



ATRIO

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A Question of Will: Addiction Treatment in Ecuador

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To Farah

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Acronyms and Abbreviations

ACE	Acuerdo de Complementación Económica (Economic Complementation Agreement)
AA	Alcoholics Anonymous
ACA	Área de Contingencia para Adicciones (Addiction Contingency Area)
ATPDEA	Andean Trade Promotion and Drug Eradication Act
CDP	Centro de Detención Provisional (Provisional Detention Center)
COIP	Código Orgánico Integral Penal (Integral Organic Penal Code)
CONSEP	Consejo Nacional de Control de Sustancias Estupefacientes y Psicotrópicas (National Council for the Control of Drugs and Psychotropic Substances)
DEA	Drug Enforcement Administration
DINACONTES	División Nacional Contra el Tráfico Ilícito de Estupefacientes (National Division against Illicit Drug Traffic)
DINACTIE	Dirección Nacional Contra el Tráfico Ilícito de Estupefacientes
DSM-IV-TR	Diagnostic and Statistical Manual of Mental Disorders Text Revision Fourth Edition (National Office against Illicit Drug Traffic)

LGBTI	lesbian, gay, bisexual, transgender, and intersex
MAIS	Modelo de Atención Integral de Salud (Model of Integral Health Care)
MAIS	Manual de atención integral en salud (Integral Health Attention Manual)
MDA	Methylenedioxyamphetamine
MDMA	Methylenedioxymethylamphetamine
MSP	Ministerio de Salud Pública (Ministry of Public Health)
NGO	non governmental organization
SECOM	Secretaría Nacional de Comunicación (National Communication Secretariat)
SENESCYT	Secretaría Nacional de Educación Superior, Tecnología e Innovación (National Secretariat of Higher Education, Technology, and Innovation)
SENPLADES	Secretaría Nacional de Planificación y Desarrollo (National Secretariat of Planning and Development)
SETED	Secretaría Técnica de Drogas (Technical Drugs Secretariat)
UN	United Nations
WHO	World Health Organization

Introduction

In 2008, Ecuador's new and much-publicized Constitution, introduced by the Citizens' Revolution,¹ defined addiction as a public health problem. This governmental decision was believed to be an important step in countering the war on drugs, sponsored by the United States, according to which Ecuador was identified as a supplier of drugs. The discourse was introduced during Richard Nixon's administration (1969-1974) and extended to Latin America in the form of an increasingly repressive wave of anti-drug policies leading to overcrowded prisons throughout the continent. Justification for the war on narcotics was the alleged danger posed by certain substances, depicted as capable of destroying a person's life with such ease that a decisive, warlike response was not only reasonable but necessary.

As a result of this ideological shift, the war on drugs led to more direct military control by global powers over poorer countries throughout the region, a state of affairs backed by the United Nations. In Ecuador, the site of my research, this began with the country's inclusion in multilateral drug control programs conducted far and wide across so-called "producer countries," such as Colombia, Peru, and Bolivia. Since Ecuador was

¹ Ecuador's Citizens' Revolution, led by former president Rafael Correa (2007-2017), took place within the context of the Bolivarian movement, started by former Venezuelan president Hugo Chávez (1999-2013), the stated goal of which was to return to principles introduced by independence hero Simón Bolívar under the guise of "Socialism for the 21st Century." For more in-depth information on this process, see Ortiz Lemos (2013).

not a major producer, most citizens and their political representatives began to rely on indicators other than supply in order to demonstrate pro-active cooperation with this multilateral effort. Under these politically odd and logically tortured circumstances, Ecuador inaugurated the practice of habitually jailing or imprisoning drug users. Through this process, the penal system's rate of incarceration became the preferred indicator for demonstrating the country's participation in the global war on drugs, in order to receive international funding.

A law passed in 1990 served as the beginning of Ecuador's participation in the war on drugs, dramatically increasing the per capita rate of imprisonment. In addition, the police were given the authority to apprehend and bring any person suspected of drug use to a hospital or a rehabilitation clinic, where he/she would be evaluated and, if it was confirmed that illicit substances had been consumed, treatment would automatically be ordered. In turn, this drug policy led to a new and growing market for drug addiction treatment. The discourse and practice developed for dealing with drug use was based on its own political logic and led to the application of therapeutics in large part based on the "12 Steps" program designed by Alcoholics Anonymous (AA). Article 364 of Ecuador's 2008 Constitution addressed not only the need to differentiate drug users from drug traffickers, thus avoiding incarceration of the former, but also led to the creation of public spaces for the treatment of addicted persons. Government regulation of private clinics changed from surveillance by a security institution, the National Council for Control of Narcotic and Psychotropic Substances (CONSEP), to supervision by the Ministry of Health. This literal redefinition required new regulations for the functioning of these spaces as well as the establishment of multitiered mechanisms of managerial control in order to evaluate their duties vis-a-vis the state.

The public addiction treatment center became the first of its kind, an evolving experiment, developed to face the challenge of generating changes in the way addiction was being addressed and in the results of interventions. As a privileged space of inquiry, the drug rehabilitation clinic is the place where old and new representations of the state come face to face and, through daily practices, the contradictions shaping therapeutic processes arise. The center is a place dedicated to

emancipation, immersed in the logic of a state determined to counter neoliberal excesses, while addressing practical day-to-day conditions of deviance and disobedience that are notoriously hard to handle. This study is an exploration of the unprecedented transition from a penal model of addiction treatment to a new, practically ersatz, model of “medico-judicial care.”

When addiction is defined as a health problem, as happened in 2008 in Ecuador, this implies that drug use is no longer considered a crime. As a result, the public center has to apply this change in meaning within a moral prohibitionist context that has been the norm for so long. These circumstances in effect turn the public center into a privileged space for observing the creation of a medical category against a strong and long-standing depiction of criminality linked to deviant behavior: the state needed to produce new modes for addressing drug use, differentiating these everyday habits from what was previously defined as abuse linked to a neoliberal logic that the Citizens’ Revolution intended to counter.

Most research on this process has focused on prisons. Thus, there are very few academic studies of the private addiction treatment market and its market logic; in fact, the “abuses” around which the clinics were constructed and their interventions were revealed to the public by the LGBTI community, as many of these centers also offered clinical “dehomosexualization” interventions. In fact, addiction was linked to deviance with the passage of Law 108, in the 1990s, when private clinics operated as treatment centers for behavioral disorders, which included homosexuality for which so-called “conversion therapies” were offered. Protests by the LGBTI movement eventually were successful in eliminating the abuses suffered in those clinics by those with non-heterosexual identities. However, people undergoing drug abuse treatment were rarely, if ever, able to raise their voices against the so-called clinical therapeutic practices from which they suffered. Moreover, because the public addiction treatment center was a new kind of institution, no studies existed about the processes involved in the construction of this new medical category.

The public clinic was built as a necessary contingency space for patients who had been treated at private clinics closed by the state. Those persons were offered one month of inpatient treatment in the

“contingency area.” According to the team of psychologists hired when the area was established, their therapeutic model was based on “universal knowledge,” taken from the World Health Organization and the American Psychiatric Association, the principal institutions defining mental disorders on a global scale. In addition, the model was an experiment based on political need and the opportunity that need presented to counter previous practices originating from the war on drugs and its responses to drug use. At the same time, public clinics adopted contributions from professionals in myriad disciplines and these were used to develop a multidisciplinary team aiming to bring a complex approach to addiction. However, the creation in Ecuador of a medical category of addiction within the public clinic, along with strategies for curing it, took place in a political and socio-historical context in which misconceptions and preconceptions about addiction, based on folk beliefs and, allegedly, science, had already affected many lives.

So, how is “addiction” defined within the state-authorized clinic? A crucial aspect in the construction of this public health disorder was the opportunity and the requirement that the affected individuals finally, at long last, had to speak about their experience. Beyond regret or apologies, what patients were obligated to say about their symptoms had never been relevant. Addiction was a behavior to be corrected or punished, and that was nearly all there was to it. The new center brought a new kind of openness into public debate, a kind of liberal therapeutics which clashed with the remains of the previous regime of medical beliefs and practices where, behind closed doors, novel 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.

This book is an ethnographic study 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 study is divided into five chapters which tell the story of drug policy in Ecuador. As a clinical psychologist with a master’s degree in forensic psychology from a university in the United States, I wondered why drug policy was mostly shaped by common beliefs and

representations, in complete disregard of scientific knowledge on the subject. I had already observed childhood friends thrown into private addiction treatment clinics, emerging with no visible change in their condition, while many more went on with their occasional drug use with no public or private consequences whatsoever. And yet, private drug addiction clinics were never seriously evaluated in policy-making circles. The public treatment center offered a unique opportunity to study drug policies from a single space where law, policy, and institutions came together with popular public and private representations, within the history of a war and including active state repression.

Similar studies have been conducted in the past. Annemarie Mol (2002) has worked in a health center on the construction of a medical category (atherosclerosis) using an ethnographic approach. A study by Ángela García (2008) of heroin addiction, carried out in 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 on the body. García describes a history of dispossession, paired with a poorly staffed and underfunded medical facility, attempting to address a problem which goes far beyond any commonly held beliefs regarding heroin addiction. Kevin O'Neill (2015) has studied religious approaches to addiction treatment in Guatemala, a country that is a transit zone for drugs coming from South America to be sold in the United States. In an earlier context, João Biehl (2013) has shown, through his work on ersatz treatment centers, such as Vita, a clinic in Brazil, the ways in which medicalization maps onto a series of social, historical, and economic factors influencing the lives of people who are essentially abandoned and left to die in places like these. 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 treat a problem but, rather, to domesticate the person affected by the problem.

In Ecuador, most studies have focused on the prison system. Núñez Vega (2006) has presented an ethnographic study of prisons and illegal drugs, analyzing the articulation between prisons and the intransigence of the supply and demand economy of drug trafficking. Núñez describes the organization and functioning of prisons, and the way they relate to

the broader social context of criminalization and the normalization of spaces of willful state neglect. Annie Wilkinson (2013) 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 his/her sexuality. Albeit briefly, Rodrigo Tenorio (2012) and I 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, though illicit, interventions based on deprivation of liberty, with the approval of family members, and with little or no oversight from the state.

The first chapter of this study addresses state and institutional changes in the legal framework that reformed the country’s repressive policies and led to the creation of numerous private clinics. I begin with the very first attempts to control substances, such as coca leaves and alcohol, in the colonial period and proceed, ultimately, to 20th century policies and, finally, the 21st century’s Citizens’ Revolution, a left-wing government which defined addiction as a public health problem. The emblematic 2008 Constitution, the crown jewel of the Citizens’ Revolution, created the very first public addiction treatment center. By chapter’s end, we observe that, in the course of changes in clinical treatment, Ecuador experienced a (rather quiet) counter-reform movement which threatened the mass warehousing of human beings and the alleged achievements of the war on drugs.

As a researcher, I found that a chapter describing the laws and policies of drugs in the country would only make sense if I saw them through the lives of people who were personally involved, in one way or the other. Rafa, a good friend, 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 a mere three kilograms of pot. His experience at the hands of the state’s legal and prison systems has demonstrated, beyond the anodyne prose of laws and policies, the raw effects not only of confinement, but also of the abuses normalized by the prison system.

Prisoners, as the main products of the war on drugs, are the unlucky object-lessons or flesh and blood targets of public policies designed to justify new forms of prohibition which, more often than not, end with the imprisoned becoming addicted to drugs they did not consume on the outside. Throughout, representations of drugs and their effects are reinforced.

Charlie, a young photographer who supported cannabis legalization, spent two-and-a-half months in preventive detention, and was later released thanks to the chart of thresholds, or maximum amounts of drugs one is allowed to possess, 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 exclusionary anti-drug practices end up affecting everyone, regardless of their political, social, or economic position on the matter. 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 works on social movements during the Citizens' Revolution, for example, by Ortiz Lemos (2013), facilitated understanding 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 about starvation, physical abuse, and demoralization, occurring mainly under conditions of forced confinement. The stories of those who experienced inpatient treatment in these centers demonstrate how the public clinic has become a "contrasting institution," which deals with addiction from a rational perspective: respecting human rights, and excluding the economic interests of clinicians and former drug users. In addition, and thanks to, the LGBTI community's longstanding efforts to raise awareness of the abuses committed inside these clinics, the public clinic did not engage in "dehomosexualization" therapies. Indeed, though the Bolivarian Revolution has been shaped by anti-neoliberal discourses, opposing the abuses of capitalism, the private clinic market falls squarely into the capitalist category. Yet, the government of the Citizens' Revolution encouraged the operation of the

clinics, although it subjected them to regulation. The new approach continues to be overshadowed by inertia accumulated over decades of representing drugs as hopelessly crime-centric or even criminogenic. The public center has to deal with public beliefs which everyone, including addicts, their families, therapists, and bureaucrats, hold to be true regarding the proliferation of drug use and the purported explosion of drug addiction.

A few years before my research began in earnest, I conducted a study of private addiction treatment centers, interviewing people who had spent time in them. I contacted a few friends, some of whom I knew had been admitted to private clinics, as well as professionals in mental health whom I knew had worked in these spaces. Another friend, a former base addict, had worked for years as a security guard at a clinic. Lastly, through self-help communities, such as Narcotics Anonymous, I was able to identify even more informants. The results were consistent with what people with experience in the public clinic had to say about private addiction treatment centers. They are a model for any new form of therapeutics, and remain an important aspect of national drug policy, although today there are regulations which are more consistently enforced. However, the stories patients tell 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 like 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 drug users into becoming particular kinds of citizens. Contradictions between what is said and what actually occurs can be grasped through observing the milieu inside the clinic, keeping in mind the foremost importance of civilizational ideologies and their translation into distinct kinds of moral practice.

Invisible mechanisms pull the structure of addiction treatment to processes that have more to do with control than with the medical aspects of treatment or the patients’ well-being in general. There exists,

in other words, an unconscious process of subjectification alongside a scientific discourse that attempts to give shape to particular therapeutic approaches. Addiction is quite possibly more elusive than any other medical category, but it implies aspects related to obedience, compliance, and avowal – i.e., how convinced is the patient of his/her illness and how committed to adhering to treatment – as the main factors determining the degree or severity of the disorder and the success of the therapeutic process. During my fieldwork, I could see, mainly from inside the clinic, the different forces operating in the construction of addiction as a medical category.

The fourth chapter addresses the close relationship the clinic has enjoyed with the state. Power relations can be observed through the interactions between the clinic and the institutions which have some sort of relation with it. The representations become apparent through the expectations of practitioners at the personal level within the clinical process. These exchanges, I maintain, are likewise occurring at the state level. While the clinic attempts to create a therapeutic community, pressure from the outside threatens without pause the project to produce normal citizen subjects. Political aspects of the clinical therapeutic process come together with beliefs through which each state official relates to the addiction treatment center.

And yet, it is not only the clinic's employees who have to operate amidst pressure from the much broader and more bureaucratic machinery of the state designed to standardize medical intervention. Any form of participation in the process requires involvement in long, complex, and, mostly, never-ending bureaucratic procedures. At the beginning of my fieldwork, I attempted to navigate 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 reached dead ends time and again. In the end, I decided to avoid the use of institutional or personal names.

Finally, 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 patients' lives. Beyond the desire to recover, the user describes conflictive drug consumption,

and what it implies in terms of manipulation. The 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 susceptible to being understood by the public and less harmful. Resembling, perhaps, the process 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 does not seem completely affected. Just as in the process of pasteurization, not all of the elements are destroyed, only those capable of causing disease. The patient, also marked by the ways in which societies define him/her, makes choices that affect the ways he/she relates to the public addiction treatment center in the quest for a self that can coexist with the rest of the world. Addiction is the axis for the definition of the subject in the process of reinventing the self 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 my brothers’ friend when they were teenagers. I still find it hard to understand what, exactly, makes the difference between occasional drug or alcohol use and a fall into the endless spiral of addiction. But I am inclined to believe that policy is an important aspect, reproducing beliefs which block possibilities for self-redefinition beyond the medico-juridical category.

The point from which I departed in attempting to understand the information I gathered while doing ethnographic work in the clinic is structured within a bio political framework, as mental health is inscribed within this realm. My research falls into the political studies, rather than a social psychology field, but it comes from an anthropological way of understanding life and practices.

What I see through 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 the actual lives of people and their

desperate families, searching for options for treating compulsory drug uses. As Valverde (1998) demonstrates in her study of alcoholism, the compulsion extends to the repetition of the same therapeutic practices coming from places other than the medical. While specific discourses and small actions appear as signs of change in the war trend, in practice, things remain the same, with the additional bureaucratic processes standardizing medical practices and, therefore, subjectivities. Although the most recent drug law refers to drug use 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 therapeutic intervention.

Chapter 1

Laws, Policies, and Institutions

Addiction treatment has been the least of concerns in Ecuador's drug policy. Following a model set by the United Nations, at the initiative of the United States, the country developed a position towards drugs aligned with the 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, in response to international pressure (Edwards 2011).

Nevertheless, the inclusion of a public health perspective in the 2008 Constitution was not something new. Past laws and policies pathologized the issue. That this is the case is very clear in the Narcotic and Psychotropic Substances Law, also known as Law 108, in force since 1990. This law was the result of a growing worldwide trend towards repression, following implementation of the 1988 United Nations Convention against Narcotic and Psychotropic Substances, which introduced new guidelines to punish drug trafficking more severely (Paladines 2016).

According to Law 108, anyone under the influence of a narcotic or psychotropic substance must be taken by the police to a health center for evaluation; when use is confirmed, treatment has to be ordered immediately. Pathologizing had already been 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 was obligated to change policing, indictment, and criminal procedure

practices: previous legislation had penalized possession, and the prison system increasingly included drug users, treating them as indistinguishable from drug traffickers.

Since this constitutional inclusion was intended to make a major difference in the lives of those affected by the war on drugs, it became necessary to go beyond official discourses in order to learn how drug laws were affecting imprisonment and treatment practices. Changes introduced since 2008 have shown very clearly how extraordinarily difficult it is to define a stable trend in drug policy; what has also been clear, as I demonstrate below, is the proliferation 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 the majority of Ecuadorians.

This chapter is thus an attempt to show the path down which this country has traveled as regards drugs, primarily by following in the footsteps of people whose life direction has been influenced by political decisions. 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, in order to introduce the context in which addiction treatment became a matter of public health.

Prison: The Background for a Health Perspective

At 9:00 am I arrived at the old prison in Latacunga. It was a Wednesday in mid-June 2013. The roads to Latacunga had been remarkably improved by the Citizens' Revolution, the movement led by President Rafael Correa. In response to any criticism of Correa's government, his defenders would say, "*Pero tenemos carreteras*" [but we have roads]. I had driven from my home in Los Chillos Valley 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 would want to eat if I found myself locked up and disconnected. Rafa mentioned wanting pizza, so I bought that, too. Latacunga

is relatively small, and friendly people were eager to give us directions. After three attempts, I finally reached the prison, an old colonial building, with high adobe walls and a very long line of people waiting to get inside.

I parked and joined the line. My fellow 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 with the owner for a small fee. After an hour in line, it was my turn to go inside. I already knew the dress code, thanks to Rafa: nothing black, no hoods, no boots, no belts, no sunglasses, no earrings or other jewelry; that is, nothing which could facilitate sneaking in any forbidden objects – guns, drugs, money – or anything posing a risk for the inmates or for others. The dark colors were to be avoided because they resembled the guards' uniform, Rafa explained; they were not allowed because they could create confusion, letting prisoners posing as guards escape. The whole process seemed much too 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, she stamped my hand. Someone else joked about my Jewish last name – difficult to spell – while registering my presence. I later found that there had been complaints from human rights organizations about nude searches in the new Latacunga Penitentiary, and that this was a relatively common practice to humiliate not only inmates but their families, as well (Garcés 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 at the time he was drunk and high on acid; he'd been arguing with his also-intoxicated girlfriend, and they hit another

¹ A small city dedicated to tourism located on the slopes of Mount Tungurahua, a volcano.

car. They decided to take off, but they were chased down by the police patrolling the renovated Citizens' Revolution roads. The officers found three 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.² 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 use 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 that he was a drug abuser. 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.

