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Hispanos in the valley of death: street-level trauma, cultural-post traumatic stress disorder, overdoses, and suicides in north central New Mexico

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HISPANOS IN THE VALLEY OF DEATH:

STREET-LEVEL TRAUMA, CULTURAL-PTSD, OVERDOSES, AND SUICIDES IN NORTH CENTRAL NEW MEXICO

BY

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DISSERTATION

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Doctor of Philosophy
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DEDICATION

First and foremost, I dedicate this work to the people of “the Valley” for whom I have grown to care enough to ardently long for an end to this pernicious overdose epidemic which has stolen from them so many wonderful and sensitive lives. I humbly hope that I have made some difference by bringing this plague and its possible structural causes to the attention of the policy makers.

To all of those teachers whom inspired me so many, many years ago: Dr. Arthur Newgarden from S.U.N.Y at Plattsburgh, who in helped me to learn to think clearly, to see philosophical concepts as “real” objects of study, and not be afraid of White people; Mr. Stone (whose first name I did not ever know) from Wallkill Prison School, who assisted me in learning to read when I was a grown man (when everyone else had given up on me), and who helped me to learn enough to get a G.E.D. which helped me to take the first steps toward academe; and Mr. Bridges (didn’t ever know your first name either) from Patrick Henry Junior High school who taught me how to play the violin, fold a New York Times newspaper for subway reading (even if I could not read most of it), but more for teaching me etiquette, and manners.

I also dedicate this manuscript to my ancestors – the African slaves, the *idios de Puerto Rico*, the Sephardim, the Moors, and even the Spanish – whose combined genes have made me strong. To my mother and father, my children, and grandchildren: I hope they are as proud as I that I am to be the first Ph.D. in our family. I now KNOW I will not be the last in our family to hold such an honor.

I dedicate this dissertation to the many students in my classes who have taught me so much.

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ABSTRACT

New Mexico has had the highest per capita drug overdose death rate in the United States, about 18 per 100,000, for more than ten years – 1995 to 2006. The USA's rates for the same period are about 5 per 100,000. North Central New Mexico (the Valley) has the highest per capita "accidental drug overdose" death rate in all of New Mexico ranging from 42 to 72 per 100,000 over the course of the eleven years examined, from 1995 to 2006. What are the differences and similarities between victims of "accidental drug overdoses" and suicide victims in the Valley (as subjectively designated by the Office of the Medical Investigator)? How can we understand these high rates of suicide among the Valley residents, most of whom are Hispanic? What are the race, class, and gender structures that set the backdrop for the high rates of overdose and suicide in the Valley? This dissertation examines the social forces that may contribute to the overdose epidemic among the predominantly Hispanic population in Northern Central New Mexico. My analysis of 34 interviews of active illicit drug users and 10 interviews of family members and professionals is anchored in sociological analysis,

concepts, and literature -- Anomic Suicide, post-Marxism, current sociological drug addiction theory, colonialism, historical/cultural trauma, and racial and ethnic inequality. The research design employs both qualitative and quantitative data, including data from the New Mexico Office of the Medical Investigator (1995-2006), historical analysis, participant observation, in-depth interviews, and autoethnography and positionality. This mixed method approach allowed for the triangulation of disparate data. I found that there was an overlap between the demographic profiles of suicide and overdose victims. I argue that the effects of colonization and "street-level trauma" (SLT) (which I define as interlocking traumatic shocks that are puissant and pervasive: chronic and acute emotional, physical, and psychological insults that are pernicious, debilitating, and untreated, and which may lead to mortality inducing behavior) may lead to a condition I call "Cultural-post traumatic stress disorder" (C-PTSD). C-PTSD may result in high incidence of morbidity and mortality amongst Hispanos in the Valley. C-PTSD may be shaped by the loss of arable land (despite high home ownership), loss of traditional and cultural norms, the whole-cloth invention of a mythological and superficial ethnic consciousness (categorical awareness), and loss of meaningful social bonds to community. When C-PTSD and SLT are coupled with a substance abuse career, the combination of all three may prove lethal; may result in suicides that are labeled "accidental drug overdoses." The implications for medical sociology are important. Treating drug overdose and suicide as a "personal trouble," an individual-level problem in the Valley, is a major limitation of current health policy. Public health programs must be implemented that do more than attempt to treat substance abuse and fail to go beyond that. My findings suggest that a community-level approach that includes an analysis of the matrix of domination (e.g., intersecting structural, disciplinary, hegemonic, and interpersonal oppressions and resistance) would shed light on the social forces that shape community health and viability. Future research should also examine the intersection of race and gender vis-à-vis hegemonic and subordinated masculinities and health policy.

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CHAPTER I: AN INTRODUCTION

Walking Through the Valley of Death

> Chicano: I was born and bred here. *I am not a Mexican*, as per sé. *My ancestors were here way prior before all of these revolutions and bullshits* since the 1500s. So I consider myself a... *an Español, a Chicano*... a Española, a Chicano; Hispanic…. just do away with the drugs and you do away with the problem (Rico, 59 years active old heroin addict, Emphasis mine)

Please picture this: you walk into a cancer ward in a hospital, with you is a knowledgeable oncology doctor. He looks around at the terminally ill patients, many of whom are in various stages of dying from their respective cancers in what would be horrific pain were it not for the large dosages of pain medication they are taking. The oncologist turns to you and says, “We really need to cure these people of their drug addiction.”

The essence of that statement is exactly what this dissertation is about. An epidemic of drug overdose deaths has been plaguing North Central New Mexico for more than a decade now. I repeatedly heard from counselors, doctors, nurses, politicians, school teachers, mothers, fathers, grandmothers, grandfathers, and even from addicts themselves, such as Rico quoted above, some variation of what the doctor said in the anecdote. This dissertation is about looking past the addictions to the “cancer” which has and continues to kill off generations of North Central New Mexicans.

Dissertation Research Topic and Principal Questions

New Mexico is a colonized "country" in the same way that the African nations, the Philippines, and Puerto Rico are colonized regions. Colonized peoples everywhere develop their own mythologies about their conquerors and about themselves (Alexander, Eyerman, Giesen, Smelser and Sztompka, 2004, Gonzales, 2000). Northern New Mexicans are no exception: they have developed their own mythologies in relationship to the conquest of northern Mexico by the United States. According to Laura Gomez (2000), these traditions in turn have produced internal conflict in those who perceived the traditions as

being different than the actual historical record demonstrates, or who are conflicted between the existing tradition and what may be a projection of another reality created by the ruling class, or Anglos (Gomez, 2007). The introductory quote by Rico above alludes to that confusion well.

New Mexico has the highest per capita mortality rate from accidental drug overdose in the United States; and North Central New Mexico has been the epicenter of that mortality in New Mexico from 1995 to 2008. "The Valley" (as North Central New Mexico is referred to by the long term residents of the region, and which will be used in this dissertation) encompasses all of Rio Arriba County and Northern Santa Fe County, Los Alamos, and Taos Counties. In Chapter IV the Valley is shown to be predominately populated by Latinas and Latinos, more than 72% of the population according to the 2000 Census. Most self-describe as "Hispanos," a word which literally translates as "Spanish." Over a twelve year period the rate of accidental drug overdose deaths in the Valley exceeded that for suicides (OMI, 2008).

What social factors may explain more than a decade of epidemic proportion drug overdose fatalities in these rural communities? That is one of the principal questions that are ethnographically explored by this dissertation.

El Problema Hispano (the Spanish Problem)

The social factors investigated in this dissertation are quite straightforward: Why are so many people, predominately Latinas and Latinos, dying of accidental drug overdoses in the Valley? What can be done about it?

This dissertation is partially based on a research study reported in 2004 conducted to determine the barriers to treatment in the Valley which bulleted challenges faced by the Valley's communities regarding alcohol and drug abuse careers (Willging, Trujillo, La Luz, 2004). The report also bulleted other challenges faced by the Valley's Community regarding alcohol and drug abuse careers. For example, many users began their drug careers between the ages of 12 and 16, an inception age younger than the national average of 16 years of age. All the principal respondents had suffered significant traumas in childhood

and or adolescence, and many suffered chronic physical and emotional pain from these traumas. These mental and bodily insults resulted in a condition that I have termed “street-level trauma” or SLT (which is defined below). Additional findings from the study were that there are older addicts in the Valley than one would expect from the national literature, that there is a great deal of intergenerational, concurrent drug use, and that most of the principal respondents in the study self-designated as “*Hispanos*.”

My additional mining of the same data set produced findings that have gone much further than the original study's conclusions. The Willging study implied, and referenced, that there were clear indications of much deeper problems than addiction to various substances; that is, factors other than simply treatment barriers and access issues come into play. However, it did not delve into those issues at any length because that was not the purpose for which the investigation had been commissioned.

Autoethnographic Positionality

I am Puerto Rican. I was born in Manti, Puerto Rico, the youngest of seven children, and I was reared in Spanish Harlem, New York from the age of 18 months. My family was welfare-government-food-give-away poor (as were most of the families around us). Most of the fathers worked in menial jobs, and the mothers all stayed at home. We were all “subjects” of a colonized migratory pattern between the Caribbean Islands and the US Mainland.

I started “mainlining” (intravenous injecting) heroin the very first time I used at the age of 12: my brother “shot me up.” By the age of 16 I was in prison serving a 12 year sentence for manslaughter as a result of a gang fight: I served nine years of that sentence on the installment plan: I was paroled three times.

I "matured out" (Quintero, 2000; Winnick, 1962) of my drug career somewhere in my late twenties in keeping with patterns revealed in much of the literature on the subject. "Maturing out" is the process by which the majority of addicts leave their drug careers somewhere between the ages of 25 and 30 years of age. This is a critical concept in my analysis (May, 2001, 1994; Anglin,

Brecht, Woodward, and Bonnett, 1986; Winnick, 1962). The maturing out process, as far as can be determined, is largely nonexistent in the geographic region of my research.

However, many of the processes I followed within the drug career are the same as the processes I discovered in my research of the communities in north-central New Mexico. For example, the manner in which the heroin was cooked and injected or the physical morbidity endemic to kicking a habit followed the same trajectories for me as for the substance users I interviewed. Of particular importance is the pharmacological knowledge I gleaned from the use of various drugs, and (perhaps most important) the knowledge I gleaned about overdose. For example, I learned not to ever inject heroin after I had been drinking alcohol because that practice often leads to death: most overdoses in the OMI records include ethanol as one of the substances found in the postmortem screening.

I overdosed three times in my drug career; the first time was about a month after I started. I shot up heroin after having injected two Tuinals (a barbiturate) a couple of hours before. Luckily my brother (who eventually died of drug related AIDS some 30 years later) “walked” me out of it: He dragged, and pushed and kept making me move and walking until I recovered. I never mixed heroin with any other depressant drug again. The second time was a few months after the first OD: I had been playing stickball for quite some time when I started to have withdrawal symptoms and went to the roof to inject. I failed to realize how dehydrated I had become. I passed out when I injected myself. I awoke to a downpour of summer rain two hours later. I was laying half out of the roof’s cupola on the roof. The last time was shortly after I was paroled; I was 20 years old. I bought some heroin to sell and decided to “test” it for purity. I made the mistake of using the same amount I had used before I was incarcerated. My wife and a friend took me to the hospital. I learned from those three incidents and never overdosed again.

So I learned early on in my drug career how to prevent overdoses, how to treat their consequences, and what the consequences were to those who ignored

these hard earned facts. Most of those who ignored the lessons died of overdoses early in their drug careers: many of my friends died in their early teens from overdose.

Both the experiences I suffered and the knowledge I gleaned lend a different perspective to my investigation and conclusions than that of a person who has not experienced a drug career of any kind. I write to this in more detail in the concluding chapter, but perhaps it suffices to say that very few of those who neglected to learn the inevitable consequences of certain drug career practices made it beyond the post-teen years of drug careers. That fact alone was one of the greatest influences on the conclusion I drew in this dissertation: accidental drug deaths past the maturing out periods of drug careers are nationally and internationally rare because addicts learn early on how to prevent them. I know this from experience: that is why autoethnographic positionality is so important in this dissertation.

In examining the Willging data from a different perspective and because of my personal experiential knowledge of the subject matter stemming from being a drug addict from the age of 12 to 28, *I suspected that the epidemic of accidental drug overdoses might actually be an epidemic of suicides*. This suspicion led me to consider the following assumption: That a systemic, structural problem of this duration and magnitude calls for a sociological explanation. As such, could the answer lie in the possibility that most of the people involved in this epidemic are "Hispanos," who are not immigrants to the United States, but rather descendants of a captured and colonized populace?

The "Number's Game": Why Study the Valley's Relatively Inconsequential Mortality Causes

The number of accidental drug overdose deaths in the Valley is relatively small, particularly in comparison to the large numbers of overdose in the United States' major cities -- Los Angeles, New York City, and Miami. However, the Valley has consistently over a twelve year period – 1995 to 2008 inclusive -- exhibited the highest per capita drug overdose death rates in the United States –

ranging from a low of about 40 per 100,000 to as much as 72 per 100,000 (compared to a national average of 5 per 100,000) (CDC, 2008; NMDH, 2009), The overdose morality epidemic in the Valley is an epidemiological curiosity that merits deeper understanding by the sheer force of the contradictions presented. Those contradictions are compounded by the social fact that almost all the people dying from accidental drug overdoses in the Valley are Latinos and Latinas, many of who own their own home.

Additionally, while the actual numbers are relatively small, they matter a great deal and are of extreme urgency to the people of the Valley itself. This relatively small geographic area of the United States is suffering great sorrows at the intersection of addiction, economics, ethnicity, colonization, cultural deviation, land policies, poverty, religion, and generalized trauma.

I posit that this concatenation of factors and "street-level trauma" (SLT) combine to produce a condition that I have named "Cultural-Post Traumatic Stress Disorder" (C-PTSD). I define SLT as interlocking morbidity sets that are puissant and pervasive: chronic and acute emotional (repeated physical and psychological insults) that are pernicious and debilitating. When these insults remain undiagnosed and untreated, they appear to lead to mortality inducing behaviors. In the case of the Valley, SLT may be shaped by the lost of arable land (despite high home ownership), loss of traditional and cultural norms, the arguable whole-cloth invention of a artificial ethnic consciousness (Gomez, 2007) and categorical awareness (Gonzales, 1997), and loss of meaningful social bonds to community.

Epidemiological: Prevention, Intervention, and Treatment

Previous studies about the accidental drug overdoses are psychological or medical in framework, that is, the research is based on agent or individualistic biological determinants: bacterial or viral infection, physical or chemical environmental insults, and generally singular or even multiple assaults. This dissertation offers an alternative approach to the current epidemiological

narrative of illicit drug overdoses in the Valley that speaks of “accidental drug overdoses" and drug addiction as a disease to be cured.

The current psychological/medical narrative is based on artificial clinical, episodic, and “experimental research,” underpinned by hegemonic[1] western medicine, that is, allopathic medicine in the European tradition of biological determinants. *Such disproportionately large numbers of overdose deaths in a provincial geographic region, as have been experienced in the current epidemic in the Valley for more than 10 years now, screams for a new perspective based on social factors and not hegemonic, single person-based approaches.* This dissertation provides an analysis of structural forces that may account for the extant psycho-sociological facts.

My observations, from a medical sociology perspective, buttressed by autoethnographic drug-career experiences, compel me to infer that *the problem of overdose mortality in the Valley is not the consequences of “accidental overdoses," but rather, in a majority of cases, they may be suicides.* If my experientially-based speculations are correct, then the solution lies not in more individual addiction treatment, as is the current practice. Rather the solution lies in new health policies that focus treatment on Street-level Trauma, suicidal ideation, anomic suicide, and alienation, and which also address adverse societal and economic conditions. What I demonstrate herein, calls for new policies for everything from prevention to post-treatment assistance.

I suggest that while illicit substance use and abuse are problematic in and of themselves, *the national evidence indicates that drug careers do not, a priori, result in disproportionate rates of overdose deaths, or even long term addiction.* In seeking a new perspective on overdoses in the Valley, which may be caused

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[1] Throughout this dissertation hegemonic is used in its traditional sense, that is the power and dominant influence exerted socially, culturally, ideologically, and economic by a particular group: Particularly in the case of medicine and the medical establishment in the United States since the Flexnor Report circa 1920.

by “street-level trauma” I illustrate real-life factors, social facts that lead me to infer that *the majority of “accidental drug overdoses” in North Central New Mexico may be actually cases of suicides*.

I make a compelling case for this conclusion by empirically demonstrating the following: It is my experience that *tecatos* (heroin addicts) learn early on in their drug career, usually within the first two years of substance use (both through trial and error, and through shared knowledge from more experienced users), that mixing certain substances is lethal. Tecatos who do not learn these lessons early in their drug careers do not have a chance to “mature out,” (Winnick, 1962, Quintana, 2000) much less survive to old age. Admittedly, there are accidental drug overdose deaths – unexpected high purity lethal levels, newly released individuals who misjudge their “re-entry” quantity and use the same amount as before they left for prison or “cleaned up” – but these are relatively rare, as the comparatively stable national average of 5 per 100,000 rate of lethal overdoses attest. Users who do not learn the anti-overdose lessons within the first two years of their drug career usually do not last long enough to become part of that later statistic, they perish early on.

The mean age of inception into drug use in The Valley, according to Arrestee Drug Abuse Monitoring Program (ADAM, 1999) data, appears to be 14 years of age, while the Willging study puts it more at 12 years of age. Both ages are younger than the national inception age of 16 years of age.

Ten years of OMI data from the Valley indicates that the majority of victims of overdose deaths had five or more active controlled substances in their system at time of death; some had as many as 25 lethal substances but were still labeled accidental drug overdoses. The mean age of overdose deaths in this 12 year period was about 39 years of age for both females and males, as compared to the national mean age of 22 (CDC, 2004).

Krivanek (1988) demonstrates in his studies of both heroin addicts and non-heroin users that agreed to use heroin for the purpose of this study, that a person not addicted to heroin was able to consume 500 mg of pure heroin

without overdosing; and addicts were able to take up to 18 times the average street dosage without overdosing. OMI heroin and/or accidental overdose fatalities had nowhere near these amounts of heroin in their system, though they did have many other controlled substances.

Examination of the 43 interviews I personally conducted with principal informants, family members, and professionals, show that sixteen of the 34 people who had expressed suicidal ideation in the past, actually attempted suicide by overdose; and most knew people who had overdosed and believed that these people had killed themselves (as opposed to dying from accidental overdose).

Just one example typical of many others within the informant pool, but atypical because it was a women, may help to illustrate my point.

> "So I sat in my car looking at it in my hand... stopped at the store and got a coke and a caquito (small cake), got in the car and uhh... debated, you know, for about two seconds... I did it. I never done a whole BB. When I get a BB I'll do it at least three times, depending on the size... and I did it.... And I start to drive out and, you know, you always know when something is not right!... I kind'a turned off a little to the side and turned it off, put the car in park, whatever... and then that was it... turned off the car ... and I said, oh my god, fuck! Next thing I knew, I woke up in an ambulance. Took me to the hospital and put an IV and shit, and I took it off, I said, I'm out of here...' I could barely walk... In thinking back I think I tried to kill myself…." (Bombón, age 42)

Bombón (double fictitious name) reported that at the time of this incident she had not ever done an entire BB (a $20.00 bag of heroin). She usually cut the BB into three fixes (injected heroin) to be used three separate times in a day . Later in the interview she speculated, without prompting, that she may have tried to kill herself by using more than usual. She was 42 years old and described herself as a Chicana who started taking heroin at the age of 25 in an abortive attempt to stop her husband from using heroin. She thought if she offered to use with him he would be fearful of her becoming

a user and would stop. He simply injected her when she asked him to do so.

Principal Questions This Dissertation Will Answer

The problem investigated in this dissertation, as iterated here from the statements above and my observations, is:

- What explains more than a decade of high rates of overdose mortality in North Central New Mexico (the Valley)?
- How does ethnic identity and cultural/historical trauma shape the face of the epidemic?

Hypothesis

From the Principal Questions I posit these assumptions to examine in this dissertation:

A. A major portion of the OMI specified accidental drug overdoses may be predominately suicides in the Valley.

B. While death occurs from injecting and ingesting lethal quantities of controlled and/or illicit substances, the preponderate number of these accidental drug overdoses may be explicated by a combination of structural factors:

    The structural factors may collectively be called street-level trauma, and cultural/historic trauma, which in combination may lead to Cultural-Post Traumatic Stress Disorder, and may be affected by ethnicity.

While some research exists on the topic of accidental drug overdoses and suicide, as far as I can determine, the argument I am seeking to advance (*accidental drug overdoses as intentional suicide)* is totally unique. I have found no literature that expresses this precise perspective: that the many accidental drug overdoses might be suicides, and further that they are actuated by Cultural-Post Traumatic Stress Disorder. There are a number of studies that associate trauma and other social determinants with suicide, but none have named the condition as I have.

Review of the literature on this topic and other related topics is done in the Chapter Two. Chapter Three explains the method and methodology used in this

dissertation. Chapter Four lists the history and demography that inform the narrative of drug careers in New Mexico generally and in the Valley specifically. These include drug trafficking patterns globally as well as locally and how globalization has exacerbated the drug scene in the valley. In Chapter Five I present the field notes and my participant observations, explaining the overarching contextual milieu I found in the Valley in the course of my two-plus years of ethnographic investigation (2002 to 2003) and the continued observations for years after the investigation (2003 to 2009). Chapter Six presents the data collected through 34 interviews with actual active substance users. This qualitative data is representative of a cross section of the principal informant interviews which demonstrate the many aspects of suicide attempts. Chapter Seven is a second chapter of qualitative data also consisting of data representative of a cross section of the principal informant interviews, but this time the emphasis is on their personal experience with lifelong trauma and the effects of chronic, debilitating pain. Chapter Eight summarizes the discussion, presents the conclusion and programs and policy recommendations. It also points to some questions for future research.

CHAPTER II: THE LITERATURE

Suicide and Addiction, Research and Theory

> "I was with a friend.... The last thing I remember was that I gave him a belt to tie around his arm [after she injected herself], then I woke up. My mom was over me crying, shaking me to wake up. Five minutes later the ambulance drove up. What had happen was that I passed out... I fell somewhere and he put me on the couch and he took off running outside the door and my mom heard the door slam and called for me and I didn't answer. She thought I had left and then when she got up she found me on the couch." (Orgullosa, age 20)

Introduction

This section summarizes the literature that informs the research perspective underpinning this dissertation. Orgullosa is an example of the drug overdose epidemic that has been sweeping the Valley for more than ten years. She was younger than most of the sample and interestingly, she was not typical of the informants that I would suspect of committing suicide. She actually was in college: selling drugs was her way of paying for that, and supporting her son and herself. She had thought the future out to the extent that she had already legally transferred custody of her son to her mother so that if she eventually would get caught at some nefarious activity which might cause the authorities to take her son, they would be unable to do so because she did not have custody.

As mentioned before, from 1995 until 2008, the Valley has had the highest per capita death rate from "accidental drug overdoses" in the entire United States (NMHD, 2009). The trend continues unabated. The latest report on health by the New Mexico Department of Health states,

> Health Secretary Alfredo Vigil, MD, said the most recent drug overdose data shows that the heroin problem continues to be a serious concern in New Mexico. The New Mexico Department of Health analyzed the last decade of drug overdoses due to heroin and found that the rates have fluctuated but remained relatively steady. There was a rise in heroin-related overdoses in 2008, similar to the rate in 1998. The rate of total unintentional drug overdose deaths was 17.5 deaths per 100,000 people in 2007 and 19.6 deaths per 100,000 in 2008, according to New Mexico Office of Medical Investigator data that the Department of Health analyzed. The increase in drug overdoses was predominately due to

> heroin deaths. Prescription drug deaths held steady during this time, compared to a considerable increase the previous year. (NMHD, 2009)

My research questions whether the epidemic of accidental drug overdoses occurring in the Valley may actually be suicides brought about by a confluence of pernicious factors resulting in a Street-Level Post Traumatic Stress Disorder. As such, in the first portion of this chapter I explore the relevant literature on suicide and more specifically on suicide and addiction in relationship to Latinas and Latinos. I then do the same as it relates to drug addiction and suicides misinterpreted as accidental drug overdoses and what relationship this has to addiction and the specific culture and milieu of the *Hispanos* of the Valley.

Lastly, I lay out the literature on historical or colonial trauma, which in combinations with other symptoms, I am referring to as "Cultural-Post Traumatic Stress Disorder." While most of the literature speaks to trauma experienced in structural manner by particular groups, it does not refer to colonial trauma as a type of post traumatic stress disorder (PTSD). I posit that it is essential to make this distinction: colonial or historical trauma *may become* a type of PTSD as it exhibits all the symptomatic conditions of PTSD, as I explain in the section on historical trauma.

I begin with the study that precipitated my thinking process on this topic in the first place, Willging, Trujillo, and La Luz (2003).

Access to treatment study

This ethnographic study combines information from participant observation and in-depth interviews to understand substance use patterns and utilization of behavioral health services from the standpoint of persons with drug use histories in the Española Valley of New Mexico. This approach clarifies how drug users conceptualize substance use problems, participate in harm reduction and treatment programs, and encounter barriers to care and recovery. This project employed three ethnographic research techniques, each designed to check and complement the others: (1) participant observation, (2) unstructured interviews, and (3) semi-structured interviews. These methods and techniques

are explained in the next chapter on methods and design. The ethnographic work was conducted from April 2002 until June 2003. I subsequently did follow up participant observation and eventually moved into the area permanently. I have been living in the Valley for more than two years now since late 2006. During this time I have lived in Santa Cruz, Abiquiu, Medanales, and La Mesilla, all of which are small towns in the Valley experiencing varying levels of the epidemic.

Willging et al. (2003) found that the most widely used substances in the Valley included alcohol, marijuana, heroin, cocaine, and prescription drugs, in that order. Poly-substance use was common and characterized as an intergenerational and multigenerational phenomenon. Initial exposure to alcohol and drug use often was traced directly to extended family and friends, and alcohol and marijuana use were routine aspects of daily living, as was the practice of self-medicating with prescription drugs. Substances classified aslicit or those taken under the direction of a medical authority were usually perceived as not posing the same harmful threats to users as street drugs.

Overdoses were familiar occurrences for the drug-using population. Local explanations for overdoses include unfamiliarity with quantity and quality of drugs, time lapse in obtaining assistance, “fixing” alone, and attempting suicide.

Our research showed that comorbid conditions influence decisions to use drugs. Exposure to traumatic events (including death of love ones and friends, physical abuse, and sexual abuse) abounded within the drug-using research sample, increasing the risks for depression, anxiety, and other post-traumatic stress related conditions – panic attacks, suicide ideation, feeling of worthlessness, and flashbacks. Drug users also complain of chronic, debilitating physical health problems that underlie decisions to use illicit drugs (above all heroin) and prescription medications, usually in combination with alcohol and other controlled substances.

Our study showed that the structure of behavioral health care and attendant support services in the region is perceived as lacking capacity to meet the treatment needs of the drug-using population. Everyday problems that impact

access to services included cost of treatment, insurance, transportation, and child care. Many people entered the behavioral health care system for reasons other than ending drug use (e.g., to “rest” from drug use or to moderate drug use). The criminal justice system constitutes a major pathway into this system. Some people describe early recovery efforts as “faking it.” Awareness that some clients were still using drugs adversely impacted the treatment experiences of fellow clients. Group camaraderie among clients was overwhelmingly seen as a key facilitator to recovery, as was access to counselors who are former users as well as non-judgmental listeners.

In summary, the study also reports that the continuum of care in the Valley was fragmented. While access to outpatient services is greater in comparison to residential treatment, the recipients of such services claim that they are more likely to engage in ongoing drug use activity because of the “free time” that is afforded to them. Persons seeking to discontinue drug use lament the lack of peer resources, including consistent access to fellowship meetings. Overall, the study suggested that drug use and help-seeking processes are not solitary practices engaged in by individuals, but instead implicate a range of community, organizational, familial, and interpersonal factors. (Willging, Trjillo, La Luz, 2003)

Looking at the results of this study led me to suspect that something greater was going on in The Valley, as I explain below, after starting with a description of suicide as it impacts this dissertation.

Suicides

> I had 140 milligrams of methadone, then shot up 4 or 5 Dilantins (Phenytoin), and I started to do some Valiums... I went out. A friend of mine that was there gave me mouth-to-mouth and kept me going until the ambulance showed up. They took me in and then I woke up in the emergency room and came out [of the hospital] I went straight to the connection. I got some heroin and started shooting up again. I had recently gotten out of the penitentiary, so I really wasn't hooked. So anyway, I went out again.... I woke up [in the hospital] again and didn't know what had happened... (48 year old, Agugero)

Agugero tried Chiva (heroin) for the first time at age 18 with a cousin, but did not get hooked until he went to prison at 23. At the time of his interview he

was 48. I explain in the qualitative data section (Chapter VI) how this overdose, and that of many of the principal respondents, fit the profiles of those who suffer from street-level trauma and "Cultural-PTSD," as defined in Chapter One. I show that those who are victims of this condition may be at higher risk of attempting or completing the act of suicide.

However, I hasten to add that not all peoples in the Valley who might meet the conditions set forth here commit suicide. Many lead normal and productive lives both as addicts and/or once they stop. Why this is true is unclear and well beyond the scope of this dissertation to attempt to ascertain. Nonetheless it is a phenomenon well worth exploring.

I predicated this dissertation on two primary sources of data as explained in the next section on methodology. The primary data set of approximately 43 interviews came from a previous study that I was one of the interviewers in (along with Dr. Cathleen Willging, Michael Trujillo). The study was undertaken in an attempt to understand the barriers to addiction treatment, and was variously published as separate papers and reports in 2003, 2004, and 2005. I have presented some of the findings above and will explain the methods of the study in the methodology section (Chapter III), so I will not address those aspects here. Suffice it to say that the findings in that study were partially responsible for suggesting the line of thought and inquiry that led from accidental drug overdoses to suicide. In particular they led me from that study's conclusion to the classical sociological literature of Durkheim and Marx on suicide for this dissertation.

Suicide: Durkheim and Marx

"The yearly toll of suicides, which is to some extent normal and periodic, has to be viewed as a symptom of the *deficient organization* of our society." (Plaut, Edcomb, and Anderson 1999, 33, emphasis mine)

In keeping with Marx's image of the normalness shortcomings of society leading to suicide within a given society, some 40 years later, Durkheim would also write about suicide as a regular and normal social fact, with various probable

causative factors which I explain below. When taken collectively within most societies, suicide has its own nature, "with its own unity..." (Durkheim, 1967/1987, 46). That is, suicide occurs in most societies in the world with amazing regularity.

However, both Durkheim and Marx make it clear that suicide is not conventional thinking: that is not thinking that is done by everyone even under a similar situation.

It would appear that in the United States there is also regularity to annual patterns of suicide. "More than 32,000 suicides occur annually in the U.S. This is the equivalent of 89 suicides per day; one suicide every 16 minutes or 11.05 suicides per 100,000 people" (CDC, 2005), (CDC, 2007).

According to the Office of the Medical Investigator (OMI), the same appears to be true in New Mexico, even though the rate of suicide per capita is consistently higher than the national average. In the ten years between 1997 and 2006 (inclusive), the number of people who committed suicide averaged 343, and ranged from 303 to 381 (OMI, 2007): This is amazingly consistent.

In the United States, suicide is studied primarily from a psychological perspective, although beginning with Durkheim's methodological discourse on suicide (1951/1897) there has also been much sociological inquiry. Interestingly, Durkheim's seminal work on suicide was actually not about suicide, but rather a demonstration of his methodology for sociology. Suicide was only a convenient topic by which to demonstrate the applicability of scientific method to social fact (Plaut, Edcomb, and Anderson 1999).

As far as I can determine, only Marx has approached suicide from a conflict or historical materialistic perspective in "Peuchet on Suicide" (1999/1846), which is the bulk of the writing (in original German, and English and French translations combined in one volume) in "Marx on Suicide" (Plau tetal., 1999). This work, along with that of Durkheim and other sociologists, laid the foundation for historical trauma which is the quoin of the eclectic theoretical perspective that I use to explain what is occurring in north central New Mexico.

Following a sociological tradition, I address suicide as a social phenomenon. The psychological perspective holds few clues to the larger causative effects of most social determinants of health, and certainly not for suicide (Marmot and Wilkinson, 1999). However, before exploring the literature any further on the topic, it is best to define "suicide" as used in this dissertation.

Defining suicide

Durkheim defines suicide as "all cases of death resulting *directly or indirectly* from a positive or negative act of the victim himself, which he knows must produce this result" (emphasis mine, 1951/1897, p 110). The two elements most relevant to my theoretical discourse are: (1) that the act either directly or indirectly results in death, or at least is directed to that end in the cases of survivors; and (2) that the perpetrator of the act knows what the end result of the act will be, namely death.

In 1969 Theodorson and Theodorson define suicide as "any death resulting from either a *deliberate act of self-destruction or from inaction when it is known that inaction will have fatal consequences*" (427, emphasis mine). Theodorson and Theodorson add to Durkheim the element of intentionality.

Both definitions imply a great deal more than actively killing oneself; they imply that any act of omission (not protecting yourself from being killed) or of continued excess (smoking cigarettes, excessive speeding in a car, and mixing alcohol with drugs, all of which we know can be fatal) whether intentional or not, are also suicidal acts. This is an arguable contention, of course, since intentionality may not be as simple to determine as implied by either Durkheim or the Theodorsons.

Suicide in this dissertation

For the purpose of this dissertation, then, I define suicide as the New Mexico Office of the Medical Investigator's staff has verbally defined it for me, vis-á-vis the "cause of death" assignation after an autopsy. I have, however, been able to secure a written definition from OMI annual reports: suicide -- "The manner of death in which death results from the purposeful attempt to end one's

life" (OMI, 2003, 97-98). Again we see that intent is important. However, it appears that each doctor performing the autopsy may use her or his own personal and professional standards in assigning the label of suicide and determine “purposefulness” in their own arbitrary manner. This is problematic, as I explained further in the methods' section, because it leaves the entire cause of death designation as an arbitrary discretion if no note is found.

Regardless, I herein define suicide as **"any destructive act against oneself that *one knows or should know* that said act may result in ones death."** To illustrate the point, I put multiple overdoses, particularly in the same day, or purposefully injected much higher dose than usual taken, or the mixing of many narcotic and alcoholic substances, and actions such as repeated drunken driving, or now smoking several packs of cigarettes per day knowing all the factual warning over the last 30 years.

However, intentionality is the key element which proves difficult to establish, in the absence of a definitive statement, such as a written note or statements to others. The difficulty of establishing intent is compounded by the medical examiners’ (and other officials') aversion to affirm suicide as a cause of death because of its potential adverse financial, religious, familial, and societal consequences. Sometimes, even when it is obviously suicide, these authorities bow to familial pressure and social conventions by declaring the deaths as accidental, thereby given way to the force against stigmatizing by labeling the act despite its obvious factuality (Leming and Dickinson, 2002; Pescosolido and Mendelsohn, 1986). For example, in one study as much as 50% of deaths that were actually suicides were declared accidental deaths (Peck, 1980).

