for another," methadone was also publicly denounced by therapeutic community leaders and Evangelical ministers (El Reportero 1981). Practical challenges arose within the methadone clinics themselves. Former employees recall that methadone was routinely under-prescribed at levels below the recommended dose leading to poor clinical outcomes. A lack of security led to high staff turnover, and the appearance of homeless encampments around methadone clinics prompted fierce community resistance (Lebron 1976). Faced with rising community opposition, DSCA's methadone clinics were scaled back from 1976

[5] This was also the case in Puerto Rico's smaller private programs, where most staff members were unpaid graduates (DSCA 1986).

onwards. At their peak in 1976 there had been 15 clinics serving 1893 patients (Lebron 1976:72). By 1997, just four methadone clinics provided care to 1078 patients (SAMHSA 1997).

While DSCA struggled to maintain its methadone program, therapeutic communities not only grew in number (Macro Systems 1972; DSCA 1990), but extended their institutional charter, taking on various 'extra-therapeutic' roles and cultivating new political allies. At the community level, they assumed many of the risks and costs of managing drug violence, which by the mid 1980s was wreaking havoc across Puerto Rico's towns (Navarro 1995). Throughout the 1980s, newspapers abounded with stories of armed robberies, gun violence, and not infrequently homicide (El Vocero 1984b). In one instance, a "death squad" of six shooters armed with AK-47s broke in to a *CREA* center Trujillo Alto, killing two residents and injuring three (El Vocero 1984b). At another *hogar*, a director and two residents were taken hostage when a group of intruders, armed with machine guns, broke in to steal $3500, having been tipped off by a current *CREA* resident about a recent car sale (El Vocero 1984a). Though such attacks prompted outcry about the inadequacy of the existing security (El Vocero 1984b), they also indirectly attest to the limited capabilities of existing social structures to contain the violence of the drug economy. Families, who were sometimes caught in the crossfire of drug-related violence, appreciated the protection from violence that came with having their relative out of the house.

An additional affordance offered by *Hogar CREA's* was the role it assumed as a safety valve for the Department of Correction. Exchanging, Mizruchi (1983) might remark, one abeyance assignment for another, *CREA* absorbed hundreds of prison

inmates each year from the mid-1970s onwards, as did several other therapeutic communities. Prison overcrowding, which had been an enduring problem in Puerto Rico since at least the 1950s (Planas, Lopez, and Alvarez 1965), had reached crisis point in the late 1970s when inmates filed a class-action lawsuit against the Puerto Rican government, which subsequently was forced to pay $250 million in federal fines (The Seattle Times 2014). Following outbreaks of infectious diseases including tuberculosis and mange, several of Puerto Rico's prisons were under orders from federal judges to make improvements (Wright 1982). Faced with a budget deficit, chronic overcrowding, and mounting federal fines, corrections found a ready way out in therapeutic communities, which presented both an expedient safety valve and a cost-shifting maneuver (the modest *per diem* that corrections awarded for court-ordered residents was significantly lower than the equivalent cost of incarceration).

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

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

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

Cross-party support eased access to fresh funding. The commonwealth legislative assembly supplied the organization with a steady stream of donations throughout the 1970s and 1980s (Ross 1995a), as did individual donors from industry and commerce (Velez 1986). In 1974, the Industrialists Association named Chejuán citizen of the year, as did the Chamber of commerce in 1976. Now public hero and "pride of Puerto Rico" (El Vocero 1987). Chejuán ratcheted up *CREA's* community mobilization efforts in the late 1980s, initiating what became hugely popular annual "crusades of faith and hope," orchestrated to expand community participation and to raise funds for the organization (El Mundo 1989). On campaign trails that snaked

through each of the island's 78 municipalities, Chejuán led public demonstrations that drew thousands of people, including interested citizens, civic groups, politicians, police chiefs, religious leaders, and trade union leaders (El Mundo 1989; Ross 1995b).