Ecuadorian laws had become increasingly punitive throughout the late twentieth century, reflecting the country's alignment with the global repressive trend that flourished during those years. Still, sentencing wasn't necessarily clear, and Rafa tried to get out of his ordeal using multiple legal avenues. There was a clear directionality towards punishment, which came from way back, something that aligned the system against him. Possession and/or use of substances deemed illicit had already been penalized during the colonial period – nothing new on that score: in 1573, the "Devil's Work," i.e., the coca leaf, was expressly forbidden, only to be later regulated, with its sale generating profits for the Spanish Crown (Bonilla 1991, 15). The tax on coca was exchanged for one on alcohol when changes in the organization of labor were prioritized: the territories that would later become Ecuador were dedicated to textile production, while mining was concentrated in Peru and Bolivia. This meant an increase in alcohol consumption by Ecuadorians, while coca leaf consumption remained linked to mining activities.

² Complaints about the indiscriminate use of preventive detention in Ecuador had reached the Interamerican Human Rights Court; it was a problem stemming from Law 108, the harshest law in relation to drugs in the country (Paladines 2013).

In 1747, more than a century later, the Real Audiencia de Quito forced distillery owners to sell their alcohol production to the Crown for less than half the price it was subsequently sold for to the public, a regulation known as the *estanco* (Borchart de Moreno and Moreno Yáñez 1995). That decision led to the rebellion of Quito's barrios in 1765, when residents formed an alliance to protest the state's drug trade monopoly.

The Republic began addressing drugs officially in 1916, with the Opium Control Law (Paladines 2016). This legal instrument, inspired by United States' initiatives to control opium use around the world, introduced moral judgment against the use of opium, thus launching the "prohibitionist paradigm within the logic of prevention" (Paladines 2016, 9). In 1924, the country adopted the Imports, Sale, and Use of Opium and its Derivates Law, which included the Preparations of Morphine and Cocaine Law; this piece of legislation targeted the poppy and coca plants, thought to be evil. In 1958, the Trafficking of Raw Material, Drugs, and Narcotic Preparations Law came into effect, further expanding the prohibitionist trend to the raw materials used to produce narcotics and introducing the concept of trafficking.

Resulting from the Single Convention of 1961, the Control and Audit of Narcotics Traffic Law was passed in 1970 (Corte Constitucional 2012). This law stated, in article 30, that the penalty for drug trafficking would include eight to twelve years of incarceration and a fine of between 10,000 and 50,000 sucres.³ Regarding drug use, the law explicitly included, for the first time, a "public health perspective," ordering anyone found under the influence to be taken to a hospital, where he/she would be tested for dependency and, if so found, would remain hospitalized for treatment (Naranjo López 2016, 6).

Four years later, and in response to the 1971 Convention on Psychotropic Substances, this instrument was reformed by identifying the National Police and the General Office of Health as the two institutions jointly in charge of governmental oversight of dependency, creating the "Inter-ministry Commission," according to which criminal court judges had the authority to review cases of Ecuadorian citizens

³ The 1970 exchange rate was 25 sucres / one dollar (Bravo et al. 2010); the fine ranged from USD400 to 2,000.

and foreigners from countries that were party to the U.N. Convention, and to arrange for the deportation of individuals when deemed necessary (Corte Constitucional 2012).

In 1978, the Control and Audit of Narcotics Trafficking Law was reformed, with penalties increased to between 16 and 25 years of prison, and the fine increased to 50,000 to 100,000 sucres⁴ (Corte Constitucional 2012). The reforms passed during this decade related to the new discourse, proposed by President Richard Nixon, who defined attempts to stop the sale and use of illicit drugs as a war (Paladines 2016). These moves are indicative of a crime control model, with emphasis on the punishment of law breakers, as opposed to a due process model, which values protection rather than punishment (Wrightsmen et al. 2002). A 1979 legislative decree reduced prison sentences to 12 to 16 years.

During the 1980s, after the incorporation of additional treaties and agreements with an interdiction perspective, drug use in Ecuador surged (Bonilla 1991). However, there were no therapeutic alternatives to address use. Mental Health appears in 1975 as an area of the National Office of Family Health in the Organic Regulations of the Ministry of Public Health, but the entity existed in name only (Quishpi 2015). In 1980, the National Office of Mental Health was created as an independent branch of the Ministry of Public Health, with its own budget, and the director of the National Division of Control and Audit of Narcotics became the director of the National Office of Mental Health. In 1983, that entity began to offer therapy for addiction through 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 Ministry of Public Health would take over; yet, due to a lack of resources and, in particular, a lack of demand, the units ultimately shut down (Andrade, P. 1991). In 1984, the National Office of Mental Health was once more downgraded to a division within the Office of Epidemiology, and its budget was removed (Quishpi 2015).

In 1984, under the neoliberal administration of President León Febres Cordero, Ecuador adopted an ideological position towards sub-

⁴ Ranging from around USD2,000 to 4,000.

stance control in the context of Nixon's war on drugs, incorporating the idea of narcotics and psychotropic substances as public enemy number one (Bonilla 1991). The following year, Ecuador and the United States signed an agreement according to which the United States agreed to finance Ecuador's antidrug operation while the U.S. Drug Enforcement Administration (DEA) was allowed to operate in the country. Already in 1987, according to the new Control and Audit of the Trafficking of Narcotics and Psychotropic Substances Law, penalties for drug trafficking were approximately the same as those for homicide (Paladines 2016). From then on, the demonization of psychotropic substances became the basis for punishment for drug-related offenses.

In 1988, the United Nations Convention against Illicit Trafficking of Narcotic Drugs and Psychotropic Substances, to which the country subscribed in 1990, established the international obligation to classify the infractions listed in the Conventions of 1961 and 1971 as crimes, as well as indicating longer sentences for offenses classified as "severe" (Paladines 2016). As a result of this instrument, during the presidency of Rodrigo Borja, the country created one of the harshest laws in Latin America, the Narcotic and Psychotropic Substances Law, also known as Law 108. While Law 108 set punishments that ranged from 12 to 16 years, in 2005, the most recent reform of this particularly insidious law increased penalties to up to 25 years for drug-related offenses.

The objective of this legislation was said to be the need to protect the community from the dangers posed by the production, supply, wrongful use, and trafficking of narcotic and psychotropic substances (Congreso Nacional 1990). With this law, the country adopted low-intensity warfare against simple drug use, defining drugs as a problem of national security (Paladines 2016).

According to article 30 of Law 108, the police are to take any person who appears to be under the influence of a controlled substance to a psychiatric hospital or assistance center, where doctors are to verify if this is the case. If so, they have to "immediately order appropriate treatment. The treatment, which must be conducted in special centers, will be carried out in those which were previously approved by the Executive Secretary, in coordination with the Ministry of Public Health" (Congreso Nacional 1990, 8).

The criminalization of possession produced a dramatic increase in the prison population of both men and women; while in 1970, only 3% of inmates were serving time for drug-related offenses, that number increased to 17% by 1980 (Pontón and Torres 2007). At the same time, by requiring treatment for anyone found under the influence, the law created a profitable market for private addiction treatment clinics for people deprived of their freedom without legal proceedings. Persons locked inside these clinics were simply abandoned, with no record of their confinement, and with very little oversight by the State.

Law 108 created the National Council for the Control of Narcotic and Psychotropic Substances (CONSEP), which managed, among myriad other responsibilities, addiction treatment (Congreso Nacional 1990). Article 28 placed responsibility for evaluating and regulating addiction treatment centers in this institution, in coordination with the Ministry of Public Health. CONSEP maintained the registry of the country's rehabilitation clinics.

CONSEP wasn't an entirely 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 attorney general's office, with the creation of the National Office against Illicit Narcotics Trafficking (DINACTIE); however, between 1981 and 1983 the institution in charge was the Inter-Ministry Commission for the Coordination of Activities for Prevention and Control of Illicit Narcotics Trafficking. DINACTIE was shut down in 1986, due to corruption by staff members (Andrade, X. 1991). Subsequently, until 1990 the National Office for the Control of Narcotics Trafficking (DINACONTES) assumed DINACTIE's responsibilities.

When Law 108 came into effect, CONSEP replaced its forerunners. The law put the Council in charge of all matters related to drug policy (Congreso Nacional 1990). The Interior, Education, Social Welfare, Public Health, National Defense, and Foreign Affairs Ministries and the attorney general were charged with creating CONSEP's national plan for the prevention of and punishment for the use, production, and sale of substances subject to control, and for the rehabilitation of persons

affected by their use. The plan was to be approved by the president and then implemented by CONSEP. In addition, the entity was in charge of reviewing and incorporating drugs into the list of controlled substances according to international agreements that the country had signed. CONSEP was also in charge of reviewing regulations of institutions whose activities related in any way to Law 108.

While Law 108 gave responsibility over rehabilitation centers to CONSEP, it directed the Ministry of Health to create specialized wings within hospitals for drug abuse treatment or, if CONSEP so recommended, and depending on drug use in certain regions, the ministry was to create and staff care homes in existing health centers. The law also stated that these services were to be free, when possible; nevertheless, addiction treatment became almost exclusively dealt with by private clinics.

With the 2008 Constitution, changes in oversight of treatment clinics took some time. During the Citizens' Revolution, CONSEP remained in charge of rehabilitation, and the Ministry of Public Health began to conduct supervisory visits to private centers in 2013, to review permits and to ask patients about care. This change appeared to have no relation to the constitutional mandate, but instead, was the result of numerous reports by LGBTI movements about treatment for addiction and other behavior disorders, among these, homosexuality. Dehomosexualization was one of several ineffective, yet very popular, products on offer in the behavior modification market.

Law 108's requirement that anyone suspected of using a prohibited substance be confined in a rehabilitation center encouraged a thriving market for private addiction treatment clinics, a paid option that replaced jail time. According to CONSEP's 2012 "theoretical model for prevention," 22,500 Ecuadorians needed addiction treatment, an estimate based on national surveys. Of these, however, and based on the registry of 4,141 people in the addiction treatment centers that this institution regulated, only 15% were receiving said treatment (CONSEP 2012). The document did not specify the criteria for determining the need for treatment, nor did it describe the therapeutic approach being used. Moreover, it failed to mention the need for a differential diagnosis or the admissions procedure. The process of entering treatment

in a private addiction clinic, with a few exceptions, occurred with no mediation; instead, it was commonly an act of force, “the final product of a process in which the family and the center participated, 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 a relative was discovered consuming illegal substances, found in private clinics temporary, discreet relief of the anguish that drug use causes, regardless of its intensity. It didn't really matter if drug use was clinically significant; the mere fact that a prohibited substance had been used was enough for relatives to diagnose a problem and decide on treatment, just as possession was enough for the legal system to process an individual for drug trafficking. Private clinics became a costly option where “patients” could be rehabilitated, but there was no diagnosis to determine the clinical significance of drug use in persons confined in these centers. Instead, the concern of family members, and their willingness to pay for the treatment, was sufficient. Most of the time, the therapeutic approach consisted of torture, forced internment, starvation, and hours of “experiential therapy” which consisted of a former addict facilitating repetitive narrations by patients of gruesome experiences (Jácome 2012). Some clinics offered treatment for behavioral disorders other than addiction, including conversion therapy, also based on abuse.

CONSEP's theoretical reference document for prevention failed to address the results that the clinics promoted were getting. Were people being cured, rehabilitated? Were they better adjusted after leaving these clinics? Studies showed that those who were admitted, began a “career” as rehabilitation center patients, brought to these entities over and over again (Jácome 2012). After years of inpatient treatment in several clinics, beginning during adolescence and extending through adulthood, most former patients could only speak with resentment about the violence they had suffered. Many claimed that jail would have been preferable. Yet, in the document mentioned, CONSEP stated that clinics only covered 15% of demand, suggesting that more were needed.⁵

⁵ According to Thomas Szasz (1992), a US psychiatrist identified with the anti-psychiatric movement, the addict does not want treatment; he wants drugs.

New Discourses and the Belief that Something is Changing

Throughout the world, illicit drug use has been addressed for decades by repressive policies, aimed mostly at questions of supply, leaving unanswered the question of demand (Bagley 1991). However, these policies have not diminished 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” (United Nations 2011). The 2011 report from the Global Commission on Drug Policy explains that neither supply nor illegal drug use has been diminished by repressive measures directed at producers, traffickers, or consumers; moreover, any apparent victory due to the elimination of a trafficking source becomes irrelevant almost instantaneously as other sources and traffickers fill these lucrative roles. Also, “repressive measures aimed at consumers block public health measures to reduce HIV/AIDS, overdose deaths, and other harmful consequences of drug use” (United Nations 2011, 2).

Countries in 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 pardons to persons, known as “mules,” transporting small quantities of illegal substances; even when this didn’t translate into policy, it freed over 2,000 people from prison. Uruguay legalized the production and distribution of marijuana (Dubove 2015); in the United States, Colorado and Washington legalized recreational use of marijuana (Johnson 2015), and so on. These changes have implied a stronger emphasis on prevention and treatment, rather than the tendency historically inclined towards criminalization. Still, the region has not implemented 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).

Though drug use has been defined as a pathology, this definition is not based on a clear conceptualization of what the disease consists of. Thus, treatment that excludes criminalization, marginalization, or stigmatization is not assured. Also, research shows that the way pathology

is understood when it comes to drugs may not be accurate as it seems to exclude other possible reasons for drug use, such as the internalization of structural violence or unbearable realities. One concern regarding medicalizing or pathologizing drug use is that it may take responsibility off the person, somehow legitimizing conflictive uses (Valverde 1998). Law 108 was based on the contradictory idea of addiction as a power of the substance over the subject; consequently, the only possibility for improvement is confinement: prison for those possessing a prohibited substance and private clinics for those found using.

From the 1970s to the 2000s, the country signed 26 international agreements which reflected global trends in the war on drugs (Paladines 2016). They included the 1999 agreement to allow for the establishment of a forward operating location by the United States at the Manta military base, in order to “intensify international cooperation for the detection, monitoring, tracking, and aerial control of the illegal activity of drug trafficking” (Ochoa 2007, 106).

The agreement was rejected by different groups, including two that declared it unconstitutional based on the following arguments: it was never approved by Congress; the Constitutional Court never issued a report regarding whether or not it complied with Ecuadorian law; national sovereignty was being compromised by allowing the free circulation of citizens, aircraft, ships, and other vehicles from the United State; the legal and fiscal immunity granted to the Americans at the Manta base infringed on principles of equality before the law; and, surrendering the right to compensation for damages caused by U.S. military presence on the base left Ecuadorians defenseless (Saavedra and Coba 2007).

Activities at the military base associated with the war on drugs continued for the 10 years stipulated in the agreement, at which point Ecuador, under Correa, chose not to renew the contract. In fact, ending the lease was portrayed by the government as a triumph of sovereignty, as the minister of Foreign Affairs, Fander Falconí, stated at the closing ceremony that “never again [will we allow] foreign bases on Ecuadorian territory, never again the sale of the flag.”⁶

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

The 2008 Constitution challenged the status quo in regard to drugs by mandating that drug abuse be addressed from a public health perspective. At the same time, a pardon for drug mules was granted by the Constitutional Assembly, but it failed to become an institutionalized policy, remaining, instead, as a one-time thing until Correa's presidency ended in 2017, at which time he issued a pardon for those with up to five-year sentences who had served 30%, a move that reduced their time by 10%.⁷

After being considered one of the most repressive countries in the region with regard to drugs, by questioning policies coming, in large part, from the United States, the changes Ecuador was making positioned it as a counterhegemonic country (Paladines 2015). These changes included amnesty for mules granted by the Constitutional Assembly in 2008, nominal prohibition against criminalizing drug users (article 364 of the 2008 Constitution), refusal to renew the forward operations location established by the United States in Manta in 2009, withdrawal from the Andean Trade Promotion and Drug Eradication Act (ATPDEA) in 2013, creation of thresholds for drug possession in 2013, and reduction of penalties for small-scale traffickers in the 2014 Criminal Code. In this context, civil society actors believed that change was actually happening.

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. He was initially sentenced to 12 years, but because of what were known as "important extenuating circumstances" (that is, rattling on other people), his sentence was reduced to five years. As soon as he arrived at the prison, a group of six inmates approached. 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 three hundred dollars if you don't want them to break your bones" (interview, June 12, 2013).

⁷ "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 of up to five years and who had already done 30% of their time], *El Comercio*, May 25, 2017, <http://www.elcomercio.com/actualidad/correa-indulto-mulas-droga-sentencias.html>

Rafa had been warned about “welcome parties,” and he knew that, if he gave in, he would be forever extorted by fellow inmates with the consent of the guards. He stood his ground and refused to pay, in spite of the beating he knew he was risking: “If you say no, they might beat you up. You have to defend yourself, and take it.” He also explained that if you can’t be intimidated, they still steal from you. The prisoners bothered him for a month and then there was a fight. Rafa defended himself. Matters got so intense that some of the men involved were transferred to other prisons. For Rafa, it was a matter of survival. 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, teaching inmates how to read. He was also participating in English classes and he attended the wood workshops offered by the prison, determined to reduce his sentence with good behavior.

The store was a one square meter wooden structure, with everything hanging on hooks. Cooking oil, soap, sweets, an array of items to satisfy his clients’ tastes. Next to the merchandise was Rafa’s bed. He managed to create his own little fortress by hanging blankets from the upper bunk bed in order to enclose the lower bunk where “The Simpsons” was playing on the color TV and where we sat to eat the pizza. Lucho, a friend who visited Rafa every week, had arrived. For a little while, it felt like we were hanging out at someone’s house. This small spot isolated Rafa from isolation, from the prison, from other inmates. Being a visiting day, his store was closed, but people stopped by 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 other inmates.

Rafa had been charged with a crime included in Law 108, still in force because the new penal code had yet to be passed by Congress, and, thus, before the creation of ‘the chart’ specifying quantities of drugs that could be legally possessed. This meant that Rafa was at the mercy of an arbitrary legal system and its decision-makers. Everyone asked for money as soon as his ordeal began and a series of lawyers made promises and offered advice. In the end, Rafa lost everything he had, spending over USD50,000 on his defense, an effort that produced no results so that he was left with no choice but to do his time.

Rafa's life in the old Latacunga prison was bleak. He had a few friends who visited often; his mother stopped coming, as did other family members. Nevertheless, he adapted, trying to make the best of this experience. Teaching other people to read, learning woodworking, participating in English lessons felt like a way of giving in a situation with severely limited options. The store made matters more bearable than they might have been. He had a cell phone on a pre-paid plan and he used it to ask his friends to chip in when he needed to restock.

Before leaving, Rafa gave me a couple of plastic containers for the seafood. 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 went to the car. Lucho and another guy who had come to visit Rafa went with me, so we could get the seafood in the plastic containers fast and go back with it. The guards took the food and passed it along to our friend. Rafa was feeling like he was going to make it. And then he was moved to the new prison.

The Chart and Its Multivocal Meaning

I was supposed to drive members of the Ecuador Cannábico and Diabluma groups around the city. Diabluma was a social movement, which defined itself as a “radical left” organization, concerned with urban tribes' discrimination, the rights of nature, abortion, cannabis, and other matters.⁸ Ecuador Cannábico was an organization within Diabluma, focusing exclusively on cannabis issues. They planned to leave graffiti on walls at strategic points to announce the upcoming World Marijuana March, and they needed someone with a car to help out. I was happy to come along. It was March 14, 2014.