Durkheim

Traditionally and historically, suicide has been condemned as immoral, except in cases of "altruistic suicide," such as a soldier dying for his compatriots, kamikaze pilots, suicide bombers, or an individual running into a burning building to save someone. Altruistic suicide depends on whose moral standards one is using: one society's selfless suicide may be another society's terrorist. From a

psychological and/or a medical perspective, suicide is abnormal and requires professional intervention. Marx's quote above suggests that suicide may be a "normal act," albeit one thrust upon the person by industrial society's propensity towards alienating people. Both Marx and Durkheim argue that suicide is a macro-level, regularly occurring, universal act in most societies regardless of individual causation (Leming and Dickerson, 2002; Durkheim, 1951/1897; Plaut, et al., 1999).

While there have been countless studies on suicide since Durkheim's seminal work, most have concentrated on specific aspects of his theoretical/methodological perspective (Lemimg and Dickinson, 2002; Plaut, et al., 1999).

The contemporary studies that have not concentrated on theory or method expansion have concentrated on social causation and other social facts -- marital status, socioeconomic factors, education, gender differences, religious affiliation, etc. -- many of which derive from Durkheim's theory. As such, it is worthwhile defining some of the main concepts of the sociological perspective of suicide based on Durkheim's theory that attributed suicide to social facts understood within social context and shared social values. This is why different societies engender rate differences in suicides (Douglas, 1967; Hughs, Martin, and Sharrock, 1995).

As with dying, there is no doubt that suicide is an individual act (even when done en masse), but Durkheim concluded (and others have corroborated) that suicide "occurs within a social context that influences individual acts" (Leming and Dickerson, 2002, 321). Durkheim defined four types of such contextual suicides -- egoistic, altruistic, anomic, and fatalistic. I summarize their definitions below.

The four types of conceptual personalities may be envisioned best as situated at the end of a continuum similar to the one shown below:

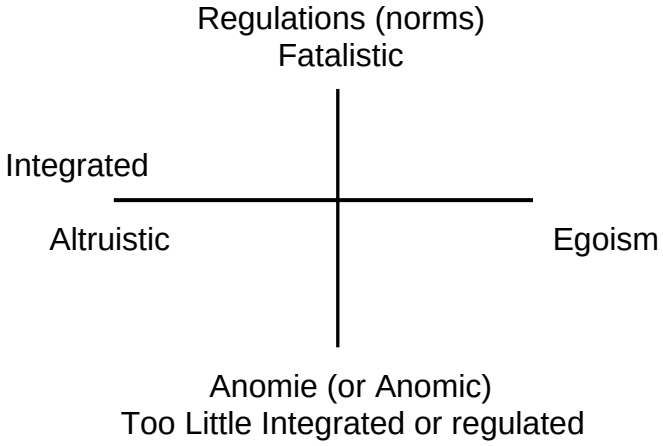

Figure 2.1: **Durkheim's Four Types of Conceptual Personalities.**

Examining these four types of Durkheim's suicides on the diagram above represents a "X" (horizontal axes) and "Y" (vertical axes) with the latter representing the degrees from complete regulation at the top to little or no societal regulation at the bottom of the "Y" axes. In like manner, the "X" axes represent from left to right the degree of societal integration.

Egoistic suicide

For those people on the extreme right end of the "X" axes as it were, who are both less regulated and less integrated into the social norms, and who may be somehow see themselves as bigger than life (e.g., celebrities, stars, politicians), and as such may be less traditionally attached to society, the self becomes the most important context, and may create an aloofness or existential loneliness that may lead to suicides.

Altruistic suicide

To those on the extreme left of the "X" axes, a person who is so completely integrated and well regulated within a society to the point that her or his individuality is compromised, altruistic suicide may occur. A person's sense of self becomes one with that society's customs, ethics, morals, and mores. This

occurs to the degree that any breach thereof, such as in loss of face, or a deep sense of obligation, may result in actions that are suicidal. Examples of this are suicide bombers, religious martyrs, or combat heroes, and others who kill themselves either by a deliberate act or by placing themselves into activities or actions with the same end results.

Anomic suicide

Those at the lower extreme of the “Y” axes, when the norms governing a society are thrown into disarray for whatever the reason, people who find themselves disenfranchised, alienated may suffer from anomie and as such may commit suicide.

Fatalistic suicide

Thos individuals that feel overly regulated on the extreme top end of the “y” axes, that is, a matter of too much societal control can result in fatalistic suicide (Kastenbaum, 1998). In fatalistic suicide, instead of being too integrated and not minding or realizing the integration into a society as with altruistic suicide, the person feels overly oppressed and exceedingly restricted.

Suicide and social determinants

Of the elements that can be referred to collectively as social determinants – culture, environment, ethnicity/race, SES, religion (Marmot and Wilkinson, 1999), my concern is with specific social determinants -- class, culture, ethnicity/race, and religion. In this section I purposely exclude any discussion of these social determinants of class, culture, ethnicity/race because I deal with these in the section on Latinas’ and Latinos’ substance use and suicide. I did not study the role of religion except as one of the expressions of pre-capitalistic and capitalistic production in relationship to the colonization of North Central New Mexico after the takeover by the United States.

Marmot and Wilkinson (1999) masterfully demonstrate the social determinants of health by asking and answering the question, "Is it plausible that organization of work, degree of social isolation, and sense of control over life...

affect the likelihood of developing and dying from chronic disease such as diabetes and cardiovascular disease?" (17)

> "Different levels of analysis produce different pictures of the determinate of health, as well as differences between individual and societal determinants. Research on differences in the health of people grouped into social classes within the society, has focused attention on determinants of health which earlier had often been ignored" (Marmot and Wilkinson, 1999, 17)
>
> .

For example, less than half of the difference in heart attack rates between junior and senior governmental officials in Britain can be accounted for by physical risk factors (Marmot and Wilkinson, 1999).

Biology and culture have an elaborate interconnection: Our cultural, economic, and social environments play significant roles in how we contact, develop, and react to both somatic and mental morbidity. Suicide also follows this pattern -- mixed societal messages about pain, chronic pain, poor socioeconomic status in society, social disorganization, lack of security and employment control, racial, ethnic, or social discrimination, age, and gender -- any or all may contribute to illness and to suicide (Morris, 2000).

For example, wide income disparity in a given population has been shown to contribute to higher rates of crime, homicide, and suicide. In these cases, "relative income matters more than absolute income" (Marmot and Wilkinson, 1999, 17). Importantly, the ecological fallacy is often attributed to societal or group risk factors when they cannot be confirmed by the biological models, but macro or structural analysis of these individually so-called unsubstantiated factors yield significant and valid results (Schwartz, 1994; Susser, 1994)

Age, education, gender, and socioeconomic status

Suicide is virtually nonexistent among children under five years of age; it increases dramatically in the teen years, levels off in middle age (a significant point to remember with regard to the median age of suicides and accidental drug over doses in the Valley), then picks up sharply in people over the age of 65.

> "Age by itself does not cause suicidal behavior. The person statistically most likely to commit suicide in the United States, however, is the white male older than age 85" (Leming and Dickerson, 2002, 333).

Interestingly, older people rarely threaten suicide, they just do it, and they rarely fail once they attempt to kill themselves (Leming and Dickerson, 2002). The question of age is of prime importance because as is seen in the qualitative data presented in Chapter VI, the age distribution is much different for suicides in New Mexico and in the Valley than it is in the United States generally.

Another study examined the association between suicide and substance use among suicides in Fulton County, Ga., from 1994 through 1998. There were significant differences among the victims who had used cocaine and ethanol before committing suicide in race, sex, and age. Males made up 94.6% of the suicide victims in whom cocaine was detected, with African American men having the highest rates (51.4%), and white men rated at 43.2%. A majority of African American teenager's suicides (86.7%) did not involve either substance or alcohol before the suicide. By contrast, 50.0% of the white teenage victims used some substance before committing suicide, and the major portion of those (41.7%) used alcohol. Alcohol usage was most common among all age groups of white decedents (Garlow and Steven, 2002)

Gender follows a similar trajectory to age, with two exceptions. First, while more women attempt suicide than men, more men complete the act. Secondly, older women do not commit suicide in the same proportions as older men do (Leming and Dickerson, 2002). The importance of the first fact will become apparent in the quantitative chapter.

One longitudinal study representing a 1% sample of the population of England and Wales, looked at ten years of employment rates and suicides, using logistic regression, and studied deaths occurring between 1983 and 1992. There was a strong correlation between suicide and individuals who were unemployed, and permanently sick. Homebound people had an even higher risk of committing suicide. Suicide was not associated with other measures of socioeconomic status, such as education and previous level of employment. Suicide and

unemployment are more closely associated than any other socioeconomic measures. The findings support the idea that unemployment or lack of job security increases the risk of suicide (Neeleman, Farrell, 1997).

Suicide notes

One of the problems that I faced in my analysis is the fact that the majority of those who died of accidental overdoses did not leave notes. However, research has shown that the lack of notes in and of itself does not obviate suicide as a cause of death (Lemimg and Dickerson, 2002; Pescosolido and Mendelsohn, 1986).

Those who leave notes affirming suicide are only about 15 to 30 percent of the total population of suicides. One study found that those who write suicide notes show no demographic variance in age, sex, or method of suicide from those who do not write notes (Shneidman, 1980). In another study it was found that more notes are left by teenagers than by adults (Weinberger, Sreenivasan, Sathyavagiswaran, and Markowitz, 2001).

Drug Addiction

Before I enter the discussion of suicide and addiction, it is necessary to discuss the sociological literature about drug addiction itself.

Commonly, drug addiction is defined as a craving for drugs, whether from psychological or physiological instigation, that drives the drug user to do whatever is necessary to obtain the required substance. However, depending on the scientific discipline in question, drug addiction may be defined in a number of ways.

In social work, psychology, psychiatric, and psychiatric public health, and medicine generally, the authoritative definition is that in the Diagnostic and Statistical Manual (DSM). Tausig, Michello, and Subedi (1999) write that “there are a considerable number of persons who regard DSM claims to scientific accuracy, validity, and objectivity as unfounded or questionable” (129). And while it’s a sentiment echoed by other scientists (Kirk and Kutchins ,1997; Mirowsky and Ross 1989b), it is nonetheless the bible in the industry. In the DSM, the term

"drug addiction" has been completely dropped in favor of "substance related disorders," "substance abuse," and "substance dependence" (DSM IV, 1999, 181-183).

For the purpose of this sociological dissertation, diagnosis itself is unimportant. The persons whose case histories are presented here self-reported as being addicted to one or more chemical substances. For our purpose the important matter is consensus on the use of a term which conveys the same meaning to all who read it. I have chosen to substitute the term "substance use and abuse" for "drug addiction" for two reasons. First, it is the term most widely in current use among sociologists as well as other researchers in the field (Shaw, 2002), and secondly the term "drug addict" carries with it a great deal of pejorative connotations both in academia, and on the streets.

Another important point of sociological departure from the diagnostic model of the DSM is that while the DSM adheres to a disease/individual model of substance use and abuse, and even utilizes behavioral deviance within social settings as prime criteria (Tausig, Michello, and Subedi, 1999), our purpose in sociology should be to look at systemic issues and attempt to find systemic solutions (Mills, 1959/2000).

In terms of substance use and abuse (SUA), in sociology, we should be looking for theory regarding the real material elements that encompass social, cultural, and/or religious forces that affect SUA (Shaw, 2002). In essence then, there is virtually no literature examining SUA from a purely sociological perspective. This is particularly true with regard to drug use and suicide. As such, this section examines the phenomenon of heroin addiction as a historical case study, with particular attention to the pervasive and ongoing occurrence of illicit drug overdose death within the poverty stricken, rural communities of NCNM counties which I mostly refer to as “the Valley.” I examined the current wave of "accidental overdose death" in NCNM through the application of medical sociology perspectives using qualitative and theoretical methods and tools.

I utilized these devices to investigate and analyze the overdoses, to see if they should be viewed as anomic suicides (May and Van Winkle, 1994; Merton, 1968, 1938; Durkhiem, 1887/1951) possibly caused by a confluence of culturally disruptive economic, ethnic, historical landscape, and structural factors, rather than merely as accreting individual, accidental overdoses of illicit drugs.

Taking a new look at the problem of drug addiction: social forces

In the United States substance abuse in general and drug addiction in particular have been studied mostly as an epidemiological, individualistic, and episodic occurrence (Shaw, 2002). It is time to look at addiction and overdoses as more than this. It is time to look at addiction and overdoses through a thoroughly sociological lens, with "a sociological imagination" that goes beyond agency to structure and systems (Mills, 1959/2000). Further, it is time to look at substance abuse from the point of view of the drug addicts, and not just from the point of view of objective observers and scientist.

While it is still essential to examine the data dispassionately, there is also utility in examining substance abuse from experiential personal point of view, without the caution and strict respect for laws and conventions of field work that may be costing our minority communities dearly in lives because the scientific method requirements appear to deal more with samples than real people and their dire straits.

Heroin overdoses: myth or reality

Even with a cursory examination of the known facts about Heroin (as heroin is called in the Valley) consumption and its physiological effects, the attribution of overdose death to accidental consumption of Heroin is particularly disturbing, and possibly misleading. While a more comprehensive examination of the literature may confirm current unproven scientific and medical beliefs about Heroin overdoses, most of the literature I have found to date actually exposes inconsistencies and misconceptions.

Much of the research evidence demonstrates that non-addicted humans can tolerate comparatively huge quantities of Heroin without much deleterious

effect, including death from overdoses. It has been empirically demonstrated that a non-addicted person can typically consume approximately 500 mg of pure Heroin without overdosing (Brecher, 1972). By contrast, a fully addicted person can tolerate in excess of 1800 mg of pure Heroin without deleterious effects leading to death. The latter quantity is about nine times the average single dose that a street addict uses (Brecher, 1972).

As of this writing, *I have been unable to find any literature that contradicts these findings*, or any other results of the extensive physiological research conducted from the 1920s to the 1960s, at Lexington Kentucky and other University and Federal facilities, as reported by Brecher (1972).

> The thousands of deaths attributed to Heroin overdoses are not in fact due to Heroin at all. The evidence [supporting this claim] falls under three major rubrics: (1) The deaths cannot be due to overdoses. (2) There has never been any evidence that they are due to overdose. (3) There has long been a plethora of evidence demonstrating that they are not due to overdose.... *A conscientious search of the United States medical literature throughout recent decades has failed to turn up a single scientific paper reporting that Heroin overdose, as established by these or any other reasonable method of determining overdoses, is in fact a cause of death among American Heroin addicts* (Brecher, 1972, 104-105; all emphasis original).

Another issue in Heroin overdoses may be the inherent bias in the reporting of deaths of known Heroin addicts or users. Heroin deaths are automatically attributed to Heroin simply because the deceased was known to be a Heroin user or addict, and not because the Heroin actually caused the death (Carnwath and Smith, 2002; Mustos, 2002; Knip:1995, Brecher, 1972). In a recent article in the Rio Grand Sun published in Española an overdose was attributed to Heroin by the authorities simply because heroin paraphernalia was found with the body, and despite the fact that repeated administration of Narcon could not revive the person immediately after he collapsed (Rio Grand Sun, 4/30/2009).

Addiction culture

Heroin addicts are a peculiar breed; part of a particular subculture with its own set of mores, values, ethics, and narratives (Cockerham, 2002; Bourgois, 1996). Their groups have been recognized as separate subcultures with their own language, distinct manner of interrelating, and definite modes of drug career inception and knowledge transfer. Included in the orientation process of addicts is a set of rules for surviving, such as who can be trusted and who cannot, who has the best dope and who does not, and how to best and most effectively "take off" (inject the heroin) (Acker, 2002; Knipe, 1995; Winnick, 1962; Agar, 1973; Willis, 1973). Perhaps one of the most important things learned in the orientation process is pharmacological interaction, as mentioned in the introduction and elucidated in later chapters.

Substance abuse in Latinas and Latinos

One of the main facts about the Valley is that the vast majority of people in the area are "Hispanos" (some 82%, as mentioned above), which are overall typically incorrectly lumped together with other Latinas and Latinos. Latinas and Latinos are not a homogeneous ethnicity or race: we are not one people. However, one similarity that most Latinas and Latinos share is that they come of immigrant families from Caribbean islands or areas of Central and South America, as well as Mexico. An important distinction as I emphasize throughout this dissertation is that the typical mode of entry for Latinas and Latinos, most of whom come from other locations in the world to the United States and are either assimilated to some extent or continue to live lives separate from the mainstream United States populations in ethnic enclaves, is not applicable to the population this dissertation addresses, namely the Hispano. In the case of the latter, unlike most Latinas and Latinos the Hispanos did not immigrate to the United States. *On the contrary, the United States' "migrated" encompasses the Hispanos! As such, the Hispanos in a very real sense are not immigrants at all, but a colonized people (emphasis mine, Gomez, 2007).*

Concerning the literature on substance abuse amongst Hispanos, perhaps the most salient features are that, (1) if research on Latinas and Latinos is scarce, particularly in contrast to studies of African American and White populations of substance users (Castillo and Hernandez, 2002, Vega, Alderete, Kolody, and Aquilar-Gaxiola, 1998), studies on Hispano substance abuse are virtually nonexistent (Willging et al. 2003); (2) More often than not, findings from one group of Latinas and Latinos are presented as if they were representative of all Latinas and Latinos, for example research conducted on a group of Puerto Ricans and the findings expressed as if they represented Cubans, Mexicans, and Dominicans, etc, when in fact these groups have distinct cultures and subcultures depending on modes of incorporation and migration; (3) Attempts to explain all geographic regions where Latinas and Latinos reside by merely examining a disaggregate group in one location. For example, explaining some facet of substance abuse for all Latinas and Latinos from a study conducted with Mexican Americans in Los Angeles; (4) There is a lack of theory associated with the research on Latinas and Latinos (Hispanics as classified by the US Census) (Sanchez Mayer, Kail, and Watts, 1993); and (5) *Most, if not all the research literature concerns epidemiological studies*, or episodic research specific to a particular region of the country, and to sub-grouping of Latinas and Latinos, such as Mexicans, or Cubans, or Puerto Ricans (Sanchez Mayer et al, 1993, emphasis mine).

Suicide and Addiction

The literature that specifically addresses the topic of suicide and addiction is scarce, and what does exist is contradictory. Suicide deaths amongst Heroin users are fourteen times more likely than in the general public and range from 3% to 35% of those who use drugs. Suicide deaths can actually account for almost 50% of all death from overdose. Additionally, Heroin users who commit suicide may also use Heroin and other drugs to do so (Drake and Ross, 2002). Contradicting Drake and Ross, a number of other studies reported that suicide rates in substance abusers were about the same as rates in the general public

(Heale, Dietze, and Fry, 2003; Buskstien, 1993; Murphy, Rounsaville, and Kleber, 1983).

Heroin overdoses were more likely than not accidental; at least that is what 92% of survivors reported (Drake and Ross, 2001). In a much older study Choquet, Kovess, and Poutignat (1993) found that suicide ideation was highly correlated with drug use. And an even older study in Texas found that very high rates of suicide in addicts seemed to be encouraged by their own families. That is, family members of addicts who had committed suicide, admitted in interviews to having encouraged them, both indirectly and directly, to commit suicide as a way out of their addiction (Stanton, 1977).

The reported bias towards overdoses mentioned above appears to have a corollary in the reporting of suicide. Misclassification of suicides as accidental overdoses is a serious problem: Often attribution of accidental overdose to addicts and users may be reported *simply to facilitate processing* even when suicide might be indicated, but is not a certainty (Carnwath and Smith, 2002; Mustos, 2002; Drake and Ross, 2002). There is even a question about the validity of current suicide reported rates because of social constructions that focus on pressures applied to local officials by family members to conceal the actual causes of suspicious deaths (Krivanek, 1988; Pescosolido and Mendelsohn, 1986).

Sociological Addiction and Death Research

Drug addiction in the United States, and in much of the world for that matter, has ebbed and flowed historically, sometimes waxing to epidemic proportion, sometimes waning to quiescence or remission (Musto, 2002); at times spreading, appearing to follow meaningful patterns, or at times appearing to evidence nothing except sheer chaos without trends (Agar, 2002).

With extremely few exceptions this ebb and flow has generally been explained from a hegemonic[2] medical model perspective. That is, the

[2] The hegemonic model of medicine is based on the 1920 Flexner Report.

explanations for addiction's spread, treatments, abatement, prevention strategies, and even legal political policies, have been shaped mostly through an agent, individual-driven perspective. That is in sharp contrast to the sociological model based on social structures or systems (Shaw, 2002).

It bears repeating that the hegemonic medical model explanations conform to the artificial Cartesian mind-body dichotomy which treats the body and the mind as separate units. This artificial philosophic contrivance informs the unifactoral (single-factor), individualistic, hegemonic medical model of western medicine (Waitzkin, 2000). The use of this individualistic, hegemonic medical model (whether used to analyze individual occurrences or as applied to an entire community), has typically been presented as a phenomenon affecting one person at a time (Shaw, 2002; Waitzkin, 2000).

The nearly total acceptance of this individualistic model since the 1920s may help to explain why addiction treatment approaches in the United States have been such a huge failures (Goode, 2008; Acker, 2002, Brecher, 1972). Addiction has yet to be scientifically explained in any universal fashion (Mechanic, 1999, 1978; Szasz, 1999/1996), though there have been some clinical attempts to find a unifying system (Miller, 1989). Few if any addicts have been "cured" through any form of current treatment (Szasz, 1999/1996; Miller, 1989; Mechanic, 1978; Szasz, 1974; Zahn and Ball, 1972).

As C. Wright Mills (1959/2000) pointed out so aptly, that individualistic solutions fashioned to cure systemic problems can cause more than just an ecological fallacy, they can actually result in harm and deception. *I explore decades of ignored evidence that indicates that there is virtually no way to cure millions of addicts one at a time.* The solutions to systemic problems are

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John Hopkins model that embraces the western so-called “scientific” individual illness based on disease agents. Hegemonic is also used in the sense that it is the most “powerful” and as such, almost completely dominant in US culture.

structural and systemic: addiction research needs to face this sociological tendency.

Additionally, when science accepts as fact speculation-based data that are not corroborated by empirical evidence and real-life events, data that fly in the face of experience, it continues a mythology that assists in keeping groups that have little or no resource unproductive. That acceptance also keeps the afflicted enslaved in scientific ignorance.

Contrary to the majority of research in the field currently, a new social approach to address the problems of substance use must be found. I reexamine the data with "new" sociological eyes to see different social facts instead of the individualistic medical “facts” that have been espoused in the past. First, I examine some of the national and local "facts."

National addiction and overdoses

The epidemiology of Heroin addiction in the United States demonstrates a continuing and substantial problem according to many analysts (Massing, 1998). It is estimated that in the United State alone, in the year 2000, there were 2.7 million users of illicit drugs among persons aged 12 or older (SAMHSA, 2002). Substance abuse has reached epidemic proportions in the United States and is even considered the number one health problem in the nation (Horgan, 2001). This assertion may be arguable, but it is not contestable that people are dying from substance use in sufficient numbers to make the issue problematic. Two graphic examples illustrate this point well: some 28.4 million people (12 and older) reported use of illicit drugs in 2001, and 3.2 million abused or depended on illicit drugs in 2002 (NDIC, 2003); and from 1979 to 1997 there were 197,000 deaths directly attributed to drug use (Horgan, 2001).

The United States is not alone in this perceived addiction and overdose dilemma. Overdose deaths attributed to Heroin are on the rise in many western nations, such as the United Kingdom and Ireland. In the United States, the death rate more than doubled in the seven year period from 1990 to 1996, from 34,000 to 70,000. Further, in all countries surveyed, addicts who lived in low

socioeconomic status (SES), appeared to have an overdose death rate six times higher than those in other more affluent SES areas. (Carnwath and Smith, 2002).

New Mexico addiction and overdoses

New Mexico (NM) which is located in the Southwestern United States has large pockets of low socioeconomic areas. It is one of the poorest states in the nation. In health care it ranks about 50th, in education is it 48th, and it leads the nation in almost all negative quality-of-life statistics (Census, 2002). In addition to these alarming and depressive facts, NM is an oversized reflection of the nation in illicit drug addiction and overdoses. It has the highest per capita prevalence of Heroin addiction and overdoses in the United States. Between 1995 and 2003, NM's drug-related mortality rate rose from 3.8 to 11.3 per 100,000 population (Scharmen, Roth-Edwards, and Shah, 2005).

Chiva: the valley of addiction and death

In New Mexico the focal point for addiction and overdoses is the Valley. Located in the north central portion of the state, the addiction and overdose rates are so high that addiction and death from illicit drug overdoses have been declared an "epidemic" (RAFCN, 1999).

According to the 2007 US Census estimates the Valley is now approximately 72% Latina and Latino. The other 18 percent of the Valley's population are roughly divided between Pueblo Indians and White non-Hispanics; there are only one or two African American families in the area. A large number of the "Hispanos" and the Native Americans in the area self-report as "White" (Census, 2007).

The region has a high level of poverty: the Valley has the second highest poverty rates in the state; a high proportion of high school dropouts, about 65%; and high levels of participation in service and manual labor occupations; and despite the high unemployment, most people surprisingly appear to be subsisting, even prospering. For example, the Valley has one of the lowest drugs to crime ratios of all New Mexico counties (NMDH, 2003a).

Historical contradictions abound in the Valley. In contrast to the "permanent urban underclass" (Wilson, 1996, 1990), home ownership is at more than 80%, despite the fact that official unemployment ranges from 25 to 40 per cent much of the time, a very high level of owner occupied homes (Census, 2001). Ownership of land and/or homes appears to come largely from subdivided Spanish and Mexican land grants or Mercedes (Ebright, 1994, 1989). It is not uncommon to find a several-acre compound containing ten or twenty homes, all of which are owned by descendants of pre-Anglo Mexican settlers (Gomez, 2007; RAFCN, 2001).

The Valley leads all NM counties in per capital rates of Chiva addiction, and is without question, the epicenter of deaths from illicit drug overdoses. From 1990 to 1998, Rio Arriba Count had an overdose rate of 50.2 per 100,000 population and had a slightly lower rate in 2002 of 48.7 per 100,000 population (Scharmen, et al, 2005). This county has the dubious distinction of leading the rest of NM in per capital numbers of overdoses, and overdose deaths.

> “The Valley had the highest drug-related death rate in the state (42.9 per 100,000), a rate that was almost three times that of New Mexico as a whole (15.2) and 7 times that of the nation (7.0). [The Valley's] drug-related death rate was followed by that of Lincoln County (21.5), Bernalillo County (21.0), Santa Fe County (19.4), Valencia County (19.3), and Socorro County (19.3)” (NMHD, 2003, 43).

In the Valley the situation is grave enough that in 1999 several of the United States Senate subcommittees, and concomitant Federal agency representatives came to New Mexico to hold a special session to investigate the prevailing Chiva addiction problems in the state, and to suggest recommendations for NM in general and the Valley in particular (U.S. Senate, 1999). Also in 1999, the Rio Arriba County Commissioners formally declared that substance abuse in general and drug addiction in particular "has become an epidemic" in their community (RAFCN, 1999).

Overarching theoretical frameworks

Marxist theories are replete with complicated nuances which have been elucidated at length in other venues (Waitzkin, 2000; Huaco, 1999; Siegel, 1978,

Shaw, 1978; Turner, 1998; Israel, 1971; Fromm, 1964, to list but a very few) and which are beyond the scope of this dissertation. For our purpose, it will suffice to explain those elements of Marxist theory that will be used as one of three main theoretical perspectives in this dissertation. The other two theoretical perspectives used are Durkheim's theory on anomic suicide (1951/1887), and what I call "cultural-post traumatic stress disorder" (C-PTSD).

There are several names that are *used in the literature interchangeably, namely,* historical trauma, cultural trauma, and colonization trauma, to describe trauma that exist both at a micro and macro level and result from historic oppression, cultural privation, and/or genocide (Alexander, Jeffery C., Ron Eyerman, Berhard Giesen, Niel J. Smelser, and Poitr Sztompka; 2004, Whitbeck et al., 2004; Duran, 2003; Morris, David S. 2000; Cox, Jeffery and Shelton Stromquist. 1998.). I have coined a different terminology, namely C-PTSD which actually encompasses these traumas at its base, but goes further to includes the consequences, namely these traumas combined with post traumatic stress disorder, a well recognized and diagnosable medical condition. This is explained more thoroughly below on page 45.

Marxist theory may also help to inform the historical events that have led to the economic and social conditions of the Valley. I review the small amount of Marxist inspired literature that directly speaks to addiction or substance abuse, such as Engels' (1846/1993) description of substance abuse in the working class in England.

Post-Marxist

Marxism is a complex of economic theories and a scientific methodology created by Karl Marx and Friedrich Engels in the latter part of the nineteenth century (Shaw, 1978; Turner, 1998; Tucker, 1972; Israel, 1968). It combines aspects of Hegelian dialectics (Huaco, 1999), the loss of community, and the theories of alienation and economic labor theory of value (Brooks, 2004). In the estimation of Vladimir Lenin (1918/1992) there were only three parts to Marxism: Dialectical Materialism, Historical Materialism, and Marxist Economics (the

economic labor theory of value and surplus). In this dissertation I use Marxism as elucidated by a number of scholars, that is Post-Marxism, rather than pure Marxist theory.

The facets of Post-Marxism utilized here are alienation, historical materialism, false consciousness, and Marx's analysis of suicide.

Alienation

Alienation in its simplest form is a loss of community, or loss of belonging to the whole, as expressed by Marx himself:

> "….The community from which the worker is isolated by *his own labour* is I itself, physical and mental life, human morality, human activity, human enjoyment, *human* nature. *Human nature is the true community of man*…" (emphasis, original, Tucker, 1972, 131).

In the capitalist production process, the more a worker produces the poorer he becomes through loss of identity and community, and induced consumerism, and the more isolated she becomes through the separation of the end product from the actual process. People hardly ever produce more than a small part of the entire product, never really seeing the entire object of their labor. They are being paid the smallest amount that the owners can get away with paying in order to make the largest profit. That way capital can be created, reproduced, and empowered (Israel, 1971).

In essence, alienation is a macro level process, a sociological process which deals more with the entire body of the working class that

> "affects the individual and his role in society... the individual's relationship to his work, his social relations, and the relations he establishes to nonhuman objects" (Israel, 1971, 6).

However, alienation does contain psychological aspects.

> "On a psychological level one can attempt to describe and to analyze those psychological experiences which are a consequence of the individual's relationship to persons and objects... the individual's perception of his own conditions in a society characterized by sociological processes of alienation" (Israel, 1971, 6).

Both the psychological aspect of alienation and the individual's relations to nonhuman objects are the elements that are important to the analysis of substance use and abuse. At the macro level alienation applies to the process that disaffects the individual from society, or his community, and at the psychological [micro-level], the actual states of disaffection (Israel, 1971).

Historical materialism

Historical materialism is both a theoretical perspective and a method of scientific inquiry used by Marx (though the term itself was "used by Engel in referring to Marx's theory…" he "never spoke of historical materialism" [Fromm, 1964, xv]). The Marxist meaning rejects the ideological historicism of the Hegelian tradition, which states that history is driven by specific universal abstract ideals or laws which in turn define the course of human social existence (Boudon and Bourricuad, 1989). Rather, historical materialism rests on the Marxist premise that human consciousness does not create reality; instead, social reality shapes and creates the types of human consciousness (McCarthy, 1994). As a methodology, historical materialism is the scientific process of analyzing social structure and social evolution, and permits us to understand the history we have created through empirical facts, that is, material facts (Tucker, 1972).

Another important aspect of historical materialism is the unequivocal need of historical antecedents, the progression of material society created by humans. In other words, nothing can occur without its necessary material precedent (Shaw, 1978; Fromm, 1964). To use an example from Marx's writings, without the destruction of the feudal system, there would not have been a need for the monolithic use of slaves as it occurred in the United States; without slavery, there would not have been the mass growth of cotton agriculture; and without cotton, there would not have been an industrial revolution (Marx, 1867/1978).

Class

Class conflict is endemic to human society. The theme of class conflict is not unique to Marxism. However, it was Marx and Engels who created the theory

of class conflict as an economic product, a dialectic process leading to change (Collins, 1994). The main focus of Marxist theory is conflicts between the owners of the means of production (bourgeoisie) and the workers who hire out their labor for wages (proletariat) brought about by the industrial revolution.

The industrial revolution brought large masses of people into the cities which swelled with many congested slums. This large concentration of laborers and their families soon made for deplorable conditions: overcrowding, unsanitary disposal of human and animal waste, and widespread poverty and illness. Substance abuse in the form a alcoholism and misuse of laudanum became so prevalent that it was excused as normal; the rich got richer and the poor got poorer and ill (Engels, 1846/1993). Marx predicted this class struggle would create a dialectical process (thesis, antithesis, and finally synthesis) that would result in revolution, ending in an egalitarian order (Marx and Engels, 1872-93/1974).

It is also important to note that, contrary to popular opinion, there were not only two "classes" involved in this conflict for power; there were others. As a matter of fact, Marx and Engels separated both the proletariat and the bourgeoisie into subgroups. For our purpose it will be helpful to understand that a particular class of workers, the lumpen proletariat, was also part of the struggle. The lumpen were the lowest class in society, composed of "beggars, thieves, itinerant workers, outcasts, gamblers, roué, prostitutes..." (Collins, 1994,64). Sound familiar? Words similar to these have been used by others to describe a number of subrosa substance abuse groupings in slums in both California and New York (Bourgois, Prince, and Moss, 2004; Bourgois, 1999, respectively).

Marx's egalitarian revolution has not materialized, at least not in the sense that he and Engels predicted. For our purpose, it is enough to note that the struggle still goes on, with new subclasses at both ends of the economic spectrum, and with even more subtle but quite powerful nuances: The productive division continues its inevitable progression towards complete global atomism, alienation, and entrenchment of false consciousness.

False consciousness

The struggle brought about a separation from the means of production, resulting in alienation, a sense of loss of community and hence a loss of one's "human nature" (Tucker, 1972), and much more as explained above. However, the ideology created by the ruling classes begins to be the real system of beliefs, the mores and morals which are pressed on the working class and become the underpinnings for all the classes. This set of factious ideas become the destruction of true thought in the working and lower classes, it becomes a type of false consciousness that defines their "*means of mental production*" (Collins, 1994, 66, emphasis original).

> "Ideologies are a class's false conceptions or false consciousness of itself. The Marxist theory of ideology provides a materialist explanation for this false consciousness. According to this theory, all ideas, all forms of knowledge and consciousness are in some way and often in a distorted way interwoven with material activity. 'By material activity' is meant the actual intercourse of people as they exist and as they are conditioned by the social and productive forces of the social worlds they inhabit. Throughout the opening section of The German ideology, the real life 'of actual human beings' as they really are' is contrasted with the conceptions (Vorstellungen), the imaginations and illusions that people hold. Ideology involves an understanding of how reality and conceptions of reality come to exist in opposition to each other, how consciousness fancies something else than what it really is. Using the idiom that Marx himself used, ideology becomes thought alienated from the real social being of the thinker, thought alienated from real life" (McCarthy,1994 ,418).

In sum, the overarching theoretical framework that combines alienation, false consciousness, class, and historical materialism assist in the analysis leading to C-PTSD and for the exploration of substance abuse in that regard.

