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Spontaneous Demand: Addiction Treatment amidst the Citizen Revolution

Ana Isabel Jácome Rosenfeld

Director: Christopher Garces

Readers: Ian Withmarsh, Kevin O'Neill, Lisset Coba, and Rachel Prentice

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To Farah.

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Quito, June of 2019



Ana Isabel Jácome Rosenfeld

Abstract

The inclusion of Addiction as a Health problem in the 2008 Constitution was interpreted as an emancipatory move designed to restore rights lost in a war against drugs, which had generated an increase on prison population and the proliferation of a market of addiction treatment through private clinics. The State opened the first public addiction treatment center in 2013, first as a contingency area for the patients rescued from private clinics which the state shut down, and later as a therapeutic community for the problematic use of alcohol and other drugs.

The clinic is a privileged space for understanding what the effects are of the change in the interpretative paradigm, from a criminalization perspective to a medicalization one. While the common understanding of addiction as a disease rests on the justification for War strategies, the new center requires the reconstruction of the concept and the subjectivities from a health perspective. The dissertation reviews the legal instruments and policies related to drugs, in order to discuss the penal and later the private security approaches of drug use as the contextual components of the public addiction treatment center.

The clinic is studied from the practices occurring in it, showing a series of contradictions between security and health in the everyday experiences of addicts undergoing treatment. Remarkably, the women are treated differently than the men, and the focus is different in the approach when the recipients are male or female. The patronizing of women and a rhetoric of protection legitimate practices of confinement that don't appear as spontaneously in the male wing.

The bureaucratic nature of the processes affects not only the functionaries of the public addiction treatment center, but they reach the private spaces of employees, which end up improvising division practices which differentiate their work and their personal lives. Patients and their families are also reached through bureaucratic procedures which make them think against internment.

It is in this context that the public clinic aims to the re-construction of subjectivities which can be civilized into functioning individuals; yet effectiveness is not necessarily sufficient yet

so as to differentiate the public and the private. In any case, health is a right, and addiction is a commodity that the small trafficker is willing to risk.

Aknowledgments

There are many people which made this research possible. To begin with, people from the National Drug Observatory of the CONSEP, the security institution previously in charge of drug issues, suggested I conduct the ethnographic research at the new public addiction treatment center; I could contact not only the Coordinator from the public center through them, but also the Director of Mental Health from the Public Health Ministry. All of them helped me in the process of definition of the space for ethnographic work.

Secondly, the staff at the public clinic was always open and ready to answer any of my questions regarding the therapeutic process or the patients, and even their own lives. I am thankful for their openness in a topic as closed as addiction.

The most important aspects of this dissertation come from the narratives of the patients. Everyone wanted to participate in the process of learning about and understanding addiction and many let me look into their histories in order to make sense of addiction trajectories and therapeutic options/choices. I am grateful for their trust and interest.

My advisor was central to the possibility of continuing with this project and making sense of it. The invitation to doctoral classes at Cornell University and the exposure to a series of ethnographies made a huge difference in the relationship I had with my ethnographic work. As difficult as it was, I am forever thankful.

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Introduction

In the fateful year of 2008, the new and much-heralded Constitution brought upon by the Citizen Revolution defined addiction as a Public Health problem. This governmental inclusion was received as an important step in a needed process of countering the War on Drugs: the traditional Ecuadorian critique of “drug supply,” a discourse which hailed from the United States, which began during the Nixon era, had by now extended to Latin America, as an increasingly repressive wave of anti-drug policies overloaded penitentiaries throughout the continent. The war on narcotics had been justified on the alleged dangers of certain substances, depicted as capable of ruining anyone’s life with such ease that a decisive, warlike response seemed not only reasonable but necessary.

As a result of this ideological shift, the War on Drugs in Ecuador ironically allowed for more direct military control from the hegemonic global powers, backed by the United Nations, over poorer countries throughout the region. In Ecuador, where my research has been situated, this control began with the country’s inclusion in multilateral drug control programs being conducted far and wide across so-called “producer countries,” such as Colombia, Peru and Bolivia. And yet, since Ecuador itself wasn’t a major producer, most citizens and their political representatives began to rely on other indicators “beyond supply” in order to demonstrate pro-active multilateral collaboration and cooperation. Under these politically strange and logically tortured circumstances, Ecuador inaugurated the habitual practice of jailing or imprisoning drug traffickers, a process through which the penal system’s rates of incarceration became the preferred indicators the country needed in order to demonstrate global participation in the War on Drugs, in order to receive international funding.

While the 1990 law that served as the flashpoint for generating Ecuador’s participation in the War on Drugs, and dramatically increased per capita number of prisoners of state, the police were also given the authority to apprehend and bring any person suspected of intoxication to a hospital or to a rehabilitation clinic, where the subject in question would be evaluated and, if it was confirmed that illicit substances had been consumed, treatment would automatically be ordered. This “drug policy,” in turn, fomented several generations of a new and increasingly swollen market for drug addiction treatment, a discourse and practice which took over for drug use and developed its own political logics and interpersonal therapeutics. The inclusion

of Article 364 of the 2008 Constitution, addressed not only the need for drug users to be differentiated from drug traffickers, and thus to avoid incarceration, but also the generation of public spaces for the treatment of addicted subjects and populations. The new governmental regulation of the private clinics moved from being under the surveillance a security institution, the National Council for Control of Narcotic and Psychotropic Substances (CONSEP), to the Ministry of Health, and this literal “re-translation” opened the need to create new regulations for their functioning as well as the establishment of multi-tiered mechanisms of managerial control in order to evaluate their duties to the state.

The public addiction treatment center became the first of its kind, an “experiment in motion,” developed to face the challenge of generating generational shifts in the way addiction was being addressed—and the results that certain interventions obtained. As a privileged space of inquiry, the drug rehabilitation clinic is the place where the old and the new representations of “the state” come face to face, and through daily practices, the contradictions that give form to the therapeutic processes, within the context of the public and the bureaucratic, arise. The Center is a place set aside for emancipation, immersed in a logics of the state meant to counter neoliberal excesses, while addressing practical day-to-day conditions of deviance and disobedience that were notoriously hard to handle. This doctoral study as a whole is an exploration of the unprecedented transition from a penal model of addiction treatment, into a new, practically *ersatz* model of “medico-juridical care.”

Considering addiction a health problem, which Ecuadorian governmentality had recently embraced, implied a shift through which drug use was no longer considered a crime, and the public center had to apply this change amidst the inertia produced by a moral prohibitionist movement that had been maintained as a moral norm for so long. These institutional circumstances in effect made the public center into a privileged space for observing the creation of a medical category against a strong and longstanding depiction of criminality linked to deviant behavior: the state needed to produce new modes of addressing conflictive drug use, differentiating these everyday customs from what was previously coded as “abuses,” linked to a neoliberal logic that the Citizen Revolution intended to counter.

While most research on this process has focused on prisons, there is hardly any scholarly material which focuses primarily on the private addiction treatment market and its market logics; in fact, the “abuses” around which the clinics were constructed and their interventions,

were made publicly known through denouncements made by the LGBTI community, as many of these centers also offered so-called “dehomosexualization” clinical interventions. Indeed, addiction was linked to deviance from the creation of Law 108, dating back to the 90s, when private clinics operated as conduct disorder treatment centers, to the point of offering what was then called “conversion therapies.” While LGBTI movements were eventually able to raise their voices in solidarity and to denounce the abuses people underwent inside those clinics, individual citizens and groups who presented conflicts with drug abuse treatment were rarely if ever able independently able to raise a voice against these widespread so-called “clinical therapeutic” practices. Moreover, the public “addiction treatment” center being a new kind of institutional place, no previous studies have taken as their object of inquiry the processes of construction of this new medical category as the subject of their analysis.

The public clinic was built as a space of necessary contingency for the intervention of private clinics: those who were interned, and needed addiction treatment, were offered the option of one month of inpatient treatment at the “contingency area” if the clinic where they were discovered had been decommissioned. Its therapeutic model, developed by the team of psychologists initially hired, was based on what they claimed to be “universal knowledge”, taken from the World Health Organization and the American Psychiatric Association, the two principal institutions that were defining mental disorders on a global scale; also, it was an experiment led by the political need and opportunity it presented to successfully counter previous practices which had originated from the War on Drugs and the representations it generated regarding drug use. At the same time, public clinics were only possible given the series of contributions each professional from myriad disciplines could come up with, developing into a multidisciplinary team which aimed to bring a complex approach to addiction. And yet, the generation of the particularly Ecuadorian medical category of addiction inside the public clinic, as well as its strategies for curing it, were developing amidst a political and social-historical context in which preconceptions of the matter of addiction had already affected many lives, and had been “known” in many numbers of traditional and scientific ways.

So, what amounts to “addiction” within the publicly authorized addiction clinic? Another crucial aspect of the construction of this public health malady was the possibility that the affected individuals finally, at long last, had both the opportunity and requirement to speak about their experience. Beyond regrets, apologies, hatred or carelessness, what the patient was

obligated to say about her symptoms had never been relevant to his or her past. Addiction was a behavior to be corrected or punished, but that was nearly all. The nature of the new center brought a new kind of openness into public debate, a kind of liberal therapeutics which clashed against the remains of the previous regime of medical beliefs and practices, where “behind closed doors”, new and undocumented approaches began to dominate the private addiction treatment market. For the very first time, patients undergoing addiction treatment were made visible to the rest of the world.

The following dissertation is an ethnographic investigation conducted at the first public addiction treatment center in Ecuador, a therapeutic community experiment which led to the creation of other similar spaces throughout the country. The dissertation itself is divided into five chapters which tell the story of drug policy in Ecuador. As a clinical psychologist, having completed a master’s program in forensic psychology in the United States, I wondered why drug policy was mostly shaped by common beliefs and representations, disregarding an immense majority of everyday and even hidden normative uses. I had already observed as many childhood friends first were thrown into and then lost inside the abysmal cracks of private addiction treatment clinics, while many more presented their occasional drug use with no public or private consequences or problems whatsoever. And yet, the private drug addiction clinics were never considered or seriously analyzed in policy-making circles. The public treatment center as such offered the unique opportunity to study drug policies from a single space which subjectively brought together law, policy, and institutions along with popular public and private representations, unfolding within a history of war and active state criminal repression.

Similar studies have been conducted in the past. Annemarie Mol has worked on the construction of a medical category (atherosclerosis) from an ethnographic approach inside a health center. Angela Garcia’s study of heroin addiction through a detoxification facility is also an account of the many aspects included in the centralization and containment process, which go beyond the substance and its effect in the body. Instead, Garcia shows a history of dispossession, paired with a poorly staffed and underfunded medical facility, attempting to address a problematic which goes far beyond any commonly held beliefs regarding heroin addiction. Kevin O’Neill has studied religious approaches to addiction treatment in Guatemala, a country marked by its condition of being a transit zone for drugs coming from South America to the United States. In an earlier context, Joao Biehl has shown, through his

work on ersatz clinics such as the Brazilian clinic called Vita, the ways in which medicalization maps onto a series of social, historical and economic factors influencing a person's biological life, disposed of in a place of social abandonment where she ultimately can be left to die. Medicalization appears not only as an opportunity to treat psychiatric illnesses, but also and more critically to legitimize abandonment after a series of quiet public and private interventions which aim not to improve a person's symptoms, but rather to domesticate them.

In Ecuador, most studies have focused on the prison system: Nuñez Vega has presented an ethnographic study of prisons and illegal drugs, analyzing the articulation between prisons and the intransigence of supply and demand economy of drug trafficking. Nuñez describes the organization and functioning of prisons, and the way they relate to their broader social context of criminalization and the normalization of spaces of willful state neglect. Anne Wilkinson focused her research on "reparative practices": conversion therapies offered in private addiction treatment centers for dehomosexualization. Her approach shows the discursive disputes and struggles that shape the formation of subjectivities, which are worked through in the definition of the individual and her sexuality. Albeit briefly, Rodrigo Tenorio and myself worked on a study of private clinics: through interviewing former patients, we found a consistent description of therapeutic approaches that relied on violence, torture, starvation, and humiliation, while the idea of addiction as an incurable disease allowed for extended, although illicit interventions based on deprivation of liberty, given the approval of family members, and with little or no control from the state.

The first chapter of this dissertation addresses the state and institutional changes in the legal framework that carried the country over from repressive policies and the surge of private clinics, going to the very first attempts to control substances in the Colonial period, and ultimately to 20th century and the 21st century's Citizen Revolution, a left-wing government which included addiction as a public health problem. The emblematic 2008 Constitution, the crown jewels of the Citizen Revolution, ultimately created the very first public addiction treatment center. By chapter's end, we observe that across the regime of clinical treatment Ecuador has experienced a (rather quiet) counter-reform movement which threatened the mass warehousing of human bodies and the quiet achievements of the War on Drugs.

As a researcher, I found that a chapter describing the laws and policies of drugs in the country could only make sense if I could see them through the lives of people who were personally involved, in one way or the other. Rafa, a good friend of mine, incarcerated for drug trafficking, showed me firsthand the broad-based social, political, economic, and gendered effects of the repression of non-violent offenders, punished with many years of imprisonment for merely three kilos of pot. His experience at the hands of the state's legal and repressive systems has demonstrated, beyond the anodyne "nature" of laws and policies, the raw effects not only of confinement, but also of the abuses ultimately routinized and made normal by the elements of the prison system. Prisoners, as the main products of the War on Drugs, are the unlucky object-lessons or material recipients of public policies designed to justify new forms of prohibition which, more often than not, end with them becoming addicts of drugs they didn't consume on the outside. All the while, representations of drugs and their effects are reinforced.

Charlie, a young photographer who supported cannabis legalization, spent two and a half months in a state of preventive imprisonment, and was later released thanks to the chart of thresholds or maximum amounts, an example of policies and their creative uses by the people affected. And Felipe, as the leader of a social movement aligned with a government which excluded opposing movements, demonstrated the importance of supporting a fair debate, as exclusionist anti-drug practices end up affecting everyone, regardless of their position. Democracy is not a matter of loyalty, though it is seductive as such, and one's personal self-perception of participation in anti-drug programs remains precisely that: only an illusion. Previous work on social movements amid the Citizen Revolution, for example by Ortiz Lemos (2012), facilitated the understanding of these broad-based and intersubjective processes.

The second chapter describes the private clinics and the dominant form of therapy for addiction: a mixture of experiential narratives with starvation, physical abuse, and demoralization, occurring mainly under conditions of forced confinement. Taking the stories of those who had experienced inpatient treatment in such centers most seriously, the chapter shows how the public clinic has become a "contrasting institution," which deals with addiction from a rational perspective: respecting human rights, and excluding the economic interest of clinicians and former drug users, as well as the LGBTI community's longstanding efforts to raise awareness of the abuses committed inside these clinics. Indeed, if the

Bolivarian revolution has been shaped from anti-neoliberal discourses opposing the abuses of capitalism, the market of private clinics falls squarely into this most curious “mercantilist” category, and yet the government of the Citizen Revolution has kept it, although regulated. The effort of generating a new approach remains overshadowed by the inertia left behind from decades of representing drugs as hopelessly crime-centric or even criminogenic. The public center has to confront or encounter public beliefs which everyone, including addicts, families, therapists, and functionaries hold dearest or true, regarding the proliferation of drug use and the purportedly uncontrolled explosion of drug addictions.

I had already conducted a study of private addiction treatment centers, through interviewing people who had been in them, a few years before my research began in earnest. I contacted a few friends, some of whom I knew had been interned, as well as professionals in mental health whom I knew had worked in these spaces. Another friend of mine, a former base addict, had worked for years as the guard in a clinic. Lastly, through self-help communities such as Narcotics Anonymous, I was able to identify even more qualified informants. The results were consistent with what the people in the public clinic had to say about private addiction treatment centers. It is a background for any new form of therapeutics, and it remains as an important local part of national drug policy, although there are regulations which are more thoroughly enforced nowadays. However, the patients tell stories which differ from those told by the state. Private addiction treatment centers, and their abuses, are still a part of the Ecuadorian reality when it comes to the everyday experience of drugs and addiction treatment.

The third chapter describes life inside an institution such as the public addiction treatment center, as a civilizing project. So-called “new” therapeutic approaches, which derive mainly from psychological, medical, occupational, social work, and popular sexual discourse, are put into motion with the objective of civilizing the drug users into becoming particular kinds of civil subjects. Contradiction between what is said and what actually occurs can be grasped through the observation of each milieu inside the clinic, keeping in mind the foremost importance of civilizational ideologies and their translation into distinct kinds of moral practice.

An invisible force pulls the structure of addiction treatment to processes of identification, while a scientific discourse attempts to give shape to particular therapeutic approaches.

Addiction is quite possibly as elusive as any other medical category, but it implies aspects related to obedience, compliance and avowal as the main factors determining the degree or severity of the disorder and the therapeutic progress. Across my fieldwork, I could see, mainly from the insides of the clinic, the different forces operating in the construction of addiction as a medical category.

The fourth chapter addresses the close and pulsating relationship which the clinic has enjoyed with the State. Power relations can be observed through the interactions between the clinic and the different institutions which come into some mode or another of relation with it. The representations jump out through the expectations of practitioners at the personal level within the clinical process. These exchanges, I claim, are likewise occurring at level the state. While the clinic attempts to generate a therapeutic community, pressure from the outside threatens the project continuously and without pause to produce normal citizen subjects. Political aspects of the clinical therapeutic process meet with the beliefs through which each state functionary relates to the addiction treatment center.

And yet, it is not only the functionaries of the clinic who had to operate amid pressure from a much broader and more bureaucratic machinery of state, designed to standardize medical intervention. Any form of participation in the process required the involvement in long, complex, and, mostly, never-ending bureaucratic procedures. My fieldwork has attempted to navigate through the bureaucratic labyrinth, and to gain formal acceptance of my research proposal, beyond the informed consent and oral agreement I had from the Clinic's coordinator and the Director of Mental Health, but I could only reach dead ends. In the end, I decided to avoid the use of institutional or personal names.

Lastly, the fifth chapter returns to the individual subject, the so-called drug user, and attempts to make sense of what is happening inside the clinic and the way the life of the clinic affects the patients' lives. Beyond the desire to recover, the user describes conflictive drug consumption, and what it implies in terms of manipulation, pasteurization of addiction appears in what I call a "pasteurized total institution" shaping new forms of discipline: The public clinic doesn't necessarily change the previous dominant structures of addiction treatment, but it does aim to make them more comprehensive and less harmful. Resembling, perhaps, the processes of pasteurization, where liquids and foods are heated in order to kill bacteria without changing their molecular structure, Public center addiction treatment tones

down the disciplinary components of its therapeutic approach, but the structure itself doesn't seem completely affected. Just as in the "pastoral" process of pasteurization, not all of the elements are destroyed; only those capable of causing disease are reduced. The patient, also marked by the ways in which societies define him, makes choices that affect the ways in which each person relates to the public addiction treatment center in the quest for a self which can coexist with the rest of the world. Addiction is the axis for the definition of the subject in the process of reinventing himself through treatment.

I doubt that this chapter does any justice to the people going through addiction treatment in a public clinic. As a reminder of how false the presumption of otherness is when it comes to addiction, one of the patients I spoke with the most had been a friend of my brothers in their teenage years. I still find it hard to understand what is, exactly, what makes the difference between occasional drug or alcohol use, and a fall into the endless spiral of addiction. But I incline myself towards policy as an important aspect, reproducing beliefs which block the possibilities of self-redefinition beyond the medico-juridical category.

The departure point from which I attempted to understand the information I gathered while doing ethnographic work in the clinic is structured from a bio political framework, as Mental Health is inscribed in this realm. When I first proposed this topic, I was told by the committee that it was all right as long as it didn't become a Social Psychology dissertation, perhaps because what was clearest in my understanding was the concept of social representations, proposed by a Social Psychologist, Serge Moscovici. It's not a social psychology study. My research falls into the political studies field, but it comes from an anthropological way of understanding life and practices.

What I see through the ethnographic work at the clinic is the direct effect of drug laws and policies, in a specific political context which is aligned with a global trend to control populations through statistics and projections. The public clinic is the materialization of all of these abstractions, and it contains actual lives of people and their desperate families, searching for options regarding compulsory drug uses. As Valverde had shown in her study of alcoholism, the compulsion extends to the repetition of the same therapeutic practices coming from places different than the medical. While specific discourses and small actions appeared as signs of change in the War trend, in practice, things remain as usual, but adding bureaucratic processes of standardization of medical practices and, therefore, of subjectivities.

Even when the latest drug law refers to drugs as a socio-economic problem, addiction is still addressed as a disease of the will, in a sense which returns to avowal and compliance as the tools as well as the objectives of the therapeutic intervention.

Chapter 1

Laws, policies and institutions

Introduction

Addiction treatment in Ecuador has been the least of the concerns regarding drug policy. Following a trend set by the United Nations, with the initiative of the United States, the country built a position towards drugs that aligned with the generalized prohibitionist trend that flourished in the twentieth century (Paladines 2016). Conventions and agreements established the path towards a war dynamic that took form through laws and institutions, which responded to international pressure (Edwards 2011).

The inclusion of a public health perspective in the 2008 Constitution wasn't a new thing either. The rhetoric of past laws and policies had already included the idea of pathologization, which strongly materialized through the Law of Narcotic and Psychotropic Substances, also known as Law 108, enforced since 1990. This law was the result of an increasing international trend towards repression, as it implemented the United Nations Single Convention against Narcotic and Psychotropic Substances, from 1988, which set the new guidelines to repress drug trafficking more severely (Paladines 2016).

According to Law 108, anyone under the influence of a narcotic or psychotropic substance had to be conducted by the police to a health center for evaluation, and once use was confirmed, treatment had to be immediately ordered. Pathologization had already shown to go hand in glove with criminalizing discourses and practices. Yet, when the 2008 Constitution included addiction as a public health problem, the state became obliged to revise its practices of policing, indictment, and criminal procedure: previous legislation had penalized possession, and the prison system increasingly hosted drug users, treating all of them indistinguishably as drug traffickers.

Since this constitutional inclusion aimed to make a major difference in the lives of those touched by the War on Drugs, it became necessary to go beyond the official discourses, in order to learn how drug laws were affecting practices of imprisonment and treatment. The last decade has shown, precisely, how a series of changes made it most difficult to define a stable trend in drug policy; what has been clear, as I demonstrate below, is an explosion of contradictions against the backdrop of an increasingly populist state regime. The lack of

public debate has left representations of drug addiction virtually untouched, and the alleged “changes” towards clinicalization have either been irrelevant or have been rejected by most Ecuadorian people.

This chapter is therefore an attempt to show the path down which this country has traveled in regards to drugs, primarily by following the footsteps of people whose life direction has been influenced by the political decisions made. Mostly, I want to tell the story of Rafa, caught with three kilos of marijuana, and the story of Charlie, busted with barely 53 grams of the same substance. Their stories overlap with those of social movement leaders and state officials, with the objective of introducing the context in which addiction treatment became a matter of public health.

1.1. Prison: the background for a health perspective

At 9 am I arrived at the old Latacunga Prison. It was mid-June 2013, on a Wednesday. The roads to Latacunga had been remarkably improved by the Citizen Revolution, a slogan for Rafael Correa’s government. Against critique of Correa’s government, his defenders would respond to any disappointment towards the new government with the common refrain “*pero tenemos carreteras*”, meaning ‘but we have roads!’ I had driven from my home in Los Chillos valley all the way to Latacunga, a trip that took an hour and a half. Upon arrival, I stopped at the local grocery store and bought a few cans of soda, chocolate, canned seafood, cheese, anything I imagined I’d want to eat if I found myself locked up and disconnected. Rafa mentioned he wanted pizza, so I bought one and brought it along. Latacunga is relatively small, and friendly people were eager to give us clear directions. After three attempts, I finally reached Latacunga Prison, an old colonial building, with high adobe walls and an interminable line of people waiting to get inside.

I parked and joined the line, but prison visitors explained the protocols for entering: I had to leave my car keys with someone else; my cell phone, too, had to be left outside. The cans of seafood wouldn’t be allowed inside. Forget soft drinks.

I left the seafood and the Cokes in the car, and I went to the corner store and left my car keys in the hands of the owner for a small fee. After an hour of waiting in line, I went inside. I already knew the dress code, as Rafa had warned me: no black, no hoods, no boots, no belts, no sunglasses, no earrings, and no jewelry; that is, nothing which could facilitate sneaking in

any of the forbidden objects: guns, drugs, money; or anything posing a risk for the inmates or for others. The dark colors were avoided because they resembled the guards' uniform, Rafa explained; they were not allowed in order to prevent confusion, so that people wouldn't try to escape posing as guides. The whole process seemed overly complicated; I felt anxious about being so thoroughly scrutinized. But at last it was *my* turn. The police officer in charge rifled through the groceries I bought. The lady in uniform inspected my clothes by patting all over my body to such an extent that I couldn't help but joke that we hadn't even met, and we should probably go out for a drink first. She smiled but continued. At last, a stamp marked my hand. Someone else joked about my Jewish last name—difficult to spell—, while registering my presence. I later found that there had been complains through human rights organizations for nude searches in the new Latacunga Prison, and that this was a relatively common practice through which not only inmates were humiliated, but their families as well (Garces 2014).

And I was allowed inside.

I hadn't seen Rafa for two years. He'd been busted, and everyone knew. He was coming back from Baños¹ as usual on a Friday night, in January 2012, but this time he was drunk and high on acid; he'd been arguing with his also-intoxicated girlfriend, and they hit another car. They decided to take off, but they were chased down by the police controlling the renovated Citizen Revolution roads. The officers found 3 kilos of marijuana in a backpack in Rafa's car, as well as a small container with marijuana in his pocket. His case was passed along to the anti-narcotics unit, and preventive prison, customary for drug-related crimes, was ordered in his case². Drug tests confirmed the presence of cannabis in his system.

Rafa's process unfolded in the midst of great political ambiguity. Three kilos weren't that much, and the Constitution had already been changed by the time he was apprehended—drunk and high—stating that drug users could not be criminalized. Unfortunately, there were no legal precedents for LSD, and the state didn't have the reagents needed to test for it, a problem for Rafa, since he wanted the courts to know he was a drug abuser, at the very least. His trial would become a matter of luck, or so he felt, aggravated by the fact that Latacunga was a small town; in Latacunga, drug cases were locally seen as trophies.

¹ A small city located in the slopes of Tungurahua Volcano, dedicated to tourism.

² The indiscriminate use of preventive prison in Ecuador had reached complaints at the Interamerican Court of Human Rights; it was a known problematic effect of Law 108, the harshest law in relation to Drugs in the country (Paladines 2013).

Ecuadorean laws had evidenced an increase in the intensity of punishment throughout the late twentieth century, reflecting the country's alignment with the global repressive trend that flourished during this timeframe. Still, sentencing wasn't necessarily clear, and Rafa tried to get out of this ordeal through multiple legal avenues. There was a clear directionality towards punishment, which came from way back, something that aligned the system against him. The regulation of illicit substances had already appeared during the Spanish Colony—nothing new on that score: in 1573, the “Devil’s Work,” or coca leaf, was expressly forbidden, only to be later regulated to profit from it (Bonilla 1991, 15). Coca was substituted by alcohol once changes in the organization of labor were prioritized: the territories that would later become Ecuador focused on textile production, while mining concentrated in Peru and Bolivia. This meant an increase in alcohol consumption for the Ecuadorians, while coca leaf remained linked to the mining activities.

In 1747, more than a century later, the Real Audiencia de Quito forced distilleries' owners to sell their alcohol production to the Crown at less than half of the price it was subsequently sold to the public, a regulation known as the “*estanco*” (Borchart & Moreno 1995). The Quito Neighborhoods Rebellion of 1765 was preceded by the decision, as an alliance was formed between different social sectors against state monopoly of the drug trade.

The Republic began addressing drugs officially in 1916, through the Law of Opium Control (Paladines 2016). This legal instrument, which drew its legal inspiration from United States' initiatives to control opium use around the world, introduced moral judgment against any attempt to use opium, thus marking the “prohibitionist paradigm within the logics of prevention” (Paladines 2016: 9). In 1924, the country adopted the Law of Imports, Sales and Uses of Opium and its Derivates, including the Preparations of Morphine and Cocaine, which repressed poppy and coca, from here on coca in particular was considered inside the list of evil plants. In 1958, the Law on Traffic of Raw Material, Drugs and Narcotic Preparations came into effect, further expanding the prohibitionist trend beyond narcotic substances towards raw materials, and introducing the concept of trafficking as the ruling verb.

Resulting from the Single Convention of 1961, the Law of Control and Audit of the Traffic of Narcotics was passed in 1970 (Corte Constitucional 2012). This law stated, in its 30th article, that the penalty for drug trafficking would include eight to twelve years of incarceration,

along with a fine from 10,000 to 50,000 sucres³. Regarding drug use, the law held explicitly maintained for the first time a “public health perspective,” ordering any person found under the influence to be taken to a hospital, where dependency would be determined and, if found, the offender would be detained for treatment (Naranjo Lopez 2016, 6).

Four years later, and as a response to the 1971 Convention on Psychotropic Substances, this instrument was reformed by placing the National Police and the General Direction of Health as the two institutions jointly in charge of governmental oversight over dependency, creating the “Inter-ministry Commission,” which maintained that penal judges held authority to review cases on nationals and foreigners from countries that were party to the Single Convention, and to arrange for deportations of such citizens when deemed necessary (Corte Constitucional 2012).

In 1978, a new reform to the Law of Control and Audit of the Traffic of Narcotics increased penalties to a range between sixteen and twenty-five years of imprisonment, and the fine changed to one ranging from 50,000 to 100,000 sucres⁴ (Corte Constitucional 2012). The reforms witnessed during this decade related to the engagement with a new discourse, proposed by President Richard Nixon, of the United States, defining the drug issue as a “War on Drugs” (Paladines 2016). These moves showed the dominance of a crime control model, in which the emphasis lays on the punishment of law breakers, as opposed to a due process model, which valued the protection of citizens above punishment (Wrightsman et al. 2002). By a 1979 legislative decree, incarceration times were reduced, returning to the twelve-to-sixteen years range.

During the 80s, after the incorporation of other treaties and agreements that held an interdiction perspective, drug use in Ecuador went through an upsurge (Bonilla 1991); however, there were no alternatives to therapeutically address conflictive uses. Mental Health appears as an area of the National Direction of Family Health in the Organic Regulation of the Ministry of Health, from 1975, but it existed only as a nominal entity (Quishpi 2015). In 1980, the National Direction of Mental Health was created as an independent branch of the Ministry of Health, with its own budget, and the Director of the National Division of Control

³ The exchange rate from 1970 was 25 sucres for 1 dollar (Bravo et al, 2010); the fine ranged from 400 to 2,000 United States Dollars.

⁴ Ranging from around 2,000 to 4,000 USD.

and Audit of Narcotics, was appointed as the Director of Mental Health. In 1983, the National Direction of Mental Health began to offer therapy for addiction when it created the Substance Dependence Treatment Units (Tenorio 1989). These therapeutic spaces resulted from an agreement with the United Nations Fund for Drug Abuse Control, which financed them for approximately one year. Ideally, after this time, the Public Health Ministry would take over; and yet, due to a lack of resources and, in particular, a lack of demand, the units would ultimately shut down (Andrade P. 1991). In 1984, the National Direction of Mental Health was once more downgraded to Division, and its budget was removed (Quishpi 2015).

In 1984, and under the neoliberal government of Febres Cordero, Ecuador adopted an ideological position towards substance control generated by Nixon's War on Drugs, incorporating the idea of narcotics and psychotropic substances as being public enemy number one (Bonilla 1991). The following year, an agreement between Ecuador and the United States was signed. In it, the United States agreed to finance Ecuador's antidrug operation, while Ecuador allowed the U.S. Drug Enforcement Administration (DEA) to maintain operations in the country. Already in 1987, the new Law of Control and Audit of the Traffic of Narcotics and Psychotropic Substances placed penalties for drug trafficking at approximately the same level as those given to homicide (Paladines 2016). From here forward, the legal demonization of psychotropic substances became a go-to reference for the punishment of drug-related crimes.

In 1988, the United Nations Convention Against Illicit Traffic of Narcotic Drugs and Psychotropic Substances, to which the country subscribed in 1990, established the international obligation to classify the infractions listed in the Single Convention of 1961 and the Convention of 1971 as crimes, as well as to provide longer terms for the prosecution of offenses classified as "severe" (Paladines 2016). This instrument made the country create, during the presidency of Rodrigo Borja, one of the harshest laws in Latin America, the Law of Narcotic and Psychotropic Substances, also known as *Law 108*. While Law 108 set punishments that ranged from 12 to 16 years' prison time, in 2005, the last reform to this particularly insidious law increased penalties, once again, to up to 25 years for drug-related offenses.

The objective of this legal instrument was described as a need to protect the community of the dangers that came from production, supply, wrongful use and illicit trafficking of narcotic and

psychotropic substances, through combating and eradicating them (Congreso Nacional 1990). With this particular law, the country officially entered a logic of low-intensity warfare against simple drug use, subtly defining drugs as a problem of National Security (Paladines 2016).

Regarding drug use, article 30th of Law 108 stated that Public Force members are obliged to immediately take any person who seemed to be under the harmful effects of a controlled substance, to a psychiatric hospital or assistance center, with the objective of having doctors verify if the person is, in fact, under the influence of such substances. If so, they had to “immediately order the appropriate treatment. The treatment, which must be conducted in special centers, will be carried in those which were previously qualified and authorized by the Executive Secretary, in coordination with the Ministry of Health” (Congreso Nacional 1990: 8).

The criminalization of possession produced a dramatic increase in prison population, a trend which started in the 70s, with only 3% of inmates imprisoned for drug-related crimes, to fully 17% by 1980. After Law 108, drug crimes became the main generator for criminalization of men and women alike (Pontón & Torres 2007). At the same time, this law’s mandate to order treatment to anyone found under the influence, generated a profitable market of private addiction treatment clinics, creating a population of people deprived of their freedom, but without the need of the legal proceedings. Those locked inside these clinics were simply abandoned, with no record of their confinement, and with very little control from the State.

Law 108 established the creation of a National Council for the Control of Narcotic and Psychotropic Substances (CONSEP, for its Spanish acronym), which managed, among a myriad of other responsibilities, addiction treatment (Congreso Nacional 1990). Article 28 placed the responsibility to grade and regulate addiction treatment centers in the hands of this sole institution, although it stated this should be done in coordination with the Ministry of Health. It was the CONSEP which housed the registry of rehabilitation clinics across the country.

The CONSEP wasn’t entirely a new institution: in 1970, the National Department of Control and Audit of Narcotic and Psychotropic Substances was founded (Valenzuela 2011). Four years later, in 1974, the Department mutated into an inter-ministry “Commission.” In 1979, the management of drug-related issues was linked to the State Attorney’s office, with the

creation of the National Direction Against Illicit Trafficking of Narcotics (DINACTIE); although, between 1981 and 1983 the institution in charge was the Inter-ministry Commission for the Coordination of Activities of Prevention and Control of Illicit Narcotics Trafficking. The DINACTIE was shut down in 1986; due to the corruption its functionaries and agents had acquired (Andrade, X. 1990). After this, and until 1990, it was the National Direction for the Control of Narcotics Trafficking (DINACONTES).

Once Law 108 came into effect, the CONSEP took the place previously occupied by these institutions. The law mandated that the Council control all material related to Drug policy (Congreso Nacional 1990). Formed by ministers or their representatives from the Ministries of Interior, Education, Social Welfare, Public Health, National Defense, and Foreign Affairs; and the State Attorney General or his delegate, the CONSEP had to create the national prevention plan for the wrongful use of substances subject to control, its production, commerce, and for the repression of production and illicit trafficking; and finally, for the rehabilitation of people affected by their use.

Among its duties, the Council had to generate an original plan for drug control, which had to be approved by the President, after which the CONSEP would have to make sure it is accomplished. Also, the Council was in charge of reviewing and incorporating the drugs which composed the list of controlled substances, in accord to the international agreements that the country had signed. The CONSEP was also in charge of reviewing any and all regulations of institutions whose activities related in any way to the scope of Law 108.

While Law 108 gave responsibility over the control of rehabilitation centers to the CONSEP, it arrogated new authority to the Ministry of Health to create specialized wings for drug abuse treatment within hospitals or, if the CONSEP recommended, and depending on the affection index of drug use in certain regions, The Ministry would need to create care homes, with suitable personnel, in already existing health centers. The law also stated that these services should be free when possible, yet addiction treatment became almost exclusively a matter of private clinics.

Once the 2008 Constitution was approved, the transition of the control over treatment clinics took a while. During the Citizen Revolution, the CONSEP had held on to rehabilitation, and the Ministry of Health only began to conduct control visits to private centers in 2013, in order

to check for documentation and to ask the patients how they felt. It seemed that this transition didn't respond to the constitutional mandate, but instead, it was the result of many denouncements made visible by the LGBTI movements, since clinics were offering treatment for addiction and other conduct disorders; dehomosexualization became another offering in the market of conduct modification, full of ineffective, yet very popular products.

While repression escalated with Law 108, the mandate to forcefully take anyone suspected of being under the influence to a rehabilitation center encouraged a thriving market for private addiction treatment clinics, a paid option that could replace jail time. In 2012, the 'theoretical model for prevention' published by the CONSEP as the guide for their work, stated that 22,500 Ecuadorians needed addiction treatment, an estimate taken from national surveys. Of these, however, only 15% were receiving it, based on the registry of 4,141 people inside the addiction treatment centers that this institution regulated (CONSEP 2012). The document did not specify the criteria for determining the need for treatment, nor did it describe the therapeutic approach that was being used. Moreover, it failed to mention the need for a differential diagnosis or the procedure for admission. The process of entering treatment in a private addiction clinic, with a few exceptions, occurred with no symbolic mediation; instead, it was commonly an act of force, "the final product of a process worked by the family and the center, sometimes with the help of a third party, who could very well be a police officer" (Tenorio 2012, 23).

Many Ecuadorian families, not knowing what to do when their relative was discovered consuming illegal substances, found in private clinics a temporary, yet discreet, relief of the anguish that drug use caused, regardless of its intensity. It didn't really matter if it was clinically significant; just having done it was enough for relatives to diagnose and decide on treatment, just like possession was enough for the legal system to process for drug-trafficking. Private clinics became a costly option in which "patients" could be rehabilitated, but there was no differential diagnosis to determine the clinical significance of drug use in each person. Instead, the concern of the family members, and their willingness to pay for the treatment, was enough to intern someone. Most of the time, the therapeutic approach consisted of torture, forced freedom deprivation, starvation, and hours of "experiential therapy": a former addict facilitating the repetitive narrations of the most gruesome stories lived by the patients (Jacome 2012). And, since clinics offered attention for addiction and other conduct disorders, some included the option for conversion therapy, also based in torture and abuse.

The theoretical reference document for prevention that the CONSEP had produced failed to address the results that the clinics it promoted were getting. Were people being cured, rehabilitated? Were they better adjusted after leaving these clinics? Studies showed that those who were once admitted, would begin a “career” as rehabilitation center patients, being brought to them over and over again (Jacome 2012). After many years of inpatient treatment in several clinics, which started during adolescence and extended through adulthood, most former patients could only speak with resentment about the violent forms of treatment they had been forced to receive. Many even claimed they would have preferred to be incarcerated. Yet the CONSEP mentioned in its theoretical reference that the clinics only covered 15% of the demand, suggesting that more of them were necessary⁵.

1.2. New discourses and the belief that something is changing

For decades, throughout the world, conflictive drug use has been approached from repressive policies, aimed mostly at questions of supply and leaving aside preventive measures addressing demand (Bagley 1991). However, this repressive front has failed in diminishing drug use, as the UN recognized in 2011 when it affirmed that “the global War on Drugs has failed, with devastating consequences for individuals and societies throughout the world” (Global Commission on Drug Policy 2011). The 2011 report from the Global Commission on Drug Policy explains that neither supply nor illegal drug use have been diminished by repressive measures directed at producers, traffickers or consumers; moreover, any apparent victory by eliminating a traffic source loses relevance almost instantaneously as other sources and traffickers spontaneously fill these lucrative and empty incumbencies. Also, “repressive measures aimed to consumers block public health measures to reduce HIV/AIDS, overdose deaths and other harmful consequences of drug use” (Global Commission on Drug Policy 2011, 2).

The Americas have experienced changes in their drug policies, in what seemed a time of shifting paradigms: Ecuador included addiction as a public health problem in its Constitution (Asamblea Constituyente 2008), while it granted a pardon to drug mules; even when this didn't translate into policy, it helped free over 2000 people. Uruguay legalized the production and distribution of marijuana (Dubove 2015); Colorado and Washington legalized recreational use of Marijuana (Johnson 2015), and so on. These changes have implied a

⁵ For Thomas Szasz, a US psychiatrist identified with the anti-psychiatric movement, the addict does not want treatment; he wants drugs (Szasz, 1991).

stronger emphasis in prevention and treatment, counterweighting a historically inclined balance towards criminalization and repression. Still, the region has not accomplished the UN Global Commission's recommendations: "to end criminalization, marginalization and stigmatization of the people who use drugs but who do no harm to others. To question instead of reinforcing common preconceptions regarding drug markets, drug use and dependency" (Global Commission on Drug Policy 2011, 2).

The perspective that sees drug use as a pathology does not warrant a clear conceptualization of what is considered a disease; it cannot ensure a treatment that excludes criminalization, marginalization or stigmatization. Also, research shows that the way pathology is understood when it comes to drugs may not be accurate as it seems to exclude other possibilities, such as the internalization of structural violence or unbearable realities, from conflictive drug use. One of the concerns which the perspective of medicalization or pathologization of drug use brings, is that it may take responsibility off the person, somehow legitimizing conflictive uses from the impossibility to change the destructive behavior (Valverde 1998). Law 108 had been built on the contradictive idea of addiction as a power of the substance over the subject, a perspective which saw the only possibility of improvement in confinement: prison became the alternative for anyone relating to drugs, as possession was enough evidence, and private clinics were the answer for those found under the influence.

From the 70s to the 2000s, the country signed a total of 26 international agreements which reflected these global trends in the War on Drugs (Paladines 2016). Among these was the 1999 agreement to allow for the establishment of a Forward Operating Location in the Manta military base, "with the purpose to intensify international cooperation for the detection, monitoring, tracking and aerial control of the illegal activity of drug-trafficking to which several political and legal international instruments refer to" (Ochoa 2007: 106).

This agreement was rejected by different groups, two of which placed a plea of unconstitutionality based on the following arguments: First, the agreement was never approved by Congress; the Constitutional Court never issued a report regarding whether or not the agreement was made according to the Ecuadorean Constitutional Law; the National Sovereignty was being compromised by freely allowing citizens, aircraft, ships and other American vehicles to circulate; the privileges of legal immunity and fiscal immunity given to the Americans at Manta infringed on principles of equality before the law; and, the renounce

of complaints for any damages generated by the military cantonment left Ecuadorians in defenselessness (Saavedra & Coba 2007).

The drug war military base remained operative for the 10 years granted in the agreement, at which point Ecuador, now under the Correa administration, chose not to renew the contract. In fact, the end of the lease was portrayed by the government as a triumph of sovereignty, as the Minister of Foreign Affairs, Fander Falconi, stated at the closing ceremony “never again foreign bases in Ecuadorian territories, never again a sale of the flag”⁶.

The 2008 Constitution challenged the status quo in regards to drugs by making it a constitutional mandate to address drug use from a Public Health perspective. At the same time, a pardon to drug mules⁷ was granted by the Constituent Assembly, but it failed to become an institutionalized policy; it remained as a one-time thing until the presidency of Correa ended in 2017, when he issued a final pardon before leaving office, aimed to drug mules with up to five years sentences who had already done 30% of their time, that is, cutting down 10% of their time as they could get parole after doing two fifths⁸.

After being considered one of the most repressive countries in the region with regards to drugs, Ecuador was making changes that now positioned it as counterhegemonic by questioning the drug policies which mostly came from the United States (Paladines 2015): the Amnesty for Mules granted by the Constituent Assembly in 2008; the nominal prohibition against criminalizing drug users (Art. 364 of the 2008 Constitution); the nonrenewal of the Advanced Operations Post of the United States in Manta, which ended in 2009; the withdrawal from the Andean Trade Promotion and Drug Eradication Act (ATPDEA) in 2013; the generation of maximum thresholds through the creation of charts to stop criminalization of drug users in 2013; and the reduction of penalties to small scale traffickers in the 2014 Penal Code. In this context, the civil society actors held on to the belief that something was actually changing.

⁶ “Ecuador retoma la base de Manta”. *El Universo*, September 18th, 2009, <http://www.eluniverso.com/2009/09/18/1/1355/ecuador-retoma-base-manta.html>.

⁷ People who transport small amounts of drugs from one country to another.

⁸ “Rafael Correa indultó a mulas de la droga con sentencias de hasta 5 años y que cumplieron al menos 30% de la pena” [Rafael Correa pardoned drug mules with sentences up to five years and who had already done 30% of their time], *El Comercio*, May 25th, 2017, <http://www.elcomercio.com/actualidad/correa-indulto-mulas-droga-sentencias.html>.

Rafa knew I was coming. The guards told him I had arrived while I was being registered and searched. We hugged, and crossed the yard towards his cell. We sat outside his door, on a sidewalk by the patio. Life in prison had been rather difficult, Rafa began. It had already been a year and a half, with at least three years to go. His trial produced a twelve-year sentence at first, but a process of ‘transcendental extenuatory’ (that is, to rat out other people,) lowered his sentence to five years. As soon as he got there, a group of six inmates approached him. Rafa explained: “six men approach you and, bluntly, they tell you they’re in charge, and that they know you have money, so you have to give them \$300 if you don’t want them to break your bones” (Rafa, personal interview, June 12th, 2013).

Rafa had already been warned about welcome parties, and he knew that giving in would mean he’d forever be extorted by fellow inmates with the consent of the guards. He stood on his ground and refused to pay, regardless of the violence he was getting exposed to: “if you stop them, they might beat you up. You have to defend yourself, and take it”. But, he explained, if intimidation doesn’t work, then they just steal from you. They bothered him for a month, after which a big fight occurred, and Rafa defended himself. It got so intense that some of the guys involved were transferred to other prisons. For him, it was a matter of choice in order to survive. Was he going to be considered a wimp? Or was he willing to take risks? He chose the latter. And even though he got beat up, he defended himself enough to be left alone.

When I came to see him, Rafa had already set up a small business inside his prison cell; he was teaching inmates how to read, and he was participating in English classes. He attended the wood workshops offered by the prison, and he was determined to reduce his sentence with good behavior.

The store was a one square meter wooden structure, with everything hanging on hooks. Oil, soap, sweets—Rafa had different possibilities to satisfy his clients. Right next to the merchandise was Rafa’s bed. Aside from the wood, the space was surrounded by blankets. Rafa managed to create his own little fortress in the lower part of a bunk bed: a color tv played the Simpsons and we accommodated inside for the pizza. Another one of his friends, Lucho, who came every week to see Rafa, had arrived. For a little while, it felt like we were hanging out at anyone’s house. This small spot achieved the purpose of isolating Rafa from isolation, from the prison, from other inmates. Being a visit day, his store was closed, but still,

people came every now and then to ask for things, and to remind us all of where we were. After all, the room Rafa lived in was shared with at least eight more inmates.

Rafa's trial was based on Law 108, still active until the new penal code was passed, and before the creation of 'the chart'. For Rafa, however, this meant that he depended on the arbitrariness of the legal system and the decision-makers. Everyone asked him for money as soon as this ordeal began and, while a series of lawyers made promises and offered advice, Rafa ended up losing everything he had, spending over \$50,000 on his defense, and finally, he was left with no choice but to do his time: a total of five and a half years.

Rafa's life in the old Latacunga prison was as livable as it could be. He only had a few friends who visited often; his mother had stopped coming, and other family were also absent. But he was adapting and trying to make the best of this experience. Teaching other people to read, learning to work on wood, participating in the English lessons felt like a way of giving amidst scarcity. The store allowed for a comfortable stay considering where he was. He had a cell phone on a pre-paid plan, and whenever he needed to connect he would ask his friends to chip in for a reload.

Before leaving, Rafa gave me a couple of plastic containers, so I can pour the seafood and drop it back inside, without the cans. The guards were okay with it as long as I hurried. We hugged, because I wouldn't be allowed back in. I picked up my keys at the store and I went to the car. Lucho and some other guy who had come later to visit Rafa came with me, so we could do it all faster. We emptied the cans in the plastic containers and went back into the entrance area. The guards took the food and passed it along to our friend. Rafa felt he could endure. And then, he was moved to the new prison.