I arrived at the Diabluma headquarters around 7:00 pm, but the guys weren't in the office. They had occupied an empty building near the National Assembly for some years, a two-story abandoned structure across the street from the building where Alcoholics Anonymous was located, and I was to pick them up there. When I arrived, Felipe, Diabluma's

⁸ “El gobierno tiene en los Diabluma a un grupo de activistas afines” [Members of Diabluma are activists supporting government policy]. *El Comercio*, November 25, 2012, <http://www.elcomercio.com/actualidad/politica/gobierno-diabluma-a-grupo-de.html>

leader, called to tell me that there was a change of plans, because Charlie, one of the Ecuador Cannábico enthusiasts, had been caught by the police with some weed, and that they were going to show their support outside the prosecutor's office a few blocks away. He asked if I could join them instead, while Gabu, Ecuador Cannábico's leader, worked on the graffiti, adding to the announcement mention of the unfair arrest. I went to the prosecutor's office.

Following the trend set by the Constitution, in 2013 CONSEP presented a maximum amounts chart, in order to differentiate between drug users and traffickers (Paladines 2013). Law 108 states that people who use drugs should not be criminalized, but it does not differentiate between users and traffickers. CONSEP, along with many other institutions, were trying to offer guidance for judges sentencing cases involving the possession of small amounts. Oddly enough, this move marked the beginning of the end for the change of direction in which the country appeared to have been moving since 2008. The chart produced a series of responses that ranged from outraged letters to the editors of print media to a campaign by the Secretary of Communications maintaining that all drug use is criminal.

As Rodrigo Tenorio, former director of the National Drug Observatory, explained, it took years to create the chart (interview, July 14, 2013). The institutions that were part of the Council participated and approved the thresholds and, when the document was approved, the government summoned CONSEP, the National Communications Secretary (SECOM), and the social movement Diabluma to a meeting.⁹

Felipe had participated in the Constitutional Assembly, along with other members of social movements who presented their demands to legislators drawing up the new Constitution.¹⁰ Specifically, he wrote article 364:

Addictions are a Public Health problem. The state is responsible for the development of coordinated information, prevention, and control programs for the use of alcohol, tobacco, and narcotic and psychotropic

⁹ Diabluma invited me to the meeting; it was at SECOM headquarters on June 17, 2013 and the core issue was the public campaign to publicize CONSEP's chart in order to generate public acceptance.

¹⁰ For further details on the Constitutional Assembly, see Ortiz Lemos (2013).

substances, as well as for offering treatment and rehabilitation to occasional, habitual, and problematic consumers. In no case will criminalization be allowed, nor will the rights of users be infringed upon (Constitution of Ecuador).¹¹

Diabluma and its branch, Ecuador Cannábico, represented the visible, organized members of civil society involved in drug issues. I met Felipe in 2010. We got to chatting, and I found myself empathetic with their anti-bullfighting position which, for them, included 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 on cannabis legalization reasonable. I had done consulting work on the topic. Felipe and I remained friends and, since my research focused on drugs and prisons, I began to spend more time with members of the group. They also relied on me for academic support, asking that I 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 CONSEP.

At the meeting, government attendees addressed the public relations strategy that would accompany publication of regulations created by CONSEP to promote public acceptance of the chart. However, the government newspaper published the chart before its scheduled release, and the news elicited a range of responses from different sectors of society, forcing the government to begin the campaign early. The objective of the campaign was to produce new discourses about illicit substance use from a public health perspective, based on the Constitution, in contrast to those produced by repressive policies. However, the spots created by SECOM left an ambiguous message that supported the hegemonic discourses, without a real change of focus. On the contrary, the spots maintained a moral perspective on drug use, without proposing other representations, justifying excessive force.¹²

¹¹ Rodrigo Tenorio describes the irony in article 364; he states that while differentiating usage from trafficking is correct, the article “erases with its elbow what it wrote with its hand when, in the next line, it says that it is enough for someone to have smoked or used once to be taken to a rehabilitation clinic” (interview, July 14, 2013).

¹² SECOM had already been criticized for a spot launched after the murder of a young woman, Karina del Pozo, because she was under the influence of alcohol and got into a car with people she

Official policies remained largely the same, derived from the war on drugs which depicted illicit substances as an evil (*mal*) to be combatted. One spot, based on the story of Fabián Soriano who was serving an eight-year sentence for marijuana use, presented the young man 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.”¹³ While the idea was to generate public acceptance of the decriminalization chart indicating maximum amounts of illicit substances that would not lead to criminal charges, the spot focused on the consequences of using drugs from a prohibitionist perspective, with blame assigned to the prisoner, while introducing a pathologizing perspective. Medicalization of addiction did not negate individual responsibility.

The ambiguity of SECOM’s campaign reflects the vagueness of governmental representations of drugs, as they don’t have a fixed meaning but, instead, their sense depends on context (Gamson 1999). The polysemic nature of the word ‘drug’ and its political use simplify interpretation into a Manichaean choice between right and wrong, emphasizing the illegal, avoiding analysis, and reducing the use of any illicit substance to a crime (Paladines 2013). Though the people involved seemed optimistic about alleged changes in policy, the spots were a reminder of Ecuador’s tradition of demonizing the topic. Beyond discourses, practice would have to demonstrate what was really going on.

* * *

Charlie had been hanging out with his girlfriend in Quito, and he got some weed to celebrate the lunar eclipse that was expected a few hours before dawn the next day. He had moved out of his parents’ home in a rural area 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

didn’t know (*El Comercio*, March 17, 2013). This campaign was criticized for blaming the woman, and led to responses from activists, such as Rocío Carpio, who claimed that the message promoted and legitimized gender-based violence.

¹³ Secretaría Nacional de Comunicación, “SPOT Drogas,” video, 0:48, <https://www.youtube.com/watch?feature=related&v=ht6MUfa6r5M&app=desktop>, emphasis added

his girlfriend decided to go to Los Chillos Valley to have a better view of the eclipse. They got on a bus at the Salesian University. While they were waiting for the bus to leave, Charlie got a phone call from a friend, asking if he could ride with him to the valley on his motorcycle. Charlie had been arguing with his girlfriend, and this seemed like a good moment to take a break. They agreed to meet again in Los Chillos, and Charlie got off the bus.

At an interchange, Charlie's friend noticed a police officer signaling for them to stop. The police had been looking for two guys on a bike, and they were stopping motorcycles. Charlie's friend didn't have the motorcycle's registration. He panicked and took off, taking Charlie with him. At the other side of the interchange, police were waiting with their guns drawn. 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 Marín police station, where they were searched. 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 papers, everything, and the scale read 80 grams. The initial police report read "80 grams of cocaine," even though it was weed.¹⁴ I later discovered that the police regularly lied about the type and quantity of illicit substances found on those arrested, but at that time it seemed like a horrible mistake (Jacome 2016). Charlie and his friend were moved to a jail cell.

The idea of gathering outside the prosecutor's office was to make a little noise, show support, and, especially, show the authorities that there were people who opposed jailing someone over small amounts of substances deemed illicit. The Diablumas and the Cannábicos met in the middle of the night, outside the police station to wait and to be seen. Charlie's parents arrived, along with his girlfriend. The Diablumas brought flags and signs and placed them on the floor near the entrance. Anyone coming or going from the police station knew someone had been taken in for a small amount of pot. Cops came out and took photos of us. A woman sold coffee and rolls on the sidewalk nearby. We

¹⁴ According to the chart indicating permitted quantities of illicit substances, marijuana is the substance with the largest amount allowed. It is the only drug around which social movements have organized, and it is depicted in a more benign fashion than are cocaine and other "hard" drugs.

stayed until Charlie's hearing date and time were announced. It was going to be two days later, at 6:00 a.m. We agreed to meet outside again.

Charlie was charged with violating Law 108, as the new criminal code was not yet in force. But CONSEP's chart was, and it became a reference point for his case. Alexandra, a member of CONSEP's staff who had worked on the chart, explained that it was only a small piece of a more complex proposal that they had outlined with the participation of other institutions forming the Council: the Ministry of Health, the Attorney General, the Ministry of Justice, among others. The Diablumas helped put pressure on the Ministry of Justice and the Attorney General so that they would support this submission to the Council.

The chart was an appendix to a document that 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. However, focus fell almost exclusively on the chart, generating a series of misinterpretations.¹⁵ For Rodrigo, former executive secretary of 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 about them; they don't need to be public" (interview, December 28, 2014).

The chart, created by the Ministry of Health and approved by the Council, set the following thresholds for possession for personal use (Paladines 2013): marijuana, 10 grams; cocaine base paste, 2 grams; cocaine, one gram; heroin, 0.1 grams; MDA, 0.015 grams; MDMA, 0.015; amphetamines, 0.40 grams. According to Paladines, a public defender who was actively participating in the constitutional debate, the thresholds set by Resolution 001-CONSEP-CO-2013 were binding, as they were presented by state drug use prevention and health entities which, legally and constitutionally, are responsible for informing the judiciary of ways to avoid criminalization of illicit drug use.

¹⁵ "Ecuador fija tabla para el porte y el consumo de drogas" [Ecuador establishes table for the possession and consumption of drugs], *El Telégrafo*, June 17, 2013, <http://www.eltelegrafo.com.ec/noticias/judicial/13/ecuador-fija-tabla-para-el-porte-y-consumo-de-drogas>

When *El Telégrafo* published the news,¹⁶ the focus was, almost exclusively, on the fact that the chart indicated the quantity of drugs that could legally be possessed and consumed when, for those who had developed the chart, the relevant issue was related to human rights and incarceration. The war on drugs had increased dramatically the number of people imprisoned for drug-related offenses and, in many cases, those sent to jail were drug users, rather than traffickers. However, the way the chart was portrayed in the media determined the meanings it produced, even after Correa left office.¹⁷ The main problem, Alexandra believed, was that the public had not been sufficiently included in the institutional decision-making process debate regarding the chart or in the proposal for drug legalization.

Alexandra compared the Ecuadorian process to what happened in Uruguay, where there was a ten-year public debate on the legalization of marijuana, after which Uruguayan citizens were ready to approve the change. However, involvement of institutions that were Council members was so limited that they didn't really understand what the chart was about, and some ended up opposing it. In the end, not even CONSEP backed its own chart, and discussion of the issue degenerated into fears and prejudices regarding drug use.

Charlie's family and his lawyer, a public defender, were the only people allowed to attend his hearing. When it was over, Felipe explained that Charlie had been sent to the Provisional Detention Center (CDP), in the former García 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 legal distinction made all the difference. In addition, CONSEP had to burn the material in order to properly weigh it, at which point the judge would ultimately decide on his fate.

Charlie was assigned to preventive detention. The penitentiary was inaugurated in 1874, during the second presidency of Gabriel García Moreno (Pino Rosero 2015). Based on the panopticon concept, the

¹⁶ *El Telégrafo* (17/06/2013). "Ecuador fija tabla para el porte y consumo de drogas" [Ecuador establishes table for possession and consumption of drugs.] <https://www.eltelegrafo.com.ec/noticias/justicia/1/ecuador-fija-tabla-para-el-porte-y-consumo-de-drogas>

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

National Penitentiary had a radial design similar to the prison in Bogota by the same architect, Englishman Thomas Reed. There are five three-story radial wings, 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 there was a chapel until 1910. I had been there in 2011, invited by the Ministry of Justice to evaluate a rehabilitation program started by a psychologist 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 didn't wait in line, nor was I patted down. The psychologist 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 for drug-related crimes.

Everything looked old, dirty, and dark inside the penitentiary. After our conversation, the psychologist decided it would be a good idea for me to speak with the inmates. He called prisoners to a meeting room and introduced me. My own prejudices were triggered when the psychologist left me alone with the inmates for the evaluation, but my training generated a rational reaction and we had a conversation about the inmates' experiences with the psychological aspect of rehabilitation. The stories I heard were horrific, of people losing decades of their lives for traveling with drugs to other countries. And their perceptions of the psychological "treatment" they received were worrisome. One of the men was unable to finish his story because he began sobbing. He was a Mexican who owned an engine repair shop in his own country, who was convinced to take drugs from Ecuador to Mexico for money. He was caught at the airport and sentenced to 25 years. 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 talking about their suffering.

My next visit to the prison was as a regular visitor. Felipe managed to have Charlie sent to the "pressure"¹⁸ wing, where men who had not

¹⁸ The *área de apremio* is for men who have not paid child support. In Charlie's case, influence, mostly Felipe's, got him placed in the *apremio*, along with police and military personnel who were behind on child support payments.

paid child support were sent, instead of the *lagartera*, where everyone else was sent, including drug offenders and men sentenced for violent crimes: having ties with the Citizens' Revolution had its perks. As time passed without Charlie's case being resolved, Felipe asked me to visit him. He was worried about Charlie's state of mind and Felipe wondered if I could help him calm down while his case got sorted out. I agreed, and we set a date, which we arranged with Charlie's parents, as only one visitor was permitted on the twice weekly visitation days.

Charlie had been at the CDP for over a month. In San Roque, the neighborhood in which the penitentiary is located, I stopped at the small store where I had to leave my keys, then met with Charlie's dad, who gave me a bag with a three-liter bottle of soda and some food. I stood in the line at 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 said that the dogs come and go, and waved me inside.

The line broke into two: one for men and the other for women. We were searched 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 searched visitors. I placed my bag in a bin and was checked by a guard, then spread arms and legs for the customary pat down. The entire process was impersonal, mechanical, and long. I no longer felt like joking when I got searched. Charlie had been told that I was coming, as we hadn't really met before. But he knew of my arrival, and the guards did, too, pointing him out to me. I had exactly one hour for the crisis intervention.

The area for visitors was a narrow corridor. The sun was visible for only an hour each day as it passed across the space. The room where Charlie was staying was a large visiting area housing pretty much everyone in the ward. We sat on a cement bench near the bedroom door, and began speaking. In psychology, crisis intervention consists of a set of tools designed to alleviate suffering and diminish the risk for further pathology after a traumatic experience overwhelms a person's capacity to operate in a normal fashion (Slaikue 1996).

In this case, Charlie's confinement, along with the uncertainty that the legal process brought, had taken a toll on his state of mind, which is why Felipe asked me to intervene. He was depressed, couldn't sleep; he felt

ashamed, and the overwhelming uncertainty of his situation was driving him crazy. We went through the story of his incarceration, the interminable legal process, and the situation inside, which, as he 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 food from family members, they watched TV and played cards, and so on. In the end, Charlie said he believed he could deal with the situation, and decided he would look at this period 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 of this time, such as keeping a diary in order to observe his situation as a scientist would. When the time was up, we said our goodbyes and I left.

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 number of 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 arrest remains on his criminal record, as he refused to pay the USD3,000 that he heard it would cost to have it removed. After getting out, 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 on one occasion, as their son had moved back home and seemed completely lost. No one really knew how to deal with the whole thing.

Prison Populism and Counter Reform

In 2014, the new Organic Integral Criminal Code (Código Orgánico Integral Penal, COIP) was passed, and with it came a new change in the classification of drug-related offenses: traffic level (persons trafficking large, medium, and small amounts of illegal substances); traffickers versus growers; drug offenses versus violent crimes; and small traffickers versus drug users (Asamblea Nacional 2014). Though it included a maximum amounts chart, it had changed, with the maximum quantities permitted

considerably decreased, thus returning to the ambiguous differentiation between users and traffickers (Paladines 2014). Similarly, COIP established differentiated penalties, ‘correcting’ the inconsistencies of Law 108 in terms of its legal proportionality. CONSEP remained the institution in charge of prevention and control of trafficking, as well as the seizure of goods. The Ministry of Health had already taken charge of addiction treatment and rehabilitation.

That same year, the new rehabilitation center in Latacunga opened. Demands for better conditions for 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 inmates from a human rights perspective. With reform of the grounds for incarceration, it appeared that the government was aiming to rectify years of repressive policies. The Citizens’ Revolution depicted itself as truly emancipatory, but it invested millions in the penal industry that had been underfunded (Núñez Vega 2006). Nevertheless, the contradictions in penal policy grew evermore evident, revealing the 21st century socialist state to be 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, on April 1, 2014, there were 269 people incarcerated in one building, that is, 300% over capacity.¹⁹ When it was closed, a health inspector ordered that 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

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

that made him think of the KTM factory, a motorcycle company that decided, in 1992, to make its bikes instantly identifiable by painting them orange (Keller 2016). Before he was imprisoned, Rafa had been into motorcycling sports: in 2009 he was a co-pilot for the Ecuadorian team at the Dakar Rally, after which he and his partner did a South American tour of 27,000 kilometers 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 his orange uniform immediately identified him as such.

The government earmarked USD244,306,956 for the new penitentiary. Of this amount, USD214,533,748.27 were spent on infrastructure; USD27,505,321.76 on food, and USD2,267,885.97 on clothing for prisoners. The Minister of Justice explained that the new center permitted equal treatment for all inmates, in contrast to 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 Secretariat of Education, Science, Technology, and Innovation (SENESCYT) allowed some inmates access to higher education.

Rafa's experience, however, told a different story. Everything was different at the new social rehabilitation center. Visiting policy was stricter: people needed to be included on a list before visiting day and there was a limit to the number of visitors listed. Rather than three days a week, visitors at the new prison were limited to one hour once a week. Inmates could have conjugal visits once a month as long as it involved the same person registered to visit. Rafa's previous weekly visits were reduced, further isolating him from the outside world. Also, moving to the new prison meant losing his source of income, his TV set, his telephone, his clothes, and other possessions. He was unable to communicate with the outside world until finding someone who would lend him a cell phone occasionally. He wanted to sneak one in, but prices were too high: when he first arrived, a phone cost USD3,000 on the inside, and more time if he got caught. At the new prison, control increased and there were considerably more symbolic aspects generating the new atmosphere of submission.

In 1970, social psychologist Philip Zimbardo conducted the Stanford Prison Experiment, choosing a few symbolic aspects in order to create a prison atmosphere and assess the effect of imprisonment on ‘normal’ people (Zimbardo et al. 2000). He concluded that certain elements, such as uniforms, the chains on the subjects’ ankles, even the fumigation ritual at the beginning of the experiment, reminded inmates of the oppressive enclosure they now inhabited. As opposed to the small shelter Rafa had been able to build for himself at the old prison, the new social rehabilitation center gave him no way to escape.

Clothing was always an issue at the new facility, Rafa recalls. Besides the fact that clothes assigned to each inmate were constantly stolen, when he first arrived there was already a well-organized informal laundry service available. But after a while, the service ended, and keeping clothes clean became each inmate’s problem to solve. 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, he couldn’t choose. “You feel safe at the new one, but that’s only at the beginning. Eventually, no doubt, it will also become overcrowded” (interview, April 25, 2016).

Cameras, more guards, and spaces organized 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 none. There also were no towels, no phone calls, and no razor blades. The men eventually had fungus on their heads, but no doctors in the building were able to treat the malady. Rafa remembers that there were only four doctors when he was moved there. There were reports of arsenic in the prison water, as the source was an underground spring linked to Mount Cotopaxi, a volcano (Morán 2015). Rafa couldn’t take it anymore. He decided he’d had enough, and so he led a peaceful 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 went to the prison.