Now that we have some understanding of the Marxist concepts that will be used to explore substance use and abuse, let us go on to the full body of this work. However, it is important to remember that with two notable exceptions, neither Marx nor Engels had anything to say directly on the theme of SUA. One exception was Marx's own illnesses and the many references in his letters to those illnesses and the drugs that doctors and friends prescribed for him -- port, sherry, arsenic, and laudanum, not to mention his intense indulgence in cigars

(Nelson, 1999, 1999b). The second exception, already cited above, was Engels' public health work concerning the misuse of laudanum in children, and the normalization of alcohol use as a palliative against the deplorable conditions of the working class (Engels, 1846/1993). Further, while there is an ocean of literature on almost every theme in sociology from a Marxist perspective, I have found only one publication that addresses SUA from the Marxist perspective and that only as a means to explain the development of conflict models, some of which have nothing to do with Marxism (Shaw, 2002).

Also worth considering here in terms of describing the context of heroin overdoses presented below, is Marx's thesis on suicide, in the guise of another's literary work, Peuchet, a French economist and bureaucrat (Plaut et al. 1999). In this piece Marx both condones and condemns suicide as a natural consequence of progression of life forces on the one hand, and as the natural consequences of industrialization on the other.

Therefore, the analysis presented here is original and as such, untested at this point. With that understanding, then, let us examine the history of the area, the research itself, as well as the findings which lead to my conclusions.

Theory

Overarching theoretical framework

My approach reflects my interest in the historical and current conditions in the Valley that have culminated in this epidemic, and which have inclined a comparatively large segment of the community to kill themselves. My approach will be to use a sociological analysis, particularly a Marxist theoretical framework. I will examine these conditions via the Marxist theoretical concepts (Marx, 1867/1978; Marx and Engels, 1972-93/1974) of alienation (Israel, 1971), false consciousness (McCarthy, 1994), lumpen proletariat (Shaw, 1978), and historical materialism (Brooks, 2004). These may serve to explain the structural conditions, currently and historically, in the Valley that may have given rise to an underground economy responding to the widespread need for addictive

substances almost as self defense mechanisms (Engels 1946/1993), and to the overwhelming drive to end one's own existence.

Briefly then, I will provide an interpretation of drug addiction within the following paradigm: the basic themes are those of class conflict, poverty, and disorganization created by capitalist productive forces in NCNM in relationship to drug addiction. The primary issues that are stressed are the use of Marxist social science tools to analyze drug addiction, in particular, explicative issues of alienation and contradictions in the capitalistic production model, all of which may serve to engender a lumpen proletariat of drug addiction careers and economy.

To summarize, I deal with real life issues within one community from a Marxist perspective; namely, the loss of agrarian productive methods and self sufficiency to capitalistic wage subsistence and new ideologies resulting in the creation of a landed lumpen proletariat within an underground economy engendered and sustained by illicit drug trafficking. I place particular emphasis on false consciousness, but not as philosophy, rather as a socio-psychological phenomenon.

Historical or Colonial Trauma

The literature on colonization which has been more recently related to historical trauma is clear. While there are several elements that contribute to this trauma one of the main elements that is particularly pernicious and debilitating is a loss or perceived loss of clear ethnic or racial identity (Dunbar-Ortiz, 2007; Gomez, 2007; Alexander, Eyerman, Giesen, Smelser, Sztompka, 2004; Cox and Stromquist, 1998; Memmi 1967, Fanon, 1967, 1966, 1963).

Some additional elements of historical trauma are

> Origins of trauma are in genocide…. Trauma is transferred across generations through impairment of traditional parenting skills, identification, and other complex processes…. Cumulative emotional wounding over time – over the lifespan and across generations…. The trauma is experienced individually and by entire communities over multiple generations. Family members who have not directly experienced the trauma can feel the effects of the event generations later" (Duran 2009, 5 to 8).

Rico appears to show this well in his confusing answer conflating Spanish, Chicano, and Hispanic; three terms which are distinctly different. Rico was 59 at the time of the interview in November of 2002. He had been using heroin and other prescription medications for some 25 years, and though he was primarily on methadone now, he still used Chiva; but his drugs of choice, when he could get them, were Seconals and Tuinals. Rico epitomizes the majority of the 34 principal respondents in their characterization of themselves as being of Spanish origin. They eschewed their Mexican heritage and identified very little or not at all with the "Anglo" culture brought in by the colonizing United States.

Duran (2003) states "**Colonial Stress Symptomatology**:

- Psychic numbing and withdrawal
- Collective sense of loss/grief dynamics and "void in history"
- Survivor guilt
- Secondary traumatization – AOD use, mental illness
- Fantasy of return to "old ways" of life, find the medicine
- Soul wound and shock—regression, repression as manifested in self-medication, disassociation, & feelings of invisibility" (Duran, 2003, 21)

The Spaniards were few and far between in Nueva España, which first became northern Mexico before it was invaded and taken as a prize of war, to become what is now known as the southwestern United States -- Texas, New Mexico, Arizona, California, Colorado, Nevada, and Utah (Gomez, 2007, Norstrand, 1992, and Gutierrez, 1991).

According to Gomez (2007), the majority of settlers in the area before the United States' invasion were of Mestizo decent (Mexicans of mixed heredity, mostly Indian and Spanish or Mexican). They were a blend of Spanish, Native American -- of Aztec origin and other northern American tribes such as Apache, Navaho, Pueblo, and others -- and later just plain Mexican. Few, if any, could delineate direct lineage to Spain. However, the colonization of northern Mexico by the United States forced the non-indigenous people of the area to consider themselves as Spanish for a plethora of reasons. For example, they did not want

to identify with vanquished Mexico, and would rather be associated with a world power from which they could trace some of their customs. Hence, they took on whole clothe, the designation of "Hispanos," a word that literally means "Spaniard" (Gomez, 2007, Norstrand, 1992, and Gutierrez, 1991).

Another important reason why the label of Mexican was rejected was that linking their heritage to Spain gave them the virtual status of Europeans and later US citizenship, and as such, the Hispanos thought they would be accepted as White by the majority of people in the United States. This White status was important because it conferred a number of benefits, such as access to the courts, land titles, and in some cases employment and citizenship (Gomez, 2007).

According to Gomez (2007), the propagated status created, in fact and consequences, its own mythological history. Acceptance of this mythology created its own problems, however, problems akin to those created by internalized racism: Customs and cultural practices that were passed down through generations became threatened by the encroaching United States systems of power.

When the United States in its "manifest destiny" invaded and finally annexed the Nuevo Mexico territory of Mexico, there were already two distinct cultures fully operative there. One had been there for thousands of years, and one was about 150 years old. The former was a Native American, Pueblo Indian culture which varied greatly while at the same time exhibited similar traits from pueblo to pueblo. The second was a culture based on land stolen from the Pueblo Indians, the imposition of Spanish/Mexican Law, the dominion of the Spanish Catholic Church, and strict class distinctions, intertwined with Native Americans and their history (Gonzales – Berry and Marciel, 2000; Guetirrez, 1991).

In Nuevo México, transient settlements began in the early 1500s. Most were temporarily reversed and interrupted by the Native American revolts against the tyranny of the Spanish invaders in the mid 1600s. It was not until the early

1700s that permanent settlements were firmly entrenched by the invasive Spanish/Native American Mestizo. The towns began as military outposts looking for natural resources, wealth for the greedy monarchy, and as religious conversion centers to proselytize Native Americans (Ebright, 1989).

Mercedes

Land ownership and loss of land has been directly tied to a narrative of colonial subjugation by the United States, for example, the treaty of Guadalupe Hidalgo in 1848 (RAFCN, 2001).

Land grants (or Mercedes) created permanent settlements for the crown (Ebright, 1994, 1989). According to Torrez (1997), the communal land grants were "the most important type of grant made by the Spanish and Mexican governments in New Mexico" (www.nmgs.org/artlandgrnts.htm). The communal grants were important to the groups who received them as the grants allowed the gathering of human capital and economic expansion (Ebright, 1994). Mercedes carried many conditions. One was the use of lands held in common, namely, whether they were to be pasture, woodland, or riparian zones. Each person named in the Merced was given a plot of land on which to build a homestead and farm. The remaining thousands of acres were reserved for common use and accessed equally by all individuals, for grazing their animals, hunting, and gathering timber and firewood. Of paramount significance was the legal construction, by Spain and Mexico (and later by the United States) of what these common areas meant to the grant. These elements of the Mercedes along with the need to build strong ties between and amongst the settlers, created an extremely strong sense of community, in both the common and Marxist sense of the word.

It is estimated that approximately 150 to 200 grants were awarded by Spain and Mexico to New Mexico settlers. Many of these communal land grants were in the New Mexico area, and have come to define the character of the culture one finds here (Torrez, 1997; Ebright, 1994, 1989).

Enter the United States

The early 1800s saw an influx of Whites (or "Anglos," as the people from the United States were called by the Hispanos). "Hispanos" were the original Mexicans who lived in Northern Mexico when the Anglos came. This Anglo influx brought with it many influences; mainly economic influences in the form of United States' private property laws which were far more individualistic than the Spanish laws. Imposition of the United States' colonization and imposition of foreign legal concepts created antagonism between the Anglos and the Hispanos, and later among the Hispanos themselves. The latter occurred as a consequence of descendants haggling over the question of who the common lands actually belonged to, since the United States did not usually recognize the "common land" as belonging to the members of the merced as a group. The United States did not acknowledge that the lands belonged equally to all the individual families of the Merced. The United States actually declared many of the Merced's common lands as available for sale by the United States after declaring them state lands without legal titles or spoils of war, if you will (Torrez, 1997; Ebright, 1994, 1989).

A second powerful influence came in the form of monetary tithing imposed by the United States Catholic Church. Formerly, the Spanish Catholic Church under the Franciscan priests simply had the constituents share their handiwork, produce, or livestock with the church as tithe. The United States Catholic Church demanded actual money. In order to comply with the Church's wishes because they were so devote, the church members were forced to produce money by selling their goods and services for currency, instead of being able to barter for their needs with the church (Gutiérrez, 1991).

Further, the narrative of racism and inferiority which had been employed by the Spanish with regard to the Native Americans to justify conquests was now employed by the Anglos to the same colonial end (Gutiérrez, 1991).

> As Anglos gloated about their moral and cultural superiority, all the time denigrating the Hispanos and Indians they found in New Mexico... much

> as the Spanish conquistadores and Franciscan friars had lambasted the idolatrous ways of their Indian subjects, so too the nineteenth-century Protestant apostles of American democracy found in New Mexico a depraved people ... whose addiction to vice had created an indolent and mongrel race (Gutiérrez, 1991, 338).

The Hispanos' rural feudal system of agriculture in northern New Mexico was a modified version of the same system employed by Spanish pre-industrial culture. This entire cultural system was so robust at the time, that it incorporated through marriage the Yankees that ventured into the area, and their ways. It incorporated them so well that in most cases of interbreeding with the Yankees, all that is left is an occasional European name in a thoroughly Latina or Latino person, with many Hispano cultural characteristics, but also with demonstrative capitalist inculcation; "flag waving apostles of American democracy" (Gutiérrez, 1991, 339). New Mexico Governor William (Bill) Richardson, for example, is the epitome of these patriotic progeny of the industrial revolution.

> The arrival of the Anglos in New Mexico initiated an intense cycle of cultural conflict over the very same issues that had pitted the Spanish against the Pueblo Indians -- religion, labor, and water.... [giving rise to] the cultural conflict that would occur in New Mexico in the second half of the nineteenth century -- a series of cultural conflicts that are still very much alive in New Mexico to this day (Gutiérrez, 1991, 340)

Loss of land, cultural displacement, and a distinct sense of having been disowned and robbed of one's values are some of the principal facets in the construction of a historical trauma narrative (Dunbar-Ortiz, 2007; Gomez, 2007; Alexander, et al, 2004; Witbeck et al, 2004; Cox et al, 1998).

> Events are not inherently traumatic. Trauma is a socially mediated attribution. The attribution may be made in real time, as an adumbration, or after the event has concluded, as a post-hoc reconstruction. Sometimes, in fact, events that are deeply traumatizing may not actually have occurred at all; such imagined events, however, can be as traumatizing as events that have actually occurred... Imagination is intrinsic to the very process of representation. It seizes upon an inchoate experience from life, and forms it, through association, condensation, and aesthetic creation, into some specific shape. Imagination informs trauma construction just as much when the referent is to something that has actually occurred as to something that has not (Alexander, 2004, 8)

What is happening in the Valley may have some basis in the historical development from Indian country to Spanish/Mexican dominion, to United States colonization (Gomez, 2007, RAFCN, 2001). These researchers speak to the possible existence of a phenomenon akin to post traumatic stress disorder (PTSD) which has causative roots in colonial conquest and subjugation. This collective PTSD may create in its victims a demoralizing sense of low self-esteem resulting in deviant behavior, or at least in behavior deemed deviant by the dominant cultures (Witbeck et al. 2004).

> "Trauma is not locatable in the simple violent or original event in an individual's past, but rather in the way its very unassimilated nature -- the way it was precisely not known in the first instance -- returns to haunt the survivor later on" (Alexander et al., 2004, 7).

While it is true that not all colonized people become substance abusers, a high percentage appear to exhibit various forms of symptoms, one of which may be substance abuse and or suicide (Dunbar-Ortiz, 2007; Gomez, 2007; Alexander et al., 2004; Witbeck et al, 2004).

Summary

This chapter covered the literature and theory used in this dissertation. The main topics were the definition of suicide as used in this work, the theories of suicide production in societies as regular and "normal," as explained by both Marx and Durkheim. Addiction was defined and explained in terms of overdoses and suicide, as was the need to look at this phenomenon from a sociological perspective, particularly the perspective of the various forms of "sociological" suicides, namely altruistic, egoistic, fatalistic, and anomic. The latter is the one most useful in the analysis of suicide with regards to overdoses. Two terms were coined and explained: street-level trauma, SLT, and cultural post traumatic stress disorder, C-PTSD.

Also explained were the Marxist concepts of alienation, false consciousness, class, and historical materialism, and the inculcation of a false

cultural identity, according to Gomez (2007), as Spanish instead of what the people of the Valley actually are, which is of Mexican origin.

CHAPTER III: RESEARCH DESIGN, METHOD, AND DATA DESCRIPTIONS

> "From today on I'm not going to give you any more worries," A.R. said to his mother as he left her home.... "I just felt something was wrong," said his mother after they found A.R. dead of an overdose. (Rio Grande Sun, March 13, 2009)

Introduction

The quote above, as reported in the Española, New Mexico, Rio Grande Sun, is a current example, similar in original narrative, to what I found in the interviews I performed six years before: A.R.'s tragic drug career path at 37 years of age, is typical of the many case histories cited in the quantitative chapter; and epitomizes the sample from which those interviews were taken. The newspaper reported that he began taking drugs at age 13 or 14 and continued all his life. He had gone in and out of treatment programs, worked most of his adult life as an artist in the underground economy of the area, and had a loving family that included three daughters. This chapter designates methods used to explore the principal question of this dissertation. What forces drive a relatively young man to kill himself which epitomize the 12 year overdose death epidemic, and why does the system, in the majority of drug overdoses, refuse to call it suicide?

As explained in the introductory chapter, all of my research had one aim: to assist a community that was screaming in agony because so many of its people were dying from drug overdoses. So my primary question was: why are so many Hispano people dying of "accidental drug overdoses" in this specific region of the Valley? Why are the general characteristics of these overdoses so different than most of the characteristics in similar populations throughout the United States? Is it possible that these "accidental drug overdoses" are not accidental at all? Is it possible that they are intentional deaths? In an attempt to answer these troubling questions I had to employ rather novel methods of assigning meaning, of "knowing."

Triangulation

One way of contextualizing and assigning meaning is through "multiple sources of knowing" (Brewer and Collins, 1981, 2). Triangulation, despite its

implied geometrical or mathematical semiotics, is the process of integrating multiple, disparate forms of data (sources of knowing) into a central, credible explanation by cross-referencing and synthesizing the various data streams into a coherent analysis of research questions (Fielding and Fielding, 1986).

I hasten to mention (because of my emphasis on Marxian and post-Marxian theory) that triangulation should not be confused with the Marxist dialectics -- thesis, antithesis, synthesis -- since triangulation is not necessarily dealing with opposing forces or processes. Rather, triangulation deals with a confluence or concatenating of disparate sources blended into a cogent response to analyze a given phenomenon.

I use triangulation of data to reach a plausible and even cogently probable conclusion concerning the hypotheses. As such, I use several first and secondary "sources-of-knowing" (data streams/sets) in the same sense that Fielding and Fielding (1986) recommend. ***As described in the appropriate sections of this dissertation***, I employ the following data streams (theories) and data sets as delineated below

- Theories as already explained in the literature review and theory chapter: Aging or Maturing Out (Winnick, 1974, 1980); Anomic Suicide (Durkheim, 1967/1897); Marx's concepts (as updated or post-Marxist) of alienation, lumpen proletariat, historical materialism, and suicide; Colonial / Historical Trauma (Duran, 2009, Whitbeck et al. 2001), or what I have termed "cultural post traumatic stress disorder" (C-PTSD); Racialization and racial formation (Gómez, 2007, Omi and Winant, 2003); and Sociological Drugs theories;
- Qualitative data set – reams of participant observation and fieldnotes; 34 principal informant interviews conducted with addicts and 15 interviews with their families, and service providers (Willging, Trujillo, and La Luz, 2003); autoethnography and positionality;

- Quantitative data sets provided by the Office of the Medical Investigator of New Mexico to show demographics of accidental drug overdoses and suicides in the Valley; and
- Government reports and informational sources such as the Center for Disease Control, the Census Bureau, various Department of Criminal Justice statistics, and the New Mexico Department of Health .

I join these disparate data through critical analysis using, respectively, theoretical orientation, heuristic and statistical computer programs, construction of tables, and lastly, an autoethnographic drug-career-path experience narrative. The latter is used in the same tradition as the "Sociological Imagination," which strongly suggests using personal experience, knowledge, and involvement to contextualize social facts (Mills, 1959/2000). The data streams or knowledge sources are detailed below.

Qualitative Data

Field research data and methodology

This section delineates the qualitative methods and tools used to gather data, and to analyze and interpret those data from naturalistic field research. Below I enunciate the process used to gather extant data which I personally collected in a research study (Willging, et al, 2005).

Observational research study

The observational research data I use comes from a study done in north central New Mexico, in the counties of Rio Arriba and Santa Fe, and mostly in the region around Española, Chimayo, and northern Santa Fe County, New Mexico, between April 2002 and May 2003 (the exact demographics and geographic details of which are presented in Chapter IV). I refer to this region as “the Valley” which is also how most of its inhabitants refer to it.

> "The overall purpose of this project [was] to provide the State of New Mexico Department of Health and Health Policy Commission with ethnographic research that examines the illness careers and treatment-seeking behaviors of drug users in north central New Mexico" (Willging et al, 2003; 7).

The data set I use from this study consist of three types of data collected through,

1. Field observation –consisted of 18 months of critical, general observation of *principal respondents (active drug addicts) and their families' milieu*. It involved my immersion in every aspect of life and the social environment into which I was allowed, such as their homes, popular stores, man-in-the-street interviews, and quotidian venues;

2. Participant observation – hundreds of hours actually staying in the environment of the key informant and observing the actions, interactions, and other drug participatory behavior in harm-reductions, treatment and venues; and

3. Unstructured and semi-structured interviews – open-ended interviewing the family members of active substance users and community professionals, and semi-structured interviewing of principal respondents, i.e., active substance users.

The three engendered hundreds of pages of field notes, over the 18 month period in which I lived and worked in the area.

Study sample and selection

Altogether, more than 90 interviews were conducted in the original Willing et al (2003) study. The selection process for the interviews was through a purposive sampling strategy. That is, the selected sample was made only from universe of former users (clean < one year) (clean > one year), and current users, not from the general population of the area. Each individual was paid 20 dollars per interview session. The sample was representative of the drug users (and the substances used) in the Española Valley. Quoted below from the study is the actual method of choosing the sample, who was represented in the sample, and also delineates the types of substances being used, how they were being used, and if the informant had or had not experienced one or more overdoses.

Sample:

> In the course of fieldwork, we interviewed people representative of the variety of populations residing in north central New Mexico, particularly in the Española Valley, a largely Hispanic setting. The region is populated by descendents of long-term residents who lived in the area prior to annexation of New Mexico by the United States in 1848 and, more recently, by a growing Mexican immigrant community. The region also contains significant Native American and Anglo minorities. Our sample for the semi-structured interviews is weighted toward the region's largely working class Hispanic population, thus reflecting the pattern observed in the area's general population. However, a notable gap in our study consists of Mexican immigrants, particularly persons classified as undocumented or "illegal." The Mexican immigrants approached to participate in our study declined to do so; we suspect that fears regarding exposure and deportation may have dissuaded these individuals from participation. Based on our discussions with behavioral health providers, it is possible that: (a) rates of drug addiction are lower in this population than among other ethnic groups in the Española Valley; (b) members of this population are less likely to be court-ordered into the local behavioral health care system; and (c) the substance of choice within this population is alcohol as opposed to illicit drugs. The use of the latter is a prerequisite for participation in the present study.
>
> Native Americans also appear to be under-represented in the treatment populations that we encountered. Such under-representation may result from low rates of drug use among Native Americans residing in the region. As potentially the case with Mexican immigrants, it is possible that alcohol is the drug of choice among Native Americans and that this population is not as frequently court-ordered to area treatment providers.
>
> In terms of our purposive sampling strategy, we sought a representative sample of former users (clean < one year) (clean > one year) and current users. In these terms, the group most under-represented in our sample was former users (clean > one year). We sought a sample that reflected the diversity of substances used in the communities comprising the Española Valley. The most widely used drugs, in order of apparent use, emerge as *el pisto* (alcohol), *la mota* (marijuana), *la chiva* (heroin), followed by *la soda* (cocaine), *las pastillas* (prescription tablets) and *las pildoras* (prescription pills and capsules), and rocks (crack-cocaine). The seeming pervasiveness of crack cocaine use and the growing popularity of crystal methamphetamine struck our research team. Perhaps under-represented were users of these substances" (Willging et al., 2005; 21).

As can be seen, the sample appeared to be representative of the substance abusers' population in the area, and also seemed to be reflective of

the general population with the noted examples, Native Americans and Mexican immigrants.

Contextualizing the sample and area

Española, where I did much of my field work, has the feel of a small, but crowded rural town. The actual population of the town proper, according to the 2000 U.S. Census is about 9,000 people; the population of RAC is 41,000, and Northern Santa Fe County is about 10,000, (Census, 2007). That brings the entire area of study, the Valley to slightly more than 51,000 people.

While the entire Valley is relatively large, the population centers are fairly small, and the entire area has a sense of rurality confirmed by the fact that population density is only 7 people per square mile (Census 2007).

I was obviously an outsider. I dressed in all black and drove a silver Volvo or rode a 2002 Honda Shadow motorcycle most of the time. I stood out like a Gringo in Harlem. No matter where I went in the town -- the High School, the restaurants, the libraries, and even the treatment programs -- few people failed to greet each other as friends or acquaintances. They even acknowledged me with a curt nod or a short wave of the hand held low against their body.

Most of the drug addicts I met, in and out of programs, were outwardly distrustful and universally loath to speak to me. The people I found friendly towards me were those who were obviously transplants or who had been introduced to me professionally, in a professional setting. However, once I had been around for a while (with the needle exchange programs, sitting all day in treatment venues, and generally hanging out in restaurants and the library) the people “in the life” were more receptive to my inquiries and general conversation. This was particularly true when I let it be known that I was an ex-con who had done nine years in prison for manslaughter, and that I had been a heroin addict for many years as a young man.

However, I was unprepared for a number of very real issues that arose. Doing observation in "the field" – in the high school, the streets, stores, libraries, and restaurants of the Valley; in methadone programs; and in and out of the back

of the needle exchange ambulance -- was quite different from the professional observation methods I had learned as a risk manager. Doing observations in these places while attempting to be inconspicuous and simultaneously and paradoxically, getting to be known by participants who would rather not be known, and attempting to surreptitiously take notes was challenging and taxing. Writing during observation was one of the most difficult facets of this study for me.

Attempting to secure entrance into a virtually closed society was frustrating. My personal experience in Harlem, in an urban drug scene, was such that as a stranger I could go to any drug setting -- the local drug bar, after-hour joint, night club, or shooting gallery. As with any stranger entering such venues, while I would initially be suspected of being a “narc” (a police officer undercover) or rat, within a relatively short time I would be in someone's house buying drugs or shooting up, because the “proprietors” of these “commercial” establishments have to take risks and be more open to outsiders if they are going to thrive with a relatively transient population of “customers.” After all, in large cities, with rare exceptions, a strikingly large percentage of any given grouping consists of outsiders arriving within the past few months (Loue, 2003, Bourgios, 1999, Agar, 1973).

By contrast, the Valley had no drug bars, shooting galleries, or clubs where I might go to hang out. To talk to people in the drug scene it was necessary to sit in the treatment and harm reduction programs or go to people’s homes. The one *tecato* (Spanish meaning drug addict) I thought of approaching outside the library one day, gave me such a hostile look that I immediately shut down and walked to my car. I approached another in Walgreens and a third and forth in WalMart and the Ace Hardware store. All, without exception, gave me the same deadly look. I even approached several whom I had met through the needle exchange program when I saw them walking down the street alone and I was coming out of restaurants or stores. Same thing: if looks could kill I would have been DOA.

People tend to dress the same, speak a mixture of Northern New Mexico English, Spanish, and Mexican idioms, making up a distinctive Spanglish dialect. The Spanglish had some Spanish words which were misspoken Spanish, and have obviously been here for generations. I heard the word "manito" or "manita" (a shortened version of the word "Hermanito/a," -brother/sister), and the word "primo" or "prima" (cousin) a great deal. When I spoke with people in the Valley, as I mentioned this or that person I had met, the listener invariably knew them personally, or was related to the listener through blood, marriage, or "crianza" (rearing). Most people I encountered who were not drug addicts or "in the life" (as being in the drug trade or having a drug career is known), were cordial, but distant with me.

It became very clear that in this rural area people were extremely distrustful of outsiders; they tended to keep within closed family and friendship circles, and they tended to stay home. That readily explains why they greet each other fondly, but would hardly speak to me. That was true even after they had seen me several times and had been reassured by service providers (a few of whom are community members), that "he's okay," or "he's here to help."

The people who tended to open up were new people to the area which meant that, while what they said was useful in that they provide a specific context to the drug scene, they nonetheless contributed little if anything to the deeper structure of the Valley's drug scene. So while they were part of the drug scene for a time, they really could not speak to the historic or sociological fabric of the overall drug scene. One of the people who agreed to be interviewed and did not show up was one of the fringe group people who, despite having grown up in the Valley, were White and not considered "in."

In this context it was very telling that many of the counselors I met in the treatment program settings were from somewhere other than the Valley. Actually, a majority of the people working in the treatment programs as head personnel (with a few notable exceptions, for instance, the director of one of the

alcoholism programs), were outsiders. Even the program that was in Santa Fe had a staff mostly from Albuquerque!

For participant observation I became involved with three programs: one was a for-profit methadone program that opened at 6:00 a.m. and closed at 11:30 a.m. (This gives them time to get their medication and get to work…" as the owner often said); the second was a treatment program operated by "outsiders," who had won a contract with the State of New Mexico, who were uniformly disliked by all the other programs in the Valley. I thought they provided the best services in the Valley: they were the only program in the Valley at the time who accepted relapse as part of the normal course of treating addiction.

The third program was a needle exchange program based in Santa Fe, but which came up to the Valley twice a week. I rode along in the needle exchange ambulance; it was stationed at different set-times at both Chimayo and Española. We gave out "paraphernalia" -- needles, cotton, cookers, tourniquets, alcohol swabs, and antibiotic packets -- to any person who was brave enough to come to the converted ambulance and ask for the stuff. I say "brave enough" because more often than not the police parked a squad car across the street from the ambulance which frightened many of the people who came. I was able to get closer to some of the circumscribed groups through my involvement with the needle exchange program. However, there the people were far more skittish than at the treatment programs.

To conserve anonymity I will not name the fourth treatment program that I tried to enlist to allow me to do participant observation, but the directors of the program were completely non-responsive to my inquiries and requests to do field work at their program. That was the case despite the fact that they were one of the largest programs in the area.

Interviews

Out of the 34 principal respondents, 21 (or 68%) had experienced one or more near fatal overdoses. Sixteen reported multiple near fatal overdoses, some

in the same day and within hours of the other overdoses. All 34 reported seeing family members, and/or close friends die of overdoses.

The majority of the principal informants fell well into one of the categories that emerged through the iterative process and shown in the table 3.1 below. The principal respondents' case histories demonstrated that despite a clear heuristic understanding of the overdose process, many of their attitudes, as well as their latent and overt behavior towards overdosing, were emblematic of anomic suicide: “results from man’s activity’s (sic) lacking regulation and his consequent sufferings” (Durkheim 1967/1897, 258). An anomie brought about by community alienation and personal trauma, and underpinned by Cultural/ Historical trauma.

Table 3.1: **The Iterative Process Produced These Categories**

Suicide	Ideation, articulation, attempts, multiple substance used, repeated overdose tries, and depression; family members, peers, assertions confirming the possibility
Alienation, Anomie, and Trauma	loss of land, labor-class or subrosa economy employment, lengthy drug career without “maturing out"
Cultural Displacement	Life-long resident of the valley who considers his or herself Hispanic, Hispano, Spanish or Chicano, and Loss of, or subsistence on historical “family" land

Unstructured and Semi-structured Interviews

Principal informant’s demographics

As described in detail elsewhere, the geographic area with which I am concerned here is large, roughly all of Los Alamos, Rio Arriba (RAC) and Santa Fe counties, New Mexico (the Valley) about 2,500 square miles. My associations with the area began in 2002 as a researcher doing participant observation at several social services venues in the cities of Chimayo, Española, and Santa Fe.

For the research itself, I interacted with the people, programs, and services from April 2002 to December 2003, and conducted 34 unstructured and semi-structured interviews with drug users, ranging in time from two hours to three hours. I have continued my association with the area off and on until 2009. I have lived in RAC going on three years now, from January 2007 to 2009.

Table 3.2: ***Name and Characteristics Individuals in the Sample***

	AGE					
	F	M	Self-Reported Ethnicity	Valley Resident	Over dosed	Drug(s) of Choice
Blondie	32		White/ English	Y	1	Coke
Cuchillo	26		Hispanic	Y	0	Heroin
Methmaid	35		White	Y	1	Heroin
Suavesita	37		Spanish Indian	Y	1	Heroin
Vanidoso		45	Hispano	Y	0	Pot/Heroin/ precription meds
Gualdalupe	40		"Chicano Background"	Y	0	Coke
Orgullosa	20		Hispamic	Y	1	Heroin/Coke
Bob		54	White Jewish	Y	1	Heroin and Coke
Nerviosa	21		Hispanic	Y	1	Heroin
Jose		21	Hispanic	Y	1	Heroin/ ckoe/ Alcohol
Flaco		43	Hispanic Coyote	Y	1	Heroin/ alcohol
Flaquito		20	Hispanic	Y	0	Heroin
Agugero		48	Hispanic Raza	Y	1	Heroin/ alcohol
Pipa		29	Hispanic	Y	1	Heroin/Coke
Rico		59	Chicano	Y	1	Seconals/ Heroin/alcohol
Asedio		42	Chicano Catholic	Y	1	Heroin
Campesino		52	Chicono	Y	1*	Heroin
Rey		54	Hlapanic	Y		Heroin
Gorra		43	Hispanic	Y	0	Heroin /coke
Llagas		39	Hispanic	Y	1	Heroin
Tempest	54		White	Y	1	Methamphetmine/ heroin
Torcida	23		Hispanic	Y	1	Heroin/Coke
Negrito		33	Chicano/Hispanic	Y	0	Heroin
Lisa	33		Japanese Maya Indian	Y	0	Crank/ Heroin
Torpe		43	Chicano	Y	1	Heroin
Mathches		22	Hispanic Mixture of Spanish and Indian	Y	1	Heroin
Analfabeto		46	Hispanic Spaniard	Y	1	Heroin
Hembra		36	Spanish	Y	0	Cocain/Perks and Valiums
Llorón		30	Hispanic Spanish inheretance	Y	1	Cocaine
Linda	44		Hispanic	Y	0	Heroin
Hovencito		27	Hispanic Spanish	Y	1*	Heroin
Bobasabia	22		Hispanic Brown Pride	Y	1	Speedball
Huido		22	Hispanic	Y	1	Heroin
Bombon	42		Hispanic Chicana	Y	1*	Cocain/Heroin
				Total	21	
Average	31	40		OD %	62%	

It should be once again noted that the original study (Willging et al., 2003) contained more than 90 interviews of which I am using the 34 that I conducted. Table 3.2 above shows principal respondents' demographics. Ethnicity or race was self reported on an open-ended question: What is your ethnicity. Often the question was not understood and examples were supplied: "Black, Hispanic, White…?"

Tables below layout other demographics in specific details – ethnicity and age (table 3.3), and drug preferences (table 3.4). The individuals in the sample ranged in age from 20 to 59, with the average age of the entire sample being 36. Females ranged in age from 20 to 54, and averaged 31 years of age. Males ranged in age from 20 to 59, and averaged 40 years of age. The majority (31) identified themselves as Chicano, Hispano, Hispanic, Latino, and/or Spanish; all of these terms were self applied. Four identified themselves as White, and none identified themselves as Native American or Black. Fifteen identified themselves as females and 19 as males.

In the "Overdose" column with 0 = had not experienced an OD, and 1= had experienced one or more ODs. Three respondents admitted attempting suicide: the asterisks beside the number 1 represent those. The Red indicates range (20 to 54 for females and 20 to 59 for males), and the yellow indicates those principal responders that self-reported as "white."

Table 3.3: ***Demographics of Sample of Ethnicity and Age***

	Ethnicity		**Age**		
	Hispanic	Anglo	Average	Range	
Female	11	3	33	20	54
Male	19	1	39	20	59
Totals	30	4			

Table 3.4: ***Drug Preference of Sample***

Heroin	Coke	Heroin / Coke	Heroin / Alcohol	Multiple Substances
16	3	8	3	5

Thirty key informants came from families that had been in the North Central New Mexico area since the 1700s, and many of them either owned their own homes or their parents or grandparents did. Homes were either handed down through generations, or built on land granted to their Spanish era or Mexican era forefathers by Spain and/or Mexico, respectively. Much of the land had either been sold off or subsequently subdivided into family compounds.

I had the opportunity to conducted five unstructured interviews of family members of self-acknowledged heroin addicts -- one sister, one brother, one mother, one father, and one of a couple (mother and father) together. I talked with a great many other family members of heroin users -- brother, sisters, aunts uncles, cousins, nephews, granddaughters -- as charted in my fieldnotes, but only the five agreed to be interviewed on record and in depth. All the others -- service providers, politicians, health care personnel, and administrators -- refused on-tape though they said I could quote them and site the source as “anonymous.”

The original tapes of the interviews have since been destroyed, and the names on the transcripts of the interviews have been rendered incapable of being directly traced to the informant since all the names have been changed twice. When I first conducted the interview I gave fictitious names to the informants, which they employed throughout the interview process. Once the interviews were transcribed, I changed the names a second time and destroyed the original transcripts. The Willging et al (2003) study was done with full approval of the Human Research Review Committee of UNM Medical School: documents are still on file.