1.3. The chart and its multivocal meaning

I was supposed to drive some of the Ecuador Cannabico's and Diablumas around the city. Diabluma was a social movement, which defined itself as a "radical left" organization, concerned with urban tribe's discrimination, nature rights, abortion, cannabis, among other things⁹. Ecuador Cannabico was an organization within Diabluma, focusing exclusively on Cannabis issues. They were going to graffiti about the upcoming World Marijuana March,

⁹ El gobierno tiene en los Diabluma a un grupo de activistas afines. El Comercio, November 25th, 2012, <http://www.elcomercio.com/actualidad/politica/gobierno-diabluma-a-grupo-de.html>.

and they needed someone with a car to help out. I was happy to come along; I thought it was a nice opportunity to hang out with them. It was March 14th, 2014.

I arrived to Diabluma's headquarters around 7pm, but the guys weren't in their office. They occupied an empty building near the National Assembly for some years already, a two story abandoned structure across the street from the Alcoholics Anonymous group, and I was picking them up there. Once I arrived, Felipe, Diabluma's leader, called to tell me that there was a change of plans, because Charlie, one of the Ecuador Cannabico enthusiasts, had been caught by the police with some weed, and that they were going to show their support outside the Unit of Flagrancy a few blocks away. He asked if I could join them instead; as Gabu, Ecuador Cannabico's leader, went on to write on the walls, adding to his task allusions to unfair Imprisonment. I went to the prosecutor's office.

Following the trend set by the Constitution, in 2013 the CONSEP presented a maximum amounts chart, with the objective to differentiate between drug users and traffickers (Paladines 2013). Law 108 already stated that drug users should not be criminalized, but it gave no tools to differentiate between them and drug traffickers. The CONSEP, along with many other institutions, were barely trying to offer some form of reference for Judges to decide on cases which were based on the possession of small amounts. Oddly enough, this move marked the beginning of the end for the change of direction that the country appeared to have been showing since 2008. In fact, the chart produced a series of responses that ranged from outraged letters published in newspapers to a campaign created by the Secretary of Communication, which sustained drug uses as wrong.

As the ex-director for the National Drug Observatory, Rodrigo Tenorio, explained, the process of construction of the chart had been going on for years (Personal interview, July 14th, 2013). The institutions that were part of the Council participated and approved the thresholds, and once the regulation was approved, the government summoned a meeting between the CONSEP, the National Communication Secretary (SECOM), and the social movement Diabluma¹⁰.

¹⁰ I was invited to this meeting by Diabluma; it was at SECOM quarters on June 17th, 2013 and the core issue was the public campaign to publicize the CONSEP chart in order to generate acceptance by the public opinion.

Felipe had participated in the Constitutional Assembly along with the social movements that were able to place their demands in before the law-making constituents¹¹. Specifically, he wrote Article 364, which read (Asamblea Constituyente 2008, 167):

Addictions are a Public Health problem. The State is responsible for the development of coordinated programs of information, prevention and control for the use of alcohol, tobacco and narcotic and psychotropic substances; as well as for offering treatment and rehabilitation to occasional, habitual and problematic consumers. In no case will criminalization be allowed, nor will their rights be infringed¹².

Diabluma and its branch, Ecuador Cannabico, represented the visible, organized civil society involved in drug issues. I had met them while my then-boyfriend was working on his dissertation on civil society amidst the citizen revolution, on the day that he interviewed Felipe, in 2010. We got to chat, and I found myself empathetic with the anti-bullfighting position which, for them, also had a political stand against colonialism and capitalism. At the same time, having done occasional illegal drugs with no consequence whatsoever since high-school, I also found their position towards cannabis legalization reasonable. I had already done consulting work on the topic. We remained friends and, since my research focused on drugs and prisons, I became interested in their processes and began to spend more time with them. They also relied on me for academic support and I was asked to join them in meetings with the Legal Secretary of the Office of the President, the Vice Minister of Justice, the Secretary of Communication, and the Executive Secretary of the CONSEP.

When the government summoned them to a meeting regarding the chart, I was invited by Diabluma per usual. The gathering addressed the public relations strategy that would accompany the publication of the regulations created by the CONSEP to promote public acceptance of the chart. However, the governmental newspaper leaked the chart before schedule, and the news generated a series of discourses from different sectors of society, which forced the government to precipitate the campaign. While it had the objective to produce new discourses surrounding substances, from the consequences that the repressive policies had produced, and from a Public Health perspective drawn from the Constitution, the spots created by the SECOM left an ambiguous message that supported the hegemonic

¹¹ For further detail on the Constitutional Assembly refer to Ortiz Lemos, 2013.

¹² Rodrigo Tenorio colloquially describes the irony embedded within article 364; for him, article 364 of the Constitution is right in differentiating usage from traffic, but “it deletes with its elbow what it wrote with the hand, when it says in the next line that it is enough for someone to have smoked or used once to be taken to a rehabilitation clinic for that first hit” (Rodrigo Tenorio Personal interview, 07/14/2013).

discourses, without producing a real change of focus. On the contrary, the advertisement spots kept a moral perspective towards drug uses, without proposing other representations for substances, justifying the excessive force, and changing nothing¹³.

The official policies, however surrounded by discourses of change, remained largely the same and derived from the War on Drugs which depicted substances as the evil (*mal*) to combat. In one of the spots, for example, one could observe the story of Fabian Soriano, doing a sentence of eight years for marijuana use, with Fabian saying: “just for using a little, my entire life was over. Other people get rich with this business, and me, dumped here. Eight years for using. *I know it was wrong*, but this was not the type of help I needed”¹⁴. While the idea was to generate public acceptance of a decriminalization chart of maximum amounts, the spot focused on the consequences of using drugs from a prohibitionist perspective, while it kept the weight of the blame over the prisoner, even when it introduced a pathologization perspective. The medicalization of addiction didn’t seem to exclusively remove responsibility from the person.

The ambiguity of the SECOM’s campaign showed the vagueness of the public governmental representations of drugs, as they don’t have a fixated meaning but, instead, their sense depends on context (Gamson 1999). The polysemy nature of the word ‘drug’, and its political use, simplified its interpretation into a maniqueist perspective of right and wrong, fixating on the illegal realm even the possibility of analysis and reducing any substance to crime (Paladines 2013). And even though the people involved in the process seemed optimistic from the alleged changes in policies Ecuador was showing, the spots were a reminder of the country’s demonizing tradition regarding the topic. Beyond discourses, practices would have to show what really went on.

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¹³ The SECOM had already been criticized by a spot it launched after the murder of a young woman called Karina del Pozo, because in it was a woman under the influence of alcohol getting in the car with people she didn’t know. (El Comercio, 03/17/2013). This campaign was criticized for sustaining a male-dominance perspective by blaming the woman, and it generated responses from activists such as Rocio Carpio who claimed that this message promotes and legitimates gender based violence.

¹⁴ Secretaría Nacional de Comunicación, “SPOT Drogas”, video, 0:48, <https://www.youtube.com/watch?feature=related&v=ht6MUfa6r5M&app=desktop>

Charlie had been hanging out with his girlfriend in Quito, and he decided to get some weed for the lunar eclipse that was expected a few hours before dawn the next day. He had moved out of his parents' home two weeks earlier and, even though he didn't have a formal job yet, he was optimistic about living in the city. That night, he and his girlfriend decided to go back to the valley to have a better view of the eclipse, and they took the bus at the departure station outside the Salesian University. While they were waiting for their transportation to leave, Charlie got a phone call from his friend, asking if he could accompany him to the valley on his motorcycle. Charlie had been arguing with his girlfriend, and this seemed like a good opportunity to take a break. They agreed to meet again at Los Chillos, and Charlie got off the bus.

When the motorcycle reached the Trebol motorway junction, Charlie's friend noticed a police officer signaling for them to stop. The police had been looking for two guys in a bike, and they were stopping motorcycles. Charlie's friend didn't have a registration, and he panicked. He decided to escape, and he took Charlie with him. At the other side of the junction, police officers were already waiting with their guns drawn and pointed at them. Charlie had his friend's backpack over his jacket, and his own bag underneath. There was nothing he could do. They were taken to the Marin's detention office, where they were searched, and the police found Charlie's stash of 54 grams of marijuana. They weighed the entire bag in which they found it, along with the metal box, the lighter, the rolling paper, everything, and the scale read 80 grams. The initial police report read "80 grams of cocaine", even though it was *only* weed¹⁵. While I later found that incriminating for more than what the person was found with was common practice by the police, at that time it seemed like a horrible mistake (Jacome 2016). Charlie and his friend were moved to the Flagrancy Unit.

The idea of gathering outside the Prosecution's office was to make a little noise, show support and, especially, show the authorities that there were people outside who rejected the incarceration of someone over such a small stash. The Diablumas and the cannabicos got together, in the middle of the night, outside the Flagrancy Unit, to wait and to be seen. Charlie's parents arrived, along with his girlfriend. The Diablos had brought some flags and signs and placed them on the floor near the entrance. Anyone coming or going from the

¹⁵ In the charts for maximum amounts, marijuana is the substance with the largest amount allowed. It is the only substance around which social movements have been organized, and the representations around it seem to be lighter than those regarding cocaine or other "hard drugs".

Flagrancy Unit knew someone had been taken in for a small amount of pot. Cops came from the inside and took photos of us. A lady sold coffee and bread in the sidewalk nearby. We stayed until Charlie's hearing date and time was announced. It was going to be two days later, at 6am. We agreed to meet outside again.

Charlie's case was also addressed from Law 108, as the new Penal Code was not yet in force. But the CONSEP chart was, and it became a referential point for his case, even though it had backfired as a political mistake. Alexandra, a functionary of the CONSEP who had worked on it, explained to me that the chart was only a small portion of a more complex proposal that they outlined with the participation of other institutions that were part of the Council: the Ministry of Health, the State's Attorney, the Ministry of Justice, among others. The Diablumas helped put pressure on the Ministry of Justice and the State's Attorney so that they would support this submission within the Council.

The chart was only an annex from a document which included the regulation of marijuana, and the Council had also been working on a project for the regulation of all illegal drugs. The proposal, Alexandra said, was "much more ambitious than the one from Uruguay". However, focus fell almost exclusively on the chart, generating a series of interpretations of its meaning¹⁶. For Rodrigo, former Executive Secretary of the CONSEP, the chart was a technical tool designed to assist judges and police officers in their decision-making: "Judges often make decisions based on technical instruments, but that doesn't mean that people have to know them; they don't need to be public" (Personal interview, December 28th, 2014).

The chart, built by the Ministry of Health and accepted by the Council, set the following thresholds for possession for personal use (Paladines 2013): For marijuana, the amount set was 10 grams; for cocaine base paste, 2 grams; cocaine was set at 1 gram; heroin, 0,1 grams; MDA at 0,015 grams; MDMA at 0,015; and amphetamines were given a 0,040 gram threshold. For Paladines, a public defender who was actively participating in the Constitutional debate, the thresholds set through Resolution 001-CONSEP-CO-2013 were binding, as they were presented by the organisms of health and drug use prevention which,

¹⁶ "Ecuador fija tabla para el porte y el consumo de drogas [Ecuador sets table for the possession and consumption of drugs]", El Telégrafo, June 17th, 2013, <http://www.eltelegrafo.com.ec/noticias/judicial/13/ecuador-fija-tabla-para-el-porte-y-consumo-de-drogas>.

legally and constitutionally, have the role of informing the Judiciary Branch of the techniques to avoid criminalization of illicit drug use.

When the public newspaper *El Telegrafo* published the news, the focus was put, almost exclusively, at the maximum amount thresholds. In fact, the newspaper story spoke about the settling of a chart for possession and consumption when, for the people working on it, the relevant issue was related to human rights and incarceration: The War on Drugs and its policies had increased dramatically the number of people imprisoned for drug-related offenses and, in many cases, those sent to jail were drug users instead of traffickers. However, the framing of the chart marked a direction which determined the meanings that it produced, even after Correa left¹⁷. The main problem, Alexandra believed, was that the process of proposing the maximum substance amounts along with the proposal for drug legalization, remained as an institutional one, without enough public debate.

Alexandra compared the Ecuadorian process to what happened in Uruguay, where there was a ten year public debate regarding the legalization of marijuana, after which the Uruguayan society was ready to approve its regulation. But in Ecuador, the chart and the regulation proposal was something in which the institutions worked on alone, excluding the public. In fact, the involvement from the institutions that were part of the Council was so scarce that its members didn't really understand what the chart was about, and some ended up opposing it. In the end, not even the CONSEP backed its chart, and the frame from which it was built diluted into the fears and prejudices regarding drug use.

The morning of the hearing, no one was allowed inside. Only Charlie's family and his lawyer, a public defender, could attend. Once it was over, Felipe explained that Charlie had been sent to the Provisional Detention Center (CDP, for its Spanish acronym), located at the former Garcia Moreno Penitentiary. In the detention complex, he had to wait for the police report to be changed, as the officers had written that Charlie was carrying 80 grams of cocaine, when in fact he had 53 grams of marijuana. The report had to be corrected in regards to the substance, as the legal distinction made all the difference. Additionally, the CONSEP had to burn the material in order to be able to properly weigh it, at which point the judge would ultimately decide on his fate.

¹⁷ Even with a new government, in 2017, the discourses regarding drugs are still focusing on the chart as the instrument responsible for the increase in heroin use (*El Telégrafo*).

Charlie was assigned to preventive imprisonment at the Ex Penal Garcia Moreno, a penitentiary which was inaugurated in 1874, during the second presidency of Garcia Moreno (Pino Rosero 2015). Following the concept of a panopticon, the National Penitentiary had a radial typology similar to the one built in Bogota, as it was the same architect, the English Thomas Reed, who built it. There are five radial wings, three stories tall, covered by flat terraces. The pavilions are joined at the center by a circular structure which allows for the surveillance of inmates, and in which a chapel operated until 1910. I had been there once before, in 2011, invited by the Ministry of Justice in order to evaluate a rehabilitation program set in motion by one of the psychologists working there. On that occasion, even though I was not allowed to enter with my cell phone, the psychologist came to greet me at the door and he himself took my phone. I neither went through a line, nor was I patted down. The prison bureaucrat took me down to the D wing through a series of stairs and locked doors, with guards at either end, to an area filled with non-violent offenders, mostly people incarcerated on drug-related crimes.

Everything looked old, dirty and dark inside the Penal. After having a conversation with the psychologist, he decided it would be a good idea for me to speak with the interns, and so we went to see them. The psychologist asked everyone to gather at the room where they usually met, and he introduced me to everyone. My own prejudices were triggered when the psychologist decided to leave me alone with the inmates for the evaluation, but my training generated a rational reaction and I ultimately carried on with a conversation to listen to the inmates' experiences with regard to the psychological side of rehabilitation. After breaking the ice and introducing myself, the process involved listening to the horrific stories of people losing decades of their lives for traveling with drugs to other countries, and their perceptions regarding their psychological process of "treatment" with the psychologist. One of them failed to tell me his entire story, as tears flooded his throat and silenced him. He was a Mexican who owned a mechanic shop in his home country, but he got convinced to take drugs from Ecuador to Mexico for money. He was caught at the airport, and he received a sentence of twenty-five years. He stood up and left after apologizing, but he came back at the end to tell me about it before I left. My training as a licensed clinical psychologist came in handy as it kept me from showing my own sadness, a nearly automatic reaction when people break down while trying to narrate their suffering.

This time, however, I was coming as a regular visitor. Felipe managed to have Charlie sent to the “pressure”¹⁸ wing, the area where fathers who had not paid child support went, instead of the *lagartera*, or the area where anyone else was sent, including drug offenders and violent ones: being close to the citizen revolution had its perks. As the days went by without Charlie’s case resolving itself, Felipe asked if I could go visit him at the CDP. He was worried about Charlie’s state of mind and Felipe wondered if I could help out by containing him while his case got sorted out. I agreed, and we set a date, which we arranged with Charlie’s parents, as only one person could visit each time, and visitations only occurred twice a week.

Charlie had been at the CDP for over a month. I arrived to San Roque, the area in which the Penal is located, in the morning; I proceeded to find the small store where I had to pay to leave my keys, and then I met with Charlie’s dad, who gave me a bag with a 3-liter bottle of soda and some food. I stood in the line formed outside the entrance, next to a stray dog that was allowed inside, no questions asked. I figured he lived there and I asked the guard at the door. He replied blithely that some of the dogs come and go, and he allowed me inside.

The line broke into two: one for men and the other for women. The process of revision and entry occurred inside the outer walls but under the strong Quito sun, right next to the door, in what looked like a large garage. A tent covered the area where the guards revised the visitors. I had to place the bag I was carrying in a bin, which was immediately checked by one of the wards, and I had to spread arms and legs for the customary pat down. The entire process was impersonal, mechanic, and long. I no longer felt like joking when I got searched. Charlie had been told I would come to see him, as we hadn’t really met before or, at least, I didn’t remember him. But he knew of my arrival, and the guards did, too, pointing him out to me. I had exactly one hour to pursue my crisis intervention.

The area for visitors was a narrow corridor in between two tall walls. The sun could only be seen for an hour each day as it passed across the space. The room where Charlie was staying was a large visiting area hosting pretty much everyone in the “pressure” ward. We sat at a cement bench near the bedroom door, and began speaking. In psychology, the crisis

¹⁸ The pressure wing or “area de apremio” is the one destined for fathers who have not paid for child support. In Charlie’s case, “palancas” or influences, mostly Felipe’s, managed to place him at the higher-end apremio, along with police officers and military personnel who had not paid for their children’s monthly fee.

intervention process consists of a set of tools designed to alleviate the suffering and diminish the risk for further pathology after a traumatic experience overwhelms a person's capacity to operate as one usually does (Slaikeu 1996).

In this case, Charlie's confinement, along with the uncertainty that the legal process brought, had taken a toll in his state of mind, which is why Felipe asked me to intervene. He was depressed, he couldn't sleep; he felt ashamed, and an overwhelming uncertainty was driving him crazy. We went through the story of his incarceration, the cumbersome legal process, and the situation inside, which, as we realized, was not so bad, except for the toll it had taken on Charlie's relationship with his girlfriend. People were friendly and empathetic, they shared the food that was brought by their family members, they watched TV and played cards, and so on. In the end, Charlie said he believed he could endure, and decided he would look at this time as a strange vacation that gave him time and space to think about his life. We figured out strategies that he could use in order to make the best for this time, such as keeping a diary that allowed him to observe his situation as a scientist would. When the time was up, we said our goodbyes and I left. While I was on my way back to the valley, I received a phone call from his mother, another one from his girlfriend, and, finally, I spoke to Felipe.

Felipe and the Diablumas were working on a strategy that used the chart in Charlie's favor, by gathering together a group of eight of his friends, who declared that part of those 53 grams had been theirs. The amount was then divided by the declared owners, which left Charlie with less than ten grams to respond to before the law. Two and a half months after being caught, Charlie was found not guilty, but his legal record still shows the incarceration, as he refused to pay the 3,000 dollars that someone told him would cost to clean his history. After prison, he came to my office a couple of times, to speak about and make sense of his experience. And even though he was already 26 years old, his parents also came once, as their son had moved back home and seemed completely lost. No one really knew how to deal with the whole thing.

1.4. Penal populism and counter-reform

In 2014, the new Organic Integral Penal Code (COIP, for its Spanish acronym) was passed, and with it came a new set of differences in the classification of drug-related offenses: between traffic level (big, medium, and small traffickers); traffickers versus farmers; drug crimes versus violent crimes; and small traffickers versus drug users (Asamblea Nacional

2014). Even though it included a maximum amounts chart, it didn't match the one proposed by the CONSEP; instead, it decreased the amounts liable considerably, thus returning to the ambiguous differentiation between users and traffickers (Paladines 2014). Similarly, the COIP established differentiated penalties, 'correcting' the inconsistencies of Law 108 in terms of its legal proportionality. The CONSEP remained as the institution in charge of prevention and traffic control, as well as the seizure of goods. The Ministry of Health had already taken charge of addiction treatment and rehabilitation.

In the same year the chart was being implemented, the new rehabilitation center in Latacunga was inaugurated. Demands for better conditions of those incarcerated, as well as the perception of increasing insecurity, were tackled from a penal populism perspective: building more prisons, but with the rhetoric of improving the conditions of the inmates from a human rights perspective. With the revision of the grounds for incarceration, it appeared that the government was aiming to rectify years of repressive policies. The Citizen Revolution depicted itself as truly emancipatory, but it invested millions in the penal industry that had previously been underfunded (Nuñez Vega 2006). Still, these contradictions in penal policy grew evermore evident, unveiling the 21st Century Socialist state on a continuum with the neoliberal war on drugs, barely touched by the state's top-down technocratic moves.

The old Latacunga Prison, in which Rafa began his sentence, had been designed to host 80 inmates, but by the time it closed, in April 1st, 2014, there were 269 people incarcerated in this one building, that is to say, filled with bodies 300% over its intended capacity¹⁹. By order of the health inspector, all of the inmates' belongings such as clothes, mattresses, and blankets were to be destroyed, and the place fumigated. The Ministry of Justice, Human Rights and Religion affirmed that the place did not guarantee the inmates' safety, as gas tanks were found inside prison cells, making the place a ticking time-bomb.

In the old prison, Rafa wore his own clothes, managed his own business, and volunteered for whatever activity might keep him occupied. When he was taken to the new 70-million-dollar facility, all of his belongings stayed behind. He was given an orange uniform, something that made him think of the KTM factory: a renowned motorcycle factory that decided, in 1992, to

¹⁹ "*Centro de Rehabilitacion Social de Latacunga se cierra definitivamente* [Latacunga Social Rehabilitation Center closes for good], Confirmado, April 3rd, 2014, <http://www.confirmado.net/centro-de-rehabilitacion-social-de-latacunga-se-cierra-definitivamente/>.

make its bikes immediately identifiable by painting them orange (Keller 2016). Before he was imprisoned, Rafa had been into motorsports: in 2009 he was a co-pilot in the Ecuadorean team at the Dakar Rally, after which he and his pilot did a South America tour of 27,000 km in two months. In 2010, he began competing in Quad Cross, and, in 2011 he won the National Championship. In January of 2012, he was a prisoner, and now he was immediately recognizable as such from his orange uniform.

The government earmarked a budget of 244,306,956 US dollars for the new penitentiary model²⁰. From this amount, a total of 214,533,748.27 US dollars were spent in infrastructure; 27'505,321,76 US dollars in food, and a total of 2'267,885,97 US dollars in clothing for the prisoners. The Ministry of Justice explained that the new centers permitted equal treatment for all inmates, leaving behind the privileges that only a few enjoyed under the neoliberal-era prison. She also mentioned the professional training workshops to which the inmates had access as a strategy for labor reinsertion. Finally, access to education was another aspect that the government official discussed proudly, as 15% of the detainees had enrolled in new courses. By 2014, a pilot project along with the National Secretary of Education, Science, Technology and Innovation (SENESCYT, for its Spanish acronym) even allowed for some of the inmates to access higher education while imprisoned.

Rafa's experience, however, told a different story. For Rafa, everything was different at the new social rehabilitation center in comparison with the old one. Visiting policy was stricter: people needed to be included in a list before visiting day, and there was a limit to how many people could go. Instead of the three days a week, the new prison could only be visited once a week for one hour. Once a month, inmates could have conjugal visits as long as it is the same registered person visiting. The visits that Rafa got every week decreased, further isolating him from the outside world. Also, moving to the new prison meant a loss of his store as a source of income, his TV set, his telephone, his clothes, and his meager stash of personal possessions. He was also kept incommunicado for a while, until he found someone who every now and then could lend him a cell phone. He wanted to sneak one in, but prices were too high: when he first arrived, a phone cost 3,000 dollars on the inside, and more time for

²⁰ "Ecuador abrirá centros de tratamiento de adicciones hasta 2015 [Ecuador will open addiction treatment centers until 2015]", Andes, January 10th, 2014, <http://www.andes.info.ec/es/noticias/ecuador-abrira-centros-tratamiento-adicciones-hasta-2015.html>

misconduct if he got caught. The new prison implied much more control, and considerably more symbolic aspects generating the new atmosphere of submission.

In 1970, the Stanford Prison experiment's designer, the social psychologist Philip Zimbardo, had chosen a few symbolic aspects in order to create a prison atmosphere and assess the effect of imprisonment among 'normal' people (Zimbardo et al. 2000). As he described the experiment, certain elements such as the uniform or the chains on the subjects' ankles, or even the fumigation ritual at the beginning of the experiment served the purpose of reminding the interns of the oppressive surroundings of enclosure they now inhabited. As opposed to the small, self-built shelter Rafa had been able to build for himself at the old prison, the new social rehabilitation center gave him no possibility to escape.

Clothing was always an issue at the new facility, Rafa recalls (personal interview, 04/25/2016). Besides the fact that the clothes assigned to each inmate were being constantly stolen, when he first arrived there was already a well-orchestrated informal laundry service in motion. But after a while, the service stopped, and it became each inmate's problem to resolve their hygiene issues. At the same time, when the prison had just opened, the food was palatable. Soon it became scarce and disgusting. "Cabbage soup every single day," he told me. When I asked him which prison he liked better (or disliked less) between the two facilities to which he'd been sent, he couldn't choose. "You feel safe at the new one, but that is only at the beginning. Eventually, no doubt, it will also become overcrowded".

Cameras, more guards, and spaces differentiated by security level gave Rafa a sense of safety that he didn't have at the old Latacunga Prison. He felt safer in the new one, even though people had been killed there. He even met the man who committed the first-ever murder inside the prison, while at the old one, there were only some "minor stabbings, nothing serious" during his time inside.

But the worst part was the water. There was no water; there were no towels, no phone calls, and no razor blades. The men eventually grew a fungus on their heads, but no doctors in the building could attend to the malady: Rafa remembers that there were only four doctors when he was moved there. There were some reports of arsenic in the prison water, as the source was an underground deposit of the liquid, which was linked to the Cotopaxi Volcanic system (Morán 2015). Rafa couldn't take it anymore. He decided he'd had enough, and so he led a

pacific protest: he decided to stop eating. He messaged me about it. I found it hard to believe that there was no interest from the media. Nobody talked about the hunger strike. No one cared about the lack of water in a prison built for so many people. A few days later, Rafa sewed his mouth shut. This got the attention of the authorities, and the Vice minister of Justice came.

An aspect that made Rafa lean towards favoring the old prison was the way visits functioned. At the new one, losing contact with the outside world is what hit him the most. Control went as far as having the inmates draft a ten-person list of allowed visitors. Spontaneous visits were discouraged, time was reduced, and contact with society became even harder. Rafa had more time to himself or, at least for him, time slowed down; time became more obvious. And even though there were modern workshops for industrial mechanics and carpentry, none opened during the year that Rafa spent on the inside. He did have certain privileges, because he chose to study. After getting 906 over 1000 points on the SENESCYT exam, he landed a scholarship at the Army University: professors came and taught inside the prison. Rafa took one semester of Logistics and Transportation, and was able to continue teaching other inmates how to read. He eventually ended up managing the library.

However, practices in terms of incarceration rates showed continuity within the age-old and newer repressive apparatus, something that resumed as official discourse when the counter-reform turned into the Organic Law for the Integral Prevention of the Socio-economic phenomenon of Drugs, and of the Regulation and Control of the use of Listed Substances Subject to Inspection (Paladines 2015). President Correa stated, in his 441st address to the Nation, that the Chart for maximum amounts presented the opportunity to carry one gram of heroin without being considered a drug trafficker²¹. “It’s not a failure of the COIP, but of the chart. We cannot go around with romanticisms”, he said, while also stating that, to free the youth from drugs, micro-traffickers would have to be punished. Correa mentioned the new amounts, and the possibility to begin using preventive imprisonment once again for drug-related offenses. Charlie’s case showed that this wasn’t a practice which had been overcome; preventive prison never really left drug-related processes.

²¹ “*Enlace Ciudadano 441, desde Puerto Limon* [Citizen Link 441, from Puerto Limon], El Comercio, September 12th, 2015, <http://www.elcomercio.com/actualidad/enlace441-enlaceciudadano-sabatina-rafaelcorrea-puertolimon.html>.

The presidential speech revealed a strong return to harsh policies against drug traffickers, as well as the unannounced come-back of the legal ambiguity through with traffickers and users have been (or fail to be) differentiated. In practice, this repositioned a punitive approach to drugs, which translated into a 60% increase in the amount of people incarcerated for drug-related crimes: while the first semester of 2015 presented 4,629 people detained for drug possession, in the following year and during the same period the number of people detained for drug-related crimes increased to 7,413 individuals. The chart reform, as well as the increase in sentencing time, has in turn increased the numbers of people detained, which does not necessarily correlate to an increase in the effectiveness of the penal public policy (Paladines 2017).

1.5. Marching through the institutions

I met the Executive Secretary of the CONSEP, Rodrigo Velez, on the day of the 2014 World Marijuana March. I had seen him before, as I was part of the consulting team researching high-school teachers' representations regarding drugs back in 2011, an investigation supported by the National Drug Observatory. In 2014 I was finishing the edition of the final report that the Observatory was going to publish, and I was familiar with some of the employees there. Ecuador Cannabico, Diabluma's branch dedicated to cannabis regulation, had organized the march for the sixth time. The march began at the skate track inside the La Carolina Park, and it ended at the *Casa de la Cultura*. The march stopped at a few places on its way: the SECOM, the CONSEP, the Prosecutor's office, and finally, outside the Culture House where there was a festival with bands, stands, cannabis cotton candy, and so on.

Hundreds gathered for this march. At the park, while departure was being organized, there were several vendors offering paraphernalia: pipes, t-shirts, lighters, grinders, rolling paper, and so on. The organization had managed to get all the permits, and police officers were accompanying the marchers in order to protect them by stopping the traffic in the intersections. We took off through the Shyris Ave. towards Eloy Alfaro, and from there we took the Amazonas Ave., one of the main streets in the capital, after stopping at the SECOM, where the movement leaders dropped a manifesto.

The CONSEP was located at an intersection of the Amazonas Ave., right next to the Santa Teresa Catholic church. The people gathered between the CONSEP and the Church, and began smoking a giant joint. I was taking pictures of the party while employees were

observing the masses from the windows. Felipe and Gabu asked me if I could join them to deliver the March's manifesto to the executive secretary, Rodrigo, and I agreed.

We were allowed to enter and we were taken to a conference room, where Rodrigo was expecting us. He kindly received us, he received the document that Ecuador Cannabico had prepared, and he stayed for a while, chatting with us. By the time he entered the CONSEP, the institution had already been coordinated by people who spoke differently regarding drugs. Rodrigo Tenorio, the former director of the CONSEP's National Drug Observatory, had been an important figure in allowing new discourses that challenged the status quo, and he claimed it was already the previous executive secretary, Domingo Paredes, who brought fresh ideas into the drug control council.

The executive secretary said he agreed that drug policy was overly repressive, and that prohibition hadn't accomplished what it said it would. However, he reminded us all that the council integrates many other state institutions, and that ultimately, it is not him who made the decisions that could affect drug policy. He was cautious in his conversation; political correctness reigned in this meeting with the radical left anarchists. What was left hanging in the air from this reunion was that it's not only the national institutions, such as the Ministry of the Interior, but also international ones who put pressure in the governments to maintain the status quo. Rodrigo tried to please everyone, but beyond his political correctness, practices remained inclined towards prohibition. We moved on from the CONSEP to our next target, but when we arrived to the Prosecutor's office, no one received us. They only received the document. I visited the fair in the Culture House across the street from there and purchased a cannabis cotton candy with no psychedelic effect whatsoever. I left soon after.

The "inter-institutional" overlapping that the CONSEP had with other institutions made its functions confusing and ambiguous but, for Rodrigo, the Council he managed was leading a historical process of reclaiming sovereignty over drug laws and policies that were traditionally marked by foreign institutions: "the world nations have, unwillingly, made this a highly profitable business, we have been very efficient in doing so, this we have accomplished with prohibitionist policies" (Personal interview, December 28th, 2014). For him, the phenomenon of drug-use could not be eradicated; instead, societies needed to learn how to administer use, and the laws, beginning with the new constitution, were slowly aiming towards this change. Rodrigo believed that the Chart was one of the steps towards rethinking

policies. He thought that, if the state regulated drug use, it would be easier to understand problematic consumption and thus generate therapeutic approaches that meet the need adequately. “Otherwise, we are trying to figure out how to address an addiction, or a drug use that has become problematic, without knowing the quality of the substance, its ingredients; we should be able to know that”.

Still, the country never really showed a clear path; it remained ambiguous. And people such as Rafa were falling through the cracks of a new penal state bureaucracy, while trying to better defend his rights and protections under 21st Century socialism as a minor user. Meanwhile, Rodrigo explained that the CONSEP generally controlled the flow of chemicals used in different industries—food, pharmaceuticals, textiles, paint, glues, and petroleum. Responding to a request from the United Nations, the CONSEP was giving advice to other Latin American countries, even giving them some computing tools used for carrying out this type of substance control. The institution, he claimed, was so well-adjusted that it had turned into a model for the other Latin American nations. At the same time, Rodrigo explained that legal substances could be controlled as opposed to illegal ones: specifically, he illustrated his point by arguing that in the cases of death by alcohol intoxication, the manufacturers could be traced and, aside from punishing those responsible, the state could also outline policies aimed to coordinate the craft production of the substance in question, something that could not be realized with illegal drugs.

For Rodrigo, the main problem of policy implementation had to do with the broader lack of popularity these topics enjoyed, “especially when we have forty years of brainwashing our societies” (Personal Interview, December 28th, 2014). The original strategy, he continued, was set in motion for colonizing purposes: hegemonic global powers controlled the markets and defined illegality in terms of what was beneficial for them. England and its control of the opium market, Rodrigo explained, pushed for illegality once they had stopped dominating it. So now, these last few years, Latin America had evidenced a reaction: “for all the tragedies we have lived, and which give us the moral authority to tell the United Nations, and the world, that with us—with Latin America—, this is it. No more imposed policies, which don’t include our sovereign approach to the phenomenon”.

The Executive Secretary also said that most countries agreed that this was a public health problem: addictions, the development of conflictive drug use is rather a health issue, which

also relates to economic development and human rights. But the approach ultimately adopted in Ecuador remained police-oriented, with the United Nations leading this position and multilaterally imposing it. Ecuador, he claimed, had asked for the involvement of the World Health Organization (WHO), although, he specified, the problem of security ought to be considered. “We can’t ignore the fact that this is a security issue, yes, of course it is.”

Lorena, a psychologist who worked in prevention at the CONSEP, and was later hired at the public addiction treatment center, explained to me that drugs carried a huge prejudice, not only with regard to prevention, but also in the therapeutics addressing them. For her, Ecuador had not begun to deal with the phenomenon in the round: religion and prejudice had been left untouched, and this inchoate or tacit consensus affected drug policies, because drugs were still popularly viewed as taboo (personal interview, November 12th, 2014):

They don’t dare speaking about drugs frontally; it is as if we wanted to ignore a reality which we have in the country, and in the world, which is [most simply] that people use drugs. Perhaps due to moral issues, moraline, to get spooked from some things but nothing happens with others, it becomes a religious issue, this is something that traverses and complicates the work.

Amidst this official contradiction, Charlie was already out but Rafa remained imprisoned. He had claimed addiction when he got caught, a strategy that would have worked if he had been caught in Quito, and if the state had the LSD reagents for blood tests, he believed. After all, it was only three kilos, and it was only marijuana. But he was apprehended in Latacunga, a place with a population of 160,000 and approximately 250 prisoners; a case of drug trafficking was something he felt the locals could not easily let go of, it was too iconic for the small town. After the initial fight, once he lost everything, Rafa was feeling hopeless. As soon as he was caught, he was taken to the provisional detention center, and he stayed there for eight months, where he remained drug free.

Rafa was a regular marijuana smoker; in fact, he was always sharing the best strains with his friends. Even though he had been drinking, smoking, and taking LSD on the day he got busted, stopping his drug use was not problematic; he didn’t consume anything for about a year. Yet once his sentencing was settled, and once he was finally moved to the medium security wing of the old prison, he began smoking base. The new habit went on for a few

months, but he stopped just as easily as he picked it up. Rafa placed all his energies on his business, the classes, the carpentry workshop, and anything that could aid in his early release.

The law stated that Rafa could ask for parole (called *prelibertad*) once he had completed two-fifths of his sentence. Having had his sentencing lowered to five years, Rafa could have left in two. He began the bureaucratic process to request his release, and everything seemed to be going well. It all looked promising. There really was no reason for him to remain imprisoned. However, after six months of beginning the legal process, he was moved to the new Latacunga Rehabilitation Center.

A couple of months before departure to the new jail, Rafa remembers that the prison received two “transfers” from Quito: a couple of hard-core drug dealers with enough money to have plenty of drugs flooding the facility. Until that moment, the only drugs available were *bazuco* and marijuana, but the new guys brought everything: heroin, cocaine, acid, and ecstasy, anything you could think of. Many became hooked, and Rafa remembers this as one of the most shocking aspects of being moved to the new jail: there weren’t any doctors or anything, and heroin addicts now had to overcome their use with no help whatsoever: “imagine, four people carrying a man in a blanket, and the blanket was soaking wet from his sweat, and nobody really knew what to do, except try to help each other through it”.

One night, after only two weeks of being moved, Rafa was taken to the nurse, as he was feeling sick. The guard that took him in asked him: “what are you here for?” Rafa replied he was in accused of drug trafficking, and the guide continued: “are you *el duro* from the old Latacunga Prison? I used to work with the rough ones at the Quito prison, and I’m looking for someone to take over your cellblock”. Rafa was surprised. But he was determined to leave, and he had no interest in becoming part of the drug distribution system inside the new prison. “There wasn’t even a fence yet, and they were already setting up the drug distribution network”, Rafa said.

Moving the inmates was a political decision, or at least that’s what Rafa thought, considering that the place wasn’t even ready yet. Since there wasn’t an outside fence, the first months were spent locked inside the cellblock. About five people per cell, with no running water, a shared toilet that was dirty, the inmates had to spend all of their time and even eat right there. Individuals with “horrible cases of abstinence” were also right there, without any type of

treatment. Everyone knows that heroin abstinence can kill, Rafa remembered. But nobody cared. The social rehabilitation system had managed to hook people to drugs that they didn't use on the outside; just to take them away at the new place, at least until the guides found the right person, *el duro* from Latacunga.

The modernization of the social rehabilitation “services” included addiction treatment for the interns²². The Minister of Justice spoke of addiction and the criminal consequences it had produced in those affected, disregarding the common conception linking prohibition, instead of drug use, with violent offenses (Hart 2012; Jacome 2016); she mentioned abstinence, and she presented the addiction rehabilitation program as an important step for the wellbeing of people deprived of their freedom. She emphasized the need for addressing drug problems from a public health perspective, as she spoke to prisoners of the Penitenciaría del Litoral (the main prison in the coast of Ecuador). The process, she added, had been designed along with the Ministry of Health and, after six months, it would allow for the reinsertion of the prisoners to their life plans. As an example of success, she explained that the interns in the addiction wing were already doing handcrafts and sports.

The War on Drugs had already been identified as responsible for the increase in prison population and consequent overcrowding, as there were no means to differentiate drug users from traffickers. While Law 108 prohibited criminalization of users, it penalized possession, once again, depicting the contradictory nature of drug policy. The Constitutional mandate gave the Ministry of Health full responsibility over addiction treatment, but it took about five years to begin a serious process of taking over. It eventually occurred in 2013, the same year that the CONSEP presented the chart as a technical tool for Judges to apply in sentencing. From far away, it could have looked as if Ecuador was giving a radical turn to the direction the country had been following for the last four decades. At the same time, the investment in prison compounds generated doubts, as an increase of prison spots seemed contradictory with an emancipatory process.

A psychologist came to the Latacunga prison a couple of months later, Rafa recalls. She began to medicate those going through abstinence. For him, everything felt improvised. He

²² “260 privados de la libertad adictos a las drogas llevan más de un mes sin consumir [260 deprived of freedom addicted to drugs have gone over a month without consuming]”, El Telegrafo, October 1st, 2015, <http://www.letelegrafo.com.ec/noticias/judicial/13/260-privados-de-la-libertad-adictos-a-las-drogas-llevan-mas-de-un-mes-sin-consumir>.

didn't pay much attention as his process of parole had already begun. It was intense, to be taken to a place with no water, and the water that they eventually had access to gave him fungus. Skin infections were denounced in the press, but the authorities insisted that everything was fine. Rafa remembers he didn't have any flip flops, there weren't any razor blades, he couldn't make a phone call, and there was no water. He decided to make a pacific protest and, one day, he decided not to take his breakfast. He and a fifty-year-old prisoner were the two protesters. When the lunch came, they didn't take it either. They were just trying to make a pacific protest, a statement. But there were 300 people in the same wing. And most of them were not really focused on leaving; eventually it got out of control. The inmates destroyed the new bathrooms, and soon enough, a team of 300 police officers, with surrounding snipers and armed helicopters, all arrived. A wet dream for the imagination of those in charge of the euphemistically labeled "social rehabilitation of people deprived of their freedom", the new term for Centers of Rehabilitation handed down by the Ministry of Justice, Human Rights and Religion. But this wasn't really a riot. Rather, the uprising was merely the protest of 300 people with no access to water. By inspecting the footage from security cameras, the police identified five individuals they thought were responsible for the massive misconduct. Rafa was among them.

"We are here to detain you", they told Rafa. He laughed: "how much more?" He was taken to the Judiciary Police, they showed the five detainees the videos that the security system had registered, and charged them with rebellion (*sublevación*). In his trial on the charge, Rafa explained, they were able to show that there was no rebellion, as you need an authority for a coordinated uprising to be considered as such. But no authority showed their face. There was no one from the government to be held responsible for the lack of water, or the arbitrary decision with which inmates had been moved to the new, half-built facility. Still, Rafa was sent into Special Maximum Security, further stretching his parole process. The prison authorities had already told him that since everything in the old prisons had been corrupted, they had to begin the process of rationalized punishment all over again, regardless of the time and money already invested. He, too, then, had no choice but to begin again.

While the process of petitioning his release moved forward, Rafa took the Senescyt test for university acceptance for the second time. He doesn't remember what he got the first time. But the 906 over 1000 that he scored the second time earned him a scholarship. He was just doing what he was supposed to do, following the new institutional norms, waiting for his

liberation. He knew that his case had already been filed by his lawyers. Someone just had to make it happen. The reason he had been given to do it all over again was the ‘corruption’. But that hadn’t changed a single bit. Rafa needed to pay the functionary in charge to do his job. Out of the blue, he contacted me and asked me if I could chip in. I created a chat in Facebook with all the friends we shared in common, and explained that Rafa needed a hand in getting out of prison. Ten, twenty, whatever. He gave us an account number, and we started transferring money. A lot of people helped. There was no reason for the process to get stuck, but it wasn’t going anywhere. Rafa couldn’t take it anymore. So he decided to have his mouth sewn shut in protest.

The system slowly corrupts itself again. Nothing had really changed; it was only taking a while to reorganize the new concentration of state and criminal forces. Eventually, people were able to sneak in scissors, needles, cigarettes, cell phones, and so on. There was one guy who created hats out of towels, and he also fixed the uniforms if they got torn or whatever. That’s where Rafa found the needle. For the thread, he ripped it off his mattress: he was able to procure a nice piece of nylon thread. A friend of his, imprisoned because of a car accident, stitched Rafa’s lips together. Another guy did the same thing. Because of Rafa’s access to the library, they had been able to make a couple of signs with their demands: that the law should be respected, that they should be released. They took their signs and went to stand in front of the security cameras.

The cameras pointing at the inmates are connected to the ECU911 system, the national emergency response institution. The police told the Prison Director, who was in Quito, that some of the inmates were demonstrating inside the new Latacunga facility; this made him come over to the new facility to speak with them. They cut out the stitches and spoke with him; they told him that there’s no resolution to their conflict in sight. He explained to them that he was new, that he didn’t know what the status of each legal process was, and he made promises that ultimately didn’t materialize. Rafa and his friend decided to go through the same process once again: with their mouths stitched shut, they stood in front of the security cameras showing their signs. This time, the vice minister came. The performance they had organized wasn’t meant to be public. The security cameras were not for the eyes of the public but of the police and the government. The newspapers failed to mention any of the proceedings. No one except for the prisoners and their families heard of inmates sewing their lips in protest.

The Vice Minister told them she was there to listen to them. But they couldn't speak, Rafa remembers, while laughter escapes from his now free mouth. They decided to take the stitches off in order to speak with the authority. They explained their situation to a major penal state official, once more. She promised to help, and they trusted her. What happened, after her visit, was that the prison director was fired. There already had been six directors, in the single year that Rafa spent at the new prison. Nobody wanted to take that job, he said. In the end, Rafa had to pay the officials, and the money we sent ended up in the hands of public employees handling peoples' release. He still had to wait.

While all of this was going on, the nearby Cotopaxi Volcano became active once again. The Geographical Institute reported on anomalous volcanic behavior in April, 2015, and a public report was issued June 2nd of the same year. I myself live at the riverside of the Pita River, an affluent of the Cotopaxi, and my house would disappear from lahars (tsunami-like mixtures of mud, rock, and glacial melt) if it were to erupt. This geological event-in-the-making made me dedicate an embarrassing amount of time to learning more about the threat and its potentialities, and one of the things I realized is that the new Latacunga Prison had been built well inside the risk area south of the volcano (I'm at the north side). I attended a meeting at the Army University in Latacunga, where a geologist described the volcano and its risks, based on previous eruptions, and I was shocked to hear locals claim that they didn't care about prisoners, and that they should be left to die, but that it was outrageous that there weren't any contingency plans regarding the Latacunga citizens' safety.

I met with Jorge Paladines, a public defender that I had seen in many of the drug-related meetings I attended in the past, to explain my concerns relating to the volcanic problem. I pointed out the Latacunga Prison situation and asked him to confirm what the evacuation plan had been for inmates. This wasn't even a matter of accountability, although we should be interested in the reasons why the government spent so many millions in constructing infrastructures in the high-risk zones (not only was the prison located in the lahar path, but so too was the new social security hospital). I simply wanted to know what the plan would be if the volcano happened to go off. Fortunately, as Jorge began asking questions to the Ministry of Justice, demanding to know what they had been doing in order to deal with the risk, Rafa was finally released. I no longer worried about the prison, as it was in the hands of the public defender and there wasn't much more I could do.

By the end of 2015, the president had already shaped a discourse taking in the concerns regarding heroin use among the national youth, and he claimed it was the *malhadada tabla* (the evil chart) the one responsible for this consumption increase. He decided to push for some changes, pressing for a reduction in the amounts chart and in the definitions of the different trafficking scales, hardening punishment for small quantities once more, and replacing the CONSEP for an institution that directly depended on the executive branch.

The Organic Law for the Integral Prevention of the Socio-economic phenomenon of Drugs, and for the Regulation and Control of the use of Listed Substances Subject to Inspection ordered the creation of the Technical Secretary of Drugs (SETED, for its Spanish acronym), a “decentered entity of Public Right, with Legal Person, and Administrative as well as financial autonomy, attached to the Presidency of the Republic”²³. This Secretary replaced the CONSEP and took over all of its roles.

The SETED’s objectives included: to increase the coordinated and articulated processes of integral prevention regarding drug use and consumption and its different manifestations in the national realm; to increase efficiency in the control of catalogued substances subject to Audit; and to increase the assessment, research and knowledge production for the addressing of public policy regarding drugs. Many of the investigations that the CONSEP had produced, in a line of thought which questioned the status quo, were removed from the SETED’s website. Concerns regarding raw material control were heard from some editorial lines, but the state didn’t reply, and everyone soon forgot about it. It felt as if things were back to normal.

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The Diabluma movement, formerly identified as supportive of the Citizen Revolution government (Ortiz Lemos 2015), began a process of separation from the repressive practices, while the regime narrowed its spaces of incidence. Being a movement who had been considered close to the government implied that they agreed with the exclusion of opposing movements, and whenever I spoke with Felipe about this, he insisted that, while they disagreed with authoritarianism, he believed that some form of imposition was necessary at

²³ “*Ley Orgánica de Prevencioen Integral del Feneomeno Socio Economico de Drogas* [Organic Law for the prevention of the socioeconomic phenomenon of drugs]”, Registro Oficial Suplemento 615, October 26th, 2015, <http://www.prevenciondrogas.gob.ec/wp-content/uploads/2017/05/Ley-Organica-de-Prevencion-Integral-del-Fenomeno-Socio-Economico-de-las-Drogas..pdf>.

the beginning of revolutions. He also believed that, being close to the government, the movement had been able to influence at least small aspects regarding the topics which they considered relevant for emancipation.

Indeed, Diabluma had been able to include an article which defined addiction as a health problem, something that they considered had to be understood as an improvement. But the definition of drug use as addiction and the implications that medicalization/pathologization had in terms of the practices surrounding legal proceedings and addiction treatment were not yet known. Moreover, this condescending relationship with power was something which generated conflict inside the social movement, and which eventually facilitated a subtle exclusion process from the illusion of participation. In the end, the Diablumas broke up with the Ecuador Cannabico branch, and each of the leaders, Felipe and Gabu, parted their ways.