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 hit him hardest. Each inmate had to submit a list of ten persons who would be allowed to visit. Spontaneous visits were discouraged, time was reduced, and contact with society became even harder. Rafa had more time to himself and, he said, time slowed down; time became more obvious. And the modern industrial mechanics and carpentry workshops had not yet opened during the year Rafa spent on the inside. He did have certain privileges, because he chose to study. After getting 906 over 1000 points on the exam administered by the National Secretariat for Higher Education, Technology, and Innovation (SENESCYT), 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, incarceration rates remained similar to what they had been prior to reforms as did practices found both in the traditional and the newer repressive apparatus. This became clear when counter-reform was spelled out in 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, in his 441st address to the nation, noted that the chart for maximum amounts meant that a person with a gram of heroin would not be considered a drug trafficker. He call this “a failure, not of COIP but of the chart” and evidence of “romanticism” and said that to keep drugs away from young people, micro-traffickers had to be punished. Correa also said that preventive detention should once again be considered for drug-related offenses.²⁰ Charlie’s case demonstrated that the practice had never disappeared in drug-related arrests.

²⁰ “Enlace Ciudadano 441, desde Puerto Limón” [Citizen Link 441, from Puerto Limón], *El Comercio*, September 12, 2015, <http://www.elcomercio.com/actualidad/enlace441-enlaceciudadano-sabatina-rafaelcorrea-puertolimon.html>

The presidential speech revealed a clear return to harsh policies for drug traffickers, as well as the return of the legal ambiguity through which traffickers and users had been (or had not been) differentiated. In practice, this was a return to a punitive approach to drugs, which translated into a 60% increase in the number of people incarcerated for drug-related offenses: while during the first semester of 2015, 4,629 people were detained for drug possession, during the same period the following year, that number increased to 7,413 individuals. The chart reform, as well as increased sentences, has in turn increased the numbers of people imprisoned, which does not necessarily correlate with increased effectiveness of public prison policy (Paladines 2017).

Marching through the Institutions

I met the executive secretary of CONSEP, Rodrigo Vélez, 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 of drugs back in 2011, an investigation sponsored by the National Drug Observatory. In 2014 I was working on the final edit of the report that the Observatory was going to publish, and I knew some of the employees there. Ecuador Cannábico had organized the march for the sixth time. It began at the skateboard track in La Carolina Park, and it ended at the Casa de la Cultura. Marchers stopped a few times on the way: at the offices of SECOM, CONSEP, the attorney general, and, finally, outside the Casa de la Cultura where there was a festival with bands, stands, cannabis cotton candy, and so on.

Hundreds participated. At the park, before departure, vendors offered paraphernalia: pipes, t-shirts, lighters, grinders, rolling paper, and other products. The organization had all the permits required, and police officers accompanied marchers, stopping traffic at intersections. We began at Shyris Avenue, marched to Eloy Alfaro and from there we took Amazonas Avenue, another of the capital's main streets, after stopping at the offices of SECOM, where movement leaders left a copy of the manifesto.

CONSEP is located at an intersection on Amazonas Avenue, next to Santa Teresa Catholic Church. People gathered between CONSEP and the

church began smoking a giant joint. I was taking pictures while employees observed the crowd from their office windows. Felipe and Gabu asked me to go with them to deliver the manifesto to the executive secretary.

We were taken to a conference room, where Rodrigo Tenorio was expecting us. He accepted a copy of the document that Ecuador Cannábico had prepared and he chatted with us. By the time he began working at CONSEP, the institution was already staffed by people with a different view of drugs. As the former director of CONSEP's National Drug Observatory, Rodrigo had been an important figure in allowing new discourses that challenged the status quo, and he claimed that the previous executive secretary, Domingo Paredes, had brought fresh ideas into the drug control council.

The executive secretary said he agreed that drug policy was overly punitive, and that prohibition hadn't accomplished what had been intended. However, he reminded us that the council is made up of many other state institutions, and that, ultimately, he would not make the decisions affecting drug policy. He was cautious in his conversation; political correctness reigned at this meeting with the radical left anarchists. What was communicated was that it is not only the national institutions, such as the Ministry of the Interior, but also international entities that put pressure on governments to maintain the status quo. Rodrigo tried to keep everyone happy, but beyond his politically correct speech, practices favored prohibition. We moved on to our next target, but when we got to the attorney general's office, we were not invited in. They did accept a copy of the manifesto. I visited the fair at the Casa de la Cultura and bought a cannabis cotton candy that produced no psychedelic effect whatsoever. I left soon after.

The "inter-institutional" overlap that CONSEP had with other institutions made its responsibilities confusing and ambiguous but, for Rodrigo, the council he managed was leading a historic process of reclaiming sovereignty over drug laws and policies that were traditionally determined by foreign institutions: "The nations of the world have, unwittingly, made this a highly profitable business, we have been very efficient at doing so; this we have accomplished with prohibitionist policies". He doesn't believe that drug use can be eradicated; instead, societies need to learn how to administer use, and the laws, beginning

with the new Constitution, were slowly aiming at this change. Rodrigo believes that the chart was one step towards rethinking policies. He said that, if the state regulates drug use, it will be easier to understand problematic use and develop therapeutic approaches that meet the need adequately. “Otherwise, we are trying to figure out how to address an addiction, or drug use that has become problematic, without knowing the quality of the substance, its ingredients; we should know that” (interview, December 28, 2014).

However, Ecuador has never adopted a clear policy on drugs. And people like Rafa were falling between the cracks of a new penal system, while trying to better defend their rights and protections as simple users. Meanwhile, Rodrigo explained that CONSEP generally oversees the flow of chemicals used in different industries – food, pharmaceuticals, textiles, paint, glues, and petroleum. Responding to a request from the United Nations, CONSEP was giving advice to other Latin American countries, even providing them with some computing tools used for this type of substance control. The institution, he claimed, had turned into a model for other Latin American nations. At the same time, he 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 poisoning, the manufacturers could be traced and, aside from punishing those responsible, the state could outline policies to oversee craft production of the substance in question, something that could not be done with illegal drugs.

For Rodrigo, the main problem of policy implementation has to do with the lack of popularity these topics enjoy, “especially since we have been brainwashing our societies for 40 years”. The original strategy, he continued, was set in motion for colonizing purposes: global powers controlled the markets and defined illegality in terms of what was beneficial for them. England, which controlled the opium market, Rodrigo explained, pushed for illegality when they lost control. In recent years, Latin America has begun to react: “All the tragedies we have lived through 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” (interview, December 28, 2014).

The executive secretary also said that most countries agreed that this was a public health problem: drug addiction and abuse are health issues related to economic development and human rights. But the approach ultimately adopted in Ecuador remains police-oriented, with the United Nations leading this position and multi-laterally imposing it. Ecuador, he claimed, has asked for the involvement of the World Health Organization (WHO), although 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 CONSEP and was later hired at the public addiction treatment center, explained that there is tremendous prejudice regarding drugs, not only in terms of prevention, but also in terms of the therapeutics addressing drug use. She said that Ecuador had not begun to deal with this phenomenon: religion and prejudice had been left untouched, and this consensus affects drug policies, because drugs are still viewed as taboo.

Lorena. They don’t dare speak about drugs in a straightforward fashion; it is as if we wanted to ignore a reality which we have, and in the world, which is that people use drugs. Perhaps due to moral issues, we get spooked by some things but nothing happens with others, it becomes a religious issue, which complicates our work (interview, November 12, 2014).

In the midst of these official contradictions, Charlie was already out but Rafa remained imprisoned. He had claimed to be an addict when he got caught, a strategy that would have worked if he had been arrested in Quito, and if the state had 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 drug use was not problematic; he didn't consume anything for about a year. Yet once he was sentenced and 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 had picked it up. Rafa put all his energy into 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 (*prelibertad*) once he had completed two-fifths of his sentence. Having had his sentencing reduced to five years, Rafa could have been free in two. He began the process for requesting release, and matters looked promising. There really was no reason for him to remain imprisoned. However, six months after beginning the 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 hardcore drug dealers with enough money to have plenty of drugs flooding the facility. Until that moment, the only drugs available were *bazuco* (base) and marijuana, but the new guys brought everything: heroin, cocaine, acid, and ecstasy. Many became hooked, and Rafa remembers this as one of the most shocking aspects of being moved to the new jail: no treatment was available, and heroin addicts now had to stop using 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 two weeks in the new prison, 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 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 inmates was a political decision, or at least that's what Rafa thought, considering that the place wasn't ready to receive prisoners. Since there wasn't an outside fence, during the first months, prisoners were locked in the cellblock. With about five people per cell, with no running water and a shared toilet that was filthy, the inmates had to spend all of their time there, including meals. Individuals with "horrible cases of withdrawal" were also right there, without any type of treatment. Everyone knows that heroin withdrawal can kill, Rafa remembered. But nobody cared. The social rehabilitation system had managed to hook people on drugs that they didn't use on the outside; then they took them away at the new place, at least until the guides found the right person, *el duro*, in Latacunga.

Modernization of social rehabilitation "services" included addiction treatment for the interns.²¹ The Minister of Justice spoke of addiction and the criminal consequences it had produced in those affected, disregarding new perspectives which link prohibition, instead of drug use, with violent offenses (Hart 2013; Jácome 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 on the Ecuadorian coast). The process, she added, had been designed along with the Ministry of Health and, after six months, it would allow for the reinsertion of prisoners into their life plans. As an example of success, she explained that inmates in the addiction wing were already participating in handicrafts and sports.

The war on drugs had already been identified as responsible for the increase in the prison population and consequent overcrowding, as drug users were not differentiated from traffickers. While Law 108 prohibited criminalization of users, it penalized possession, once again, demonstrating the contradictory nature of drug policy. The constitutional mandate gave the Ministry of Health full responsibility over addiction treatment,

²¹ "260 privados de la libertad adictos a las drogas llevan más de un mes sin consumir" [260 imprisoned drug addicts have not used in more than a month], *El Telegrafo*, October 1, 2015, <http://www.eltelegrafo.com.ec/noticias/judicial/13/260-privados-de-la-libertad-adictos-a-las-drogas-llevan-mas-de-un-mes-sin-consumir>

but it took about five years to begin seriously assuming this responsibility. That finally occurred in 2013, the same year that CONSEP presented the chart as a technical tool for judges to apply in sentencing.

From afar, it might have seemed as if Ecuador was radically changing the direction in which the country had been heading during the previous four decades. At the same time, investment in prisons generated doubts, as an increase of prison capacity seemed to contradict the emancipatory process.

A psychologist arrived at the Latacunga prison a couple of months after he did, Rafa recalls. She began to medicate those going through withdrawal. Everything looked improvised to him. But he 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 he got a fungal infection from the water they eventually had access to. Skin infections were reported 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 stage a peaceful protest one day, refusing breakfast. A 50-year-old prisoner joined him. When lunch came, they refused that, as well. They were simply making a statement. But there were 300 people in the same wing. And most of them were not really focused on leaving; eventually the protest got out of hand. Inmates destroyed the new bathrooms, and before long, 300 police arrived, including snipers and armed officers in helicopters. It was a riot, according to those in charge of the rehabilitation of "persons deprived of their freedom," the euphemism for inmates of rehabilitation centers invented by the Ministry of Justice, Human Rights, and Religion. But this wasn't a riot. It was a protest by 300 people who had no water. From security camera footage, the police identified five inmates as the individuals responsible for the outburst. Rafa was among them.

"We are here to detain you," they told Rafa. He laughed: "How much more [time]?" 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*). At his trial, Rafa explained, they were able to show that there had been no rebellion, as you need an authority to rebel against. 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 sentenced to special maximum security, further delaying his parole process. The prison authorities told him that, since everything in the old prison system had been corrupt, they had to begin the process of creating rational 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 for his release moved forward, Rafa took the SENESCYT test for university admission a second time. Again, he scored 906 over 1000 and this earned him another 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 bit. Rafa needed to pay the employees in charge to do their job. Out of the blue, he contacted me and asked me if I could chip in. I created a chat on Facebook with all the friends we had in common, and explained that Rafa needed a hand in getting out of prison, ten, twenty, whatever they could afford. He gave us an account number, and we started transferring money. A lot of people helped. There was no reason for the delay, but the process wasn’t going anywhere. Rafa couldn’t take it anymore. So, he decided to have his mouth sewn shut in protest.

The system slowly corrupted itself again. Nothing had really changed; it was only taking a while to reorganize state and criminal forces. Eventually, people were able to sneak in scissors, needles, cigarettes, cell phones, and so on. One inmate made hats out of towels and also mended torn uniforms. That’s where Rafa found the needle. He ripped a piece of nylon thread off his mattress. 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 stood in front of the security cameras.

The cameras filming the inmates are connected to ECU911, the national emergency response system. The police told the prison director,

who was in Quito, that some of the inmates were demonstrating inside the new Latacunga facility. He traveled to the facility to speak with them. They cut out the stitches and spoke, telling him that there was no solution to the conflict in sight. He explained that he was new, that he didn't know what the status of each judicial process was, and he made promises that he didn't keep. 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 holding up their signs. This time, the vice minister came. The inmates' performance wasn't meant to be public. The footage from the security cameras was meant not for the public but for police and government officials. Thus, there was no mention of the protest in the media.

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 out in order to talk to the authority. They explained their situation to a major state prison official, once more. She promised to help, and they trusted her. After her visit the prison director was fired. There had been six directors by that time, in the single year Rafa spent at the new prison. Nobody wanted the job, he said. In the end, Rafa had to pay officials the money we raised to process his release. He still had to wait.

While all of this was going on, nearby Mount Cotopaxi became active once again. The Geographical Institute reported on anomalous volcanic behavior in April of 2015, and a public report was issued on June 2. I live on the banks of the Pita River, a tributary of the Cotopaxi, and my house would disappear under lahars (tsunami-like mixtures of mud, rock, and glacier melt) if it were to erupt. In light of this geological event-in-the-making, I dedicated an embarrassing amount of time to understanding the threat and its potentialities. One of the things I learned is that the new Latacunga Penitentiary had been built well inside the risk area south of the volcano. (I live on 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 the prisoners should be left to die, but that it was outrageous that there weren't any contingency plans regarding the safety of Latacunga's residents.

I met with Jorge Paladines, a public defender whom I had seen in many of the drug-related meetings I attended, to explain my concerns about the volcano. I pointed out the Latacunga Prison situation and asked him to find out if there was an evacuation plan for inmates. This wasn't even a matter of accountability, although we should be asking about why the government spent millions building a prison in a high-risk zone. (And it wasn't only the prison that was in the path of lahars; a new social security hospital was, as well.) I simply wanted to know what the plan would be if the volcano happened to go off. Fortunately, as Jorge began asking questions at the Ministry of Justice, demanding to know what they had been doing in order to deal with the risk, Rafa was finally released. I could stop worrying about the prison, as the matter 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 regarding heroin use among the nation's youth: he claimed the *malhadada tabla* (the doomed chart) was responsible for an increase in consumption. He decided to push for some changes, including a reduction in the quantities individual were allowed to possess and in the definitions of the different trafficking scales, again increasing penalties for small amounts, and replacing CONSEP with an entity that responded directly to 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 Drugs Secretariat (Secretaría Técnica de Drogas, SETED), a decentralized legal and administrative entity with financial autonomy, under the Presidency of the Republic.”²² This secretariat replaced CONSEP, assuming all of its duties.

SETED's objectives include: increasing integral drug use prevention processes and manifestations throughout the country; increasing efficiency in the control of catalogued substances subject to audit; and increasing assessment, research, and knowledge production for addressing

²² Ley Orgánica de Prevención Integral del Fenómeno Socio Económico de Drogas [Organic Law for the prevention of the socioeconomic phenomenon of drugs], Registro Oficial Suplemento 615, October 26, 2015, <http://www.prevenciondrogas.gob.ec/wp-content/uploads/2017/05/Ley-Organica-de-Prevencion-Integral-del-Fenomeno-Socio-Economico-de-las-Drogas..pdf>

drug policy. Many of CONSEP's investigations questioned the status quo and were removed from SETED's website. Concerns regarding raw material control were expressed in the media, but the state didn't reply, and everyone soon forgot about it. It felt as if things were back to normal.

* * *

Members of the Diabluma movement, formerly supportive of the Citizens' Revolution (Ortiz Lemos 2015), began to distance themselves from the regime's punitive approach, while the government reduced opportunities for their involvement. Being a movement viewed as close to the government implied that members agreed with the exclusion of opposing movements. Felipe insisted that, while they disagreed with authoritarianism, he believed that some form of imposition was necessary in the early stages of revolutions. He also believed that, being close to the government, the movement had been able to influence at least small aspects of topics they considered relevant for emancipation.

Indeed, Diabluma had been able to include in the law an article defining addiction as a health problem, which members considered an improvement. But the definition of drug use as addiction and the implications that medicalization/pathologization had in terms of the practices during legal proceedings and addiction treatment were not yet known. Moreover, this condescending relationship with power was something which generated conflict among members of the social movement, and which eventually disabused them of the illusion of participation. The Diablumas finally broke ties with the Ecuador Cannábicos, and their leaders, Felipe and Gabu, parted ways.

Both movements remained active, but both seemed to have lost the momentum that fueled years of activism. Charlie went to a couple of meetings of Ecuador Cannábico after his release, but the experience was painful. A couple of months after his release, he got a job as a photographer in a photo studio in the valley. A couple of years later, he bought the studio. He invited me for a photo shoot with my baby, as a way of thanking me for the time I spent with him while he was in prison. We sat down for tea and he told me he had been doing all right; he had no interest in activism or in fighting for cannabis legalization.

He just 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 problems with drug use and ended up in prison for a while. They were now friends, she was doing better, and he had come to terms with their breakup. He was okay with having a criminal record because, as a business owner, it made no difference.

Rafa tried several things after his release. First, he 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, too, was doing all right. He had been in prison much longer than Charlie, and it took a while to adjust to the world outside. He had many friends who were very happy 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's never too late to do the right thing;
do today what you didn't do yesterday.
Daily phrase, women's wing, public clinic.
December 23, 2014

Including addiction as a health issue in Ecuador's 2008 Constitution was perceived as a major improvement in terms of restitution of rights, in a context in which security discourses justified the country's participation in the world's war against drugs. The move was especially intended to address the increasing incarceration of harmless individuals solely for possessing a substance subject to state control; medicalization of drug use implied that those who did so were no longer criminals.

The medical perspective was never really foreign to drug policy in Ecuador. Treatment was included in previous legislation. However, by ordering that anyone suspected of being under the influence of an illicit substance be taken by force for a medical examination and, if found to have consumed drugs, be ordered to undergo treatment, Law 108 placed civil commitment in the hands of police and family. This means that there was no need for judicial processes and, therefore, the accused had no opportunity to defend him/herself. During the 1990s, a thriving market of addiction treatment clinics came into being. These were private prisons in which desperate families could drop their loved ones for

a break from everything addiction implied. Many times, the clinics were the first option, even before drug use became problematic. It was enough for families to find an illegal substance to assume that their relative was an addict, and to turn to the only choice available: the private clinic.

The public center was an experiment intended to counter traditional approaches to drug use, but it developed in the same context in which the private clinics became dominant, even when the “services” offered consisted of violence, cruelty, torture, i.e., addressing addiction with no regard for human rights. Private clinics operated behind closed doors, shielded by discourses of addiction as an impossible monster requiring absolute isolation to be tamed. In their defense, families didn’t fully understand what treatment consisted of, and often clinic owners lied to them. Addiction was a concept flexible enough to blame for any complaint from people undergoing inpatient treatment; the urge to consume would make them lie. The families, especially those dealing with disruptive 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. Under the guise of treatment, they had been forced to listen to gruesome stories of others’ drug use, and they were forced to repeat how bad they were for putting their families through so much suffering.

The public clinic was not only generating a medical category and a therapeutic approach, but 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 the story of private clinics, told by the people who were forced into treatment in these centers.

The New Center

An area for women was not included in the plans for the public clinic. The center was meant to host adult males only, and regulations for recovery facilities prohibited mixed gender clinics (Ministerio de Salud 2012b). But the first public inpatient treatment center was soon flooded

with desperate recidivists (or their families), including women and teenagers. Virtually everyone –both male and female, teen and adult– I spoke with at the public center had been confined in one or more private clinics. And everyone was willing to speak about their grim experiences.