It was during both the interviewing and the transcript analysis that I first started thinking about the possibility that the accidental overdoses were not so accidental. At the time of these interviews our purpose was not to search for possible causes of overdoses, so I concentrated my analysis on the issues required for the study. However, in reviewing some of the margin notes and writing I complied for the initial study, I became confident that mining these interviews would yield much by way of answering the research questions of this dissertation.

Fieldnotes

> "...I approached this project with a great deal of enthusiasm and even greater naiveté. I am an experienced administrator and risk manager whose career-life has necessitated paying particular attention to observable phenomenon. I am also an ex-heroin addict who was intimately familiar with the street life of the inner city, the paranoid behavior of tecatos, and had no illusions about the drug life. I thought these two experiential factors would prepare me well for this project. I was right, they did. However, I was unprepared for a number of very real issues that have arisen. Foremost is the difference between doing observation in a professional setting and dictating my observations and findings for my secretary to type, and doing observation in "the wild" -- in the streets, stores, school, libraries, and restaurants of Española; in a methadone program; and in and out of the back of the needle exchange ambulance. Doing observations in these places while attempting to be wallpaper and paradoxically getting to be known by participants who would rather not be known, and attempting to inconspicuously take notes...." (La Luz, 2002)

The second data I used from the Willging et al study are my fieldnotes from participant observation conducted over an eighteen month period in 2002 to 2003. I spent hundreds of hours in several harm reduction venues -- needle exchange programs, methadone clinics, drug counselors' offices -- and throughout the Chimayo, Rio Arriba, Pojoaque, and Santa Fe areas. During part of those hundreds of hours I also gathered copious fieldnotes of my observations or man-on-the-street type encounters of many people in all manner of venues in these geographic areas. I filled about twenty reporters' notebooks consisting of three to four hundred pages of fieldnotes. In all instances and cases I used

fictitious names for both the people and the locations where I ran into them or in which they accosted me because they happen to have heard that we were conducting the study.

Quantitative Data and Methodology

Office of the medical investigator data sets

While I was provided two original data sets -- the Cause-of-Death data set, and the Toxicology Screen Data set -- by the New Mexico Office of the Medical Investigator (OMI), I employ only the latter set as I explain below. The two data sets were conveyed to me on a compact computer disk which contains four data files, two each in MS Access and MS Excel formats. Another OMI secondary data sources are the Official Annual Reports of that office.

The data are used to contextualize the qualitative data findings, through frequencies, annual statistics, and determination of the numbers of substances found in most decedents. The data are also used to demonstrate demographically the impact of the epidemic on the Valley in comparison to the rest of New Mexico. I also employed descriptive statistics to demonstrate similarities and differences between accidental drug overdoses and suicide, and between the entire state of New Mexico and the Valley[3].

OMI annual reports

The secondary data set contains ten years of the Annual Report Office of the Medical Investigator State of New Mexico (1997-- 2006, inclusive). These annual reports graphically illustrate the causes of death in the state of New Mexico. They were used to create charts, tables and graphs to compare (1) drug caused deaths -- "A death caused by a drug or combination of drugs. Deaths caused by ethanol, poisons and volatile substances are excluded" (OMI, 2003,

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[3] I did not go beyond these statistical manipulations in this dissertation as that would be beyond the scope and need of this topic at this juncture in my work. The data sets will be mined in subsequent papers.

97-98). (2) Drug involved deaths -- "A death in which a drug or combination of drugs is present in the body at the time of death.... The drug(s) is not the cause of death, but may have contributed to the death. Therapeutic drugs exceeding therapeutic levels are included" (OMI, 2003, 97-98), and (3) suicides -- "The manner of death in which death results from the purposeful attempt to end one's life"(OMI, 2003, 97-98).

The report generated by OMI is part of the public record and was obtained from OMI in print, and over the Internet as Acrobat files (PDF formats).

OMI cause-of-death data sets

The second sets of data used in this research were specifically created for me by the head of the computer unit of the New Mexico Office of the Medical Investigator office from the data banks. It is important to note that while I had to do some recoding of variables for ease of statistical manipulation, the data sets did not require any other type of cleanup in order to analyze the data using MS Access, MS Excel, and SPSS. The data elements were entered into the OMI database by professional staff of the computer department. The data was taken directly from forms completed at the autopsy and death scene investigations by the presiding medical examiners, and are reviewed by the examiners for accuracy. As an example, a completed report form (with confidential data blacked out) is attached as Appendix --. In the same appendix, there is a list of all the variables provided on the CD and a listing of new variables created.

The greatest difficulty in working with the two data sets was the large number of what appeared to be 30,000 cases in one data set and 4,090 cases in the second data set. The sets contained all deaths in New Mexico, whether from accidents or suicides. The larger set also contained a full drug and alcohol screening for each case, some of which were quite lengthy which is why the set is so large. This initially presented a challenge because of duplication of case identifiers per drug screen. That is, each individual case may have one to 30 or more drugs screens attached to the same case number.

The small set contains 38 variables of which only a few were used for analysis and 4,090 cases each coded with their respective identification number. That is, "n" equals 4,090. The set contains twelve years (1995 -- 2006, inclusive) of annually reported deaths in the Valley that were either declared as "Suicide" (SU) or as "Accidental drug Overdoses" (ADO). While fluctuations are apparent in the number of deaths per year, the prevalence is relatively consistent over that time span for both categories as is shown in subsequent discussions.

New Mexico OMI Demographics

Frequencies: helping keep the numbers straight

The tables and graphs below are original tables created with the statistical program SPSS from the original or recoded variables listed below in the quantitative data set methodology section.

The salience of RACE in OMI data

The designation of "Race" by OMI is problematic; there are several issues that need clarifying here. First and foremost, unlike the Census where race and ethnicity are self-designations, in OMI reporting the designation of “Race” is done by the person doing the autopsy. People filling out the census documents designate the categories to which they themselves believe they belong. In the case of OMI, by contrast, the medical investigator decides who is what race or ethnicity -- American Indian, Black, Hispanic, and Anglo. If a person has an Anglo surname and looks Anglo, s/he is usually designated as Anglo despite the fact that s/he may be Hispanic. As a matter of inquiry, I estimate that at least 10% of those designated as Anglo are actually not what the Census Department would classify as Anglo Non-Hispanic, but rather Anglo and Hispanic, or Coyotes as the New Mexicans call those of Anglo and Hispanic extraction.

Secondly, OMI does not differentiate, as does the Census, between race and ethnicity. The Census department acknowledges race and ethnicity: As such, a person can designate themselves as any of the listed races or ethnicities. In sociology, while we fully acknowledge the social construction of both race and ethnicity, by and large, sociologists tend to distinguish the two as separate levels

of reified stratification. That is, in sociology we generally accept the social fact of four "races" -- Black, Red, Yellow, and White -- but an infinite number of ethnicities (Anderson and Collins, 2004). OMI on the other hand, does not make the distinction of race or ethnicity, OMI conflates the two into one category such that Black, White, and Hispanic are all separate indications of race.

The question of race and ethnicity designation was a serious issue to contend with in the analysis of OMI data. While the larger portion of the sample is Hispanic, the actual number of those that would be classified in north central New Mexico as Hispanos would be much larger than the number shown by OMI.

The tables below illustrate the demographic of the OMI sample. As can be seen in Table 3.5 below, the largest percentage of decedents were Hispanics (1946) at 47.6 percent. Whites made up the second largest group at 1,827, or 44.7 percent. It is again important to note that Hispanic can be of any race including White, Black and Native American, but they are not distinguished as such in the OMI data.

Consequently, OMI conservatively estimate that as many as ten percent of all cases that are listed as “White” in their reports may also be Hispanics. Extrapolating to cases here, about 183 of the “White” decedents would also be Hispanos bringing the total of Hispanics to 2,129 (52.0%) or a clear majority of the decedents.

Table 3.5: ***Ethnicity and Race in the 12 year OMI sample, 1995 to 2006, of suicides and accidental drug overdose***

Race	Year	%
Hispanic	1946	47.6
Native American	188	4.6
Other	129	3.2
White	1827	44.7
Total	4090	100.

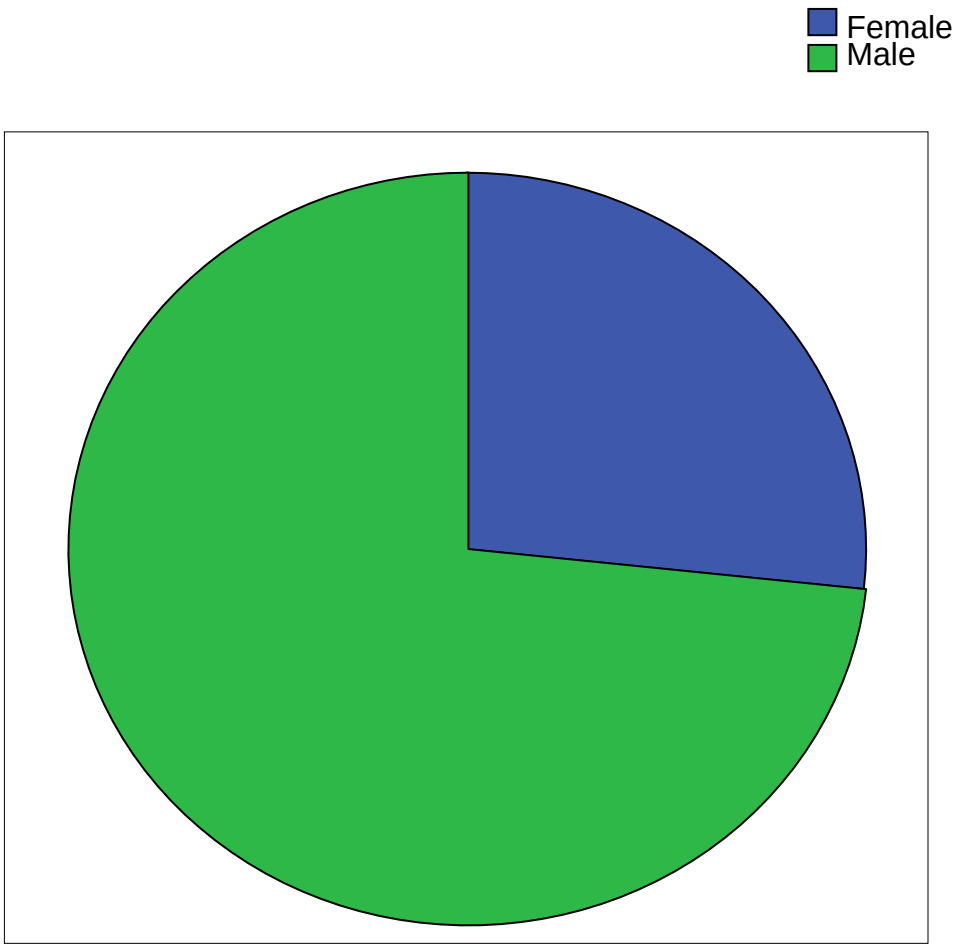
Importance of gender

In sociology "gender" is generally considered socially constructed, and "sex" the biological designation of male or female. Though I hasten to add, as Richmond-Abbott (1992) has written, even in the biological designation there is a wider spectrum of sex traits than is commonly supposed. Since OMI uses "Gender" instead of "Sex" as the biological designation I will refer to sex as gender with regards to the OMI data. In all other instances, I will employ the sociological assignations.

As table 3.6 below illustrates, the gender frequencies of the sample were 1,092 female decedents (26.7%) and 2,998 (73.3%) male decedents over the twelve year period. The pie chart below the table graphically and rather dramatically illustrates the large difference in decedents' gender.

Table 3.6: ***OMI Data of Gender of Decedents from 1995 to 2006***

	Frequency	***Percent***
Female	1092	26.7
Male	2998	73.3
Total	4090	100.0



In the pie chart above, the Green area represents 2,998 Males (73.3%) and the Blue area represents 1,092 (26.7%) females in the sample

Age

Age is an important variable in this analysis because it speaks to the anomalies that are occurring in the Valley with regard to persons who are experiencing accidental drug overdose. In this sample, the mean age for the decedents is higher than the national average. I speak to this in more detail in the conclusion.

Table 3.7: ***Categorical Division of Age, 12 Year Age Groupings, 1995 to 2006***

	Frequency	Percent
19 and under	186	4.5
20 to 29	683	16.7
30 to 39	1121	27.4
40 to 49	1351	33.0
50 to 59	568	13.9
60 to 69	130	3.2
70 and Above	51	1.2
Total	4090	100.0

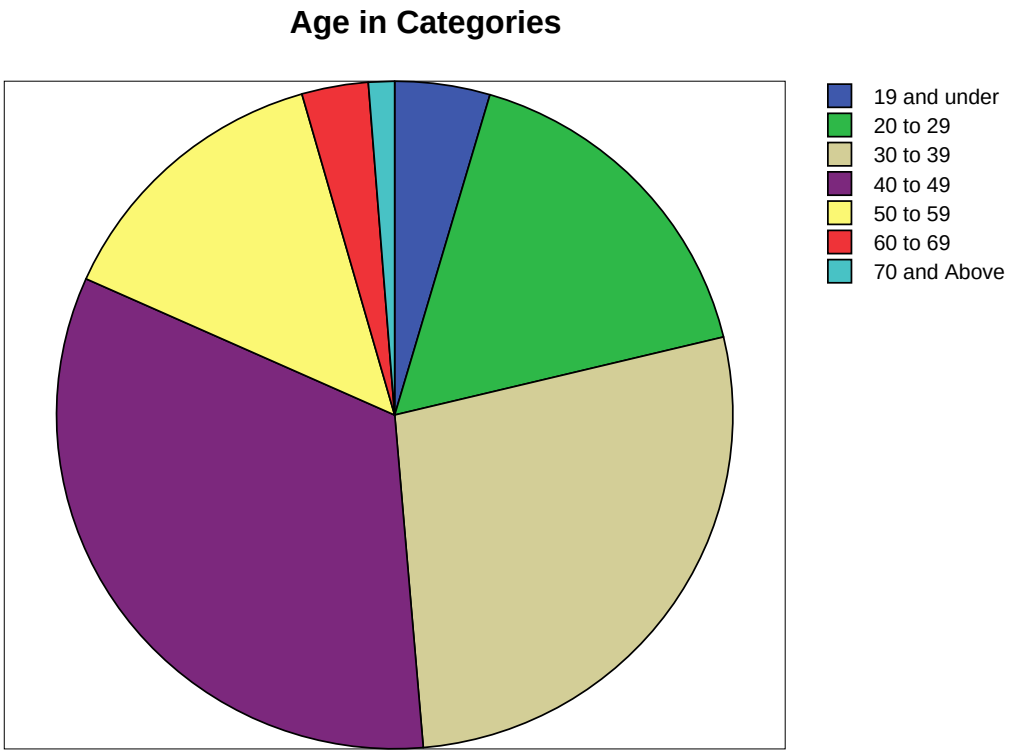


Table 3.8: ***Suicide (SU) and Accidental Drug Overdoses (ADO) That Were Drug induced – 1995 to 2006.***

		Manner_first				
	Year Pronounced	ADO	SU	Yearly Total	SU percent Of total	ADO Of total
	1995	217	92	309	0.30	0.70
	1996	233	85	318	0.27	0.73
	1997	231	76	307	0.25	0.75
	1998	268	55	323	0.17	0.83
	1999	305	93	398	0.23	0.77
	2000	285	88	373	0.24	0.76
	2001	237	65	302	0.22	0.78
	2002	263	49	312	0.16	0.84
	2003	323	43	366	0.12	0.88
	2004	279	47	326	0.14	0.86
	2005	310	45	355	0.13	0.87
	2006	349	52	401	0.13	0.87
Total		3300	790	4090	0.19	0.81
Yearly	Average	275	66			
	N= 4090					

Table 3.8 above, created from the OMI data set shows all deaths in New Mexico that were caused by lethal substance intake and who were declared accidental, and all drug related suicides. The OMI defines SU as "The manner of death in which death results from the purposeful attempt to end one's [own] life" (OMI, 2003, 97-98). The category of SU includes any and all types of deaths that were actually declared suicide by the presiding medical examiner -- from gunshot wounds and hangings to poisonings and drug overdoses. Over the 12 years period there were a total of 790 cases of SU as compared to 3,300 overdose deaths. In the same 12 year period here was an annual average of 275 accidental drug overdoses as compared with 66 suicides. Eighty-one percent of the 4,090 decedents were accidental drug overdoses.

Problems with determination of decedent's status

Directly after a body is found by the local police, they will call in the OMI to conduct an investigation:

> The investigation will start at the location of the death. Specially trained medical investigators will be called in by the police. The investigator will talk to family members, witnesses and others, work with the police in identifying features of the death, obtain medical histories and records, and photograph the scene of the death. The investigator will authorize the removal of the body to a location where an examination will be conducted (OMI, 2005, Web page of New Mexico OMI).

Curiously, there is nowhere an exact definition of "accidental drug overdose," (ADO) though the term is used in both the reports and computer generated data sets. The only directly related definition I found was "[a]ccidental: the *manner of death* used when, in other than *natural deaths*, there is no evidence of intent" (emphasis original; OMI, 2004, 71). The designation of ADO includes any and all types of drug related deaths including those caused by ingesting or injecting illicit drugs, prescriptions, and non-prescription overdose (but curiously excludes alcohol death) that were not supposedly intentional, and which were actually declared as ADO by the presiding medical examiner. In the data set there are 351 cases of ADO over the ten year period which is higher than the national yearly average per capita.

The determination and/or designation of either ADO or SU are arbitrarily assigned by the doctor performing the autopsy, *according to the doctor's own criterion*. I was unable to discover a set medical protocol for either determining who is labeled as a SU or who is labeled as an ADO. This is problematic as has been well documented by a number of studies (Krivanek, 1988; Pescosolido and Mendelsohn, 1986) detailed in the literature review (Chapter II).

Toxicology screen data

The toxicology data was imbedded with case numbers and also contained screening for substances that were irrelevant the analysis. The case numbers correspond to the case number in the Causes-of-Death set, but in almost all instances there are multiple screenings associated with the same case number,

representing the various toxicology screens that were run on the decedent's fluids -- blood mostly. Concerning the toxicology screening which is integral to my analysis, the office of the medical examiner has written this:

> "In all cases investigated by the Medical Investigator, including those where autopsies are not conducted, fluids are taken for toxicological tests. The results of the tests are often important factors in being able to determine a cause and manner of the death, i.e., suicide by drug overdose, and in providing motives and explanation for behaviors (alcohol levels in fatal motor vehicle accidents). In New Mexico, these tests are performed at the State Laboratory in Albuquerque" (OMI, 2005, Web page of New Mexico OMI).

The number of substances a decedent has in his or her system at the time of death is important information. In order to make the screens meaningful to the analysis, two steps were taken. First all the drug screens were isolated by case number producing an aggregate variable, Manner_First. Then that variable was divested of a number of screened substances that were irrelevant to my analysis using the following syntax:

```
IF (DrugResult = "0" | DrugResult = "Negative" | DrugResult = "negative"  |
DrugResult = "No other drugs detected" | DrugResult = "No Drugs
Detected" | DrugResult = "No drugs detected"    | DrugResult = "No pills in
stomach contents to identify" | DrugResult = "None detected" | DrugResult
= "none detected" |  DrugResult = "None detected" | DrugResult = "None
detected% saturation" | DrugResult = "Not present" | DrugResult = "null" |
DrugResult = "o" | DrugResult = "sample unsuitable for analysis" |
DrugResult = "Test cancelled" | DrugResult = "Test was canceled due to
Sample Matrix Problem" |  DrugResult = "TNP" |DrugResult = "unable to
perform analysis" | DrugResult = "Unable to perform analysis" |DrugResult
= "Unable to perform on tissue")  DrugCase = 0.
```

This run eliminated: caffeine, glucose, potassium, sodium, and insulin, as well as the empty sets. The classification of substances is according to the Center for Disease Control Drug Caused Death codes, a set of which was supplied to me by the New Mexico Health Department, but which has no explanation of standard protocols for usage.

Analysis method

Using SPSS, the descriptive statistics calculated included averages, frequencies, and sums to ascertain and to compare the variable with newly created variable. The statistics calculated were also used to compare the Valley to all of New Mexico.

Autoethnography, Positionality, and Reflectivity

It is important that I include this section. Autoethnography (Vidal Ortiz, 2004), positionality, and reflectivity are legitimate forms of qualitative expression that assist a scientist to reach a more meaningful conclusion. No conclusion or finding is completely free of bias. By disclosing and engaging in a narrative that explicates the qualitative process and the experiences that culminate in the conclusions, the findings are better understood and judged.

Who I am, as well as my lived experiences in relationship to the dissertation topic, particularly with regards to my personal journey through the labyrinth of drug addiction, both elucidates and may have confounded my findings. Though, I hasten to add that a number of careful oversight precautions prevented the latter.

From the age of twelve until well into my 27th year of life, or the greater portion of fourteen years, I was a heroin addict in Harlem (New York City). That is, from about 1958 to 1974 I maintained a full blown heroin habit, including some of the unfortunate time I spent in prison during that time. My addiction career had a clearly delineated pathway which in many ways assents the current drug addiction literature on maturing out, but my drug career was markedly different than that of the populations I studied for this dissertation.

Analysis Method

I analyzed these ethnographic data by both an iterative process consisting of repetitive coding of specific words and action of the respondents through coding into the computer program NVivo. Amongst other things, the data were used specifically to explore the association between accidental drug overdoses, suicide attempts, and drug careers trajectories from age of inception through

maturing out or not. The data are also used as qualitative representation of other elements such as career path, repeated overdose behavior, and suicide ideation or attempts.

Summary

The methods used in this dissertation were delineated and explained – triangulation; ethnographic field work; other contextual settings and Autoethnography, Positionality, and Reflectivity the as well as the length and breadth of the interviews conducted. Also laid out were the data sets used – 34 semi-structured interviews conducted with active drug users and interviews with family members of same, and professionals; a twelve year data set – 4,090 cases of accidental drug overdose and suicide deaths in New Mexico and the Valley -- from OMI data, which also contained the number of substances found in each of the decedents who died from accidental overdose. The selection of the sample of these data sets were explained and the demographics of each. For each category the manner of analysis of the respective data sets was explained. Lastly, issues that were problematic were also discussed: OMI definition of race and ethnicity; the arbitrary designation of either suicide or Accidental Drug Overdose.

CHAPTER IV: TRAFFICKING IN DRUGS DEMOGRAPHY, HISTORY, AND HISTORICAL TRAUMA

Introduction

“Going to the *corneta*" in the Valley means "going to the connection," or the local drug dealer to get heroin or other illicit substances. In this mountainous, penurious, rural area of north central New Mexico, which has the highest per capita death rate from drug overdoses in the US; where a large share of the local inhabitants, known as Hispanos, can trace their roots back to the invading Spanish/Mexican forces in the seventeenth and eighteenth centuries, there are no drug pushers. Demand here for banned or controlled substances -- Chiva (heroin), polvo (cocaine), and maria (marijuana) -- is so great that no one needs to "push" anything. The addicts here flocked to the familial provincial network of cornetas for their daily cutritas (little fixes); many also used and abused alcohol and pildoritas (prescription pills).

The alcohol they get from the local liquor stores, gas stations, and grocery stores. The pildoritas they get from friends, family members, and well meaning doctors who often prescribe these drugs with good intentions because they want to help the addicts kick their habits (Reichelt, 2001; Shaening and Associates, 1998).

Drug use and abuse is so prevalent in Northern New Mexico that it has been called an epidemic by local and national government agencies, service providers, and the people on the streets (Reichelt, 2001). The Catholic Church has waded into the controversy by writing about the epidemic and the need to do something about it (Sheehan, 2001). The situation is grave enough that in 1999 several of the United States Senate subcommittees and concomitant Federal agencies, held a special session, on site, to investigate the prevailing heroin addiction and overdose problems and to suggest recommendations. Also in 1999, the Rio Arriba County Commissioners formally declared that substance abuse in general and drug addiction in particular "has become an epidemic"

because combating it was consuming more than 20% of the County's annual budget (United States Senate, 1999, 48).

It is important to arrive at some conclusions regarding the nature of the confluence of conditions that have lead to this state of affairs in The Valley. The drug abuse there has reached epidemic proportions relative to the size of the population. What is worse, the epidemic appears to be inter-generational, and shows no evidence of diminution. The presenting epidemic appears to be unlike the drug abuse trends in the rest of the country which wax and wane. Here it continues to grow and encompasses a broader geographic area each year. In seventy years it appears to have spread from an epicenter of one small village across the entire Rio Arriba Valley -- from Santa Fe to Los Alamos, Rio Arriba, Sandoval, and Taos counties (IPR Strategic Business Information Database, 2001(a), 2001(b); ABA Report, 1999 Jacobs, 1999).

For example, the Valley has had the highest per capital heroin overdose and heroin usage rate of any region in the United States for most of the 1990s and 2000s, and traces the origins of heroin addiction to the 1930s. Pervasive conditions contribute to the inter-generational transmission of an extended familial drug culture. These issues appears to be culturally widespread and deep-seated (Reichelt, 2001; United States Senate,1999; Shaening and Associates, 1998).

As mentioned before, I conducted research in The Valley for eighteen months trying to understand the apparent epidemic and barriers to treatment (Willging, Trujillo, La Luz, 2004). We conducted hundreds of hours of interviews in the community with current and former users, as well as family members and service personnel. I have found startling implications. *My informal estimate is that approximately three out of every five people with whom I spoke were involved with drugs in some fashion* -- users and former users, family members of users or former users, or close relatives of users or former users. It was fascinating to me just how many people I came into contact with actually fit this profile -- librarians, nurses, service workers, school counselors, shop owners,

store clerks, teachers, waitresses, addiction counselors, general office staff, and clerical staff at social services agencies and elsewhere.

If my educated estimate is even close (it still needs to be independently verified), then, in a population of roughly 39,000 people in The Valley, some 60 percent of the population is involved with illicit drugs in some fashion. This number is staggering. Additionally, the majority of users and former users whom I interviewed had either experienced drug overdoses themselves, or had firsthand experience of overdoses of friends and/or relatives.

This estimation of massive illicit drug involvement in the Valley led me to examine the drug trafficking history. Of course, an exhaustive discussion of trafficking would be far beyond the scope of this chapter; however, since cocaine, heroin, and marijuana are the illicit substances of primary abuse in The Valley, outside of alcohol, they are covered throughout the paper, beginning with discussions covered below. However, I can at least show one tiny sliver of the picture, by briefly tracing the growth of heroin and cocaine trafficking, through history and through modern colonial routes to the Valley. To accomplish this, this chapter sets out to link New Mexico and world-trade.

The next section of this chapter gives a brief history of ancient and modern drug trafficking in Chiva and maria, with explanations of how the shift occurred from the Middle East, to Southeast Asia, and then to the New World. It also shows how coca spread from the Americas to its global prominence. Section three shows Mexico's central role in current patterns of drug trafficking to the United State, New Mexico, and The Valley. It delineates current ports of entry and major trafficking routes in the US and their ties to New Mexico. The local implications for the US and New Mexico of the North Atlantic Free Trade Agreement and the war on drugs' economic incentives and their effect on poor and minority peoples are examined. The last section concludes with the effects of the "war on drugs" internationally, but with an emphasis on local ramifications.

Brief History of Modern Drug Use and Trafficking

Entire tomes have been written on the history of each of the various illicit drugs -- cocaine, heroin, marijuana and others -- and on drug categories such as hallucinogens, and designer drugs. In the brief discussion that follows, only marijuana, opium, and cocaine are examine historically because they are the primary illicit drugs of choice in The Valley.

Ancient history

"Going to the corneta," has been around in one fashion or another for a long time. Feral and domesticated non-human animals have used fermented fruits and psychogenic plants since prehistory. It has been shown that even Neanderthals used drugs 50,000 years ago. The history of drug use and its trafficking indicates that ancient human cultures -- from the Incas to the Iroquois in the Americas and from the Mongol to the Zulu in the Old World -- have all had some type of drug use (Gahlinger, 2001).

The drug trinity of coca, marijuana, and opium has been around a very long time. Globally, illicit drugs are as ubiquitous as food, and often a great deal cheaper to obtain. Every country in the world has drug addicts and some type of drug trade. This is true now and seems to have been the case to a greater or lesser degree throughout all of recorded history (Gahlinger, 2001; Glynn, Hohm, and Stewart, 1996; McCoy,1991).

In the majority of ancient documented findings, drug use was primarily for mystic folk practices, and occasional recreational use. The association of drugs with health and illness is also as ancient as their use for religious and recreational purposes. Acute and pernicious addiction was rare, and virtually nonexistent in most ancient cultures. Widespread addiction appears to be a fairly modern phenomenon unknown before the Middle Ages. This appears to be the case even though addiction warnings about opium and other substances were recorded by medical providers as far back as 100 B.C. (Gahlinger, 2001; McCoy, 1991).

The beginning of a global drug trade

There are various types of records of drug use in ancient civilizations around the globe. These have been recorded on various media from stone carvings and pictographs to aural/oral histories and scrolls. All the modern nation-states of Africa, Asia, and Europe evidence antecedent use of marijuana and opium, and their export to the New World (with concomitant drug trafficking, trade, and legal consequences). Cocaine made a global appearance soon after global trade routes were established in the 1500s (Gahlinger, 2001; Glynn et al., 1996; McCoy, 1991).

Marijuana and hashish

Marijuana makes its appearance somewhere between 2700 and 1400 B.C. Records are found detailing marijuana's medical and recreational use in China and India. It was known as the "big numb" in China, and "bhang" in India. There are records of marijuana's use in the Veda, a holy Hindu text, and the earliest of the herbal encyclopedias in China compiled by Pen Tsao Ching. Hashish, the concentrated form of marijuana, records its appearance from around 100 A.D., both in China and the Middle East. Marijuana, as hemp, was used medicinally and for recreational purposes, as well as for clothing and ship sails. It is from the latter that the term "canvas" originates as a fabric made from "cannabis," and used exclusively for sails until the invention of the cotton gin around 1850 (Gahlinger, 2001, 33).

From China and India, marijuana and hashish had spread throughout Europe and Africa by the fifth century B.C. Then both became widespread in their medicinal, recreational, and religious use by the Middle Ages. Soon after, marijuana went into mass cultivation as hemp for clothing, paper, and rope in the Old World.

When marijuana was transplanted to North America it quickly expanded throughout all the Americas. It was first cultivated in large quantities in Canada and the United States in the 1700s by edicts of King James of England. Both George Washington and Thomas Jefferson "cultivated thousands of acres," with

Washington using it often to relieve dental pain. It was soon thereafter traded throughout all the Americas (Gahlinger, 2001, 33).

Marijuana remained in legal use in the US until 1937 when the US Congress passed the "Marihuana Tax Act" which indirectly led to the criminalization of cultivating or selling Marijuana. The legislation demanded that any grower, distributor or seller of marijuana pay a tax: One hundred dollars per ounce. It also imposed fines of $2,000 and or five year sentences on production and drove the selling of it underground, which in turn, created grounds for arrest and convictions (Gahlinger, 2001).

Opium and derivatives

The Greeks detailed medical use of opium as early as 500 B.C. The Romans recorded its use around 200 A.D., and records indicate its appearance in India and China around 900 A.D. (McCoy, 1991). Harvesting opium for the purposes of wholesale trade was first recorded around the1400s in China. The records indicated the harvesting practices used in Arabia by opium merchants. This type of planting and harvesting, which is employed in its ancient form even today, spread from the Middle East to southern Asia by the 1700s, then to southeast Asia by the early1800s, and finally to the Americas by the middle of the Nineteenth century. By the 1500s European traders had learned to capitalize on the sale of opium throughout the known commercial world, namely Asia, Asia-Minor (what is now know as the Middle East), Northern Africa, and Europe (McCoy,1991).

Portuguese and Dutch

Opium trafficking routes were firmly established along the spice trade routes by 100 B.C. These routes were between the Middle East, where it was grown and harvested (in Afghanistan, Iran, Pakistan and Turkey), and India and China. However, opium exports were packaged in the same quantities as other spices and herbs that were used for culinary, medicinal, and recreational purposes. That is, opium export was not a business unto itself until the early 1600s, when the Portuguese and Dutch discovered how lucrative it was to

conduct intra-Asian trade solely in opium. They soon established a trade that exceeded more than 50 tons a year. Huge quantities of opium were directly traded to China and the Southeast Asia. New poppy fields expeditiously sprouted in Southeast Asia to accommodate increased demand in Burma, Thailand, and Laos, known as the "golden triangle" -- (Glynn et al., 1996; McCoy, 1991).

Enter the British

During the British colonial period in the late 1700s the export of opium mushroomed globally. World demand expanded both in harvest and trade. The forceful insistence of the British Empire constrained China to become a mass consumer and producer of opium after it lost two wars to the British. To increase profits, Britain began massive export campaigns to Africa and the Americas (McCoy, 1991).

By the middle of the nineteenth century, opium, marijuana, and hashish could be found in every country in the world, and a new era had dawned for opium: The era of large scale demand and supply, and even larger profits and national addiction. The British Empire trafficking load grew from 15 tons in 1729 to more than 90,000 tons per year in 1900 (McCoy,1991).

The demand was made even greater by the synthesis of morphine in 1803 by Friedrich Sertürner, a German pharmacist assistant: it was named after the Greek god of dreams, the son of Hypnos, the god of sleep. Morphine use became rampant in the United States during and after the Civil War, particularly as a pain killer for the wounded and during surgery. It was estimated that over 400,000 veterans were addicted by the end of the Civil War. This pales in comparison to China which had more than 13.5 million by 1900, or more than three percent of its national population (Gahlinger, 2001; Glynn et al., 1996).

The synthesis of heroin (diacetylmorphine), first in 1874, and its mass production in 1898 by Bayer, the United States subsidiary of the German owned pharmaceutical corporation, soon surpassed morphine in its devastating effectiveness. Ironically, heroin, as with morphine before it, was developed to be

a less addictive substitute than its predecessor. Morphine for opium and heroin for morphine both proven to be even more addictive than its antecedent. At the time, morphine and heroin were as easy to secure as alcohol and aspirin, and cost far less than alcohol (Gahlinger, 2001; McCoy,1991).

Intravenous use helped solidify heroin's and morphine's place in both medicine and recreational use (Gahlinger, 2001). While apparatus for intravenous injection and infusion started being used as far back as 1670, the development of the syringe in 1853 by Charles Gabriel Pravaz and Alexander Wood, with a relatively fine needle that could easily pierce the skin and veins, made injections a routine matter in both medicine and the illicit drug trade (Bellis, 2001).

Cocaine

Sometime before 2500 B.C. the coca tree was domesticated for coca paste production by the Native Americans of the higher Andes Mountain range of what is now Latin America. The paste comes from mixing the pulverized coca leaves with a type of alkaline substance (originally sea shells) to allow absorption. Coca leaves became so important that they actually were used as a form of currency in inter-tribal trading throughout the Inca Empire. By the time the Spanish invaders came to the Americas in the late 1400s, coca had been cultivated into four distinct varieties and diffused throughout all of what is now south and lower Central America (Gahlinger, 2001).