Both movements remained active, but both seemed to have lost the momentum they built with years of activism. Charlie went to a couple of meetings of Ecuador Cannabico after his release, but the entire thing felt painful. A couple of months after being liberated, he got a job as a photographer in a photo studio located at the Valley. A couple of years later, he bought it from his boss. He invited me for a photo shoot with my baby, as a way of thanking me for the time I gave him while he was in prison. We sat down for some tea and he told me he had been doing all right; he had no interest in doing activism or in fighting for the cannabis liberation. He only wanted to do his thing, pay his bills, live his life. He mentioned that after his release he broke up with his girlfriend, but she eventually developed conflictive drug uses and ended up interned for a while. They were now friends, she was doing better, and he had overcome the sadness of their breakup. He was okay with having a criminal record, because as a business owner, it really made no difference anymore.

Rafa tried several things after his release. He first moved to the beach, because of his mother's health, but he came back to Quito after the 2016 earthquake; his house had been destroyed and he needed to start all over again. He was trying to open a restaurant. He was all right also. He had been in prison much longer than Charlie, and it took a while to feel adjusted once more. He had many friends who received him happily when he got out. His social network, while diminished during his prison time, was relatively easy to repair. After all, he wasn't a violent offender; he harmed no one. He had always been hard-working, and he managed to make things work.

Chapter 2

From Private to Public

Nunca es tarde para bien hacer; haz hoy lo que no hiciste ayer.

It is never late for doing the right thing; do today what you didn't do yesterday.

Daily phrase, women's wing, Public clinic.

December 23rd, 2014.

Introduction

The inclusion of addiction in the Ecuadorian 2008 Constitution was perceived as a major improvement in terms of restitution of rights, in a context in which discourses of security backed the country's participation in a World War against drugs. The main aspect that this move wanted to address was the increasing incarceration of harmless individuals for the sole possession of any of the substances subjected to the State's control; medicalization of the behavior of drug use implied that the person was no longer considered a criminal.

The medical perspective was never really foreign to drug policy in Ecuador. Treatment was already present in previous legislations, but Law 108's disposition of taking by force anyone under the influence for a medical examination and, if found to have consumed drugs, to order their treatment, placed civil commitment in the hands of police and family, without the need of court processes, and therefore, without the possibility of defense. The decade of 1990 saw the proliferation of a thriving market of addiction treatment clinics: private prisons in which desperate families could drop their loved ones for a break of everything addiction could imply. Many times, the clinics were the first option, even before the person had developed problematic drug use. It was enough for families to find any illegal substance to assume that their relative is an addict, and to turn to the only imaginable choice, the private clinic.

The public center was an experiment opposing the traditional approaches to drug use, but it developed in the same context in which the clinics became dominant, even when the "services" offered consisted in violence, cruelty, torture: a disregard of human rights as the way of addressing addiction. Private clinics operated behind closed doors, shielded behind discourses of addiction as an impossible monster which required absolute isolation to be tamed. Families, as might be said in their defense, didn't fully understand what the treatment

consisted of, and many times they were lied to by the clinics' owners. Addiction was a concept flexible enough to blame for any complain that the people undergoing inpatient treatment could manifest; the urge to consume would make them lie. The families, especially those dealing with conflictive drug users, couldn't help but believe the clinics. After all, they had already been lied to, manipulated, and tricked by their addicted relative.

Most patients at the public clinic had been previously interned in private ones. Everyone agreed: they were mistreated, starved, chained, beaten, humiliated; they had been forced to listen to gruesome stories of others' drug use as the form of treatment, and they were forced to repeat how bad each of them were for putting their families through so much suffering.

The public clinic was not only generating a medical category and its therapeutic approach. Also, it was doing so in a context in which the punitive/medical approach had already been dominant for three decades, with society's complicity and lack of interest. This chapter is about private clinics from the experiences that the people who were forced into treatment had inside of them.

2.1. The new center

The women's area at the public clinic was not planned. The center was meant to host adult males only, and the regulation of Recovery Facilities prohibited the functioning of mixed gender (male and female) clinics as a whole (Ministerio de Salud 2012). But being the first public inpatient treatment center, the public clinic was soon flooded with desperate recidivists (or their families), and this included women and teenagers. Virtually everyone I had spoken with at the public center had experienced being interned in one or more private clinics, regardless of being male or female, teen or adult; it only made sense to try the new public place. And everyone seemed willing to speak about the gruesome experiences they had encountered.

The day of the Christmas program, on December 23rd, 2014, I arrived quite early; Tuesdays are the days in which my vehicle had been under restriction against circulating during rush hour, and I was parked inside the public clinic before seven in the morning. The girls came back from breakfast around eight, and I took the opportunity to hang out with them while they got ready for the celebration. Resembling a typical school event, it included different presentations that the patients had prepared, as well as a bag of assorted candies for each one.

Sweets weren't allowed, but the holidays permitted a break from the law, a day of minor release from the structure²⁴. This was also a day in which males and females got to hang out together, something that seldom happened.

I had asked one of the facility psychologists what the difference between the public center and the private clinics was. Ivan, a former addict himself, replied that everything here was voluntary. "It's totally different, if you look at the premises, we don't have any bars here, doors are open, we have an influx of people, forty something, who come because they want to, and you can see that abstinence, conflict management is pretty good" (Personal interview, November 14th, 2014). While employees defined the public clinic as a space of freedom and will, which differentiated itself from the private institutions by the fact that people were free to leave but chose to stay, the women were locked up. Their area was located at the second floor of an old building which had belonged to the old leper asylum. This building was the last one; behind it was a huge yard where the orchard was eventually placed, and the houses of the remaining Hansen patients, built towards the back, could also be seen from there. The land was limited by a wall, and behind it was the slope towards the Machangara River. The women's wing occupied the furthest architectural extension within the public clinic.

Being an old place which had been adapted for the therapeutic community, the public clinic was filled with contrasts: the two buildings furthest down were rectangular structures composed of two stories each, but only the second floors had been renewed. They were accessible through an external corridor that linked both of them. Underneath it, the first floors of both blocks remained untouched, giving the appearance of abandoned warehouses, or enchanted cellars, endless rooms filled with useless furniture, construction debris, old rubble which looked dangerous while awakening some primitive curiosity. I couldn't help the mixed feelings that this disparity produced, and I surprised myself daydreaming about cleaning up several times.

The opposition which the public clinic wanted to show regarding private clinics, by offering a voluntary therapeutic community, clashed against the bars that separated the women from the rest of the space. I rang the doorbell, and the nurse in charge came with the keys to open the

²⁴ I had seen something similar in high schools: there was a day in which everyone could get wasted. To drink with the uniform, inside or outside the premises, or to hang out with the students was a transgression any other day. But once a year, the school hosted a party in which everyone, including students, teachers and parents had permission to "break the law" (Ortiz et al, 2014).

gate. I entered the conference room to the left and sat down with some of the girls. I had mostly seen them at the occupational therapy hour, outside of their area, where they would entertain themselves with videogames, handcrafts, books, ping-pong or whatever. On that day, they were waiting for the psychologist to come and lead the morning meeting, but after forty minutes they decided to do it on their own. I was asked to participate just like everybody else. In the male meetings, the guys had joked about me being in outpatient treatment, at the most, but I was allowed to just sit and observe without intervening. The girls gave me a different sense of what it might be like to sit there and to expose oneself to whatever the others – patients and counselors alike – might expect of you.

We sat on a circle, facing two cardboard signs that they had made: the first one described the morning meeting, and the second one had the Home Philosophy handwritten.

Morning meeting

1. Write the morning phrase.
2. Mood (everyone).
3. Daily evaluation (everyone).
4. Daily achievements (everyone).
5. Observations to myself and observations to others: deliver alternatives (optional).
6. Analysis of the daily phrase (optional).
7. Dynamic.
8. Philosophy of the home.

Veronica took the marker and wrote a popular saying. Her time at the public clinic had been difficult; she was constantly arguing with the other girls, and didn't seem to be able to fit in. Whenever she spoke to me alone, she would mention her son, a five-year-old boy living with his grandparents in Tulcan, a border city in the north of Ecuador, and how hard it was for her to accept that she had been a bad mom: she had lost custody to his grandparents on the father's side. But when there were other girls around, she spoke about boys, she fought, and she was considered problematic, even by the staff.

“It is never late for doing the right thing; do today what you didn't do yesterday”.

“Let’s move on to mood”, Diana, a seventeen-year-old girl said. “I feel good. I woke up feeling better than yesterday.” The girls continued around the circle.

“I can’t sleep, I feel anxious”. Whoever identified with what the others said made a sound by hitting their own leg with the palm of their hands.

“I am angry.”

“I feel depressed”.

“I am happy to be here.” I felt sleepy, but it didn’t seem right to say that. I wondered what was expected of me, and of each girl exposing her mood to the rest of the group behind a locked door made of bars, and with no authority to witness us. Foucault had described technologies of the self as those which allow individuals to perform a certain number of operations over their bodies and souls, thoughts, behaviors or any form of being, in order to transform themselves and thus obtain a state of happiness, purity, wisdom or immortality, and these operations could be done on their own or with the help of others (Foucault 1990).

Similar to Nguyen’s (2010) findings regarding technologies of the self amidst the AIDS epidemic in African countries, confessional technologies in the public center operated from the triage process and determined the possibility of accessing addiction treatment which, in some cases, also meant having a place to live when there was no family or the family had had enough, or when the other options were narrowing down towards judicialization. Life or death were not as obvious as they were in a context in which access to medicines depended on the performing skills an AIDS patient could develop, but the functioning seemed similar, at least in the public clinic. Not so much in the private addiction treatment centers.

The daily evaluation inside the women’s wing aimed to the wording of the previous day. How had I behaved? I was doing my ethnographic work. I lost the plane ticket to Buenos Aires because of the trip to New York; I had been asked by my supervisors at the University to revise my priorities and I decided I would postpone traveling to the south of the continent. I had done all the paperwork for the spring semester at Cornell University. I felt it had been a good day. Or had it? I wondered if I was filling a void with whatever pleased me, or with what I believed could be said within the circle without disturbing anything, instead of

searching underneath my own unconscious resistance. The routine question to oneself, the daily confession with or without a therapist, was it working as a way of finding the desired state of mind, the appropriate behavior? I did feel it was an achievement to be at the women's meeting for the first time. Most of them felt their achievement focused on having been sober one more day. Or did they? The door was locked, and the nurse had the key. I was left with a sensation of senselessness.

Foucault had described confession as something done in the presence of someone else, located in the position of judging the confession (Foucault 1978). The public clinic managed to increasingly convert the patients into the ones judging their peers to the point of not needing the psychologist to conduct the meeting. It wasn't like they were telling anyone of their judgments afterwards; that didn't seem necessary. It was more of an effect through which the weight of judgment didn't need to be shared among the psychologists, psychiatrists or anyone from the multidisciplinary team. Instead, it was shared between the judged.

The rest of items in the daily meeting list were optional, and I abstained. The observations to oneself included statements such as "I observe myself for feeling frustrated, and I give myself the alternative of accepting things", and these were responded by someone else with motivational slogans: "you can do this, believe in God and be strong." The observation to others turned a little harsher, as it implied saying something about someone that feels annoying. "I want to make an observation to Veronica. I know you think you're the only one suffering, but you're not." A particular kind of "option" or "choice" had to accompany the observation: "I believe you have the alternative to be nicer to the rest of us". Clapping sounds supported the statement. The positive orientations were also optional, and they consisted in choosing nice words for anyone in the group: "I want to positively orient Diana, Diana, you are very young, and I think you can do this. Be strong and keep trying".

The psychologist arrived in time for the analysis of the daily phrase, a proverb or saying which one of the patients had to propose for each meeting and which was analyzed; a moral tool aimed to the shaping of the self in the direction set by the proverb. She explained she had been held at a staff meeting, but she was glad to see that they went on. The conversation revolved around accepting past mistakes and present decisions, the dynamic was skipped, and then it was time for everyone to repeat the philosophy of the house, which was written in a cardboard sign next to the whiteboard. They had it memorized. We stood up and held each

other in a circle. The women recited (Center meeting, personally attended, November 14th, 2014):

Thank you Lord for not being the persons we used to be. Teach us to become who we should be; give us solidarity, tolerance, strength, and understanding to recover, and to be useful people for the family and the society.

Today we decide to be different women, dignified, with values that enhance our personality in order to face reality without fears and to fight against our defects.

We want to be loved and respected, we are valuable, and we deserve a better life, the happiness and trust of our loved ones.

Whoever decides to forget their past could repeat it, but whoever remembers it and reflects on it, will succeed.

Long live the Women's public clinic!

The girls were then given some free time in order to get ready for the Christmas party: they wanted to fix their hair, put on some make-up, dress up for the occasion. I came along; everyone gathered at Ale's room and we started speaking about private clinics.

"I once stabbed a man inside a clinic." Ale was a Colombian girl who had been into drugs ever since she was nine. She had been in different clinics, in her country and in Ecuador, and her story of the time she was at an Alcoholics Anonymous group triggered a series of comments and memories from the others. She met her boyfriend, Paul, at those AA meetings in Quito and, after a dramatic period of shared use, involvement with crime, violence and separation, they were reunited at the public clinic, being the only open couple in treatment, as love between patients was forbidden.

On that morning, Ale was the one leading the process of make-up application for everyone. Alternating between fashion opinions (after all, this was a day they would spend with the boys), and horror stories, the girls spoke about their memories of torture and forced confinement in the clinics: "I had to sit through the addiction stories of everyone else: therapy was everyone locked in a room all day listening to everyone's drug stories, and I wasn't allowed to go to the bathroom", Diana said. "So, I would stick a sock in my vagina in order to be able to pee in it. Do you have black eyeliner?"

Confessional technologies are put into motion inside the public clinic, not only during triage but also as the main component of treatment. They differ from the ones used in private clinics in that the objective in those seems more related to “jouissance”, a concept used by Lacan to describe an excess of enjoyment which produces suffering, instead of a transformation of the self (Lacan 1992). Private clinics, more than therapeutic, appeared as symptomatic: a repetition not only of the narratives, leading to nowhere, of drug use experiences, and, as Valverde (1998) explained, a compulsory repetition of the same modes of addressing addiction, regardless of their uselessness, over and over again.

The public clinic had appeared as a contingency center, necessary for giving the people inside busted private clinics an option after ‘liberation’. The Ministry of Health had taken over addiction treatment centers, previously in the hands of the CONSEP, and even though it had produced a document for the regulation of addiction clinics in 2010, it wasn’t until 2012, when Minister Carina Vance took over, that close control actually began. Vance, a lesbian and GLBTI activist, took a stand against addiction treatment centers for conducting dehomosexualization therapies (Wilkinson 2012). Surprisingly, the only reason why these clinics began to be intervened by the State was the public knowledge of dehomosexualization cases offered and carried in these facilities. The GLBTI community managed to publicize specific stories of the horrors lived inside these centers by homosexuals, sent by their families in order to change²⁵²⁶ (Herrera 2012).

Violent practices were disclosed to the public by organizations representing GLBTI population. María José, known as Majo, was a psychologist working at *Equidad*, a foundation which offered cultural, social and health services for GLBTI, and which participated in the process of raising awareness of private clinics and their approach to conversion therapy. She had been a student of some of my former psychology classmates, and she would hang out with some of my friends from time to time. One of the cases Majo worked with was a girl who had been interned in a private clinic by her parents: just like addiction treatment,

²⁵ “Ecuador investigará supuestas clínicas que ofrecen curar la homosexualidad [Ecuador will investigate alleged clinics that offer to cure homosexuality]”, *El Universo*, January 26th, 2012, <http://www.eluniverso.com/2012/01/26/1/1447/ecuador-investigara-supuestas-clinicas-ofrecen-curar-homosexualidad.html>.

²⁶ “Investigan clínicas en Ecuador que curan la homosexualidad a los golpes [They investigate in Ecuador clinics which cure homosexuality through beatings]”, *Infobae*, January 26th, 2012, <http://www.infobae.com/2012/01/27/1042941-investigacion-clinicas-ecuador-que-curan-la-homosexualidad-los-golpes/>.

dehomosexualization or conversion therapy required a family willing to cover the costs of internment.

Majo's patient suffered a series of abuses when she was interned. She had been able to contact Equidad to request the support of the foundation, because her internment had been against her will, and some activists, Majo explained, went to the clinic to ask for explanations of what had happened. "We contacted the family and we met with the psychologist of the private clinic to find out what the diagnosis was. They affirmed it was a case of drug addiction which generated a confusion regarding her sexuality." Most clinics based their treatments in experiential therapies. But some clinics had psychologists and psychiatrists working in them and, many times, witnessing the abuses and violations of rights, and even participating in the legitimation of these practices from their expertise.

The Equidad foundation had already addressed some cases in which treatment consisted in repenting and adopting socially accepted gender behavior. Majo explained: "for example, women are forced to dress with feminine clothes and to wear make-up. In many cases, the so-called treatment included sexual abuse from the guards. There are also testimonies of electric shocks, beatings, cold water showers, and so on." Many of these clinics had a religious background, thus appearing more trustworthy to families looking to change their deviant relatives. Aside from the sexual components, which Majo explains were exclusive to gender modification therapies, the conversion procedures shared physical violence and torture, as well as demoralizing practices such as starvation and solitary confinement, with addiction treatment.

Denouncements usually came from the social movements and rights organizations, and Equidad was one of them. The people who had been through these experiences didn't always want to publicly denounce what had occurred because, in most cases, it was their parents who had contacted the clinics and paid for the treatments. An activist from the Lesbian Movement Woman and Woman had an explanation for the difficulty this posed for those who had suffered internment due to their sexuality. She explained that "who had retained you against

your will is your family, and the affective issue weighs in. This is not a fight between parents and their children; this is a fight against those clinics”²⁷.

While the LGBTI movement, through different organizations, was eventually able to raise awareness through denouncements and investigations, even achieving the shutting down of some clinics and the involvement of authorities in the process, Majo felt there was still more to be done. “I am unaware if anyone responsible has ever been punished. But a colleague and I mentioned the case I told you about in an interview, and the clinic owner denounced us for defamatory statements.” The clinics had been working since the 90s, with no intervention from anyone. Through shame and fear, their business was founded on the promise of a normal and obedient person, while shame and exclusion worked on their favor. The business was thriving until the LGBTI movements became involved in activism. The appointing of an LGBTI person as the Minister of Health gave more strength to their claims, and clinics began to be intervened in 2013.

After unveiling the common denominator of violence in addiction treatment, the Minister decided to create a contingency area in order to offer some alternative to desperate families, while also presenting a new regulation, clearly forbidding these clinics from conducting any form of dehomosexualization or conversion treatment. At the same time, the Constitution claimed that the State had the responsibility of offering a therapeutic option for addiction. Juan, the coordinator for the public center explained the public clinic’s story (Personal interview, November 10th, 2014):

When I came here, this was a contingency center, this means that, since the patronage of therapeutic communities went from the CONSEP to the Ministry of Health (MSP for its Spanish acronym), the first thing they did was to control the communities, considering all the denouncements they had: mistreatment, kidnapping, that sort of thing. So what the MSP did was, it started shutting down the communities that lacked permits, and so on, and these kids that were admitted for inpatient treatment had the opportunity to come here and continue their process for a month. Why a month? These people came from long processes of internment, so, to propose something longer, nobody accepted. If they were told it’s only a month, they

²⁷ “*En Ecuador hay unos 80 centros clandestinos que ofrecen rehabilitación de adicciones* [In Ecuador there are about 80 clandestine centers offering addiction rehabilitation]”, *El Universo*, July 27th, 2013, <http://www.eluniverso.com/noticias/2013/07/27/nota/1213536/ecuador-hay-80-centros-clandestinos-que-ofrecen-rehabilitacion?amp>.

accepted. And this is how it worked, as a contingency center, for almost a year. When I came, there was a sign that read, “Happy birthday ACA²⁸, one year”.

Experiences at the private addiction clinics were consistently horrific. I had only met one person who had something good to say about the private clinic in which she received treatment. Michelle was using two to three grams a day of cocaine when she was finally admitted, first in a psychiatric hospital, and later at a very expensive center, which eventually shut down because there was little money left; they spent the 2,000 a month that each patient paid in a nice house and many well trained therapists (personal interview, April 10th, 2012). It was not a good business. Still, Michelle’s group therapy inside that center was mostly based in the twelve steps outlined by alcoholics anonymous, but it included massages, individual therapy with a psychologist, individual sessions with an experiential therapist, sessions with a psychiatrist, a yoga instructor, and a nutritionist. Michelle’s experience was the exception. The rule, when it came to private clinics’ stories, involved traumatic memories that produced nightmares years later.

I asked Diana if her experience at the private clinic, with the sock and all, had been a long time ago. “No, it was my last clinic. It’s still open. It’s called Bridges of Life²⁹, have you heard of it? It’s famous. They just force everyone to pretend whenever people from the Ministry or the CONSEP came.” Private clinics had been operating above the law for so long, with everyone’s approval also, that some form of inertia kept determining their modus operandi. It had been so complex, that Minister Vance herself had publicly denounced that one of the clinics violating the rights of its patients through dehomosexualization practices, belonged to a functionary of the Ministry of Health³⁰.

Until 2012, the private facilities which were registered worked on a self-regulation logic that only obliged them to send statistical information to the CONSEP, the institution that had been in charge of everything related to controlled substances since the nineties (Gobierno del Ecuador 1991). This dynamic made it hard for observers to obtain access to these clinics: it was difficult to find the clandestine ones, and the regular ones had no interest in granting

²⁸ Addiction Contingency Area.

²⁹ Names have been changed.

³⁰ “*Clinica de caso Zulema es de una funcionaria de Salud, dice ministra Vance* [Clinic of Zulema’s case belongs to a functionary of Health, Minister says]”, El Universo, July 19th, 2013, <http://www.eluniverso.com/noticias/2013/07/19/nota/1182611/clinica-caso-zulema-es-funcionaria-salud-dice-ministra>.

anyone permission to come in. Unless, of course, you were a drug user. Then, it was rather easy to enter: all it took was a preoccupied family member or friend, and the money to cover the monthly rate.

Ale wanted everyone to hurry. She had trouble getting along with other women, so a chance to spend time with Paul instead was more than welcomed.

2.2. Paul's lockups

I met Paul in November of 2014, after the director, the occupational therapist and a psychologist had recommended I speak with him. He was clearly a favorite: he was charming, intelligent, collaborative, and everyone in the public center wanted to see him improve, so much that they let him bring his girlfriend to treatment with him just to have him stay. Paul and Ale could hug and hold hands whenever they coincided in the premises, even though this didn't happen often. After all, addiction had brought them together, and they weren't ready to let go. Paul conditioned his stay at the public clinic with Ale's presence, and she was accepted at the women's wing.

The third child of hardworking parents, Paul grew up in San Carlos, a relatively new middle-class neighborhood near the northern area of the beltway, the outside of the surrounding highway of the city (de Maximy & Peyronnie 2000). At twenty-two, he had already been in enough private clinics to know that he would not stand for one more, ever again. His decision to come to the public clinic had been based on the fact that this place required that he wished to become a patient, and, while that wasn't totally clear, he felt he needed to stop. In August of 2014, Paul went to the center, secretly smoked his last bit of base in the bathroom, and after making sure that Ale would also come, he went on to sign the papers for his admission.

Paul introduced me to his parents on the day the Minister of Health came to the clinic. After visiting the different areas, everyone gathered at the auditorium: the staff, the interns, and the families. They had been asked to join the special occasion about four hours earlier, but the authority arrived late. Still, Paul's parents had been waiting. Paul and I sat together at the auditorium. Minister Vance gave a short speech, hoping to be done quickly, but people wanted to talk to her: gratitude for a treatment center that didn't abuse them, for the food, the humanity; the patients and their families spoke of a difference they never imagined possible. Most of them had spent thousands in private clinics achieving only hopelessness.

The public addiction treatment center offered a different approach that didn't include torture, and the people were thankful and hopeful. Many mentioned the need for work as the only thing missing: maybe the state can get them something, maybe the Ministry of Labor can get involved. I asked Paul if he was going to say anything. He told me he had nothing to say, he only came because they all had to. Ale was standing in the back of the room with the rest of the girls. Paul's parents were sitting a few rows down. He joked about someone else's intervention and we quietly laughed. Once the whole thing was over, he introduced me to his parents, Gaby and Jorge.

In Ecuador, the criminal perspective had entered so much into the pathological one, that the Law mandated cops to take those suspected of intoxication to addiction treatment centers, unless they were found with drugs, in which case they would be charged for possession and go to prison. Like its predecessor, Law 108 stated, in Article 30th, that Public Force members are obliged to immediately take any person who seems to be under the harmful effects of a controlled substance, to a psychiatric hospital or assistance center, with the objective of having doctors verify if the person is, in fact, under the influence of such substances. If so, they had to "immediately order the appropriate treatment. The treatment, which must be conducted in special centers, will be carried in those which were previously qualified and authorized by the Executive Secretary, in coordination with the Ministry of Health" (Congreso Nacional 1990: 5).

The clinics that appeared throughout the country were regulated by a security institution, the CONSEP, which exercised little control over what went on inside each of the private centers. What they offered, what standards should be applied, or what price range they should keep, the CONSEP didn't regulate these aspects. Plus, a series of underground, clandestine clinics were created, as the business got increasingly profitable. By 2013, the Ministry of Health and the Prosecution had identified around 150 clandestine centers operating in the country, and they had already rescued 500 people from some of these clinics³¹.

While the law stated that police should take suspects of drug use to clinics, the public centers began skipping this step by organizing capture forces, teams of interns and private security

³¹ "Existen más de 150 clínicas de rehabilitación clandestinas en Ecuador [There are over 150 clandestine rehabilitation clinics in Ecuador], Ecuavisa, November 8th, 2013, <http://www.ecuavisa.com/articulo/noticias/actualidad/45703-existen-mas-150-clinicas-rehabilitacion-clandestinas-ecuador>.

guards (mostly former addicts as well), in charge of capturing the consumer at the request of the families (Jacome 2012). No longer was the judge necessary, nor was the doctor or a representative of some sort of knowledge needed in order to detain someone and lock him for months; all it took was a family willing to pay; the clinic would take care of the rest. For Jorge, while none of the clinics in which Paul was interned actually cured him of anything, at least he felt the tranquility of knowing where his son was (Jorge, Personal interview, December 11th, 2014):

He used more and more every day. And he began to get lost. The first time he disappeared, 11 days went by with us not knowing where he was. It was horrible. We did a poster with his photo, and we left copies at the Community Police Units. We took him to the clinic in Cuenca when he showed up at Miguel's house, asking for food, looking like a vagabond. This was two years ago. Two years ago he stopped coming home. He arrived at his friend's house, and he took him in, had him shower. And he called us. This was before Portoviejo. After Cuenca.

For Paul, it soon became a dynamic of punishment that had him locked away for too long. He had already spent many months in confinement when he began disappearing (Paul, personal interview, November 12th, 2014).

For my dad, it was the worst to see me high. He didn't care what he had to pay; he had to have me locked down. So he sent me to clinics. Not one, not two. Not three. Not even four. Many clinics, all against my will. I was always captured. I would escape, they would capture me again.

After the second clinic, a nightmarish place from which it was impossible to escape, Paul stopped. He was around 16 or 17, and he was able to stay clean and sober for two years. Out of fear, out of will, Paul wasn't entirely sure, because it had been traumatizing: "I was always hungry, always dominated, always abused. For me, bars are the worst thing there can be." Paul went back to "normal" for a couple of years. Back to school, he found a job, he behaved. But it felt like a performance of responding to society's expectations. And things eventually went back to what he had always known as normal.

I arrived at Paul's house in the afternoon. The house was right in front of a small park, two blocks away from the Occidental (west beltway) in the north of Quito. Paul had mentioned

that he grew up in a drug-flooded neighborhood: “there were more pipes than balls in the park” (Personal interview, November 9th, 2014). I figured this was the park. Jorge opened the garage door, and I drove inside. Separating the house from the garage was another door, with a lock; security seemed to be an issue in this part of the city. A mixed breed dog greeted us. “The dog is Paul’s. It was at the center, but it turns out, it is forbidden to have dogs, so we brought it here (Personal interview, December 11th, 2014)”. Gaby petted the puppy as she showed me the way inside. Paul’s parents had prepared a folder with Paul’s story: mostly, a collection of family photographs at the different clinics where Paul had been. Family memories were built inside the walls of his confinement.

Even though Paul was around eight years old when he discovered glue and its effects, his parents only found out about Paul’s drug use years later, when he was kicked out of his school for gang involvement. He was always in some kind of trouble, but they refused to believe it was something serious. Paul often came home beat up, with broken bones, bleeding. Yet, they couldn’t see what was happening. One day, Jorge stayed home from work, and decided to clean up Paul’s room. Underneath the mattress, he found a small plastic bag with white powder, and another one, and then another. The school suggested they take him home until he recovers, while they subtly expelled Paul from their institution. The police had been involved: they were investigating a series of robberies and they had identified Paul as a gang member. He was around fifteen. Jorge had no choice (Jorge, Personal interview, December 11th, 2014):

Sometimes, out of ignorance, you make decisions, and sometimes I admire myself of how naive I was, maybe it happens to many parents... I had no idea what to do, and I thought that, maybe taking a month off, doing some sports with my son would help. So I stayed at home with him, but then, one time he came and told me, dad, I need to smoke. It was like a physiological need, and, well, then we started to worry. And people told us to find a place where he could be helped. The first place that they recommended was the Alcoholics Anonymous group. A colleague told me she knew of someone who also worked at the social security, but that due to his alcoholism he had lost his job and that now he was at AA. She said that it had worked for him, and also for his son who was also an alcoholic; his son was already in college. So we went looking for this place, something that can work, we went looking for the offices, and this was the first place, the first experience of trying to help.

Paul's brother and sister were much older, and they were always doing their own thing; his parents were constantly working, and he only saw them very early in the mornings. He was usually asleep when they came home at night. He was mostly alone, and he soon turned to the streets of his neighborhood, searching for mentors, models, and friends. Paul's life happened outside of his parents' knowledge, and this included his early drug use, from household items such as glue or liquor to the drugs he got from the older friends in his neighborhood.

At the same time, Paul did belong to a family dynamic, even if it excluded him. "Ever since he was a little boy, he was quite sharp", his mother, Gaby, remembers (Personal Interview, December 11th, 2014). "He developed faster than his siblings, in everything: walking, speaking..." One of Paul's teachers had suggested that he is placed at a school for the gifted. Unfortunately, he recalls, his father thought he should be treated just like everybody else, and he blocked the possibility. It is Paul's opinion that his dad was always angry, at him or at his mom, especially when he was a little boy. "He didn't have any patience. He would help me with math homework, but he was always frustrated, always angry (Personal interview, December 2nd, 2014)".

Paul soon learned to leave the house in the afternoons; at least outside he could make friends with the people who lived around him. "I learned to imitate the behaviors of the people in my neighborhood, and it started showing with the problems I had at school (personal interview, December 2nd, 2014)". At his neighborhood, what Paul remembers learning was to fight and to use drugs. When he was 9, having already used glue for a while, he saw the opportunity to try base, and he took it: "A friend of mine, he must have had his 20 years and I was 9, he asked me for a dollar, for drugs. I said, ok, I give it to you; I'll give you more than one dollar, but let me try. That day I tried cocaine base."

He introduced himself to drug abuse and dependence, and he did it in such a way that nobody appeared to notice until he was a teenager. Until then, he had tried several substances, although alcohol was one of his favorites; he learned to drink at home, from his dad's supply: "Because of his work, people often gave him top shelf bottles. I would come from school and I would pour a little alcohol, a little coke, a little ice, playing adult. Sometimes, I would make whiskey ice-pops (personal interview, December 2nd, 2014)". What he liked about it the most was to feel older, braver, like the guys he admired in his neighborhood. But he managed to

keep his drug use a secret: “I didn’t brag about it, I was ashamed. I saw kids my age and I wondered, do they ever do the things I do? I didn’t think so. And I felt ashamed.”

Paul’s parents reacted to the shock of finding out, after years of use, that their son was into substances, by choosing the Alcoholics Anonymous clinic. As a principle, the AA proposes a voluntary approach to addiction, but he was given no choice (personal interview, December 2nd, 2014).

They took me by lying, they said, let’s go, Paul, you can listen to one therapy session and if you like it, you stay... I believed them, but when I finished the so-called therapy my parents were gone, there was a suitcase out there with my clothes, my soul dropped to the ground. It was a horrible place, one single room for forty-five people, with bunker beds for two or three people, I was the only minor there, and there were homeless people that had just come out of jail, and instead of recovering, I came out much worse, I learned so many things. I came out pissed off at life.

Being taken against his will, without him knowing, generated resentment in Paul which only seemed counterproductive. From his point of view, his childhood choices were left to him, and he had exercised his freedom by doing drugs and joining gangs; he had stolen, he had fought, he had seen friends die, and he had been detained by the police. Suddenly, he was taken to a clinic, with no trial, no defense, and no possibility to make any sense of this. After three months in, the staff told him that his parents are coming. The clinics usually have a policy of no contact with the family, and Paul had not heard from them ever since they fooled him into confinement. “I was happy, I was certain they would get me out, I packed my bags, I didn’t eat, I’m leaving, I said. When they arrived, I said, ok, let’s go, but they refused. I cried, I begged, but they left me there. I was so resentful that I chose to stay for a year and a half (personal interview, December 2nd, 2014)”.

While Paul’s story echoes the experiences of any other person who has been locked inside a private addiction treatment center, against his will, and with no signs of recovery whatsoever, Paul’s parents struggled to make sense of this defeat, as Gaby explains: “perhaps he was too young... He was at another center afterwards. Our life is hard, confused (personal interview, December 11th, 2014)”. While Paul was in AA, he got a sponsor that recommended a stronger

approach. AA had been too open, and the way Paul was binge-using, he might need the classic, forced clinic, he claimed. Gaby continued:

People who had been through this advised us. He told us about a clinic in Pifo, and prices were terrible, a thousand dollars, six hundred dollars, and even though we both worked, we couldn't afford it. We took him to Pifo, and they charged us four hundred a month. He spent six months there. We were only allowed to see him after five months. I went to family therapy every Friday. I had to tell my boss about this, because it was an hour and a half just to get there. They told us there was no violence there, but we later found out that there was. We saw him well, logically, when he stopped, he looked better. He wasn't discharged; my husband decided it was enough after six months. I said alright, let's do this. He found another AA group, to maintain his sanity, but I don't know when it was that he began using again. And so we found another clinic in Cuenca, private as well, that one was more affordable.

Law 108 generated a strong punitive response to drug possession that translated into an increase of the prison population in Ecuador (Edwards 2011). The initial emergency to fight against the evil that drugs represented had quieted down, while repression increased silently. Law 108, implemented in 1991, decriminalized use but criminalized possession, making it impossible for drug users to defend themselves. Confinement, then, was virtually the only option for drug users, either in prison or in clinics (Paladines 2013). While there are 66 legal centers for confinement managed by the Ministry of Justice, Human Rights and Religion, there are approximately 148 centers for addiction treatment, under the control of the Ministry of Public Health. At the same time the CONSEP, in its "theoretical base for prevention", had estimated that 22,500 people needed treatment for drug use, while the clinics had only received 4,141 requests for admission, suggesting that about 85% of people in need for treatment were not receiving it (CONSEP 2012). After Minister Vance faced the private clinics issue, the Ministry of Health created the Policy for Mental Health, a document which, among other things, stated that Ecuador didn't have the data differentiating people who present a conflictive drug use and those with occasional uses, while other countries in the region, like Colombia, Peru, Chile and Argentina had included differential diagnosis criteria in their measurements. The document took the World Drug Report index, which stated that 0,6% of the population between 15 to 65 years had developed a dependency relationship with substances throughout the globe, and projected that the Ecuadorian population within that

age-range would include approximately 59,058 people with dependence to illicit substances (Ministerio de Salud 2014).

It wasn't until 2008, after a rather complex process of construction of a new Constitution (Ortiz Lemos 2015), that drug use was officially decriminalized through the inclusion of an article that defines addiction as a health problem, prohibiting incarceration and guaranteeing a therapeutic response from the Public Health System (Asamblea Constituyente 2008). While article 364 aimed to decrease imprisonment rates, it also gave the state the obligation to offer medical attention for substance use.

The State was faced with the need to address the issue not only due to the constitutional inclusion, but mainly because LGBTI movements had been able to politicize involuntary confinement in private addiction treatment centers, through denouncing practices of dehomosexualization as part of the therapies being offered in private addiction treatment centers³². The “therapeutic process” was pretty much the same as it was for drug users: a concerned and uninformed family member would arrange for the kidnapping of their relative against their will, in order to be forced, through a systematic deconstruction of the self, based on violence and humiliation, into normal sexual identification – or into abstinence, for addicts. While drug use had failed to place a voice of outrage in the public, the LGBTI movements were able to demand a previously absent State intervention in these businesses.

As personal stories began to circulate in the Media, the country was facing a loss of legitimacy regarding drug policies. The public started hearing about addiction treatment centers and their practices of “rehabilitation”, a topic seldom discussed. The stigma of addiction silenced individual as well as family experiences of drug abuse and treatment, and the clinics operated behind closed doors, even though there were many more people locked in them for drugs than there were for homosexuality. Still, there was no room for even considering the wrongfulness of this approach. The LGBTI outrage was the breach that the private addiction treatment centers needed to have the abuses they suffered unveiled as medical prisons for “a stigmatized population so as to neutralize the material and/or symbolic

³² “En 2012 el MSP registró 123 centros de rehabilitación legales en Ecuador [in 2012 the MSP registered 123 legal rehabilitation centers in Ecuador], El Telégrafo, July 19th, 2013, <http://www.eltelegrafo.com.ec/noticias/sociedad/1/en-2012-el-msp-registro-123-centros-de-rehabilitacion-legales-en-ecuador>.

threat that it poses for the broader society from which it has been extruded” (Wacquant 2000: 378).

In the following years, the Health Ministry began a slow process of identification, regulation, inspection and control of private addiction treatment centers³³ (Ministerio de Salud 2013). As I learned from interviewing the technical coordinator and the psychologists that worked at the public clinic from the beginning of the contingency center, the Ministry found clinics which had to be closed down for malpractice, lack of regulation, and even human rights violations. The legitimacy crisis regarding drug policy was an emergency that, when addressed, produced other urgencies that needed to be dealt with. Many of those inside the clinics had conflictive relationships with substances that they could not manage on their own, and they, as well as their families, demanded addiction treatment. And, although the Constitution guaranteed health services for addiction, only a few public hospitals offered some form of outpatient treatment.

As private clinics seemed the only choice for desperate parents, they were also a thriving business opportunity for “addicts in recovery” (Jacome 2012). In other places, such as Guatemala, the State had also been found to be absent from the addiction treatment centers, mostly Christian institutions which operate as soft security mechanisms without the State (O’Neill 2015). I contacted a high-school friend who had owned one: a former alcoholic, a usual trait for people who own a center, he explained that he usually had 20 people in inpatient treatment, at a rate of \$900 a month, that is, an average of \$18,000 that he would receive every month to cover for all expenses, including salaries, rent, food and so on, leaving a net gain of over \$10,000 per month (Diego, personal interview, 03/11/2013). He had to shut down his clinic in 2012, when Minister Vance took over, because the requirements became harder to fulfill. Three years later, he opened another addiction treatment center, and the last time I saw him, he was getting ready to open a second one. He even offered me a job.

Paul compared private recovery centers to being in prison (Personal interview, December 2nd, 2014):

³³ “En 2012 el MSP registró 123 centros de rehabilitación legales en Ecuador [in 2012 the MSP registered 123 legal rehabilitation centers in Ecuador], El Telégrafo, July 19th, 2013, <http://www.eltelegrafo.com.ec/noticias/sociedad/1/en-2012-el-msp-registro-123-centros-de-rehabilitacion-legales-en-ecuador>.

My dad, the worst thing in the world was to see me like this, and it didn't matter how much he had to pay, he had to lock me up. And he did, in many clinics. Not one, not two, not three, not four. So many clinics, against my will, captured. I would break free, they would capture me again. The worst one was the second after the year and a half one. It lasted six months. I tried breaking out from it like five times, until I accepted I was at an impossible place. Horrible. I cried a lot, I suffered like you have no idea, I was horribly mistreated. I was hungry all the time; I was submitted all the time and, well, for me, the worst thing I can see are bars. I swear to you. I see bars and I go crazy, desperate, it was like being in jail, worse than being in jail.

How could a clinic be worse? Private clinics function from a punishment logic, legitimating the annulment of rights for the addicted. Yet, the inclusion of the public health perspective in the Constitution forced the country into a change of discourse, from criminalization to pathologization of the behavior of drug use, a change which put into practice certain regulations and controls over private clinics that didn't exist before. The alleged change remained ambiguous, because the shift to medicalization of the addictive behaviors implied a release of the responsibility in the choices made by each individual (Valverde 1998).

At the same time, the possibility of a substance to take over a person's life in such a way that the individual would no longer be capable of making rational choices seemed to legitimate war-like responses from the authorities, ever so concerned of the populations' well-being. The rhetoric surrounding drugs has held the notion of a problem of which the affected person is unaware, as can be seen, for example, through the techniques of "intervention" (Carr 2013). This same notion operates in private clinics, where former patients were forced to self-define as addicts, a category charged with a moral implication. But, contrary to what can be seen in the TV show, the private clinics in Ecuador had thirty years of operating behind closed doors, with no need to self-regulate, and with no regulation from the State. What is understood Due to the lack of public spaces that treat addiction, private clinics that have gone through the relatively new regulation process still operate, while surveillance by the state in order to guarantee human rights is limited.

In practice, private clinics operated as private prisons in which families can always deposit their addicted, as many times as they want, regardless of the lack of their effectiveness or lack thereof. Gaby explained what was going through their minds by the time they locked Paul for the third time: "So we sent him there, and he spent some time there, and we always trust, we

are always waiting for that miracle, those of us who trust God, and so, in that occasion, we thought, maybe the fact of finding himself in such a horrible place” (personal interview, 12/15/2014).

2.3. A place to live

Private clinics consistently operated as spaces of senseless repetition of horror drug stories; Diana’s testimony was echoed in what Albert, the patient with the longest time at the public clinic, could remember of his previous internments. At the public center, he was considered a difficult case of opiate addiction. A 38-year-old man, he recalled therapy in his last clinic before finding the public center: “By 6:30 in the morning you had to sit in a huge room where there were 50 people, while one man shared. In there, the one who drank the most was the coolest” (personal interview, September 28th, 2015). Albert remembers “therapy” in a private institution as a performance in which people ‘bragged’ about their use from 6:30am to 9pm. He recalls the story of a father and son who he had met while in his last clinic, an AA oriented facility in which some people lived, while others only came in the nights.

Militants, they are the ones who came only at night, and shared with those admitted, they were called militants. I believe that was useful for them; if I had a place to live, and if I only went as militant, it would have worked for me as well. But living there was horrible.

After his father died, in 2012, Albert was on his own. The only job he ever had was as a staff member for his dad, a well-known singer and musician. He had remained with him after his parents got divorced, when he was a teenager, and they would share marijuana often. At some point, however, his dad was sent to jail, and Albert began visiting every day. In there, they started smoking cocaine base, their drug of choice from then on. His mom sent him to a clinic once, around 2007. And his girlfriend sent him to another. But when his dad died, Albert was left with no choice. Clinics became a matter of housing.

Albert’ drug use had been a part of his life since he was a teenager. He began with alcohol, mostly because it made him feel less inadequate in front of other people, a feeling which he grew up with. “I spilled the glass of juice every single meal. My dad used to tell me not to worry, because that was just the way I was. My mom thought something was wrong with me (personal interview, September 15th, 2015)”. Being an extremely shy adolescent, Albert created an imaginary world in which he could talk to the girl he so much liked, and this

imaginary land became the place he preferred to live at. Alcohol made it easier to get there, and he developed routines for daily use. Marijuana also became a customary practice: he associated it with playing different instruments. His mom had told him, when he was a child, that he would become an alcoholic. But his dad was open about substances, and they soon became partners in use.

Experience with clinics was usually linked with a decision made by the family, but in Albert's case it was his girlfriend. He was 22, 25, he doesn't remember, when Karina decided to have him captured. His mom was living in the United States. His dad, he doesn't remember. The clinic was a center in Guayllabamba (outside of Quito, in a small city in which Karina has a country house). "I still hadn't even met heroin at that time. It was only freebase and codeine pills, I was an adult but this was so long ago. I remember telling the psychologist, Doc, I will change, now I know, I just lied a lot. But deep down I kept thinking, this has already gone to hell (Personal interview, September 28th, 2015)".

Families, spouses, close ones play a role in the way subjectivities are shaped into addiction. Biehl (2013) had seen the alteration in a patient's sense of being and value to others through the story of Vita, a woman living in a Hospice with no apparent possibility of reinsertion. In her case, psychopharmaceuticals seemed to participate in an important manner, while the family acquired new forms of judgment, reworking the dynamics within the family. In Albert's case, his mother had left the country, and the only close person at that time was his girlfriend. She had been with him for many years without even knowing he used substances, but once she realized, she decided the best thing to do was to intern him. Just like in Paul's case, there were no other choices. Drug use equated to private clinic internment.

The second time he was admitted came after his mother returned to Ecuador (personal interview, December 15th, 2014). She had been living in the United States, but she returned in order to fix Albert.

She said, Albert, you will live with me. I didn't want that. I told her, I had been so many years without her, she hadn't even asked about me, and now she wanted to live with me? I didn't realize it then, but now that she is dead it hurts me that I treated her that way, because she must have suffered a lot, she cried. Everyone tells me she suffered so much over me. At first, I felt really guilty. But I have learned to cope with it.

Albert and his dad didn't have a home. They lived in different hotels, depending on how much cash his dad had on him, and they smoked base every single day. When his mother came, it had already been years of this same routine, and Albert wasn't even thinking of quitting. "She left when I was 17, 18. She wanted me to go with her; she was always more concerned about me than about my brothers. She ended up leaving with my younger brother (personal interview, December 15th, 2014)".

Albert had found a new form of entertainment in our conversations. He wanted to speak of his addiction and therapeutic experiences, even when there was a difficulty in organizing his life story. "I'm sorry if I tell you things as I remember. My story might come back and forth (personal interview, December 15th, 2014)", was something he repeated a few times on different occasions. He spent over eight months at the public clinic, until his process of social reinsertion seemed en route. He had found a telemarketing job selling medical insurance over the phone, and he rented a small room near the San Roque market, a place where drugs were very accessible. He was released with the compromise of coming back for outpatient treatment, a follow-up process with his therapist. He was on his own. Both of his parents had died, and his brothers lived in different countries. He didn't get along with his extended family. He only had Karina, his ex-girlfriend and her parents. He came back about six months later, when he quit his job and finished all of his savings.

A friend just came back here, Freddy, he is the one who received me when I first entered here. And now he is drunk and relapsed. And I tell him, man, don't relapse, but he answers, at least I don't look as bad as you do, he gets defensive, so I tell him fine, brother, you look fantastic. But then I hear that his cause for relapse was that he caught his wife with someone else, and so he got wasted. I think that if something like that ever happened to me, I wouldn't come back; I would just go find a way to kill myself. I mean, you know, I say this, but when it comes to that, it's not like that.

It was in his last center before the public clinic that Albert learned to drink rubbing alcohol. He had already reached a status of confidence, being allowed to sometimes leave the premises, and he would get 1 dollar for transportation. One time, he decided to enter the Supermaxi³⁴: "I could've stolen a bottle of whiskey or something, but I stole rubbing alcohol. I went to the bathroom inside the mall and drank two mouthfuls. And I felt the '*fuff*' (personal

³⁴ Supermaxi is the major chain of grocery stores in Ecuador.

interview, December 15th, 2014)”. He came back to the AA clinic knowing there would be consequences: “they broke my head with an ashtray for relapsing, because those people, they hit you, they call you a recidivist, and that generates resentment, the way they treat you. Here it is different, very different.”

The main contrast that the Public center wanted to show was the different approach that they had against private institutions. There were no public spaces; the places that were free had been financed by the church, by charity or by the AA groups, and while there were some clinics that operated for free, most of the private centers viewed addiction as a profitable business. Juan, the coordinator, explained: “This idea of the experiential therapists came from a course that the CONSEP organized, legitimating and certifying former addicts. I’m not saying they were all bad, but there were excesses.”

It is in this context that the public clinic aimed to generating something different, something rational, integrating many aspects that Juan believed intervened in the development of substance abuse or dependence (personal interview, November 6th, 2014) :

It all moved to the health side; the medical model will always clash against the social side. I am sure there are psychiatrists who are convinced that, only with pharmaceuticals, a person can improve. I have met those who say that a little therapy won’t hurt them, but they are not convinced. In this community, what works is the one and the other.