The day of the Christmas program, December 23, 2014, I arrived before seven in the morning. The girls came back from breakfast around eight and I hung out with them while they got ready for the celebration. The program resembled a typical school event, with presentations by patients and distribution of bags of candy to everyone. Sweets were usually prohibited, but the holidays were an exception, a day of minor release.¹ This was also a day in which males and females got to hang out together, something that seldom happened.

I asked one of the clinic's psychologists about the difference between the public center and private clinics. Iván, a former addict, replied that everything at the public center 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" (interview, November 14, 2014).

Though staff defined the public center as a space of freedom where, unlike private institutions, patients were free to leave but chose to stay, the women were locked up. Their area was located on the second floor of an old building, formerly a leper asylum. Behind the building was a huge yard where fruit trees were eventually planted, and the houses of the remaining Hansen patients could also be seen from there. A wall surrounded the complex, which bordered on a slope descending to the Machángara River.

The public center was housed in an old building which had been adapted for the therapeutic community and was filled with contrasts: the two buildings farthest from the entrance were rectangular two-story structures in which only the second floors had been renovated. They

¹ I had seen something similar in high schools: there was a day when everyone could get wasted. For students, drinking while wearing the school uniform, on or off school premises, or for teachers hanging out with the students, these were prohibited except for that one day a year, when the school hosted a party in which everyone –students, teachers, parents– had permission to "break the law" (Ortiz et al. 2014)

were accessible through an outside corridor that linked the two buildings. The first floors of both blocks looked like abandoned warehouses, room after room filled with old furniture, construction material, rubble.

The contrast between the public center and private clinics, with the former claiming to be a voluntary therapeutic community, clashed with the bars separating the women from the rest of the center. I rang the doorbell and the nurse in charge came with the keys to open the gate. I entered the conference room to the left and sat down with some of the girls. I had mostly seen them during the occupational therapy hour, outside of their area, where they would entertain themselves with videogames, handicrafts, books, ping-pong, and so on. On the day I visited, they were waiting for the psychologist to lead the morning meeting, but after 40 minutes they decided to do it on their own. I was asked to participate just like everybody else. At the male meetings, the guys had joked about me being in outpatient treatment, but I was allowed to 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.

We sat in a circle, facing two cardboard signs the patients had made: the first one listed points to be covered during the morning meeting, and the second one presented the home philosophy.

Morning meeting schedule

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 fit in. When she spoke to me alone, she mentioned her

son, a five-year-old boy living with his grandparents in Tulcan, a city on Ecuador's northern border, and how hard it was for her to accept that she had been a bad mom: she 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.

Veronica wrote the saying for the day: "It is never too late to do the right thing; do today what you didn't do yesterday." "Let's move on to mood," said Diana, a seventeen-year-old girl. "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 clapping the palm of her hand against her leg. "I am angry." "I feel depressed". "I am happy to be here" (morning meeting, December 23, 2014).

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 with bars, and with no authority to witness what we were saying. Foucault (1990) describes technologies of the self as those which allow individuals to perform a certain number of operations on their bodies and souls, thoughts, behaviors, or any other form of being, in order to transform themselves and thus obtain a state of happiness, purity, wisdom, or immortality. These operations can be done by an individual alone or with the help of others.

Similar to findings by Nguyen (2010) regarding technologies of the self during the AIDS epidemic in African countries, confessional technologies in the public center were essential to the triage process, that is, the possibility of being admitted for 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 other options were narrowing towards judicial measures. Life or death outcomes were not as obvious as they were in a context in which access to medicines depended on the acting skills an AIDS patient could develop, but in certain respects, the situations were similar, at least in terms of admission to the public center, though not so much in private addiction treatment centers.

The daily evaluation in the women's wing was about the previous day. How had I behaved? I was doing my ethnographic work. I missed the trip to Buenos Aires because of the trip to New York. I had been

asked by my supervisors at the university to change priorities and I decided to 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 questioning 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 the girls felt that their achievement was having stayed sober one more day. Or did they? The door was locked, and the nurse had the key. I was left with a sensation of meaninglessness.

Foucault (1978) describes confession as something done in the presence of someone in a position to judge the veracity of what is being confessed. The public center converted patients into their peers' judges to the point of not needing the psychologist to conduct the meeting. It wasn't as though they were telling anyone about 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 psychologists, psychiatrists, or anyone from the multidisciplinary team. Instead, it was shared among the judged.

The other items on the daily meeting agenda were optional, and I abstained. The observations of oneself included statements such as "I observe myself for feeling frustrated, and I give myself the alternative of accepting things." These were responded to by someone else with motivational slogans: "You can do this, believe in God and be strong." The observation of others was somewhat harsher, as it implied saying something about someone that felt annoying. "I want to make an observation about 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 of choosing nice words for someone 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 meant to shape the self in the direction set by the proverb. She explained she had been held up at a staff meeting, but she was glad to see that they had carried on without her. 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 on a cardboard sign next to the whiteboard. They had it memorized. We stood up in a circle and hugged one another. The women recited the center's philosophy (November 14, 2014):

Group. Thank you, Lord that we are 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 family and 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 in Allie's room and we started talking about private clinics.

"I once stabbed a man inside a clinic." Allie 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 in crime, violence, and separation, they were reunited at the public clinic. They were the only open couple in treatment, as relationships between patients were forbidden.

On that morning, Allie led the process of make-up application. 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 used at the public clinic, not only during triage but also as the main component of treatment. They differ from those used at private clinics where the objective seems more related to “jouissance,” a concept used by Lacan (1992) to describe an excess of enjoyment which produces suffering, instead of a transformation of the self. Confession at private clinics, rather than therapeutic, appears to be symptomatic: a repetition of narratives of drug use experiences leading to nowhere and, as Valverde (1998) explained, a compulsory repetition of the same modes of addressing addiction, in spite of their uselessness, over and over again.

The public clinic came into being as a contingency center, necessary for giving people in private clinics that had been shut down an option after ‘liberation.’ The Ministry of Health had taken over addiction treatment centers, previously in the hands of 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 there was close supervision. Vance, a lesbian and GLBTI activist, took a stand against addiction treatment centers conducting dehomosexualization therapies (Wilkinson 2013). The reason the state took action against these clinics was because the dehomosexualization therapy practiced there became public knowledge. The GLBTI community publicized specific stories of the horrors suffered by homosexuals who had been sent there by families^{2,3} (Herrera 2012).

² “Ecuador investigará supuestas clínicas que ofrecen curar la homosexualidad” [Ecuador will investigate alleged clinics that offer to cure homosexuality], *El Universo*, January 26, 2012, <http://www.eluniverso.com/2012/01/26/1/1447/ecuador-investigara-supuestas-clinicas-ofrecen-curar-homosexualidad.html>

³ “Investigan clínicas en Ecuador que curan la homosexualidad a los golpes” [Clinics in Ecuador which cure homosexuality through beatings investigated], *Infobae*, January 26, 2012, <http://www.infobae.com/2012/01/27/1042941-investigan-clinicas-ecuador-que-curan-la-homosexualidad-los-golpes/>

María José, known as Majo, was a psychologist working at Equidad, a foundation which offered cultural, social, and health services for members of the LGBTI community, and which participated in the process of raising awareness about private clinics and their approach to conversion therapy. One of the cases Majo worked with was a girl who had been confined in a private clinic by her parents: like addiction treatment, dehomosexualization, or conversion therapy, required a family willing to cover the costs of confinement.

Majo's patient suffered a series of abuses during her time in the private clinic. She contacted Equidad to request the foundation's support, because she had been confined against her will, and some activists, Majo explained, went to the clinic to ask for explanations. "We contacted the family and we met with the psychologist at the private clinic to find out what the diagnosis was. They affirmed it was a case of drug addiction which generated confusion regarding her sexuality." Most clinics based their treatments on experiential therapies. But some clinics had psychologists and psychiatrists on staff and, many times, they witnessed the abuses and violations of rights, and even legitimized these practices, based on their expertise.

The Equidad foundation had already addressed cases in which treatment consisted of repenting and adopting socially accepted gender behavior. Majo explained: "For example, women are forced to wear feminine clothes and make-up. In many cases, the so-called treatment includes sexual abuse from the guards. There are also testimonies of electric shock, beatings, cold showers, and so on." Many of these clinics had a religious affiliation, thus appearing more trustworthy to families looking to change what they believed to be the deviant behavior of relatives. Aside from the sexual components, which Majo explains were exclusive to gender modification therapies, as with addiction treatment, conversion therapy included occasional physical violence and systematic torture, as well as starvation and solitary confinement.

Reports of these practices usually came from social movements and human rights organizations like Equidad. People who had been through these experiences were not always willing to report what had occurred because, in most cases, it was their parents who had contacted the clinics and paid for treatment. An activist from the lesbian foundation *Mujer y Mujer* explained the difficulty this posed for those who had suffered

confinement due to their sexuality: “It was your family who had you detained against your will; the affective issue weighs in. This is not a fight between parents and their children; this is a fight against those clinics.”⁴

While LGBTI organizations were able to raise awareness through publicizing their research findings, and even getting authorities involved and shutting down some clinics, Majo felt there was still more to be done. “I don’t know if anyone responsible has ever been punished. But a colleague and I once mentioned a case of abuse to someone, and this got back to the clinic owner who accused us of defamation.” The clinics had operated since the 1990s, with no supervision by anyone. Their business was founded on the promise of delivering a normal, obedient person after treatment based on shame and fear, and the fact that they were working with people – addicts and homosexuals – excluded from society worked in their favor. The business was thriving until the LGBTI movement got involved. The fact that an LGBTI person was the minister of health strengthened their claims, and authorities began to take action in 2013.

The minister created a contingency entity as an alternative for families desperate for treatment for addicted members, as well as new regulations that forbade clinics from conducting any form of dehomosexualization, or conversion, treatment. The contingency entity was in line with the Constitution, which requires the state to offer therapy for addiction. Juan, the public center’s coordinator, described its history.

Juan. When I came here, this was a contingency center. This means that, since responsibility for therapeutic communities was transferred from CONSEP to the Ministry of Health (Ministerio de Salud Pública, MSP), the first thing they did was to provide oversight of clinics, in light of the reports they had received involving mistreatment, kidnapping, that sort of thing. So, what the MSP did was shut down the clinics that lacked permits, and so on, and young people who had been admitted for inpatient treatment could choose to come here and continue that process for a month. Why a month? These people had been confined for long periods

⁴ “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 27, 2013, <http://www.eluniverso.com/noticias/2013/07/27/nota/1213536/ecuador-hay-80-centros-clandestinos-que-ofrecen-rehabilitacion?amp>

already, so nobody was going to accept a longer period. If they were told it would only be a month, they 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 ACA,⁵ one year' (interview, November 10, 2014).

Experiences at the private addiction clinics were consistently horrific. I met only one person who had something good to say about the private clinic in which she received treatment. Michelle was using two to three grams of cocaine daily when she was finally admitted, first to a psychiatric hospital, and later to a very expensive center, which eventually shut down because few could afford it. Treatment cost USD2,000 a month and patients were housed in a lovely facility and treated by a team of well-trained therapists. Group therapy was based mostly on the twelve steps outlined by Alcoholics Anonymous, and also included massages, individual therapy with a psychologist, individual sessions with an experiential therapist,⁶ and sessions with a psychiatrist, a yoga instructor, and a nutritionist. Michelle's experience was the exception. The rule, when it came to private clinics, produced traumatic memories that led to nightmares for years (interview, April 10, 2012).

I asked Diana about when she had been in the private clinic, with the sock and all. "It was my last clinic," she said. And she added, "It's still open. It's called Bridges of Life.⁷ Have you heard of it? It's famous. They just force everyone to pretend whenever people from the ministry or CONSEP visit." Private clinics had been operating outside the law for so long, with everyone's approval, that inertia determined their *modus operandi*. The problem was very complex. In one case, reported by Minister Vance herself, the owner of one of the clinics violating the rights of its patients through dehomosexualization practices was a public official who worked at the Ministry of Health.⁸

⁵ Addiction Contingency Area.

⁶ This was a category created by CONSEP. The entity certified former addicts as experiential therapists, though they had no formal training usually received by professional therapists.

⁷ Name has been changed.

⁸ "Clínica de caso Zulema es de una funcionaria de Salud, dice ministra Vance" [Clinic in Zulema's case belongs to a public official at the Health Ministry, says Minister Vance], *El Universo*, July 19, 2013, <http://www.eluniverso.com/noticias/2013/07/19/nota/1182611/clinica-caso-zulema-es-funcionaria-salud-dice-ministra>.

Until 2012, registered private facilities supervised themselves, their only obligation being to send statistical information to CONSEP, the institution that had been in charge of everything related to controlled substances since the 1990s (Gobierno del Ecuador 1991). This made it hard for observers to obtain access to these clinics: it was difficult to find those which were not registered and therefore operated clandestinely, and those that were registered had no interest in granting 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 worried family member or friend, and the money to cover the monthly rate.

Allie 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.

Paul's Lockups

I met Paul in November of 2014, after the director, the occupational therapist, and a psychologist recommended that I speak with him. He was clearly a favorite, charming, intelligent, collaborative. Everyone at the public center wanted to see him improve, to the extent that they let him bring his girlfriend to treatment. Paul and Allie could hug and hold hands when they were both on the premises, 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 on Allie's presence, and she was accepted in 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 stretch of the Occidental, the beltway along the western side of Quito. At 22, 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 was based on the fact that it required his consent to become a patient, and, while he wasn't totally convinced that he needed to stop using drugs, he decided to give it a try. In August of 2014, Paul went to the center, secretly smoked his last bit of base in the bathroom, and after making sure that Allie would also come, he signed the admission papers.

Paul introduced me to his parents on the day the Minister of Health came to the clinic. After visiting the different areas, everyone – staff, patients, families – gathered in the auditorium. They had been asked to participate in the event about four hours earlier, but the authority arrived late. Still, Paul’s parents waited. Paul and I sat together. Minister Vance gave a short speech, hoping to leave quickly, but people wanted to talk to her: to thank her for a treatment center that didn’t abuse patients, for the food, the humanity; the patients and their families spoke of a difference they never imagined possible. Most of them had spent thousands on private clinics and had gotten only hopelessness in return. Many mentioned the need for jobs 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 had come because they all had to. Allie was standing at the back of the room with the rest of the girls. Paul’s parents were sitting a few rows down.

In Ecuador, the criminal perspective was as much a part of the approach to addiction as the illness perspective; the law mandated police to take those suspected of using drugs to addiction treatment centers, unless they were found with drugs, in which case they were charged with possession and sent to prison. Like its predecessor, article 30 of Law 108 stated that the police are obliged to immediately take any person who seems to be under the influence of a controlled substance to a psychiatric hospital or assistance center, for doctors to verify if this is the case. If so, they must “immediately order the appropriate treatment. The treatment, which must be conducted in special centers, will be administered in those approved and authorized by the Executive Secretary, in coordination with the Ministry of Health” (Congreso Nacional 1990, 5).

The clinics that sprung up around the country were overseen by a security institution, CONSEP, which paid little attention to what went on inside these private centers. CONSEP offered no guidance as to what the clinics offered, what standards were to be applied or what prices charged. In addition, underground clinics were created as the business got increasingly profitable. By 2013, the Ministry of Health and the attorney general had identified around 150 centers operating

in the country, and had already rescued 500 people from some of these clinics.⁹

While the law stated that police should take persons suspected of using drugs to clinics, the private centers began taking a more proactive approach, organizing capture forces, teams of interns and private security guards (mostly former addicts), in charge, at the request of the family, of detaining the individual consuming drugs (Jácome 2012). No longer was a judge necessary, nor was a doctor or a qualified person in some field related to drug use needed to detain someone and lock him/her up for months. All it took was a family willing to pay; the clinic would take care of the rest. As far as Jorge was concerned, while none of the clinics where Paul had been treated cured him of anything, at least he had the peace of mind that came from knowing where his son was.

Jorge. He used more and more every day. And he began to get lost. The first time he disappeared, eleven 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 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 bum. This was two years ago. Two years ago, he stopped coming home. He went to his friend's house, who took him in, had him shower. And he called us. This was before Portoviejo. After Cuenca (interview, December 11, 2014).

For Paul, it soon became a form of punishment. He had been locked away for too long, having spent many months in confinement when he began disappearing.

Paul. 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 (interview, November 12, 2014).

⁹ "Existen más de 150 clínicas de rehabilitación clandestinas en Ecuador" [There are over 150 clandestine rehabilitation clinics in Ecuador], Ecuavisa, November 8, 2013, <http://www.ecuavisa.com/articulo/noticias/actualidad/45703-existen-mas-150-clinicas-rehabilitacion-clandestinas-ecuador>.

After the second clinic, a nightmarish place from which it was impossible to escape, Paul stopped using. He was around 16 or 17, and he was able to stay clean for two years. Was it fear, will power? 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" during those years. He returned to school, found a job, behaved. But it felt like a performance, responding to society's expectations. And things eventually reverted to what he had always known as normal.

Paul's house was across from a small park, two blocks away from the Occidental in the north of Quito. He grew up in a neighborhood where drugs were readily available: "There were more pipes than balls in the park" (interview, November 9, 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 dogs aren't allowed, so we brought it here," said Gaby, Paul's mother. 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 a patient. Family memories were built within the walls of his confinement (interview, December 11, 2014).

Even though Paul was around eight years old when he discovered glue and its effects, his parents only found out about his drug use years later, when he was expelled from school for gang involvement. He was always in some kind of trouble, but they refused to believe it was anything 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 recovered, thus subtly expelling 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 15. Jorge had no choice.

Jorge. Sometimes, out of ignorance, you make decisions, and sometimes I admire 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 office, 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 for his son who was also an alcoholic; his son was already in college. So, we went looking for this place, something that would work, we went looking for the offices, and this was the first place, the first experience of trying to help (interview, December 11, 2014).

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, searching for mentors, models, and friends. Paul's parents had no idea of the life their son was living, and this included his early drug use, involving household items such as glue or liquor as well as the drugs he got from 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," Gaby, Paul's mother, remembers (interview, December 11, 2014). "He developed faster than his siblings, in everything: walking, speaking...." One of Paul's teachers had suggested that he be placed in a school for the gifted. Unfortunately, he recalls, his father thought he should be treated just like everybody else, and he rejected the possibility. Paul believes 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" (interview, December 2, 2014).

Paul soon began leaving 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 in the problems I had at school”. In his neighborhood what Paul remembers learning was how to fight and to use drugs. When he was nine, having already used glue for a while, he tried something new: “A friend of mine, he must have been 20 years old and I was nine, he asked me for a dollar, for drugs. I said, ‘Ok, I’ll give it to you; I’ll give you more than one dollar, but let me try it.’ That day I tried cocaine base” (interview, December 2, 2014).

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. By 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, add a little ice, playing adult. Sometimes, I would make whiskey ice-pops”. What he liked about it most was that it made him 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 if they ever did the things I was doing. I didn’t think so. And I felt ashamed” (interview, December 2, 2014).

Paul’s parents were shocked when they found out that their son had been using substances for years, and they reacted by choosing the Alcoholics Anonymous clinic for treatment. In principle, AA requires that treatment for addiction be voluntary, but Paul was given no choice.

Paul. They lied to me, 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, a single room for 45 people, with bunk beds for two or three people. I was the only minor there, and there were homeless people who had just come out of jail. Instead of recovering, I came out much worse, I learned so many things. I came out pissed off at life (interview, December 2, 2014).