CREA's success in winning over the Puerto Rican political class is revealed by its attendance lists at graduation ceremonies, which in 1988 included Governor Hernández Colón, the President of the Chamber (José Ronaldo Jarabo) and the President of Association of the Mayors (Pedro Padilla), as well as a host of senators, judges, and businessmen and various Catholic and Evangelical religious leaders (El Mundo 1988).

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

Therapeutic communities, in contrast, allocated substitute work to hundreds of volunteer graduates across dozens of segregated communities. Seen thus, *CREA's* persistence and invigoration throughout the twenty-year period of the commonwealth

addiction program is best explained not so much by the failure of the state to offer alternative treatments, as by the adaptability of therapeutic communities as abeyance mechanisms. They were repeatedly and routinely co-opted by diverse interests to serve a variety of purposes. The trajectory of therapeutic communities in mainland United States during this same period offers a contrasting case.

Professionalization of mainland therapeutic communities

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

On the mainland, the sub-contracting model provided therapeutic communities with a steady stream of public contracts. In the 1960s and 1970s, this was done through the NIMH. When federal programs were phased out by the Reagan administration in the 1980s, they obtained contracts from city and state governments (Besteman 1992:78).

But public contracts entailed heavy regulatory demands, many of which were broadly similar to those made on hospitals and other medical institutions.

Though complex historical reasons underlie the changes that were instituted across mainland therapeutic communities between the 1970-1990s (see White and Miller 2007), the regulatory reach of the mainland sub-contracting model was crucial in facilitating such reforms as the abandonment of harsh punishments, the introduction of a 40-hour working week, and the employment of professionally trained staff including psychologists, social workers, cooks, and cleaners (Deitch and Drago 2010). Ballooning operating costs associated with mandated professionalization prompted many therapeutic communities to close down in the late 1970s and 1980s (White 1998). To sustain financial viability, those that remained either relocated to prisons, or privatized and significantly reduced lengths of stay from 1-2 years to 3-6 months (Deitch and Drago 2010). Today, long-term residential therapeutic communities occupy a much smaller role within the US addiction field relative to outpatient programs and short-term residential detox (SAMHSA 2013).

Neoliberal reform

Therapeutic communities' independence from DSCA proved crucial to their survival of a series of health care reforms known as *La Reforma.* Between 1993 and 2001, the public health care system that had operated in Puerto Rico since the 1950s was dismantled and a private managed care system installed (Mulligan 2014). In 1993 DSCA was closed down altogether and replaced by a new department that unified addiction and mental health services (ASSMCA, see figure 1), a change modeled on similar consolidations on the mainland. Through a series of administrative and

legislative actions, the state's role shifted from provider of addiction treatment to that of administrator.

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

Though therapeutic communities remained dominant, *La Reforma* also spawned a network of managed behavioral health organizations (MBHOs), which, though still relatively small in capacity (SAMHSA 2013), now offered a range of biomedical therapies (e.g., motivational interviewing, buprenorphine therapy). In departure from its predecessor (DSCA), the current administrative body responsible for overseeing addiction treatment (ASSMCA) eliminated all references to Eriksonian personality theory from government protocols. It aligned itself, via the 2008 amendment of the

Mental Health Act, with the DSM-IV model of addiction as a 'substance use disorder' (DoH PR 2008).

While proponents of *La Reforma* anticipated it would increase access to biomedical addiction services, utilization actually remained low (Alegría et al. 2001), partly because MBHOs began to funnel drug users away from expensive treatments (e.g., with psychologists or psychiatrists) and towards cheaper support groups (Jordán et al. 2016). To date, *La Reforma* has not induced the swing towards biomedical therapies that its architects anticipated. Instead, healthcare privatization has further entrenched the divides of what was already a highly fragmented landscape, leaving a stark disjuncture between the new department's ambitions for a "modern" biomedical treatment system (Hansen 2018) and the realities of Puerto Rico's therapeutic landscape. The bulk of licensed treatment facilities in Puerto Rico continues to be private non-profits (SAMHSA 2013), mostly therapeutic communities, who for the most part have been wholly unaffected by the new department's endorsement of biomedical therapies. This is not least because, along with the majority of non-profit providers, therapeutic communities are legally exempt from the new department's regulations on mental healthcare standards (see Hansen 2018). Thus, whatever their aspirations and doctrinal commitments, public health officials in Puerto Rico continue to operate in an environment shaped by historically entrenched political, institutional, and legal-regulatory mechanisms that are highly conducive to the persistence of therapeutic communities and unpaid labor therapies.