While Albert agreed that this center was considerably nicer, without the violence, and with the necessary trust, and while he believed that an outpatient model could have helped him more in his previous internments, he remembers that he went back to using drugs while going through inpatient treatment in the AA clinic (personal interview, December 15th, 2014):

They were open, if you are there long enough, you can go to the store, or you can go look for a job, like that. So, all the time, I was only thinking about my relapse, when I get out, I’m going to look for a job, a room, and period. Just like when I started living alone. But I won’t go crazy this time, that’s what I kept telling myself.

Albert’ return to drug use went as far as going back to his pill addiction, even while he was still living in the AA clinic. They were allowed to smoke, and so he could ask the outpatients

for 25 cents, for a cigarette. He would collect two or three dollars in one day, go to the drugstore in the corner, and buy over the counter opioids. Codeine was available without prescription back then, and he got hooked. He had seen the pills that Karina took for a complicated hemangioma, and he soon discovered he could buy them with no prescription (personal interview, December 15th, 2014).

I used to buy the strong one. It turns out it had codeine. I became addicted to codeine. You are the first person I tell this to. They sell those pills freely because if you take one or two, nothing happens. But if you take 15, you'd be fuddled. So, when I was at this group, the box was 3 dollars. I would buy a box, which lasted for two days: I'd take 15 pills one day and 15 on the next.

The public clinic controlled drug use with blood and urine tests. The reagents were applied to everyone, especially after a home visit. As opposed to the AA clinic that Albert described, if someone was caught with substances in their fluids, they would have to leave the program. The public clinic was a voluntary space of treatment which had to control voluntariness by testing its participants. The way things were in regards to drug policies, generated a different scene for each participant; for Albert, being kicked out would mean losing his current home; for Ale, it would mean going back to the streets, possibly to Colombia; and for Paul, it could even mean he would have to go to prison on robbery charges that were being held until he showed the court his interest in getting clean and sober.

2.4. Burning down the house

Many of the patients, like Paul, had already been in several private clinics, and Juan felt the need to offer something beyond the usual. For Paul, clinics had a meaning that didn't relate to his relationship with substances. Instead, it had become a matter of losing or winning against his dad, against the system (personal interview, December 9th, 2014):

He told me, as long as you decide to keep on taking drugs, I will decide to keep on locking you down. It was like a challenge. And this is why I began disappearing. At first it was a few days, but then I would leave for months, because I knew that the minute they found me they would send me to some clinic. I was sick of it. So, the last time they sent me to one, I set it on fire. I had already learned how to handle clinics: I would earn the trust of whoever was in charge, and then I would find an easier way to just take off. I manipulated the program perfectly. I'm sure I would be a great experiential therapist. I know all of the aspects of

therapy. I've memorized the back book, and the Narcotics Anonymous texts. I understood the *terapia de palo* (the therapy of the stick), and I was just sick of it.

While clinics had been a part of our society since the nineties, and virtually everyone knew at least someone who had been admitted to at least one, hearing the details of what occurred behind the closed doors of these places was still shocking. The violence implied in the definition of a therapeutic approach consisting of a stick to hit people with cannot begin to describe what many, most of the people now at the public clinic had been through, at the expense of their families, and with no results whatsoever. Paul continued (personal interview, December 9th, 2014):

Imagine that in one of these places, they kept me standing for two months, from 6 am to 10 pm, standing. They damaged my hips from all the hitting. I was handcuffed to the toilet, while people came to pee, defecate; I was handcuffed to the toilet. I guess one of the worst things that they did to me was to pour sugar water over me, it was one of the clinics in Chone³⁵, sugar water, and they left me in the yard. The ants screwed with me, and then the people threw soap water over me. My skin was destroyed. And then, for seven days, all I had to eat was banana peels. Like a hog, like a hog. And it was worse if I refused to eat, I would get the stick, I had to eat.

Regardless of the knowledge of their son being mistreated inside the different clinics, his parents continued punishing/protecting Paul with captures and confinement: this was the only option they knew of, and they approached it with the hope that, this time, the miracle would occur. Gaby prayed for the miracle. Jorge became a protestant (he had been catholic). Their religious belief accompanied the decision to lock their son down over and over again, regardless of the money spent, the uselessness of the “treatment”, or the refusal that their son constantly manifested (personal interview, December 11th, 2014):

We are always trusting, hoping for the miracle, those of us who trust God”. Paul had learned to manipulate, and he would write letters with bible quotes to please his parents and to request liberation from the clinics he found difficult to escape. At the same time, they tried to make sense of what was happening, and Paul knew how to use this uncertainty. Jorge continued: “Paul wrote a letter in which he told us he had wanted to take his own life. He said he was

³⁵ A city in the Coastal region of Ecuador, north of the Manabi province. In 2007, an estimated of fifty private clinics operated in Manabi without the permits (La Hora, 01/02/2007).

desperate, and there were many bible quotes. But the AA clinic doesn't allow the bible, maybe that is the bad thing. Because, well, Paul has told me, 'dad, I know more about the bible'.

Jorge's miraculous expectations were never fulfilled, regardless of the internment of Paul in several clinics with religious orientation. As O'Neill (2015) had found in Guatemala, here too, religion played an important role in the "soft security" offered by rehabilitation clinics, but in Ecuador, the private centers, regardless of their use of religious components, gave form to gruesome practices of "rehabilitation". They weren't so soft. After being mistreated to the point of trauma, Paul was finally able to escape from the worst clinic he had been into. But as soon as he arrived back to Quito, they were waiting for him, the same capture team (personal interview, December 9th, 2014):

Fucking shit. I wanted to make the car crash. They had to put me to sleep. And well, when I got back there, I was there for two weeks, and I burned the clinic down. Perfume was not allowed, but that week, someone had sneaked some in. I found a bottle of rubbing alcohol. The perfume. Other people got into the plan with me. I had already poisoned the water; I wanted someone to die so that the clinic got shut down. Good thing nobody drank it, they realized it had acid. Anyways, on that day, I found matches in the backyard, and even though they always had an eye on me, that day they let me be. I set up the mattresses, made a hole in a lightbulb and poured the alcohol and the perfume. That was enough. I had two matches, but I only needed one. I lit the lightbulb, and I stepped outside. In ten seconds, there was nothing else to do. It burned down completely, that bullshit place.

The newspapers reported that an intern had caused a fire in order to escape³⁶. They never mentioned mistreatment or forced confinement; the behavior was clearly framed as the result of an addiction. Criminality coming from drug use as the representation was reinforced with the forms of resistance that people in private addiction treatment centers could have. Paul was convinced he had done the right thing. The clinic owner didn't do much more to find Paul or to collect any money from the damages. Paul's father felt he had no choice; for him, this showed how far Paul could go. Jorge felt he no longer had a choice. Paul had won. His parents accepted they couldn't do anything else for him and they stopped. It had been exhausting. Both Gaby and Jorge had quit their jobs, they had been separated from their extended families due to stigma, and they had no idea of what else they should do. After all,

³⁶ "*Causa incendio para escapar de clínica* [causes fire to escape clinic]", El Diario, April 16th, 2013, <http://www.eldiario.ec/noticias-manabi-ecuador/259751-causa-incendio-para-escapar-de-clinica/>.

they had been doing what everyone, from school to co-workers, had advised: they had locked Paul in every private clinic they heard of. Once Paul burned down the last center, they ran out of options. For Paul, even though it was a relief to know that they no longer were trying to intern him by force, the damage had already been done. He hadn't won.

While the state focused on repression, private clinics appeared as an alternative to discreetly dealing with addiction, behind closed doors and with the endorsement of the law. Before the eighties, addiction hadn't been an issue in Ecuador (Andrade, P. 1991). When it appeared as a social phenomenon, it already had a series of concepts and beliefs that defined it; it was already framed as something terrible. And this framing only worked in favor of the increasingly profitable business. Many addicts had begun as curious teenagers smoking weed. But once their parents found out, the decision would be confinement, regardless of whether or not there was addiction. In Paul's case, addiction had developed years before his parents even noticed.

The 2014 National Plan for Mental Health described the problem of private addiction treatment centers, as something which appeared in the "years previous to the Government of the Economist Rafael Correa" (Ministerio de Salud 2014, 10), as a result of the lack of control and regulation, as well as the lack of public spaces for the attention of problematic drug use, along with the stigma associated to drug use. While the Plan states that there have been violations of human rights, its proposal is limited to the strengthening of the control and surveillance of private centers while offering public addiction treatment for people who use alcohol and other drugs, with a human rights focus.

As opposed to the private centers, which operated under little or no control from the State, the public center's open doors implied not only a personal choice of staying, but also, the possibility of outsiders to look at the process. The public clinic opened in what used to be the leprosarium, and next to it, the Dermatology Hospital still functioned; although it was closed in 2015 and replaced by the district's offices. For Juan, the coordinator, the program that was taking form in the therapeutic community was being developed for a low income population: "maybe for someone from a high class with conflictive drug use, this program won't help. But the people we are attending to, always the least favored, which have, besides drug use, problems with the law, the family, low income, little education, it is for them that we are developing the program, and I believe this is going to take a long time."

For Guerrero (2010), the private administration had silenced the voices of the population being administered: even in terms of the presence that they had in archives. The government could no longer see these groups, and would only hear from them by others' voices. In the private administration of drug addicts, a phenomenon that took strength in the nineties, something similar occurred. Addicts were not seen by the state, but their ventriloquists, the private clinic's administrators, would give statistical information to the CONSEP. Whatever happened on the inside remained behind closed doors; not even the families, paying for the administration of their relatives, would know. The explanations included concepts of co-dependency, and the people were urged to not believe their family member when it came to complaining, as they will say anything as long as they can keep using.

In 2012, I went to see JP, a friend from high school who had been inside clinics since he was 16. At 28, married, expecting his first child, JP still remembered the trauma of being locked down. He explained the way families were deceived into locking the person down (personal interview, may 10th, 2012):

There was this center in where I was, it had a pool, pretty cool, the pool, and the family members came and saw the pool, everything cool, you know? But the pool served the purpose of drowning you. If you misbehaved, if you didn't talk right in therapy, or if you said what you really thought, I mean, you were supposed to speak: drop your crap, why do you get high? Everything was so violent, so suggestive, do you understand me? So people come out resentful, wanting to smoke again. There is no conscience, the expected outcome doesn't happen, there is no spiritual awakening, that God come and touch you, or that you respect a higher power, which never happens. All there is resentment, and that eats you down, all they do is damage you, and your family, more. They don't know how to handle a patient.

I asked people who had been interned in clinics if people recover after being there. Paul, who had been in several clinics, believed internment did help him stop and regain some control with his life (personal interview, December 9th, 2014):

I was consuming chemical substances every single day, I spent all the money in the world, I lost control of my life, and I really needed to be interned. But there are also retarded parents who live in different times, I don't know what it is they think, and they found a random joint from their kid, and instead of counseling, having a conversation, explaining things to him, even taking him to meet someone like me who really is an addict, instead of that they lock him

up, a 16-year-old kid, who's barely enjoying life. Not everyone belongs in a center, but they are necessary. It worked for me, but after ten years of drug use, from which the last four were totally out of control.

In a complex organization of responsibilities in terms of internment, families are the key actors, deciding from their own sets of beliefs, strongly reinforced by media, laws and policies, if a loved one required addiction treatment. The only option was found in private clinics, which also reinforced the beliefs surrounding drug use (undifferentiated from addiction or problematic drug use) through their contact with each family. Paul's parents show the trajectories; once the school tells them that Paul is having drug problems, their responses come from the information received by friends, co-workers, people who had been through the private clinic realm already. None of the clinics they went through did a differential diagnosis. The "medicalization" perspective was ever present, but it had strong criminal connotations. No one, not them nor the clinics or the friends, no one questioned the choices they made in regards to Paul's "treatment". It was only up to him to make it stop, and he did that by burning the last clinic down.

Ricardo had also been in private clinics. When asked if people recover after being in one, he answered: "percentages are very low, but there are people who recover. More than the clinic, it depends on the person, therapy influences, but it's more the person. The percentage I see from people who remain clean is around 10% (personal interview, My 12th, 2012)".

Patricia had spent some time in psychiatric hospitals as well as in private rehabilitation clinics throughout the country. Some had been for females only, and others were mixed. She was practically an expert in regards to clinics. When asked about recovery rates, she explained: "I have something stuck in my mind; the first thing that comes with this question is two out of a hundred. I want to be among the two. Everyone thinks of success as being among those two who recover. But sometimes they don't make it (personal interview, May 15th, 2012)"

Juan Fernando had been interned in several private clinics, but now he was going through outpatient treatment, it wasn't intensive. He was also involved in Narcotics Anonymous groups, and he had been clean for a while. I asked him if people recover after being interned in clinics. "Rates, percentages, I really don't know. But from my personal experience, from

what I have lived, the answer is no. There are people who recover, of course, but the majority doesn't (personal interview, May 16th, 2012)".

Michelle had been in one clinic only. It was expensive, and it eventually shut down because it wasn't cost-effective: she had different therapeutic approaches while she was there. Her entrance was a referral from a psychiatric hospital, where she was taken as an acute case. After stabilization, she was taken to this place, with a total of eight patients during her time there. I asked her about recovery: "I have heard that one in a hundred will recover, and I don't know if this is a real number. However, from the group I was in, we were eight, I know I am the only one, maybe some other girl but I never heard from her again, so I know with certainty that I am the only one who is sober. It has been four and a half years already, yeah (personal interview, May 13th, 2012)".

Dr. Luis, a psychiatrist who worked in an addiction clinic, believed that recovery was very difficult to achieve. "From my perspective, it has very few possibilities of recovery. There are many relapses, maybe we can say, a 20% recovery rate per year, but this lowers as time passes (personal interview, May 13th, 2012)". People could abstain from using for certain periods of time, like Paul had when he stopped for a couple of years. But as time passes, the possibility of relapsing increases.

Everything I had heard in the past about clinics kept on coming out at the addiction treatment center. Yet the State decided to maintain the private clinics, creating the regulations and conducting surprise controls. I asked the girls about it, how clinics can still be operating like that, if the State has intervened. Diana answered: "Hah, they are all like that. I am telling you, I just came out from one, only a few months ago (personal interview, November 14th, 2014)". The rest of the girls agreed. Private clinics hadn't changed their practices in a profound way. Instead, they were learning to deal with inspections from the Ministry of Health. And if someone seemed too problematic, they would let that person go. This was the difference. Diana felt they let her go because she threatened the clinic with speaking in front of the Ministry visitors.

On May 20th, 2015, inhabitants of the Vicentina Baja, the neighborhood in which the addiction treatment center is located, organized a night protest against the clinic. The event resembled a witch-hunt: the neighbors, armed with torches and signs, walked toward the

clinic, regrouped on the main entrance, and yelled slogans, demanding that the public clinic be moved elsewhere (Juan, personal interview, June 10th, 2015). The request, which had already been pursued for months³⁷, was sustained on the idea that criminality in the Vicentina Baja area had increased since the addiction treatment center began operating.

The Vicentina Neighborhood committee had already worked on a public opinion strategy: They placed black ribbons in every corner of the area, with signs that read slogans relating outpatient addiction treatment to the increase of crime; they spoke to businesses owners, they visited homes, and they called the news and organized performances like the torch one. In 2012, before the clinic existed, the Ministry of Health had offered the construction of a brand new health center in the extensive land belonging to the Gonzalo Gonzales Dermatology Hospital, the place in which the former leprosarium was founded. In 2015, the Health Center remained a broken promise, while people in addiction treatment came and went for their daily meetings. The arguments for protesting had focused on an increase in crime, something that the police from La Vicentina claimed was inaccurate, as denouncements had not augmented. If people were being robbed, they weren't telling the cops.

Regardless of the lack of evidence against the public clinic, the Vicentinians felt threatened by its patients: drug use had been linked to criminality for approximately forty years, thus creating an argument that legitimized a war against them, and it was only normal to witness the way in which representations were taking the form of a witch hunt outside the center³⁸, through people's signs and slogans, and through their torches. As the functionaries struggled to have the neighborhood accept the clinic, which opened in May of 2013, they were also dealing with their own share of criminal issues: Paul, who had been readmitted after two months of his release, dropped out, fled the facility, and took the PlayStation with him. His parents, ever so embarrassed, had come to drop it off after they found the gadget in their home. At that time, they didn't know where Paul was; their worst nightmare had returned, their son had not recovered and was, once again, lost in the streets.

³⁷ "Moradores de La Vicentina protestan por cambios en el Hospital Gonzalo Gonzalez [Inhabitants of La Vicentina protest against changes at the Gonzalo Gonzalez Hospital], Teleamazonas, May 7th, 2015, <http://www.teleamazonas.com/2015/05/moradores-de-la-vicentina-protestan-por-cambios-en-el-hospital-gonzalo-gonzalez/>

³⁸ Social representations are images in which many meanings are condensed, and that function as the basis of the interpretation of what is happening (Jodelet, 1991). In social representations, there are categories used to classify circumstances, phenomena and people with whom the subject deals, theories that serve for establishing facts about them.

After thinking about Paul's story, I am left with a concern for the enjoyment attributed to drug users as a reason to punish their deviance. Especially considering that their lives unfold in the transitions between one private clinic to the next. Who is enjoying that? Not Paul, that was clear. But as compulsive his drug use increasingly became, so was his father's response, a mad quest for the one clinic which could make a difference. He never found it. And he had to stop looking when Paul made it clear that the next time he would kill someone. Enjoyment may be confused with *jouissance*, a horrifying encounter with uncontrolled pleasure (Lacan 1992), but private clinics reproduce, in their violent ways, the *jouissance* they supposedly treat.

At the beginning of this research, I believed that social representations made private clinics a profitable business. But the representation of addiction as evil didn't seem sufficient. The entire system supported, willingly or not, the surge of a profitable business which benefited from fear, sadness, desperation, and in many cases, ignorance, resting upon the idea of drugs being something uncontrollable, to the point of requiring a warfare approach. The changes that came with Minister Vance's work responded to a voice that the LGBTI community had been constructing for a long time; up until November of 1997, being gay was a crime typified in the Penal Code. But even though she did mention that addicts were also being mistreated, the normative her Ministry created prohibited that homosexuals be locked inside these clinics, while the private centers remained. Human rights were mentioned in the documents for the regulation of clinics, and in the Mental Health policy proposals. How long will the functionaries of the Ministry of Health keep on checking on the registered clinics? It seemed a corruptible space, just like prisons. Patients were telling stories of a continuum in which clinics still operated from repression. They were learning to disguise their methods to the eyes of functionaries. They let problematic patients go before denouncements became clear. The system's design didn't address the behind-closed-doors practices and, therefore, required the constant surveillance from the State. Nothing forced private clinics to self-regulate besides the sporadic visits from functionaries.

Soft security, as placed in hands other than the State's, operated in private addiction treatment centers (O'Neill 2015). Resembling a private administration of the populations, this aspect linked both to health and criminality had been mostly in the hands of private businesses, the majority of which were owned by "former" addicts, or addicts in recovery. They, too, had been locked in clinics during their own addiction trajectories, and they understood the

business and made the rational choice of focusing on the profit addiction implied. Just like some former drug users had found a business in drug-trafficking, rationally stopping their conflictive drug uses in order to focus on the business (Jacome 2016), clinic owners had also found ways to making addiction a source of income.

Some people, like Paul, found different ways to resist the not-so-soft mechanisms of security imposed upon them. He was lucky that the clinic's owner didn't press charges; he had public opinion against him, and it would have been hard to defend himself in a context which assumes addicts lie, manipulate, and are willing to do anything in order to satisfy the need for drug use. Unlike the LGBTI population, Paul didn't have a social movement willing to raise a voice for addicts interned in private clinics. Families, overcome by the stigmatization resulting from their relatives' drug use, preferred the behind-closed-doors system. They wanted their family members to remain anonymous.

The public clinic had the task of not only generating a new way of addressing all that came with a conflictive drug use; it also dealt with the complex sets of identifications, resulting, as Biehl had proposed, from a "continuous process of experimentation – inner, familial, medical and political" (Biehl 2015: 136). Those who had been in private clinics had experienced identifications as forced impositions of their subjectivities, while their families and the society agreed. After all, private clinics had developed in this same society now proposing public addiction treatment centers. How could new forms of identification operate? The system needed to offer something different, and the public clinic's main one was the condition of an open space.

Chapter 3

What is addiction?

Introduction

My thesis has been adumbrated differently in the last chapter. This much we know: addiction had been included in the 2008 Ecuadorean Constitution as a public health problem. While article 364 was meant to counter decades of repression, producing the incarceration of countless drug users who were being treated as traffickers, the definition of addiction as a health problem gave the State the obligation of offering treatment. It took a few years for the first addiction treatment center to open, in the context of controlling, and sometimes shutting down, the private clinic market, which had by and large dominated since the nineties. After denunciations of dehomosexualization practices inside addiction clinics became public, the Ministry of Health began inspecting each of the private centers to make sure they were operating within regulations. Since many were not, they had to be shut down, and the State offered a contingency process for the patients of these places. Eventually, and as a response to increasing demand for addiction treatment, the constitutional mandate was honored with the creation of the first public therapeutic community, an addiction treatment center which belonged to the National Health System.

The new public clinic offered an opportunity to redefine problematic drug use as something other than a crime or a shameful disorder. At the same time, it posed the possibility of showing that the State could attend to health issues in a much more effective way without making a business out of it. The Citizen Revolution strongly relied on the anti-neoliberal discourses in order to legitimate its policies: the National Plan for Good Living 2009-2013 (SENPLADES 2010), as well as the Good living National Plan 2013-2017³⁹ (SENPLADES 2013), spoke about privatization of public services as the result of neoliberal ideologies which placed private interests before rights or needs of the population. The center became a place of particular interest due to the many implications it was built upon.

The following chapter is the result of an ethnographic work undertaken inside the clinic, in order to understand and differentiate the perspectives which define drug problems from each

³⁹ The National Secretariat of Planning and Development, SENPLADES, had published English versions for both plans.

of the disciplines participating of the therapeutic approach offered by the State. It is divided in six sections or subchapters.

The first part describes the place in which the public clinic was placed, a physical manifestation of contrasts which show the old management of leprosy against the modernization of addiction treatment. The second deals with the psychological component of the therapeutic approach, as the one weighing the most. It shows different definitions and techniques which come from each psychologist, and it also describes the contradictions within the discipline when defining and addressing problematic drug use.

A third part is dedicated to psychiatry as a traditionally dominant approach which is counterweighed at the public clinic while keeping a specialized perspective capable of recognizing mental disorders and assisting in the management of drug abuse and dependence, while the fourth describes occupational therapy and its conceptualization of addiction as an imbalance in daily activities. The section offers a perspective based in the description made by the therapist as well as the observation of the space, the practices and the descriptions from the patients.

The fifth part describes social work as the least important discipline, and the conflicts which arise from this perception inside the team. The definition of addiction coming from this perspective is included. Finally, the chapter ends with a review of the gender aspects involved in defining and treating addiction.

The chapter's contents come from a study of institutional talk, marked by restrictions of certain practices which, whether implicit or explicit, set some ground rules for the interaction between the addicted selves and the healing parties. Institutional talk becomes a way of reaching actions upon actions, a mode of power relations which differs from ordinary conversations (Heritage 2013). The objective of studying institutional interaction allows for the discovery of the 'institutional, as well as the examination of the "causal relationships between the larger social context of an institution and the use of particular interactional practices, and the relationships between their use and the outcomes of interaction" (Heritage 2013: 5).

Ethnographic studies in the context of mental health have previously found the uses of diagnostic categories in everyday conversations among professionals and in the therapeutic settings that enable formulations of the subject that provide for paths of action in conditions of ambiguity, shaping an ethical approach that counters the uncertainty of the disorder (Lester 2009). Ethics are constantly renegotiated in the process of building new approaches that address a disorder like addiction, especially when previous therapeutic approaches have been managed by private institutions, generating complaints related to the expediency with which they operated. The need to offer a scientific, humane and effective treatment for addiction in order to support new discourses that include security, welfare and sovereignty discourses clashes with previous hegemonic discourses and practices which make the interactions between clinicians and patients a struggle among shifting significations of health and sickness, amidst complex and always-evolving aspects of society.

Although the clinic is defined as a multidisciplinary institution without a hegemonic discourse, it is the psychological aspect of the therapeutic approach the one considered the most important. Through ethnography, it is possible to observe the way through which different disciplines overlap in the process of treating a public health problem such as drug addiction. Given the complexity in which this new therapeutic approach unfolds, a study of the subject of addiction will produce more questions than answers. The goal can no longer be to create absolute truths but to unveil the contradictions and uncertainties that play a part in the intricate subjective path to recovery from addiction. Most certainly, such an ambitious project will need to control for the quality of its results, without giving up on its “reality apprehension” objectives.

3.1. The place

The becoming of the first public addiction treatment center seemed less planned than accidental. The LGBTI community was finally able to denounce dehomosexualization, unacceptable to the public eye, but mostly based on the same “therapeutic” practices used for addiction. Yet, those who had been sent to private clinics hadn’t been able to organize a resistance against these centers. At the most, they fought: some escaped, others, like Paul, burned the last clinic down. Many others just suffered through each internment, but there was no public display against these clinics. Even prisoners were able to protest every now and then (Garces 2010).

But the places which dealt with addiction had found a space free of control, created by the laws and supported by the security forces, completely hidden from the public with the complicity of families eager to hide the shameful relative. Each person did what they could, while families kept on paying and hoping a miracle would occur. The success rate was far from promising. One to ten in a hundred patients was the common knowledge circulating among users (Jacome 2012). But none of this influenced the functioning of the clinics like the LGBTI community did. The movement was able to define what it should not be, by taking conversion therapy off any limit and moving the curtain a little for everyone to see.

Changes in the Constitution also seemed to work in favor of the people going through addiction treatment. When Felipe, the Diabluma leader, included Article 364 in 2008, he was thinking of all the people going to jail even though drug use was not a crime. He wasn't thinking of addiction treatment as a threat, or an abuse or a problem. I found out he was the one who included it in 2012, on a casual conversation we were having. I had interviewed Rodrigo Tenorio, a psychoanalyst who had worked as Director of the National Drug Observatory, and when asked about art. 364, he mentioned it contradicted itself when it mandated treatment for occasional drug users. Felipe jumped to explain he wrote it, almost to stop me from giving an opinion. Addiction treatment wasn't the center of attention when the first reforms were taking place⁴⁰. The focus had been mostly on the increase of prison population, generated by law 108, and Felipe had that in mind during the Constituent Assembly. The private clinics were not visible, and the drug users didn't have a voice. Although this definition of addiction as a Public Health problem placed the responsibility for treatment on the State, there were no specialized centers. There were mental health hospitals, as well as professionals in the general hospitals and the health centers. But the first specialized center was yet to come.

The first public addiction treatment center is located in what used to be the Verdecruz Leprosarium. The Green Cross National Leprosy Hospital was established in 1927 in order to isolate Hansen patients in the city of Quito (Montenegro 2007). In 1927, after being officially designed as the National Leprosy Asylum, the Verdecruz Leprosarium maintained its double function as a prison and a hospital, surrounded by big walls and allowing communication only through the "*parlatorios*", mesh-covered windows through which the patients could speak to

⁴⁰ Paladines explains the reforms and counter-reforms seen in the last decade regarding drug policies in his 2016 text called "In search of lost prevention: Reform and counterreform of drug policies in Ecuador".

their relatives or dictate letters (Montenegro 2007). Inside, the patients did not have access to regular currency; instead, they had to use stamps that replaced bills. Also, they received a daily ration of “masita” (little dough), which consisted of a piece of bread dough. Patients remained incommunicado and with the doors locked for life.

The Leprosarium, as a particular heterotopia for the exclusion of those who were ill, responded to the logic of exclusion by separating the people with Hansen disease from the rest, in order to contain the threat that the illness posed for everyone else⁴¹. The confinement to which the Hansen patients were subjected loosened in 1957, when Dr. Gonzalo Gonzalez, a dermatologist who wrote his doctoral dissertation on Leprosy treatment, was named Hospital Director (Montenegro 2007). From then on, the Hansen patients were allowed to use regular money and to send and receive mail; the *parlatorios* or communication windows disappeared and the place began to function more as a hospital than as a prison. With the help of international NGOs, the Hospital was able to build small homes for the patients who could no longer be reinserted in society due to lack of family or social networks. Some of them still live there.

The social representation of Leprosy generated a psychological barrier that separated the area from the rest of central neighborhoods in Quito, a barrier that has not yet been broken (Córdova 2013). Only after the arrival of Dr. Gonzalo Gonzalez, in 1957, the beliefs surrounding leprosy began to shift towards a medical understanding to the disease, but the premedical representations remain⁴². I couldn't help but notice my own fear of contagion the first few times I walked through the premises. I knew it was irrational, and I made the effort to read about leprosy and to face my unconscious reactions. I had been researching drug issues for years, and I had always questioned the easiness with which addiction was linked with consumption and, as a result, I felt less threatened by addiction patients, as opposed to many others working in the public center or the dermatology hospital, or, eventually, the

⁴¹ Heterotopia is a term that Foucault uses to describe places of otherness or difference, that is, spaces that are “absolutely other with respect to all the arrangements that they reflect and of which they speak” (Foucault 1997a: 332). In so-called primitive societies, heterotopias were spaces for those who were in a state of crisis, such as adolescents, elderly, women in labour, among others. However, Foucault believed they were being replaced by heterotopias of deviance, places in which people whose behavior deviated from the norm could be placed. These include prisons, insane asylums, rest homes, and even nursing homes, as places in which crisis and deviance overlap.

⁴² Jodelet (1991) explains the premedical representations as the beliefs surrounding medical conditions, which shape the relationship that a patient has with the community regardless of the scientific knowledge about the disease.

Vicentina community. But the sensations produced by the history of the space, and my lack of knowledge regarding Hansen disease, gave me a closer idea of what happens with addiction and its subjects.

The almost accidental nature of the public addiction treatment center's creation left the definition of addiction relatively open: The Constitution said it was a public health problem, and this is why treatment shifted from the security institution to the Ministry of Health. Still, its conceptualization had not come from public debate or extensive scientific research. It was occurring, along with the practices being implemented. Addiction was becoming a concept right there, with many contradictions contributing.

I arrived for the first meeting with the Coordinator, and I felt the need to park inside. The Vicentina neighborhood might be safe, or not. But the Hospital is located at the very end of the city, at a margin, at the border, right next to the slope leading to the river. I got off the car at the gate to speak with the guard on duty, who agreed to open the door after I explained my business there. At the gate, the security guard station has two flat screens where the surveillance cameras are projected. Although the area currently occupied by the Dermatology Hospital is the one with the expensive equipment, all cameras are located inside the drug addiction treatment areas, reflecting a surveillance practice that targets the patients. The alert gaze, related to a logic of plague and population control, juxtaposed that of simple exclusion of lepers in the public center. I signed the log and parked inside, and later learned that it had been the Dermatology Hospital's director who had the surveillance installed. He could access the system from his cell phone, and on a few occasions he called in the middle of the night to alert the staff of movement in the patients' areas.

The Hansen Asylum, which operated in these premises during the 20th century, was run by a congregation of nuns, and some of them still live there and take care of the patients which remained. To the left of the entrance, toward the city, the first area is the one occupied by the religious. Below them, there is a structure which includes a small snack and coffee store, the administrative offices, and the Dermatology Hospital⁴³. Down to the right, the main area where the public center operates is found, occupying the old, renewed buildings which used to be the leper asylum. The male ward was located at typical hacienda construction, a building

⁴³ The Dermatology Hospital was replaced by a Public Health Center in 2015.

shaped in the form of a U, with a patio in the center, and a water fountain with a Virgin Mary statue in it.

The patients' bedrooms shared the space with a nurse station, the psychologists' offices, the psychiatrist office, and the meeting room. The back of the building had a balcony where the coordinator's office was located, some of the psychologists' offices, and more bedrooms. And below it, a basketball court and a soccer field right next to the wall. Further down, in the river direction, the Hansen patients' homes are located. I was directed to Juan's office by a patient. Once there, I met with him and the Director of Mental Health from the Ministry of Health. They both had to approve my research, and they were very interested in opening the space for this type of work. Even though they approved, I was later asked to start a bureaucratic process of permission, which I did, but it was never answered. I kept going anyways, as I had their consent and patients were informed.

The main patio at the male wing had a door which is always open. In front of it, there is another small patio leading to the Occupational Therapy area. There is a narrow corridor behind it, leading to physiotherapy, the gym, and the nurse station for the dermatology hospital. Towards the left, the old leprosarium buildings, in the process of renovation, are located. The female ward, behind bars, at the very last building, lay on its second floor. It seemed that, while males were located in a plague-like space, monitored and controlled, females were left within leprosy practices that excluded and isolated them.

I asked the coordinator about the women being locked, and I felt until the end that I unwillingly fell into avoiding the gender issue with enough attention. He had explained that the women were put behind bars as a way of protecting them from the men, and it didn't click until later that it made no sense to lock the potential victims while the potential offenders were free to move. Not only was "protection" a reason for locking women down. In general, they were depicted by the staff as problematic, conflictive, dramatic, and it seemed like everyone just wanted to avoid the whole thing. Juan kept a couple of manuals for treatment of addiction in women in his drawer, and he kept on hoping there would come a time when he could prioritize the revision of the therapeutic approach for the female wing. In the meantime, and with so many requirements from the authorities, the center was applying what they had outlined for men in the women's area. There were no gender aspects involved, even though everyone mentioned that the females were in a different situation: sexual aspects were

different, motherhood was different, the places women occupied in society were different and the therapeutic approach was not addressing any of that. But the time never came.

Heterotopias can function in different ways depending on the social and historical context (Foucault 1997a). In this case, the same space has different forms of otherness in terms of gender when it comes to therapeutic practices, or, as Foucault puts it, “the heterotopia has the power of juxtaposing in a single real place different places and locations that are incompatible with each other” (Foucault 1997a, 334). I felt this was the case: most of the time, when functionaries described the project and its rationale, it seemed they were simply excluding the female wing from their speech. After all, the public clinic was meant to host males only, and the regulation prohibited mixed clinics. Still, it was a thing which needed to be done, as they felt that it would be wrong to refuse treating women. There wasn’t a female public clinic just yet. But in practice, the differences were striking.

The public center was born from the state’s attempt to modernize substance abuse and dependence treatment in the country, while responding to a public demand of decriminalization that manifested in the 2008 Constitution by defining addiction as a public health problem. At the same time, and under the pretext of “available space”⁴⁴, it was installed in a place where time had frozen, in which old exclusionary practices have rooted so deeply in the city’s dynamics that contradictions coexist inside its perimeter and in its relation to the social reality⁴⁵. Heterotopias are defined precisely for this heterochronism, a grouping of different times in one place of otherness. From its beginning, the public addiction treatment center posed an array of contradictions, in which addiction and its treatment were meant to be defined.

Private treatment centers for addiction, as I have described, were characterized by the use of forced internment. Although it is an illegal practice, admission requirements were reduced to family or friends concern and willingness to cover the expenses. The public center was careful not to reproduce these practices, associated with the neoliberal perspective that the “socialist state” is supposed to fight against. As a result, people are voluntarily admitted,

⁴⁴ There were over 400 immovables in the hands of the State by the end of 2016 from drug-trafficking, seized during police operations and transferred to the State. The government had created a company to manage all of the State’s properties, yet it chose the old Lepper house next to the dermatology Hospital (Inmobiliar, 2016).

⁴⁵ This is explained by Foucault’s fourth principle of heterotopias: they are connected to fragments of time, non-compliant to the traditional time (Foucault, 1997a).

except for a few cases in which there was a court order, something that annoyed Juan, although he felt he could do nothing but accept. Anyone could leave if they felt they no longer wanted to be there. All they had to do was talk, and say they didn't want to remain in treatment. Except for the court cases, and the underage patients; minors could not be released unless their parents agreed. They ran away, every now and then, which posed a problem for Juan as he felt the responsibility over court-ordered minors was too much. The public center aimed to representing a voluntary desire for the treatment of, precisely, a disease of the will, a contradiction that hides other aspects of internment, while the State kept pushing, one way or the other, for a security increase. The initial assessments made triage processes depend on voluntariness: it was up to the patient to be considered for inpatient treatment, depending on what he could elaborate.

Heterotopian inhabitation does not respond to will, but to either force or submission to rituals of purification. In the case of the public center, it had developed an entering process which began with a few months of attendance to the outpatient pre-community group, and only when the leading psychologist believed that the person had built up a demand of her own, he or she could be admitted in the inpatient treatment process, unless the person actually requested to be interned and her consumption was bad enough that the staff decided to open the space. In Albert's case, for example, the category of inpatient released him from the condition of homelessness at a time he felt he could no longer support his daily pill consumption.

Heterotopias have been defined to play with exclusionary practices in ways that are mostly concealed and that unfold on top of emancipatory discourses. As such, the public clinic was filled with good intentions, yet it was placed at the Leper asylum, with everyone around it expected it to become a security institution. Even the Ministry of the Interior, when informing of a protest against the clinic by its neighbors, referred to it as a "social rehabilitation" place, a concept linked directly with prisons (Ministerio del Interior 2015). Still, for some people, the public addiction treatment center represented the possibility of a home that they couldn't otherwise have. Albert was one of them. Paul and the obligation to sign a weekly checkup at the prosecutor's office was another. His other option was prison for theft.

In 2012, when Minister Carina Vance took over, the Ministry of Health began exercising control over the private addiction treatment centers which were registered, while it identified

an approximate number of clandestine clinics, in order to find them and either regulate them or shut them down. At the same time, she wrote new rules for the private clinics, specifically prohibiting treatment for homosexuals. Part of the planning included the creation of an Area of Addiction Contingency (ACA, for its Spanish acronym), for which the Ministry recruited a few psychologists who began developing the treatment plan.

Ivan, a former addict and a clinical psychologist, was one of the founders. He explained to me that the protocol for attention began with the investigation of a private clinic that had been denounced; once the center was investigated, and if there were enough motives to shut it down, then the people would be transferred to the ACA, where they were psychologically evaluated and given the choice to remain at the public clinic for a month (Personal interview, December 1st, 2014). At that time, three options were offered: ambulatory treatment, intensive ambulatory treatment, and inpatient treatment that lasted a month. Once the center became a therapeutic community, there were some changes: mostly, there was time added to the duration of treatment, and other approaches had been introduced. The psychological one remained the most important.

My job consists on conducting the initial interview in each case, after which I determine the type of treatment corresponds, or would be the most adequate, and, once the participant has been checked in, to accompany him through the problems standing behind the symptom, which is drug use. In AA they say this can only be treated by another addict. And this could be an advantage. But I don't think so, I don't have to be a thief to speak with thieves, Jesus didn't have to fall into that to be able to speak with those people. It might be an advantage, in order to understand what they are going through, but my work is professional.

Juan, the coordinator, had arrived when the Ministry decided to convert the ACA into a therapeutic community. He recalled his impressions when he started working at the public clinic (personal interview, November 10th, 2014):

At the ACA, it was more of a contingency, that is, to keep the youngsters somewhere while the centers got legalized or shut down or whatever, and so there would be, say, twenty patients, so, what the Ministry wanted to avoid was to shut down and send everybody home, so these people would come here and be held while their families came and fixed things; it

would be explained to them that it was illegal to keep them against their will, and they could find other places or leave them here for a month, so there was some therapeutic stuff, a psychologist, a medic, so after that, I tell you, we got together with the team and we saw that the ideal thing, I mean, what, not logic, but science, what evidence says is that a treatment, in order to be minimally effective, would have to last a minimum of three months.

Juan was aware of the human rights violations that accompanied the process of regulation and control of private clinics. Having had experience in open therapeutic communities, he had seen treatments which didn't consist of kidnapping, torture, starvation, or other forms of violence. He also considered that some of the people who were rescued from private clinics demanded addiction treatment. And he understood the differences between the contingency area and the public center. The ACA was created so that those rescued could continue their process for a month (personal interview, November 10th, 2014):

Why a month? The justification given then was that these people came from very long processes of confinement, five or six months, eight months, a year, and to propose a longer treatment, well, nobody accepted. So, when they would explain that it would only be a month, while they get the help they need, obviously the families would think, -okay, they were taken out of the clinic but at least they keep them here-, and so that is how it worked, as a contingency center. And this is how it worked when I arrived.

The therapeutic value of the month at the ACA was unclear. The people came from violent, irregular clinics, to a place which fed them and treated most nicely. After the month was over, they would receive a diploma and be discharged. Some of the people had returned after it became a therapeutic community. The diploma hadn't been enough. The disease needed to be redefined, and addiction treatment had to become something more than just a contingency or a repetition of the dominant approach.

The most common understandings surrounding addiction were closely linked to criminality and dangerousness. The public center's coordinator had the challenge of building something new in the middle of ruins: old buildings as well as old beliefs which affected the everyday life at the public clinic. The Dermatology Hospital was right next to the addiction center, and even though Juan had been cautious when choosing his team members, health operators also came from next door. It hadn't been long since the addiction clinic installed a gym for its patients, and one day, the male patients found a loose screw in a machine. The male patients,

eager to work out and experience the release it produced, decided to solve the problem the same way they would at home: they went to the kitchen, found a regular dinner knife, and tightened the screw. Afterwards, they started using the equipment, and forgot about the kitchen knife. However, someone from the dermatology hospital walked by and saw it on the floor. Immediately, an official communication was sent through *Quipux*, the official documentation management system that the government used for communicating between institutions. The memo was directed to the Ministry of Health, raising the alarm regarding weapon use between the addiction patients, and requesting security measures to prevent their access to bladed weapons in order to protect the staff and the patients from the dermatology hospital. Juan was annoyed, but he understood that part of his work included dealing with whatever people thought about his patients.

The public center represented the attempt to break the total institution dynamic which came from the private clinics. Juan wanted to do this through the definition of addiction and the emphasis in a professional and scientific approach. To begin with, the door was metaphorically open⁴⁶. Anyone could leave if they wanted to, and family could come and visit freely. The perimeter walls were the same tall barriers built for the leper asylum. One day, as I was sitting in the balcony across Juan's office, waiting for Paul to come out of his psychological therapy session, the men were playing basketball in the court across from the building. Suddenly, the ball went over the wall, to the street. One of the men, as casual as possible, climbed the three or four meters, jumped to the other side, sent the ball back to the court, and climbed back inside.

In fact, and regardless of how easy it might be to break it, there is a barrier separating this population from the outside world. The attempts to smooth out the division, including the openness to family visits, weekends out, or a phase in which the patient goes to work and returns to sleep, don't affect this division.

Also, and even though the public center has tried to build its own process as an experiment, specialized hospitals are subject to the regulations coming from the Health System. The

⁴⁶ Goffman's description of total institutions matches day to day life inside a private clinic; the inmates, deprived of their self, are forced into submission through practices that include baptism or initiation that aims to show the new patient that there is no space for self-representation (Goffman, 1961). The public center, through the constitution of a multidisciplinary team, attempts to break these practices, but some of those described by Goffman remain.

Model of Integral Attention of the National Health System, or MAIS, for its Spanish acronym, an attempt to standardize public health services, stated that attention in specialized centers could only be possible once a health center had assessed the case and referred it to the third level (Ministerio de Salud 2012). *Spontaneous demand* is not acceptable; anyone who wants to enter treatment must first go to a public health center that will derive the patient to the public addiction center. Interestingly, while the Ministry attempted to standardize the medicalization approach through the bureaucratic procedures, Spontaneous demand was the main point of focus during triage: did the patient want to come for treatment? Was the person looking to improve? Was there a genuine interest in working the issues involved in addiction? Spontaneous demand was a key aspect of the shaping of a new subjectivity through addiction treatment. Yet, bureaucratic procedures blurred it through the obligation of attending the different levels for the proper referral process.

The public clinic had found a way to comply with the bureaucratic requirement by speaking to the health center's workers: people were asked to go there, get the certificate of referral, and come back: the real assessment would be conducted at the public center. Once there, the patient was assessed first by a psychologist, then by a medic, and finally, by the psychiatrist. The social worker would also interview the person. The decision to admit someone was then taken by the team, depending also on space availability, although on very few occasions, the coordinator would decide on adding a bed and accepting a patient who could no longer be on the streets.

Because of the lack of beds, and after experiencing the abandonment of treatment by some of the admitted patients, the staff added another condition for internment: there had to be an initial period of intensive ambulatory treatment that allowed for the team to measure the commitment someone had with recovery; an obedience test to avoid beating the dead horse, to ensure that those who are willing to commit to treatment are the ones getting the scarce beds. This mechanism met the protests of the Vicentina neighbors, arguing against the open door policy of the addiction treatment center. The Ministry decided to remove ambulatory treatment and to open it elsewhere, and the psychologists who were hired for this part of the process for a year, left. The requisite was changed to having spent time at the outpatient facility and to bring their recommendation for inpatient treatment.

Once inside, the therapeutic process had been divided in the time spent with each of the multi-disciplinary team members, as well as with the routine morning and evening meetings, which sometimes were managed by themselves. Definitions of addiction took meaning in each of these disciplines, different techniques aiming to civilize addicted persons into society, creating a mosaic of modes of understanding, which were then revised, and sometimes challenged, through the team meetings, and the conflicts which eventually arose.

3.2. Psychology

Doubtlessly, the most important discipline for the public center was psychology. The therapeutic community came after the ACA as an attempt to create an evidence-based medical approach to addiction, and the first thing which the team defined was the duration of the recovery process. At the contingency area, the purpose was to give an opportunity to deal with the closing of a clinic without leaving the person abandoned. At the public center, the objective was to produce a change in behavior, which would hopefully last. Juan explained (personal interview, November 10th, 2014):

We began the staff meetings, and we saw that what evidence suggests is that a treatment, in order to be minimally effective, should last at least three months. It's not like after three months they leave; it depends on how they're doing, but as a minimal time, the three months are established: the medical aspects, the psychiatric and psychological ones are set. The treatment is holistic, it includes both psychology and psychiatry, but it is a low psychiatric intensity, and a high psychological intensity. You have group therapy, individual therapy, you have the therapeutic groups, also the self-help groups, with total and unrestricted respect for people's rights.

Juan had a view of the problem, shaped by extensive experience in the field of addiction. He knew that therapeutic communities, regardless of their effectiveness or their technical managing of people, had become the dominating form of treatment when it came to addiction. But he explained that, while emphasis had been placed on inpatient treatment alone, basing it mostly on experiential therapy, there were actually three moments in therapeutic processes which treated drug abuse and dependency. He described them as pre-community (the person comes to daily meetings and spends many hours a day in the clinic, a form of outpatient treatment); community (inpatient treatment), and reinsertion, the follow-up of cases while they returned to society. For him, these moments had to be led by psychologists.

Being the first public addiction treatment center, the public center was soon flooded with people looking for treatment. He thought it was necessary to incorporate pre-community groups in order to give people a choice even when there were no beds: “it had a practical purpose, because you can respond to the need or the demand for treatment, without having to set a waiting lapse; you didn’t have to tell them to come back on May 30th, no (personal interview, November 10th, 2014)”. Juan also knew that if people were given more time before starting treatment:

They would go and use, it is like giving them a date to begin, and until then they just go and party. With the intensive outpatient option, they can begin even without internment, so, they do have a containment level which results interesting, even if it’s an outpatient modality.

When Juan opened the group, however, he noticed that psychologists had trouble administering the responsibility or the schedule for this section, and the outpatient group would end up on their own on many occasions. He took over, he started directing the outpatient group, but he soon realized that his duties as the coordinator prevented him from honoring such a commitment. He decided to hire two psychologists to focus mainly on this part, the earliest phase of anyone undergoing addiction treatment at the public clinic. Ramiro was one of them.

I asked Ramiro if I could speak with him. He invited me to his office, a recently organized room in the first floor of one of the older buildings. Juan was hoping to have all of the areas renewed, but someone from the Municipality had stated that these buildings were not safe; at the same time, budget was progressively decreasing. Still, with the help of the interns, a couple of offices had been cleaned up, and Ramiro set his office in one of them.

Ramiro had been a psychologist in a psychiatric hospital his entire life. He was no longer working out of necessity, he had already retired. But he wanted to remain active in his practice. Having worked at the psychiatric hospital for many years, he had plenty of experience with drug use disorders. He explained the intervention he was about to have. He offered that I stay and observe. “We will talk about mental health and we must offer a treatment for the patient to improve. It is one of the first cases, and you must consider that the mom is almost never there. Only the nanny” (Personal interview, December 9th, 2014).

A family had the next appointment. The mom, the dad, and a teenager who was in outpatient treatment. Ramiro proceeded to explain to them a few concepts in regards to mental health. This reminded me of a technique typical of private centers. In 2012, I interviewed a psychiatrist who worked at a private clinic for addiction treatment. Dr. Luis had a private psychiatric hospital of his own, but he also had a job at the clinic where he spent an average of eight hours a week. He had described the practice of psycho-education as part of the therapeutic approach which came from psychiatrists: “Well, to talk a little about the effects of drugs, the chemical effects, how drugs generate addiction, how an alcoholic cannot taste one little beer because even after a year of not using he can reactivate his pleasure issues and come back to addiction, that sort of thing (personal interview, May 15th, 2012)”. For Luis, his job was to educate, in order for the patient to obey the knowledge. Unfortunately, mental disorders are not a matter of logic. Why would addiction be any different?