Being taken against his will generated resentment in Paul, which seemed counterproductive. From his point of view, his childhood choices were left to him. He had exercised his freedom by doing drugs and joining gangs: he stole, he got into fights, he saw friends die, and he was arrested. Then, suddenly, he was taken to a clinic, with no trial, no defense, and no way to make any sense of it. After three months, the staff told him that his parents were coming. The clinics usually have a policy of no contact with family, and Paul had not heard from them since they tricked 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” (interview, December 2, 2014).

Paul’s story echoes the experiences of others who have been locked inside a private addiction treatment center, against their will, and with no signs of recovery whatsoever. Nevertheless, 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, confusing” (interview, December 11, 2014).

While Paul was in AA, he had a sponsor who recommended a stronger approach. AA had been too open, and the way Paul was binge-using, he might need a clinic that didn’t require that the patient agree with his confinement.

Gaby. People who had been through this advised us. This person told us about a clinic in Pifo, and prices were terrible, USD1,000 dollars, USD600 dollars, and even though we both worked, we couldn’t afford it. We took him to Pifo, and they charged us USD400 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. He seemed to be doing well, logically, when he stopped [doing drugs], he looked better. He wasn’t discharged; my husband decided it was enough after six months. I said all right, 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, one that was more affordable.

Law 108 generated a strong punitive response to drug possession that led to an increase in Ecuador's prison population (Edwards 2011). The initial urgency 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 a clinic (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 Ministry of Public Health. At the same time, in 2012 CONSEP, in its "theoretical base for prevention," estimated that 22,500 people needed treatment for drug use, while the clinics received only 4,141 requests for admission, suggesting that about 85% of people in need for treatment were not receiving it (CONSEP 2012). After Minister Vance took up 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 data differentiating people with conflictive drug use versus occasional users, while other countries in the region, including 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 world's population between 15 to 65 years had developed a dependency relationship with substances, and projected that the Ecuadorian population within that age range would include approximately 59,058 people dependent on illicit substances (Ministerio de Salud 2014).

It wasn't until 2008, after the new Constitution was approved (Ortiz Lemos 2015), that drug use was officially decriminalized through the inclusion of an article that defines addiction as a health problem, prohibits incarceration, and guarantees a therapeutic response from the Public Health System. While article 364 of the 2008 Constitution of Ecuador aimed to decrease detention rates, it also required that the state offer medical attention for substance use.

The state was forced to address the issue in part due to the constitutional inclusion, but mainly because the LGBTI movement had been able to politicize involuntary confinement in private addiction treatment centers, through reporting dehomosexualization practices among therapies offered in said centers. The “therapeutic process” was similar to that for drug users: a concerned but uninformed family member would arrange for the relative to be kidnapped and forced, through a systematic deconstruction of the self, based on violence and humiliation, to adopt normal sexual identification – or, for addicts, abstinence. While drug addiction treatment had failed to outrage the public, the LGBTI movement was able to demand state intervention in the private clinic business.

As personal stories circulated in the media, government drug policies lost legitimacy. The public started hearing about addiction treatment centers and their practices of “rehabilitation,” a topic seldom discussed previously. The stigma of addiction had silenced individual as well as family experiences of drug abuse and treatment, and allowed clinics to operate behind closed doors. Even though many more people were locked in these private addiction treatment centers for drugs than for homosexuality, LGBTI outrage opened them to public scrutiny of the abuses suffered in what were, in effect, medical prisons for “a stigmatized population so as to neutralize the material and/or symbolic threat that it poses for the broader society from which it has been extruded” (Wacquant 2009, 378).

In the following years, the Health Ministry began a slow process of identification, regulation, inspection, and control of private addiction treatment centers¹⁰ (Ministerio de Salud 2013). According to the technical coordinator and the psychologists who worked at the public clinic from the beginning, when it was the contingency center, the ministry closed down clinics for malpractice, lack of oversight, and even human rights violations. The drug policy legitimacy crisis was an emergency that, when addressed, produced other matters that

¹⁰ “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 19, 2013, <http://www.eltelegrafo.com.ec/noticias/sociedad/1/en-2012-el-msp-registro-123-centros-de-rehabilitacion-legales-en-ecuador>

needed to be dealt with. Many patients in clinics could not manage their substance abuse problems on their own, and they, as well as their families, demanded addiction treatment. Although the Constitution guaranteed health services for addiction, only a few public hospitals offered some form of outpatient treatment.

Private clinics seemed the only choice for desperate parents and they were also a thriving business opportunity for “addicts in recovery” (Jácome 2012). In other countries, such as Guatemala, the state had also taken a hands-off approach to addiction treatment centers, mostly Christian institutions which operate as soft security mechanisms with no oversight (O’Neill 2015). The owner of one center I spoke with was a former alcoholic, a trait common among people who own centers. He explained that he usually had 20 people undergoing inpatient treatment, at a rate of USD900 a month, that is, an average of USD18,000 that covered all expenses, including salaries, rent, food, and so on, and a net gain of over USD10,000 per month (Diego, interview, March 11, 2013).

He had to shut down his clinic in 2012, when Minister Vance took over, because more stringent requirements were put in place. Three years later, he opened another addiction treatment center, and the last time we spoke, he was getting ready to open a second one. He even offered me a job. Paul compared private recovery centers to prisons.

Paul. So many clinics, against my will, captured. I would escape, they would capture me again. The worst one was the second after the year-and-a-half one. It lasted six months. I tried escaping like five times, until I accepted that I was in 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 forced to submit 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 (interview, December 2, 2014).

How could a clinic be worse? Treatment in private clinics is based on punishment, denying that persons with addictions have rights. By including the public health perspective in the Constitution, the country was forced to change its discourse, from criminalizing to pathologizing

drug use, a change requiring that private clinics abide by new regulations and controls. The change was ambiguous, because medicalization of addictive behaviors implied that individuals were no longer responsible for the choices they made (Valverde 1998).

At the same time, if a substance could take over a person's life in such a way that the individual was no longer capable of making rational choices, then war-like responses from authorities, concerned about the population's well-being, were legitimate. The rhetoric surrounding drugs includes the notion that the affected person is unaware of his/her problem, as can be seen, for example, in "intervention" techniques (Carr 2013). This notion operates in private clinics, where patients are forced to self-define as addicts, a category charged with moral implications. But, contrary to what can be seen on the TV show "Intervention,"¹¹ private clinics in Ecuador operated behind closed doors for 30 years, with no oversight. Due to a lack of public addiction treatment spaces, private clinics that have gone through the relatively new regulation process continue to operate, while oversight by the state is limited.

In practice, private clinics operate as private prisons where families deposit addicted members, often repeatedly, regardless of their effectiveness or lack thereof. Gaby explained what was going through their minds by the time they placed Paul in the third center: "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, on that occasion, we thought, maybe the fact of finding himself in such a horrible place [would work]" (interview, December 15, 2014).

A Place to Live

Patients who had been in private clinics repeated the same horror stories. Diana's testimony was echoed in what Albert, the patient who had been in the public clinic longer than any other patient, could remember about his previous confinements. At the public center, he was considered a difficult case of opiate addiction. A 38-year-old man, he recalled

¹¹ [https://en.wikipedia.org/wiki/Intervention_\(TV_series\)](https://en.wikipedia.org/wiki/Intervention_(TV_series))

therapy in his previous clinic before finding the public center: “At 6:30 in the morning you had to sit in a huge room where there were 50 people, while one man shared [his story]. There, the one who drank the most was the coolest”. Albert remembers “therapy” in a private institution as a performance in which people ‘bragged’ about their use from 6:30 a.m. to 9:00 p.m. He recalls the story of a father and son he had met in his last clinic, an AA oriented facility in which some people lived, while others came only for sessions at night: “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 had a place to live, and if I had gone there as a militant, it would have worked for me as well. But living there was horrible” (interview, September 28, 2015).

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 stayed with him after his parents divorced, when he was a teenager, and they would share marijuana often. At some point, his dad was sent to jail, and Albert began visiting every day. 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 avoiding homelessness.

Albert’s 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 he grew up with. “I had a glass of booze 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” (interview, September 15, 2015).

Being an extremely shy adolescent, Albert created an imaginary world in which he could talk to a girl he liked, and this imaginary land became the place where he preferred to live. 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 told him, when he was a child, that he would become an alcoholic. But, as noted, he and his dad became partners in use.

Experience with clinics was usually linked with a decision made by the family, but the second time Albert was admitted to a private clinic,

the decision was made by his girlfriend. He was 22 or 25, he doesn't remember, when Karina decided to have him confined. His mom was living in the United States. He doesn't remember where his dad was. The clinic was in Guayllabamba, a small city not far from Quito where Karina has a country house. "I still hadn't even met heroin at that point. It was just base 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 that I just lied a lot. But deep down I kept thinking, this has already gone to hell" (interview, September 28, 2015).

Families, spouses, friends play a role in the way subjectivities become addictions. Biehl (2013) saw the change in a patient's sense of being and value to others through the story of Catarina, a woman living in a hospice with no apparent possibility of returning to her community. In her case, psychopharmaceuticals seemed to be an important part of the matter, while the family acquired new forms of judgment: Catarina was mad and there was nothing they could do about it. In Albert's case, his mother had left the country, and the only person he was close to at that time was his girlfriend. She had been with him for many years without realizing he used substances, but once she did, she decided the best thing to do was to have him committed. As in Paul's case, there were no other choices. Drug use meant confinement in a private clinic.

The third time Albert was admitted came after his mother returned to Ecuador. She had been living in the United States, but she returned in order to "fix" Albert, who described the experience.

Albert. She said, 'Albert, you will live with me.' I didn't want that. I told her that I had lived for 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, I'm sorry 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" (interview, December 15, 2014).

Albert and his dad didn't have a home. They lived in different hotels, depending on how much cash his dad had, 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" (interview, December 15, 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 difficulty in organizing his life story. "I'm sorry if I tell you things as I remember them. My story might jump around" (interview, December 15, 2014).

This was a statement he often repeated. Albert spent over eight months at the public clinic, until his process of social reinsertion seemed on the way. He had found a telemarketing job selling medical insurance, and he rented a small room near the San Roque market, a place where drugs were very accessible. He was released on the condition that he return 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 returned to the clinic about six months later, after he had quit his job and spent his savings.

Albert. A friend just came back here, Freddy, he's the one who approached me when I first entered here. And now he's drunk and has had a relapse. And I tell him, man, don't do that, but he tells me, '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 the reason for the 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 (interview, December 15, 2014).

It was in his last center before the public clinic that Albert learned to drink rubbing alcohol. He had already earned the staff's trust and was occasionally allowed to leave the premises, and they gave him a dollar for transportation. One time, he went to a supermarket: "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". He returned to the AA clinic knowing there would be consequences: "They beat my head with an ashtray for having a relapse, because those people, they hit you, they call you a recidivist, and that generates resentment, the way they treat you. Here it's different, very different" (interview, December 15, 2014).

The public center staff wanted its approach to be completely different from that of private institutions. Before the public center opened, the only places that didn't charge had been financed by a church, by charity, or by AA groups. For most private centers, addiction was a profitable business. The public clinic aimed to generate something rational, integrating the many aspects involved, according to Juan, in the development of substance abuse or dependence. In other words, treatment at the public clinic would not be based on any one approach but would involve all approaches that provided results (interview, November 6, 2014).

While Albert agreed that this center was considerably nicer, without the violence, and while he believed that an outpatient model could have helped him more during his previous confinements, he remembers that he went back to using drugs while going through inpatient treatment at the AA clinic.

Albert. They were open, if you are there long enough, you could go to the store, or you could go look for a job, like that. So, all the time, I was only thinking about the relapse I had. 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 (interview, December 15, 2014).

Albert's return to drug use included going back to his pill addiction, even while he was still living at the AA clinic. They were allowed to smoke, and so he could ask the outpatient staff for 25 cents, for a cigarette. He would collect two or three dollars in the course of a day, go to the corner drugstore, 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.

Albert. 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 in this group, a box was three dollars. I would buy a box, which lasted for two days: I'd take 15 pills one day and 15 the next (interview, December 15, 2014).

Patients at the public clinic were there voluntarily, and staff monitored drug use with blood and urine tests. Everyone was tested, especially after a home visit. Unlike the AA clinic that Albert described, if someone at the public clinic tested positive for drug use, they would have to leave the program. This had different consequences for each participant; for Albert, being kicked out would mean losing his current home; for Allie, it would mean going back to the streets, possibly to Colombia; and for Paul, it could even mean going to prison on robbery charges that were on hold while he demonstrated to the court that he was serious about staying clean.

Burning Down the House

Many of the patients at the public clinic, like Paul, had already been in several private clinics, and Juan felt the need to offer something beyond the usual. For Paul, clinics meant something other than his relationship with substances. The issue had become a matter of losing or winning against his dad, against the system.

Paul. He told me, 'As long as you decide to keep taking drugs, I will decide to keep locking you up.' It was like a challenge. And this is why I started disappearing. At first it was for 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 [AA] black book, and the Narcotics Anonymous texts. I understood the *terapia del palo* [the therapy of the stick], and I was just sick of it (interview, December 9, 2014).

While clinics have existed in Ecuador since the 1990s, and virtually everyone knows someone who has been admitted to at least one, hearing the details of what occurred behind closed doors at these places was still shocking. The violence implied in the definition of a therapeutic approach consisting of hitting patients with a stick does not begin to describe what most of the people now at the public clinic had been through, paid for by their families, and with no results whatsoever.

Paul. Imagine that in one of these places, they kept me standing for two months, from 6:00 a.m. to 10:00 p.m., standing. They injured 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 at one of the clinics in Chone,¹² sugar water, and they left me in the yard. The ants screwed with me, and then the people threw soapy water over me. My skin was ruined. 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 (interview, December 9, 2014).

In spite of their son's mistreatment in these clinics, his parents continued punishing/protecting Paul with confinement: this was the only option they knew, and each time they chose that option 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 up over and over again,

¹² A city in Ecuador's coastal region, in the north of the province of Manabi. In 2007, an estimated 50 private clinics operated in Manabi without permits (*La Hora*, February 1, 2007).

regardless of the money spent, the uselessness of the “treatment,” or their son’s constant objections: “We are always trusting, hoping for the miracle, those of us who trust God,” said Gaby. Paul had learned to manipulate, and he would write letters with Bible quotes to please his parents and to ask to be released from the clinics he found difficult to escape from. At the same time, they tried to make sense of what was happening, and Paul knew how to use this uncertainty. According to Jorge, “Paul wrote a letter in which he told us he wanted to take his own life. He said he was 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’” (interview, December 11, 2014).

Jorge’s hope for a miracle was never fulfilled, in spite of Paul’s confinement in several clinics with a religious orientation. As O’Neill (2015) found in Guatemala, religion played an important role in the “soft security” offered by rehabilitation clinics in Ecuador, but the private centers, regardless of their religious affiliation or lack thereof, applied gruesome practices to achieve “rehabilitation.” After being mistreated to the point of trauma, Paul was finally able to escape from the worst clinic he had been in. But as soon as he got back to Quito, they were waiting for him, the same capture team.

Paul. 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 (interview, December 9, 2014).

The newspapers reported that a patient had started the fire in order to escape.¹³ They never mentioned mistreatment or forced confinement; the behavior was framed as the result of an addiction. The view of criminality resulting from drug use was reinforced by distorting acts of resistance by people in private addiction treatment centers. Paul was convinced he had done the right thing. The clinic owner didn't try to find Paul or to collect money for damages. Paul's father felt he had no choice; Paul had demonstrated how far he was willing to go. He had won. His parents accepted they couldn't do anything more for him and they stopped trying. It had been exhausting. Both Gaby and Jorge had quit their jobs, they were distanced from their extended families as the result of the stigma, and they felt they had no further options. After all, they had been doing what everyone, from school personnel to co-workers, had advised: they had locked Paul in every private clinic they heard of. When Paul burned down the last center, they ran out of options. But Paul realized that, even though he was relieved that they no longer were trying to commit him by force, he hadn't won.

While the state focused on repression, private clinics appeared as an alternative to discreetly deal with addiction, behind closed doors and with the endorsement of the law. Before the 1980s, addiction hadn't been an issue in Ecuador (Andrade, P. 1991). When it appeared as a social phenomenon, there already existed concepts and beliefs that defined it; it was already framed as something terrible. And this framing only worked in favor of an 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 describes the problem of private addiction treatment centers as having appeared in the "years previous to the administration of Economist Rafael Correa" (Ministerio de Salud 2014, 10), due to the lack of oversight, as well as the lack of public spaces for dealing with problematic drug use, along with the stigma

¹³ "Causa incendio para escapar de clínica" [Causes fire to escape clinic], *El Diario*, April 16, 2013, <http://www.eldiario.ec/noticias-manabi-ecuador/259751-causa-incendio-para-escapar-de-clinica/>

associated with drug use. The plan states that there have been human rights violations at private centers, but simply proposes strengthening oversight while offering public addiction treatment with a human focus for people who use alcohol and other drugs.

While the private centers operated with little or no state oversight, the public center's open doors implied not only that patients were there voluntarily, but also that the public was to be aware of the treatment on offer. Juan, the program coordinator, explained that treatment took place in the therapeutic community being developed for a low-income population: "Maybe this program won't help someone with conflictive drug use from the upper classes. But the people we are treating, always the least favored, have, besides drug use, problems with the law, the family, low income, little education, we are developing the program for them, and I believe this is going to take a long time."

According to Guerrero (2010), private administration silenced the voices of the population treated, even in terms of records of their presence. The government could no longer see these groups, and would only hear from them through the voices of others. In private treatment of drug addicts, a phenomenon that grew in the 1990s, something similar occurred. Addicts were invisible to the state, but their ventriloquists, the private clinics' administrators, would give statistical information to CONSEP. Whatever took place inside the clinics stayed there; not even families paying for their relatives' treatment knew what was happening. The justification for this secrecy included the need to avoid co-dependency. Family members were urged to disbelieve stories of mistreatment from patients who, as addicts, would say anything in order to keep using.

In 2012, I went to see JP, who had been in clinics since he was 16. At 28, married and expecting his first child, JP still remembered the trauma of being locked up. He explained the way families were deceived into locking a member in a private clinic.

JP. There was this center where I was, it had a pool, pretty cool, the pool, and family members came and saw the pool, everything cool, you know? But the pool was for waterboarding. 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 what I'm saying? So, people come out resentful, wanting to smoke again. There is no consciousness, the expected outcome doesn't happen, there is no spiritual awakening, that God comes and touches you, or that you respect a higher power, which never happens. There is only resentment, and that eats away at you, all they do is hurt you, and your family even more. They don't know how to handle a patient (interview, May 10, 2012).

Unlike other people I interviewed about their experience, Paul, who had been in several clinics, believed that confinement did help him stop using and regain some control over his life.

Paul. 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 confined. But there are also retarded parents who live in different times. I don't know what it is they think, and they find a random joint on 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 just enjoying life. Not everyone belongs in a center, but they are necessary. It worked for me, but after ten years of drug use, of which the last four were totally out of control (interview, December 9, 2014).

In a complex organization of responsibilities regarding confinement, families are the key actors, making decisions based on their own beliefs, strongly reinforced by media, laws, and policies, if a loved one requires addiction treatment. Private clinics reinforced beliefs surrounding drug use (undifferentiated from addiction or abuse) in contacts with families. The response of Paul's parents demonstrated what happens: when their son's school tells them that Paul is having drug problems, they respond based on information from friends, co-workers, people who have been through the private clinic option. None of the clinics their son was confined in did a differential diagnosis. The "medicalization" perspective was ever present, but with strong criminal connotations. No one, not the parents, the clinics, friends offering advice, no one questioned the choices they made in regards to Paul's "treatment." It was 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 helps, but it’s more the person. From what I see, around ten per cent of people stay clean” (interview, May 12, 2012).