Conclusion

After an impassioned riff on the lack of scientific evidence to substantiate therapeutic communities' claims of efficacy, a long-standing critic of *Hogar CREA* concluded

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

Throughout the second half of the 20th century, Puerto Rico’s therapeutic communities have been successively recruited to serve a variety of alternative, varied and even, at times, competing interests. For an overwhelmed corrections department, they have provided a highly convenient safety valve and cost-shifting device. For local governments, private businesses, and individual politicians, they have supplied a cheap workforce; for families, a way out of desperation; and for mayors, they have variously been mobilized as election allies and as levers of community approval. Their endurance, therefore, not only reflects their capacity to patch the cracks of multiple faltering systems (including employment, corrections, family), but it also reflects their protean vulnerability to appropriation: that is, the ease with which they are co-opted by other actors for alternative purposes. All this suggests that the criticisms they draw from treatment activists - as “unscientific” and “not evidence based” (IPR 2015; OSF 2016) - may, in the final analysis, be beside the point. These niches will likely persist owing to their capacity to be repurposed for a variety of different utilities.

There are, of course, alternative readings. Therapeutic communities could be parceled into one of several existing frames: as stations within biopolitical circuits of clinic, jail, and prison (Gowan 2010), as appendages of a particular political project, such as the penal state (Wacquant 2009), the new penology (McCorkel 2013), or narcopolitics (Garriott 2011), or as technologies of liberal or illiberal governing styles (Bourgois 2000; Zigon 2010). But framing therapeutic communities as abeyance mechanisms offers distinct affordances of its own. Instead of suggesting the emergence of some "new" political project, the present account has emphasized how a versatile niche can lend itself to a plurality of different affordances. As *potential* resources that arise from a tendency of modern capitalism to generate surplus (Arendt 1951), abeyance mechanisms may be seized upon by any number of *potential* beneficiaries, each characterized by their own context-driven interests and ideologies. Thus, abeyance mechanisms do not coalesce around any unified logic. They are likely to consist of multiple projects that may be constantly changing.

This article challenges the argument that therapeutic communities are the simple result of the state failing to invest in alternative treatments. Between 1973 and 1993, DSCA constituted one of the most comprehensive efforts (in design, not scale) to provide centralized publicly funded addiction treatment in US narcotics history. Yet in the end, characterological therapies found in the commonwealth program a certain symbiosis. Endorsed by DSCA's senior leadership and promoted by therapeutic community paraprofessionals, characterological therapies were taken up by the commonwealth's own residential centers, and were never seriously challenged by its widely unpopular methadone maintenance program.

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

The Puerto Rican therapeutic community story should also serve as a reminder, therefore, that in our efforts to comprehend the care or management of any illness or disorder, we must also be attuned to the wide variety of interests and concerns that drive and channel therapeutic regimes. These extend far beyond "therapeutic" matters of sickness and healing, and also extend beyond developments in the clinical sciences. By widening our ethnographic angle of inquiry to include these "extra-therapeutic" developments, the anthropology of medicine can illuminate the congeries of local interests, socialities, and political projects that may, at a given time and place, animate and give shape to therapeutic movements.

In the wake of Puerto Rico's recent economic and environmental crises, abeyance's future incarnations are difficult to predict. During what is sure to be a fraught re-

construction, therapeutic communities may well take on additional roles. This should come as no surprise. As we have seen, this exchange of one abeyance assignment for another has been an enduring, if not defining, characteristic of Puerto Rico's therapeutic community movement.

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Figure 1: List of abbreviations

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