However, despite its use by many Europeans in the Americas, chewing coca leaves did not catch on in the Old World until the mid 1800s, when three separate events telescoped it to prominence. In 1859, the coca leaf was extolled in a number of essays as an amazing physical stimulant by an Italian neurologist, Paolo Mantegazza, who was well read by other professionals. Second, in 1860, cocaine was isolated from the coca leaves by Albert Nieman, a German graduate student. Third, by 1884, Dr. Karl Koller started routinely using it for eye surgery, which standardized its use in the medical arena (Gahlinger, 2001).

Cocaine quickly became a routine additive to many foods, drinks, and medicines, including the soft drink Coca-Cola. Ironically, Coca-Cola was developed as a substitute for alcohol during Prohibition. In 1885, Parker-Davis began marketing a full line of cocaine concoctions -- cigarettes, sniffing powder, and injections. The list of dignitaries who were singing cocaine's praises in the late 1800s and 1900s was impressive -- Thomas Edison, Pope Leo XIII, Ulysses S. Grant, Sigmund Freud, Robert Louis Stevenson, and many, many more (Gahlinger, 2001).

The distribution and trafficking of coca or cocaine in the 1800s has been virtually impossible to trace, as has been the quantities, but it is currently estimated that the annual yield from South America alone is some 600 million pounds per year (Gahlinger, 2001).

The concerned commence

Even before the global mass distribution of opium propagated by the British, signs of problems with large scale usage of opium were becoming evident. Turkey banned the use of opium and hashish in the late 1500s. China followed suit in the mid 1700s and by early 1800 China had forbidden all imports of opium products. However, in 1858 after the Opium Wars, trade was initiated again (United Nations, 1965). In similar fashion, the deleterious effects of cocaine also soon came to light by the 1900s (Gahlinger, 2001).

By the end of the Nineteenth century most world governments acknowledged some type of problems with opium, marijuana, and cocaine, but few did anything about it. The first international attempt to enacting strict laws against the substances were mostly aimed at opium, particularly the action of the League of Nation's Hague Convention of 1912, which

> stipulated that the production and distribution of raw opium were to be controlled by law; that opium smoking was to be gradually suppressed; and that manufacture, sale and use of manufactured narcotic drugs (i.e., of morphine, other opiates and cocaine) *were to be limited by law exclusively to medical and "legitimate" needs* (emphasis added, United Nations, 1965, 13).

The League of Nations imposed further sanctions on the trafficking and manufacturing of controlled substances in 1925 and 1936, as did the United Nations, which in 1947 created the Commission on Narcotics Drugs which still exists today. In all cases, while the illicit trafficking of controlled substances was banned generally, it was allowed for medicinal purposes and at the discretion and control of each nation to enforce its own brand of justice (United Nations, 1965).

Current Patterns of Drug Trafficking

The Twentieth century -- between 1913 and 1970s -- saw a new swell of drug use and abuse. The widespread use of opium and cocaine derivatives, as well as the perfection of the hypodermic needle, dispersed these substances for both medicinal and recreational use. There was during this time a concomitant increase in addiction among soldiers coming home from several wars -- United States Civil War, World War I, Spanish American War, World War II, the Korean Conflict, and Vietnam. Many average citizens also succumbed to quotidian medical remedies, as well as supposed cures and prescription palliatives containing cocaine and opium derivatives (Gahlinger, 2001; Glynn et al., 1996; McCoy, 1991).

World trafficking

Despite the numerous League of Nations' and United Nations' conventions imposing strict protocols of international and national conduct, trafficking of cocaine, marijuana, opium and its derivatives, increased dramatically in the 1900s. By 1989, it was estimated that global consumption of illicit drugs had reached a staggering 500 billion dollars, equivalent to 25% of all the world's exports at that time (Duhalde, 1989).

While there had been some geographical shifts in growing, harvesting, and producing both opium and cocaine, the bulk of these products remained in their places of origin. Most of the world's opium is still produced in the Middle East and Southeast Asia with exports from these areas now reaching well into the billions of dollars per month (UN Chronicle, 1998).

Mexico became one of the larger producers of heroin for the western United States. There appears to have been some unsuccessful attempts to grow coca in regions of the world other than Latin and Central America (UN Chronicle, 1998). However, Latin American countries (including Mexico) retain their world dominance in coca production (Gahlinger, 2001; IPR, 2001(a), 2001(b); ABA Report, 1999; Glynn et al., 1996; McCoy,1991).

The United States

Most of the white powdered heroin that is marketed on the East and West coasts of the United States still originates in the Middle East and Southeast Asia. However, South and Central America, and Mexico, have produced white powdered heroin since the 1970s and this furnishes the bulk of the heroin supplies to the Southeast United States, as well producing virtually all the cocaine that is sold into the United States. Mexico has become the largest producer of Black Tar heroin in the world, eclipsing powdered heroin in many parts of the Southwest, particularly in New Mexico (La Luz, 2002; Gahlinger, 2001; McCoy,1991).

The Republic of Mexico

"Marijuana is now the largest cash crop in the United States" (Gahlinger, 2001, 173). These drugs account for the largest portion of any single type of drug consumed in the United States. Virtually all the marijuana and derivatives that are sold in the United States are produced locally, or in Mexico (BEW, 2002).

Marijuana is not the only illicit cash crop grown in Mexico for export. Mexico had been a port of entry for many illicit drugs to the United States since the mid to late 1800s. The border was big enough that it made for easy smuggling by syndicates from all over the world (Recio, 2002; Toro, 1995).

At the dawn of the twentieth century, opium addiction in United States population was three percent (Recio, 2002). This, coupled with the temperance movement, made smuggling lucrative, particularly through Mexico's Northwest Territory -- what is now the states of Baja California del Norte, and Baja

California del Sur, Sonora, Chihuahua, and Sinaloa -- which were a kind of no-man's land.

The Harrison Act which was passed in 1914 and made smuggling into the United States, illicit drugs – opium and its derivatives, and cocaine, and marijuana, but the latter was later removed as not habit forming (Gahlinger, 2001). If the Harrison Act made it fairly lucrative to sell these products on the black market, then the Volstead Act (Title I. to Provide for the Enforcement of War Prohibition, 1920) imposed the prohibition on intoxicating beverages and made it became exceedingly profitable because it paved the way for wholesale creation of smuggling syndicates and routes that would prove long lasting and important to drug trafficking between Mexico and the United States (Recio, 2002).

> "Total prohibition [of alcohol] created black markets worth millions of dollars, and the long border... encouraged the expansion of liquor and narcotics markets on the Mexican side" (Recio, 2002, 47).

If the Volstead Act made it highly lucrative to smuggle narcotics, by 1920 the subsequent administrative and court rulings to the Harrison Act, which imposed a total ban on some drugs and handed a virtual monopoly to the medical industrial complex to prescribe drugs, made it lucrative to actually start growing, planting, and harvesting the raw materials in Mexico. Poppy fields sprung up all over the countryside of northern Mexico (Recio, 2002).

There seems to be some historical disagreement as to who actually started the growing of poppy fields in Mexico. Toro (1991) and Friedman (1999), attribute it to a group of Chinese immigrants, while Recio (2002) claims that it was Mexican nationals, and that while "a group of Chinese" (p39) made an attempt, they were arrested. Regardless of who began the planting, it appears to be a fact that by 1930, at the end of Prohibition, opium poppies were being successfully grown in the states of Sonora, Sinaloa, Nayarit, Chihuahua, and Durango. About 30 percent of all the opium and heroin that entered the United States that year, (and much of the marijuana provided to the west), came from Mexican fields (Recio, 2002;Toro, 1991).

Mexico currently spends about one third of its entire defense budget on the war on drugs, and the attorney general's annual budget loses 55 percent of its budget to this same cause. Despite that, while many of the fields have been destroyed, many more are planted. *Perhaps the greatest lesson to be gleaned from all this is that the prohibition of a commodity in one country without a concomitant reduction in demand, can make it very lucrative for another country to grow and export that commodity.* As a direct consequence,

> ...what emerges as striking is the longevity of Mexican drug channels. The Mexican states that now play an important role in drug trafficking began their activities in this trade around 1916. The northwestern states of Mexico have approximately ninety years' experience in developing and improving channels to distribute drugs into the United States (Recio, 2002, 42).

Nuevo Mexico

Mexico supplies virtually all the marijuana and opium and cocaine derivatives that are sold in New Mexico. While marijuana accounts for the largest portion of any single type of illicit drug consumed in New Mexico, heroin and cocaine are the most lucrative for traffickers, though there appears to be a marked increase in the use and distribution of amphetamines and other designer drugs (La Luz, 2002).

Drug trafficking through land ports of entry (POE's), across the New Mexico-Mexico border, is a serious problem in New Mexico. There are three main POE's on New Mexico's 180-mile border with Mexico: Antelope Wells, Columbus, and Santa Teresa. The busiest of these is Columbus, the only one that is open and staffed 24 hours a day. Three major interstates -- 10, 25, and 40 -- as well as various secondary roads, connect these three POE's to major cities in New Mexico and other cities in the United States. El Paso, Texas, and Ciudad Juarez, Mexico, both major POE's, are within 15 miles of New Mexico's southeast border. Its proximity to Mexico and its topography, which is mostly high desert and barren mountainous regions, makes New Mexico vulnerable to drug smuggling. The topography gives easy access to Mexican criminal

organizations and drug trafficking organizations (DTO's) which take advantage of sparsely populated topography to smuggle drugs by air and land (La Luz, 2002).

Currently, the Mexican DTO's and criminal organizations are the primary wholesalers of mid-level distribution of heroin and cocaine. Outlaw motorcycle gangs (OMG), prison and street gangs, and local family groups, are involved in the distribution of drugs at the retail level. The Bandidos Motorcycle Club, with headquarters in Las Cruces, is the OMG most involved in retail drug trafficking and maintains chapters in Alamogordo, Albuquerque, Santa Fe, Taos, and other areas in New Mexico (La Luz, 2002).

The Valley

New Mexico appears to be an epicenter of drug distribution for areas to the north -- Colorado, Utah, Idaho, Montana, and Wyoming -- and to the east -- Oklahoma, Nebraska, and even into Illinois and Iowa (La Luz, 2002). The Valley appears to have played a significant part in this distribution process for about seventy years, but the exact role is unclear at this time. There is some speculation that the large number of overdoses in the area may be due to the nature of the dilution process used in trafficking and distributing large quantities of heroin. "Testing" of the drugs once they have been "stepped on" (diluted with other substances to increase volume for sales), may cause overdoses because no one is sure of the potency until an addict injects it and testifies to how potent or poor the mixture may be.

It is my observation, that while there have been several large drug sweeps of the area resulting in the arrest of comparatively large numbers of people, the trade in narcotics seems to go on unabated. For example, in two recent sweeps some 60 people were arrested, mostly from two families. Nothing seems to deter the trafficking to and from The Valley.

Family distribution and sales networks seem to be the pattern in The Valley. It is my experience, from first-hand experience as well as interviews with principal respondents, that most narcotics in the area are sold within family distribution groups. One of the informants, a young woman, told me that she

deals to support her family and pay her way through school. She was quick to tell me that she is an exception, that her "friend" (a male companion I have also met who is about twice her age), allows her to deal "through" his family, because she has always been close to them and they know she would not give them up (identify them to authorities).

Interestingly enough, she expects to be caught eventually, but feels it is worth the risk to traffic in heroin, because there is no other way she could earn the kind of money she needs to support her family and go to school. She is so convinced that she will eventually get caught that she has already transferred legal custody of her only child to her mother, who is a retiree from a United States research laboratory.

In another interview I conducted, I interviewed the family of a heroin addict who is currently incarcerated, having been turned in by his parents because he broke into their house while they were on vacation. This was one of many times he had robbed from them. The father and mother informed me that the son had begun using because the father's cousin, who lived around the corner in their family complex, had dealt heroin to the son. The cousin, the father informed me, had also dealt for and to many of the family members in the complex, particularly the father's brother who was still hooked. The father had also been a heavy alcohol drinker and pot smoker when he was younger.

In two other interviews I gleaned that two grandmothers in two separate families were the family "dealer." That is, they would purchase the heroin and distribute it within the family to keep harmony and not allow the males to fight over it. No women in the family were hooked, but there were several generations using.

There are numerous newspaper articles which speak to the drug situation in The Valley, but I have not found any peer reviewed journal articles or books. I have read one unpublished paper (Friedman, 1999) on the subject, but it is almost entirely based on newspaper accounts and unverifiable sources.

Perhaps the writing of our research team will shed some light on these questions and provide some scientific direction for future research.

World market stability

Crude oil accounts for less than 10% of the world's annual exports, and yet a disturbance in the delivery system, or a decrease or increase in world production can have catastrophic effects on world markets. While it is true that in part this domino effect in crude oil price variations is partly due to its influence on many other areas of the world economy such as home energy, automobile and airline fuel, and plastics production, it is nonetheless true that the net effect is one of profit and loss driven by supply and demand, whatever the underlying causes.

Similarly, it must be understood that fluctuations in the production of illicit drugs would have similar global impacts because of the sheer volume of money generated by this sector of the world economy (Young Kim, et al., 2000). As mentioned before, in 1989 illicit narcotics trafficking and its concomitant subsidiaries, accounted for 25% of the world market exports (Duhalde, 1989). Currently the global “trade of black market drugs is estimated to be about $400 billion per year, or about 8% of the entire global economy" (Gahlinger, 2001, 176).

Consequently, the war on drugs, which has concentrated its devices on reducing supplies of illicit drugs and has done virtually nothing to decrease the demand, has driven the prices of drugs to all time highs, increasing "the prices of marijuana, cocaine, and heroin ...about 100 times more than they would be in a free economy" (Gahlinger, 2001, 173).

It is estimated that in a single successful trip from Latin America to the United States with a modest amount of drugs, a carrier nets more than s/he could earn in an entire lifetime of legal work (Gahlinger, 2001). In the United States, for example, a modest drug operation employs hundreds of people, mostly adolescents that would not otherwise find employment in inner city economies. While most of this employment is, contrary to popular belief, not very lucrative for

the average street vendor in the underground drug economy, the work is steady and provides a safety net that otherwise would not exist for these young men and their families (Young et al., 2000).

North American Free Trade Agreement

North American Free Trade Agreement (NAFTA), which was enacted in 1994, has caused an imbalance in trade in a number of ways (*an unforeseen and unreported side effect may be a contribution to the rise in heroin addicts in the state of New Mexico)*. NAFTA's legal benefits have accrued largely to the countries of greater wealth so that there has been a demonstrable income increase for the wealthy businesses of the countries involved, with a concomitant gap in the distribution of wealth. That is, under NAFTA, the wealthier have become wealthier and the poorer have become even more poor (Young Kim, 2000, et al., 2000).

The drug traffic issue is no exception. The implementation of NAFTA in 1994 has dramatically increased cross-border traffic at POE's along the southwest border: Cross-border commercial truck traffic has increased 170 percent. New Mexico's POE's are no exception. From 1999 to 2000, commercial vehicle traffic increased 30 percent at the Santa Teresa POE, located south of Las Cruces, and 1 percent at the Columbus POE. Drug traffickers have taken advantage of this increase. Both private and commercial vehicles are commonly used to smuggle drugs into the State. "Shotgunning" is one transport method that involves the division of large quantities of drugs into several smaller shipments that are sent at approximately the same time to the same POE. Thus, even if law enforcement officers stop one or two vehicles, most shipments will still reach their target destination. A similar technique involves use of "sacrificial" vehicles, which smugglers expect law enforcement personnel to stop and seize. As attention is focused on the seized vehicle, others pass through the POE without an intensive inspection (La Luz, 2002).

Cargo and passenger rail lines are also used to transport illegal drugs into New Mexico. Authorities have found false compartments in grain cars, concrete

hoppers, and boxcars. Seizures have been made from both passenger and freight trains. Mail and parcel delivery services are another mode used by Mexican DTO's and criminal groups to transport cocaine, methamphetamine, heroin, and marijuana from Mexico into and through New Mexico (La Luz, 2002).

The increase in New Mexico of heroin use beginning in 1995, and the even greater increase of heroin overdose, coincide rather well with the implementation of NAFTA a year before. I do not think that is a coincidence: there is ample evidence in the literature that shows addiction increases in areas that are a center for distribution (Carnwath and Smith, 2002; Gahlinger, 2001; Booth, 1996; McCoy, 1991; Trebach1982). So it may certainly follow that the massive increase in heroin across the New Mexico border probably had the effect of increasing the usage locally. This is theory well worth future investigation.

Concluding the Trek

This chapter has laid out the basic framework concerning illicit drug trafficking historically and in particular from Mexico to and through New Mexico. In particular, it begins to delineate these issues in relationship to the transport of cocaine, heroin, and marijuana to, and through, the Valley.

I show that the majority of illicit drugs that enter the United States come from old and established points of origin -- the Middle East and Southeast Asia for heroin, and Colombia and Peru for cocaine. However, the majority of heroin and a large portion of the cocaine that enters the southwestern United States, and particularly New Mexico, come from Mexico. Marijuana appears to be either homegrown or mostly imported from Mexico.

I have also shown here the impact that U S policy has had on the birth and growth of illicit drug trafficking in the United States. I believe it is fair to say that if it had not been for the United States government, we might not have as great a drug problem in the United States. Both the government’s complicity in the past and their current war on drugs have served to exacerbate the situation.

The valley

Concerning The Valley specifically, I find it of paramount importance that the birth of a heroin addiction appears to coincide with the initial blossoming growth of opium poppies in Mexico during the 1930s. This is an interesting finding and one that bears further investigation: this may account for the speculation that The Valley has been a distribution hub for Mexican trafficking of heroin, and is increasingly a hub for Mexican cocaine trafficking. This may also account for the seemingly entrenchment of a widespread subrosa drug culture and drug fueled economy in the Valley.

In the 1930s New Mexico was a sparsely populated state, mostly populated by farmers, miners, and sheep herders. The United States military took an acute interest in New Mexico for its nuclear program precisely because it was so isolated. However, this very fact also made an easy place through which to transport the new illicit products of Mexico.

The culture of heroin addiction has been around The Valley for some 70 years, and has become commonplace and may have achieved a de facto acceptance by the general public. While most of the residents of The Valley are decent, honest, and hard working, most have become embroiled with the drug culture in some fashion. Whether they are "involved" because a family member is addicted or selling, or because the underground economy that thrives on the movement of illicit drug dollars forces them into its use by dint of the lack of a legitimate quotidian open market place, it appears from my interviews, field work, and participant observations that most are "involved" in one way or another.

In the following chapter I take the subject matter from the general to the specific. I contextualize the landscape, the people and the epidemic in specific relief and contrast by sharing the interviews I had with friends, family members, and the general public.

CHAPTER V: CONTEXT, DENIAL, DEATH, ACCEPTANCE: WALKING THROUGH THE CHIVA MILIEU

> My own grandmother regulated distribution of the Chiva to the jefitos in the family. Once grandmother died, the family split down the middle. The drug side stayed together and the alcoholics went a different way. Some of the alcoholics, like my dad, made it and so we kids did okay. But the drug side mostly went to jail and still do it. They no longer even talk to each other." (Ms. F, High School Social Worker, in her 30s)

Introduction: Contextualizing the Minefields

Ms. F., a “Hispana” who had lived all her life in the Valley, was one of the social workers at the high school. Her narrative was typical of many I heard from others during the years of being in the Valley. She told me that drugs were a problem all throughout the Northern area. Places like Dixon, Terra Amarilla, and many others, were all being affected negatively. She said that Chiva was everywhere. Ms. F. typified the ubiquitous ethos that permeated the region concerning the substance abuse scene in the Valley which wrapped around and interwove through the principal respondents' reports and case histories like a tape worm. Substance abuse (including alcohol) in the Valley, in this high desert, arid environment with the attitudes of blind religious acceptance, denial and stoicism, all have served to enshrine the overdose epidemic and create a type of verbal minefield that one must maneuver with extreme care or run the risk of getting hurt or even killed.

This chapter explores the contextual factors – landscape, cultural milieu, interpersonal outlooks, and attitudes – towards the substance abuse issues generally, but more specifically the epidemic of “accidental drug overdoses,” though the narratives of 40 interviews with family members of the substance abusers, and with professional – counselors, nurses, program and hospital administrators, teachers – as well as “man in the street” encounters. What I do in the following pages is what,

> “The ethnographer as author must *represent* the particular world he has studied (or some slice or quality of it) for readers who lack direct

acquaintance with it" (emphasis original; Emerson, Fretz, and Shaw, 1995, 169).

The milieu that I observed is emblematic of anomie that "results from man's activity's (sic) lacking regulation and his consequent sufferings" (Durkheim 1967/1897, 258). An anomie brought about by community alienation and personal trauma underpinned by cultural / historical trauma. The Valley is also marked by intergenerational addiction, hopelessness, and the type of resignation that one reads about in clinical case histories of people that have lost hope. I postulate this same anomie as being brought about by community alienation and that coupled with Street-Level Trauma (SLT) and cultural / historical trauma may lead to Cultural-post traumatic stress disorder (C-PTSD), as explained before.

General Context: Deep Contradictions

As I have mentioned before, I am no stranger to the Valley formally; for the past three years (2006 to 2009) I have lived in Rio Arriba County, the heart of the study area. Before that I interacted with the people, programs, and services from April 2002 to December 2003 for the Willging at al. study (2003), but I continued my association with the area off and on until recently. Altogether I have spent a great deal of time in the Valley for the last eight years.

In these eight years I have come to know something of the area's unique cultural milieu, its desiccated desert geography, its pre-colonial, colonial, hostage, and modern history, its variegate ethnic makeup, and its consumptive addictions, particularly the nationally recognized high rates of heroin addiction and substances induced overdoses in the area.

In this context, it is striking to note the number of drug and alcohol treatment programs in the Valley. For such a relatively small area, there were six or seven drug and alcohol treatment programs in Española alone. Several have come and gone since 2002, and the ones that seemed to last the longest are the ones opened and operated by the local churches.

Acquiescence, Acceptance, or Fatalism?

In spite of what many of the drug and alcohol program administrators said, in general, I found in the area acceptance of drugs and the drug use so prevalent by the general population that it was unlike anything I had experienced in fifty some years of dealing with drugs scenes. As an addict, as a public official, and as a program director myself, I had not encountered anything like what I found there. Nowhere else in the United States had I encountered this level of drug overdose death, nor did it resemble anything I had read about in the literature.

I perceived a deep contradiction in the general attitude towards drugs and addiction. On the one hand, I discovered pride and condoning in the user population and even in some of their family members, in regard to their drug use. Simultaneously, I encountered abhorrence and condemnation of drug use in all of its facets in the general population and even amongst the same people who exhibited the initial pride and condoning. There was a concomitant fatalism or stoicism about the entire issue of drugs use which permeated every facet of daily life in the Valley. There was a tergiversation between the two moral and ethical positions that was perplexing, but a social fact nonetheless.

Marijuana and alcohol were so widespread, they were not considered to be much of a problem except by some of the authorities and a few community members. Both seemed to be accepted as a "normal" part of the Hispano lifestyle. Occasional use of heroin called “chipping” or of cocaine, and prescription drugs, was virtually accepted as "normal" by a large segment of the population. I would often hear people say (and I paraphrase a composite here): everybody uses something some time. A little of this or a little of that, not in excess, ain't too bad. As long as they can be men about it (no one ever mentioned a female) and control it and not get hooked, there is really not much of a problem. It's only those people who don't know how to hold their liquor or *polvito* (little powder meaning heroin or cocaine) who are the problem and end up dead.

Home Delivered Drugs: Blindness, Complicity, or Stoic Resignation

While I devote an entire section of Chapter IV to trafficking, it is important to make a general contextual or milieu-related observation here. Despite occasional arrests, the trafficking was done openly, in the most capitalistic of ways, and seemed to be done with oblique condoning. So much so, that the authorities seemed to be either blind, complicit, or stoically resigned to the ever present existence of the drugs in their respective communities. This region is one of the few places where I have studied this topic or lived, where anyone can have drugs delivered to their home by simply making a telephone call to the *corneta* (the heroin seller). Every other place I have examined the drug scene, or where I have been in the drug scene, home delivery of illicit drugs was a privilege reserved for the wealthy or well known athletes and rock stars. In the Valley it was a commonplace occurrence.

Pride and Prejudice: College Students' Public Confessions

There was another disconcerting factor. In virtually all classes I taught over a seven year period at the University of New Mexico, when I mentioned my dissertation research topic, there would be one or two (sometimes more) students in the class from north central New Mexico who would tell of cousins, uncles, brother, fathers, grandfathers, and even mothers, sister, and grandmothers who were heroin addicts or had died from overdose. I found it astounding that they spoke of it in a rather matter-of-fact, unabashed, or unembarrassed manner, many times in front of an entire class. When I first noticed this phenomenon, I attempted to truncate what they were going to say because I did not want them to reveal such personal details in front of the class. However, it soon became apparent to me that some students had a compelling need to be heard about the problem. Others students seemed actually proud that they were part of the drug scene. Almost as if there was some pride associated with coming from that area that had so many drug deaths.

I was quite shaken both in terms of what I learned about drugs in the area, and in terms of working with academicians, State health bureaucrats, and politicians. Amongst the latter three groups I found an appalling ignorance of what was actually going on despite the many years that the drug problems had existed in the area. At least I would like to believe that it was ignorance. If it was not ignorance, then it would have to be, at best, purposeful denial, and at worst, complicity for self-aggrandizement.

Hegemonic Approaches to Addiction: Or Leaders Without a Clue

Besides the participant observation and the interviewing of drug addicts that were mostly still using (many in combination with their methadone program and taking other prescription medications), I also interviewed a large number of other people in the area. I talked with nurses, school counselors, social service providers, and administrators, with hospital administrators and hegemonic medical treatment providers (western medicine practitioners most of whom believe in the veracity of averages and singular disease production agents), with social workers, socialites, and family members of addicts. I also had extensive conversations with waitresses and busboys, motel desk clerks, cleaning staff, security guards, casino workers, store clerks, auto mechanics, store keepers, and restaurant owners. I visited with local, county, state, and federal politicians and bureaucrats; with writers, religious workers, street workers, other college students; and with a number of ex-users involved in treatment programs and other venues who did not want to be identified with the drug scene, or as ex-users. I came away from the experience quite shaken, as my interview below shows.

Hospital Administrator: Denying the Obvious

An excellent example of this was my interview with the local hospital administrator.

I arrived at the hospital at 2:45 p.m., announced myself to the reception staff, and waited in the "business office" lobby. The business lobby is set off from the main lobby by two large doors which appear always to be held open.

There was a large family (in both senses of the word “large”) in the waiting room. Waiting rooms in most hospitals in New Mexico are poorly designed after the hegemonic model of predominantly White areas. They are inadequate for a quintessentially familial culture: when one member of the family goes to the emergency room, the entire family goes; and if it is *abuela y abuelo*, (grandmother and grandfather) the room can be three to four generations deep. Most waiting rooms are badly overcrowded, as this one was, with family members waiting to hear results about their family members.

I waited for about 15 minutes and then a young woman came through the main lobby doors, and asked me if I was waiting to see Ms. R, one of the few top-level women executives in the area. She was a “Hispanic” who did not refer to herself as a Hispana/o. I answered that I was and she took me to Ms. R's office. It seemed pretentious to me to send a secretary to fetch me when she could have come herself. We exchanged names and a handshake, she waved me into a chair and said, "Well, now what's this about, I only have about 15 minutes to give you. I am very busy." (She put me in mind of the Queen of hearts in Alice and Wonderland with her haughty attitude and impatient greeting. I would have only been slightly surprised if she had said “off with his head!”)

I thanked her and told her about the study, the name of the principal investigator (PI) and who was funding the research study. I did not expressly say anything about overdoses because she had been so negative about the topic on the telephone when I attempted to secure the interview. So I tried to engage her in a conversation about the study itself. Despite that, the very first thing she said was,

> "First of all, you have to realize that it's a negative media frenzy. They have blown this [drug problem] out of proportion. You'd think that there were no decent people in this town the way they make it sound. Not everyone around here is a drug addict! Most [of the drug addicts] are not from here. They are brought here from other areas with overdoses. It's just the news media blowing it all up.... Unfortunately it has been made into a sensational situation; an attraction-type sensational situation. For each OD we see, we see a 100 people here for legitimate medical

reasons. Unfortunately we have gotten a bad rap. It breaks my heart to see all the negative media attention."

I mentioned to her the prevalence rates for heroin overdoses in NCNM in comparison to the US rates in general. At the time they were roughly 48 per 100,000 versus 5 per 100,000 respectively. I asked her if she thought the Valley's rates were average compared to the national ones, or if she thought they were fabricated by the news media. She told me that the statistics were probably accurate, but that they were just over-reported too, making it sound like a bigger problem than it was.

"It's not just a heroin problem, you know. It's a poly-drug problem. The people we're seeing in the ER with overdoses have a number of substances in their blood systems, including substances like barbiturates, other opiates, cocaine, marijuana, methadone, Valium, and almost always high levels of alcohol."

I asked about ages and sex of those that overdosed. She said they tended to be males of all ages, but mostly older -- over twenty-five and some in their forties and fifties -- but a few were adolescents.

"This is a multi-diagnosis problem that includes behavioral health, and drug and alcohol addiction. But around here they treat it as if it was only one thing or another of these. As if it was one kind of problem. Maybe talk to Amistad or Ayudante [treatment programs] and see what I mean. The other thing is that all of them want to do outpatient rehabilitation, when what these people need is inpatient treatment. They also need to start sooner taking adolescents in. They need to include the entire family; from child to grown-up."

I asked about the procedure when an overdose comes into the emergency room. She said that doctors generally have an idea of what kind of overdose it is. They do a complete assessment, a full immediate screening including blood gases and other tests, an entire triage, and give Naloxone [4] where appropriate,

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[4] Naloxone is a drug which literally stops the effects of an opioid overdose (including heroin, morphine, methadone, etc.). Its pharmaceutical name is Naloxone and is also marketed under the trade names of Nalone, and Narcanti.

but Naloxone is only good for opioids. For other drugs they have to do other things; which she did not go into despite my request for her to do so.

Public Health Officials: Ignorance in a Lab Coat

In meeting with several public health officials of high rank, I was astounded at their ignorance of both the drug scene and more at the attributions they made about the drug overdose deaths. Several actually pointed out that the most probable cause of the drug overdoses was that people were killing each other by injecting rivals or people that owed them money with large quantities of heroin. When I pointed out that in most cases where a dealer or a rival wishes to kill someone it is much simpler and less costly to simply doctor a small amount of heroin with battery acid or rat poison, a practice I personally observed in other regions of the country.

The High School Visit: An Adventure in Contextual Drug Realism

The high school sits on a high plateau east of Española, north of Santa Cruz, and northwest of Chimayo. It is a prime feeder for the addiction population. With rare exception my principal respondents had virtually all passed through the high school. Some had actually finished, and most had started using drugs during the same years they were attending high school. I visited the high school to talk to a number of people -- school nurse, counselors, and teachers. I was taken there by Ms. M, a Hispana nurse and psychiatric social worker who worked at the hospital.

The Nurse from the Emergency Room: Power and Knowledge

When I visited one of the high schools in north central New Mexico, the first person I was introduced to, by my escort who was a local Hispana social worker, was Ms. A., ironically, the nurse heading up the urgent care unit at the local hospital. I asked her what she was doing at the high school. She said she came to the school once a week to teach Child and Family Network Planning classes because pregnancy rates were so high and also so many of the girls already had children. She stepped out of the classroom long enough to speak to me for a few minutes, gave me the doctor's name who ran the emergency

department (whom I did not ever get to interview), and she said that she would be very happy to visit with me about the situation in NCNM and particularly the overdoses.

She said she thought that a large part of the problem was over prescribing by a number of physicians in town, particularly one who had a peculiar theory on prescribing for abusive spouses. She said that particular doctor believed that if he kept heroin addicts supplied with narcotics, they would not beat up their wives, and might actually settle down and kick the heroin habit, and that the husbands were much better off on prescription drugs which were relatively cheap, than on heroin. The nurse excused herself and went back into the classroom.

School Teacher: Helping the Pregnant Graduate

I met Ms. C, who was, from her appearance, countenance, and accent, apparently a Hispana, but had an Anglo maiden name. She ran a program for mothers-to-be and students with children. The girls in her program are taught parenting skills and are helped to stay in school through graduation. Many go on to college. "I'm doing this because my kids all grew up and I didn't know what to do with myself, so I went back to school and became a teacher. I really love doing this. It helps the girls so much!" She didn't appear to be old enough to have children that were "grown and gone." She appeared to me to be in her mid 30s. She walked out before I could tell her about our study and ask her opinion on the matter of early addiction related to "my girls" or their impregnators or boyfriends.

Another Nurse: Foreboding and Futility at the Drug Scene Contradictions

She was an older white haired Latina, who Ms. M introduced as Ms. D, a Hispana nurse practitioner who operated the clinic in the school for the pediatrics and adolescents program. She helped those pregnant women who stayed, or came back to school after giving birth. She helped them with their children and

answered their medical questions. I told her about our study and asked her opinion regarding the topic in general and in the High School in particular.

Her response was thick with a sense of foreboding and futility that seemed to accompany many of the responses from the other professionals. It mirrored the others' responses in pointing out many of the contradictions inherent in such a disorganized and inchoate system of treatment delivery. She told me that she felt that

> "Most of the programs around here -- Hoy, Rio Grand Center -- don't really want to treat them [the addicts], because they put so many obstacles in their way. In most places they cannot go unless they go to detox first! Ridiculous! They expect these poor jovenes (youngsters) to go to detox, stay clean for as much as two weeks and then go into treatment. Detox should be part of treatment not separate from it. Are they Crazy! And even when they have the fortitude to do that, they find it hard to get in. They have to have insurance, or some way to pay. We all know that if an addict has to choose between stealing for a fix or stealing for treatment, they will always choose a fix! We need insurance that covers these people. If not, we aren't going to beat this problem. Also, most of these programs demand a full physical be performed before the person can be admitted for treatment! That's ridiculous! Why can't they provide the physical at the time of intake! It's like these people are throwaways: no insurance, no money to pay for treatment, no money to pay for physicals. AND if we manage to get them into some hospital for detox, they finish their detox and are sent right back to the streets. We need to look at new ways, perhaps alternative medicines like acupuncture: my son had a heroin habit and he is doing much better since he had acupuncture treatments. I also think that we need to start treatment in High School. If it were up to me I would have a treatment center in the school. But I guess the law prohibits that. So what we should do is have treatment as an elective course offering that kids could get credit for in high school. I would do it just the same way we do other electives."

The Families: Seemingly Blameless and Helpless

I met and interviewed several non-using family members -- a sister and mother of one active heroin addict, a mother and father of another, and sisters, cousins and brothers of yet other active heroin addicts. Their stories were poignant and many times tearful. Few family members, particularly parents, accepted or attributed any blame to anything they themselves may have contributed to the problem's origin, though many demonstrated oblique

complicity, or even active involvement in the addiction careers of their children. However, all were desirous of having their loved one rid of what most of them considered a disease, their addiction.

In this regard, the cases I present here are typical of the other family members I interviewed. To present more would be redundant and not any more productive or illustrative, so I start with Dulzura. At the time of the research, she was the older sister and daughter of two active heroin addicts.