Ramiro went on to describe different types of disorders (personal interview, December 9th, 2014):

We deal with several types of disorders and we must differentiate them: depressive and bipolar, the attitudes of the ill are determined with 15 days in which the patient is irritable, not hungry, very sleepy without having done anything, plus they are overwhelmed by a guilt feeling which leads them to suicide, loss of social interest, the religious is no longer important, the sexual factor is altered, the person is edgy over the minimal situation. The bipolar does not apologize, as opposed to the depressive. You, ma'am, where would you classify him?

The mother replied she would place her son in the one below. “The bipolar?” “Yes.” Ramiro went on:

Consumption generates that all good and redeemable goes to the trash, and a new type of personality is born, in which the person becomes a liar and little by little they threaten society. The support at home is important, because you must accept that your son is sick, in order to help him progressively diminish his consumption dosage. Family union is still redeemable; he wasn't prepared for the universe, you must prepare him. So, if he is rebelling against society, we cannot assume that drug addiction centers are the solution, they are not. Youngsters who have been locked there come out with the older men's infatuations and also they risk getting raped. So, it is important that the time he is going to spend here he has the memory of his parents telling him that they will remain together for him. That is the help he needs. [Ramiro

turns to the teen] What we are interested in is to recover, little by little your hobbies, and the time you have lost, so that in two or three months you can be on your way to college, but that's your decision.

In a single session, the teen went from depressive to bipolar to antisocial. Ramiro hadn't been in the team meetings preceding the decisions which shaped the therapeutic approach that Juan wanted to apply at the public center. He was, after all, hired for his vast experience: over thirty years in one of the public psychiatric hospitals. He came and applied what he knew, but it gave me the impression of an outsider working with the outpatient treatment, on the outside of it all. The family left, and his next appointment arrived. A man who asked for help with his anxiety. Ramiro asked me to join him for a hypnotherapy session. We walked past some offices which still contained debris from the previous century. A room had been accommodated for this type of intervention. Old equipment had been pushed towards the wall to make space, and an old gurney had been cleaned. I sat on a chair next to it. Ramiro, needle in hand, proceeded to hypnotize his patient. It felt surreal.

I remembered Freud's experience with hypnosis and the development of the psychoanalytic method, as a free association of ideas, from an awake patient. Freud believed that the only way to produce a long-lasting, effective change in regards to symptoms consisted in uncovering the link they had with the unconscious: a traumatic experience, a fixed meaning, a mnemonic footprint which distorted the person's well-being. But here was Ramiro, poking the patient's hand to make sure he was hypnotized, and telling him to feel happy, energetic, motivated, and free. I figured, whatever works.

While I never studied hypnosis as a clinical technique, I had learned about it through Freud's work. Indeed, the father of Psychoanalysis had participated in studies of hypnotism at the Salpêtrière Hospital, under the teachings of Charcot, who was applying hypnosis to hysterical paralyzes (Bachner-Melman & Lichtenberg 2001). Back in Vienna, and along Dr. Breuer, Freud worked with regression through hypnosis, as a technique to reach traumatic experiences thought to be found at the genesis of hysteria symptoms.

While hypnosis shed the first lights into the definition of the unconscious, Freud abandoned the technique for several reasons, including the impossibility to use it with all patients, the fear of the patient losing contact with the present, the possibility of patients becoming

addicted to the technique, and so on. Also, the return of symptoms or the development of new ones after hypnotic interventions discouraged Freud from continuing the application of this technique. But Ramiro seemed to rely on it; after all, it produced the numbness in the area where he poked with the needle, generating an effect of trust in the patient, and it lowered anxiety for at least a little while. No one else used it in the public center.

I left the outpatient experience with the sensation of a moral gaze defining the problem and a solution which placed responsibility on the parents' marriage: a reduction of a complex phenomenon placed on traditional beliefs regarding family. Disciplinary practices screaming from all of the slits coming from the old, dusty, rusty, piled up debris. Addiction treatment was not being based on violence, as it had been in most private clinics, but it still carried plenty of leftovers from its recent past. The State eventually divided treatment modalities and created new centers to specialize in each, and the clinic shut down the pre-community services. Ramiro and the other psychologist went back to the psychiatric hospital. Outpatient treatment was sent to a different institution in Quito, and patients had to go there as a first step before being considered for inpatient treatment at the public clinic.

The rest of the psychologists had been a part of the staff either since the opening of the contingency area or the therapeutic community. They had participated in all of the staff meetings, where the concepts behind this project were discussed and agreed upon. They all came from different schools and backgrounds: some had studied at the Catholic University, under a strong influence from Psychoanalysis; others came from the Salesian University, which placed emphasis on social circumstances; and others yet came from the Central University, with a mixture between behaviorism and cognitive behavioral approaches. Practice, therefore, varied a little. But the team (which included the professionals from other disciplines as well) seemed to agree most of the time, at least at the beginning.

The public center had placed most of its efforts in the clinical psychology approach. Those going through inpatient treatment had morning meetings, usually with the company of a psychologist; each had at least one weekly individual session with their psychologist; there were group therapy meetings in at least one afternoon a week, and a psychologist accompanied them in the evening meeting. Psychologists also met with the parents or family members of the patients.

The work done by the psychologists related with what they believed was the problem when it came to addiction. For Ivan, who spoke not only as a psychologist but also as a recovered addict, there was a problem in what the patient believed of himself which derived in the addictive behaviors which eventually became problematic. He explained: “An idea becomes a thought, a thought becomes a behavior, and a behavior becomes a personality trait, and this is who you are. There is even a Bible verse which says that, how a man is in his thought, that’s how he is (personal interview, November 14th, 2014)”.

Ivan described the way he had divided the three months of treatment. On a first phase, he explained, the work focused on rebuilding the way people see themselves (personal interview, November 14th, 2014):

I work on this because, personally, it hurts me to see how they perceive themselves when they begin treatment. For example, I’m an addict, I’m sick, I’m incurable, and I have a disorder. These are things that come from the introduction, I’m an addict, and my name is Juan. What I work with them comes from a perspective that equates them to a dog: I tell them, what does a dog do? In general, they bark. But, why won’t they meow or tweet? They have it engraved, what a dog does. I bring this to their story. What does Pepito do on the weekend? He gets high. What does Pepito do with a 100 bucks? He gets high. What does he do with a cell phone? He smokes it. And then, what does a rehabilitated person do on a weekend? He spends it with his family. What does a rehabilitated person do? He works, he invests. And what does he do with the same cell phone? He uses it to communicate with others, he takes care of it. If I see myself as an addict, unconsciously, what are the chances to free myself from that? None, he will use drugs, because he conceives himself as an addict. This worries me a lot, because the way I look at myself determines what I do.

For Ivan, the process aims to unveiling the unconscious reasons why someone uses drugs. He compares this moment of insight with seeing the light, and it is the reason why he believes the whole thing is worth it: “it is exciting when a patient has everything a little clearer, even if he doesn’t stop using drugs (personal interview, November 14th, 2014)”.

I spoke with another psychologist for a few times, trying to understand what addiction was. Before coming to the public clinic, Lorena worked at the CONSEP, in the area in charge of prevention. A clinical psychologist who had seen the state’s policies from up-close, she was

part of the team which Juan assembled for the therapeutic community. For her, there is an ethic in the addicted which needs to be addressed (personal interview, November 12th, 2014):

For instance, there is an impossibility to take responsibility for things which everyday life throws at you, like work, being a father, being a man, or a woman, you realize that, in the end, being an addict gives you the possibility to play dumb feigning ignorance with these things, parenthood, and so on, because you become lackadaisical, when there are drug uses which are severe, the psychological issue stops functioning in society, because they can't operate like fathers, husbands, citizens, employees, sons; there is this secondary gain which comes from playing dumb with these things. If a label is put, this is a disease, what better! I'm sick, and that's it. So, my actions, the things I do are the products of my disease. I am not to blame. The possibility of giving the patient back his responsibility when he comes armed with the discourse of I am a "drogo", well, well, there, wait a minute, you are a human being, you are not an addict, you have a problem with drugs, but what you are is a human.

While Lorena's ethical reflection came most certainly from her interpretation of Lacan's seminar applied to the construction of a citizen of addiction⁴⁷, her reference to the label made me notice the effect of the War on Drugs in the everyday lives of drug users. Granted, not all of them. But those who fell into addiction were representing the script written by decades of portraying drug use from the problematic cases, in order to create an enemy worth fighting a war against. Drug use had been described as a gate to losing oneself into the evil of powerful substances. The will was non-existent when it came to addiction, and the staff usually referred to it, precisely, as a disease of the will. Those people whom the clinic meant to civilize were already playing a role.

While Ivan saw the self-representations as something saddening, reflecting his own experience with what each patient brought, Lorena viewed them as a way of justifying many failures, deviances and excesses. Both psychologists were there to assist the patient with the reorganization of these beliefs. Part of the treatment, Lorena explained, was to convince the person of the possibility of changing. "The patients suffer a lot, and they have an inability to take responsibility of some things (personal interview, November 14th, 2014)". From a

⁴⁷ For Psychoanalysis, the subject is an ethical subject, capable of responding, of taking responsibility over his desire, assuming the responsibility according to the historic, social and political moment. What is at stake in the psychoanalytic process is precisely that: the responsibility of the subject over everything that happens to him (Lacan 2007).

Lacanian perspective, guilt is a way of avoiding responsibility. The ethics of psychoanalysis aim to diminish suffering, through the possibility of being responsible from one's own choices.

The cure, Lorena believed, had to do with the transition from the mere act to the word: the symbolic order taking over the real. For the addict, she explained, there is no middle; all there exists is a very limited space of events: I fought, I felt angry, and I got high. There is no mediator which would allow for links with others. Only closed causes and effects. Speaking, therefore, works as an introduction to the symbolic, the reconstruction of meanings. Albert, who was a patient of her already on his second period inside the public center, didn't know any of the details which formed the theoretical frame with which she worked with. He wondered (personal interview, September 9th, 2015):

She is at her desk, and she says, ok, speak, and she grabs her notebook, and while I tell her stuff, she looks at me and writes things down. Whatever does she write? One day I got there and she said, ok, continue, I mean, I hadn't even sat down yet, you know what I mean? It was like it crashed against me and I don't even know what else to talk about and I tell her, I don't know what I should talk about, and she says, Albert, there has to be something you can tell me, more than 20 years of use, a whole life, you have to have something, and she's right, I mean, in some ways she is right, but sometimes, it just doesn't work like that, with someone just telling you to sit down and speak, it just doesn't come out, only sporadically. And when you feel forced to disclosing, you put a barrier for yourself, you block everything.

Private clinics had many hours of a freak show-like experiential therapy, in which the therapist – a former addict – told patients about his darkest moments as a drug user, and encouraged everyone to describe the most gruesome experiences within the drug world. Most people who had been at the public center had previously been at one or more private clinics. These “therapeutics” were common. The modality used in most private clinics was inherited from Alcoholics Anonymous, but transformed into an imposition, which I lean to believe responds to the Lacanian psychoanalytic concept of *jouissance*. Instead of a technology of the self, confession in private clinics is closer to the symptom than it is to the therapeutics of it.

The Alcoholics Anonymous model begins with an act of surrendering to the condition of alcoholism: the first of twelve steps is the admission of being powerless in regards to alcohol

(Pierce, Rivinoja & Koenig 2008). But in private clinics, there is no such admission: people were forcefully taken to these places and admission of dependence or abuse of substances resulted from a need to stop the violence with which patients were being forced to do so. The Alcoholics Anonymous effectiveness has been found to come from key aspects of their spiritual model of recovery, mostly: the provision of a community, the narrative framework for meaning making, the possibility of coping through submission and redemption, and the prescription of lifestyle behaviors such as forgiveness and altruism. These components unfold amidst an atmosphere in which alcoholics try to view themselves as ordinary people trying to overcome a form of suffering.

But in private clinics, most of which used the twelve step model, acceptance of alcoholism as something bigger than oneself was replaced by the imposition of the self-definition as an addict: it was through forced confinement and violent practices that the clinics attempted to make the addict define himself as such. Those who had been interned for longer periods often took the position of guards and took over security inside the clinics – resembling practices in concentration camps which used Jews as security guards (Levi 1995)–, and therefore, the generation of a sense of community was harder to create than it would be in a regular Alcoholics Anonymous group. The public center didn't use the twelve steps, but it did return to a logic of admission – before admission, the person had to show the desire of recovery, which implied admitting to have a problem which they could not control on their own. “Older brothers” were assigned at the public center, but without the persecution associated to private clinics; perhaps a sense of community had a better chance to appearing here than in the private rehabilitation centers.

The clinic changed the public display of drug-related experiences into private, individual sessions. And while in an ordinary psychoanalytic process, the patient decides on what he wants to speak about, even though this may mean that resistances are operating, the public center's times put pressure into the staff for making the unconscious conscious fast enough. For Albert, it felt as if he was being forced to talk. There was something he felt was expected of him in terms of his therapy sessions. He, like the others, learned to respond to the demand, thus remaining in the non-responsibility area. He often mentioned he felt afraid of telling his psychologist about his longing of consumption; he felt she had the power to use that ‘against’ him when deciding on release.

While the first group-therapy sessions which the public center offered consisted in working with the entire group of patients, by the time Albert was on his second internment there, the clinic had rearranged this form of intervention. It no longer worked as a random, one topic at the time meeting. Instead, every psychologist had a group, formed by the people they were currently treating individually. Albert explained (personal interview, September 9th, 2015):

Each doctor works differently, I believe. Lore, mostly, sits and says, guys, free topic, whoever wants to talk, about whatever, says it and we take it from there. So we all sit there until someone begins and we talk about whatever they brought up. This is very important, and there is something different, like an empathy process, this thing in which you and I are patients of the same psychologist and we feel identified with something, and so, for all of us there, it's a different thing.

During Albert's first internment, group therapy was more of a workshop. A series of dynamics allowed for a cathartic experience in which patients could talk about their childhoods, their fears, their art perceptions. One of the sessions was led by Mercedes, a clinical psychologist who had specialized in addiction treatment many years ago. The session was more of a workshop with all the interns, men and women, and with the use of visual stimuli, Mercedes generated a series of responses which allowed for the group to speak, about their families, their drug use, and, mostly, the perception they had of themselves.

Group therapy organization, Albert believed, had improved now that it was his own psychologist leading the meetings. Identification seemed like an interesting form of individualization: the addicted citizen came into being once empathetic relations formed within the smaller groups. Or did he?

While everyone seemed to subtly agree in that addicts failed to function socially, that is, they became lazy, irresponsible, lackadaisical, and so on, the staff believed it was more important to attend the group therapy meetings than to help the nuns. Juan complained (Staff meeting, November 8th, 2015):

The nuns, they want the guys helping them all the time and I always say yes, yes, but yesterday, it was too much, there were only five people in the community meeting, and everyone else was doing something else. There is a group of clowns, and the District asked us

to send them, it was for the campaign of, what is the campaign of now? Promoting I don't know what, promoting health. But this is a small group which has formed, and they are very good at it. The rest, they were in the kitchen, and in therapy there were only five people. And so, these are things we need to modify.

Obedience, rules, therapy as the most important objective in order to generate empathy and the will to function in society properly: the process and its representations influence the way people's behaviors are interpreted. There are rules, and one must follow. Even if these rules are made to produce hard-working employees, caring fathers, helpful neighbors, and even if helping the nuns in charge of the remaining Hansen patients could represent some of the goals which therapy had. Juan had the difficult task of making everything work while responding to the Ministry's demands, orders and expectations, as well as the staff's and the patients'. Had he been a part of the psyche structure, he would have been the Ego. He was the one dealing with everything, trying to please everyone, while working for a better outcome of the therapeutic process.

The openness with which the public center started its task began to slowly close. The visits were regulated through the psychologists, with the designation of one day for the patients of each one. May, the occupational therapist illustrated (Personal interview, May 9th, 2016): "for example, on Mondays, I believe it's Alejito's day, all of Alejandro's patients have their visits." Psychologists were the core of the treatment but, at the same time, they were placed in an authority position which made it difficult to let transference flow. The public center resisted, but inertia operated against.

3.3. Psychiatry

Private clinics were mostly run by former addicts. A few had a psychiatrist working there a few hours a week, yet most used Sinogan, a major tranquilizer on their patients, especially after capture, when people were desperately trying to resist confinement. It didn't take a medic to administer it. Force did it. Still, psychiatry remained an important voice in addiction issues, even when its position was unclear. Medics carry the representation of an unquestionable knowledge, thought to accompany any hospitalization process. Sometimes the idea of the psychiatrist was more than enough.

Traditionally, regulations stated that a psychiatrist had to be in charge of any addiction recovery unit. But for the public center, the Ministry selected Juan, who had studied psycho-rehabilitation and special education, and had plenty of experience in therapeutic communities. Juan had given more weight to the psychological approach over the medical. Still, the meeting with the psychiatrist was one of the unavoidable steps for entering the therapeutic process at the public clinic. The assessment looked for detoxification needs, as well as for the presence of dual pathologies. If the case was severe, the person would remain under the psychiatrist's care. May, the occupational therapist, explained the process (personal interview, December 3rd, 2014):

If he needs detox, generally it won't be handled here, it is the psychiatrist who will deal with it, with "*sueritos*" ("little intravenous", a colloquial way of depicting intravenous medication) or something, and after that, the person is welcomed to the house. We assign an older brother to explain the rules, the norms.

Since the regulations required a psychiatrist for each center, Juan hired one when he set up his team. Jane was a Cuban psychiatrist who handled the cases at the public center. She explained that the psychiatric approach was always unique, as each patient was different, and that the decisions regarding treatment depended on the team's assessment (personal interview, December 2nd, 2014):

There are standard medications, fluoxetine for depression, risperidone, the antipsychotic, or if the patient has epilepsy and so on. We conduct an assessment from psychology, a medical evaluation, and a psychiatric one, and this is how we determine which medication this patient is receiving, if any. We take into consideration the opinion of the psychologists because they can identify if the patient is borderline, things like that, and so we modify medication with these criteria, if they can't sleep, etc. The psychologist can also suggest things which allow us to regulate.

Patients at the public center had mentioned in a conversation that they found it easy to manipulate psychiatrists into prescribing something which could get them high. Albert and Francisco agreed upon the perfected ability to fool the doctor to receive prescriptions. Jane explained that she never prescribed addictive medication in the context of the public clinic (personal interview, December 2nd, 2014):

I have been a pioneer here of not prescribing psychotropic medication. Me, benzodiazepines for the patients, no, unless it is strictly necessary, sometimes the patient needs it, and if he needs it, ok, well, but we try to not, the medics and me, to not give any medication which could generate dependence. If it was necessary, unavoidable, it is set for a certain period of time, just as it is described, so that we don't risk the development of dependency.

Jane's concern with patients' development of further addictions had a basis in the characteristics of the medications, and especially, of the patients. People like Albert had been hooked on pills for a long time, and her preoccupation of the medicine being worse than the disease seemed understandable. For her, addiction was a disease; a disorder which made the patient put a drug in their body to alter his mind (personal interview, December 2nd, 2014):

Sometimes there are people who have used drugs in parties, all of their lives, but it never becomes a problematic drug use. And this is the thing; we only treat problematic drug use. An addict is when there really is a problem with drug use. And that's the thing; we only treat problematic drug use. Not everyone who uses drugs requires treatment. Not everyone develops a problematic drug use. And there are people who, yes, after just one dose, especially of heroin which is the most addictive, people can get hooked. But there are those who don't. Who only use it at parties, every so often, without developing a problematic drug use.

Differentiation between drug use and drug abuse or dependence had not been a concern during the private clinics' dominance. Drugs were believed to operate on their own and, whether or not a person had developed a problem with a substance, if she was found using drugs at all she could easily end up in treatment. But the public center was breaking this trend and trying to work from a differential diagnosis. Drug use was not enough of a sign to diagnose addiction, much less treat it. Being a public center, this clinic wasn't after a profit, it didn't need the business.

Once the patient entered inpatient treatment, drug use was out of the question. Jane mentioned harm reduction as an international trend worthy of revision (personal interview, December 2nd, 2014):

That a patient uses something less toxic, it is preferable. Or if he manages to reduce frequency and dose, we must recognize it as an achievement. But any patient coming in here cannot use. Period. This is a specialized center, and the people who manage to enter from their will, they

are not forced to anything at all. Treatment is explained to them, what is done, what isn't, so that they are absolutely informed regarding each of the therapies. This means that they can't use drugs, at least those at inpatient, and intensive outpatient treatment. We do toxicology controls frequently, to be sure, to rule it out.

In the public clinic, addiction consisted of a disorder in which the person could not control her intake of a substance to produce a psychotropic or narcotic effect, but this is what was expected once someone was admitted into the program. Since the doors were open, abstinence could not be forced upon them. It was claimed to be voluntary, and it was expected to be such. But just in case, to be sure, it had to be coerced through the testing of the patients' fluids with the possibility of losing treatment. The medical authority required no meaning of a relapse; only a reaction from the testing techniques was necessary. Of course, a breaking of the rules didn't always mean the person would have to leave. In all cases, the assessment from the team left a space for discretion in decision-making, and exceptions could be made. But this didn't exclude the fluid scrutiny. Jane continued (personal interview, December 2nd, 2014):

They have therapeutic outings, recreational activities, to pools, to nice places, to walks, with the objective of making them feel that we trust them, that they are not locked here. But almost always, after a family leave for the weekend, we conduct a toxicology exam. And if they use, the approach is different, the team meets, and decisions are made, because right now, there are many patients on the waiting list.

Contradictions are not necessarily evident. In fact, most of the time we lack a full understanding of that which we are saying or doing. The public center was no different; contradictions abounded but they weren't obvious. Some stood out more over the others, like the old structures hosting new therapeutic approaches. Still, they affected the course of treatment which, in turn, produced a sad sensation in health operators, not only Ivan as a former addict but any of them. Even the feeling was limited to what the patient was able to see; there was little question of the disciplinary agent's view of things.

I found everyone gathered near the nurse station, and I asked some of the guys what the commotion was. Patricio, one of the patients, was upset because his drug screening came out positive for marijuana, but he insisted he didn't smoke on his days off. He was demanding a

new test, as the consequence for using while on treatment is the expulsion from the program. Someone else from the crowd said it had happened to him as well, but when they did a retest it came out clear. There could be false positives, but the patient's reaction was definitely going to be discussed at the staff meeting.

While this was going on, chitchat in the halls mentioned Carlitos, a patient who had already left the program out of his own will but was readmitted. The public center only allowed a new internment for those who finished the program, and then relapsed. However, Carlitos was charismatic, and everyone liked him. The team decided to give him another chance. I had been in a meeting in which Juan, a young man in his twenties, was reintroduced to the group. He had abandoned treatment after a month and he had gone binge drinking. His main problem was with alcohol. He had been out for a couple of weeks, after which he came back asking to be accepted again. His treatment mates observed him (patients' meeting, December 17th, 2014):

- "I observe you, Carlitos, because you have an attitude. And I give you the option to calm down and make the best of the opportunity you have here."

- "I want to observe Carlitos, dude you become too angry, listen we are all going through this. I ask you to think of the way you treat the others, because this is difficult for everyone, not just you, and you go crazy man but that's not the way, with the help of God, but Carlitos you have to control your anger."

Others addressed him similarly. After all, he had left, which created a sensation of hopelessness. Identification within the groups was important, perhaps too important, and a quitter puts everyone's process at risk. During the meeting, and due to his abandonment, he wasn't allowed back inside the group; he had to stand outside of it. After everyone had addressed him, he was able to respond. He apologized for leaving and thanked everyone. The group clapped and he was welcomed back into the circle. The men recited the philosophy of the house, and the meeting was over.

A couple of weeks later, Carlitos left again. The other patients agreed: What he did is wrong. The rules that forbid their return if they choose to leave, they reasoned, are necessary; otherwise everyone would leave in order to use, and then return. Treatment then would be

useless. They leave the program out of pride, although it appears to be a pride that covers for the urge to use. Then they come back because of the use. In general, they don't want to do it anymore. Eventually, it was assumed that the problem with Juan was related to a dual pathology that included addiction and a form of epilepsy that manifested itself as an anger attack. But this wasn't a neurological hospital. Those patients with complex pathologies, the team reasoned, should be treated elsewhere.

Similar to Dr. Luis, Jane believed addiction was a matter of understanding (personal interview, December 2nd, 2014):

I wish I had a magic wand to clean the brain and help them realize that they are killing themselves. Sometimes you can be talking to them for hours, explaining this to them, but they don't listen. They can't see the harm they do to themselves, and that is terrible. A patient, the father of a patient, a humble person asked me if it was true that I had an IV which takes addiction away from his son. I told him I wish I had, that would fix everything.

The definition of addiction remained ambiguous. Was cure the possibility of understanding the doctor's explanations", and was this the much needed responsibility taking which Lore had referred to? Is the addict a deviant subject by choice? I asked Jane which factors intervene in the development of addiction (personal interview, December 2nd, 2014):

Basically, personality, family, the age of first use, friendships, social background, everything. It depends of many things, and no person is the same to the next. We are all unique. Otherwise everyone who got divorced would consume, or all who had bad parents would consume. The sad part is that it's three months, and it's an entire life against a short span. There are multiple factors, each person is like a world, with their own story, and sometimes there are horror stories, of rape, abuse, sometimes they lost their mother, there are many problems and they are all different. Poverty; while some people had everything, but nothing interested them; and so on.

Jane went on explaining that uniqueness is what justifies individual therapy besides group processes. Even though people might open up within the groups, the personal space they had with their psychologists allowed for a deeper understanding of their own factors, their own reasons for drug use. The patients also opened up with the psychiatrist, and she took her time in the interviewing process in order to try and understand what goes on. This is also why she

believed a multidisciplinary team was necessary, and the weekly meetings had that objective, to be able to share observations regarding the patients.

When Albert came back for the second time to the public center, his individual therapy focused on depression. He was released from his first inpatient process after many months of internment, but when he left, he already had a job and he had rented a room. However, once he made a little money, he went ahead and paid his landlord for four months ahead. This gave him a sense of protection which took away the need to continue working. Telemarketing was boring. He wasn't good at it.

Albert had only been employed by his dad in the past. His father was Korean American, and he moved to Ecuador when he was a teenager, because his step-father, from the United States military, was assigned to this country. Jim began his music career and became well known. Albert grew up in the context of his father's fame and, apart from learning to play the guitar, piano and drums himself; his only job had consisted of being a staff member for Jim whenever he performed. He had also played with him a few times, but mostly, he carried stuff. Going from the artist life, with stages, parties, hotel rooms and drugs, to a telemarketing job, didn't suffice.

Albert soon found himself spending the savings he gathered while still living at the public center. He had quit his job, and even though he was searching for something else, what he really was doing was nothing. He described the months before coming back to the clinic (personal interview, September 9th, 2015): "I tell you, I fell in a situation in which, at the beginning, the room I lived in, even if it was only a room, I kept it clean, I changed the sheets, I dusted, I swiped the floors, I made the bed, I mean, I had it as I wanted it, I washed the dishes. When I fell, then, a disaster." "Like the worst times with your father?" I asked. "Exactly. But now it is worse, because in the past, at least I washed the pots and pans. Now, I would grab a crusted pan, dirty with old food from I don't know when, and right there I would put water and cook potatoes and eat them."

I asked him what he spoke about in his individual therapy, if he was talking about depression (personal interview, September 9th, 2015):

It was what I talked about the most. According to the psychiatrist, she says she is going to have to prescribe me antidepressants for life, she says, because they are afraid that this is going to get me, you know, these people, and I mean, not so much for them, but for me. But I don't think it depends on an antidepressant, to tell you the truth. It depends on me.

3.4. Occupational Therapy

May was one of the star workers in the public clinic. She was in charge of everything: she had the schedules, she kept the keys, she oriented the patients, and she dealt with the Dermatology Hospital Director. May was an occupational therapist, a profession she described as dealing with all of the occupations of a person. May organized the therapeutic process starting from the most basic activities (or occupations) which a person must perform in her day to day life: “Brushing their teeth, getting cleaned and dressed, eating, basic activities which every well-adjusted person performs daily. These activities are individual; each person does them for themselves.”

Indeed, people who had been lost in consumption, like Paul, Ale, or Albert, arrived skinny and dirty. Only after a couple of months, they seemed changed: being in the center cleaned them up. They all looked healthy: there was a nutritionist looking after their menu (there are certain things which are believed to trigger addiction such as coffee, sugar, and others, and their diet had to be observed); also, they took a shower every day, and their clothes were washed. The civilizing process began with these most basic activities.

Once these activities were settled, the process moved on to what May considered advanced life activities: “we call them instrumental daily activities, and these occur with other people, daily: taking a bus, looking after the children, looking after the elders, handling money, buying stuff, things that are done every day. We work these through dynamics with other people, cooking, that sort of thing (personal interview, November 12th, 2014)”.

Even though Albert would survive on boiled potatoes while at his worst, his second internment gave him a chance to explore business possibilities. He hadn't been able to find a job, and he knew he didn't want something he disliked like the telemarketing gig. So, Albert began doing turnovers (dough filled with either cheese or meats) and selling them to the staff; after a while, he added sandwiches to what he had to offer. He used the occupational

Therapy's kitchen. Cooking was no longer just an activity from treatment, but something he thought could eventually help him live a normal life.

May continued describing the human occupations: "Then there is sleeping, resting, because this is an activity that you mostly do every day. Then there is work, or the exploration of work: what is it that I want to do, what am I good for, what are my resources, studies, abilities, what kind of job could I perform well in (personal interview, November 12th, 2014)" According to her view, the approach could not only consist in finding a job, but it should be something for which the person is good for. A way of guaranteeing a positive outcome, something rather complicated when there are so many patients and so much to do. But Albert had been in the public center for too long, he never had a job other than with his dad, he didn't really have a family or social network, and when he found the telemarketing gig, the clinic agreed. He never sold one single insurance. All he earned was a part time salary, with no sales fees. It was enough for a few months' rent. But it was bound to failure.

Education, social life, and free time activities were also considered part of the daily occupations of a person. The occupational therapist, May, explained, aimed to assist the person in achieving an occupational balance (Personal interview, November 12th, 2014):

Some people work too much, and there could be an occupational dysfunction, because we must learn to balance between all occupations. This brings us to the kids' routines and habits (referring to the patients). In their case, drug use is a habit which has caused them many difficulties and problems, and many dysfunctions in all of their other occupations.

For May, addiction was explained as a habit, a common interchange of words within drug discourses. If it was a habit, I wondered if it could be considered as one of the occupation groups she described (personal interview, November 12th, 2014):

No, it's not categorized, I mean, these are habits we acquire depending on the context around us, so it's not categorized in the occupations of human beings; instead, it's a context, a cultural habit we develop. It unbalances all the other occupations, people begin to dedicate only to drug use, and then we have a problem. This is why I try to let them explore other options while they work on their occupations, so that they see that there are many things which are more important than drug use, so that this balances automatically.

Being a center which depended on voluntariness (except for the court-ordered cases), it was likely that most people going through inpatient treatment already knew many of the things which psychologists, psychiatrists or occupational therapists wanted them to realize.

Addiction was commonly seen as a matter of logic, something the patient could be educated about. But it was obvious, by attending any of the meetings, that everyone knew addiction was harming them, physically, socially, work wise, and so on. They all knew. It wasn't a matter of knowing or learning that drug abuse or dependence is bad for you. Yet the clinic's different disciplines seemed to operate on the premise of a body of knowledge each had, and which the therapeutic process allowed for the patient to also have. However, if problematic drug use was unique, a different meaning, coming from different factors in each one of the persons seeking help, then maybe a therapeutic process based on teaching them something was silencing the possibility of discovering what was that which made each case tick. Still, there were plenty of individual spaces, and the identifications which the group dynamic generated, could operate the possibility of change. Three years after the Therapeutic community began, Juan believed they had an approximate of 40% of relapses. Many of the cases, then, seemed to improve. Almost half of them didn't.

Occupational Therapy was a good time to speak with the patients, even though sometimes the music was a little loud. I found Paul sitting on a table outside of the room, in the porch looking over the patio. The area which had been assigned to May had previously been the dining room for Hansen patients. It reminded me of a classroom, perhaps a preschool or an elementary school one. It had some tables and chairs, an area full of books, some puzzles which had been donated, but they were for small children; there was a piece of furniture where the TV set and the PlayStation were, with chairs in front of it, and a bureau with drawers, with the sound equipment on top. In the center, next to the back door, was May's desk, and at the left, the kitchen. On special occasions, the group would organize themselves to cook special traditional meals: *fritada* (roasted pork), *colada morada* (traditional beverage for the day of the dead), fried fish, it depended on who knew how to make what, and they all chipped in.

On December 15th, 2014, the patients weren't cooking. Inside, some people were listening to heavy metal; others were playing Mortal Kombat in the PlayStation. Some were reading, and others were just talking. Paul was sitting alone. He had white glue and folded pieces of paper, and he was putting together a paper goose. The entire scene could fit in any elementary

school. He was encouraged to work on these handcrafted projects; everyone agreed on his impressive ability to make detailed paper objects. “They gave us a class some time ago. I liked it, I like doing this (personal interview, December 15th, 2014)”.

While addiction can be seen and addressed in multiple ways, which tend towards the need for obedience and understanding or knowledge, for Paul, being an addict meant having no choice but to consume (personal interview, December 15th, 2014):

In my case, I couldn't spend ten minutes without getting drugged. I wouldn't get desperate, like many people. But I carried the substance with me at all times. Whenever the matter caught up with me, I would get my pipe and have a hit, calm myself down, and continue walking, talking. And the moment least expected, I would feel bad, and again. I didn't use because I enjoyed using. It was because I couldn't just be, it was too strong, it hurt me, I would start screaming, I would lie in bed and twitch and turn, there weren't words, I could resist for two days at the most, but then I couldn't.

While neither logic, nor responsibility or knowledge regarding drug mechanisms seemed to matter in Paul's case, being in the public clinic meant he had already been clean for three months. He had been clean in the past, and the experience didn't feel new, but he had reached the bottom, or so he believed (personal interview, December 15th, 2014):

I was at the summit of my ruin, at the very end. And it really is gratifying, to live something different, it's awesome to know that each day I struggle against desire. When I just came here, they had to put me to sleep; I was in such a bad shape that they had to sedate me. And now, there is a desire, but there is also the other thought that makes me keep on going.

The white goose was coming along nicely, although some of the feathers, made with pieces of neatly folded paper, were being glued asymmetrically. Paul's focus was mostly on his story, while mechanically adding little pieces to his feathery creation. Occupational therapy ended and Paul and the others went to the yard for a soccer match. It was time for their daily exercise.

3.5. Social Work

If psychology carried most of the therapeutic weight, social work appeared as the least visible of the components of addiction, its definition and its treatment. Eve defined her job at the public clinic (personal interview, October 5th, 2015):

What we do is, let's say, we educate the people who come asking for information. People come in a state of anguish and desperation, because they have been to one place and another, and they haven't received the help they need. Mostly, the people who come by are the family members, who don't know what to do.

When the public center opened as a therapeutic community, it was advertised as a service offered by the State. People started coming for information, looking for an option for their relative, but they could not be attended unless they came referred from a health center. I was sitting at the secretary's office, with the coordinator, when a man entered. "Excuse me, where is social work? I would like to know if I could be helped, you see, I have a problem with addiction, but when I came here they told me I couldn't get treatment here." Juan asked him if he was assessed by the staff. Two women, the wife and the mother, came in and explained that he was consuming to the point of threatening the wife. "We don't know what to do, and they send us from here to there. They sent him to a psychiatric hospital, but the doctor said she can't treat him if he is doing drugs. He came here, but they told him he wasn't accepted."

While the secretary looked for the man's file, Juan listened to the family. When the public clinic opened, it was considered a third level institution, meaning its status was that of a specialized hospital. Within the public health system, this meant that people had to come with a referral from the health centers, the first level in public medical attention. In theory, assessment at the first level was enough to accept the referral, but due to the nature of the problem, it took a little more than just a person willing to be included: the team needed to make sure that the person wanted to undergo addiction treatment, and also that there was the will to face addiction and whatever else came with it. In 2016, other places had been open and new protocol was established: evaluation became the task of the intensive outpatient centers, and the public center required that evaluation. But evaluations weren't necessarily detailed, and the process at the clinic kept on including their own. The initial assessment considered these aspects, and if they found that the person needed to work on her demand for attention, they would refer them to the intensive outpatient units.

Juan reviewed the file and advised that the family get an appointment for a reevaluation. It had been many months, and he didn't understand the psychologist's handwriting. Hopefully they could get an appointment with Ivan, and the team would consider admission after the revision. The family seemed desperate. The wife said she didn't know what to do, because her husband had threatened her. He was becoming violent, he hadn't stopped consuming except for a couple of weeks, and they weren't getting answers from anywhere. Juan understood. An appointment at the entrance would allow them to reenter the admission process at the public clinic. "Do you want to be treated this time? Because admission is decided on voluntariness, and if you weren't admitted in the past, perhaps it was because you didn't want it." The man replied he was ready, and the family left.

Eve explained the process of admission and the difficulties that the clinic had with abandonment of the therapeutic process, not only in terms of what it meant for each patient to leave in the middle of treatment, but also regarding the clinic's rates for successful therapeutic processes (personal interview, October 5th, 2015):

Referral has to come from the intensive outpatient, because this is something which affects the high abandonment rate which the public center had at the beginning. Because we evaluated the case, and the psychologist determined that the person needed inpatient treatment, but sometimes they came moved by certain circumstances which were occurring at that time, perhaps the family told them they won't help them anymore, or maybe there is a legal issue in between which scares the person into treatment. But once it started, maybe he discovered it wasn't what he wanted, and this made the rates of abandonment be pushed up.

In theory, after spending a few months in the intensive outpatient treatment, the patient would feel more aware of what internment means, and he might have better chances of continuing with his process. This was the idea when the Therapeutic community first opened, but the state had them shut down the outpatient area, and people were referred to the newly opened units. Still, Juan maintained the evaluation process for the inpatient clinic. The social workers' first duty was to direct the people looking for information on the process. Admission included the opinions from the psychologist, the medics, and the social worker. They worked with the family or social network of the patient to evaluate the situation in which the person is living, and the options for reinsertion that the patient had. But social work didn't conduct any form of treatment, per se.

From the social work's perspective, drug use is a public health problem, and not a crime. Eve specified (personal interview, October 5th, 2015):

Obviously many of the people who use, in order to have access, to consume, have committed some minor offense, but this shouldn't be addressed from a criminal perspective, and this is something I believe the country has made some progress at. Because, obviously, it was criminalized before, as if everyone who uses drugs is a delinquent, and it's not like that, not everyone who uses has committed a crime, so, from my perspective, this is a social problem.

While Eve believed the country had moved forward in defining addiction as a public health problem, she also considered addiction was beyond the medical approach, because it included other aspects (personal interview, October 5th, 2015):

Other areas, other environments, the problem ascends to a family level as well, and I believe that the main basis for drug use lies within the family, from the family situation to the problems that they have. From what I have seen, within the families we attend, they are multi-problem, they don't have just one problem, maybe the parents split up and that wasn't properly managed, and the child has an abandonment problem, and tries to incorporate to a group in order to satisfy that need, and this is how the person begins drug use, from what I have seen. From what I have studied, there is a deeper issue with the person's environments, and sometimes it is hard for the people to notice this situation, in which the problem is not only the person who is using drugs.

Social work's approach looks at the circumstances in the person's life. Who does the patient live with, what is the status on basic needs, how supportive is the family. And in many cases, Eve says, what she needs to do is educate the patient, regarding the process of admission, but also regarding the sharing of responsibility. The process, as described, can't be reduced to a psycho-education session (or two), because each case is unique, and family support could also generate a failure in the responsibility process. Social workers had the duty of learning about the individual circumstances surrounding the cases, and based on their findings, they made recommendations to the team. But since they didn't conduct a therapeutic activity on their own, they felt that their work was being undervalued.

The hierarchies within the clinic's staff organized themselves in terms of who had the most therapeutic time, or at least, that was my impression. Since social work did more of an

assessment of the patient's situation, they sometimes felt mistreated inside the team, as if excluded from the multidisciplinary approach. Roberto, the social worker, explained (personal interview, October 5th, 2015): "No, the area which has been denominated social work, we are the last ones. What we do, the information we gather from the patients, we take it to the team so our colleagues have a clear idea; we do the home visit, we inform them, and it seems like..." In this moment Eve interrupts him: "We are seen like we are the psychologists' assistants!"

Roberto agreed. The psychologists would ask them to phone a family member, things like that, but when they wanted to give an opinion regarding someone's therapeutic process, they felt that the psychologists didn't even think of their suggestions. Eve continued (personal interview, October 5th, 2015):

We are not looking for ways to integrate the different areas, and if our perspective is minimized... The psychologists' role, obviously I have it clear that the strongest work at a therapeutic level is the psychological one, but the other areas are supposed to complement, but our opinions are not being considered.

Roberto felt they were treated as if they were the personal assistant of someone: "they come and tell us, 'you need to call and tell someone they have therapy'. And that's as far as they see. I mean, social work is no one's secretary, I mean, family contact is part of our job, but this is the sensation they give us (personal interview, October 5th, 2015)". Social workers felt their functions had been confused with those of a personal assistant. They did have to contact the family, but not to remind them of an appointment. Instead, their job was to find family, make home visits, and understand the social context in which the person was immersed. And if there were problems covering the basic needs of a patient, then the social worker could identify this and assist in finding solutions.

The social workers were feeling sensitive about their role mostly because one case triggered the conflict inside the team. The problem had to do with the definition of addiction, even though that didn't come out clearly. Eve explained (personal interview, October 5th, 2015):

I already said in the meeting, I believe our opinion is not being considered, because we give the information from the home visits. The problem was that a woman wanted her son to be

here, interned with her, and obviously they ask you what you think, and I said, I disagree with the kid coming here because this has already happened to us, first of all, we are at a health house, this is a hospital, and children can't be here, the space is not adequate for a child, I believe this is a three year old child, and the last time this boy came, who had to look after him ended up being the other participants, also the nurse auxiliary team ended up in charge of him and this generated conflict.

The case in question was one of a girl who had lost custody of her boy to his grandparents on his father's side. What the psychologists were suggesting is that the infant came to the addiction treatment hospital, because the woman was claiming that "if they don't let me see my boy, I will relapse", as Eve recalled. The patients, she continued, are (personal interview, October 5th, 2015):

very manipulative, and they demand things from the psychologist and the psychologist just allows them, and so we had to explain this to the psychologist, and her, Lore, there was a confrontation with her because we disagreed with the kid being brought back here, because it has already happened with the same girl, that she brought the child but she didn't look after him, it was the other participants, her fellow patients, and the staf.

For the social workers, while addiction was a complex problem which involved not only a mental disorder but also the different environments in which the people lived, addicts were manipulative and the staff had to be cautious of the way they responded to the patients' demands, especially when they were placed as conditions for remaining in treatment. Eve believed that there were differences in the treatment of males and females, because inpatient treatment for women placed other factors in conflict, such as the children. Women wanted to be in constant contact with them, but internment was bound to a set of rules and regulations. She believed this was the reason why it never really worked, the treatment with women.

One thing that was clear from the social work perspective, and which repeated through the multidisciplinary team's discourses was that the problem was not the substance. Instead, it was the person who became addicted, and, from Eve's point of view, that was what the public clinic worked with (personal interview, October 5th, 2015):

The substance will still be there when they come out, and they will have the same problems, maybe even worse, but what we do is we prepare the person for a new form of life, we aid in

the acquisition of new habits, new aptitudes, new behaviors, and this implies taking distance from the factors which increased the risk of a relapse.

3.6. Sexual control

The first public addiction treatment center had been developed as a therapeutic community for adult males. Treatment was outlined considering a population of free males willing to stop using substances. However, after a short while of its becoming into a specialized center for the treatment of problematic drug use, as it was formally called, women began to arrive. Juan felt obliged to open something up, because women had no options for addiction in the public sector. The women's wing opened in the furthest area, with a jail-like door which was meant to protect them. Gender issues come into play when addiction treatment has been designed for a male population. The effects in the subjectivities of the women in treatment will also unveil the configurations of power relations in the Ecuadorian society.

In public addiction treatment practice, abstinence is displayed as a day to day aspect that relates not only to drug use, but in fact extends to many other areas of the patient's life. While the public center has been an experiment in motion, the first of its kind, a trial and error arena, it was originally designed as a male treatment clinic. However, the demand for women's therapeutic spaces eventually led to the creation of the female wing, an experiment that never succeeded and which ended with the wing's closing. Juan still feels this is a debt society has towards women: the creation of a specialized space with gender considerations, as there is no such place yet. In the meantime, the metal bar door is now open, and the meeting room is now a classroom. The bedrooms have been emptied, the hospital beds are piled up and the mattresses have been stored in one of them. The silence and the piled up equipment appear as a newer version of the debris in the abandoned, not yet restored rooms throughout the clinic.

The male participants explained to me that any form of relation between males and females was forbidden (Casual conversation, July 21st, 2015), including looks, smiles, or any other form of flirting. If the girls were here, they explained, then the guys must be there. There were certain exceptions, as Pedro and his girlfriend were both patients at the public clinic and they would hug, kiss and interact in any given chance they got with no consequences; after all, Paul agreed to be admitted as long as Ale was too. But for the rest, interaction was not allowed.

“Since it is forbidden, it is like you get more taste out of it (patient, casual conversation, July 21st, 2015)”. The male patients were discussing a conflict which arose because of this interaction. It was common practice that the males and females would exchange love letters, while the staff tried pointlessly to prevent such epistolary contact from occurring. While there are some intermediaries that cooperate (girls you run into by chance or even staff members), the contact with patients from the other sex can have consequences such as having to wake up earlier for a week, washing dishes for a week, that sort of thing. The adding of consequences eventually leads to a stronger one, such as being expelled from the program. One of the guys had received a letter from a female patient, but one of his peers noticed and told a psychologist about the love exchange. The psychologist came to see him and demanded: “David, give me the letter.”

David claimed he wanted to “*tirarse el muerto*”: to ‘carry the dead body’, to take the blame for what had happened, but that he was threatened with expulsion if he didn’t say who the girl was. His buddies added: “we don’t know what consequence the girl had, but David was forgiven.” Confession is added to abstinence: as they are expected to feel no sexual or romantic interest in the girls, but they do, confessing and betraying them may grant a pardon. Private clinics had their own version of this kind of disclosure, usually deriving in a forced abjection of one’s gruesome details of the drug use life. Here, the value of honesty overcame the value of solidarity. David ratted his girl out.

Avowal didn’t belong exclusively to the legal system. It was linked with addiction treatment as a form of showing the interest in the therapeutic approach: fluid tests to check for drug use were also a form of fomenting it. If someone had relapsed, they had a better chance of staying in the program if they confessed, as opposed of being discovered through the reactive. Suspicion, on the other hand, characterized the gaze of the staff. After all, addicts manipulate, commit crimes, steal, lie... Avowal was a form of contrast from the clinics in the sense that it excluded violence or explicit forms of humiliation.

The guys went on with David’s story. He wrote a letter to her, explaining that if he took the blame he would have been forced to retire from the program. After she read the letter, they met secretly for a little while, and he was able to apologize. She forgave him; they kissed and shared some candy, also forbidden inside the center. Avowal was a change given to David, not to the girl. I wasn’t able to speak with David’s lady to ask her how she felt. He was going

to check with her if she agreed first. I didn't want to repeat the disclosure without her consent. Albert added to the conversation that, had he met someone he liked, he wouldn't have cared if he was going to get consequences. He would have written a letter to tell her he liked her.

Many of the rules were constantly broken. Everyone had candy; there was a small store inside the clinic which sold it to the patients. Also, there were love stories all over the place. Some had been caught; either someone had seen them, or there had been a snitch; sometimes it was the surveillance system working at its best. But there were also romances which remained secret. At least until the girl came back pregnant and relapsed, and then everyone found out. Sexual control by locking down the women had at least two effects: one was that they were the ones made responsible of whatever happened between them and the males. Regardless of how conscious this was, when David disclosed his girl's name, she was the one punished. The other one was that this reinforced a view of women as the difficult ones. Why were they the ones locked down for their protection? Treatment for them worked much less than it did with the guys. And the staff was constantly referring to them as problematic: always fighting, complaining about everything, used to exploit their own bodies in exchange of drugs, women's protection also revealed complex views of the feminine.