Patricia had spent some time in psychiatric hospitals as well as in private rehabilitation clinics in different parts of the country. Some had been for females only, others were mixed. She was practically an expert on clinics. When asked about recovery rates, she explained: “I have something stuck in my mind; the first answer to this question that comes to me 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” (interview, May 15, 2012).

Juan Fernando had been confined 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 confinement 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 don’t” (interview, May 16, 2012).

Michelle had been in one clinic. It was expensive, and it eventually shut down because it wasn’t cost-effective. She was treated with different therapeutic approaches. She was referred to the clinic by a psychiatric hospital, where she was taken because hers was an acute case of addiction. After being stabilized, she was placed in the clinic which had a total of eight patients during her time there. I asked her about recovery.

Michelle. 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 there was one other girl but I haven’t 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! (interview, May 13, 2012).

Dr. Luis, a psychiatrist who worked in an addiction clinic, believed that recovery was very difficult to achieve. “From my perspective, there

is little chance of recovery. There are many relapses, let's say, a 20% recovery rate per year, but this diminishes as time passes" (interview, May 13, 2012). People can abstain from using for certain periods of time, as in the case of Paul who stopped for a couple of years. But as time passes, the possibility of relapse increases.

Everything I had heard in the past about clinics was confirmed at the addiction treatment center. Nevertheless, the state decided to allow private clinics to remain open, subject to regulations and surprise visits. I asked the girls about the situation, how clinics could still be operating with all the abuses if the state had intervened. Diana answered: "Hah, they're all like that. I'm telling you; I just came out of one, a few months ago". The rest of the girls agreed. Private clinics hadn't changed in any serious 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 believed that they discharged her because she threatened to speak to visitors from the ministry about conditions (interview, November 14, 2014).

On May 20, 2015, residents of Vicentina Baja, the neighborhood where the addiction treatment center is located, organized a protest against the clinic. The event resembled a witch hunt: the neighbors, armed with torches and signs, walked toward the clinic, regrouped at the main entrance, and shouted slogans, demanding that the public clinic be moved. The request, which had already been presented to authorities months earlier,¹⁴ was based on the idea that crime in the Vicentina Baja area had increased since the addiction treatment center opened (Juan, interview, June 10, 2015).

The Vicentina neighborhood committee developed a public opinion strategy: They placed black ribbons on the corners around the center, with signs that associated outpatient addiction treatment with the increase in crime. They spoke to businesses owners, visited homes, called the media, and organized protests. In 2012, before the clinic opened, the Ministry of Health had offered to build a health center on the large lot belonging

¹⁴ "Moradores de La Vicentina protestan por cambios en el Hospital Gonzalo González" [Residents of La Vicentina protest against changes at the Gonzalo González Hospital], *Teleamazonas*, May 7, 2015, <http://www.teleamazonas.com/2015/05/moradores-de-la-vicentina-protestan-por-cambios-en-el-hospital-gonzalo-gonzalez/>

to the Gonzalo González Dermatology Hospital next door. By 2015, the health center remained a broken promise, while people in addiction treatment came and went for their daily meetings. According to authorities in La Vicentina, claims of an increase in crime were not backed up by reports to the police. If people were being mugged, they weren't telling the cops.

Regardless of the lack of evidence, residents of La Vicentina felt threatened by the clinic's patients: drug use had been linked to criminality for approximately 40 years, an argument that legitimized a war against users. In light of this fact, the way in which representations (Jodelet 1991) were taking the form of a witch hunt in demonstrations at the center was to be expected. As state employees struggled to get the neighborhood to 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.

After thinking about Paul's story, I am left with a concern about the enjoyment attributed to drug users as a reason to punish their deviance. Especially considering that their lives unfold in the periods between confinement in one private clinic and the next. Who is enjoying that? Not Paul, that was clear. But as his drug use worsened, so did his father's mad quest for the one clinic that would 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, a profitable business which benefited from fear, sadness, desperation, and, in many cases, ignorance, resting upon the idea of drug use being something uncontrollable, a problem requiring a warfare approach. Minister Vance's changes responded to the voice of

the LGBTI community, a voice constructed over a long period of time. Until November, 1997, homosexuality was defined as a crime in Ecuador's criminal code. But though she mentioned that addicts were also being mistreated, the norms her ministry created prohibited confining homosexuals in these clinics while allowing them to continue operating. Human rights were mentioned in documents outlining the regulation of clinics and in mental health policy proposals. How long will Ministry of Health employees continue checking on registered clinics? They seem to be places vulnerable to corruption, as are prisons. Patients told stories of a continuum, along which some clinics continued to use punishment as a therapeutic measure. Clinic staff members were learning to disguise their methods. They discharged problematic patients before abuses were reported. The system's design didn't address the behind-closed-doors practices and, therefore, required constant state oversight. No measures were taken that would lead to effective self-enforcement of norms, other than sporadic official visits.

Soft security, in hands other than the state's, operates in private addiction treatment centers (O'Neill 2015). Its application has been primarily in the hands of private businesses, linked to the fields of health and corrections involved in drug addiction rehabilitation. Most of these businesses are owned by "former" addicts, or addicts in recovery. They, too, had been confined in clinics during their own addiction treatment; they understood the business and chose to focus on the profits to be earned from addiction treatment. In the same fashion, some former drug users turn to selling drugs, and in the process stop their drug abuse in order to focus on the business (Jacome 2016). Both are rational choices.

Some people, like Paul, found different ways to resist the not-so-soft security mechanisms imposed upon them. He was lucky that the clinic's owner didn't press charges for the fire he started. With public opinion against him, it would have been hard to defend himself in a context which assumes that addicts lie, manipulate, and are willing to do anything in order to satisfy their need for drugs. Unlike the LGBTI population, Paul didn't have a social movement willing to raise its voice for addicts confined in private clinics. Families, overwhelmed 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 not only to generate a new way of addressing all that came with drug abuse; it also had to deal with the complex sets of identifications resulting, as Biehl proposed, from a “continuous process of experimentation – inner, familial, medical and political” (Biehl 2013, 136). Those who had been in private clinics had experienced identification as addicts as an imposition, one with which their families and society agreed. After all, private clinics were created 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 difference was that it was an open space.

Chapter 3

What is Addiction?

Addiction was defined in the 2008 Constitution as a public health problem, as noted in chapter 2. Article 364 was meant to counter decades of repression during which countless drug users were being treated as traffickers and jailed for long periods. When addiction was defined as a health problem, the state was required to provide treatment. The first public addiction treatment center was opened several years after the Constitution went into effect. In addition to treating addicts who came to the center on a voluntary basis, the intention was to oversee and, if necessary, shut down private clinics which had, by and large, been the only treatment option available since the 1990s. When reports of dehomosexualization practices in private addiction clinics became public, the Ministry of Health began inspecting them to make sure they were operating in a lawful fashion. Those that were not doing so were closed and the state offered a contingency option for patients who had been confined in them. 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 under 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 was intended to demonstrate that the state could attend to health issues in a much more effective way than by turning

treatment into a business. The Citizens' Revolution relied on anti-neoliberal discourses in order to legitimize its policies, explained in the Plan Nacional para el Buen Vivir (National Plan for Good Living) 2009-2013 (SENPLADES 2010), as well as the Plan Nacional para el Buen Vivir 2013-2017 (SENPLADES 2014).¹ These documents describe the privatization of public services as the result of neoliberal ideologies which place private interests above the rights and needs of the population. The center became the focus of particular interest due to its many implications.

This chapter is the result of ethnographic work undertaken in the clinic in order to understand and differentiate the perspectives which define drug problems from each of the disciplines participating in the therapeutic approach offered by the state. It is divided into six sections.

The first describes the complex in which the public clinic was located, a building formerly dedicated to the treatment of leprosy now converted into a facility for the modern treatment of addiction. The second deals with the most important component of the therapeutic approach, the psychological. The various definitions and techniques applied by each psychologist are described, as are the contradictions within the discipline when defining and addressing problematic drug use.

The third part is dedicated to psychiatry as a traditionally dominant approach, counterbalanced at the public clinic with a specialized perspective capable of recognizing mental disorders and assisting in the management of drug abuse and dependence. The fourth section describes occupational therapy and the conceptualization of addiction as an imbalance in daily activities. The section offers a perspective based on the therapist's description as well as observations about the space, the practices, and descriptions from patients.

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

¹ The National Secretariat of Planning and Development, SENPLADES, published English versions of both plans.

The chapter's contents are based on an analysis of institutional speech, marked by restricting certain practices which, whether implicit or explicit, set some ground rules for interactions between the addicted selves and the healing parties. Institutional speech becomes a mode of power relations that differs from ordinary conversations and that, in this case, generates a learned script through which the institution and the subjects within are constituted (Heritage 2013). The study of institutional interaction in a public addiction treatment center allows for an understanding of the causal relationships among elements in the social context in which it appears, as well as the outcomes, even if they reproduce those of private clinics.

Ethnographic studies in the context of mental health are used to develop diagnostic categories based on everyday conversations among professionals and in therapeutic settings and these categories enable formulations of the subject that provide for paths of action in conditions of ambiguity. In this way, an ethical approach that counters the uncertainty of the disorder can be shaped (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 scientific, humane, and effective treatment for addiction, in order to support new discourses that include security, welfare, and sovereignty ideals, clashes with previous hegemonic discourses and practices which make 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 that does not fit within a hegemonic discourse, the psychological aspect of the therapeutic approach is considered the most important. Through ethnography, it is possible to observe how 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 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.

The ethnographic approach began with a thorough review of the laws, policies, and previous addiction treatment experiences in the country. However, its core lay within the public addiction treatment center, its day-to-day practices, the life experiences of those trying to become something other than the addicted subjects, between their own will to improve and imperatives from elsewhere to consume or to improve, to get better, to become someone other than the addict. Ethnography implies being there, in the center, in the meetings, in the therapy sessions, in the lunch room, and describing reality as it unfolds. My ethnographic inquiry is guided by theoretical problematization in situ.

The Place

The first public addiction treatment center’s coming into being seemed more accidental than planned. To begin with, the LGBTI community was successful in bringing unacceptable dehomosexualization treatment into the public eye. This treatment was largely based on the same “therapeutic” practices used for addiction. Yet, those who had been sent to private clinics for addiction treatment hadn’t been successful in organizing resistance against the centers. At most, they fought back: some escaped, others turned to more drastic solutions, like Paul, who set fire to the last clinic in which he had been confined. Many others simply suffered through each confinement, but there was no public protest against the clinics, a move even prisoners resorted to every now and then (Garces 2010).

The centers dealing with addiction had found an unregulated space, created by law and supported by security forces, completely hidden from the public, with the complicity of families eager to hide embarrassing, out of control relatives. Each patient survived as they best could, while families kept on paying the fees charged for treatment and hoping for a miracle. The success rate was far from promising. Between one and

ten of every 100 patients was said to recover from addiction, according to users (Jácome 2012). After the LGBTI movement made the private addiction center dynamics public, everything changed in terms of the way those clinics functioned. That was the end of conversion therapy, thanks to the LGBTI community's efforts.

Changes in the Constitution seemed to work in favor of people going through addiction treatment. When Felipe, the Diabluma leader, was getting article 364 included, in 2008, he was thinking of all the people who ended up in jail even though drug use was not a crime. He wasn't thinking of addiction treatment as threatening, abusive, or problematic. In 2012, I learned that he was responsible for the article's inclusion during a casual conversation. In the past, I had interviewed Rodrigo Tenorio, a psychoanalyst who had been director of the National Drug Observatory. When asked about article 364, he mentioned that it contained a contradiction in mandating treatment for occasional users. Felipe jumped in to explain that he had written the article and that addiction treatment was not the center of attention when the first reforms were being developed.² The focus had been primarily on the increase in the prison population because of Law 108, and this was what Felipe had in mind during the Constitutional Assembly. Private clinics were not visible to the public, and drug users had no voice. Although the 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 health centers. But the first specialized center had yet to be established.

The first public addiction treatment center is located in what used to be the Verdecruz, or Green Cross, Leprosarium. The national leprosy hospital was established in Quito in 1927 to isolate Hansen patients. After being designated the official national leprosy asylum, the Verdecruz Leprosarium maintained its double function as a prison and a hospital, surrounded by high walls and allowing communication only through the *parlatorios*, mesh-covered windows through which patients could

² Paladines (2016) explains reforms and counter reforms regarding drug policies in his work, *En busca de la prevención perdida: reforma y contrarreforma de la política de drogas en el Ecuador*.

speak to their relatives or dictate letters (Montenegro 2007). Patients did not have access to regular currency; instead, they used stamps. Also, they received a daily ration of *masita*, a small piece of bread dough. Patients remained incommunicado behind locked doors for life.

The leprosarium, as a particular heterotopia for the exclusion of those who were ill, separated people with Hansen disease from the rest in order to contain the threat that the illness posed for others.³ The confinement to which the Hansen patients were subjected loosened in 1957, when Dr. Gonzalo González, a dermatologist who wrote his doctoral dissertation on leprosy treatment, was named hospital director (Montenegro 2007). From then on, Hansen patients were allowed to use regular money and to send and receive mail; the *parlatorios* disappeared and the place began to function more like a hospital than a prison. With the help of international NGOs, the hospital built small homes for 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 Quito's neighborhoods, a barrier that has not yet been broken (Córdova 2013). Only after Dr. González's arrival did beliefs surrounding leprosy begin to shift towards a medical understanding of the disease, but premedical representations remain.⁴ I couldn't help but notice my own fear of contagion the first few times I was on 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 ease with which addiction was linked to use and, as a result, I felt less threatened by addiction patients, unlike many others working in the public center or the dermatology

³ Heterotopia is a term that Foucault (1997, 332) 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." In so-called primitive societies, heterotopias were spaces for those who were in a state of crisis, such as adolescents, the elderly, women in labor, 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.

⁴ Jodelet (1991) explains premedical representations as the beliefs surrounding medical conditions, which shape the relationship that a patient has with the community regardless of scientific knowledge about the disease.

hospital, or, eventually, the 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: according to the Constitution, 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 together with practices being implemented. Addiction was becoming a concept right there, with many contradictions contributing to the way it was understood.

I arrived for the first meeting with the coordinator, and decided to park inside. The Vicentina neighborhood might be safe, or not. But the hospital is located at the very edge of the city, at the border, right next to the slope descending to the Machángara River. I got out of 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 connected to surveillance cameras. Although the area currently occupied by the Dermatology Hospital has expensive medical equipment, all cameras are located in the drug addiction treatment areas, reflecting a surveillance practice that targets patients. The all-seeing gaze, related to the logic of plague and population control, juxtaposed that of the simple exclusion of lepers in the public center. I signed the log and parked inside. I later learned that the Dermatology Hospital's director had the surveillance equipment 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 on 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 who remain. To the left of the entrance, facing the city, the first area is where the nuns live. Below that level is a structure which includes a small snack and coffee shop, the administrative offices, and the Dermatology Hospital.⁵ To the right

⁵ The Dermatology Hospital was turned into a Public Health Center in 2015.

is the main area where the public center operates in the old, renovated buildings which used to be the leper asylum. The male ward was located in a typical hacienda structure, a U-shaped building with a patio in the center featuring a water fountain with a statue of the Virgin Mary.

The patients' bedrooms are located in an area with the nurse's station, the psychologists' offices, the psychiatrist's office, and the meeting room. The back of the building has a balcony where the coordinator's office is located, along with additional psychologists' offices, and more bedrooms. And below are a basketball court and a soccer field located next to the wall. Further down, in the direction of the river, are the Hansen patients' homes. 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. Both had to approve my research and were very interested in the work I proposed to do. Even though they approved, I had to go through a bureaucratic permission process, which I did, though with no response from anyone. I went ahead anyway, as I had the coordinator's consent and patients had been informed.

The main patio in the male wing has a door which is always open. In front of it, there is another, smaller patio leading to the occupational therapy area. Behind is a narrow corridor leading to physiotherapy, the gym, and the nurse's station for the Dermatology Hospital. To the left are the old leprosarium buildings, in the process of renovation. The female ward, behind bars, is in the very last building on the second floor. It seemed that, while males lived in a space that was monitored and controlled, they were free to move around, whereas females were remanded to a leprosy ward where they were isolated.

I asked the coordinator about the women being locked in, and I felt throughout my research that I hadn't paid enough attention to the gender issue. He said that the women were behind bars to protect them from the men. It didn't click until later that it made no sense to lock up potential victims while potential offenders were free to move about. Not only was "protection" the reason for locking women up. In general, the staff depicted them as problematic, conflictive, dramatic, and it seemed like everyone just wanted to avoid the whole issue. Juan kept a couple of manuals for treatment of addiction in women in his drawer, and he kept hoping for time to prioritize development of a therapeutic approach for

the female wing. In the meantime, and with so many demands from 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, women's places 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. 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 1997, 334). I felt this was the case: most of the time, when state employees described the project and its rationale, it seemed they were simply excluding the female wing from their description. After all, the public clinic was meant to host males only, and the rules prohibited mixed clinics. Still, women needed treatment, and they felt that it would be wrong to refuse to treat them. There wasn't a female public clinic just yet. But in practice, the differences between male and female wings 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 for decriminalization of addiction which was defined, in the 2008 Constitution, as a public health problem. At the same time, and under the pretext of "available space,"⁶ the center 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 within its perimeter and in its relation to social reality.⁷ Heterotopias are defined precisely by this heterochronism, a grouping of different times in a single place of otherness. From its beginning, the

⁶ There were over 400 properties in the hands of the state by the end of 2016, seized during police operations against drug traffickers and others. The government created a company to manage all the properties; nevertheless, it chose the old leper asylum next door to the Dermatology Hospital for the addiction treatment center (Inmobiliar 2016).

⁷ This is explained by Foucault's fourth principle of heterotopias: they are connected to fragments of time, non-compliant with traditional time (Foucault 1997).

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 were characterized, as described, by forced confinement. Although it is an illegal practice, admission requirements were reduced to concerns of family or friends and their willingness to cover expenses. The public center was careful not to reproduce these practices, as they are associated with the neoliberal perspective that the “socialist state” is supposed to fight against. As a result, admission is voluntary, except for a few cases in which there is a court order, something that annoyed Juan, although he felt he could do nothing about it. Anyone could leave if they no longer wanted to be there. All they had to do was say they didn’t want to remain in treatment, unless they had been remanded by the court or were minors who could not be released without parental consent. Occasionally, a minor would run away, which posed a problem for Juan, who felt that responsibility for court-ordered minors was too much. The public center was intended to fulfill a voluntary desire for treatment of, precisely, a disease of the will while, at the same time, ordering mandatory treatment for persons sent there, a contradiction that hides other aspects of confinement. In addition, the state kept pushing, one way or another, for increased security. During initial assessments, triage depended on voluntariness: it was up to the patient to be considered for inpatient treatment, depending on whether he/she expressed the desire for said treatment.

Heterotopian emplacement is not a matter of choice but responds to either force or submission to purification rituals. The public center developed an admission process which began with a few months of attendance in the outpatient pre-community group, and only when the leading psychologist believed that the person had come to understand the need for treatment would he or she be admitted as an inpatient, unless the person in question requested to be admitted and his/her drug use was serious. In Albert’s case, for example, being an inpatient meant that he was no longer homeless at a time he felt he could no longer afford his daily pill consumption.

Heterotopias have been defined as a way to deal with exclusionary practices in a concealed fashion and that develop in the context of emancipatory discourses. As such, the public clinic was filled with good

intentions, yet it was located at the leprosarium, and the surrounding community assumed that it would be a detention center. Even the Ministry of the Interior, when informed of a protest against the clinic by neighbors, referred to it as a “social rehabilitation” institution, 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 wouldn’t otherwise have. As mentioned, Albert was one of them. Paul, who was obliged to check in weekly 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 supervising registered private addiction treatment centers. The ministry also identified a number of clandestine clinics, in order to either regulate them or shut them down. At the same time, she wrote new rules for private clinics, specifically prohibiting treatment for homosexuals. Part of the planning included the creation of an Área de Contingencia para Adicciones (ACA, Addiction Contingency Area) in 2013, for which the Ministry recruited several psychologists who began developing the treatment plan.