Double the Tears and Pain: A Sister and Daughter

Dulzura first approached me several semesters after she had taken an Introduction to Sociology class with me. She had heard about the research I was doing in the Valley, and wanted to talk to me: she wanted to know if I could help her brother. I told her about the study I was doing and she agreed to be interviewed. On May 15, 2002, I interviewed her in my car and at one of the more popular restaurants (where she had not ever been before), for several hours. At first it surprised me that she had not ever been to this restaurant because it was a hangout for students about her age. In retrospect, this drove home the point to me that many of the students who had spoken to me about the drug problem in the Valley appeared to be quite diffident, and spoke of going back and forth between UNM and home almost daily. They seemed rather isolated from the other students and often stayed either alone or only with other Valley students.

Dulzura and I met at the intersection of Yale and Redondo Drive on the UNM Campus around noon. She was on time, I was anxious that I would not recognize her. I was right. If she had not come up to the car I would not have known who she was. She looked to be pretty young, a Latina women in her 20s. She had on faded blue jeans and a matching blue, short sleeve v-neck sweaterwith white buttons down the front. She flashed a nervous, but very pleasant smile.

We exchanged greetings and I asked her if a particular eating place was all right with her or if she had another preference. She said it would be fine, that any place would be good: "I haven't been there," she said.

We exchanged small talk about school on the 20 or so block drive to the restaurant. I asked about her semester; she said she was only going part-time and the semester went well. She asked how mine went and we spoke about class a little. She seemed nervous, but not scared. She did not look in my direction, but instead stared straight ahead the entire time we drove to the restaurant. When we arrived I parallel parked and she expressed that she would still be there because she had trouble parking "like that." I had her go inside and save a place in line while I fed the meter five quarters.

I walked in and she immediately asked me "What is all that?" pointing at the wall menu, "What's good here? I haven't been here before." She seemed uncomfortable. I assured her that, at least the chicken and vegetables plates were good, as I had tried most. She ordered a small hamburger. When I looked at her I noticed she was as tall as me. I looked down to see if she had heels on. She did not, but her white sneakers had an inch platform. I could not help noticing, as I looked at her, that she had several piercings on one ear but not on the other.

I paid, though she had taken her money out of her wallet to pay for herself, and we went to sit in the upper corner of the restaurant. I got up and retrieved straws for our pop, and she thanked me. I also noticed that her burger had come plain, without garnishes so I asked her if she wanted them before the server left. She said she did, looking at him, I repeated her request and he moved away.

I had asked her over the telephone if I could take notes and/or bring a tape recorder. Without hesitation she had given me permission to do so. I was going to ask her again now when I noticed it was already on. I must have banged it on in transit. I apologized to her, explained what I thought had happened, and asked her again if it was okay with her if I recorded our talk. She replied that it was okay for me to do so. I tried to make the tape recorder as

inconspicuous as possible by putting it out of her direct line of vision, but about half way through the talk I knocked it over. I restarted it wrong and it played back a cacophony of noises, so I just turned it off.

I thought she might feel more comfortable if I refreshed her memory about my background which I share with students in order to demonstrate to them that if I have made it with all this against me, they can do anything they reasonably want to do. I asked her if she remembered that I was a *pinto* (one who has been in prison) and an “x-*tecato*” (former drug addict). She nodded her head and said with rather uncharacteristic forcefulness, "Sure, I remember!" I asked her to tell me about her work on campus, I thought this might put her at ease. She told me she worked for an office at UNM: The job ends the Friday after the interview, and then she would start at a Boys and Girls Club in one of the Pueblos around Española. "They’re actually going to pay me to have fun with the kids!" I then asked her if she would like to tell me about her brother, or her family, or her community. She nodded her head.

"My mom and dad got divorced a long time ago... I don't know much about my father."

"Is he in the area?”

"No, I have no idea where he is. My mom brought us up."

"How many of you are there, do you have other brothers and sisters?"

"There're four of us, me, my brother, and two sisters."

On prompting from me she told me that one sister was a junior in high school, and one was at home with cerebral palsy from birth. Her mother "cleaned house" to support all of them and received some Social Security Insurance. Dulzura’s father stopped helping a long time ago, though her mother, who was 45 years old at the time of the interview, got the house in the divorce. I asked if many people she knew owned their own home and she said almost everybody she knew owned their own home. They have been in the area many generations, but she was not sure how long.

Dulzura’s mother’s maiden name was the same as her dad’s family name, but her mother’s family came from Española, while his grandfather came from “T.A.” (Tierra Amarilla), which I misheard and said "Terra Maria." She didn't correct me, but later several times she spoke the complete word instead of the abbreviation. What she did struck me as culturally familiar because this was the very manner in which I had been taught to "correct" people's mistakes, by example instead of saying something pointedly, so as not to give umbrage and have them lose face.

I asked her about her brother. She said that he had been in and out of trouble and rehabs. He has been to the "Mora Rehab" and "Santa Rosa, you know, Desert Hills." She said that recently,

> "They sent him to rehab in San Francisco and he just came from Tucson.... He gets to go all over the place, but it don't do any good. He still goes back to that [heroin]."

I asked her who "they" were that sent him to rehab. She said she was not sure but

> "it was the courts and the Española chief of police... Gene Aldaz. No I don't think he's chief.... I'm not really sure what he does on there, but he's a policeman. He lives in Chimayo, close to us."

I asked where her brother was now, and she told me that she thought he had gone with their father who lived in Denver. I asked if she knew when her brother started taking drugs or why. She said she was not sure because it seemed he had been doing it a long time before they found out. She thought it started right after "my mom got divorced." When I asked her how long ago it was she began counting something on her finger by holding her hand out and folding each finger into a fist. "I think, it was about ten or eleven years ago." "How old were you?" "I was born on March 31, 1982, so I was about 10, I think."

I asked if her brother spend a lot of time in the bathroom. She looked startled or surprised.

> "Yeah. He spent so much time in the bathroom and locked the door so much he finally broke the lock. What's that mean?”

“Well, I'm not positive, but when I was using I would lock myself in the bathroom to shoot up because the first 10 to 20 minutes, you kind'a nod off and I didn't want anybody to see me like that. Then when I came out I was normal."

She said, "He wasn't normal. He was always real quiet and got angry if you spoke to him. He used to get angry all the time at all of us when we talked to him."

"When you talked to him about anything, or when you talked to him about dope?"

"About that stuff, he didn't like to hear anything about cleaning up or anything. And he was always dirty. He stayed out sometimes for days and we didn't know if he was dead or alive. It really bothered my mom. She bought him everything. She would spend a lot of money on his clothes. Good clothes! And he'd sell everything and be dirty all the time. Sometimes he didn't take a bath for days. He really hurt my mother. I'm glad he's gone maybe this time he'll clean up... but with my dad.... He's an electrician or something like that. He uses something, but I'm not sure what. My mom didn’t talk about it much."

"You mean he messes around with heroin?"

"No. Maybe; I don't know. But he does something."

"Where is he now?"

"I think, in Denver somewhere, I'm not sure."

"How old’s your Dad?"

"44."

"And your mom is 40"

"No, 45."

"Besides your brother and dad, do you know anyone else that messes around?."

"Sure, some cousins, some couples, and a few friends."

"You mean girlfriends?"

"Girlfriends and guys too.”

"And couples? You mean like husband and wife."

"Yeah, but mostly boyfriend and girlfriend."

"Anyone in your family?"

"No, just my cousins. But all the families around us have someone or even two, who do that stuff."

"You think maybe I can meet some of your friends and their families when I'm up there."

"Yeah, when you go up, sure."

It struck me that not once in all our conversation did she offer any of her family members' names. It struck me even harder when I reflected on the fact that I did not once think to ask! It all harkened back to when I was a kid in Harlem and we never learned people's names, and did not ask about family stuff, much less names! We just knew each other by nicknames. It also struck me that she did not once use the words, "heroin," or drug addict, or tecato, or any other reference except when I used it first.

Dulzura spoke quite matter-of-fact, without much expression or feeling one way or the other that I could discern. I looked at her closely as she spoke. She was mostly looking down into her plate, but not, I think in embarrassment or anything of the kind. She smiled occasionally and it was a warm open smile which showed me the piercing on her tongue. The first time I saw the tongue piercing, it startled me. I do not know why, but it did[5].

A Mother's Take: Blindly Seeing the Truth

I chose this particular interview because it was quite typical of many of the other family members with whom I visited both formally and informally. She exemplifies the somewhat confused feeling about her relative (in this case her son) using "hard" drugs -- cocaine, heroin, and pills -- and yet knew about the use of both marijuana and alcohol by her son from a rather young age.

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[5] **A tragic note:** Dulzura called me before this dissertation was done to inform me that the week before her call to me, her brother and father had been found together in the same cheap apartment, both dead of overdoses.

She was the first one of many people who spoke to the phenomenon of home delivery of drugs -- heroin and crack cocaine -- in the area. She was not the last person to mention that; many more would tell me of home delivery and the ease of securing any type of drug in the area with nothing more than a telephone call: “just like pizza delivery” one said.

She was also typical in that she had worked away from the area. She worked for the telephone company, and had retired the month of the interview after 25 years with the company. Of particular note and also typical is that family members, even fathers and mothers, spoke about the situation as if they had absolutely no control or blame. Of note also in this interview is that the son does not allow his parents to visit the high school after a particularly embarrassing incident which supposedly provoked him into leaving school. The parents seem to speak about the incident as if the son was in control instead of them having the parental power.

Also typical, she and her husband owned their home and it was in a family complex (the father's lineage), and several family members in the complex were drug users, though *this* mother and father were not. The father drank alcohol and admitted to drinking alcohol and smoking marijuana in front of the "boys" when he himself was a young man.

I explained to her how tough I know it is to talk about someone we love who is using drugs. I asked her to start by telling me when she thought he started using, and the kind of things that led her to believe that he was using or hooked. She spoke matter-of-factly but occasionally cried, and/or demonstrated impotence by shaking her head.

> "I don't know. To tell you the truth he told me he started after he had his son. He was 17 and she was 15 when they had their son. He said they started with the cocaine after he was born. He did tell me he was smoking pot since he was 16. He drinks now that he is older but he never had an interest in drinking. He would just take a beer now and then. For a while he was drinking every day. Then he just stopped. [I started noticing changes in him when he got in to high school. He was a very strong willed child. He was different from his older brother [who did not use, he would cry when I was leaving to go to work and beg me not to go so I could stay

with him. Ambros was different, he was fine, he never cried or anything. I guess that made me feel really guilty that I kept working after he got into all of these drugs. I felt like maybe it was my fault and that he needed me. When you are young and working, both of us were working, you think everything is going to be alright. Ever since he was little has been so attached and it is like he has got the mentality of a 16 or 17 year old. He doesn't want to let go of mom and dad. Those drugs have made his life a living hell and ours too. He really started getting bad was when he was about 18 or 19. He started on the cocaine and people would tell me that he was doing drugs. His girlfriend's mom would tell me and I didn't believe her. He could act different here, cover it up. We always had a real close relationship where we could talk, it was real open. *He would tell me that he wasn't doing hard drugs, that he did smoke pot every now and then.* He dropped out of school when he was a sophomore in high school cause a teacher told him that he would never amount to anything. They always seemed to put him down since he was a little boy, I don't know why. Maybe because of the way he dressed, he used to dress Cholo type. He dropped out to school cause he came home really upset that day. I left work and I came home and he told me that: before he dropped an incident happened at school where the teacher made him take off his shoes and socks in front of everybody because he accused him of having drugs. He humiliated him really bad. He felt really bad about that and *he wouldn't let me go talk to the teacher or the principal* because he said that he didn't want them to think he was a rat (emphasis mine)."

As the emphasis points out, when she spoke I thought of her acceptance of marijuana use in her statements, and in the second part her acquiescence to his authority to forbid her to talk to the principal. I found that curious.

"So, that was really dumb of me not to go. I told him he had to go back to school and he did for a while. Then he begged me not to make him go back, he was literally crying. He said that he would be home schooled, which we did for a while. He did good on that but then he stopped that too. All he needs: he has tried to get his GED, and I think he needs his English and math tests. He always seemed like he had to have his way. He had a real hard time accepting "no" for an answer, always, and even now. He has used the drugs to try and intimidate us or manipulate us, and it has worked. My husband and I have always just tried to protect him."

She paused and looked vacantly at the crucifix next to the china cabinet, and then as if she suddenly became aware of my presence, she said:

"Umhum. It is just recently that I went and got a restraining order on him and threw him out [this is more than seven years after they discovered he was using heroin regularly]. That is the last thing we ever wanted to do.

The way he was on the drugs and stealing, he was totally out of control. We left the house for a weekend and when we came back everything was sold. I called the police and they took him in. We never wanted to put him in jail cause we feared the worst for him. I have put him in jail before for drugs and going in to rages with us. There was a time there for a while that he pulled out a big butcher knife on his dad and wanted to kill him. It was Father's Day. He threatened to kill himself. *He has attempted suicide twice. The first time he hung himself in his room with a belt.* I just heard this real funny noise and he had his door locked and he wouldn't answer. I kept hearing a gasping for air and I opened and I saw him hanging from the closet. He just looked real limp so I called the ambulance. They came and got him, took him to the hospital and put him in intensive care for one night and let him out. They didn't think they needed to help him. No follow-up, nothing, they just let him go. I went over there and pleaded with them to put him in Dixon, in Embudo, that clinic. The lady told me that they didn't have room. This happened 5 years ago, he was 24, 25." (Emphasis mine).

"*The second time [he attempted suicide], he took my bottle of Trazodone*[6]*, the whole bottle and swallowed the pills.* It didn't take long before it took effect and he fell on his brother and he picked him up and called the ambulance. They took him back to the hospital and they just let him out the next day (emphasis mine)."

The family tried to get him help through one of the workers that the other son knew with a local treatment program or somebody, but he disappeared for a week ("*he went on vacation or something"* is how the mother explained it). The addicted son would say that he would go for counseling, but it was just not for him, he did not think that he was being helped at all. He thought it is a waste of time.
"He got back in to the drugs again, the heroin. He never did heroin until about 1 year ago. [father said two years and brother 5 or 6]. He was always on that crack cocaine. *Why he started on heroin, I don't know. He told me that he tried it before and he didn't like it. Then all of the sudden he is shooting up. I found needles in his room. It really upset me cause I thought he wasn't doing that* (emphasis mine)".

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[6] Trazodone hydrochloride is a prescription drug that is used to treat depression. It is not exactly known how this medication works, but it is thought that it works by balancing serotonin levels in the brain and by blocking certain other serotonin receptors.

As she spoke the last few sentences, she spoke in a very quiet voice. So much so that I had to strain to hear her sometimes, though luckily the recorder picked her voice up well.

> "Yeah, and he said he was shooting up cocaine. Then somehow he did admit to doing heroin too. I remember him always telling me that he would never hide anything from me, that he couldn't lie to me. He would try to lie but he would have to tell me the truth cause he knew that I knew. He really is a good person. He is very loving and very affectionate. I know he loves us and I know he knows that we love him." [But] "If he doesn't get what he wants, money, car, he goes into a rage. I feel that he is just trying to intimidate us. Yeah he has. I could say, when he first started going in to those rages. Yes and no, I don't know how to put it. It would get to the point where I would have to call the police. Very abusive. He has pushed me and thrown me and punched me in the face and verbally.... He only has been that way when he really wants that drug. *If we didn't give him money, a lot of times we would [give him money] just so he would leave*. I know that was wrong but when you are stressed like that you can't even think straight. It has been really horrible. I just hope and pray that there is some help. I feel if there were the help he would get it. It is so discouraging for him because he feels like there is no help. He feels hopeless, like it's no use. Like I said he would do one year in jail and he would come out doing good, really wanting to do well. He wrote several letters where he says that he is sorry and he is asking us for forgiveness. I feel he wants to change so bad but he just doesn't have that power. *When he comes here, they come and bring him the stuff, they give it to him*. It seems like they smell him being out. He can be here with us and here come the old buddies again or the dealers. It's like they know (emphasis mine)."
>
> "Now that he is in jail he says that he is cleaned up and his mind is a little better. He is not having the withdraws, he has already gone through them. That is good cause he said that he didn't want to get out of jail until it was totally cleared from his body. Now we are at the point that we can't trust him. We have always given him the benefit of the doubt and he has always failed us. Now we don't know what to do. We don't know if we should keep him there, or get him sent to rehabilitation: he says he can go straight out of there and he doesn't want to come home, he wants to go straight in to a place, anywhere besides jail."

When I asked about others in the family with possible drug use problems, she said, "Drinking, *my dad was an alcoholic. He never did drugs*. My brothers were heavy into drinking and they have come out of it, but not drugs. On his

father's side his brother is a cocaine addict." The brother deals cocaine right out of the complex.

When I asked her how she thought her son may have begun using, she said, not acknowledging her husband's or her own family's role in any way:

> "His girlfriend. I think he started with all of these friends that he had around here, they were not good. They were a pretty bad influence. *They were always our neighbors here, are one of the biggest dealers in Espanola, the grandmother lived here.* I believe that he got them started on it so they could buy the drug from him. [My son] got into a big mess with him, stealing, I don't know how much worth of cocaine from him. They threatened us, they said the Mexican mafia would kill us if we didn't give them the money. We didn't buy into that and nothing happened. This was about 5 or 6 years ago. Oh it was longer than that.... it has been about 8 years ago." (Emphasis mine)
>
> "*He says he doesn't want to live.* He says 'mom, I am tired of living, I can't go like this anymore.' *He will say "I am tired of doing drugs, I am tired of this life."* He compares himself to his older brother and he wishes he was a good son. He has a very low self esteem. I feel that because he was always the outcast, even in school they always thought he was in gangs. They used to treat him really bad, the teachers. He used to wear the Cholo pants and the long shirts, he liked to dress that way. It wasn't until he went to jail that he had to put a tattoo on him. He was never into gangs. To me gangs are real bad kids, troublemakers. Yeah, he would get in trouble but it was nothing really bad. I don't know how he got caught in the web. *He feels he can't get out. He just needs someone to believe in him. If he had that encouragement, he needs it and we failed him there.* He will go back into the drugs and we will get upset instead of encouraging him and telling him. My husband has a real hard time speaking positive words, and I have slid down that too. I know it is all the stress that he has put on us. We have just not helped him much. We have tried. When we see that he is not trying himself, it is easy to say "you don't want help." That is the kind of words I tell him. He just tells me "you don't understand." I tell him that I am trying to understand. To me it is just that he is taking and taking and if we don't do anything he will end up dead. [She's crying at this point] My grandson's mother is a drug addict too, so he is going through a real hard time... It is hurting a lot. He wants the love of both parents and he has none. He keeps saying that he wants to straighten his life up for his son but he doesn't do it. I believe that when that happened it just made it worse. I paid money for an attorney to get custody of the baby. It worked for a while but then she wouldn't bring him when she was supposed to. It got to the point that it got so expensive that I couldn't afford it. He has given up." (Emphasis mine)

Chapter Summary: Pain, Suffering and Contradictions

I close this chapter with an anecdote which wraps up rather neatly the contextual underpinning of the drug scene in the Valley. One of my guides throughout much of the professional networking was a Master's level professional herself, who was working on, and has since finished a PhD in counseling. She invited me to her home to discuss a nascent drug problem her teenage son was having. She was a single parent to the male child. When we went to her home the first social gesture she made was to offer me a large serving tray of marijuana and rolling papers, so that I could roll a joint. I politely declined and we went on to talk about how she could best approach curtailing her son's experimental drug use. She did not express, and I did not point out the inherent contradiction concerning her marijuana use ("which was mostly to relax and for religious purposes"), and her son's experimentation with harder drugs and alcohol.

Sociologically, then, the interviews with family members and professionals presented in this chapter contextualize the general ambiance surrounding the drug scene in the Valley, and also demonstrate a structural acceptance of the frustrating systems that are supposed to aid the addicts, but actually do little if any good. The milieu evidenced in this chapter, expressed by the many interviews with hegemonic medical professionals, teachers, social workers, and family members of users, bespeaks an impotence and acquiescence to the drug culture beginning with an acceptance of the widespread use of alcohol and marijuana, and ending with a deep sense of anger, desperation, and at the same time a contradictory acquiescence, religious fatalism, and resignation to what is seen as inevitable and inexorable.

The frustration of the parents was palpable. The sense of incurable doom expressed about the treatment structure by many, and the testimony of attempted suicides, was daunting. Interview after interview, observation after observation screamed the same conclusion: there is a desperate need for curative processes, but very little is effective or forthcoming.

In the next chapter I begin to cover the interviews with some of the key informants, showing how their drug careers and life in general was traumatic and potentially deadly.

CHAPTER VI: MASQUERADED PALL -- DRUG OVERDOSE AS SUICIDE ATTEMPTS

> “I got in the habit of playing Russian Roulette.... Like when you fill up your syringe full of cocaine, say that much (holding his thumb and index fingers about two inches apart) and shoot in your neck, and you don't know if you're going to make it to the dark side or the light side.... [I did it] for entertainment: I didn't have anything better to do... [than] Alcohol, cocaine, and heroin." (Asedio, age 42)

Introduction: Stopping the Dance, or Sifting Through Respondents’ Narratives

> Such a narrative requires selecting only some small portion of the total set of fieldnotes a [and interviews] and then linking them into a coherent text representing some aspect or slice of the studied world…. Rather than composing a tightly organized analytical argument in which each idea leads logically and exclusively to the next we… ethnographies as narrative ‘tales’ (Emerson, Fretz, and Shaw, 1995, 170).

Asedio’s narrative expressing the experience of several overdoses is similar to the other principal respondents (PR) that I interviewed whose suicide attempts masqueraded as drug overdoses. Presented in the following pages, their case histories clearly illustrate the principal components underpinning and overarching the premise of this dissertation. These histories/narratives show individual and historical trauma, alienation, anomie, and ultimately the similarity of these case histories to the cases labeled "accidental overdoses" by the Office of the Medical Investigator of New Mexico, an admittedly arbitrary designation with problematic issues of veracity. Not all suicide attempts are neatly tied up with a ribbon or note.

Some suicides do it directly and leave a note or tell family and friends of their intent. Others, as the case histories below demonstrate, chose less obvious, though not always very subtle, methods to end their own suffering without letting others know. The case histories provided below are of lives where the principal informant did not succeed in suicide, though in several cases, it was

not for lack of trying. What I present then, are suicide attempts in various forms. Asedio's case history and that of many of the other principal respondents in the interviewed sample, overwhelmingly illustrate that a large portion of what the Office of the Medical Investigator is designating as "accidental overdose deaths," could actually be, and most likely are, suicides.

Narratives of Near Death Experiences: Interviews and Observation of Participant Respondents

As with the Asedio's interview below that illustrates the experience of suicide attempts driven by trauma, alienation, anomie, the evidentiary material that follows illustrates the iterative categories delineated in the methods chapter. I use the interview data augmented by my observations of the interviewees and of other principal respondents -- family members of PR, local and New Mexico state government officials, services providers (some of which were ex-users or "recovering"), and man-in-the-street type observations.

Suicide

In the iterative process under the rubric of suicide were other subheadings – alienation, anomie, trauma, cultural displacement -- which illustrate the possibility that in the Valley "accidental overdoses" were suicide. While I could illustrate each subheading with case histories, it would be an artificial and redundant endeavor. Most of the PR's case histories evidence several, if not all, of the subcategories. As such, to separate some of these subcategories was pointless. What I have done is to explain within each respective case history what categories they best serve to illustrate.

Some of the principal respondents (PR) reported actually trying to commit suicide by overdoses as in the case histories of Jovencito and Campesino. As Bombón and Bee admitted, many PRs too gleaned retrospective understanding that a particular OD or series of ODs were actually suicide attempts. In the case of others, they reported knowing people who had used ODs to kill themselves as was the cased reported by several PRs.

Equally of interest, because of their illustrative value, were those PRs who neither admit to suicide attempts by OD, nor even considered it a possibility that their OD was an attempted suicide. However, as the case histories of Agugero and Huido illustrate, their actions appeared to evidence attempts at suicide because of the manner of their comportment towards ODs. For example several reported *knowingly* taking an overdose two or more times in succession in the same day. That is, they OD'ed repeatedly in one day with full knowledge that they were overdosing and that it might lead to their death, but despite this they did not mention the series of overdoses as suicide attempts. They OD'ed more than once in succession and ingested and/or injected large quantities of several toxic substances in a rather short amount of time, also with full knowledge that they might die.

Case Histories for Suicide

Asedio

At the time of the interview Asedio reported that he was 42 years old, had served 17 years in prison in what he called "Chapters" which included "second degree murder, burglaries, aggravated assaults, and possession of heroin. I think that's enough. No?"

He volunteered that he was five foot ten inches tall, though to me he looked much taller, probably because he was very skinny. He wore the typical summer uniform for the area, a white t-shirt, blue jeans, and cowboy boots. His barely controlled nervousness and mostly monosyllabic answers (common mannerisms in long term prisoners) put me in mind of the "big yard" at Sing-Sing prison. He insisted on calling me "sir," even after I asked him not to, and lived up to the jailhouse moto; "Don't tell the man nothing, and answer questions with only a short answer." This made the interview process more actively probing than most -- one of questioning, re-questioning, and re-questioning to mine any meaningful data.

Though he had once had a roadside stand where he sold art objects and pottery, Asedio now eked out a subsistence selling carvings of Jesus, saints, and

Indians, and occasionally cocaine or heroin. Yet he first reported being unemployed, and then later also reported having underground economy jobs, "I am self employed right now. I am an artist, I paint cars. Oil paint, at body shops. I paint cars.... I also play in a band too." He said the last item twice with obvious pride.

When I asked his "ethnic background," he did not seem to understand the concept. In Spanish I said, "Latino, Hispano, Chicano, Blanco, Negrito," he responded, "Catholic Chicano." He said that meant "From the hood, brown pride, superior." And while he knew both sets of maternal and paternal great-grandparents and grandparents, he could not, or would not, say if any of them had owned land. He simply kept insisting that they were "good people." He reported that his maternal grandfather was an alcoholic who "came back from WWII... a little loony."

Asedio had started his pills, pot, and heroin career at the age sixteen, and preferred mixing alcohol, cocaine, and heroin. He also reported experiencing several overdoses during his drug career up to the point of the interview. When playing cocaine/heroin "Russian roulette," he preferred to start by drinking alcohol. When asked how many overdoses he had experienced he said, "I can't count it.... Too many." Then he related that many of his family members had died of "drugs and cirrhosis" of the liver.

During the 26 years of using heroin, cocaine and other substances, his dad was shot to death and his mother died of cirrhosis. Both parents used drugs, as well as his mother's sister, who died of an overdose. These series of traumatic events alone would, under normal circumstances, predispose a person to post traumatic stress disorder and Asedio's circumstances were anything but normal. PTSD can and often does lead to suicide if left untreated (Nelson and Manson, 2000; Oquendo, Friend, 2003, Duran, Duran,1995).

Agugero

Agugero, reported he was unemployed, though he considered himself an artist who sold artifacts to tourists for a living. He was 48 years old at the time of

the interview, had been using heroin for 26 years, and reported with some pride that he had no intention of seeking treatment or quitting heroin use.

His black/brown hair was well fixed; combed back neatly and parted. He was tall; light skinned, and very thin. He wore clean jeans, a heavy, woolen, brown-plaid shirt, and cowboy boots: typical winter attire around the Española Valley. He reported spending 18 years in prison, "on the installment plan." During those 18 years his time outside prison ranged from 30 days to three years. He had been sentenced to "5 to 45 years," for an armed robbery he had committed while drunk. He'd been out of prison now for about 7 years. He had used heroin throughout most his 18 years of incarceration.

Agugero reported his ethnicity as "Hispanic, I guess." When I asked him to explain what that meant to him, he answered "Someone who's... got Spanish blood in them, I guess -- speaks the Spanish language or should anyway. Raza." This categorical awareness was typical of the majority of PRs. Their responses were an excellent example of what Gomez (2007) refers to as the "exceptionalist thesis" which obviates the Mestizo heritage of New Mexicans and ensconces Spanish colonial rule as the legitimate heritage. This embracing, according to Gomez (2007) of partially mythical Spanish heritage and obviation of their Mestizo heritage, is part of the structural process that leads to historical trauma (Alexander et al, 2004). This is detailed in the Chapter IV, Demography and History.

Agugero, a graduate of Española high school, reported he was born in Española and has lived there most of his life, as did his parents, grandparents, and great-grandparents. His answer about land ownership by his parents, grandparents and great-grandparents affirmed another aspect necessary to historical trauma: they all owned/inherited land which they could not farm now: his parents "own what they live on and that's it. I don't own anything." Loss of land, or loss of ability to farm the land is another prime factor in cultural/historical trauma (Alexander et al, 2004).

Agugero had overdosed two times in one day in quick succession, though he considered it three ODs, as I explain below. The interview was at 10:00 in the morning, and he appeared a little shaky since he had not fixed yet. I could smell the alcohol on his breath, which he later reported to use every day to supplement the heroin and methadone: "I've cut down a lot on the alcohol and heroin... Now I drink from 7 to11 tall cans [of beer] all day." He needed the $40.00 from the interview to fix.

He was one of five children -- two males and three females -- all of whom had done some drugs. The women mostly "might have smoked weed here and there a little -- a little beer." One brother had died of "blood cancer," and the other was now a pastor though he had been a heroin addict. Several of his cousins had died of ODs. Agugero reported that he was with one of his first cousins when he OD'ed: "He died suddenly. He died and his brother also OD'ed. He was in a coma for a long time before he got out, like three months." His best friend, Flaco, was another PR, who had also OD'ed several times, and who allowed his son, Flaquito also a PR, to shoot up with them. Something Agugero disapproved off.

Agugero was one of several PRs who got hooked on heroin at an older age than most PRs: he was 23 years old when he got hooked in prison. He started his general drug career at about age fourteen, in junior high school -- smoking pot and crushed "rojos" (literally "reds," Secondals). He started drinking alcohol at age 15, and first tried heroin at age 18, "with my elder brother," but did not use heroin again until five years later when he went to prison:

> "got incarcerated and got introduced to it.... I started with a little codeine, Tylenol 3s, and liked the feeling. From there I got introduced to heroin a lot more.... By the time I got out I was bringing in 3 grams a week myself."

He reported overdosing three times in the same day shortly after leaving prison, the last two of which were, in actuality, only the second OD: During the second OD he came to and passed out again, so he counted that as two ODs. In answer to the question "tell me about the ODs" he responded,

> “Oh, there were various. I had 140 milligrams of methadone, then shot up 4 or 5 Dilantins [Phenytoin], and I started to do some Valiums... we were sanding a car... I went out. A friend of mine that was there gave me mouth-to-mouth and kept me going until the ambulance showed up. They took me in and then I woke up in the emergency room and came out [of the hospital], I went straight to the connection. I got some heroin and started shooting up again. I had recently gotten out of the penitentiary, so I really wasn't hooked. So anyway, I went out again.... I woke up [in the hospital] again and didn't know what had happened....”

What had happened was that he went home from the hospital (via the connection) after the first OD and when he fixed at home he OD’ed again and his father had a cousin help him to the hospital again. These frequent multiple ODs coupled with overloaded ODs (with multiple substances) were what gave rise to my suspicions that the "accidental overdoses" were not so accidental at all, particularly when I considered the ages of the people doing it.

Flaco

Flaco was an excellent example of someone who was killing himself almost knowingly, but I believe was in full denial. I met Flaco through several sources: first through the needle exchange -- where he once tried to sell me a very well carved Kachina doll which I later found out he had carved and painted. Secondly, I interacted with him through the methadone program where I did my daily observation; and thirdly through a mutual acquaintance who is an artist and makes and sells pottery for herself and a number of pueblos. I have never seen him without a smile or a good word for most people. He always looks disheveled and unkempt, but never dirty. He has long hair always in a braided ponytail, and a painter's white hat. We talked a number of times in the methadone program's parking lot and foyer. He agreed to have me interview him, called me several times, but we kept missing each other. We finally connected after two months of trying.

The interview was conducted in October 2002 when Flaco was 44 years old. He was raised by his mother, a single parent, and in terms of siblings, he reported having "three girls and two brothers." He considered himself a Hispanic and a Coyote (pronounced in Spanish and usually meant that a person had a

parent who was White) "well both of my parents are fluent in both Spanish and English, but my dad's Y [and] my grandma she was gringo (sic)." In his case it had been his father's grandmother, all other relatives were Latinos. I have not ever heard the word used outside of referring to direct parentage. Of his mother's parents heritage he said, "They were both Spanish."

Flaco reported he was self-employed part-time, making and selling “Etchings on black pottery, painting on pottery. I make bows and arrows, drums, spears, dream catchers, medicine pouches, walking sticks." He had been incarcerated "almost once a year" since he was 17 years old, which is also the age at which he began using Chiva, and at which he was diagnosed with cirrhosis of the liver. He still continued to drink vodka and use various illicit substances.

He believed he was not already dead because a Curandero (healer) had saved him even though he had not been cured. He reported he had started using other drugs -- mota, alcohol, and pills -- when he was in elementary school. He and his sister had started together including heroin, but she quit once she married and had a baby. She moved to Albuquerque. They were the only two siblings to graduate from mota and alcohol to Chiva. He mentioned he was also now shooting up with his son, Flaquito, who had finished college then started using Chiva, "with the big boys." Flaco had overdosed at various times; once his mother found him in the back yard with purple lips and ants crawling over his body. Despite that he continued to use alcohol and Chiva together. He said, "To me, drinking and heroin go hand in hand. *One of the deadliest mixtures,* you know. But my body is used to it already" (emphasis mine). More frequently now he used the two in combination with methadone. He claims to continue using Chiva and methadone because he is in constant pain.

> There was a time when I couldn't even walk, turn my neck or anything like that from injuries that I had. But slowly, went for acupuncture, acupressure, and went through physical therapy. And so you know I suffer a lot. This bone sticks out over here. My ribs and both ribs fractured on both sides. A horse kicked me over here. But drinking and drugs and all

> that helps me. Cause most days I can't even get out of bed you know, I hurt so much. Those are just why, they help with the pain.

His pain seemed palpable and so did his high; neither hid the other well. He grimaced in pain often, and shrugged his shoulders a great deal as if throwing the pain off.

Huido

Huido talked about overdosing twice. At the time of his interview he was 22 years old, had already been to prison for an attempted murder at 13, and had begun using heroin with his uncles. The uncle was his mother's brother. She r had smoked marijuana since Huido was a young boy. All his mother's brothers used heroin.

Huido reported repeated bouts of severe depression. The first time he overdosed he was working in Tierra Amarilla, and as soon as he got paid he called his friends from Espanola who came to get him. When they got back to Espanola, he related that:

> We ended up doing cocaine all night, cocaine and heroin. When we did heroin again in the morning, we both overdosed. [We] because I stayed up all night doing cocaine, then we took some 5 or 6 Valiums to calm down, then we decided to do $40 gorras. Heroin too.

Huido and his friend each mainlined one entire $20.00 gorrita, on top of five or six Valium's each had taken. While he had been clean for about three weeks, he and his friend were both experienced heroin users. Huido’s friend's brother happened to pass by the car which he recognized as his brother's. He found them both unconscious, and he called an ambulance.

The second time he overdosed he was at home. He bought heroin from his next door neighbor, and went home to his bedroom. As he reported:

> Oh, I had done some heroin and I got high. I was high. And they [mother and stepfather] saw I was high and started telling me off. So I went in and done some more and I laid down and overdosed.

In both cases one can see both a lack of judgment and maturity, but more importantly, an intentionality that seems obvious to those of us that have been through similar circumstances.