Juan explained that at the beginning the women as patients were only an exception, but it eventually became necessary to open a wing. The regulation was clear: No mixed clinics, that is, only males or females; and no mixing adults with adolescents. The public clinic also broke the rules (personal interview, November 10th, 2014):

There is the need, and you must decide between leaving them in the street or admit them. So we are opening a wing for adolescents. I am asking for a meeting, because treatment is different: first of all, they don't come out of spontaneous demand, but most of them come with a judiciary order; once they come in, it is more frequent that they break the rules, and they can leave but you can't just let them walk away as you would with an adult, there has to be a legal process, which makes things more complicated, and since the space is so open, it scares people a little, because it is too much responsibility, and the kids can escape.

Juan was aware of the failures the program was presenting, especially for adolescents. He wanted to summon experts through a seminar, to create or adapt the therapeutic programs along with people from the police, or the institutions working with children and have

experience. With women, the same thing was happening (personal interview, November 10th, 2014):

we are now applying the same program as with the males, and that's not right either, what happens is that there is no time, and it takes some thinking, but there is a program for women, because many have been pressured by their partners, it hasn't been a free choice (the drug use), like when they do sexual work and they get some pills, it is very complicated, and so empowering and gender violence need to be addressed.

The treatment of women, not only from discourses, which came from other women as well, but also from the managing of spaces, like the door, the control, and the fact that avowal didn't do them as much good as it did the men, they all seemed forms of patronizing. And patronizing women was not a male thing. Everyone did this with the female patients. Female psychologists complained of their attitudes, social workers discussed their wickedness in the staff meetings, nurse aid personnel informed of a rule broken at the women's wing. And while they were criticized and patronized, the possibility of them taking any responsibility over their life choices diminished. What therapeutic effect could control have, along with subtle downgrading by simple comparison? With the men, treatment was something that could be handled. They cooperated, they adapted, they identified, regardless of the final results (after all, the cure is an "*a posteriori*" result). But the women were women. Ivan reasoned (personal interview, December 1st, 2014):

I read once that among the main needs of a lady is to be admired, and this is seen in the process, because we need to be aware. The males can handle the groups on their own, but not the women, we need to be there supervising. Conflict arises from everywhere: how they get along, how the nurse stared at them, the other's gaze. It's a gender thing, the complexity of working with women comes from the feminine issues, a different way of thinking, they fight even for their hair bands, and the way they solve a conflict is different. It's a gender issue.

For Ivan, the gender issue didn't mean that women were being treated differently for being women, which they were. It meant that there are differences inherent to their female condition which needed to be addressed differently in therapy. And even though for Lore the unconscious doesn't have a gender, the female patients, or the patients identified with a female position, are different. One of the aspects in which the male and the female positions

varied, had to do with how each person represented themselves within addictions (personal interview, December 1st, 2015):

For example, considering the sexual aspect, many of the girls who are here have been through very complicated sexual situations because of drug use. I'm not saying that men haven't; but because of the gender issue and the differences, it is more common in women, I mean, that a man sells his body for drugs, is something which doesn't come out, ever, and if it happens, it's like a secret. Those who have done it don't discuss it, as opposed to females, it is more normalized, more accepted, you have an addiction, what will you sell? Your body, that's the logic. The guys know the girls from other places, and end up talking about it, and that's the difference.

Sexual issues were so when it was a female in question. Women are considered fragile, victimized and mistreated, entering the world of drugs because of their partners. How could treatment help them? It was hard enough to help the men see their own responsibilities in the addiction process. The women were portrayed as easy to influence, which meant they were somehow released from the need to take control over their lives. How can someone control themselves, when the door is locked?

The definition of addiction is an ongoing process, something which has not been finished, but a construction in motion. There are constant changes which respond to different factors. One of them is the discipline from which the definition is built. But, even though each professional brings their own mode of understanding drug abuse and dependence, everyone shares the remaining of a war which hasn't ended. The patients represent the roles assigned, and reinforce the beliefs surrounding the behavior.

Each of the disciplines conforming the therapeutic community contribute to the complexity in defining addiction but, while they are all based in some form of scientific knowledge, they all show a hidden set of representations which end up maintaining, and sometimes even reinforcing the practices which the public clinic was built to counter.

At the same time, the therapeutic process unfolds amidst a set of preconceptions, perhaps unconscious, which are visible through the contrasts that the space selected presents with the project it hosts. Still, there are many cases which require hospitalization, or at least, which

benefit from it. But the disorder is not yet defined, and it still needs more observation, more research to widen what is known about it and therefore to allow for a more complex approach.

The surge of a female wing showed the way in which society sees women and how this affects or influences the therapeutic approach. Representations are the strongest when it comes to women, which leads to treatment becoming the hardest, or the least effective. There is a social debt in terms of recognizing the views which limit the assistance which can be given to addiction patients from a gender perspective. Mostly, there seems to be a confusion regarding the definition of gender issues which also influences the way treatment is handled.

Throughout the time I spent in the public clinic I kept feeling I wasn't paying enough attention to the women and their situation in there, either as addicts or as patients. I kept asking about the women to different staff members, and I always felt the answers avoided the female issue: their treatment wasn't a part of the plan, it was just a contingency, gender issues need to be included but we haven't had the time, so far we are using the same model we use for males, it works with males, they are much more complicated, conflictive and problematic, and they are sexual: women have sex-related issues that are not as obvious in males. For example, they exchange sexual favors for drugs. If men do, staff would explain, they don't talk about it, "we don't hear it". And so on. The women issue was never clear, and I feel I didn't insist enough.

Even though I went to their meetings, I played card games with them, I heard them talk about love and deception, kids and dreams, I always felt I was missing something. I had been reluctant to fall into simplifying ideological categories, but I now believe I ended up believing this could not really make a full chapter. I now wonder if I gave up to subtle pressures – everyone avoided in-depth discussion of the women and their treatment.

In fact, even though seeing that they were the only ones locked up "for their protection", it was only during writing that I wondered why, if they were considered at risk of being in any way threatened by the males, it wasn't the men who were being restrained. The women never had a space beyond confinement, regardless of their schedule and their daily visits to the different spaces outside their wing, and they were never thought of from a therapeutic perspective. It was with the women that the reproduction of a punitive approach was most evident; it was sexuality being punished while addiction was left untreated.

I also believe that this feeling of debt is something I share with, and probably something I even got from, the coordinator. The last time I saw Juan, he said “we are in debt towards the women”. The female ward had shut down because the state opened other spaces, but Juan said they weren’t working out. Women didn’t have any more options than the private clinics. There was a public center for female teenagers, but the functionaries of the first public clinic had heard it wasn’t optimal.

Juan kept the addiction treatment manuals for females on his desk. Intentions aside, the daily occupations coming from the public center and the bureaucratic demands from the Ministry and all, he never had the chance to organize an experts’ meeting, as he would have wanted, in order to define the therapeutic approach for women. The staff didn’t mind when the women’s wing shut down. They could finally focus on their original task, which was male addiction treatment.

Chapter 4

Addiction treatment and bureaucracy

So, if anyone comes wanting to be seen by a psychiatrist, are you going to attend them? Leave, I mean, with that, please give me your resignations, go home, because, you either have not understood anything, I mean, I'm sorry, but I can't accept this. I mean, we have this huge necessity in the country, but not here, no; in here, yes, this is the only hospital where people's rights are respected, because anyone comes and asks for anything, and they get it, forgive me for getting like this. I wish I didn't have to get like this in this place, I see a total lack of respect to the fact that we have policies and they are not being followed, I can't accept that, I cannot accept that, there is a disposition from the president of the Republic which is not being followed here, but it's great that you are humanistic so as to let anyone come and see anyone, this is not the attention model from our country. It's not like that. There are clear dispositions, Ministry agreements which say that and we need to comply. I mean, I would like to have what you are doing here audited, because you are losing resources from the Ecuadorean State, you are misusing, that is what you are doing, and I can't accept that.

Minister of Health, during her visit.

Introduction

Addiction treatment in the public sector wasn't a thing from the clinical site alone. Instead, it was crossed by the context of political change in which it was created: that of the Citizen Revolution, led by a left-wing government which proposed the return of the State against privatization. The visit from the Minister of Health is an opportunity to see the way the State relates to the institution and the subordinates.

The visit of an authority such as the Minister, a direct representative of the Executive Power, is not spontaneous; it takes weeks of preparation to fulfill the expectations. The visit demands preparation in several fronts: while the interns are collaborating in the clean-up of the physical space, the psychologists are working on attention protocols, and the coordinator is meeting the requirements of the Minister's advisors.

This chapter begins with the visit to continue an analysis of the relationship of the public addiction treatment center with the State. The space in which the clinic is set seems relevant, as a traditional site of exclusion, being the old Leper asylum, with a specific location and a specific architecture. At the same time, it remains in a legal and administrative loophole, as its condition of “project” affects the lives of the functionaries, dealing with labor instability and the implicit threat of losing their jobs.

The physical space, a set of old buildings later qualified as unsafe, pairs with the lack of legal status in the definition of the clinic in the public dynamic. Addiction remains a matter of exclusion, something which becomes materialized through the public clinic and its details.

The sharing of space with the Dermatology Hospital, which is later dissolved, generated power disputes which also tell a story about addiction and its place in society. At the same time, those seeking the attention the public clinic offers are trapped in bureaucratic procedures, disciplinary practices which shape the public health system.

Finally, the chapter takes a look at the power disputes occurring inside the multi-disciplinary team, and the way the illusion of “team” is dissolved in the difficulty of reaching agreements regarding the handling of cases.

4.1. The visit

Although everyone seemed excited, the pressure of having the Minister of Health visiting the Hospital had been exhausting. The Ministry officials had announced her visit for at least three different times already, but on each occasion the event had been moved to a different date. During that entire month of canceled appointments, Minister Vance’s assistants had requested reports, numbers, statistics, descriptions, and a series of documents in order to accurately inform her about the first public addiction center. It wasn’t a gathering of information alone; her future presence in the premises required several adjustments, in different areas, ordered by those working for her: the Direction of Mental Health, her personal assistants, and the Director of the Dermatology Hospital.

A few weeks prior to her arrival, the news about the Minister’s visit had managed to get everyone busy with other than the ordinary chores. The men undergoing inpatient treatment were cleaning and organizing the first floors of the buildings that used to belong to the

Leprosarium, which had not been in use for years. These two structures were contemplated in a recuperation plan that intended to restore and utilize this space within the public center, in order to increase the capacity of the rehabilitation clinic. At the same time, the staff had organized itself into groups for the coordination and execution of all the demands that the official visit generated. Some of the psychologists were preparing reports and treatment protocols which had been requested, while the occupational therapist was making sure all requests from the Dermatology Hospital were being met. Juan, the technical coordinator, usually cheerful, seemed less inclined to smile as he attended numerous meetings with the Director of the Dermatology Hospital, the minister's personal advisor, the director of Mental Health, and anyone involved in this particular event.

Not that any other day went smoothly. But the exception of the visit had everyone working, filling paperwork, cleaning abandoned buildings, organizing things. It was only an exception, with the urgency to satisfy the demands of the executive, the need to produce the knowledge that the Minister would need for her visit, and to make the place look nice. While Cheliotis had proposed the use of art to hide suffering within prisons (2014), the clean-up at the public addiction treatment center seemed more like a way of attenuating the contrast between forms of exclusion through confinement, formerly applied to the Hansen patients, as well as to the people locked inside private recovery clinics, and modern therapeutic approaches to addiction, proposed by the State. It wasn't part of the arts and crafts performed during occupational therapy either; just for the visit, it all needed to look "nice": *que se vea bonito*.

It had been Minister Vance who pushed for the regulation and control of private clinics. Abuses had gone as far as offering behavioral changes and dehomosexualization: a hard to imagine fantasy, which seemed inspired in a Burgess novel⁴⁸, hooking ignorant and desperate families, confused not only by the prejudice against addiction but also against sexuality. In reality, there were no changes; many of the private clinics produced only torture, starvation, rape, and in some cases, death. The public clinic was the antagonist to the neoliberal abuse which addiction market had produced, and the team was making an effort, with the pressure from the Ministry's employees, to make it look nice: the processes, the paperwork, the premises.

⁴⁸ Author of "A Clockwork Orange".

Being the first public addiction treatment center, the clinic was a work in progress. It wasn't the product of clearly defined policies; instead, it had been born out of emergencies, such as the need to offer something to the patients interned at the intervened clinics which were shut down. Abstinence as a cure had created spaces in which preventing someone's drug use justified anything and everything, and this mode of operation had extended towards what was being loosely called "conduct disorders" (American Psychiatric Association 2013), including homosexuality, a curious match considering that the latter is no longer classified as a disorder and, since 1995, it's not a crime either. But private addiction treatment clinics were mixing drug users, homosexuals and people with impulse-control disorders in the same pool. It wasn't something exclusive of the private clinics. On the contrary, even the Citizen Revolution's first set of regulations for private addiction treatment centers mixed everything: Article 9, which prohibited the functioning of mixed centers (men and women), also stated that the attention needed to be given separately to different groups: teenagers, male, female, adults, elders. At the same time, it reads (Ministerio de Salud Pública del Ecuador 2012: 4):

The creation of specialized centers for their treatment will be encouraged, as well as for dual patients (addicted psychiatric patients), teenagers with conduct disorders, and people with disorders in their identity or primary sexual orientation, as well as impulse control disorders, such as pathological gambling (F63.0 DSMIV-TR) and other addictions, non-pharmacological dependencies.

Further down, the same document states, in Article 25, that in the recovery centers, people coming for causes other than those defined in the regulation can't be admitted, even "prohibiting practices known as 'dehomosexualization interventions', conduct modification, among others, which infringe their dignity, sexual identity, gender expression, and physical, psychological, sexual and spiritual integrity, including patients with HIV" (Ministerio de Salud 2012: 10).

In the years following the inclusion of addiction as a health problem in the Constitution, the Health Ministry began a slow process of identification, regulation, inspection and control of private addiction treatment centers, especially once Minister Vance took over (Ministerio de Salud 2013). As I learned from interviewing the technical coordinator and the psychologists that worked at the clinic from the beginning of the contingency center, the Ministry found clinics which had to be closed down for malpractice, lack of regulation, and even human

rights violations. The legitimacy crisis regarding drug policy was an emergency that, when addressed, produced other urgencies that needed to be dealt with. Many of the people inside the clinics had conflictive relationships with substances which they could not manage on their own, and they required some form of addiction treatment. At the same time, many parents, many wives, didn't feel confident enough to take their family member back. And, although the Constitution guaranteed health services for addiction, only a few public hospitals offered some form of outpatient treatment.

After about a year of working with one-month inpatient treatment, which ended with a diploma and a release, the public clinic was promoted to a therapeutic community. This opened an opportunity to experiment with a form of treatment which not only offered the addressing of the disorder, but also a way of showing the superiority of the new socialist state over previously dominant neoliberal clinics, a response to an increasing demand for decriminalization, and a place which offered hope for all the lost souls and their families as a right, and not as a commodity. This shift was marked with the recruitment of the Technical Coordinator in May of 2014, Juan, informally known as the director, a psycho-educator with years of experience in therapeutic communities.

Juan's first task was to create a technical team that would shape the new treatment center. It included a physician and a psychiatrist, five psychologists, two social workers, one occupational therapist, and three nurses. With the guidelines that were first established by the contingency psychologists, the process of building-reconstructing this center began. In a symbolic aspect, the previously outlined protocols and theoretical perspectives were revised and enriched with medicine, psychiatry and other contents; in a practical way, the center opened a female ward out of an increasing demand, and extended service to underage patients and outlined a three month long inpatient treatment; and, in an architectural domain, the previously abandoned spaces or those which were being used by the Hansen patients were reorganized: what was once the dining room for the former asylum became the occupational therapy room; the area which was first used by males was converted into a separated area for women, with a bar door added to it, while the men were sent to the building where the offices were. The new dimensions of treatment were implemented as a reactive strategy, a way of lowering the commotion generated by the scandalous cases from private clinics which became known.

The minister's visit, then, was charged not only with the honor of receiving one of the president's closest representatives but, also, with the vigilant gaze of power over this new practice of considering drug abuse and dependence as a medical problem instead of a crime. On that day, usual salutations were replaced by comments on this visit, the stress it had caused, the long wait that family members who had been asked to come were forced to endure, and so on. Everyone seemed busy, concerned or annoyed. Except for Albert, one of the patients with the most time inside the clinic. He approached me as I was waiting for the event. When I asked him what he thought of it, he showed no interest in the visiting authorities. He didn't understand what all the fuss was about. While it was hard to tell if people around him were excited or scared or both, he didn't care. He was just having his usual day, heading to the occupational therapy room to play the guitar, almost as if he was enjoying the calmness that everyone's stress represented for him. Chaos around him only gave him more time to hang out.

As many of the patients living inside the public center at the time, Albert was just happy to talk, even if it was about his addiction and his therapeutic process. The clinic was his last option against homelessness, but during his time there, he had stopped taking opiates, and he was thinking about his life-long relation to base cocaine and heroin for the first time, he felt, something which hadn't happened to him in any of the other clinics he had been admitted to. We chitchatted for a few minutes until the minister arrived, and the tour began. It reminded me of a *procesión*, that is, a resemblance of a catholic procession in which the figure of a saint is carried around town while everyone prays and sings, something I had seen in my mother's hometown. Just like a religious gathering, the highest authority had arrived, accompanied by her close advisors and collaborators, and was greeted by people from the Mental Health department, a branch of her Ministry. Also, the Dermatology Hospital's director, Dr. Ochoa and his own crew were ready for the tour, as well as Juan from the addiction clinic and some of the staff. There also seemed to be some extras, people that were just there, like me. Maybe family members or patients from the Dermatology Hospital. A little crowd formed, and the tour began.

4.2 Spontaneous demand and the reorganization of health

At the gate of the public center, the security guard station has two flat screen TVs where the security cameras are projected. As opposed to a usual security system pointing at the borders or the expensive equipment, this one had all of the cameras aimed to the addiction treatment

patients. Voluntary admission, praised as one of the key aspects contrasting the neoliberal, profit centered and unscrupulous private clinics, coexisted with surveillance. Minister Vance didn't visit the guard station at the gate.

To the left of the entrance, underneath the area where the nuns resided, right next to the coffee shop, was the dentist's office, the statistics and administration offices, and the Dermatology Hospital building. This is where confusion began. While the Dentist is a maxillo-facial surgeon, which, for Juan, makes sense in a Dermatology Hospital, the Minister asked why there was a dentist in this hospital. Dr. Ochoa replied by affirming that the dentist works for the addiction clinic and not for the hospital. Juan was shocked: while the recovery unit's patients got their teeth checked with her, she belonged to the Hospital. The Minister was disturbed with this reasoning, as it seemed as an excess of human resources for a center specialized in addiction. But the confusion was only beginning. While explaining the entry process through statistics, someone in the crowd mentioned that the people who come to the addiction treatment center do so by *demanda espontánea* (spontaneous demand). For the Minister, this was unacceptable. Had they not read the *Manual de Atención Integral en Salud* (Integral Attention in Health Manual, MAIS)?

After the return to democracy in 1978, the Citizen Revolution argued, the country had entered a neoliberal logic that resulted in less investment in public services, which converted health into a commodity to be acquired through market regulation, a practice "recommended" by the international financing organizations (Naranjo Ferregut et al. 2014). The government of the Citizen Revolution, which came into power in 2007, was characterized by a strong anti-neoliberal discourse, and one of the things it did after changing the Constitution was a health reform, aiming to counter the effects of neoliberalism, particularly those related to the reduced access to health services in the poor (Asamblea Constituyente 2008; Secretaría Nacional de Planificación y Desarrollo 2007; Ministerio de Salud 2012). This implied a reorganization of medicine that no longer focused on the disease and treatment but, instead, it expanded its focus into a wider perspective that included statistical information, probabilities, costs, and prevention.

One of the key aspects of the new model of health was the redistribution of medical services in three types: At the first level there are public health centers, which can treat most minor illnesses; in the middle, the general hospitals, which are better equipped for emergencies and

for more complex medical problems, are located; and, at the third level, the specialized hospitals. The Specialized Center for Addiction Treatment is at the third level, which means that patients need to be referred from a first level center: a bureaucratic procedure that, in practice, keeps the clinic's workers sending newcomers to the neighborhood's Health Center to get the referral. For the Minister, spontaneous demand was understood as skipping the proper referral steps, the established procedure to determine access to this specialized center. The sovereign power over life had been organized already in the health context through laws, norms, protocols which could not be broken.

But when someone mentioned spontaneous demand, they meant something entirely different. President Correa's discourse utilized the concept of the *larga y triste noche neoliberal* [the long and sad neoliberal night] in reference to neoliberal policies which he claimed diminished the role of the State while favoring the private sector. In terms of health, for example, he explained (Correa 2012):

But what did the neoliberal fundamentalism told us? That we had to have tributary neutrality, we all had to pay equal taxes, and the less taxes, the better, and that the minimization of the State was needed, among other things, through an aggressive privatization plan. This means that even human rights as fundamental as the access to health should be converted into simple merchandise provided by the private sector.

Indeed, addiction treatment during this time was violently enforced by family members and center owners: by request and funding of the family, the suspected addict was hunted down by personnel from the private clinic in a process they referred to as rescue – also known as capture –, and locked for months at a time, adding up, in many cases, for years of confinement. For family members faced with the problems associated with conflictive use, these clinics seemed to offer an option to imprisonment, homelessness, delinquency or whatever else. Paul's previous inpatient treatments, for example, gave his parents some tranquility regarding his whereabouts; at least they knew where he was, even if he hated it. On the day of the Minister's visit, they had been asked to be a part of the welcoming crowd.

Once Gaby and Jorge found out about Paul's drug use, they feared for his life, for his health, and for his safety, so they began a long, frustrating process of hospitalization in different clinics throughout the country. The endless treatments he received as a teenager didn't seem

to work in regards to addiction but, for his parents, at least confinement kept him safe, or so they believed. With the threat of jail or violent death in the streets, the clinics offered redemption: a sort of non-consent sacrifice involving reclusion, torture, violence, surveillance, humiliation, and so on, without families fully understanding or knowing how it works on the inside, but with the idea that it couldn't be worse than being outside on the streets or in jail. Paul's parents only stopped when he set a clinic on fire: he had been captured very soon after breaking from it to bring him back, and he couldn't take it anymore so he burned it down. Jorge decided it was enough: Paul showed he could be a danger for himself or for others if he was forced into treatment. When he came to the public clinic, Paul had returned home after some weeks in the streets, and he asked his parents to find him a psychiatric hospital, but he was referred to the specialized center, where he chose to stay.

In a context in which private clinics operated from force, with the law encouraging the internment of anyone who used drugs, *demanda espontánea* referred to the individual's own interest in finding treatment for his problematic drug use, although in many occasions the demand came from the family, and in those cases, intensive outpatient was the option which allowed the patients to "work on their demand", so that, when they do come, they want to. For the first time ever, Paul voluntarily admitted himself in the public clinic through the reference and evaluation process, not before going to the bathroom and smoking his last hit, as well as negotiating his girlfriend's admission. He had to spend at least three months inside, and his therapist, after an evaluation made by the technical team, would have to recommend his release. He could leave if he chose to, but he would lose the opportunity for treatment. If someone decided to leave before the evaluation process, and wished to return after a while, they would have to go back to the outpatient group meetings until they could show a genuine interest in being admitted again, that is, after evaluations of the outpatient technical team recommended it because they found a genuine demand in the patient.

Avowal, at this point, didn't respond to previous practices of torture or violence, common in the private clinics that followed their own interpretations of Alcoholics Anonymous programs. Neither did it resemble a process of naming the condition for it to disappear: in 1846, a French Psychiatrist published what seemed a revolutionary therapeutic approach to insanity: a moral treatment (Brigham 1847). It consisted in a series of practices designed to produce pain or discomfort in order to prevent and dispel whatever condition he wanted to remove from his patients. After making the patient describe his delirium, Leuret made him

promise not to believe in it anymore, while giving him the punishment of a cold shower. This moral approach is repeated until the patient stops insisting on his delirium or on the fact that he is being forced to deny the perception of it as a reality (Foucault 2014). At the public treatment center, the denial of the delirium became the construction of the person's demand for treatment, while the cold shower had been replaced with the expulsion from the recovery program. The moral psychiatrist is now a multidisciplinary team which decides if a person should stay longer, or if she can be readmitted after abandoning the process.

The confusion between these two forms of understanding spontaneous demand only deepened as the Minister walked through the male ward and the therapists' offices in the back. She was greeted by the Psychiatrist's smile. A foreign specialist, Jane had been hired as part of the technical team following the specifications set by the Ministry's office. When the Minister asked her who she was, she responded, explaining that she was in charge of the psychiatric treatment for the patients. But the patients currently admitted in the public clinic added a total of 40 at the most. One psychiatrist for forty patients, in the reasoning of the Minister, was another waste of resources. In order to clarify, Jane explained that she gives attention to every person that comes, not only those in inpatient treatment. Instead of clarifying anything, the Minister was confirmed that this "spontaneous demand" implied skipping other parts of the process of accessing public health. People needed to be referred from the Public Health Centers; they needed to follow the manual. Somebody would be fired over this, the Minister assured, while continuing the tour toward the Hansen patients' area.

What the psychiatrist meant, but couldn't articulate, especially since at the beginning of the tour she was in her office seeing patients, and she missed the previous confusion in regards to spontaneous demand, was that she saw people that were part of the inpatient treatment, those who were going through intensive outpatient, newcomers who needed to be evaluated for admission, people that had already been released but were still on medication, and so on. Without really understanding what she had done wrong, Jane went back to her office, no longer smiling. A few weeks later, she was reassigned to a level two General Hospital. She now had to divide her time between the public addiction recovery center and this new job the Ministry had assigned her for.

The Minister was received by the Hansen patients in their communal room, the place where they held special events, such as Christmas celebrations, or wakes, when one of them died.

The clinic's crew remained outside and I waited with them. After a few minutes, we followed the Minister to the Auditorium, where the addiction patients and family members were expecting her. She gave a very short speech emphasizing the effort of the state to improve health services, and apologized for having so little time for a conversation; she had to leave. Still, people had expected to participate, and they waited for her. Word was given to the public.

Most patients who spoke were thankful for the creation of the public clinic. Many of them referred to past experiences in private treatment centers, where they were mistreated, some even tortured. The stories included hunger, abuse, violence, and fear, all under a process of forced confinement which the law permitted. For the first time, some said, they felt they were being treated as human beings, and they were thankful for the possibility of working on their addiction problems in this space. Some parents also spoke. An elderly woman, whose son had been admitted, cried while she told of her experience as the mother of an addict. She had felt hopeless, and she was thankful that the State was now offering some hope for her son, something which was not fulfilled by the private clinics where her son had been previously admitted. Everyone clapped, identifying with her suffering.

Towards the end, a demand which was backed by many of the patients came up. This is all great, the place, the treatment, it's all perfect. But they all needed jobs. Rehabilitation was difficult amid stigmatization, and jobs were hard to find for people who had been confined for years and didn't have a stable work trajectory. Also, some of them, like Paul, had not even finished high school. The patients requested an alliance between the Ministry of Health and the Ministry of Labor in order to help them find work as part of the reintegration to society. The Minister agreed and made some promises before leaving.

Neither Albert nor Paul spoke at this meeting. They had nothing to say. I was sitting next to Paul, and his parents were nearby, but the three of them remained silent through the whole thing. Albert was somewhere in the back. He had told me in different conversations that he feels as if he can't talk to his therapist honestly, because he feared that, if he spoke of his fantasies of drug use, she would tell him, "Oh, Albert, no, no, you're not ready to leave yet". He remained unnoticed through the Minister's visit.

After the dialogue concluded, the Minister went for lunch with the Dermatology Hospital's director, the Technical Coordinator of the addiction clinic, her own crew and, again, a couple of extras. Juan told me afterwards that he had the chance to speak directly to her during this lunch, and that he had been able to clarify the 'spontaneous demand' confusion. He felt relieved as she showed her approval of the work that was being done, especially after hearing patients speak of their experiences and the gratitude towards the Government of the Citizen Revolution.

4.3. Sharing space

The decision of placing the addiction treatment center in the old premises which used to belong to the Leper asylum came with a long and strong confusion regarding who or what was in charge of the clinic. While the clinical aspect has individual and group spaces, the administrative aspects function from a different logic that responds to the demands of the Ministry of Health more than to the needs of the patients. Juan, the coordinator, explained the current legal situation of the clinic by saying that the Minister had stated that the private centers which "are doing things right" should be licensed (Personal Interview, July, 27th, 2015).

The Ministry took control of the clinics over the security institution, keeping but regulating them. When the public clinic opened, it began as an experiment which depended on the Julio Endara Psychiatric Hospital, and it had the status of a pilot project from the Direction of Mental Health. Yet, the vicinity with the Dermatology Hospital caused confusion in terms of who is in charge. This sensation was not exclusive of the people working at the addiction center, but the Ministry itself did not know where to place it, how to upgrade it from project to an institution in its own right and with its own budget. Financial issues became the main concern as the months, and years went by without regulation of the clinic's status. The idea, Juan argued, was to convert it into a Decentralized Economic Unit. But, after two years of operation, they still did not know who they belonged to: *The clinic is like in a legal/administrative loophole.*

While it still had a project status, the plan was to take all of the buildings, fix all of the rooms, and add beds to a total of 90. The CONSEP, which was putting some of the budget for this project, had requested a meeting with the coordinator. It was December of 2014, only a few days before Christmas. I came to the meeting, and I was surprised to see the Director of the

Dermatology Hospital right there. Not only that: he was the one presenting the plans for increasing the capacity of the addiction treatment center. I asked Juan afterwards, why was he presenting his power point with the plans for the clinic? Juan laughed. He had found everything was just easier if he confronted less. Juan knew he was the coordinator, the boss of the addiction clinic. But he didn't feel he had much time to deal with the Director's need of command. And, just like he didn't argue against the surveillance system, he also let this meeting and the director's display of power, slide. After all, he knew that the Hospital was being shut down, and that the specialists were going to be moved to the second level. Hansen's disease was no longer a threat, and the Dermatology Hospital seemed an expense which the State found unnecessary.

When the clinic first opened, the Hospital had already been there for decades. It represented a major historic process of change towards the leprosy patients. It merged an exclusion period with a containment one: once Dr. Gonzalo Gonzalez managed to restore some form of citizenship to Hansen patients, the dynamics changed while the place remained. And when addiction patients started coming, the Hospital's staff felt they owned the place, and also, they felt threatened by those in addiction treatment. I arrived one day and found the girls sitting in the patio outside of occupational therapy. They were waiting to use the newly installed gym, but the door was locked. I sat with them while they waited for May. A doctor from the Dermatology Hospital walked by and stopped. "Why are you here?" The girls explained they were waiting for the gym door to be unlocked. "You can't use this gym; it is for physiotherapy patients! Who told you you could use it?" None of the girls were looking directly at her. She left, not before making us all feel uncomfortable. Ale said: "Oh, how I would love to stab that bitch." How did the hospital staff relate to them, how were they treated? Mostly ok, they explained. Except for this particular doctor. "She is always looking for something to reprimand us about."

I asked May about the issue. The gym came from the addiction clinic's budget, and its purpose was to aid in the rehabilitation of problematic drug use through exercise, more of a diversion for the patients, nothing forced (personal interview, December 9th, 2014). Yet, the staff from the Hospital were assuming the gym was 'theirs', and there had been a couple more incidents. Juan had to go and speak to the Hospital Director, budget from the addiction project in hand, to clarify things and to nicely request that people stop harassing the patients when

they only wanted to work out. But aside from this particular intervention, the problem wasn't limited to a circumstance or a misunderstanding.

On the day of the outing to the El Tingo pools, I was chatting with the clinic's driver. He had been working at the Dermatology Hospital for a while and, since the addiction clinic had a bus donated to them by the Psychiatric Hospital, his duties were extended to driving it whenever necessary. Since he worked for both spaces, I asked him how he perceived the relationship between the Hospital's staff and the clinic (personal interview, July 21st, 2015):

Oh, they're scared of them. Not me, no, I come from the valley. You come from the valley as well, don't you? There are a lot of addicts in the valley, and a lot of clinics. So they don't scare me, I'm used to them. I never did drugs, but I had friends who did. So it doesn't bother me. But the people from the hospital, they don't understand, and they fear them. You can tell.

He was right. The valley had been known for hosting many clinics, including clandestine ones. The youngest brother from one of my closest friends, JP, had been through many. His mother found a joint among his things when he was 16 years old. And from then on, JP was forced into many clinics. He was 27 when we spoke about it. He was working, he got married, and he was expecting a baby (personal interview, July 21st, 2015):

In all of the centers from the Valley they get tortured, this is where the most clinics are concentrated. And I tell you this as an addict, the addict does not recover, unfortunately it's an incurable disease. I found out, if this, taking you by force, was legal, I spoke to a lady and she said it isn't, she said I could sue them. My wife tells me all the time, why don't you sue them? I have horrible dreams, that I escape, that I run away, it's an anxiety, an anguish that I have all the time, I have shook many things off me but this anguish I just can't. Being old I have that anguish and the memories. I felt so bad for the young kids, how much they cried, how they suffered, they ended up getting raped by other interns.

Whatever was in JP's mother when she decided to lock him up at a clinic, it was a persistent representation, visible in the employees from the Hospital, and even some employees from the addiction clinic. Juan explained that he had to let the first social worker go, when he heard her say that she disagreed with the addicts getting all this, when they didn't deserve it. For him, social workers needed a little more empathy in order to be able to perform well within a therapeutic community. But her beliefs surrounding addiction were more than generalized.

Representations of a moral problem, rather than a health one, were dominant still, as the doctor reprimanding the girls showed.

Administratively speaking, the relationship with the Hospital was not so bad, from the perspective of the occupational therapist: having a status of its own, the Dermatology Hospital was able to help the addiction clinic with some of its purchases. May felt this was a form of support. But in general, having the therapeutic community right there had generated conflicts: the men in treatment lived in the premises, and they moved around from one activity to the next. In those moments they acted like teenagers, joking around, or speaking loudly. May described the discomfort this produced with the Hospital's staff (personal interview, July 21st, 2015):

They are here, enclosed, so, when they go out, they joke around, just like any group of boys, no, because most of them are young, that bothers the rest of the hospital, there is always some criticism, like, how they walk, how they yell, what they look like, I mean, they [the Hospital's staff] have the conception of a hospital, a hospital is silent, quiet, and for us, it's a little complicated to be like that, and precisely with what happened to me today, if yeah, the women are there at the gym, I never saw them more controlled than at that moment. But for them, the perception that they have is that the women are yelling, they are doing this, they are doing that, it's the lack of practice, perhaps, to be in a hospital and also have a community, like it doesn't add up for them, it clashes a lot, and that's the problem we have, we try to keep our own spaces, because the shared use is very conflictive.

While for May the conflict related to the shared spaces, the fact that the clinic could not function on its own because of a lack of legal status placed it in a position of submission towards the Hospital from the beginning. The Psychiatric Hospital, located elsewhere, was supposed to be the administrative matrix for the therapeutic community, but that never really worked well. The distance only made it easy for the hospital to forget about the clinic. But at the same time, patients needed medication, supplies, food, and the management of their budget according to the plan. This is why, to "make things easier", the Dermatology Hospital ended up "helping" the clinic. In practice, what this meant was that the hospital director had too much power over a project which didn't belong to his hospital at all; it didn't even belong to the same direction. Mental health was a whole different thing, but the director just assumed he had the power to decide, which, he sort of did. Juan avoided conflict most of the time, but

every now and then he had to ask the Director of Mental Health to step in and set some boundaries, draw some lines. The hospital was eventually going to be dismantled, and it made no sense to fight with people who were going to leave soon anyways.

The main problem coming from the lack of status was that the public addiction clinic didn't even have a permit: "you need to be linked to someone, there has to be a document linking us to whichever institution, and they are still in that debate. We are no longer linked to the Dermatology Hospital, because it is in the middle of its closing process, we can already say it shut down."

Juan recalled the center's trajectory through status within the Health System. The addiction clinic began as a project with pre-established resources which included a budget and a spending schedule to manage costs. But after its creation, once the project consolidated, it required a change of status in order to guarantee its sustainability. Transition to current expenditure was necessary because it implied that the State had to always have a budget for the program. Up until mid-2016, the therapeutic community still had a project status, which meant it was an investment which could be cancelled at any time. In May, 2016, the staff was beginning to feel worried about their job situation, because there were no signs of the inclusion of the clinic in the National Budget and the contracts were a month away from ending; a major earthquake had hit the coastal regions, and resources were being channeled through emergency decrees to the affected areas. Juan explained (personal interview, May 7th, 2016):

Since nature didn't help us, with the destruction of the coast and all, then there is a complicated thing, because you need to guarantee that these resources are already set as regular expense forever, and so that money is not there, and they have lost three months, and we are already doing the procedure for the next six. The idea is to pass everyone to current expenditure.

Juan had been following the process with the Direction of Mental Health, and they kept telling him not to worry: "they say they are doing the bureaucratic process in the Ministry of Finance to change the status of the clinic, so that it passes to current expenditure, and the second legal thing this would generate is that the job positions would go to merit and opposition contests." Regulation, something needed to ensure the employees some form of

job stability, came with the direct threat of losing the jobs. Everyone felt concerned. The idea was that on June 30th, they would finally become a current expenditure. Juan had already been through this on the previous year (personal interview, May 7th, 2016):

I imagine what's going to happen is what always happens, I guess we will extend for three more months until this is settled, because the money is there in the Direction of Mental Health, but I'm telling you, this is more of a legal issue than a financial one, I mean, money, in Mental Health, as I understand, there is money until December. But what they want is to move that money back to the State and tell everyone, all right, thank you. There is no stress. What's the stress right now? That the same thing which has happened before, that is, that the payments come late, they're there at the Ministry of Finances, they're there, but they are missing the signature no. 254, but they're there, don't worry. When did they come out last time we were dealing with this?

Bureaucratic control was mostly exercised from the instability that these jobs, and the existence of the entire clinic, had to deal with. Six months, earlier, before the extension as project was granted, the coordinator was trying to have this dealt with. Similar projects in Health had already shifted to programs, with a status of current expenditure. But the addiction treatment center was taking its time. There had been changes in the Department of Mental Health; the director I had met when I began was long gone. I never met the second one. And by 2017, the position had been taken by a former advisor from the first one. The processes seemed to depend on someone doing the paperwork, fixing the mistakes, filing again, calling, asking... a follow-up which took so long that key positions kept on changing while the requirement hadn't been answered.

After a while, the District took over the administrative responsibility of the clinic. But the administration of the budget remained a problem, which actually aggravated with time, as May explained: "What happens here, there is no disinfectant, no toilet paper, and no napkins, there is nothing, and the District has returned 25,000 dollars". Juan, the coordinator, clarified: "It's 250,000 dollars." In the Ecuadorean system, if an institution doesn't execute the entire yearly budget, it loses the amount not spent, it has to be returned to the Ministry of Finances, and the next year's budget will have to limit to what it did execute, and no more. The loophole in which the addiction clinic was stuck, threatened its survival in basic aspects.

People began complaining, because the juice started coming out without sugar (personal interview, May 7th, 2016):

If it was orange juice, you drink it, right? But if it's a guava juice, it comes out distasteful. So, what happens, one of the ladies, somebody's mom, because we can't ask them for anything, but one of the moms, her son told her, and she thought about bringing some for her son, but then she thought she couldn't just bring sugar for him, and she decided to bring a cental of sugar.

Besides cleaning supplies and other things, the problem with being linked to the District was that, not being a health center but an administrative institution, it lacked the permit to purchase medication. And in the case of the addiction clinic, this was problematic. The law didn't allow for an office which didn't directly relate to public health care to purchase medication (Juan, personal interview, May 7th, 2016).

We have fixed this temporarily. The medication is ensured through the Zonal Administration, but just so you see that we have these kinds of problems. On the other side you have that, being a third level center, we should be linked to the zone, but that means you need to have a manager, a human resources person, I mean, be independent, and financially, that is not doable for now, and it won't be for a while.

Juan is a problem solver. He is constantly thinking of the program's components, the yoga lady, the relaxation times. He thought of the intensive outpatient segment, and he managed it for a while, until it became an element of addiction treatment, even when it was moved elsewhere. He maintained a political relationship with the Hospital's director, even when he had the surveillance equipment connected to his cell phone in order to watch what they were doing from the comfort of his own home. He now had to deal with the budget cuts and the problems this brought. He was thinking that disinfectant was something they couldn't do without. He was thinking he will tell the patients, if anyone can bring some, it will be welcomed. "Even if it's only a sachet, but we need to come out of this."

While the coordinator was trying to figure out how to solve some of the issues which came along with budget mismanagement, he was constantly insisting with Mental Health (personal interview, May 7th, 2016):

Sometimes, they just don't answer the phones or the emails, but on the day-to-day activities you learn, that we are out of something, or we have it but they are not authorizing the use, so I have to go and ask the storage keeper, hey, man, how are we doing. And then you learn, aha, this is the problem; we are out of something because they didn't buy it. And you know the thing is that the State is not buying for the clinic, it's buying the supplies for the District, and they have certain parameters, but I just can't wait for the process. Toilet paper, those things, from a while back. So on family visits we tell them to please bring a toilet paper roll, and now each one has their own paper, their own towel, and the things which the State is no longer providing for. And now Sandy, the secretary, out of her own initiative and risk, brought some trash bags for the patients because there are no more bags either.

When the Dermatology Hospital was dissolved, and its experts relocated to second level hospitals, the District office ended up taking control of the clinic. In 2013, the Ministry of Health reorganized the management of health services through the division of the territory into zones and districts, something that had been introduced by the Citizen Revolution from the National Development Plan, in charge of outlining the functioning of the institutions belonging to the Executive Branch (Ministerio de Salud 2013). The division aimed to a decentralization of resources and an equitable distribution throughout the country, and it was put in motion through a Ministerial Agreement in November, 2013. The District in charge of the Vicentina zone moved its offices to the former Dermatology Hospital in 2016, and took control of the administration issues of the clinic without a process of training. The first few months were chaotic. But eventually, things began to get organized. Still, something else needed to happen in order to grant the center the possibility of administering itself

Regardless of the minor setbacks that not having toilet paper or cleaning supplies represented, Juan felt things were improving (personal interview, may 7th, 2016):

I mean, we have made progress in the fact that the discussion regarding what level we are at, whether it is first level, second level of attention, that has been settled, a resolution came out that we are a third level, specialized center, and that has been settled. Now, where we belong, who we belong to, that hasn't been defined yet, because, it's expensive, right, and there are legal voids.

The staff contracts had been moved to the district. The people were getting paid through the District's pay roll, but money for their salaries still came from Mental Health's project

funding. Everyone was still under a project contract, something which created job insecurity. Times, the coordinator explained, are too long, and it remained as an unresolved issue. And on top of that, the aspects relating to who should be interned here and not elsewhere, had not yet been defined. “Someone from the Psychiatric Hospital comes here and says that they decided after a meeting that patients who are unfit to plead or unpunishable should come here, there is that debate, those things are still being organized.” The bureaucratic labyrinth kept trying to take the public addiction treatment center, a therapeutic community, into the repression realm, and the lack of clear definitions regarding its legal status only worked against the center as a project for addiction treatment, breaking the inertia of repressive policies. Juan continued (personal interview, May 7th, 2016):

Not here, come on, because those people are deprived of their freedom [the euphemism to refer to prisoners was *people deprived of their freedom*, as decreed by the Government of the Citizen Revolution], they need follow-ups and, theoretically, the main aspect for them would be the reason why they were declared unpunishable, but well, it seems it’s this eagerness to optimize resources, there are psychiatrists here, psychologists, physical space, but it’s not really like that, so, this juridical limbo has these things, someone from the technical secretary [the institution which replaced the CONSEP] comes and tells me they are looking for another space for us to be moved, but then people from the Direction of Mental Health comes and says that they [secretary] have no place regarding our space, ‘we have decided you are staying here’, and well, I don’t really know what to make of all this.

The assertions against the privatization of health services, with the rhetoric of emancipation through the creation of an omnipotent, omnipresent State, met the difficulties in defining who is in charge and what their duties are. Aside from finding a place where addiction wasn’t being treated like a criminal behavior, the public clinic, a place which allowed for therapeutic individual and group spaces as the main component of treatment, and based on the willingness of the patients, met the lack of toilet paper, sugar, and basic cleaning supplies. Beyond these practices, which seemed to be nobody’s fault, the struggle of employees amid job instability got together with the patients and their need to find meaning to their symptoms and behaviors, as well as to the therapeutic opportunity. And above all of these operational issues, there was the possibility of wanting to turn the clinic into a center for the criminally insane. Juan and the staff kept on resisting the outside pressure while they continued to work on the inside.

4.5. Procedural therapeutics

On top of the systemic glitch which inaugurated this clinic into submission from the start, everyone felt annoyed by the clinic and its patients. Fear moved most of the annoyance and justified these practices of discipline: the reprimands, the official memos to the Ministry, and complains were day-to-day occurrences. May deepened into her perception (personal interview, November 20th, 2014):

Besides, they [hospital staff] have a lot of resistance also, they have the idea that they [patients] are going to rob them, so, for example, sometimes the kids help me take some things from the storage room, we go there, and since they are strong and all, we go so they help me, but the guy in charge of the storage goes: stop there, have them stay right there, don't come further... those things are annoying, and I try to keep calm and all. I get along with them alright, except with the doctor [who yelled at the girls]; I can't talk to her because she becomes too altered.

For the occupational therapist, part of the work consisted in educating the staff, reassuring them that the patients were not prisoners, nor criminals, and that they were safe sharing the space with the rehabilitation clinic. Most people, she believed, had slowly changed their perceptions and relaxed towards the population living right next to their work place. At the same time, the staff at the therapeutic community had learned to control the space better. On the first days of functioning as a therapeutic community, someone stole the toilet tops, big and heavy ceramic pieces. Everyone felt surprised by the theft, but it generated certain changes. Whenever I wanted to go to the bathroom, I had to ask one of the therapists for their keys. The open spaces were slowly and subtly enclosing. The relocation of outpatient treatment also helped with the security feel around the clinic.

Juan believed that, even though there were certain aspects which still needed to be worked on, the system was slowly moving in a different direction than the dominant prohibitionist path. For one, there was an addiction treatment clinic which belonged to the National Health System, a right instead of a commodity. Private clinics had been fomented and reinforced by policy, he argued: “this thing about experiential therapists, it all came from a certification given by the CONSEP, they legitimated it, and they gave people a certification. I'm not saying they have all been bad, but there have been some excesses (personal interview, May

7th, 2016)”. Yet the shift towards health, from a security perspective, faced the inertia set by decades of war.

The implementation of referral procedures, apart from establishing previously non-existent mechanisms, was marked by the beliefs surrounding the addiction center and the disorder it treated. On a few occasions, this resulted in the arrival of patients which needed an emergency room but were brought to the clinic instead. Once, the police brought a man who was intoxicated with alcohol (Juan, personal interview, May 7th, 2016):

Imagine a doctor and a nurse at the first level health center, and they bring an intoxicated alcoholic with psychomotor agitation, and he’s knocking everything down, what do you do? You get scared at the least. Plus, there are other patients there, my bet is they all left, it must have been chaotic, and so they send him here, when the protocol clearly states he should have been taken to a hospital.

Indeed, the addiction center was not prepared to take care of these kinds of emergencies. It wasn’t its purpose, either. The medication, the equipment required to make sure that the patient’s life is well taken care of in such critical moments; the clinic had none of that. There were some reagents to test for drugs in the patients’ system, but with a disciplinary purpose, and there was some psychiatric medication for those needing it, and there was the basic stuff. But this was not an emergency hospital. Yet, members of the police, the staff at the first level health centers, judges, sometimes some politicians, kept sending random cases which needed to first be attended elsewhere. The National Health System had a protocol, as the Minister had highlighted during her visit. But the entire system failed to understand and apply it, not only the clinic.

When the clinic first changed from a contingency area to a therapeutic community, the functioning of referral protocols was confusing and ambiguous for everyone, not only the National Health System employees, but also for the public. People heard of this new center for addiction treatment and came. The team was trying to figure out how to give everyone a fair share of medical attention while complying with the bureaucratic procedures of referral, especially after the State opened new places for outpatient treatment, and female adolescent attention. But this was also a process which merged everyone’s singular choices; each staff

member was solving the issue from their own perspective. One of the team meetings addressed the issue (September 14th, 2015):

Occupational Therapist: “we can keep on evaluating the patients, and we send them directly to the health center, and they send them back to us, we should send them already evaluated, when he gets to a health center, they should understand when it is that the patient needs internment and then send him here, but they are doing it backwards.”

Social Worker 1: “Since this center was created first, and then the outpatient centers, we are doing it backwards.”

Social Worker 2: “No, but the thing is that what I am doing now is that the people who come requesting information, I ask them where they live and then I send them, either to the Guamaní outpatient center, or the Calderon one, or to Chimbacalle. And if they, over there, decide the patient needs an outpatient treatment, then they don’t need to come back here.”

Psychologist: “Oh, right.”

Occupational Therapist: “So that they don’t go through so much of the bureaucratic procedures, because this becomes a bureaucratic procedure.”

Psychologist: “In the entire world, the person would first be referred to a place where they could be assessed and then send them here; we are evaluating to send them back there.”

The fact that the State had opened many other places for addiction treatment, and in different provinces, had allowed for a lowering of the demand: there were centers in Guayaquil, and the people from coastal provinces had that option; there was also one place at the East of the country. The Quito clinic was no longer the only one. Before the creation of the new places, the public clinic in the capital had reached a waiting list of 70 people expecting a space for inpatient treatment. People had to wait for two or three months. Teen centers were also opened in Quito and Guayaquil, which allowed for the clinic to focus on its main, original purpose: the attention to adult male patients.

Male adolescents that had been accepted at the clinic due to the lack of a specialized center for underage patients would now go to the new adolescent center located in Guayaquil. The decision to create a center for teenagers in this city came as a response for an increasing concern over Heroin use in that city among high school students. And while the female ward opened as a contingency response for an increasing demand for addiction treatment in women, once the euphoria of the new public center passed, the demand diminished and this ward eventually closed. For Juan, however, this was problematic because adult women had no place to go to if they had problematic drug uses, and they did.

While everyone agreed that the referral process was not yet properly functioning, the team members still needed to define the steps they would take to make things easier for it to be applied. Should they evaluate at the clinic? Should they send the people to the previous stages elsewhere for the evaluation? What if the person did need internment but the other centers missed that? In general, medicine is an ambiguous practice, and while there are statistical manuals for the diagnostic of diseases and disorders, people tend to look for second opinions; there is always space for subjective judgments when diagnosing. Problematic drug use was no different, and it seemed that the staff at the public clinic feared that the rest of the Health workers lacked the knowledge to properly differentiate the symptoms and the type of treatment each person required. It made sense, considering the types of cases they were constantly receiving through referral. The conversation in the meeting continued:

Occupational Therapist: “I mean, there is an information problem in the rest of institutions because they don’t know there are outpatient centers, and they send everyone here.”

Social Worker 1: “Right, because the ones which are outpatient only are those in Calderon and Guamani.”

These changes, the introduction of new centers offering outpatient treatment alleviated the flow of patients coming to the public addiction treatment clinic, but referral was still being problematic, and the people were increasingly confused. Level 1 health centers were referring patients to the clinic when they should have been referred to the outpatient centers. People would come months later, stating that they were tired of not finding answers for their relative’s problem with substances. Could someone please help them? The established

procedures didn't always serve the people looking for attention. Instead, it was generating confusion and delay in the attention of related disorders.

The confusion had extended to the inside. Just like the entire system was rearranging referral and attention procedures, the clinic also kept working on their own processes, in order to improve their efficiency and efficacy. After all, their numbers were being checked by the Ministry. The following year, the process had been broken down into phases. The outlining of each phase took some time, and it was the occupational therapist who worked on the generation of a schedule structure for each patient to follow. Each one of the stages implied a different space, and by this time the clinic had already extended to the renewed buildings.

Spaces had been reorganized with time; the hacienda-like space where the male wing was located at the beginning became the third phase area. Those who were closer to leave the treatment process were moved there, because "they self-regulate, you go and control, they have their therapies and stuff but physically they have more freedom, less control" (Juan, personal interview, May 6th, 2016). The offices had moved to the back buildings, and the rooms for first and second phase were placed near them. The old male wing was closer to the main entrance, and there were no offices located in that area anymore. The logic came from experience: "people are going to leave you on the first two weeks, so we concentrate the majority of the staff here."

While at the beginning everyone did every activity together, the division in phases separated newcomers from those already in for longer. This allowed a differentiation in the focus of each person's process, instead of having to go back to the beginning every time someone new came (Juan, personal interview, May 7th, 2016):

Before, patients had a lot of confusion, they were all going to the same therapy, and they said, many times, this was boring, even in occupational therapy they were doing the same activities and they kept saying they were tired already. Now, they work on different topics which help them see towards the outside, so these are activities which, on top of motivating them, are preparing them.

I wondered how effective this was. Studies had found that those in addiction treatment had the same recovery results compared to those who didn't undergo any therapeutic approach

whatsoever (Vaillant 2005). In fact, brain studies suggested that psychological approaches were not effective because the problem linked to the pleasure centers activated in consumption was not located in the cerebral cortex, but in the primitive, reptile part of the brain⁴⁹. Yet, addiction treatment was a cultural element, something which would be offered whether the State supplies it or not. Something the families needed. Perhaps, a way for patients to take some of the guilt from their actions, their choices. In Alcoholics Anonymous, the belief in a higher power served the purpose of addressing guilt, an emotion otherwise responsible for relapses: alcohol, aside from being a mediocre antidepressant, works as a guilt solvent. The therapeutic process seemed a form of redemption: there was a process being established; the need to go through a procedural set of actions in order to advance in phases. A vowal stood behind techniques; actions were constantly being outlined and organized.

Juan explained the mechanism (personal interview, May 7th, 2016):

We upgrade phases to someone, but we do it based on a mechanism: they present a letter, there is a grading thing, there should be a grade as well, I mean this person, great if someone tells them, you deserve to get upgraded, because there are kids that really camouflage themselves and the house says: hey, but you didn't participate in the activities, or you are late, those are people who don't give the staff any trouble but they are poorly perceived at the house because they hide.

The decision, then, was going to be placed upon the patients regarding the other patients. The judgment, inside the clinic, is no longer shared among the experts; the team is not the only one looking at the patients. The bureaucratic process in which the therapeutic community was converting made the patients a part of the decisions regarding each one's process. Juan continued: "It's just that it's valid, that someone tells them directly, no, you can't come up, if the opinion is that, then no, that's it. Because you do get the sensation of having some people who the kids say shouldn't be here or shouldn't leave yet (personal interview, May 7th, 2016)". The decision came from the idea of reinforcing, directly from the peers, the behaviors that everyone considered desirable. "If you have done this or that, you deserve to shift to second phase. But if everyone tells you no, then that is giving us an idea of how, in their day-to-day life, things are not right."

⁴⁹ Carl Hart questions the theory of the disease of the will, after conducting an experiment with crack and meth addicts. He finds that, given the right options (such as five dollars or a hit), people can make rational choices different than the mere consumption (Hart, 2013).

A person who wants to escalate in the therapeutic ladder, must present a request for passing onto the next level, and it would be reviewed not only by the treating psychologist, but by the multidisciplinary team, and ultimately, by the other patients. If the decision is negative, then the person must reapply in two weeks or in a month. The process felt like a way of placing the responsibility of therapeutic failure in the patient, a failure which assumed that addiction treatment was, indeed, a moral issue. Are they making the effort? Are they admitting their fault? Are they cooperating in the process of psycho-education and occupational training? Are they being nice to their fellow patients? Compliance became an indicator of improvement, even if it wasn't a known predictor of relapse or maintenance of abstinence. The therapeutic process was increasingly disciplinary, regardless of the obvious contrasts the public clinic had with the private traditional forms of addressing addiction.

There were other aspects which the staff changed after some debate. One of them was the issue of family visits. At the beginning, the families could drop by at any day, and weekends were visit days. This was something Paul's parents liked, because they could just come over and bring him his soccer shoes for the tournament; the patients, through one of them who worked at a public hospital, had managed to sign up for one which included hospital staff teams from different health centers, and Paul was participating. His parents noticed the difference with private clinics, in which they could not see their son for months at a time. On Saturday and Sunday, there was someone from the team on duty, but there were no structured therapeutic activities. Any meeting with the staff addressed administrative issues: if there was any paperwork, or something the patient needed the family to bring. The process wasn't including the families as the team felt it should. The clinic switched to a controlled family visit model, giving one day a week for the family members of each psychologist's patients.

Juan explained the decision: "we realized that what the families really need is a space where they could be listened to, and, well, the families always have had family therapy, this has been strengthened with the possibility for psychologists to have more time to focus on family therapy." The clinic set the limit to 50 patients' total. The plans of expanding the service to 90, as the Dermatology Hospital's director had presented to the CONSEP in 2014, could not be reached because of budget issues, and the team settled and organized with 50. This meant that each of the five psychologists were in charge of ten patients and their families, aside from the people in follow-up processes. The psychologist was the same during the three phases. Family visits were now limited and organized in a specific day a week, and each family

member had a color card which differentiated them from the other psychologists' patients and families. Free family circulation was no longer permitted in the premises.

Another thing that changed was the inclusion of self-help groups: Alcoholics Anonymous (AA) and family groups of alcoholics (AL ANON) were now meeting inside the clinic. Juan explained this addition: "it sounds ugly, but families are forced to attend the self-help groups, the ladies come here. I think one of the most redeemable aspects of the self-help groups from Alcoholics Anonymous is AL ANON, because they work a lot in differentiating the person from the problem, that is, you have a problem, but you are also a person in need of support; I believe they do well there."

Alcoholics Anonymous are founded in the idea of voluntariness. The entire process depends on the will to stop drinking. Narcotics Anonymous has taken the model and applied it to other substances. But private clinics, and now the public clinic, used it as a mandatory aspect of therapy, as if will was something which could be forced into people. Of course, there were noticeable differences in the way private clinics applied the twelve steps, in comparison with the public center. Meetings didn't last the entire day; usually, they occurred once a week and they kept the format usually applied on the outside world groups. Once in third phase, or after finishing the program, the patient was required to choose a group of their fancy and joining as part of the follow-up process, because daily occupations sometimes interfered with the continuity of their processes here at the clinic.

I only attended one meeting of Alcoholics Anonymous in my life. I was doing my master's degree in Forensic Psychology in Washington D.C., and the attendance of a meeting was an assignment for the Substance Abuse Counseling class. I found a group near my apartment, and I went to the meeting. I think this is one of the strangest experiences in my life. I felt I was invading; only now, more than ten years later, I can understand a little more of the importance of the will to participate. I suppose that people with alcohol abuse or dependence, who are forced to attend these meetings, feel as inadequate as I did. I was working as a bartender in order to pay for the masters, which now seems kind of funny.

Even though a decade has gone by, I remember the meeting, the feeling. I had trouble concentrating in people's stories; everyone knew each other, as it was a rather small group, and there were constant indirect allusions for newcomers to go ahead and participate, you

know, don't be afraid, tell us your story. I couldn't wait for it to be over. I forgot about it until now. At that time, and for the class, I had read the black book, and I remember the professor saying that up until then, Alcoholics Anonymous was the most effective form of treatment for alcoholism. People stopped drinking, and they maintained sobriety through their involvement in these groups. What stuck the most in my understanding of the AA model was the need for voluntary adherence. AA could not be forced. The entire thing depended on the person's own desire to take control back. Yet, in Ecuador, the model only served the purpose of pretending; private clinics practically lacked voluntary participants. Most of them were forced into treatment. Most of them could not wait to get out. According to the Geoplades Study, at least 20% of patients had escaped a private clinic at some point (Geoplades 2012).

4.6. Team issues

The process of creating and improving a public addiction treatment center involved many aspects: it responded to a complexity that went beyond the patient's compliance. The clinic had to comply with the State's procedures, by applying the National Health System's manual for attention, and while trying to figure out the ways to deal with the lack of normative stability. At the same time, it was a therapeutic community which offered to treat problematic drug use, and the people came expecting some results, even if these were minor. There were patients and families coming from all over the country in search for answers to their difficulties with substances.

The clinic had to deal with the community and the hospital, which eventually shut down and was replaced by the district's offices. It had to coexist with the remaining Hansen patients as well. But also, the first public addiction treatment center had to work with a multidisciplinary team, trying to merge different perspectives into a model which had to have some form of efficacy while satisfying everyone. Sometimes, this complexity generated conflicts which needed to be addressed within the team.

The decision of dividing the therapeutic process into phases responded to many of the arista involved. The main issue was to avoid senseless repetition of the therapeutic content, and to make the process clearer for newcomers. When the group was still being treated as one, the newcomers were lost and confused, while those who were in the process for a while got bored with all of the repetitions and explanations of the thing they felt they already knew. The

model outlined the division in phases, but the clinic had to implement the spaces first. Once that was set, the process moved to the phases model, also created by the team. Once outlined, and before implementation, the model was revised by the Ministry, which approved and published it. May explained (personal interview, May 6th, 2016):

We made it, but when the time came, they only placed their names, and not ours. They sent Mercedes there once, because they required her help and they told her, ‘you have already done an emergency psychology brochure’, and they made the brochure and all, and they send it here for us to give to the people, and there were all of their names except for Mercedes’ name, hers wasn’t, and she was the one who made it.

Recognition of one’s work was an issue, present in regards to other institutions, and sometimes, within the team. After all, the staff members were also humans, immerse in the same conflicts as their patients, the same representations, the same modes of functioning, the same thought processes. Recognition may interfere as an unconscious aspect, but it did appear amid conflict. In regards to the new spaces which the State had opened for addiction treatment, the staff from the clinic began to notice they were not yet effective in the services they were offering. This meant that, even when the norm stated that patients should first undergo outpatient treatment, some of them had to be interned because they would not stay in their outpatient processes. May explained (personal interview, May 6th, 2016):

We need to be realistic. The people who need residential treatment go for a day and then they disappear, because they need inpatient treatment, so, it’s not real, but they had put that in the brochure, that the first thing needed was the outpatient treatment, in order to access inpatient treatment, which is absurd, because if you are already in outpatient and you are doing ok, what’s the point of going to inpatient? So it’s illogical, this part, but that’s the norm, you must send them to outpatient first, but there have been some cases that, if they seem too complicated, then they are admitted.

Mental health and health in general, is not something which can be decreed. Many cases respond to complex circumstances, and some present acute symptoms which require more than an ambulatory process. Albert, for example, had the risk of becoming homeless on top of his addiction. Paul had already been in the streets before arriving. Intoxication could occur in some cases. Internment had to respond to the individual cases, but there was a norm. The staff used discretion. They made the choices they believed served the patients, even when this

meant skipping some of the steps or failing to comply with the manual. The first phase was useful for the generation of a personal demand for treatment, even in cases where that was not clearly defined when the person arrived. The process of upgrading into other phases, with the letter of request and the evaluation by the staff and fellow patients, served the purpose of strengthening the patient's own compromise with the therapeutic process. The team had developed a sheet of parameters for phase change, following the objectives for each one.

The checklist for phase upgrade included aspects such as recognition of the general norms and principles, rules and codes of conduct. These were analyzed with everyone involved: operators, social workers, psychology, psychiatry, medicine, and all, to see how they each saw the patient. Did he adapt to schedules and community activities? Yes, no? Is his participation positive and motivated? Is he respectful of his fellow patients? To the staff? While it was an attempt to give objective parameters for progress monitoring, the entire process was subjective and it mixed personal opinions with the idea of therapeutic merit. Conflict was inevitable.

The division into phases was also designed to deal with the conflict perceived in regards to differences in treatment, perceived preferences to one or another patient. The team would constantly hear from patients: "Why is he leaving?" "Why do you help him and not me?" Phases narrowed down the options for the patients. It made it harder for random preferential treatment. It helped maintain a sense of fairness. The main focus for the first phase, then, was the adherence to the program; during second phase the patients focused on skills; and in the third phase they could start going out to the real world looking for work and all. But this didn't prevent for some team members to feel that some colleagues had preferences. Eve, the social worker, explained: "I see this difference, with some patients yes, and some others no. For example, if there has been any form of drug use, some are allowed to stay. And this is very serious, I see this and I, oh my god, and I mean, it depends on the psychologist you have (Personal interview, May 6th, 2016)."

These differences, or the power to decide a patient's fate beyond the norms, generated the need to control for arbitrariness. Phases worked as a control mechanism not only for patients, but also for staff members. Otherwise, some members of the team felt the process lost credibility, an aspect of therapeutic relevance, as Roberto, the social worker, mentioned: "You have to deal with the group [of patients], I mean, if they find out, it's a complicated risk."

Evidently, if a person broke the main rule, the rule of abstinence, and didn't have consequences while other people did, this threatened the disciplinary aspects of the process.

Being in a multidisciplinary team implied an approach to each case from different perspectives, which had to negotiate their points of view regarding patients. Sometimes, however, the team members would address issues without fully disclosing information. One day, in a meeting, a psychologist referred to a behavior displayed by one of the social workers, but without fully addressing it. They felt annoyed, as Roberto explained: "well, there is also this fear of saying anything, I mean, for example, sometimes I hear them say, 'well I have my motives, but I can't say anything because of confidentiality. I mean, like they were dealing with the cleaning staff. But we are a multidisciplinary team. So that also kills me.'" If definition of addiction proved to be a difficult thing to agree upon, team work was no different, and it also presented challenges. "There is a difference between confidentiality and team work, there are certainly some things which you don't need to disclose, but not everything, and if this is what you're going to say, better remain silent."

Team members felt a lack of trust among them. They also felt undervalued, especially when they weren't psychologists. Comments like these increased the sensation of breakage inside the group, an illusion falling, the loosening of cohesion. Eve said (personal interview, May 6th, 2016):

They make you undisposed, obviously, like when a psychologist said 'I can't tell you any of this but this is very serious', I mean, so much hermetism, but in the end it's like they do tell us, to show they know something we don't. So, we turn to joking about it and I have said, 'Is it me?', because you don't know who they are talking about, maybe the kids [patients] are even lying, but you can't even defend yourself.

Conflict inside the team showed a difference in the share of power each of them had, which apparently related to the knowledge field they belonged to. Psychology had been positioned as the main discipline: they were the ones who spent the most time with the patients. It seemed they had a knowledge (regarding theory, and also regarding each patient) which the other staff members lacked. It also seemed to hold some form of privilege: they could call the shots, lead the decisions, and address the coordinator if they felt someone was opposing them. Or at least this is what the rest of the team seemed to interpret.

Since the clinic offered a therapeutic approach to the suffering (from addiction and anything which came along), I wondered if there were any self-care practices outlined for the protection of team members. Having worked in contexts of trauma and crisis intervention (I was the National Program Director of an NGO which gave psychological assistance to Colombian refugees; I had trained people working at the Commissioner's Office for Women and Families which attended cases of family violence; I taught Crisis Intervention at the Catholic University, and so on), I was familiar with the concepts of Compassion Fatigue and Burnout, which referred to the risks of secondary stress that psychologists and people working in care had, especially in contexts of trauma and suffering.

Studies had found that self-care strategies could lower the possibility of developing secondary stress (Burnett & Wahl 2015), and I asked the coordinator what strategies, if any, the team was using to protect from compassion fatigue and burnout in a context of trauma, suffering and frustration. He replied that they had been to one of the team member's house for a Karaoke night, and that they got drunk. Other than that, they hadn't really defined any strategies of self-care. For May, the problem was that the *compañeros* (team mates) didn't like to socialize, and most didn't attend when they set dates for social gatherings. It was funny, and I laughed – with them – at the thought of alcohol use as the only resource they could think of for self-care strategies.

Departing from Annemarie Mol's (2008) ethnography of family medicine, the public addiction treatment center was a proposal allegedly based on evidence, an application of a logic of care, versus a previously dominant market of private clinics, which could be thought of as within a logic of choice. Yet a closer look showed something different. The 'logic of choice' model in private addiction treatment clinics couldn't care less about their patients' choices; the service was not something they offered for their patients, but instead, for desperate families not knowing what to do in the face of drug use. It had nothing to do with patient preference. Perhaps it was because Mol was talking about health services, and private clinics were in a different order. But, after the inclusion of addiction as a health problem, and the taking over of the Ministry of Health, the provision of addiction treatment by the State would fall under the 'logic of care', which Mol described as not concerned with the will, but instead, with what the patient did. Yet, from the very start, addiction treatment in the public sector revolved around the will. It could not be offered to someone who didn't want it. At the same time, Mol described the logic of care as a matter of various hands working together

toward a result; the constitution of a multidisciplinary team seemed to fall under this logic. However, power disputes within the team showed something other than a sole interest in the result. Again, perhaps it was because addiction treatment hasn't yet clicked as a health service, but it remained in the disciplinary realm.

Recognition appeared as an issue not only within the team, but also in regards to the redistribution of different modes of attention. The model finally approved by the Ministry of Health placed follow-ups in other institutions, but this was causing discomfort inside the team. Why would others finish the work which the clinic had begun? May explained that psychologists were objecting to this (personal interview, May 6th, 2016):

They don't want to send them; 'I'm not going to trust my work to the first level health centers.' For example, there is a guy who's already had one year of internment, Santi, and he is already tired of coming. He was interned for five months, and he has been coming to follow-up for seven months, but the problem is that follow-up is not only a group process, it's also individual. But imagine, if they already have their patients, with more, they won't be able to manage.

May was proposing a limit of three months for follow-up, a differentiation between personal psychoanalysis and an element of the therapeutic community's process. Bureaucratic discipline was a way of addressing conflicts inside the team, and also a mechanism of control for the staff. The creation of more and more regulations for the therapeutic process responded to the need of controlling the differences and the power circulation between staff members.

The failure to integrate different perspectives through the multidisciplinary team can be seen in power conflicts that occur on the inside, as hierarchies are formed and struggles arise. Rational, evidence-based argument is replaced by statements such as "*it is my patient*", or even the clear instruction to "*stay away from my cases*" (Field notes, 10/05/2015).

Disturbances inside the team are increasing, while its members try to explain them from lack of experience, frustration over therapeutic failure, lack of self-care tools, lack of clinical analysis of the cases, and the road towards the punitive. Also, bureaucratic obligations blur the line between the work with the patient and working for the Ministry, further complicating

the roles of the staff. All of this occurs while the issue of job stability remains only temporarily fixed, with the remaining possibility of the program being cancelled.

The rules inside the clinic were believed to be necessary in order to help the patient assume the need for treatment, the staff explained (Director, personal interview, August 18th, 2015). The demand for treatment, they believed, can sometimes become a self-deception mechanism, as people left the clinic voluntarily but continued to come for physiotherapy and medication. For the staff, this implied the need to generate a mechanism that would regulate the procedures of abandonment and returning to treatment.

The stages that were being proposed in order to achieve this were divided in three: the initial stage of major contention; a second phase of controlled visits to family; and a third stage of reinsertion. This change to stages took some time to implement as many details had to be addressed. The idea, as described by the occupational therapist, was to determine a clear path for treatment that narrowed the possibility of fooling the system by leaving and returning at will (Personal Interview, October 5th, 2015).

The coordinator had to deal with two more hospital directors before the Hospital finally shut down. And the people from the district seemed a lot easier to handle.

Every year the story repeated itself, and the lack of stability caused unrest among employees. Some of them applied to other, more secure jobs within the state: two of the initial psychologists left. Employees talked about this in the halls (Casual conversation, June 30th, 2016). “My friend was telling me to apply to the Sangolquí Hospital. That’s where Al applied.” I asked if he would stop working here if he was chosen. “Yeah. But from having nothing, to having a job appointment, anyone.” Someone else intervened: “Our contract lasts until the 30th. And no one is telling us a single word about this.” The secretary added: “I called today, and they told me that the final report has been sent, but that the last sheet was missing, it didn’t get scanned. So we need to repeat the bureaucratic procedure.”

Some, like the psychiatrist, migrated to the United States. And the rest waited. In 2016 the clinic’s status got sorted out, sort of, by becoming a part of the District’s budget. The District had moved its offices to the premises, while the Dermatology Hospital was shut down, and a first level Health Center was relocated there. Being a part of the District was only a temporary

solution, which at least guaranteed everyone's salaries for a little longer. But for whatever reason, the clinic kept being denied a status on its own right within the National Health System.

In any case, some of the previously offered services, which responded to an increasing demand, had been reassigned to other clinics. Those in intensive outpatient treatment no longer came to the clinic, and this lowered the volume of the neighborhood protests against it; instead, a psychiatric center in Calderon was in charge for those patients who did not require internment, or who needed to work on generating a demand. Also, the cases with dual pathology (comorbidity), such as Carlitos, were thought to be better cared for at the Julio Endara Psychiatric Hospital, as the issue of alcohol use could have been a secondary symptom. The women had been sent to a place located near the "Middle of the World", a known spot identified by a geodesic commission back in 1736 which came to determine if the world was round⁵⁰, but that didn't last long and it left the coordinator a sensation of debt towards them. At their wing, the door was now always open; the meeting room had been turned into a classroom, and the bedrooms had been cleared up, except for three which hosted the hospital beds and the mattresses, piled up, stored, almost looking like the new version of the old debris rooms in the abandoned buildings.

In 2016, Minister Vance resigned and a new Minister took over. The clinic had been informed of her desire to come and visit the clinic, in order to understand its functioning. Juan felt it was more of a lobbying thing, an interest from the Direction of Mental Health to make the Minister visit the clinic. In any case, a date hadn't been set yet, but Juan already knew what would happen. History repeating itself; nothing to worry about. He was curious to learn what her new orientations were in regards to addiction: "Because of the earthquake, we don't know if there is a new policy coming with the new Minister. There isn't a clear policy change, they are in elections, and finally drugs are only news when someone dies, that's when you have an answer from the authorities and you can see what the position is."

Public addiction treatment is influenced by different forces. These include the authorities representing the State and the dominant political perspectives, as well as the individuals for

⁵⁰ The first geodesic mission arrived in 1736, and it included the french Peter Bouger, Louis Godin and Charles la Condamine, the spanish Jorge Juan, and Antonio de Ulloa, and the Eucadorean Pedro Vicente Maldonado. After nine years of working on it, the land began to be known as land of the Ecuator, in reference to the paralell dividing the planet in two hemispheres (Espinosa, 2012).

which the treatment is designed and their families. Also, the way the multidisciplinary team is conformed and organized poses another element of influence in the way therapeutic approaches unfold.

The governmental authorities see themselves and are seen as deities or religious figures from the get-go. I had experienced this up-close and personal when the Cotopaxi Volcano reactivated and those of us living in the lahar risk areas were demanding risk management. Whenever we had the chance of speaking with an “authority”, people automatically showed a reverence which I found annoying. We needed sirens and signs showing the way out, yet my fellow potential victims were concerned about the respect I was willing to show authorities. In the Ecuadorian context, a visit from the Minister of Health becomes a display of reverence as well as of power, hers and her staff’s. It is also an opportunity to measure power balances (or imbalances) within the clinic and its neighbors, and to display any differences found. The visit, however, meets a series of patients and families who desperately seek humane attention and, mostly, some form of answers to their prayers. While relief is not always the result, the possibility of being treated nicely makes a difference which the people appreciate.

The therapeutic approaches end up favoring bureaucratic procedures, and the clinic struggles between attending someone they feel is in need of attention beyond the steps outlined by the policies and manuals. This is done amid pressure from a Ministry which controls the possible excesses favoring a small portion of the population, regardless of the abuses and exclusions which they have suffered in the hands of private clinics. At the same time, objectivity is lost amid personal needs for recognition among team members.

The public clinic, functioning since 2013, remains in a legal loophole, affecting its budget, its supplies, and the job stability of the team. While some staff members have left, most remain working for the center and hoping they will still have a job the following year.

The implementation of phases and the division of activities in relation to the progress each patient is making shows a disciplinary approach which places the weight of the guilt in punishing over the patients themselves, while it sets moral values as indicators of therapeutic progress. Failure or success, then, becomes dependent on compliance and obedience. At the same time, procedural therapeutics function as a form of limiting discretion and arbitrariness

among the multidisciplinary team members, thus controlling the differences in power relations present within the staff.

While the addiction treatment center was created as a response to the long neoliberal night's abuses, and with the aim of generating a contrast towards a repressive approach which treated addicts as criminals, inertia operates inside the public clinic, slowly moving an increase of control and a moral approach to the substance abuse or dependence disorders.

Regardless of the constitutional mandate to make addiction a public health problem, as well as to offer medical treatment for it, beyond the decree the therapeutics of problematic drug use have not entered a logic of care yet. They remain in a different place than what could be thought of as the medical, leaning still more towards the disciplinary.

Chapter 5

The individual user

Introduction

More than a clearly defined medical category, addiction is some sort of escape goat for anything related to mental health. Granted, psychiatric disorders, especially psychotic ones, are known to generate anxiety in the families, as I was taught when studying psychology, and I could see in the cases of psychosis I saw through my practice.

After years of family diagnostics, addiction had become the easiest explanation for anything deviant, anything abnormal. María's case is an example of the way in which families gave in to the compulsion of diagnosing addiction. This is what had made the market of private rehabilitation clinics so profitable. This last chapter looks at the construction of the addict as a subjectivity influenced by the others – from family members to therapists and fellow patients inside a public addiction treatment center.

People inside the clinic struggle to define who they are against what others have to say about them. Their own voices have to find the right equalization amidst the volumes and tones of the others' voices also aiming to describe them.

Albert is one of those voices looking for a place, a channel in the recording of his own life: he is looking for a place to live, a place to work, a place within society which he is not yet able to find. He is locked in a therapeutic loop: after being interned in the public center for three different occasions, Albert was sent to a public center in a different city, mainly because the public center in Quito was no longer allowed to receive him a fourth time. Per request of the coordinator, the new center lets Albert skip treatment components. They just let him be, they spare him the dramaturgy required of the other patients.

Addiction patients are generally depicted as lying and manipulative, but this description doesn't always come from the outside. They, too, see themselves as deceiving, especially when consumption depends on their ability to feign. Manipulation, however, is not a matter of addicts alone, but of an entire system susceptible of it at different levels.

Pasteurization of addiction is a form of toning down the disciplinary aspects of addiction treatment, while they remain as the core of therapeutic interventions. Addiction is not affected in its molecular structure, just like foods and beverages remain the same after being pasteurized. The result is a specialization in dramaturgy, for both the patients and the staff, especially when they are being judged by higher authorities.

5.1. Addiction on the outside

The management of substance-related disorders and of mental disorders in general, is not a problem which is limited to protocols or bureaucratic procedures. There is much more than just a Decree, a Ministerial Agreement or even a Norm, as Maria's case shows. At 39, she presented a psychotic outbreak characterized by paranoid ideations surrounding her mother's identity. Maria had been kidnapped a couple of years before any of this happened, and when she spoke of her beliefs regarding her mother's conspiracy, she explained that it all began when she was in the hospital recovering from that. She believed she had been given medications to blur her thoughts and to manipulate her into giving her mother the house they both lived in, which had belonged to her father.

Maria's condition slowly worsened: she started noticing that her computer couldn't connect, or that there was something anomalous about the wireless signal affecting only her equipment. Her boyfriend, she explained, got scared when she started talking about all of this, and they broke up after many years of relationship. According to her son, the separation from her boyfriend triggered Maria's entrance into an acute phase of her delirious disorder. She began building walls around the house, she started confronting her mother more and more every time, and she began to go through every single piece of paper from her parents, her childhood, any old documents, everything she could possibly locate or uncover. Maria's father had died when she was a teenager; she started to believe he had been murdered. Her paranoid delirium also made her increasingly violent, and she attacked her mother a couple of times, until she decided to leave the house and her daughter. Maria's son, scared of her violent behavior, also left her and moved in with his dad.

Maria was alone. Her mother was unemployed, just like Maria was, and she was staying a few days with one of her relatives, only to move to someone else's home after a while. She could no longer afford to pay the bills at the house, and Maria soon found herself without water service. She began losing weight for lack of food, and she began to receive help from street

people: car watchers, the guards, anyone willing to give her a little something. Her teeth deteriorated: her mother explained she had trouble with her saliva's ph. balance, and this, in tandem with malnourishment, was affecting her dentition. She didn't shower. Maria seemed to be left to die when I received a phone call from her. She had been a friend of my brother's when they were teenagers, and I knew her somewhat. She told me her family had been conspiring against her, that her mother wasn't her real mother, and that she needed to speak with a lawyer. I called a friend who is a lawyer, and I asked him to see her as a personal favor. It all seemed odd, but as a forensic psychologist, I am trained to doubt my first impressions.

After my friend saw her, we spoke. There were no indications of foul play. No evidence of identity theft. Nothing. He looked at all of the documents she had. She had nothing. It was, he claimed, all in her head. I hadn't seen her in years, and I didn't really know her family. But we shared a friend in common, and I contacted him to mention that she seemed to need assistance. In response, he told me of the rumors she was into crack cocaine, and that she had borrowed money from him but never paid him back. Still, he decided to go check in on her. When he saw Maria, he tried to convince her to go with him to a Psychiatric Hospital. She almost agreed. But when they were on their way, she changed her mind. When he left her, he called me. Her teeth were black, he said. She probably weighed 90 lbs. He was certain this all was due to addiction. "It is exactly like *Requiem for a dream*⁵¹. That's exactly what's happening." I hadn't seen her, but the most obvious symptoms pointed to a psychotic outbreak. If anything, this was the acute disorder at the moment. Neither her mother nor her son knew of any drug use. If she was going to get any kind of help, it needed to begin there; even at the public addiction treatment center, it was clear that a patient with a dual pathology, presenting a psychotic outbreak, would need to be treated from that first. But our friend decided it's addiction. He called her mother, told her that her daughter is a drug addict and recommended an internment in an addiction clinic. He knew of one in the Rain Forest, far away from the city. Perhaps she could go there. He even offered to pay for it.

Addiction, or drug use, is easily taken as the scapegoat for any other thing that can trigger anxiety or anguish among friends and relatives. Psychotic disorders are very difficult to understand, and everyone, from her son to our friend, believed she needed to be told that her delirium is a delirium. Even when none of them ever read Leuret's moral treatment of

⁵¹ Aronofsky, Darren, Director. 2000, Movie.

insanity. It was all in the representations: not only the idea of addiction itself, but the approach to any mental disorder was usually charged with a moral blame, and since she refused to comply with the acceptance of her delirium, then the easiest thing to do was to intern her in an addiction clinic. I strongly disagreed; I gave the mother the contacts of four well-known psychiatrists, and suggested she speak directly to any of them. What she needed was understanding and guidance. But even she was much more comfortable with the addiction idea, even when she knew her daughter's teeth were damaged from a previous disease. Granted, her daughter's mental illness had changed her life; it affected everyone around her. But addiction worked as a form of reduction of the phenomenon in such a way that it put Maria at risk of being sent to a place that would definitely harm her, considering her state of mind.

This escalated into a kind of family madness in a matter of days. Maria got a voice message that her aunt had sent to her cousins, because one of them had forwarded it to her, explaining that Maria is a drug addict and that her paranoia is due to that. Maria now knew her family was conspiring against her to intern her in some hospital where, she believed, she would be disappeared. The family was contributing to the worsening of her condition, with an increase of the risk of an acting out⁵². I explained to her mother that it is a specialist, not a member of her family, who needs to say whatever needs to be said about her. A biased friend or a resentful aunt could never provide a full or even a minimally insightful diagnosis. She needed assistance, but it seemed more and more difficult as time passed. Meanwhile, she was surviving on the food her friends were able to give her, every now and then. My friend the lawyer decided to wait and see what happened with the arrival of her son, before denouncing the state of abandonment in which she found herself.

Addiction treatment is the first choice in everyone's mind when it comes to rectifying disorder. It simplifies reality, making people feel less frightened about something otherwise complex and difficult to grasp, such as seeming psychotic outbreaks or schizophrenia. The moral blame appears to function as a way to ensure that whatever is happening to a certain person is occurring because of her own poor choices. At the same time, addiction functioned as a representation which made the unfamiliar – the paranoid outbreak – something familiar, regardless of the lack of knowledge people can have about addiction⁵³. Everyone had heard of

⁵² acting-out in psychotic outbreaks:

⁵³ Moscovici had explained anchoring as a mechanism which set strange ideas into a familiar context.

it; everyone knows about some clinic. A paranoid schizophrenia⁵⁴ or a Capgras⁵⁵ syndrome sounds much weirder and even more ominous. So her aunt took the representation she ‘understood’, and told everyone that Maria’s problems are due to her drug addiction.

The representation of addiction did become a form of objectification. Maria’s delirium, something disorganized and difficult to understand, could now be grasped as a condition, drug addiction, and something could now be done with it: internment in a private clinic. A single word explained the complexity of her behavioral changes, while the direct family didn’t need to address any of this anymore. And considering that the State was making it increasingly difficult to reach public psychiatric hospitals, and that private hospitals were expensive (for Maria’s case, the psychiatric hospitals which her mother was considering ranged between 80 and 200 dollars per day), the possibility of a private addiction clinic seemed more affordable.

Maria’s story was occurring outside the clinic. Hers was an isolated occurrence, which could not really illustrate who the subjects of addiction really are, or the way addiction and its representations affected individuals. In order to understand this, the public addiction treatment center becomes a privileged space of ethnographic rendering, as it condensates the political, economic, medical, cultural and moral aspects that shape the milieus in which the addicted transit through life. The creation of a multidisciplinary approach opened the possibility of seeing what becomes of the subject of addiction in a therapeutic context marked by a political ideology. Ethnography of the clinic allowed for a look inside this “unfinishedness” (Biehl 2013), instead of a direction towards a specific signification of addiction.

5.2. Addiction truth

There were many fronts for the production of truth regarding addiction that could be grasped much better from the insides of the public addiction clinic. The center had been born out of the denouncements of rights violations by private clinics, and the State intervention in them, in a context in which addiction had been included as a public health problem in the 2008 Constitution. The legal frame in which the first public addiction treatment center was created was a contradictory one: it proposed a health approach to drug use while it maintained repressive measures against drug trafficking. The division of this crime into different scales aimed to install the principle of proportionality, but parameters set by the new Integral

⁵⁴ Paranoid Schizophrenia

⁵⁵ Capgrass syndrome

Organic Penal Code, in 2014, were changed again in 2015. The truth of addiction, coming from the State, remained ambiguous, prone to be modified if public opinion became an issue (see chapters 1 & 2)⁵⁶.

The dialogical truth⁵⁷ coming from the public had been shaped through decades of the War on Drugs and its campaigns, and it linked drug use with criminality almost automatically. When the first social worker the center had said she didn't understand why the state was giving so much to this undeserving group, her comment was only reflecting a position shared by the Ecuadorian society. And this perspective wasn't isolated inside the clinic: the fearful attitudes, concerns, memos regarding safety, and the constant reprimands from the Dermatology Hospital's staff towards the addiction center's patients were a not-so-gentle reminder of popular beliefs toward individuals with problematic drug use.

Ivan, a psychologist working at the addiction center since its foundation as a contingency area, had mentioned that the Minister liked things empirical, evidence based, scientific, and that they built the therapeutic model with these qualities in mind. The team claimed to be working with objective facts, which had been validated: empirically based truths. Documentation of each case, from the referral process on, seemed to work in this direction. And it appeared to me that surveillance also had this unintended purpose of keeping some form of forensic truth in mind. The clinic had different forms of surveillance: the security system with cameras pointing to the patients was the most obvious, but the line which formed outside the nursery after weekends, for patients to receive their daily medication, and to drop

⁵⁶ Counter reform was a shift back to a dominant perspective which had operated for decades. While the country saw signs of change in the way drug issues were addressed, such as the drug mule pardon from 2008, the inclusion of addiction as a health problem in the same year's constitution, the withdrawal from the ATPDEA and the ending of the Manta Base concession in 2009, the chart generated by the CONSEP as the security organism in charge of drug issues, in 2013, which differentiated between drug users and traffickers by establishing maximum amounts, and the inclusion of this chart in the COIP in 2014, the following year, the President spoke of Heroin use in children and ordered a revision of the "*malhadada tabla*", the evil chart making them use drugs. The shift in amounts came with a change in punishments, affecting proportionality again. This can be further revised in Paladines, 2016.

⁵⁷ In the process led by the Truth and Reconciliation Commission after the apartheid fell in South Africa, there were public hearings set throughout the country to gather the stories of perpetrators and victims, with the means to generate awareness and forgiveness (Dhunpath & Samuel 2009). The report produced by this commission identified four kinds of truth: Forensic, Personal, Dialogic, and Restorative. Forensic truth referred to the facts, to what could be validated through empirical processes. Personal truth was the narrative of those experiencing the events which were being reported. Dialogical truth came from society: the public understanding of groups and individuals: oral discourses, spoken and written media, lives as told. Finally, the healing truth referred to the restoration of dignity through the reconstruction of lives. Choosing this model for the understanding of truths displayed in the therapeutic context of an addiction clinic makes sense for the criminal connotations given in the traditional interpretations of drug use.

samples for drug tests, also showed one of the ways in which the clinic built its truths regarding its population layer by layer.

Another mechanism for truth-gathering was the oral report. This was of particular interest on Mondays: whoever was on guard on the weekend would report to the team:

Nurse: “Someone smoked at the girls’ wing. It smelled like tobacco, and one of the girls, Elisa, told the nurse that one of the other girls was smoking. It was Maria José, I confronted her but she denied everything.”

Coordinator: “Who is Maria José’s psychologist?”

Psychologist: “I am. She has been caught smoking in the past. She knows it’s not allowed, but this is at least the third time breaking the rules. We need to make a decision, because apparently she was making the other girls smoke.”

Once the phases were installed, the burden of truth was placed on the patients. It was up to them to determine if a person is ready or not for the next phase. Surveillance was no longer a matter of the authority from above; the camera pointing from the ceiling was replaced by the same-level gaze of themselves. In private clinics, the more one manages to cooperate or comply, the sooner one gains privileges, including going outside for the “captures” [“rescues,” as they are called] of other addicts; if a person fights too much, punishment also comes from the entire team, like a punch tunnel formed by the other interns, who hit the one who has to walk through it. But the public clinic didn’t have a dynamic of physical punishment or capture; everyone was free to go. The process was different, the patient had to find his own truth in such a way that it should release him from dependence, but it had to be validated by his peers as well as by the team. In a context in which relapse is generally expected, the objective, or the therapeutic goals, overlapped with compliance and avowal. Addiction, inside the clinic, loses its clinical interest as it becomes an issue of obedience. Still, the clinic also allowed for a personal journey through the patients’ trajectory. Each had the chance to eventually address their personal issues, even if the clinical setting had its share of disciplinary mechanisms.

Inside the public addiction treatment center avowal, as an equation which brings together the relationship between truth, subjectivity and first person speech (Foucault 2014), has the peers added to the equation as guardians of the truth about the self that each patient can elaborate. The other patients become witnesses for each one's process of subjectivity building; as a group, they are made to testify, corroborating or opposing each patient's avowal of who he is. Avowal in private clinics seemed a little more primitive in the sense that it occurs as a compulsory form of focus over the crime, that is, drug use. Private clinics, as tergiversations of Christian self-mortification practices turned into torture mechanisms designed to force disclosing the worst acts committed amidst drug use, seem to aim more to the *jouissance* of the symptom than to the construction of a subjectivity in recovery. But the public clinic attempts to leave the logic of disorder found at private clinics, in order to enter one of health care, is materialized with the inclusion of the peers as judges, witnesses, elements of what ends up constituting a penal logic instead.

In the research of something as obscure and ambiguous as addiction, a biographic methodology has the advantage of allowing the observation of “the interplay of society, history and biography” (Niehaus 2006: 53), meaning that the way different discourses and practices surrounding substances, as well as the way different institutions aim to shape drug related behavior come into play in a person's life-narrative. How each individual comes into contact with substances, which are allowed, which are prohibited, how contradictory positions give form and meaning to life experiences inside the addiction treatment clinic, with the eventual aim to re-enter society, in some cases, with no familiar bonds or social network, without job skills or education, hoping merely to become something other than an addicted subjectivity—all of this becomes subject to ethnographic inquiry through biographic constructions. Self-representation can also be seen through a story of someone's life, and the way it is influenced through the subjective processes operating in an addiction treatment process.

Although life stories have been criticized in terms of the possible exaggerations that an informant can have when narrating his or her own life experience, this methodology has also been considered as a possibility for revealing “history and culture as lived” (Peacock & Holland 1993, 367) as an individual life happens as kind of *topos*, or a place grounding history and culture on a common plane of existence. At the same time, this methodology

allows for a look into the multiple relationships which, on a day-to-day basis, human groups go through and to which they are linked due to different needs (Mallimaci & Gimenez 2012).

In addiction treatment, the histories unfold throughout the process of change, which implies the necessity of a narrative that must be elaborated and re-signified in order to achieve the desired subject of recovery. The path to recovery, whether it is a private clinic or the public center, begins with the recognition of a problem. In psychotic disorders, such as the ones treated by Leuret, it is now recommended to follow the delirious construction without contradicting it, until medication can stabilize thought processes and the risk of acting out diminishes⁵⁸. But in addiction, now considered a public health problem, the acceptance into the program depends on the person's will to undergo the therapeutic inpatient process; each patient had to have a spontaneous demand.

5.3. Compulsion to treat

Albert had been in the clinic the longest. While he wasn't a leader, he got along with everyone. He was never into conflict, he complied with the rules, and he stayed out of trouble. But due mostly to his story, everyone considered him an important case. Juan, the coordinator, subtly pointed him out in one of my first visits: "If I took a third of the pills Albert takes, I would die, it's like eighty opioid pills a day." Albert sat with me after the morning meeting. He wanted to tell me his story, and he took every opportunity he had to tell me more. We met several times afterwards: between 2014 and 2016, he was interned in the public clinic three times, for over six months each. He told me about his drug use on the first meeting, when I asked him why he was interned (personal interview, November 18th, 2014):

You see, I realized I lost control with the substances I took, because one day I stopped using, and I got epilepsy, when I stopped using heroin and the pills [codeine], I became like, arthritic, and so, it wasn't a matter of pleasure anymore, it had gone beyond that, I mean, it's my medicine; the pills, when I was out I would enter into a panic syndrome, and I would tell myself, 'what do I do now?', and I would spend the entire day like that, telling myself, 'what do I do now?', and I would get some money for more, and this is when I realized I was bad, and getting worse, and with liquor, worse yet, and I would shake, and I had the need to drink a sip of liquor to calm myself down, and to calm my nerves, so, what started like a chilling thing, so to speak, that I have a little drink, ended in a week of drunkenness, I realized I have

⁵⁸ While substance related disorders are not necessarily psychotic, the therapeutic approach resembles the type of treatment that this population has received. There is a trend towards de-hospitalization

problems. I wasn't drunk, I could speak, just like now, but with alcohol, always, all the time, all day I would spend it like that, and if I didn't have the bottle, I would feel desperate, I needed to see it right there to avoid the panic, that's when I knew I was really bad.

Albert always specified that his memories were confusing and disorganized; he constantly apologized for not being able to tell a linear story of his life. He came from a family of artists; his father had been a famous Korean singer, and he grew up in a comfortable situation. I, too, am from an artistic family: my mother is a singer and an actress, and my three older brothers formed a band quite well known in Ecuador. One day, I was talking to my brother about my research, and I mentioned Albert's case. To my surprise, he recognized the character. "You're talking about Albert, Chin-Fu's brother? They used to come to our house to rehearse with Sergio's band" (a band which my brothers' friends had formed, but which didn't have all the instruments yet, so they came to rehearse at my brothers' studio). While I remember that this band came every now and then, to be honest I remembered neither Chin-Fu nor Albert. I told Albert about this, and he remembered both my brothers and my house. He had been friends with my brothers long before he began drinking.

His parents had the financial aspect covered, but they were always arguing. Albert's dad was famous, and his mom was jealous. Fights sometimes took entire weekends of his parents locked in their bedroom arguing. Albert grew up in the middle of it. His dad had always smoked weed; he mentioned that in Korea it was a cultural thing, no big deal. His older brother was the first one to experiment with alcohol. Albert thought that his admiration for Chin-Fu, his older brother, made him want to follow in his footsteps. And thus he was framed as an alcoholic before he'd even started (personal interview, November 18th, 2014):

My mother said, this one is going to be like that. I had so many arguments with her, so many fights with my mother. I remember so clearly, I never liked going to school, I was very lazy, and I had to go... I had to..., but I always looked for trouble in order to get out, I would prefer to be home or in the street than at school. Whenever I said anything to her, if I ever gave my opinion about anything, she would say 'oh, it's just that you, Albert, I distrust you with everything – she said – I distrust that, I already know that at some point you are going to become an alcoholic, *marihuanero*, with that attitude of yours.' She would say those things, and I was so angry, I thought 'why is she controlling me so much?' I didn't have a good relationship with her, we didn't click.

Albert was being observed inside the clinic in a very similar manner to the way in which his mother looked after him. Not much hope, not many expectations, his mother had made up her mind regarding her son ever since he was little. He remembers his parents telling him that they believed he was deaf when he was born, because when they called his name, he didn't turn to them. But the doctor checked him at one year of age, and he didn't have anything. He was always seen as the clueless, lackadaisical one; his father used to say he was naïve when he was little (personal interview, November 18th, 2014).

I was reckless, I remember; my shoelaces used to be untied, and I used to fall. Always, when there was a family meeting, I'd spill my glass – always – and they'd tell me, 'hey, you're exactly like *El Chavo*⁵⁹', and hey, I was so resentful, I felt so angry, but I was reckless, I spilled the juice every single day. They would move my glass and tell me, 'don't put it there, Albert, you're going to spill it', and I always did. So they would say, 'he's dumb'. My dad had my back, he would tell me, 'Albert, don't worry, this is who you are, don't worry.'