Suicide or Not: A Retrospective Look

Several of the PRs who OD'ed did not think they were attempting suicide at the time of the ODs, but when they looked back on their actions they specifically questioned whether or not it was simply an accidental overdose, or a veiled suicide attempt. Two case histories that illustrate this point well are Bombón and Blondie.

Bombón

Bombón was 42 years old at the time of the interview and had started using heroin at the age of 25 in an abortive attempt to stop her husband from fixing. She thought that if she threatened to start using that he would give it up for her. Instead he actually helped her fix the first time and for ten years after, until they broke up. Seven years after their breakup, she was still using cocaine and heroin on a daily basis. She continued to use despite the overdose deaths of her husband and their best friend, who was also there when she "got her wings" (to inject heroin for the first time).

Though it was 1:00 in the afternoon when I interviewed her, she claimed to not have used yet that day. However, she seemed high to me -- the eyes were listless and she was too overly calm, as many of us are when we're high. When she spoke she answered quickly in long bursts, in a kind of stream of consciousness.

She was about four feet eight inches tall, had prominent cheek bones and either had a deep tan or permanent light coffee colored skin. To me she looked Native American. She had long thinning, dark brown hair which was poorly dyed. Her gray roots showed in several places especially because she wore her hair loose. It fell around her shoulders and down her back. She was dressed neatly in a pair of clean blue jean coveralls with a ruffled, pink halter top, held tight against her flat chest by the bib of the coveralls.

She considered herself a "Chicano" (sic), and when asked what that meant to her she said, "What does that mean? (Long pause) ...Spanish, that I'm Hispanic, that I'm a Chicana in a Spanish speaking... not Mexican…." Yet another example of the exceptionalist process (Gomez, 2007). She reported living in New Mexico all her life with a brief sojourn to California. She claimed to be from Chimayo and Puachupantuv which she reported was an alternative name for a hilly prominence near Española, but reported that she was born at the Española hospital.

As a child her mother would lock her in a closet to punish her because that's what her grandmother had done to her mother to punish her. She attributes both claustrophobia and her high school graduation to her mother's persistence and punishment. She graduated from Española high school though she was pregnant at the time, "Yeah, I went up to get my diploma about eight months pregnant.... we graduated in June and I had my daughter June 21st."

Bombón was unemployed. She had worked with her husband doing construction until she went to prison. She would not say how much time she did for the unspecified crimes, and reported that she had only worked sporadically since her release. She freely admitted exchanging sex for drugs and vehemently argued against the fact that anyone, male or female, would deny that they would have sex for drugs. Specifically referring to a group encounter at one of the drug programs she had been to, she said:

> "...addicts fucking sit here and tell me they weren't... I never shared a syringe. I never gave my body for drugs.' ...don't give me that shit. Anybody who's a drug addict, if they weren't stealing or hustling, there was a time when you couldn't hustle anymore, you needed that binge, you were gonna give that guy a piece of ass! If you were out there and had something you needed to take and you didn't have a syringe, don't you fucking tell me you aren't gon'a use someone else's syringe! We all shared syringes... we all shared our bodies at one point!"

When I asked how many times she had OD'd, she replied:

> "Oh, man, too many to count, you know? I mean, shit, I started at 25, I'm 42... 17 years... there's just too damn many to count... some bad ones and some not so bad ones".

One of the worst times was when she found out her ex-husband had died of an OD. Soon after she was with her son in the mountain home that she and her ex-husband had built by themselves. She was in the bathroom getting ready for a barbeque, when her son found her prostrate on the floor from an OD.

However, the OD that is most relevant to retrospective acknowledgment of a suicide attempt is one that Bombón reported occurring four months before the interview. At the time of this incident, despite her long drug career, she reported that she had not ever done an entire "BB" (a $20.00 bag of heroin). She usually cut the BB into three fixes (injectable portions) for use three separate times over the course of an entire day. She had just been fired from a construction job in Los Alamos, drove back to Española, and purchased a BB.

> So I sat in my car looking at it in my hand... stopped at the store and got a coke and a *caquito* (small cake), got in the car and uhh... debated, you know, for about two seconds... *I did it*. *I never done a whole BB. When I get a BB I'll do it at least three times, depending on the size... and I did it*.... And I start to drive out and, you know, you always know when something is not right!... I kind'a turned off a little to the side and turned it off, put the car in park, whatever... and then that was it... turned off the car ... and I said, oh my god, fuck! Next thing I knew, I woke up in an ambulance. Took me to the hospital and put an IV and shit, and I took it off, I said, I'm out of here...' I could barely walk.... (Emphasis original to interview)

Later in the interview she speculated without prompting, (as did Blondie below and other PRs) that she may have tried to kill herself by using more heroin than usual in one shot.

Blondie

I had set up the interview with Blondie, who had been using Chiva for about 19 years, while I was in Houston at a conference. She called me and I had to reschedule several times because of prescheduled conflicts, so I was very glad the meeting had come to fruition. I waited for her in a restaurant in Española, where we had agreed to meet -- I took bets with myself that she would be late, if she came at all. She was late, but she did come.

She was 20 minutes late. She wore a summer pants suit: muted gold and black stripes, baggy pants, sleeveless, v-neck top. I had not seen it on her before at the methadone program where I first met her -- her methadone dosage was high enough that she would need to medically withdraw if she decided to stop using it. She looked clean and athletic. She had a crisp walk, clear blue eyes, and her dark, long blond hair, which had always been pulled back in a pony when I had seen her before, was now loose around her face. All those elements combined with her haughty bearing, made her look upper middle class. However, there had always been this undertow of emotion when I talked to her at the program and during the interview. It was almost as if she were going to start crying with the slightest instigation. She had always seemed out of place at the methadone program, but that may have more a reflection of my own chauvinistic internalized racism than her bearing.

She apologized for her lateness and explained that her mother had to take care of her children and had some problems, and then her car had coolant problems. "It's been a good little car, but for some reason its coolant was all over the ground... but it didn't overheat. I'm not sure what's going on!"

The interview with Blondie, who was 39 at the time, provides a good example of retrospective suicide attempts. She was atypical of the sample in that she was a White female ("I was born in England."), and had lived in several places in the United States. However, in many ways she also typified the sample in that she spoke Spanish fluently, had been in the Española Valley for more than 25 years off and on since her parents' moved there in the 1970s to follow a "hippy lifestyle." Blondie dressed exactly like the other women of the Valley and it seemed to me that she had assimilated into the lifestyle and culture of the Hispanos.

Blondie was six years old when her parents first brought her to the Española Valley. She started using alcohol, cocaine and mota when she was eleven years old, with her younger brother. They would steal the alcohol and drugs from their parents stash. Both parents had used cocaine, Chiva, and mota

all during her formative years. Also, both her parents dealt mota, Chiva, and cocaine which she reported they brought up from Mexico. Her father discovered her mother was having an affair and left. Blondie reported that he now lived in New York City and still used drugs, but her mother had been clean for a long, unspecified time.

Blondie had been in several abusive relationships and had two children. She had started using Chiva with her first husband 20 years ago when she was 19 years old. She was a single parent on welfare. When asked if she had ever sought treatment for depression, she said,

> Yeah, and that should be, yeah and that was dealt with in the out-patient program. I mean they dealt with all sorts of mental health stuff..... and they have to, um..... they need more....um.... what's the word..... what's the word.....oh, abuse. Mental health and abuse stuff. They addressed abuse and things too, and co-dependency and just everything.

The incident that she reported which illustrates a retrospective suicideattempt, occurred while she was in a treatment program. She had detoxed from methadone and alcohol several times, but this time she decided to start drinking again:

> And I found this guy, and we went out and kicked up our heels for about 24 hours, we snuck back in one night, I guess, um.... to the bottom cellar thing, fell and broke a window, fell on the pool table, um ... and we got caught, the next morning we got taken in for a urine test, and I was dumb enough to like, to try to dip the thing in the toilet. I don't know what planet I was on. (laughter) And, very hung over, j*ust embarrassed and I think I just kind of gave up on everything. I think back. "Cause I've always said no, I don't want to commit suicide', but I think back to why I did all this stuff, and it was like, pretty close to it,* cause I was really pretty messed-up... (Emphasis mine).

Out of the 34 interviews with principal respondents who were actual users of heroin, cocaine, and or other substances, four reported that they had attempted suicide at some time in their life. That is about twelve percent of the sample. Nationally, the rate of suicide is about 10 per 100,000 population. A straight-line comparison cannot be done since the sample is too small and not

randomized. Nonetheless, twelve percent of 34 people is an exceedingly large number when translated into per capita calculations for an area of about 38,000 people. Jovencito and Campesino are a graphic example of an attempted suicide.

Jovencito

Jovencito was twenty-seven years old when I conducted the interview. He reported that he began using marijuana and alcohol at about age seven. He said he remembered the exact age because he was caught in the second grade with a bag of marijuana and his parents were called in. He further reported that when his father came to get him at the school, his father did not actl surprised at the fact that he had been caught with marijuana. There had been no consequences from the incident.

Jovencito had become a gang member in junior high school, and considered the gang his family. Despite reporting that he had used heroin, cocaine, alcohol, and amphetamines for the last five years with virtually no hiatus, he was still husky and clean cut looking. He was about six feet tall. He was dark complexioned, and wore his dark brown hair short and parted, and his clothes were clean and well pressed -- brown slacks, a blue shirt, and sneakers. He still had all his teeth, and smiled often, though nervously. He spoke in quick bursts, which put me in mind of a person on cocaine or crystal methamphetamine. He claimed to be only on methadone.

When I asked him to describe what he liked about heroin's effect his answer was virtually the same as all the principal respondents. They usually began by saying they did not know or that it was difficult to describe, and then their description, whether males or females, were almost exactly like Jovencito's, referring to the easing of life's burdens. He closed his eyes and his face went expressionless, he said,

> That high, and you know, I liked that high. You know, really honestly, I like that high. It's just why it's hard to explain why I like it. I love it, but I hate it. It's like a love/hate relationship for me. I love feeling high and nothing in the world could bother you, you know. No matter how deep your problems are, when you're high on heroin, you don't even worry about it, you know.

For his ethnicity, Jovencito reported that he was, "a Valley resident. I was born and raised around here. Hispanic culture, I feel strongly about my culture." When I asked him to tell me what the Hispanic culture meant to him, he said,

> "Hispanic culture and just the Spaniard sentiment. Just the culture right around here both religiously and just artistic. There are a lot of artists who come here from the Valley - craft workers, painters, stuff like that."

I found it interesting that his ethnic definition made no mention that his father was an "Anglo" from Ohio, as he related later in the interview.

His mother and father met and married in Española, and divorced after 23 years. His mother was Latina, originally from the Farmington area. Jovencito and his sister were both born and raised in the Española valley. She and he "smoked pot" as they were growing up, but she did not evolve into a drug career because,

> "she used to go out with a local drug dealer from here and she seen the impact, she seen that he was dealing death to everybody and you know it saddened her to the point where she was able to stay away from the drug use, you know."

However, he reported that his father was an addict who would beat him a great deal. He felt he had suffered child abuse.

He had been arrested several times for petty crimes such as shoplifting, but the charge he spoke most about was a child abuse charge that he was currently facing. He had beaten his two boys for leaving the apartment when he and his wife were passed out in a narcotic stupor. The neighbor, who was also his corneta, (connection) called the police. As a consequence of the child abuse charge appearing in the local newspapers he had several altercations in county jail that resulted in several felony charges. He had assaulted an inmate with the help of several other fellow gang members who were also incarcerated at the time.

As a result, he was charged with assault and battery, conspiracy, and tampering with evidence. He was moved to the violent offenders section of the jail and another inmate tried to stab him. He was again moved to segregation where he became angry and destroyed the sink and toilet by kicking them. That

resulted in a felony criminal damage charge. He ended up with 32 felony charges and was waiting to stand trial for all the charges at the time of our interview. He was in county jail 32 days before he was eligible for bail. His wife bailed him out.

Since he first started using heroin, Jovencito had often offered it to his wife; they were childhood sweethearts. And while she used other drugs -- mostly methamphetamine -- she had not ever used heroin, but after his insistence, she finally gave in to him,

> She started using… she did like I did… she kind of gave up on it and, you know, she kind of gave up on trying to push it away. After a while it just became normal to see that kind of stuff. I had always offered her for years now. We've been together 8 years and I've been offering her since I started 5 years back and she was always able to stay strong and not use you know. She was unattracted (sic) to that. But here right before we got in trouble and everything, our children were taken away, well she gave up. She started using. She seen me just always high and everything and she probably as you can imagine gave up. I don't know. She kind of gave in.

Despite their joint drug use, she would actually quit and clean up before each pregnancy, stay clean throughout the pregnancy and then start again once she stopped breast feeding. Jovencito would stop every so often and clean up so he could work and let her enjoy being high without working. However, most of the time she worked as a waitress, even while they were both strung-out. She was usually the bread winner and the supplier of money for them to get high. Occasionally he or she or both would sell drugs. Currently they were both seeking treatment, but still currently using heroin and methadone. They were hoping that if they could get and stay clean they could win custody of their children who were currently wards of the state, and actually fostered out to his sister and brother-in-law. He related that:

> I want to get off the dope and I want to get away from the life because the life is ruined my freedom: it's ruined my family, and to be honest with you, there's not a whole lot of people right now in my family or outside of my family that are really even willing to help me because I've burned so many bridges because of my drug use. You could say it like I guess a lot of people have kind of gave up on me. A lot of people think that I'm too far beyond repair, but I like to think not.

When I asked if he had ever OD'ed, his reply surprised me when he frankly admitting that he had attempted suicide by OD. I must admit, I did not expect anyone to admit it.

> Yeah, I've overdosed twice on heroin and on pills. *One of the times, it was intentional.* One of the times, my first time that I overdosed; I overdosed myself because I wanted out of this kind of life style. *Basically you could say I just kind of put my guard down and I just kind of gave up*. And I'm real glad that I didn't die (emphasis mine)

He then related, with tears streaming down his face, how he had attempted suicide after arguing with his wife, and though he left the house with the intention of committing suicide, he did not tell her. She had refused to give him the money she usually gave him every morning when she came home from serving tables. Despite what he relates as an intentional suicide attempt, if he would have died, it is quite likely his death would have been ruled an "accidental overdose" because he neither left a note nor mentioned his intention to kill himself to anyone.

> I had intentionally intended to go out and find some drugs and I want to give myself that fatal dose and I was just that tired of the life style. So I took off into town and I found a friend of mine at some local projects here and he receives prescription drugs. I went and told him that I was going to withdraw and I needed to know if he could help me out with some money, that I would pay him back. Well, the guy felt really sorry for me so he gave me a prescription to Percocet. He told me you know don't go take them all at once. He said you know take a couple and they'll help the withdraws. He said this prescription should last you the 4-5 days that it will take for you to break.... I took off and ran into another friend... I sold the CD player out of my car to him for $40..... I took off... bought a fifth of Vodka.... right there in the parking lot I downed the whole prescription. There was 18 Percocets. I downed the whole prescription and chased them with the fifth of Vodka... as I was leaving the parking lot... I ran into a person that was selling heroin... so I bought a BB as well. And I shot up the BB of heroin on top of the Percocet and the alcohol. I became really incoherent, real dizzy, I couldn't stand up straight or anything. Well I showed up back at home and my companion came out very concerned because she could just look and see by the look of me she knew that I wasn't all right. You know I opened up the door to the car and I fell flat on my face right there right in front of her.... I lost consciousness....They admitted me into the emergency room about 10:00. They told her I had overdosed on whatever

> I had taken that morning. She had no idea what I was on or anything, but she told them heroin so they gave me the Narcon and I didn't come out, I didn't snap to. They pumped my stomach. I had slipped into a coma. I didn't come out of the coma for three days. (Emphasis mine)

Bobasabia

Bobasabia is married to Jovencito, and was obviously high when she was interviewed. She was 22 years old at the time of the interview in June 2003. She reported that she had attempted suicide, when her mother and stepfather intervened, though they did not take her to the hospital.

> I went into a real bad depression and tried to commit suicide. We got back together and I did cocaine, but then when I found out that I was pregnant, I stopped everything. He was still doing the cocaine. I was taking some depression pills called Serzone and got more in depression and wanted to kill myself and I tried slicing my wrists. With arazor blade. I was at my house... my parents' house. I was at my parents' house and my mother had went in and saw me and she sent her husband in there to go get me. They stopped the bleeding.

She reported that her mother took her to a psychologist who prescribed the Serzone which she was on for five months. She felt it did not help at all.

She had overdosed once because she took too large a speedball (cocaine and heroin mixture).

> I did more than what I was supposed to do. I did a speedball -- cocaine and heroin -- and it was like uh 35 cc's, and I did that in one blast. And I didn't know at first that I was going out, but then I started realizing I was going out. My boyfriend had got a cold rag and put it on me cause I was out of it. That was in January.

She had also been with her husband when he overdosed and had taken him to the hospital. The doctors had told her that they had found cocaine, mota, alcohol, Valiums, and heroin in his system.

> My boyfriend had overdosed last year. He had overdosed and I brang him to the ICU because I didn't know what was going on. He was stiffening up and he was hallucinating. So I bring him to the ICU -- or to the emergency room -- and they took him to try to stabilize him and then they took him up to the ICU in the emergency room. They took everything out of him. They gave him charcoal. They found different things in his system. Marijuana, alcohol, cocaine, methadone, Valiums, and heroin.

She had begun using mota in the sixth grade when she was twelve. One of her friends had told her to take a hit off her friend's joint. She did and she liked it and continued smoking it. She was thirteen years old when she begun snorting crystal meth, which she got from her cousin. She "was hooked on it for a while. Then I got off of that and started doing cocaine..." she was fifteen years old. She began using Chiva with her husband five years before the interview, when she was 17 years old. Her drug of choice was the "speedball." When I asked her to tell me a little bit about her ethnic background, she said, "I'm Hispanic -- what do you mean by ethnic?" When I asked what Hispanic meant to her she said, "Just means brown pride -- just like back in the 1800s when the Spanish people have fought the Indians, fought for their rights and all that, like a strong heritage."

She has lived in Española all her life, dropped out of school at 16 years of age when she was in the tenth grade, "I guess I was tired of learning." She often seemed confused. For example when I asked her if she was employed she said she was not, but when I asked her what she did when she was employed she said, "I pay bills and use drugs." When I explained further, she said she was a waitress. I found it amazing when she reported that she literally stopped taking drugs, drinking alcohol, and smoking both times she wanted to get pregnant, stayed clean during her entire pregnancy, and then started using as soon as she stopped nursing. She reported she stayed clean because she had seen a television program:

> I just watched TV and looked at Discovery Channel and all that and it showed how the baby was affected by the cocaine and heroin, cigarettes and all that. And I didn't want my boys to be like that. Drinking, oh yeah. I went straight for two years.

She freely admitted trading sex for drugs before she got married, but she later felt disgusted about it. When I asked if she had ever been incarcerated this is how she explained her incarceration:

> We were using really heavy on heroin and coke. We were staying at a friend's house up in Santa Clara apartments and we ended up real bad on it. And we didn't sleep, We were up for like a week straight without sleep. One morning we went to sleep and my boys were asleep. We went to

> sleep, it was like at 6:00 and I guess my boys had got up at 7:00 and they had got out of the apartment. They [the two boys] are two and three. And we were very intoxicated from a week and drug using. And they [the children] got out of the apartment and they ended up going up to our dealer's house cause I guess that's the only place they knew. And they knocked on her door and she came down and woke us up and told her where our boys were. We went when we found out they were up there with her and we were like still intoxicated and still half asleep and now knowing what happened. I went up there to get the boys and bring them back down. That's when I held them down while Joe spanked them. That's how we got child abuse charges. Our dealer had called the cops because we were using drugs and not taking good care of our kids.

I almost laughed at the irony of their drug dealer turning them in for using drugs and not being responsible for their children.

She reporting having seven siblings (half-siblings and step-siblings), and that several of them used drugs. She reported that her uncles, aunts, and several cousins on her mother's side were alcoholics and cocaine users, but on her father's side the uncle and aunts were "only alcoholic." She reported that her father used alcohol and cocaine, and her paternal grandfather was an alcoholic. Her maternal grandfather was also an "alcoholic and coke user. He died recently. My grandma, she's an alcoholic and she used to be a coke addict." He was 81 years old when he died "recently," and her grandmother is 74. Both sets of grandparents had inherited land, but her maternal lineage owned land in Farmington, whereas her father's family had inherited land in Española.

She explained how her mother had become hooked, as she described her own consumption

> Well, yeh, cause I used to drink vodka and just beer and tequila. When I was younger I used to drink a lot of tequila. When I was like about 15 years old, well, actually when I was 12 or 13. I was doing tequila cause my mother was allowing it in the house whenever my older sisters would have parties, drinking parties... well she [her mother] didn't know about the crystal meth until me and my sister and my friend went and told her, well come and do a line with us. Try this out. And gave it to her. She tried it and she liked it. Got hooked on it.

Campesino

I interviewed him in November of 2002; he was very verbal, a large indigenous looking man, with long braided hair, and rough outdoors type clothing. He had rough looking hands, the type one sees on laborers or field workers. He spoke with a distinctive Valley twang that bespoke a rural upbringing in this area, and which is distinct from the speech used in the larger towns such as Española, Santa Fe, or Taos. In term of ethnicity, he self-identified as, " I call myself Chicano, I guess.... Chicano (sic) means to me like La Raza, you know? Sticking with my own generation, you know."

At the time of the interview Campesino had been a heroin addict, on and off, for about 30 years. He was 52 years old, and had been introduced to heroin in a New Mexico prison at the age of 22, and became addicted while there. His drug career trajectory was different than many of the principal respondents, but not completely unusual in that several of the other PRs reported starting use of Chiva in prison, or directly after leaving prison which has influenced their decision to use.

Campesino had started using alcohol at an early age and was around drugs because many of his friends used pot, heroin, and cocaine, but he had not ever had the urge to use heroin before prison. He only began smoking mota after he was released. Some five or six years after that he started using cocaine, heroin, and drinking rather steadily:

> Well, since I was about 17 I quit school and I started living with a girl. I lived with her for about 5 years and then I started getting in trouble. That was in 1969, that is the first time I got in trouble. I did a whole year in the county jail in TA. So, I came out and at that time I wasn't doing no drugs. I was just drinking my beers and smoking my little mota (pot), no?. I stayed out of trouble for about one year. From there they gave me 2-10 and I went to Santa Fe. I stayed over there from 71 until 1976. I came out in 76. We started living together and I started working and getting along and then I started drinking. I started messing around with another chick and I just partied. I had problems with her, and the girl stayed with me, no?. So, in about '78 I got [a parole] violation. I messed up with my parole was I violated. Anyway, when I went back and stay... I beat them, I went back in '78 and I beat them so they had to release me. Then in '97... maybe a year later, a year and a half later I got in trouble. That was for

> robbery and a stolen vehicle. Then I went back to joint and a that's when I started messing around with, you know, heroin. I didn't know nothing about it really... I knew about it but I never did any, and then over there, you know, there's a lot of things in that's people think that there isn't, no?

Campesino never referred to what he did as suicide. By the time Campesino reported the incident below, he had overdosed four times before, twice with mixed drugs and heroin, and twice with mixed drugs and cocaine. However, his act of ingesting and injecting several toxic substance and finally opening his own gut with a knife, were clearly a suicide attempt. He reported the following violent, dramatic incident, where he omitted explaining the use of other substances including cocaine and heroin before this incident actually took place.

> I went through a depression at one time. I almost, *pendejo como fui casi me mato* (idiot that I was, I almost killed myself)... it had to be the middle 80's. I was out, I was still with my old lady. We were having problems and I went away for five days. She kept looking for me. A friend finally found me and told me that the old lady was worried about me. I guess I was so depressed, I had to be depressed because I went home but I was pistiando (inebriated) all I remember is that I went inside the house and sat in the recliner and I guess I must have been kind of loaded because my old lady tells me that we were king of talking, like arguing... *not really arguing, but you know, and that I just go up and I went to where you keep the knife and all that stuff and went and got a knife and stabbed myself.*... when I woke up I said, where the hell am I?' Then I had tubes and all that stuff and my old lady and my mom were there and they were crying.... I thought I had gotten into a fight. They explained to me that I came in to the house and she told me that, all of sudden you got up off the chair and got the knife and stabbed yourself and then the *chotas* (police) came.' They took me to Los Alamos. So like I said, I had a blackout. Finally the girl got busted. So, I just kept on doing it. *One day a friend of mine told me, carnal, you're either going to have to stop or get on the methadone or they going to find you dead one of these days.* So *al fin bine y me meti en la medicina* (I entered the "medicine" program, i.e., methadone), I have been in the medicina ever since, and I have been doing alright, no! That's when I stopped drinking. I did drink, but not like I used to. It took me on that trip...I don't know... *Like I said to myself, I was lucky I didn't die...because they told my old lady that I only missed by a real little bit to kill myself...* I had gone mad and thing like that, but that was the only time...you know, but I haven't gone that way... so far. (Emphasis mine)

As had been seen in most of the case histories present, depression was a theme that ran like a great wave through the majority of principal respondents' discourse. Most expressed it openly and honestly as a weight on their lives. Typical of this was the poignant description given by the next case history.

Hembra

The interview with Hembra was conducted in a trailer in a treatment provider's compound. The trailer was large and spacious, clean and well furnished, and gave the appearance of a home. She held a little dog during the entire interview.

Hembra at the time of the interview had lived in the Española Valley most her life, though she had been born in California. She said she was 36 years old, had been arrested twice, and had dropped out of Española high school in the eleventh grade. She reported her ethnic background as "Spanish." When I asked what that meant to her she said, "To me? That I am, I don't know, I'm an ancestor (sic), I guess, of the Spanish people. That's the way I interpret it."

She had a broad face with short white teeth and large gums in an ample mouth; features that put me in mind of indigenous Mexicans I had seen in the state of Queretaro in central Mexico. She was large-boned, slightly overweight, and shapely. She wore her brown-black hair (which already had slips of gray) loosely held back with blue barrettes on either temple. She had on blue-jean coveralls and a blue, elastic, halter top, but unlike Bombón, despite the fact that she was quite thin, the bib of the coveralls barely contained her large halter-covered breast.

She reported that she was married at age 18 to a man 23 years older, right after her boyfriend had died in a car wreck; he was intoxicated. She reported that the marriage only lasted nine months.

> Because I really married for money, if you want me to be truthful.... I married for money.... He was just a good, good friend of the family and he just came from out of town. I had just, maybe six months prior to him coming into town, I had just lost my boyfriend of three years in a car wreck. So I was devastated to the max. And no, he was very respectful, but I caught my eye on him. At the time, I was going through a bad time

> and he caught my eye. How wealthy he was, and he liked me and told me basically if I married him, I could have anything I wanted. Not even sex involved as long as I was by his side.

She had been with her current live-in boyfriend, who owns a landscaping business, for 13 years. However, she reported that she had been disinterested in him for the last four years, "It's breaking us, on and off now.... *And I'm choosing the drug over my life*.... I've already done it. I mean it's going on four years, he's the one that's hanging on."

Hembra had four brothers, two of which were addicts. Her father had used heroin and cocaine on a regular basis. She reported that she had occasionally consumed "perks" (Percocets), and marijuana since she was 13 years old (which she had stolen from her father), and that she had been a heavy alcohol user since she was 18 years old. She had been using cocaine unabated for the last six years, and occasionally other drugs -- heroin, Percocets, Valium.

She had started taking cocaine when her father had died of an OD. A family friend had offered her "a line" of cocaine to comfort her, and she had been using ever since. When I asked her to tell me when she started taking drugs, she said,

> Well, it goes back about, I don't know, five or six years... Yeah. My father, (I never say when he died, because to me I think he's coming back.) So my father left and at that time, me and my dad were real close. And I couldn't handle it and somebody treated me to a line of coke and from there it went....Because at the time, I was mourning my father so bad, and I'm the type of person that, I don't cry. I keep everything inside of me, and like for a year, I secluded myself from everyone and everything. All I wanted was my little dog on my king-sized bed with my TV. That's all I wanted. And all I did was think of my dad. Look at videos of him. I became obsessed. I wanted to go with him, and you know what, I should have gotten help at the time, but I didn't. And I got caught up doing drugs so bad, trying to take away the so-called hurt, and I fucked up. I just did.

She had not OD'ed as of the interview, but her description of depression and helplessness against the drugs seemed ominous to me. At one point in the interview I asked her what allowed her to continue using drugs even though she

had expressed wanting to quit (a paraphrase of a question from the research instrument). Her reply was thick with emotion and tearful:

> Cause right now, the reason why I do drugs right now, as we speak, ***is because right now I don't have a future***. That's what I see in my life. I had one, I fucked up, I lost it, through stupidity, but right now in the present, to go get high, that's my goal. **Right now... *Because I'm totally depressed, I'm unhappy,*** because of my father, for what happened after my father.... Just because the drugs are easy to get, if the drugs were hard to find, I'm not the type, like I said, that likes to hustle. I don't like that shit. *The drugs are so easy to get. I mean I could place one phone call and in five minutes, I met with someone and I have my drugs*. That's how easy it is, and that's the reason why I continue. If I didn't have money, I'm pretty sure I could get money. I have so many material things that I could sell. Money is not the problem. ***Because the drugs are there, that's it.... And at the same time mixed up in there, because my life is just fucked up right now.*** I'm unhappy or whatever. See I love... there's a song, ok, by Marilyn Manson, which you are probably not into, but it goes, "I hate the drugs but the drugs love me." And that is so good, perfect model for me, cause that's what it is. I hate them so much, girl! I hate them, I hate them, and I've hated them.... *Because these drugs are really, its like cockroaches, I mean they are really piling one after another, and to me, I'd prefer to see a person dead of an OD than continue in their everyday life of hustling for drugs*. (Emphasis mine)

Nerviosa

Nerviosa was 22 at the time of the interview in October 2002. She was waiting for me in the library. Her grandmother, as I found out later, was with her, but left before we interviewed. She was dressed in a loose, black and white sports team shirt, black pants, and black sneakers with white soles. She appeared to be nervous, agitated, or so I thought at first. After a short time, it appeared that she might have some kind of neurological problem. Her hands, besides moving all the time, shook. She had a number of facial tics and could not sit still. She giggled a great deal before and after each question and each answer. It would have been irritating if it had not been so interesting a phenomenon.

If the pupils of her eyes had not reacted as normally as they did, (her movements had the effect of moving her face in and out of the direct sun light), it appeared to me that she was on speed or some type of upper. The interview

was difficult to conduct because Nerviosa would repeat almost every question, laugh or giggle nervously, and not answer very much. She giggled a great deal, fidgeted, and generally could not sit still. She seemed brained damaged to me: she reminded me so much of my brother who had survived falling eight stories from a tenement building in New York City, but had been brain damaged. Interviewing her was like pulling teeth.

She reported that she had been using Chiva for about five years, though she reported that she started using mota and alcohol when she was 15 years old. The same grandmother who had brought her to the interview and Nerviosa's ex-boyfriend had supported her Chiva habit of $50.00 every other day. Now that same grandmother paid for her methadone treatment.

Nerviosa was raised by both her grandmothers: Nerviosa had spent time in both Albuquerque and Española as she was growing up. Her parents had divorced when she was two and neither was around much of the time. She reported having had four siblings from the same father, but only her younger brother was a full-brother. He smoked mota, but did not do any other type of drugs.

Nerviosa spent her time mostly with friends, with whom she had begun drug usage. Both grandparents owned their own home. She reported that she started using Chiva because she was depressed about her life, though the manner in which she spoke of the depression was odd.

> Depressed (giggle)... I was depressed maybe, too. Just depressed with my life. (giggle) Just my life, family... ahum.... My parents weren't around, I guess, I don't know. (giggle) I wasn't that depressed but I was depressed. (Giggle) I wasn't like, you know, like all depressed, depressed, (laugh) but I was depressed because my parents were never around. They were around sometimes but not all the time. (Giggle) Just depressed. I was feeling like how come my parents aren't together -- different things going on in my mind (giggle).

Like many of the others, when asked her ethnicity she did not know what the word meant. After I explained she said she was a “Hispano (sic), Spanish.”

Bringing all it together

There were interviews presented which illustrated admitted attempts of suicide – Jovencito who admitted to attempting suicide because he was tired of living the drug life; Bobasabia who attempted to slice her wrist out of depression then overdosed because she knowingly took a larger amount than usual of heroin and cocaine mixed; Campesino who tried to commit suicide by injecting and ingesting several substances and when he was unsuccessful at that, he took a kitchen knife and slit his gut open.

Other case histories showed retrospective agreement that the overdoses taken were attempted suicides -- Bombón and Blondie, both of whom admitted that a particular overdose they took was in fact a suicide attempt.

There were a number of case histories that demonstrated such blatant acts of disregard for personal safety that I would say they were attempts of suicide – Hembra, who claimed to have not OD'ed at the time of the interviews but who admitted being severely depressed because her father had died of an OD, and said she started taking Valiums, heroin, cocaine, Percocets, and marijuana, often in combination of several, to ease the depression; Asedios' playing Russian roulette, and having multiple OD's; Agugero's who OD'ed three time in quick succession in one day ; Flaco's continued use of alcohol and heroin together, along with methadone; Huido who not only mixed multiple substances such as valiums, cocaine, and heroin, but who in anger at his parents, purposely overdosed.

These were only ten representative examples of the entire sample, many of which had similar case histories. As mentioned in the methods section, 21 out of the 34 had overdosed one or more times with multiple substances. From the case histories, all of the respondents appear to evidence a history of Street-level trauma: chronic and acute physical and mental insults and all either lived in the Valley all their lives and/or came from Hispano families who owned land. All appeared to show some apparent confusion about their "ethnicity."

In the next chapter I examine the possible links amongst Alienation, Anomie, and Trauma as elements or phenomenon that possibly influence SLT and C-PTSD.

CHAPTER VII

ALIENATION, ANOMIE, AND TRAUMA: RELATION TO SLT AND C-PTSD

All of the principal respondents had experienced serious trauma. Some had experienced high impact car collisions resulting in permanent neck, back, and limb damage resulting in chronic pain and in several cases, complete legal disability, several reported being the victims of sexual child abuse; others experienced trauma inflicted through fighting, and through incidents while incarcerated; and more than half reported experiencing the trauma of the death from overdose of an immediate family member, close relative, or close friend. These life changing events are what I am referring to as street-level trauma which coupled with historic/cultural trauma may lead to what I am calling Cultural-post traumatic stress disorder (C-PTSD).

All but one of the 34 principal respondents were ostensibly unemployed, and yet most eked out a subsistence by selling created artifacts, drugs, or their bodies. Some worked in underground economy jobs such as street auto mechanics, painting cars, construction, recycling stuff from houses they would break into (sometimes their own home or relative's homes), or by stealing and hustling. Clearly all would have been classified as part of the lumpen proletariat, though many either owned their own place, or lived with their parents and grandparents who owned their own place. In most cases that land was not arable, not even for small gardens.

Literally all the case histories laid out above -- Asedio, Agugero, Flaco, Huido, Bombón, Blondie, Jovencito, Campesino, Hembra, Nerviosa -- and those delineated below, clearly also fall under this important category since they all suffered significant traumas, alienation, and anomie as demonstrated in their reported drug careers, work histories, and general life histories. More importantly, the case histories presented are not exceptional, but rather firmly represent most of the sample of 34 PRs in the study (see page 81 for a chart of all the informants).