The relationship Albert had with his father seemed like a normal identification process; his mother also chipped in by comparing him with his dad from an early age. Perhaps unknowingly, I wondered, the staff was reproducing these unconscious processes by patronizing Albert.

As Albert grew up, he made his clumsiness a mechanism for attention-seeking; if he had to go to the blackboard in school, he would pretend to fall. "I don't know why, I was just calling people's attention, I don't understand it, I simply tell you." He constantly felt the need to do something, to move around, to call people's attention. At the same time, he grew up to become an extremely shy teenager: the first girl he ever fell for was a classmate, and Albert was never capable of telling her anything. All he did was create a fantasy world in which he spent the happiest of times with her (personal interview, November 18th, 2014):

After school, instead of hanging out with my friends, I would go lock myself in my bedroom to think only of her while listening to music. This was a pattern I had, maybe a part of some personality, perhaps you know what this might be, but that's what I did. And this made me more of a person who didn't relate to friends.

⁵⁹ El Chavo was a '70s television character created and performed by Chespirito, a Mexican comedian whose artistic name meant "little Shakespeare" (he was short). His show gained worldwide popularity. Albert was called like that by his family for his clumsiness.

For him, it was this obsessive personality which hooked him into drugs. He had been obsessed with his classmate, yet without being able to tell her, and later on he grew obsessed with the drums, particularly after performing with no practice and making a fool of himself. Albert told this story as an anecdote: at fifteen, his relationship with reality was strongly mediated by fantasy, and the differentiation between both was something which caused him anguish (personal interview, November 18th, 2014):

Remember, you see, we were forming a band. So we were in a friend's house, in his backyard, and they had their guitars, it was just my brother's friend, him and me with supposedly a drum set, but I didn't have a drum set, just some jars. And supposedly I played, and my brother, well, he had joined an at-night community high school to finish his senior year, and anyways he says, 'there is a meeting of whatever at school and they said we should play.' Great! I agreed, and it was the first time in my life sitting in front of a drum set, in front of an entire school. I was a kid still, I didn't know, didn't know drum had sets of pedals. Imagine that! I fell from the chair, I wrecked the drum set in the middle of a song, it was a mess! Yeah, and I went home crying. I mean, I felt really bad. My brother yelled at me, and I said no, it won't stay like this. And that's when I really began to dedicate [myself to music].

Albert sold his piano and bought a drum set, and began skipping school in order to practice. Around the same time, he started drinking and smoking weed. He obsessed with the girl, then with the drums, and then also with alcohol: "I said to myself, 'hey, this is what I needed in order to feel good.'" Albert felt intimidated by people and what they thought of him: social reality was difficult to bear. For him, substances made everything more tolerable. Inside the clinic, he began to understand these aspects from his history, which are only now beginning to make any sense. He confessed (Personal interview, November 25th, 2014): "I am very afraid of people, I still am, I have learned to deal with that much better than I did before, but my fears haven't left me, I still have them."

The drugs Albert developed a problem with were mostly alcohol, base cocaine, and over time, heroin. Base lied at the center of his consumption habits; he'd developed a taste for it with his father, and they became drug-use partners. At that point in time, his parents had already separated, and Albert decided to stick with his dad. The affectionate link they had was crossed forged in part by shared drug use. His father gave him the freedom to do drugs, he claimed,

perhaps because he needed a partner in crime, someone to be an addict with (personal interview, November 25th, 2014):

My brothers, no, you couldn't give my brothers a hit, but Albert, yeah, and so that was it. When he was in jail I went to see him every day, and that was another reason for going: I knew he was going to give me some [base]. And I would leave his cell freaked out. One day he tells me, 'this is really going to get you...' I don't remember what he said. But it was a rock. And you know what it was? There, at the Penal⁶⁰, they used to cook the coke, with sodium bicarbonate and water: it was crack.

For Albert, the turning point in which he got seriously hooked to drugs was linked to his father's imprisonment. Visiting him every day meant living his life, sharing his drugs. All Albert did was go see his father every single day. And on the evenings, he would hang out with his girlfriend, who didn't know about his drug use for the ten years they dated. "I don't blame him. It's just life." Albert lived a double life, something he was familiar with since his early teenage years. Albert showed his girlfriend an image of a relatively normal guy, but he was an entirely different person when he was with his father. After his dad was released, his theatrical existence continued. And prison guards would deliver the drugs to his house, something which made sense with what Nuñez Vega had found regarding prison systems in Ecuador (Nuñez Vega 2006). Albert moved back in with him, and spent hours smoking base and playing prison card games with him.

Juan and I were talking about the demand for treatment. Did the patient want to stop using drugs? He believed most patients tend to place the blame on their parents or experiences they have had throughout their lives (Personal interview, November 10th, 2014): "I haven't seen people which come one hundred percent convinced that this is harming them, because there is a pleasure anyways, a function of the symptom. Part of what we do is to work the subject's position in regards to drugs. Drugs have you. It's difficult to leave them." It appeared that the subject's position in regards to drug-use was also the subject's position with regard to himself and others. A process of self-definition, which began with the simplest, most basic occupations, and continued inexorably towards the more sophisticated of technologies of the self (Foucault 1990).

⁶⁰ When Albert was living alone with his father, he was imprisoned for almost a year. He served his time at the "Ex penal Garcia Moreno", an old panoptical structure from the 19th century. Base use was hearsay common knowledge; everyone knew that prisoners ended up smoking it.

Albert was already quite well along in the process of coming to grips with where he stood in relation to drug use, but he was already 38 years old. Only recently did he claim to realize he had a drug use problem, even though he had already been forcibly interned in private clinics. It became clearer to me that the hook which held him suspended had to do with avoidance of unpleasant realities; a sort of defense mechanism so embedded in his daily functioning that it seemed nearly impossible to change the way he understood himself and his relationship to drugs. Yet there he was, clean and sober, relaxed, and additionally, it seemed, almost happy. I never observed him suffering from withdrawal, yet he did speak about wanting to consume (personal interview, November 25th, 2014):

It's like they tell you, come on Albert, chill out, change already, until when, but I didn't care. The Minister could come and tell me, Albert, change already, and I don't care. And you really wait for something terrible to happen to you in order to realize things. I was left homeless; imagine that, because that's what happens to me. I'm homeless. I had such a nice life, and [now] I'm homeless. People told me, 'hey, take advantage of all the gifts you have, take advantage [of the fact] that time flies.

Albert explained that being told to change didn't make any difference. Discipline was not what worked for him, regardless of where it came from. I thought of a forced process of identification, such as the one described by Freud in his *Group Psychology and Analysis of the Ego* (1921), with the President, the Minister, or any of the therapists trying to place themselves in the place of the father with whom the patients should identify in order to change. I thought perhaps experiential therapists may feel they have a better chance of generating identification processes because of the supposed shared understanding they have of drug uses. Perhaps this is why the clinic required a desire of change as the prerequisite to enter the program: the will to change may facilitate identification with any ideal, a process reinforced and sustained by the very identification of others' narratives, or perhaps the clapping sounds performed in group meetings, as I could see in the ones I attended (see chapter 2 & 3). If so, in any case, it would seem to be an unconscious, two-way process of identification: and yet, identification as a therapeutic mechanism was never mentioned by anyone. The *ego ideal*⁶¹ didn't seem to operate that way. Even if it was the Minister herself

⁶¹ Freud described the 'ego ideal' as the instance in charge of "self-observation, the moral conscience, the censorship of dreams, and the chief influence in repression. We have said that it is the heir to the original narcissism in which the childish ego enjoyed self-sufficiency; it gradually gathers up from the influences of the environment the demands which that environment makes upon the ego and which the ego cannot always rise to;

telling Albert to change already, he explained, he didn't care. And recidivism rates spoke about failure.

Most patients came from therapeutic trajectories which compelled them to define themselves as incurable addicts—stick in the hand of the authority. For Ivan, addiction patients came already believing they were misfits—mischievous people, sorely deserving punishment. At the same time, this identification with the incurable operated as an authorization towards relapse. In the end, families agree to intern their relatives because they don't know what else to do about the management of such recklessness, similar to what Biehl found by following Catarina's story of psychiatric illness resulting in social abandonment (Biehl 2013):

It comes to the point where families only want to get rid of the addicted son. They go from one side to the other, and nobody gives them an answer. The clinics are managed in a perverse way, pushing the idea that addicts are liars, are manipulative, and so, when the family finally visits their relative in a private clinic and he complains of being mistreated or tortured, the family reasons, well, he is manipulating me because he wants to go get high. It is a perverse system which is still operating in private clinics.

5.4. Manipulation

Francisco had already been inside the clinic two months when I met him. He had joked about me being in intensive outpatient after seeing me in the meetings a few times, even though everyone knew from the beginning I was doing research. He was a leader: he organized others into the house activities, designating tasks and writing them down on the board; he proposed themes and activities for the special holidays, and always participated actively in the group meetings. He seemed to behave like a regular outside person, just passing by the addiction clinic. One day, the meeting addressed a particularly sensitive issue: during the weekend, Jorge had brought pills after being out on his visit, and he had given one to Pedro. Taking drugs while on inpatient treatment was forbidden, but they had also done it inside the clinic, which aggravated the situation. The psychologist addressed this in morning meeting, and announced that the consequence for Jorge was to be expelled from the program. If Jorge

so that a man, when he cannot be satisfied with his ego itself, may nevertheless be able to find satisfaction in the ego ideal which has been differentiated out of the ego" (Freud 1921, 110). In group psychology, the figure of the Father of the primitive herd takes the place of the ego ideal, through processes of identification which generate a sense of belonging.

wished, he could join the intensive outpatient program. But the patient could no longer be permitted inside. For Pedro, weekend leaves were suspended until new orders.

Francisco approached me after the meeting. He and Albert sat with me while everyone else went to the basketball court and soccer field for sports. They wanted to tell me about their experiences. Francisco started the conversation, and he took Jorge's example to speak about his own drug use (personal interview, November 18th, 2014):

See, if this guy wanted to consume on his own, I understand, because I could do the same thing, because nobody is one hundred percent cured, but it bothered me that he triggered more people into doing it. I mean, if you are going to die, then die on your own, not in a house where the foundations are the values. There's a huge difference between if he says 'I did consume,' than when they have to ask him, and do the drug tests to see if he did use or not. You have to highlight it, because, I mean, I have thought that I'll leave here and take a lazy hit, here and there, and with my profession, with my work, I guess it's not wrong, because in the past. [Still,] I was afraid of talking about it. And I think I have improved in my therapy. I no longer fear being judged, I simply know I'm here to change.

Although the multidisciplinary team spoke of harm reduction, abstinence was still the only indicator of improvement. Compliance remained at the center of addiction treatment, and patients circled around it in their processes, under the increasingly vigilant gaze of everyone—patients, family, authorities, and the multidisciplinary team itself. Still, most patients shared an even broader set of reasons for being there. Francisco continued (personal interview, November 18th, 2014):

This is the space where no one can judge you, we are all here for the same reason, and I always tell myself, 'you'll be out of here soon', and yeah, we have to leave this place and start over, but there's another personality, which says, 'if you have a hit, nothing bad will happen, no harm in that'; and it's like a daily struggle between the one and the other, and there, that's all there is. But no, I'm not convinced of all that, that I've stopped using, and that this is a process... I'm realistic, and I know I will smoke again at some point, and I struggle against it, but I know myself.

Contrary to Francisco's description, I was under the impression of this place being mostly designed for regular observation and judgment: from the psycho-educational practices to the

occupational therapeutic approach—or the decisions regarding leaves, and passing through the different surveillance techniques applied—, the patients were there to be seriously evaluated. Assessment posed a judgment regarding the demand: “Do you really want treatment?” Spontaneous demand was part of the triage: a contradiction through which the patient had to desire treatment in order to be accepted for it, a willful quest for what the coordinator had described as a disease of the will. In any case, nobody seemed concerned about Francisco inside the team. He was cooperative, he was charming, and he played the guitar in every special event. His drug use didn’t seem to worry anyone; he was never a part of the team discussions. He had mentioned that, during his confinement in private clinics, he had learned to manipulate psychiatrists into medicating him. He felt capable of deceit. Albert, on the other hand, generated less optimistic expectations among staff members. It almost seemed no one expected him to recover from addiction (personal interview, October 10th, 2016):

You know, before coming here, I got to the point where I was drinking, you know what? Antiseptic alcohol. Yes, I would go to the pharmacy, in this last times I became so addicted to pills, that I would go into pharmacies, they were drugstores from people I already knew, and I would go with my prescription, I had a prescription because, [you know] how life is, I knew my brother’s father in law, he is a psychiatrist, and I went, I manipulated him. ‘No, Albert, you know I can’t’, but I would insist, please, so there, three boxes of Rivotril, but then I would go and tell the pharmacist, ‘hey partner, come on, a little help here’, and they would sell it without prescription. Then I became addicted to other pills, Zetix, and for me, at the very end, I had to think what to invest my last fifty cents in, not food, but a substance, so I kept thinking, fifty cents—however much of this, that, or the other can I get with some change.

While addiction is depicted as the disorder affecting the will, there is a contradiction in the belief that the addicted does manipulate. Is the will really affected? Karl Hart had found the possibility of making rational choices in meth and crack addicts (2014). But most clinics, private and public, have kept operating their therapeutic approaches through different forms of submission, as if what the addict needs is a taming of uncontrollable impulses, while considering them fully accountable as such for any relapses (or any other forbidden behavior). Albert went through a number different phases, beyond those differentiate forms of treatment discourse inside the clinic. His three periods of internment allowed for alternating insights

regarding his self, the slowly developing comprehension of his addiction, and the realization of other problems which directly affected his adjustment to the “*real world*.”

Albert looked forward to meeting with me, as if the process of speaking or materializing his past allowed him to understand his own life, his current situation (personal interview, October 10th, 2016):

I wanted to talk to you, to tell you about this new phase, because you are following my history for a long while, right? My latest phase was no longer consumption, it entered into a deeper frame, insecurity, the question regarding, what am I going to do. And now that I don't know, I entered a depression, I didn't know that depression is to stay at home in your pajamas all day watching TV and waking up at three pm, but I felt really bad, I mean, with my conscience.

Albert had gone through the therapeutic procedures twice at the public clinic. He followed the necessary steps, spoke with his individual therapist, looked for a job, and when he didn't find one, he began a “micro-entrepreneurship” making sandwiches and other such comestibles, selling them at the clinic and on the outside. He had found a room and moved in there, and he would come back to the clinic. He did all of this twice. But by the third internment, the team knew they could no longer host him there; regulations prevented them from Albert's intake a fourth time. Once he was homeless again, Juan made a phone call to El Puyo clinic, a public center which opened in the Rain Forest region, the Amazonia zone in which other clinics, mostly private, were also located. The jungle, where the mutual friend Maria and I shared wanted to send her for private addiction treatment. Juan called them and asked them to host him there. He didn't need to undergo the entire therapeutic process. It would be useless. He just needed a place to stay. Was he manipulating the system?

Regardless of the staff's contradictory positions towards the representations of addicts as manipulative, when the public clinic was addressing the issue from a constitutional mandate of considering addiction a health problem, practices resolved any doubts by treating the patients as deceitful and placing surveillance techniques and technologies all around him. He was therefore to find his path to redemption amidst different perspectives depicting him as either the poor defenseless addict or the manipulative liar. In either case, the therapeutic ethics of allowing the search for one's truth was already stained with strong representations of deceit. Juan tried to make sense of it (Personal interview, July 22nd, 2015):

The guys, the pathology of addiction is really complicated, because among other things, it is thought that they are manipulative, but instead, they are very smart. You find one of them outside, and ask him what he is doing, ‘Ah, May sent me to gather something’, but when you ask her she says she hasn’t even seen him all day, so now, everyone (the staff) has a radio, and if we find them walking down the hall, you ask her right then and there, ‘May, did you send so and so?’ No? Ok then, you’re screwed.

Just like in the forensic arena, therapeutic spaces become places of truth-telling and truth-finding. The process of inpatient treatment is no longer a means for a pursuit of the truth leading to emancipation or the submission of the will to a regime of truth. Instead, it becomes a process of convincing those with the power of deciding over permanence in the process that one is ready to overcome this disorder of the will, because one *a priori* already has the will. At the same time, when the phases were already operating, Albert was being kept in treatment because and had nowhere to go, as May explained (Personal interview, October 10th, 2016):

he is in third phase, but we can’t sign his release because he has no place to go, and we are trying, I mean, these are patients who have a different connotation, which, in spite of the rules, in spite of the program, we have to bend ourselves a little and look for [alternative] options, [and] in his case, it implies to let him be here for a month or two until he finds a job and gets some money, some funds.

The staff had given some thought at Albert’s process, because even though he had found a job, they felt that rushing into recovery had been a mistake. Having any job out of necessity was not working for Albert (even if it works for anyone else working out of necessity), and so he needed to find something he liked. The increase in the organization of therapeutic procedures was a way of controlling not only the patients, but also the differences that the staff showed towards each case, as it could be problematic when dealing with a group of people. On the other hand, Albert’s therapeutic failure after his compliance placed a critique to the program itself. So it was best to bend the rules and let it slide until they could find another option for him. Albert had no social or family network. He was on his own.

Francisco’s case was different: he had a family, a girlfriend, a social network, and he had a job waiting for him on the outside. He explained that he learned to manipulate doctors by

understanding the symptoms which were commonly treated with pills (Personal interview, November 18th, 2014):

I made a psychiatrist in a private clinic prescribe me with Meleril of 200mg⁶², he gave me one in the morning, but then I made him give me one in the evening; those pills, the meleril gets you, it's a very strong pill, so obviously I already knew of some symptoms, if I could sleep, or I would say my hands were sweating, or if I felt uneasy, or about to explode.

Certain drugs have been known to generate dependence, by diminishing the production of neurotransmitters fitting the receptors occupied by the substances. Francisco's idea of deceit felt like an elaboration he had built based on representations of addicts, but I wondered if the medication he referred to was actually something that made him feel better in the absence of those molecules fitting his receptors. I asked Francisco if he invented the symptom of anxiety (personal interview, November 18th, 2014):

I mean, the discourse was that of anxiety, so when I got the pill, and so I would come back and explain, you know, I am in here because of pills, you could give me twenty and nothing would happen, so, they would say ok, we cannot give this man a baby Tylenol, and they would give me this pill, and I found out that I didn't want to change, I wanted to keep on getting high. But then I discovered that by jogging I could overcome myself.

Francisco's perception of himself seemed shaped by his time in private clinics; he understood his need to use drugs as a form of manipulation, a matter of will. Manipulation was something that patients also did to themselves, he explained (personal interview, November 18th, 2014):

Sometimes they [the patients] use the pretext of wanting to go out and see their families, but they only want to go out and smoke. One doesn't realize that you are manipulating yourself and it's not necessarily voluntary to say goodbye, I sign off, but how do I deal with anxiety and with the conscience of needing a change. Yet the person who is forced to be here, well, that won't work either, because they can be here for a long time but they are never going to change.

⁶² Meleril is an antipsychotic medication used in acute psychotic outbreaks. It is also used in anxiety and depression disorders. Usually recommended for inpatient processes and the follow-up of outpatient treatment modalities.

When Francisco finished his inpatient process at the public clinic, he got married, he had a baby, and with the help of his family, he began a catering service which later would become a restaurant. Regardless of the truth surrounding addiction, the contradictions or the “unfinishedness,” this is what seemed to have worked for him. And yet, his stated personal goal wasn’t described as a life of abstinence. He only wanted to achieve some form of equilibrium with regular drug use and daily activities. He left the treatment center, and continued with outpatient process over the course of several further months. He didn’t relapse, at least not over the following two years.

After being in many private clinics, Paul’s last resource seemed the public addiction treatment center. And, even though he came out of his own will, after telling his mother he needed a psychiatric hospital, there was also a legal benefit in his admission. He was in the middle of a penal process for robbery, and when the Judge learned of his addiction treatment, she agreed to hold sentencing back, as long as he presented himself to the prosecutor’s office on a weekly basis. Paul’s father, Jorge, explained (personal interview, December 12th, 2014):

For me, it is a miracle that he is free. I had to go find out what was happening with this trial he had; I knew my son had been detained, so I went and told the prosecutor that I was his dad and that he has problems with drugs. So she said ‘ok, I will help you. Bring your son if you find him.’ When he came back from Colombia, I took him, and she made him sign as if he had shown up five different times.

Manipulation and deceit were not a matter of the addict alone. The entire system seemed to be designed for allowing, or even encouraging the possibility of manipulating. Paul had robbed, and in fact, he had mentioned that the rush of robbing someone was the thing he missed the most, even more than smoking base in his pipe. He was charming, everyone liked him in the clinic, and it seemed his charisma also helped him in the legal system. Luckily, the prosecution couldn’t find any evidence against him, and, after presenting himself for a few additional months, the case was dropped. For Paul’s parents at least, this was a miracle. But they yearned for a bigger one: that he stopped consuming. Paul wondered what he would do if he couldn’t rob people in the streets. He hadn’t finished high school, and even though he was a piano player, he felt he had no skills to survive beyond what he already knew he was good at (personal interview, December 9th, 2014).

I was a very skilled kid in robbing; I made a lot of money out of that. With that shit, and being able to have a reasonable life level, well, we [him and his girlfriend Ale] were very close to living really badly, to being homeless. We were harming each other, you can't really explain this, watching her consume, it affected me, love began to transform into annoyance, we have to be clear, when you begin to get high, everything is pleasurable, the sex, drugs and alcohol, but when you love someone it's not pretty to see them like that, it hurts you to know she is by your side living like this.

Paul had learned to gain attention and affection from his peers by being reckless: drugs, gangs, street fights: these were all part of the skills he considered he had. In the clinic he was clearly a favorite, everyone liked him and they allowed him to have his girlfriend in her own process. For Paul, the resignation of a life of drug use also meant renouncing to the recognition he had achieved in the streets. He managed to make himself admired and appreciated; his luck was actually his charm and the way he knew how to reach people to his benefit. Whether or not that made him manipulative remained unclear; he had learned to survive on his own on an early age, because he was always alone. The need for recognition appeared at an early age, when he was alone and when he had felt undervalued at his own home. His dad was always angry. His parents, when he was a kid, were always working, and the issues inside their marriage took any attention left. Paul learned to find recognition elsewhere. And he was very skilled at being liked wherever he went, including the prosecution's office.

Social identities were part of the struggle within the therapeutic spaces, and it did make a difference if someone had a social network or if they didn't. Albert hadn't been able to find one; all he had was his ex-girlfriend's parents inviting him over for the weekends, with no expectations of him recovering. Francisco had his girlfriend, the baby, and his parents. The staff felt that was something which helped him in redefining himself.

Paul, on the other hand, fell straight through the cracks of his therapeutic process and would relapse. He was readmitted back into the program, a practice which the staff struggled to avoid because it made it seem like rules can be broken, and the therapeutics were all for naught, yet Paul responded—incredulously—by stealing the clinic's PlayStation video game console. Paul disappeared for over a year, but, later on, would revisit his therapeutic process from an outpatient modality. His psychologist explained that after he had finished his

relationship with Ale, and he found a girl who had graduated as a medic. They began a relationship with her, and he went back to high school. He found a job, and he seemed to be doing great. But a few months into his process, he broke up with the girlfriend and went straight back to binge-smoking cocaine base.

5.5. Pasteurization of addiction

Addiction proved difficult to define and understand beyond compulsory drug uses affecting the person's life. It remained unclear if it was an impairment of the will, or if it was only a form of disobedience. Also, the disorder was confusing in terms of what the patient needed to know about it and the expectations of behavior after being *educated*. Education had been described, along with actions racial improvement and civilization of customary practices, as part of the process of *mestizaje* (miscegenation), as a reproduction of ethnic and class differences in which mixed ethnicities remain inferior to the whites (Kingman 2002). The complex process of truth-finding inside the clinic had shaped the therapeutic program into a civilizing process of pasteurization of the subjects: the steps towards the cure shed some light into the way the disorder was being understood.

People arrived to the clinic in a state of disorder: they came disorganized, dirty, and malnourished; most people in chronic stages of drug use were skinny and generally unkempt. Inside the clinic, they were slowly trained into acceptable citizens; beginning with a process of clean-up in which patients learned the most basic daily activities such as showering and brushing their teeth, to a stage of development and potentiation of skills in order to access the productive world, the undeserving addicts were to become productive members of society. Albert believed that this was the most difficult aspect of his recovery (Personal interview, December 23rd, 2014):

That's the point, Ana, look, even today, I am afraid, I know that when I get out I will have to rent a room, an apartment, a cave or whatever in order to move there, alone, at the beginning, and I will have to say, 'no, Albert, we are not going to drink, we are not going to smoke', while the other side is saying, 'what the fuck! You're alone!' You understand, there are two characters there and they are both there all the time, I have been told that this is a common occurrence, but to you, I can tell you that sometimes, carelessness wins. 'Now, I'm gonna go hang out somewhere there, nobody is going to tell me anything, until I organize myself, until I get myself a family, I boycott myself, I manipulate myself.'

Albert accounted for his concerns surrounding recovery, mostly with facing down the process on his own. Having a family seemed to have worked with Francisco; he had someone next to him balancing the two sided self. But Albert didn't. Neither did Paul; when he left the clinic, he had Ale, a girl with the same issues as him. The inclination, while with her, had shown to favor drug use and robbery. But when he met his new girlfriend, a well-adjusted citizen, a professional, a medic, he was able to redefine himself from there. The balance shifted and Paul stayed clean for a while. Breaking up resembled a true breakage of the fine lines holding his recovery.

The path towards social reinsertion was described as free, open, and voluntary. Ivan explained that “we have a forty some affluence of people who come because they want to, and you can see that abstinence, and conflict management, is very good.” These were ways in which discipline was veiled, behind the concept of spontaneous demand: it is the patient who wants to be here. The clinic doesn't force treatment upon anyone.

The outings functioned as ways to teaching the patient to deal with the outside from different behaviors, no longer having to numb reality issues. May took the patients to different places, and always, someone related the visited spot with their drug use. One day, the group went to downtown Quito, to the Panecillo⁶³ (personal interview, November 18th, 2014):

We had a guy who, it turns out, used to consume at the Panecillo, and when we got there, he had an adverse reaction, he became nauseous, he vomited, he got really bad, but this also helped him grow stronger. I mean, he was with the group, he was with the other guys, and he was able to talk. Those are things which are very satisfying here, in fact, you see changes and you see them expressing themselves.

Sometimes, the process of recovery extended to other areas, to experiences lived during addiction and its therapeutic trajectories. There was one patient, who had been raped, but he wasn't able to disclose this to the group, nor was he asked to. The problem was that he felt the need to always carry some type of weapon, and May worried that the freedom in which the clinic's patients lived, made it easier for him to find something *else* and use it as a weapon (personal interview, November 18th, 2014):

⁶³ El Panecillo is a small hill located in the Colonial Downtown of Quito. It hosts te statue of a virgin, and it is known to be a hot spot for base.

It had become pathological, so, we started to help him. My colleague would ask him every day, ‘is there anything you want to tell us, or is there anything you want to give us?’ Because he says it’s beyond his control, he feels he needs it for protection. But this has lowered, and he has turned in the things he had, like spoons and stuff.

May’s reference of the spoon made me smile. There had been a complain regarding spoons by the Dermatology Hospital’s staff, concerned for their safety because the patients had taken their lunch juice and they had frozen it with the spoon. Their ice-cream raised concerns, once again, showing representations which reached absurdity. Still, the staff was building a process of civilization which should bring tranquility to the neighbors, because the addicts would eventually leave their primitive forms in order to become well-adjusted citizens: “They like become adjusted here, they see other attitudes, and they adjust to them, I mean, the way they look at themselves.” May was explaining a process of referential construction of the self by observing others in the same process. Addiction seemed to be related to the way people defined themselves. Not everyone used drugs; from those who did, not everyone developed problems. And from those who did, not everyone stayed. Some were able to stop.

The process of self-reconstruction was well received by Paul’s parents. After so many experiences with private clinics, finding a place in which Paul was being treated nicely made a difference for them. Gaby, in tears, explained: “In every other clinic, he has been treated like scum. But here, they treat him with respect; they don’t receive him as if he was scum. His self-esteem is lifted, while in every other clinic it has been lowered.” Jorge, Paul’s dad agreed (Personal interview, Deember 11th, 2014):

The way he is treated is different. But also, in the private clinics, there are practically no psychologists. Even in the best ones. It really is only a business, in which what has dominated is maltreatment, typically with the food, punishments, sometimes, I think, they don’t know how to treat, or this is considered untreatable people, with problems, dangerous. I do admire these people, it must be hard to open a clinic, and typically these are people who were addicts themselves, with the same capacity to mistreat, obviously just trying to do something to prevent this people from being in the streets.

Paul’s parents noticed a difference when their son started his medication, something which he never had in the past. They felt that the public clinic was professional, when they were used to strictly violent places. The medical perspective was a relief for them; their son came in a

condition of “skin and bones”, and after a while he was noticeably better. They could physically see an improvement. It was different. Addiction treatment wasn’t the same violent submission it had been in private clinics. Paul had the chance to think of other things than escaping or consuming. Inside the public clinic, he was wondering what all he could become (personal interview, December 9th, 2014):

I cook very well. I’ve always loved cooking, but I don’t think I want to become a chef, no. There is something else, I mean, I love music [he was a piano player from an early age], but I don’t like the bar atmosphere, I mean, today music is therapeutic for me, if I’m stressed I play the piano and that’s it. I guess I have two choices: I could dedicate to production, or maybe I would be interested in studying psychology, believe me, studying psychology would be very helpful, because I have a good capacity for analysis, and besides all the bullshit I’ve been through, and still go through, it’s like there is a good experience. But life is life, I’m twenty-two years old and this is the good thing about all this, there is a life ahead.

Paul reckoned this was the first time he ever thought about the future. He was accustomed to dealing with a day-to-day dynamic, whether it was in drug use or inside a clinic. The public addiction treatment center gave him a chance to reshape the way he looked at himself or at his life. It gave him a time to stop, to calm down, to think. He no longer felt in a hurry; he was beginning to generate a desire different than that of addiction. It wasn’t a matter of taming the abstinence alone. He could envision himself in a future he didn’t think he had in the past.

On the day the Minister of Health visited, Julio’s mother spoke. She was only thankful; her son had been consumed by the evil disease of addiction, she said, which caused years of suffering to her family. She was an older woman, from humble origins. She was holding back her tears when she spoke (General Meeting, December 9th, 2014):

How could we ever thank you? We can’t, but God will pay you for your kindness, the heart you have had towards my son and all these people, many of them live sick, abandoned in the streets, Madame Minister. To my sons, my family said, drop him, leave him in the streets. But he’s my blood, *doctorcita*, please help us. Not only me, but all of us with their feet here, and just like you brought your feet to this clinic, Miss Minister, God will bless you with wisdom, for all the good doctors and psychologists you give us for this disease, because we didn’t think this disease would make us suffer like it has. God will pay you, Miss Minister.

For the families, understanding of addiction didn't yet click with the discourses of health rights. This clinic was seen as a favor, after finding only dead ends in the recovery labyrinth. Regardless of the disciplinary measures, the technologies of the self, or the preoccupation in patients' compliance, the public clinic brought upon a different approach to problematic drug use, something which needed research, and which could definitely improve. But it broke a pattern of systematic violence towards drug users, who were being left with the options of private clinics or prisons. The process of pasteurization of addiction was being pulled by inertia, but it gave a different feel to a disorder which was difficult to grasp.

Following Latour's Pasteurization of France (1988), I wondered if the agents were the substances. But the way I saw it, it was the treatment which had took form in private addiction treatment centers what had to be seen as the illness, what needed to be pasteurized. Treatment itself hadn't changed in structure, just like foods and beverages are unchanged through the pasteurization process; only the dangerous components, capable of harming consumers, are diminished. Same thing happened with addiction treatment. It remained a disciplinary practice; it didn't quite fit into the logic of care described by Mol (2008). But torture, violence, human rights violations, these were the agents which were diminished through its pasteurization.

5.6. Dramaturgy

In the Ecuadorian context, knowledge about addiction is not generated; no studies are conducted in order to mark paths for addiction treatment. Instead, knowledge is borrowed from different contexts in order to generate a dramaturgy, an interplay in which both bureaucrats and patients perform the theatrical work needed to remain employed, or, in the case of the addicted, to have a place to live and to avoid homelessness or prison. Compliance saved some of the issues with family members, exhausted from years of compulsive drug use and avoidance of responsibility.

The slow increase in surveillance and disciplinary measures were showing a concern over the maintenance of the job; breaking the therapeutic process into different spaces, and sending the responsibility of spontaneous demand to the intensive outpatient centers improved the rates that the public clinic had. Results were monitored by someone, regardless of the difficulty in defining the health problem in question. The clinic was trying to reach an equilibrium which

worked for everyone: on one hand, functionaries who depended on their jobs; on the other, patients looking for housing and food. Francisco had mentioned: “I’ve been here for three months, and I feel I am on vacation, but I always have the disposition of, whenever I leave, I will go to work, and make a living, something I don’t do here.”

I had asked Albert, during his first interment, why had he come here. He answered (personal interview, November 14th, 2014):

Because I had nowhere else to go. Where I was staying they told me I had to leave. And someone recommended this place, they said there would be psychologists that could help me, and now I consider them my family. The first time I came I was on a different trip, and I can’t remember how hard it was to enter here, when I was in outpatient I went partying on weekends, and that wasn’t working. Irresponsibility was increasing and my social life was being completely destroyed. I was left with nothing.

The following year, Albert was on his second time inside. He felt tired of the scheduled therapeutic activities, he no longer enjoyed structured meetings, and he was bored. Tolerant, yet bored. And yet, he still needed a place to live (September 8th, 2015):

You lose the will to participate. You feel it’s an obligation, going in circles and saying the same things over and over again, it was boring. When we were a smaller group that was fine, it was a rich conversational space. But with too many people, it was only a process of reciting stuff that made no sense but that made everyone happy. I remember one day, a doctor came into our meeting, and people were speaking and he said, why don’t you stand up to speak? No, No, people are going to notice you are standing up and put more attention and so on. I swear to you, sometimes they seem retarded.

Nine months into his second internment, Albert was unimpressed by the treatment protocols: “I guess I’ll be here longer, I do what I’m told, and it’s just that for me it is easier to do just that (personal interview, September 8th, 2015)”. Albert began to play his role as a compliant patient, but he wasn’t able to find a job and an apartment. When he did, he left for the second time, only to fail again and return to the clinic. But after three times, he couldn’t be accepted a fourth. He was recommended into another clinic, sparing him the need to perform as a patient. Juan had called the center and asked them to “just let him be.”

Private clinics encourage a performance in which the addicts expose themselves as such, telling over and over again their most horrific experiences, reading the bible, showing remorse. Beyond the walls of these clinics, however, the outside world becomes the backstage in which they show their true self, or the performance is one of revenge towards those responsible for internment by performing the failure through binge-consuming. The public clinic is subtler: even though there are dramatic spaces, they are much more controlled in the sense that performance calls for something else: the manifestation of an engagement with individual processes, the acceptance of treatment, whatever. Expectations of recovery focus on the manifest behaviors that a person presents. Albert is an example of a well-adjusted dramaturgy which fails to materialize through the adjustment to society and its expectations. His case is never resolved, regardless of treatment and compliance; he remains at a public addiction treatment center, no longer required to perform as a patient in recovery.

Conclusions

Drug policy is funded on ambiguity. Shaped by and for a number of moralistic slogans, such as “say no to drugs”, the War on Drugs has remain in force even when its reasons for existence have been contradicted by its own guiding principles. In practice, the last decade has witnessed great changes in drug policy, culminating in a return to a security rhetoric which never actually left, and allowed for the comeback of the prohibitive measures and punitive policies. Amidst such contradiction, Ecuador now introduces a Public Health perspective to its approach to illegal substances.

While public health has been celebrated as a key aspect of the politics of drugs, and rhetoric emphasizes the unfairness of repressive policies, the country has reinforced criminal law by building more prisons and introducing the concept of maximum security, but, perhaps unwillingly or unwittingly, also reinvigorated corruption of the prison system and its major players. Addiction is not opposed through imprisonment; instead, people become addicted. Meanwhile, the broader public perception of addiction is typically linked to criminality, as opposed to my findings in this dissertation, which demonstrate how prohibition policies subtly influence the criminalization of addiction. In a vicious cycle, imprisonment ultimately feeds what it is supposed to fight.

Ecuador has lacked public debate, not only in the area of drug consumption habits, but also on any of the characteristics that lead one to drugs. All of this raises fresh questions about drug-war era democracy, its meanings or its material practices. Social movements opposing the broader prohibitionist logics were silenced and blocked from public debates, while only those aligned with prohibitionists remained, with their illusion of being able to implement changes from privileged cultural and political spaces. Yet, this form of “citizen’s participation” seems decidedly unrealistic; as anti-prohibition movements object to the new drug policies, they often find they themselves are blocked from expression or influence across the political arena. The marginalized condition of anti-prohibition allies has had the effect of delegitimizing them in the public opinion, and certain movements grow more accepting of the exclusion of others, a process which might be called “siloiing of debate,” which risks their very existence. Only Diabluma and Ecuador Cannabico, for example, have been visible in debating drug issues, while the LGBTI movement has been virtually the only one raising awareness regarding private addiction treatment centers.

What we have seen these past ten years are a series of memorable public speeches that seem to please official audiences on demand: the CONSEP was so obedient it became an example, a referential institution for other Latin American countries, while at the same time it also began producing research that questioned the status quo. In the end, the president of the Republic decided to shut down the Council and to replace it with an institution that depended on the executive branch, lacking the independence that the CONSEP once had by belonging mostly to the State's Attorney office (which linked it together with several other institutions).

It has to be noted that the contradictory nature of drug policy allows for a certain arbitrariness to thrive across the police, legal and prison systems. A history of the legal instruments shaping the representations of substances and their uses demonstrates continuity in the shift to addiction as a health problem. The idea of dangerousness as well as the need for confinement as the therapeutic approach remains fundamentally intact in spite of the turn to Public Health. Criminalization prevails, and drugs are considered malevolent agents, capable of generating a disease which impairs the will. The effects of this ideological assemblage would seem to reproduce the same approach that the security paradigm has presented, while any expected results, such as the decrease in prison rates, have been merely temporary (Paladines 2017). Emancipatory measures such as regulation or legalization of substances is no longer discussed in the halls of government; any attempts to propose new policies using this paradigm, even when they come from the State, are silenced from within.

The inclusion of addiction as a public health problem in Article 364 of the 2008 Constitution comes with mandatory treatment for all uses, from occasional to problematic, placing the disease, once again, in the behavior and the substance rather than historical context or interpersonal dynamics. The counter-reform finds no resistance; indeed, it consolidates the maintenance of repressive policies in the name of protection or security.

In a context of political 'change' in the approach to addictions, the establishment of a medical category in the Ecuadorian constitution presupposes a need to address addiction treatment from a perspective that is more aligned with discourses of wellbeing, a trademark of the central government for the past seven years.

However, these hopeful changes face a complex set of relations that intertwine different aspects of society together, ranging from international relations to moral beliefs. In the same way, these relations have played a major role in the construction of subjectivities around the use of substances, making of addiction studies a privileged space for the study of culture, politics, and society.

As the state attempts to regulate addiction treatment, the new centers of addiction rehabilitation now confront more than just a medical category. In the Public Clinic, the creation of multidisciplinary approaches aims to treat not only a conflictive relation with a substance, but other aspects of addiction ranging from neurobiology to social work.

In the process of treatment, the subject is objectivized as the result of power relations that determine the possible range of behaviors within and across the population. From this “realist perspective,” medical discourses can no longer be considered absolutes, but instead, they become reflections of the political, moral and epistemic orders that are established by the ruling powers. Addiction subjectivities show not only the relation of the individual with a substance, but also reveal a complex life experience that interacts with the social, economic, moral, epistemic and judiciary regimes that comprise any society.

Public addiction treatment implies an action from the state, a welfare state trying to save the lives of its citizens—actions performed by the individual, and observed through official rationalizations that justify them. The rehabilitation clinic is an institution that condensates a series of power relations that take shape in the day to day realities of the addicted subjects, reworked in the form of medical, familiar, legal or religious discourses.

The concept of Addiction—its definition and therapeutic approach, which offer a privileged possibility of political studies—is founded in certain truths that correspond to human rights violations in the name of healing, while creating a profitable market of conduct transformation. Through ethnography, the subject of addiction becomes a construction in motion, a subjectivity in the struggle of adapting or adjusting to a specific order of health and wellbeing, along with the possibility of becoming a productive element of society. Ethnography goes beyond the official discourses as a way of inquiry in which the experience of the drug user is displayed, at the interaction points between his existence and the moral, legal, economic or epistemic frames that shape it. This dissertation has therefore offered a

starting point for understanding the complexity of addiction and its treatment as a space of reflection of power relations across Ecuador.

As Ecuador's domestic politics shape new ways of addressing the relation people have with substances, the creation of public centers for the treatment of addiction open new spaces for relevant social research. My dissertation's ethnographic mode of inquiry has brought together different, methodologically distinct ways of accessing the experience of the people going through rehabilitation from drug abuse or dependence. Anthropological work in this area describes not only the individual experiences of the addicted, but also more complex social relations that influence their lives and processes of reintegration.

Ethnography implies, above all, a profound respect for one's informants, the space their voices have in the process of understanding becomes the most important tool of and for inquiry. Double-checking with the participants the findings implies the right to become more than what a specific discourse, whether legal, medical or otherwise, typically reduces them to. Ethnography opens the door for complex analyses in human matters, including fulfillment, suffering, abandonment, belonging and anything that takes part in the act of living through addiction.

While the study of this scene at the public addiction treatment center can be used to locate the major elements that are put into play in the power relations that have generated through discourses of morals and knowledge, it also poses more questions than it does answers. However, one important outcome of ethnographic work is the possibility of questioning the "evidence-based medical approach" through practices that occur in the quotidian existence inside the clinic, as a form of exception that reaffirms the rule.

The new discourses reveal themselves as different versions of the old discourses, put into play through the coexistence of surveillance and control that still responds to the sovereign power of deciding who lives and who dies. The study of addiction treatment in the discursive context of state anti-neoliberalism, such as we currently see in Ecuador, serves as a magnifying glass of what happens beyond the elements of the unfettered capitalist apparatus, and in the lives of those typically governed by it.

Addiction treatment's failures and abuses are not only the result of neoliberal policies from which the therapeutics are perverted for profit. It goes beyond the market issue, as the inclusion of addiction as a medical category in the 2008 Constitution ultimately fails to generate a health model of care. The emphasis placed on the will, whether it is on the impaired functioning resulting from drug use, or as the requisite in order to access treatment, keeps the entirety of addiction locked away inside a disciplinary realm. The problem remains that of deviance and misconduct, and it is addressed through different strategies for the modification of subjectivity as a continuous process of identifications, one which is never fully resolved through the therapeutic spaces alone. Those who do "recover" have a well- or at least predictably functioning social and familial network, and are less dependent on the way they are perceived by the outside world. The ones who lack such networks face less possibilities of social reinsertion.

One of the clearest aspects influencing the possibility of abuse in addiction treatment is the "behind closed doors" policy found at private clinics: the expectations of controlling treatment through surprise visits and regulations coming from the state are a mistake. This modality of control and assessment is hardly sustainable and susceptible to corruption; the entire system risks the return of the practices which were once denounced by the LGBTI movement and which were corroborated through the State's document of Mental Health Policy of 2014. Indeed, through denouncement of conversion therapies inside private addiction treatment centers, the LGBTI movement was able to open the doors of businesses which were profiting from family fears and social stigmatization, by offering punitive practices in spaces other than those of prisons. The pressure generated by the LGBTI movements made the State organize interventions in the private clinics, which in turn resulted in the shutting down of many and the regulation of more. This is where the origin of the public clinic is located, as it was first designed as a contingency area for those interned in private centers which were shut down.

In practical terms, what would work best is the generation of processes of "self-regulation" of the private clinics, something which would be possible by installing a policy of open doors. This process would need to include families, as their own beliefs and representations are the main supporters of the closed-door policies, due to the stigma associated to drug use. And since it is the family the institution deciding on internment, and financing it, "coming out" as families of addicts should be encouraged, the same way it has been for those living secret

lives amidst sexual diversity. The stigmatization is reinforced by silence, and it is a key element allowing abuses. Drug policy can focus on this aspect in order to improve the situation of private clinic patients.

Stigma may not be solely responsible for family silences and complicities. Rather, it derives from an overlapping array of laws, policies, and institutions which shape the way our society relates to drug use. This largely hidden ideological assemblage affects not only the private clinic realm, but public addiction treatment centers are influenced as well by the same forces which generated the addiction treatment market.

Whether or not addiction is a medical problem is not clear in practice. And while there are medical components in the addressing of addiction, the public clinic has not been able to escape the punitive weight of addiction. Technologies of the self are still the key components of the therapeutics involved in addiction treatment.

While the newest legal instrument defines addiction as a socio-economic problem (Asamblea Nacional 2015), I doubt that drug use can be reduced to having or not having a job. After conducting this research, I believe that the way drugs and users are being depicted is problematic, and it is a part of many of the problems related to drug use. Panic regarding drug users is ever present in official discourses. Ecuadorian society hangs on to a rhetoric born in the War on Drugs; there has been no emancipation on that front whatsoever.

It is therefore necessary to face down these discourses critically, asking ourselves about normal drug uses and by debunking drug myths in spaces other than the clinics. Research on drug use which is considered largely unproblematic is necessary to rework the way drug use can be understood. This shift in research priorities also implies that drug policy can no longer come from above; it needs to be constructed across horizontal spaces or connections of mutual understanding. Moral panic, criminalization, and medicalization—all have worked through stigmatization and silenced people in regards to the drugs they consume. Drugs are part of culture, and drug users are part of society.

The inclusion of addiction as a health problem does not automatically generate a health care model of attention. Instead, what we see is a hybrid complex of care and coercion, resulting from the attempt to generate logics of treatment within logics of security. Addiction is still

strongly viewed as a criminal category. This could be compared to other places (and currently, Ecuador) in which policy has produced decrees against chronicity in psychiatric disorders. It is all more complicated than a single policy or a decree, and the effects from assuming that emancipation is something which comes from above, in these cases, can be dramatic, such as homelessness or social abandonment in hospices.

While I am left with the sensation of not giving enough attention to the women in public addiction treatment, I believe that their situation is not something which will improve solely through the inclusion of gender components into their treatment plan, as the staff may believe. Women, and the ways in which they are treated, clinically as well as socially, are crossed by sets of representations or theories defining not only their behaviors in relation with addiction, but their very nature. More than working on the gender components, I believe that the first thing which needs to be addressed relates to the unconscious theories of the feminine operating in everyday practices. Again, what comes to my mind is an idea of treatment as the illness which needs intervention.

The 2008 Constitution redefinition of addiction as a public health problem, and the generation of a public center for addiction treatment shows how representations are not changed by decrees or regulations coming from above (even when the “above” is constituted by privileged social movements). Instead, the definitions of reality should be the result of rational, public debate. Most people agree against dehomosexualization practices or conversion therapies, as they have been taken to public debate. Our society is just as capable of rational public debates about addiction, given the minimal opportunity.

Recommendations for policy-making are always well-received, I understand. NGO’s and the State itself usually pay for research leading to recommendations for policymakers. But I feel I do not know how this research should affect policy when it comes to drug use. What I take from it is that policy must not be designed from above, drawing from specialized knowledge which ends up legitimizing the reproduction of repressive practices.

I hope that, more than generating specific policy changes which end up maintaining the status quo, this kind of research feeds an increasing public debate regarding drugs and the way we relate to them. These debates should open themselves, just like private clinics should, to

others beyond political authorities, academics or religious representatives. Debates should include drug users, occasional and problematic, their families, including men and women.

The objectives for any debate should go beyond the mere end-point of policy making, pursuing first and foremost a more complex understanding of drug use, addiction, and subjectivity, as well as the compulsion to normalize subjects into citizens. Indeed, I believe our society as a whole currently needs treatment from the illness which private addiction treatment centers have become. A symptom of our society's violent approach to the normalized torture, starvation, and humiliation administered with the tacit approval of families, police, doctors and judges, with nearly all of society looking the other way. We should be more ashamed of addiction treatment than of addiction itself.

The appearance of public addiction treatment does offer the opportunity for different modes of engagement with the addicted subjectivities. But it is not enough to treat this social disorder—this compulsion to treat addicts. Clinics should be opened to the public to see what goes on inside. Society should be able to see itself through what goes on inside them. It is the private clinics which need self-regulation, not only the addicts. Historians of the future may perhaps agree. Ethnographic interventions help to understand what such an inversion in public perspective might look like in spaces of the most hopeful social transformation.

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