The next four cases histories, Chuchillo, Llagas, Negrito, and Llorón, provide an excellent illustration of the process of alienation, trauma, anomie, and in Cuchillo's case also an excellent example of the lumpen proletariat.

Cuchillo

Cuchillo is an excellent example of the landed lumpen proletariat. He was extremely nervous to the point that as we walked into the interviewing room I noticed he had an open knife in his pocket. I tried to put him at ease by sharing my own story with him, and that seemed to help.

He answered almost every question during the interview by either repeating the question, questioningly, or asking me to repeat the question. When I affirmed a question, then he would give a fairly short answer, reminiscent of police questioning and responses. The reason for his manner of answering became clear when he told me he had been incarcerated for five years. He had used Chiva most of the time while incarcerated. At the time of the interview, July 2002, Cuchillo was 26 years old, and reported his ethnicity as Hispanic and that he had stated using mota at age six, had begun using Chiva when he was fifteen; had used various drugs since then, but he preferred heroin to anything else. However, he reported repeatedly going back and forth between heroin and methadone.

When he stopped using heroin this time, nine months ago, he was using about $100.00 per day of heroin. He was now on methadone, along with his "girlfriend." They each had one child with someone else, though her child lived with them. He reported that he had not overdosed, that he was chronically unemployed (he mostly stole to support his habit) though he was a mechanic and high school graduate.

He also reported that he had been homeless for a time as a consequence of a group of "guys" burning his house down over an argument about his sister. He reported being very depressed about that. He now lived in a trailer on the property he had inherited, where his dad and other family members also had

their house. There was no arable land in the compound. When asked if the land had been inherited, he said, "Oh yeah, it's been in the family forever."

Llagas

Llagas is Hembra's brother. Llagas, was dressed in dirty, dark-grey, parachute-material pants (with all the pockets and zippers), and a dirty turquoise/green T-shirt. He did not understand when I asked him what his ethnic background was until I said, "like Hispanic or Latino?" He responded that he was Hispanic and repeated the word several times, as if making sure he was saying it right. He had lived most of his life in Espanola. His father worked in California for five years until he had an auto accident while intoxicated which left him almost dead (according to Llagas, "he was an alcoholic all his life"), and he returned to his family so they could take care of him. He reported that he was 39 years old at the time of the interview and had started using when he was 15 (two family friends had introduced him to heroin, both of whom were dead now from OD's), though he reported that he started using alcohol and pot at an earlier age.

> When I was 15... 14 I got introduced to heroin.... they're both dead, the people that introduced me to it. ODs, both of them.... Well, I was an alcoholic... well, I used to drink when I was a kid, like 11, smoke pot and all that. And at 15, tried heroin, like a little bit because they didn't want me to OD. Then a year passed, tried it again. That time, there was "Yellow Perks. So those were better than.. heroin, you know.... They're a Percocet or Percodan that were yellow, I don't know, I don't think they are making them no more. ((Note: yellow perks are actually Percodan and not Percocets)). And at that time I had veins so...pretty much gone now, with the Seconals… Reds. I used to throw Reds too and those eat up your veins fast once you shoot up, it like irritates the vein. Seconals are, um, do you know what it is?

Llagas had three brothers and a sister (Hembra cited above). One of his older brothers had used heroin, but quit about ten years ago. His father was an alcoholic and died at 57 (of an OD, though this fact was not revealed by him, it was revealed by Hembra).

He had been arrested twice, once for trafficking and contributing to delinquency of minor because his children were with him when they picked him up, and once when he was younger.

> When I was like 18, I had a shootout with some people, and then they got me for four attempted murders and six aggravated assaults. Took the kid to court and I won the four attempted murders, lost the six aggravated assaults. I was looking at prison time. In the year that I was out on bond, I got into another predicament of trafficking, which I wasn't, I was sort of set up, but at that time I was younger, I didn't know that much, anyway. I went and did time, 18 months back then. [That was back in] '85, '86. I was already, I had just got married and had a kid, that's when… and then the time passed. '88 I had another kid, a boy, and then '89 I had a girl, which are currently living with me. They have been living with me ever since I got a divorce, like 9 years ago. I was married for like 9 years.

Actually, his mother and sister were taking care of the children. He reported that his wife did not do drugs, but she smoked pot and drank alcohol.

> So we had three children together, stayed married for 9 years. In those 9 years, she went out on me three times. Second time, almost gave me a VD. Still stayed with her for our kids. Third time threw her the divorce papers, and took my kids; it's hard, all of them.

He repeatedly told me he did not drink alcohol "on a regular basis" and that he had not drank on this occasion, but I thought I smelled alcohol on his breath. The other possibility was that the smell emanated from all the ointment he had applied to his body. During the entire interview he continued to applying ointment to various places on his body which appeared to be abscesses on his neck, arms, and legs. He told me these were caused by his just shooting wherever, "anyplace I can get close to a vein because I don't have no veins left." The process of injecting outside the vein (missing the vein altogether either by going through it or around it) ended by causing the abscess of the immediate region. Abscesses are a very painful and life threatening event which I personally experienced twice in my life.

Seeing all those abscesses, and knowing firsthand how painful they are, a general feeling of sickness overtook me during the interview. At one point when he was describing the process of "booting-up" (of pushing the blood and liquefied heroin back and forth until the needle clogs), I excused myself, and I actually had to go outside and vomited.

Several times during the interview, he expressed a severe love/hate relationship towards heroin which was similar to what most principal respondents reported as their relationship to heroin or cocaine. He expressed his frustration at himself for wanting to continue to shoot up and wanting to leave the habit at the same time. Llagas had a hunched over posture, very like an old man despite the fact that he was only 39. I even commented that he was a young man, to which he laughed sadly, and said, "man, don't you see I have white hair? I'm an old man." His expression of body was telling: he would hold his hands palm up, arms in a in a supplicant position his arms forming a "W" extended out to either side of his body, and his shoulders hunched high round his chin. His frustration at his confusion of conflicting emotions was almost palpable.

Llagas had OD'ed "four or five in the hospital, but really like 12, 15 times." and when I asked him why he OD'ed, he said, "mixing all the drugs; mixing alcohol and pot and pills and heroin and everything." The desperation in his voice was something which affected me deeply. I left the interview more drained than usual, went back to the motel room, collapsed on the bed, and cried.

Negrito

Negrito was 33 at the time of the interview, had started using drugs and alcohol at the age of 18, and lived in the Española Valley all his life. He considered himself Chicano, Hispanic, and Catholic. His life and work history were similar to many of the PRs who personified alienation. His tragic story is typical of many of the other users that are in chronic pain.

Negrito worked home construction, but had to go to Los Alamos or Santa Fe in order to secure work. Now he's on disability as a result of a automobile collision which crushed his leg and left him with chronic debilitating pain after leaving the hospital. He's on Prozac along with heroin, occasional pain pills secured in the underground market, and methadone. When asked about his drug of choice, Negrito reported that:

> [I] prefer heroin. Drug of choice... yeah... used to take away all pain. I feel like it takes away all your pain and calms you down and.... It calms you like calm down, like so you don't feel pain or nothing, just calm down and

> everything. I was depressed just sometimes... get mad or something. Now I'm sick and tired of drugs. I just want to be normal. I don't want to do drugs no more. Just want to get help if I can. This was rough, kind of rough.

As of the interview, Negrito had used heroin for 16 years, along with his three older brothers. Negrito reported that he had not OD'ed, but his brothers had as well as his wife. One of his brothers and Negrito's wife died of ODs.

He reported that both his maternal and paternal grandparents had owned land as did his mother and father. Their lands had been inherited, but he did not know if the land had come from land grants, though his family had been on the land for several generations.

Rico

Rico at first appeared to be high or partly drunk or both (I debated interviewing him at all), but after all was said and done, I was glad I had interviewed him. His interview actually epitomized the chromic disability, brought about by trauma that many principal respondents evidenced. He was exceptional in that he apparently had money which he claimed to have gotten through real estate transactions. I was intrigued by his expensive clothing and prescription glasses -- trifocal, photogray, glass lenses and designer frames -- very expensive. I estimated them at about $500, since mine were similar without designer frames and I paid $300 when I bought them two years before. He had a blue denim cotton shirt with "Presbyterian" the name of the local hospital embroidered on the breast pocket, draped over his shoulders like a cape or shawl. Underneath the denim shirt he had a disheveled, wrinkled designer shirt which, as a former tailor I recognized as very well made: The stripped patterns perfectly matched at all the seams, collar and cuffs, and the breast pocket was virtually indistinguishable because it blended so well with patterning. Tailored shirts of this type usually cost about $150 to $300. He wore ill-fitting, but expensive designer jeans with no belt.

The guy was definitely intriguing; I could tell there was a great deal more there than met the eye. This was particularly true because as I began to

interview him, his "high/drunkenness" gave way to a keen sharpness: the blurred speech cleared up even quicker than his photogray lenses. I later found out he had another addict who "chauffeured" him around in a top-of-the-line Cadillac which Rico owned but could not drive. He also supported the other addict.

Rico was 59, at the time of the interview in November of 2002. He had been using heroin and other prescription medications for some 25 years, and though he was primarily on methadone now, he still used Chiva. However, his drugs of choice, when he could get them, were Seconals and Tuinals. He had lived in Española all his life and as a young man worked at the lab in Los Alamos, though he would not say what he did there. He claimed to have a very high Federal government security clearance, and that all his family members -- brothers and sisters -- were Ph.D.s. In the sample, in terms of education he and his family were exceptions with regards to educational attainment. The majority of respondents, including some of the family members, had little or no college attainment, and most had not finished high school. He received government disability as a consequence of a severe back injury:

> I am disabled from the back. I have tried to work through the process of being disabled, I can't work. I got hurt in an accident at work. And I have back problems...my first five vertebras, beginning from the colon upward are fractured, or destroyed or something is wrong with them: I still don't know.

At the time of the interview, he reported that he had only overdosed once because he was drunk and fixed. About his ethnicity he said,

> Chicano: I was born and bred here. I am not a Mexican, as per sé. *My ancestors were here way prior before all of these revolutions and bullshits since the 1500's*. So I consider myself a... an Española, a Chicano... a Española, a Chicano; Hispanic" (Emphasis mine).

He reported that he owned land as had his parents, who were now deceased. He was one of the PRs that most evidenced my theory that this area had created Marx's lumpen proletariat, but with land ownership.

Llorón

I interviewed Llorón May 2003. His case history evidences the type of acute and chronic trauma that many of the principal respondents suffered. He seemed to me to be high on speed or cocaine. He reported his ethnicity as Hispanic, which he said meant "I'm just having Spanish inheritance. I don't know if that's the word, but...."

He was 30 years old at the time of the interview and had been using cocaine since he was 18 years old. He started when he was released from prison. A friend offered him "a line" in front of a blind date, and he pretended that he had used it before; he just followed everyone else's lead. He reported that he occasionally used mota and had tried Chiva but didn't like it; he preferred the thrill he got from shooting cocaine. He had been smoking mota since he was 13 years old when his cousin's husband had turned him on to it.

Llorón reported that he had lived in the Española Valley all his life, and had graduated from high school there and received an associate's degree as an electrician:

> I was, ah, it wasn't hard for me, you know, I also done good in school and that. You know, I was pretty easy I should say, you know. I even went as far as going to college and I graduated that too, certified electrical

But at the time of the interview he had not worked for over a year because of physical problems which made him feel too weak to work.

> I couldn't maintain it physically. I did for awhile, but physically I was unable to maintain the job.... It was just too hard and then my physical abilities aren't as they used to be because of the drug usage. Well, I suffer from my prostate and then I can't really do much physically because I get weak and exhausted real fast. Then I have Hepatitis C, I don't know if that is affecting me in that manner. I guess [the prostrate] its inflamed, you know. Swollen and that. It's been at least a couple of years. [No insurance] That's why I can't continue my doctor's visits.... Seen a urologist but he didn't give a reason as to why or anything like that. No explanation.

Llorón reported that he lived at his father's house which was in a family complex inherited from his grandfather's side of the family. The complex was not arable.

Like many long term cocaine users, Llorón spoke of depression several times during the interview. He reported severe bouts of depression. He described one episode in particular very graphically. He was supposed to go home and take care of his son, but instead stayed away from home for days getting high, then as he did reach his house he couldn't turn into his yard, instead he said:

> I just started to crying. Started crying, just feeling really bad about myself and I turned around and I was just [going] and then I landed in a church. I was just passing through and then I ... my church, so I got down and I was in church crying and praying this and that then I called my mom cause at the point I was like all shaky and that, I couldn't drive.

Llorón was petitioning for Supplemental Security Income (SSI) because of his illnesses and an accident while he was in a rehabilitation program in Arizona.

> Well, like I was saying earlier, I'm always weak, fatigued, I can't really do much and I get really exhausted. And then I got ranned over in Arizona when I was at a halfway house on a pedal bike. I got knocked off. So my leg, my right leg, knee and foot always are in pain, like arthritis I guess.

He received a settlement from the accident, but it all went to pay back child support.

Cultural Displacement

With the exception of four principal respondents all of whom were Anglo – Bob, Kathy, Methmaid, and Blondie (who was more like the Valley sample than the other Anglos) -- all the other informants were life-long residents of the valley who considered themselves Hispanic, Hispano, Spanish or Chicano, and with only one exception (Rico), the loss of, or subsistence on historical "family" land was the norm, not the exception.

By contrast none of the Anglo respondents own or expected to inherit land nor did their parents; only Blondie's parents had owned a house in the Valley and they had since long moved away.

In every case as principal respondent after principal respondent reported their ethnicity (a term most did not understand without further qualification) they invariably enlisted the "exceptionalist thesis" (Gomez, 2007): not one of them considered himself or herself Mexican or of Mexican descent. Two mentioned Indian heritage, but also considered themselves Hispanos and all harkened their roots back to Spain, embracing the myth according to Gomez (2007) of pure or near pure Spanish heritage, though a few did acknowledge some indigenous roots, and one or two even brooked a glancing of White Unitedstatian heritage. However, the latter was quickly discounted or played down as unimportant, or disdained.

The important factor to them was their link to Spain. Many even disparaged Mexicans or "wetbacks" as some called them. Some blamed the Mexicans in the area for the flood of drugs, though it is evident from police reports and historical factors, that while the drugs do in fact come up from Mexico, particularly Mexican Black Tar, the majority of Chiva distributors are local people as several of the informants candidly admitted.

I met many of the informants in the complexes where they lived though I thought it best to not report it before. In particular I met family members -- a brother of one addict who had OD'ed a number of times; a sister of another heroin addict who was on the run with his father who was also addicted; and the father and mother of a heroin addict whom they help maintain his habit so he would not roam the street looking for money. In all cases, these families lived in a type of family compound.

These compounds usually had one entrance which could be gated, but often was not. There were always several dogs around, and at least from the vantage point which I could see, there was no arable land. Virtually every inch of land had even houses (some actually build on the roof of others and into the hillsides), sheds, cars, trucks, (both abandoned and apparently working), or boats on them.

Chapter Summary

The principal respondents' case histories demonstrated that (despite clear heuristic[7] understanding of the overdose process), many of their attitudes, as well as their latent and overt behavior towards overdosing, was emblematic of alienation, and anomic suicide. An anomie brought about by community alienation and street-level trauma underpinned by Cultural/ Historical trauma. As I have mentioned before, these two conditions together may (and appear to) lead to C-PTSD.

Some suicides are clearly that because the decedent leaves a note or tells family and friends of their intent. Others, as the case histories demonstrated, chose less obvious, though not always very subtle methods to end their own suffering without letting others know with a note or spoken word. The case histories provided lives where, obviously, the principal informant did not succeed in suicide, though in several cases, it was not for lack of trying. What I presented were, I believe, suicide attempts in various forms.

The principal respondents who had experienced several overdoses evidenced suicide attempts that masqueraded as drug overdoses. Their case histories illustrated the principal components underpinning and overarching the argument of this dissertation. These histories illustrate individual and historical trauma, alienation, anomie, and ultimately the similarity of these case histories to the cases labeled "accidental overdoses" by the OMI.

As shown in the past two chapters and as spoken to by family members, most of the principal respondents had experienced street-level trauma: High impact vehicular collisions resulting in permanent neck, back, and limb damage, chronic pain, and many complete legal disability; several reported being the victims of sexual child abuse; others experienced trauma inflicted through fighting

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[7] I use the heuristic in its classic sense: “involved or serving as an aid to learning, discovery, or problem-solving by experimental and especially trail-and-error methods” (Merriam Webster, 2003).

and while incarcerated; and more than half reported experiencing the trauma of the death from overdose or killings of an immediate family member, close relative, or close friend. These events are what I am referring to as street-level trauma because they are life changing (though it is also apparent that many in the Valley also have similar experiences and do not end up in drug careers or with SLT). I believe that SLT coupled with historic/cultural trauma may lead to Cultural-post traumatic stress disorder (C-PTSD). In turn, coupled with a life-long substance abuse career may lead to anomic suicide, which I believe may be then labeled as accidental drug overdoses by the OMI.

Street-level trauma and cultural-post traumatic stress disorders are unique concepts. While these conditions have been alluded to in some fashion in several forms in different disciplines, the concept of broken lives lived in situations that appear to be similar to war zones – Harlem, New York, East Los Angeles, California, and the Valley, as well as many other places around the world with similar colonized situations and an abundance of traumatized lives mixed with substance abuse – no one, as far as I have been able to determine, has ever given these very real conditions a name. Names that are both appropriate and accurate and which, with further study, I believe, will lead to more efficacious and accurate prevention and interventions modalities than the one-on-one, agent driven system of addiction cures that now exist. We may actually come up with system/structurally driven programs to really help.

CHAPTER VIII: FROM DARKNESS TO LIGHT: CONCLUSIONS, RECOMMENDATIONS AND FUTURE RESEARCH

Introduction

Since this dissertation began, at the very least three and possibly the entire sample of principal informants have died from overdoses. When I was doing the field work, I would invariably encounter one or the other of the PRs in my daily travels throughout the Valley. As this manuscript goes to press, I have now lived in the Valley for more than two years. I have not encountered one, not a single one, of the PRs. I have made no inquires as to their whereabouts because I did not think it appropriate without permission from the IRB, but their absence is, to me, an ominous harbinger of an epidemic that continues unabated despite the introduction of Naloxone, and the seemingly best efforts of the New Mexico Health Department and local authorities.

Ultimately, and *more important than even this dissertation to me, is my fervent hope that out of this action oriented research and analysis will come solutions to the destructive phenomenon of overdoses that has been killing so many people for more than 10 years in the Valley*

The findings below make a compelling argument for change of protocol and framework to stem the dying. I submit that it is time for a change of visual aspects, from individualistic modalities to a systemic one. It is time that the powers-that-be look to sociology for an answer. Such as answer to the questions I posed in the introduction of this dissertation:

- What explains more than a decade of high rates of overdose mortality in North Central New Mexico (the Valley)?
- How does ethnic identity and cultural / historical trauma shape the face of the epidemic?

Hypothesis

From the Principal Questions I posit these assumptions to examine in this dissertation:

A. A major portion of the OMI specified accidental drug overdoses may be predominately suicides in the Valley.

B. While death occurs from injecting and ingesting lethal quantities of controlled and/or illicit substances, the preponderate number of these accidental drug overdoses may be explicated by a combination of structural factors:

B.1 The structural factors may collectively be called street-level trauma, and cultural/historic trauma, which in combination may lead to Cultural-Post Traumatic Stress Disorder, and may be affected by ethnicity.

Getting to the End: Concluding, Recommending, and Future Studies:

Not to prove, but to shed light

In the social sciences it is axiomatic that it is virtually impossible to "prove" or show conclusively that some social phenomenon or dependant variable, "A" is caused by a particular set of social phenomena, or independent variables "b" through "x." Regardless of the proof phenomenon, some basic assumptions are made in order to reach conclusion about anything in the universe. Most scientists (including social scientists) make basic assumptions about the nature of reality. One such assumption is that an objective reality exists for the observed and the observer. Even if one presupposes social construction and that these realities are not totally congruent each to the other, there must be some point of departure; if not, there would be no basis for any human communicatione (Tuner, 1998).

Summing up

I make the assumption that these realities can be accessed, though I fully understand that they are a reality that must be edited (even mediated) by the observed, the observer, by environment, and contextual circumstances (Agar, 1986). While I firmly believe that my central research questions are correctly answered by the data I presented; that many of the so-called accidental

overdoses in the Valley are actually suicides. This assertion is nonetheless highly problematic under the most optimal of "experimental" conditions. Under real life conditions such deduction of conclusive proof is nigh impossible.

My intent then, was to show that it is plausible and even cogently probable, that many if not most, of the accidental overdoses in older substance abusers are actually suicides. I think I have shown this by using several first and secondary "sources-of-knowing," (data streams) in the same sense as Fielding and Fielding (1986). I think I have come close to an apparent determination. I joined these seemingly disparate data streams through critical analysis using theoretical orientation, qualitative and statistical computer programs, and actual life experience narratives -- of users, family members of users, services professionals, and my own autoethnographic narrative.

Additionally, participant observation and 34 interviews with key informants, buttressed by my own drug career experiences, lead me to infer that the determination of overdose deaths in the Valley, in many of the cases, are not "accidental overdoses," but are rather suicide. I base these conclusions on the affirmation of the majority of PRs and their family members concerning actual attempted suicides, retrospective acknowledgement of attempted suicide that I present in the data, and contextual chapters.

There were interviews presented which illustrated admitted attempts of suicide – Jovencito who admitted to attempting suicide because he was tired of living the drug life; Bobasabia who attempted to slice her wrist out of depression then overdosed because she knowingly took a larger amount than usual of heroin and cocaine mixed; Campesino who tried to commit suicide by injecting and ingesting several substances and when he was unsuccessful at that, he took a kitchen knife and slit his gut open.

Other cases histories showed retrospective agreement that the overdoses taken were attempted suicides -- Bombón and Blondie both of whom admitted that a particular overdose they took was in fact a suicide attempt.

There were a number of case histories that demonstrated such blatant acts of disregard for personal safety that I would say they were attempts of suicide – Hembra, who claimed to have not OD'ed at the time of the interviews but who admitted being severely depressed because her father had died of an OD, and said she started taking Valiums, heroin, cocaine, Percocets, and marijuana, often in combination of several, to ease the depression; Asedios' playing Russian roulette, and having multiple OD's; Agugero's who OD'ed three times in quick succession in one day ; Flaco's continued use of alcohol and heroin together, along with methadone; Huido who not only mixed multiple substances such as valiums, cocaine, and heroin, but who, in anger at his parents, purposely overdosed.

These were only ten representative examples of the entire sample, many of which had similar case histories. As mentioned in the methods section, 21 out of the 34 had overdosed one or more times with multiple substances.

If I am correct in my hypothesis, and I contend that the social facts presented appear to uphold that, then the solution lies in treatment for suicidal ideation, or conditions leading to suicide and depressive states, and not in treatment solely and specifically for addiction. For example, having suffering from Street-Level Trauma and Cultural/Historic Trauma possibly leading to the condition of Cultural-Post Traumatic Stress Disorder.

While the addiction may be problematic, the literature indicates that it does not a priori result in disproportionate number of overdose deaths. Consequently, such disproportionately large numbers of drug overdoses as are being experienced in the current epidemic that has lasted, through minor ebbs and flows, for some twelve years, scream for a new perspective. In seeking a new perspective we need to consider the follow real life factors.

As substance abusers, we learn within the first two years of our drug careers, through both trial and/or shared knowledge from experienced users, that mixing certain substances is lethal. Those that do not learn this lesson usually perish within the first few years of their drug career.

The mean age of inception into drug use in Rio Arriba County appears to be between the ages of 7-12 years. It would hold then that most of the accidental overdoses would occur within the first five or six years of a substance abuse career, and not at middle age as is the case in the Valley: the mean age of these so called accidental overdoses over the twelve year period examined is 39 years of age. This is an average much higher than the national norm of 22 years of age. Ten years of OMI data indicates that the majority of OD's have several substances in their system at time of death. A mean of ten substances was found with a range of five to 30 plus substances at the time of death. A person not addicted to heroin has been shown to be able to consume 48 mg of pure heroin without overdosing. Addicts have been shown to be able to take up to 18 times the average street dosage without over dosing.

Thus it would appear that older, and more experienced substance users are ingesting and/or injecting many different types of substances resulting in overdose and death. To any rational person such massive abuse of potentially lethal substances, particularly concurrently used in combination with each other, speaks volumes in turns of intention. It is reasonable to assume that this type of behavior is indicative a willful self-destructiveness, as appeared to be the case in the majority of interviewees who attested to this fact.

Additionally, the willful or oblique complicity of OMI in ruling as accidental the death of a person that dies with that many substances screams for a reevaluation of the protocols used in that office to determine who has committed suicide and who has not. The lack of a set policy on the issue bespeaks at best a benevolent neglect on the topic or at worse a meaningful manner of avoiding the classifying of suicides. There may be many reasons for this practice, not the least of which may be a very real concern for the family members, many of whom are Catholics and to whom such a declaration would be devastating.

That well meaning actions, nonetheless, make for the production of erroneous modes of prevention, intervention, treatment, and cure of substance

abuse in the Valley. Examination of the 34 interviews I conducted myself shows a large number of people who have (a)expressed suicidal ideation in the past; (b) actually attempted suicide; and (c) knew people who had overdosed and believed that these people killed themselves (as opposed to dying from accidental OD's).

Street-level trauma and C-PTSD

There are ample case histories of repeated acute and chronic traumatic events leading to widespread street-level trauma and cultural post traumatic stress disorder which require structural intervention. The majority of principal respondents and their family members repeatedly pointed to massive repetitive trauma that the substance abusers had suffered throughout their earlier lives.

The unique concept of street-level-trauma is the result of such lives lived in pain and constant reoccurring trauma both physically and mentally, as well as economically and culturally. Every one of the Hispano respondents appeared to show signs of this condition. There appears to be ample social facts that point to the so-called accidental drug overdoses being anomic forms of suicides brought about by multiple forms of historical/cultural and street-level trauma combined, possibly resulting in C-PTSD in many of the people in the Valley.

The Venn diagram (Figure 8.1) shows what may be the interaction between the three "conditions" – Substance Abuse (SA), Street-Level Trauma (SLT), and Historical /Cultural Trauma (H/CT). **Area A+B+C is the area I posit that results in C-PTSD.** With the intersection of all three zones "C" being the most dangerous since it combines the stressors of all three conditions.

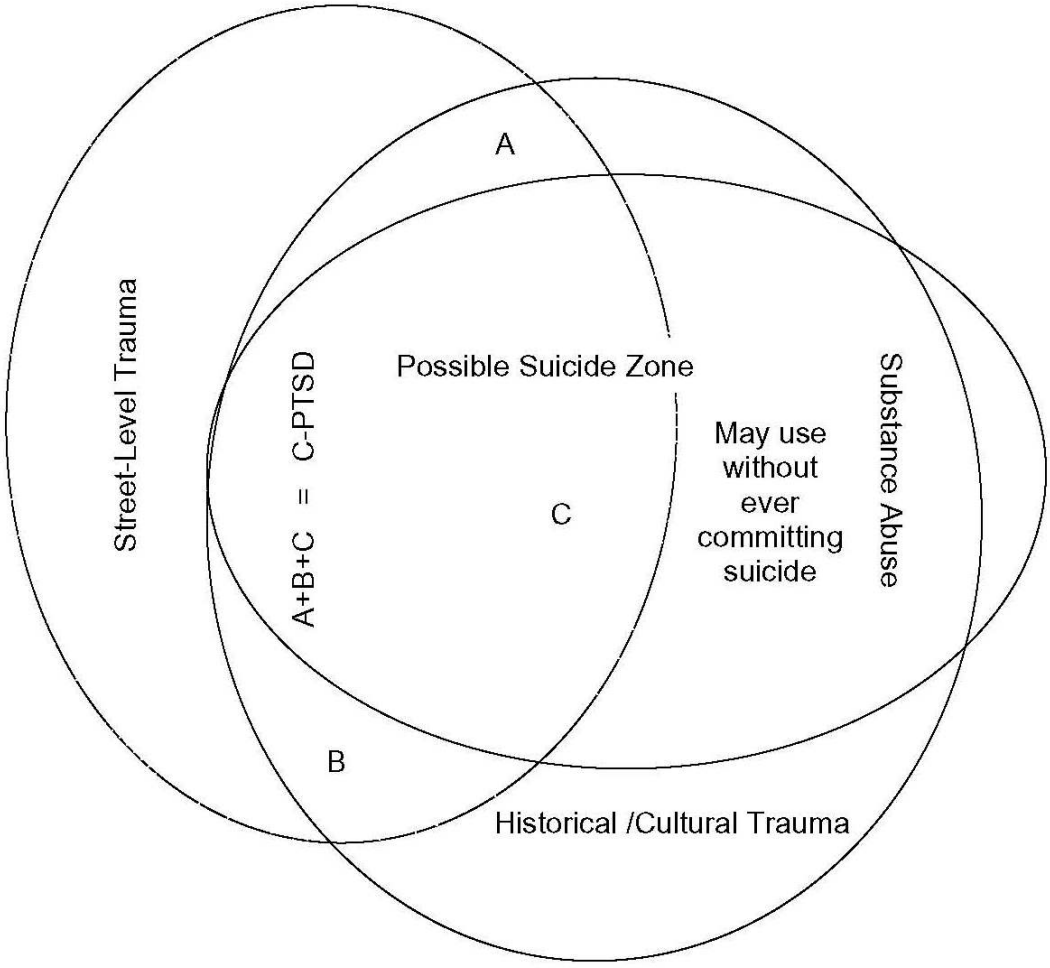

Figure 8.1: **Intersections of Street-Level Trauma, Historical/Cultural Trauma, and Substance Abuse**

Individuals located in zone "B" who are located outside the SLT and SA, and the individuals located in zone "A" outside the SLT and SA, are those that experience Historical/Cultural Trauma, but who somehow have the resiliency to survive without succumbing to either drugs or SLT.

While not everyone in the Valley who experience Street-Level Trauma, or Cultural /Historical Trauma, and the resultant combination of C-PTSD, ends up abusing drug and alcohol or committing suicide, it appears that a disproportionate number of people in the Valley do succumb to substance abuse, as the higher than national average 100,000 per capita figures demonstrate over the last twelve years. Of intense interest is to study the people in the Valley that do not succumb to these pressures. How do they stave off the pernicious phenomenon that engulfs so many of their relatives and friends? Unfortunately, such an examination was beyond the scope of this dissertation. However, that question is well worth pursing in future research and stands as a prime recommendation.

Relevance to other colonized peoples

I submit that both this apparent C-PTSD (resulting from SLT and Historical/Cultural traumatization), and SLT by itself, may be applicable to any colonized peoples anywhere in the world – Puerto Rico, the Philippines, the Dominican Republic, Haiti, and many more – particularly those peoples that have been either pushed or pulled in to ethnic enclaves or ghettoes. The latter often become more like war zones than centers of gentile civilization. Diagnosis of these conditions may go a long way towards providing palliative and curative measures for those peoples as well.

Recommendations

It is now the practice of most hospitals in New Mexico to treat and release anyone that presents with a drug overdose. The practice is equally observed by first responders to a drug overdose call. The patient is stabilized and unless they request other assistance is released. This practice fails to consider that what is being done is tantamount to treating and releasing a massive cardiac infarction without inpatient follow up.

The first recommendation then, has to do with this practice of treat, stabilize, and release overdose patients, what I call a strategy of “catch and release.” When a person presents with an overdose, beside the immediate

treatment to save the life, after stabilization, a full physical and psychiatric evaluation should be performed to determine if the person is suicidal, if they actually require palliative remediation for other acute or chronic conditions, and what interventions should be undertaken for these medical conditions. Street-level-trauma and C-PTSD should be diagnosed and treated instead of the "catch-and-release" system of medical care we now have in place for overdoses. An excellent instrument to use for this purpose is the shorter version of the standardized Prime-MD. It is easily administered and interpreted.

The epidemic of drug addiction in the Valley in particular, but also in all New Mexico and the United States has its roots in the Prohibition-like mentality that has swept the nation with draconian anti drug laws. These legislative endeavors while clearly meant to help the situation have not worked and have only served to create a prison population in the United States which now exceeds two million people behind bars, and is greater than all the other prison populations of all nations in the world combined. Clearly, it is time for a dramatic and efficacious change in legislation. Additionally these laws have had the same effect on nefarious drug activities as did Prohibition, namely to create huge syndicates of intrepid entrepreneurs who have capitalized on the demand by supplying the goods illegally.

Prison is NOT a form of treatment. My second recommendation is that there should be more effective way to implement prevention and intervention programs, other that the hit and miss systems that exist today.

Further, it seems apparent to me that the systemic problems that exist in the Valley require systemic, wholistic solutions. As such, the second recommendation is to economic development, and public health solutions should be devised and pursued in the form of education programs, and monetary assistance to develop new green enterprises that would help employ and give a sense of self-worth to those involved.

OMI recommendations

Concerning the Office of the Medical Investigator, there are two recommendations:

1. A set protocol should be put in place to determine more strictly who should be designated as a suicide victim and who should be designated as a victim of accidental overdose death; and
2. A deeper examination or search of social facts should be made to determine the ethnicity or race of a decedent.

Future research

Perhaps the most important research that could be undertaken immediately is to determine if any of the principal informants are still alive, or if as I fear, they are all dead. If the latter is true, then a concerted effort can be mounted to develop interventions and prevention programs from the results of the data of such a study which would concentrate their efforts on mental health evaluation and assistance, and economic development.

Research needs to be done on what will be the consequences in implementing the recommendations: there must be a determination of the social cost, the macro and micro effects of treatment, economic development and educational programs, as well as the broader ramifications of replacing the "catch-and-release" protocols..

Another direction that should be pursued is the detailed statistical analysis of the OMI data set for the last 12 years which was beyond the scope of this dissertation. Mining of that data set would yield true statistical analysis beyond the scope of this dissertation but which may prove to be critical in the analysis of accidental drug overdoses as suicide.

Of paramount importance is to determine as soon and as clearly as possible why some of the Valley residents are resilient and do not succumb to the substance abuse career despite exposure to the same or similar conditions the substance abusers are exposed to, including SLT, Cultural/Historic Trauma, and C-PTSD. Further research should also be done on those individuals in the

Valley that try various illegal substances and do not continue using them as others obviously do. Comparison of four sets of data – (1) long term users, (2) former users permanently not using any more, (3) those that have try illicit substances but never used again, and (4) those that never used.

Also an important point for future research is what has happen to Anglos who have been assimilated into the Hispano culture and how they may have also incorporated the same trauma almost by osmosis. An example of this is Blondie who in many ways acted almost as if she were a Hispana (female Hispano).

Lastly, it may be well worth researching how portable the concepts of Street-Level Trauma and Cultural-Post Traumatic Stress Disorder are to other colonized cultures – Native American in all the Americas, Dominicans, Native Hawaiians, and Puerto Ricans. Each of these are groups that have suffered colonization and all experience high rates of suicide and may be experiencing even higher rates if the accidental drug overdoses they are experiencing are also suicides. More research should also be conducted in these areas with a particular eye towards racial stigmatization, and the intersections of race and gender.

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