Iván, a former addict and a clinical psychologist, was one of the ACA’s founders. He explained to me that the protocol for attention began with an investigation of private clinics reported to authorities; if findings warranted a clinic’s closure, the persons who had been confined there would be transferred to the ACA, where they underwent a psychological evaluation and were given the choice to remain at the public clinic for a month. At the time, three options were offered: ambulatory treatment, intensive ambulatory treatment, and inpatient treatment for a month. After the center became a therapeutic community, in 2014, changes were made: the treatment period was lengthened, and other therapeutic approaches were introduced. The psychological approach remained the most important (interview, December 1, 2014).

Iván. My job consists of conducting the initial interview in each case, after which I determine the type of treatment required, or that would be most appropriate, and, after the participant has been checked in, I accompany him through the problems causing the symptom, which is drug use. In AA they say drug abuse 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 (interview, December 1, 2014).

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:

Juan. The ACA was more of a contingency area, that is, a place to keep young people while the private centers got legalized or shut down or whatever. And so there would be, say, 20 patients. So, what the ministry wanted to avoid was to shut down a center and send everybody home. So, these people would come here and stay while their families came and fixed things. We would explain to family members that it was illegal to keep someone against their will, and they could find some other place or leave them here for a month. There was some therapeutic stuff, a psychologist, a doctor. Later we got together with the team and we saw that the ideal thing, science, what evidence says is that a treatment, in order to be minimally effective, would have to last at least three months (interview, November 10, 2014).

Juan was aware of the human rights violations that had led to 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 understood that some of the people who were rescued from private clinics required 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.

Juan. Why a month? The justification given then was that these people came from very long periods of confinement, five or six months, eight months, a year, and to propose a longer treatment, well, nobody would

accept that. When they explained that it would only be a month, while they got the help they needed, obviously the families would be okay with that. They were taken out of the clinic but at least they kept them here. So that is how it worked, as a contingency center, when I arrived (interview, November 10, 2014).

The therapeutic value of the month at the ACA was unclear. The people came from violent clinics, accountable to no one, to a place where they were fed and treated decently. After the month was over, they would receive a diploma and be discharged. Some people returned when the ACA 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 a simple contingency or a repetition of the private clinic approach.

The most common understandings surrounding addiction were closely linked to criminality and dangerousness. The challenge for the public center's coordinator was to build something new out of the ruins: old buildings as well as old beliefs which affected everyday life at the public clinic. As indicated, the Dermatology Hospital was next door to the addiction center, and even though Juan had been cautious when choosing his team members, health personnel also came from that institution. Before long, the addiction clinic installed a gym for patients. One day, the male patients found a loose screw in a machine. They were eager to work out and experience the release it produced, so they solved the problem the same way they would have at home: they went to the kitchen, found a knife, and tightened the screw. Then they started using the equipment and forgot about the knife. However, someone from the hospital walked by and saw it on the floor. Immediately, an official communication was sent to the Ministry of Health, raising the alarm regarding weapon use by addiction patients, and requesting security measures to prevent their access to objects with blades in order to protect staff and patients from the dermatology hospital. Juan was annoyed, but he understood that part of his work included dealing with what people thought about his patients.

The public center represented the attempt to break the total institutional dynamic coming from private clinics. Juan wanted to do this

through the definition of addiction and an emphasis on a professional and scientific approach. To begin with, the door was open.⁸ Anyone could leave if they wanted to, and family members could visit freely. The perimeter walls were the same high barriers built for the leper asylum. One day, as I was sitting on the balcony across from Juan's office, waiting for Paul to finish therapy with the psychologist, the men were playing basketball on the court across from the building. Suddenly, the ball went over the wall, into the street. One of the men 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 is to get around it, there is a barrier separating this population from the outside world. Attempts to attenuate the division, including family visits, weekends out, or a phase during which the patient goes to work and returns to sleep, don't erase this division.

In addition, even though the public center has tried to build its own experimental process, specialized hospitals are subject to regulations issued by the National Health System. The Modelo de Atención Integral de Salud (MAIS - Model of Integral Health Care), an attempt to standardize public health services, states that attention in specialized centers is only possible when a health center has evaluated a patient and referred him/her to the third level⁹ (Ministerio de Salud 2012a). *Spontaneous demand* is not acceptable; a person who wants to enter treatment must first go to a public health center that will refer the patient to the public addiction center. Interestingly, while the ministry attempted to standardize the medicalization approach through bureaucratic procedures, spontaneous demand was the main focus during the intake evaluation, known as triage: does the patient want to come for treatment? Is the person looking to improve? Is there a genuine interest in working

⁸ A description by Goffman (1961) of total institutions matches day-to-day life inside a private clinic; the patients, deprived of autonomy, are forced into submission through practices that include an initiation, colloquially called a baptism, to show the new patient that there is no space for self-representation. The public center, through the constitution of a multidisciplinary team, attempts to break these practices, but some that Goffman describes remain.

⁹ The Ecuadorian health system is divided into three levels of attention: the first level includes community health centers, the second level is made up of hospitals which offer general attention, and the third level consists of institutions offering specialized care.

through the issues involved in addiction? Spontaneous demand was the key to shaping a new subjectivity through addiction treatment. However, bureaucratic procedures confused matters due to the different levels of the official referral process.

The public clinic had found a way to comply with bureaucratic requirements by speaking to the health center's workers: potential patients were asked to go to the nearest community health center, get the certificate of referral, and come back. The real assessment would take place at the public addiction center where the patient is first evaluated by a psychologist, then by a physician, and finally, by the psychiatrist. The social worker also interviews the person. The decision to admit someone is then made by the team; their decision also depends on available space although, on rare occasions, the coordinator will decide to add a bed to keep a patient off the streets.

Because of the lack of beds, and after some patients dropped out of treatment, staff added another condition for admission: a prior period of intensive ambulatory treatment during which the team evaluates the prospective patient's commitment to recovery, to ensure that scarce beds are being used by the truly committed. This mechanism was met by protests from residents of the Vicentina neighborhood who argued against the addiction treatment center's open-door policy. The ministry decided to relocate ambulatory treatment elsewhere, and the psychologists who were on a one-year contract for this part of the process left the center. The requirement was changed to having spent time at the outpatient facility and to bringing a recommendation from that staff for inpatient treatment.

The therapeutic process for patients admitted was divided among members of the multi-disciplinary team, and also involved routine morning and evening meetings, which patients sometimes ran themselves. Definitions of addiction took on meaning within each of these disciplines, and different techniques were used to reinsert addicted persons into society. The process created a mosaic of modes of understanding, which were then reviewed, and sometimes challenged, during team meetings, as were conflicts which eventually arose.

Psychology

The public center's most important discipline was psychology. The therapeutic community developed after the ACA opened as an attempt to create an evidence-based medical approach to addiction. The team first defined the length of the recovery process. At the contingency area, the purpose was to give patients an opportunity to deal with the closing of a private clinic without being abandoned to their own resources. At the public center, the objective was to produce a lasting change in behavior.

Juan. At staff meetings we saw that evidence suggests that 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 the minimum time established is three months during which the medical, psychiatric, and psychological aspects are set. Treatment is holistic, it includes both psychology and psychiatry, but psychiatric intensity is low, and psychological intensity is high. 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 (interview, November 10, 2014).

Juan's view of the problem was shaped by extensive experience in the field of addiction. He knew that therapeutic communities, regardless of their effectiveness or their techniques for managing people, had become the dominant form of addiction treatment. But, he explained, while emphasis had been placed on inpatient treatment alone, based mostly on experiential therapy, there were actually three moments in therapeutic processes which treated drug abuse and dependency. He described them as pre-community (daily meetings and many hours a day at the clinic, a form of outpatient treatment), community (inpatient treatment), and reinsertion, the follow-up of patients after their return to society. Juan believed that these processes had to be led by psychologists.

The first public addiction treatment center was soon flooded with people looking for help. Juan decided 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 setting a waiting period. You didn’t have to tell them to come back on May 30”. Juan also knew that if people had to wait for treatment “they would 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 being admitted, so they do have a degree of confinement...even if it’s as an outpatient” (interview, November 10, 2014).

When Juan started the group, however, psychologists had trouble assuming responsibility for this section, and outpatients would end up on their own. He took over directing the outpatient group, but soon realized that, as coordinator, he didn’t have time for this new commitment so he hired two psychologists to focus mainly on the outpatient group, the earliest phase for those undergoing addiction treatment at the public clinic. Ramiro was one of them.

I spoke with Ramiro at his office, a recently renovated room on the first floor of one of the older buildings. Juan had hoped to have all areas renovated, but a municipal inspector said that, as they were very old, the buildings were not safe; at the same time, the budget was running out. Nevertheless, with the help of patients, a few rooms had been cleaned up, and Ramiro’s office was in one of them.

Ramiro had been a psychologist in a psychiatric hospital his entire life. Though he had retired, he wanted to continue practicing. Having worked at the psychiatric hospital for many years, he had plenty of experience with drug use disorders. He invited me to observe the intervention he was about to have. “We will talk about mental health and we must offer a treatment for the patient to improve. It is one of the first cases... the mom is almost never there. Only the nanny”. Indeed, they talked about mental health, with Ramiro educating the patient in regards to addiction (interview, December 9, 2014).

The next appointment was with a family, mom, dad, and a teenager who was in outpatient treatment. Ramiro explained to them a few mental health concepts. This reminded me of a technique typical of private centers. In 2012, I interviewed a psychiatrist who worked at a private addiction treatment clinic. Dr. Luis had his own psychiatric hospital,

but he also spent about eight hours a week at the clinic. He described the practice of education in psychology as part of the psychiatrist's therapeutic approach: "We talk a little about the effects of drugs, the chemical effects, how drugs generate addiction, how an alcoholic cannot have just one beer because even after a year of not using he can reactivate his pleasure issues and come back to addiction, that sort of thing". Luis's job was to educate, to convince the patient to accept the process. But mental disorders are not a matter of logic. Why would addiction be any different? (interview, May 15, 2012).

Ramiro. We deal with several types of disorders and each is different: for depressive and bipolar patients, the attitudes of the ill are determined within 15 days during which the patient is irritable, hungry, very sleepy without having done anything, plus they are overwhelmed by guilt feelings which lead to suicide, loss of social interest, religion is no longer important, the sexual factor is altered, the person is edgy over the slightest situation. The bipolar does not apologize, as opposed to the depressive. You, ma'am, where would you classify him? (The mother replied that she would place her son in the one below). "The bipolar?" "Yes."

Using drugs results in all that is good and redeemable going into the trash, and a new type of personality is born. The person becomes a liar and, little by little, a threat to society. Support at home is important, because you must accept that your son is sick, in order to help him progressively diminish his dosage. The family can still be saved. Your son wasn't prepared for the universe, you must prepare him. If he is rebelling against society, we cannot assume that drug addiction centers are the solution. They are not. Youngsters who have been locked up in these come out attractive to older men and they risk getting raped. So, it is important that during the time he is going to spend here he remembers that his parents have told him that they will be there for him. That is the help he needs.

(Ramiro speaks 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 (interview, December 9, 2014).

In a single session, the teen went from depressive to bipolar to antisocial. Ramiro hadn't been involved in meetings where participants chose the therapeutic approach to be applied at the public center. He was, after all, hired for his vast experience: over 30 years in a public psychiatric hospital. He applied what he knew, but as an outsider working with outpatient treatment.

The next appointment was man requesting help for 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 arranged for this type of intervention. Old equipment had been pushed towards the wall to make space, and an old gurney had been cleaned. Ramiro, needle in hand, proceeded to hypnotize his patient. It felt surreal.

Freud describes his experience with hypnosis, and the development of the psychoanalytic method, as a free association of ideas by a patient who is awake. He believed that the only way to produce long-lasting, effective change is by uncovering the link between symptoms and 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.

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 Jean-Martin Charcot, who applied hypnosis to hysterical paralyses (Bachner-Melman and Lichtenberg 2001). Back in Vienna, Dr. Josef Breuer and Freud worked with regression through hypnosis as a technique to reach traumatic experiences thought to produce symptoms of hysteria.

While hypnosis shed the first light on the definition of the unconscious, Freud abandoned the technique for several reasons, including because it could not be used with all patients, because some patients feared losing contact with the present, because patients might become addicted to the technique, and because symptoms sometimes returned or new ones developed after hypnotic interventions. But Ramiro seemed to rely on it; it produced numbness in the area where he poked with the needle, generating trust with the patient, and lowering anxiety, for at least a little while. No one else at the public center used it.

I left the outpatient experience with the sensation that problems had been defined morally and that solutions, in the case of the family appointment, involved placing responsibility on parents keeping their marriage together, a complex phenomenon reduced to traditional beliefs regarding family. Disciplinary practices screamed from all of the old, dusty, rusty, piled up debris. Addiction treatment was not based on violence, as it had been in most private clinics, but many characteristics of its recent past were still in play. The state eventually divided treatment modalities for inpatients and outpatients, and created new centers to specialize in each, and the clinic shut down the pre-community services, as they were provided by a different institution. However, around 2016, new outpatient centers were created. Ramiro and the other psychologist went back to the psychiatric hospital. Outpatient treatment was provided by a different institution in Quito where patients were evaluated for inpatient treatment at the public clinic.

The other psychologists had been on staff either since the contingency area or the therapeutic community opened. They had participated in all staff meetings, where the concepts behind the project were discussed and agreed upon. They all came from different schools and backgrounds: some had studied at the Universidad Católica, with its strong emphasis on psychoanalysis; others came from the Universidad Salesiana, which emphasized social circumstances; and still others came from the Universidad Central, with its combination of behaviorism and cognitive behavioral approaches. Practice, therefore, varied somewhat. But the team (which included professionals from other disciplines as well) seemed to be in agreement most of the time, at least in the beginning.

The public center's emphasis was the clinical psychology approach. Inpatients attended morning meetings, usually with a psychologist; each had at least one weekly individual session with their psychologist; there were group therapy meetings at least one afternoon a week; a psychologist participated in the evening meeting. Psychologists also met with the patients' parents or family members.

The work done by psychologists related to what they believed the problem to be when it came to addiction. For Iván, who spoke not only as a psychologist but also as a recovered addict, there was a problem with what the patient believed about himself which resulted in

addictive behaviors which eventually became problematic: “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, the way a man is in his thoughts, that’s the way he is” (interview, November 14, 2014).

Iván described the way he had divided the three months of treatment. During the first phase the work focused on rebuilding the way people see themselves:

Iván. 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 comes from a perspective that equates them to a dog: I tell them, what do dogs do? In general, they bark. Why don’t they meow or tweet? What dogs do is engraved in them. 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 that I will free myself from that? None, he will use drugs, because he conceives of himself as an addict. This worries me a lot, because the way I look at myself determines what I do (interview, November 14, 2014).

For Iván, the process aims to unveil the unconscious reasons for drug use. He compares this moment of insight with seeing the light, and it is the reason he believes the process is worth it: “It is exciting when a patient has everything a little clearer, even if he doesn’t stop using drugs” (interview, November 14, 2014).

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

the therapeutic community. She believes that there is an ethic in the addicted which needs to be addressed.

Lorena. 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 about these things, parenthood and so on, because you become lackadaisical. When drug use is 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 used, this is a disease, great! 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, 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 (interview, November 12, 2014).

While Lorena's ethical reflection came most certainly from her interpretation of Lacan's seminar applied to the construction of a citizen of addiction,¹⁰ her reference to the label pointed to the effect of the war on drugs on the everyday lives of users. Granted, not all of them. But those who fell into addiction were playing a role in the script written by decades of portraying drug use on the basis of problematic cases, in order to create an enemy worth fighting a war against. Drug use had been described as a gate to losing oneself to 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 bring back to society were already playing a role.

While Iván saw these self-representations as sad, reflecting on his own experience compared to those of each patient, Lorena viewed them as a way of justifying failure, deviance, and excess. Both psychologists were

¹⁰ For psychoanalysis, the subject is an ethical subject, capable of responding, of taking responsibility for his desires, assuming 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 for everything that happens to him (Lacan 2007).

there to help patients reorganize these beliefs. Part of treatment, Lorena explained, was to convince the person that change is possible. “The patients suffer a lot, and they are unable to take responsibility for some things” (interview, November 14, 2014). From a Lacanian perspective, guilt is a way of avoiding responsibility. The psychoanalytical ethics aim to diminish suffering through taking responsibility for one’s choices.

The cure, Lorena believed, had to do with the transition from the act to the word: the symbolic order taking over from the real. For the addict, she explained, there is no middle; all that 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 her patient and who had been in the public center once before, was unaware of the theoretical frame from which she worked.

Albert. 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 into disclosing, you put up a barrier for yourself, you block everything (interview, September 9, 2015).

Private clinics scheduled many hours of 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 their most gruesome experiences in 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 tend 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 cure.

The Alcoholics Anonymous model begins with an act of surrender to the condition of alcoholism: the first of twelve steps is the admission of being powerless in regards to alcohol (Pierce, Rivinoja, and Koenig 2008). But in private clinics, there is no such admission: people were taken by force to these places and admission of substance dependence or abuse resulted from a need to stop the violence. The effectiveness of Alcoholics Anonymous is primarily the result of key aspects of their spiritual recovery model: the provision of a community, the narrative framework for meaning making, the possibility of coping through submission and redemption, and the prescription of behaviors such as forgiveness and altruism. These components unfold in an atmosphere in which alcoholics try to view themselves as ordinary people trying to overcome a form of suffering.

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 self-definition as an addict: it was through forced confinement and violent practices that the clinics attempted to make the addict define him or herself as such. Those who had been confined for longer periods were often hired as security guards, a practice akin to what took place in concentration camps which used Jews as security guards (Levi 1995). A sense of community was thus harder to create than it would have been in a regular Alcoholics Anonymous group. The public center didn't use the twelve steps, but it did turn to a logic of admission – before being accepted for treatment, the person had to show the desire to recover, which implied admitting to a problem which they could not control on their own. “Older brothers” were assigned at the public center, but without the persecution associated with private clinics; perhaps a sense of community had a better chance to develop here than in private rehabilitation centers.

The center exchanged the public display of drug-related experiences for private, individual sessions. And while, in an ordinary psychoanalytic

process, the patient decides what he wants to speak about, even though this may mean that resistances are operating, the public center put pressure on the staff to make the unconscious conscious quickly. Albert felt as if he were being forced to talk. There was something he felt was expected of him in his therapy sessions. He, like others, learned to respond to the demand, thus remaining in the non-responsible state. He often mentioned that he felt afraid of telling his psychologist about his longing for drugs; he felt she had the power to use that against him when deciding on release.

While the first group therapy sessions offered by the public center involved all patients, by the time Albert was on his second stay there, the center had changed this practice. Group therapy no longer worked as a random, one-topic-at-a-time meeting. Instead, each psychologist had a group, made up of the people they were treating individually.

Albert. Each doctor works differently, I believe. Lorena, 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 bring 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 (interview, September 9, 2015).

During Albert's first stay, group therapy was more like a workshop. A series of dynamics allowed for a cathartic experience in which patients could talk about their childhood, their fears, their perceptions of works of art, as in the session 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 patients, men and women, and with the use of visual stimuli, consisting of paintings which contained smaller pictures within the main pictures.¹¹ Mercedes generated a series of responses which allowed for people to speak about their families, their drug use, and, mostly, the perception they had of themselves.

¹¹ Paintings by Oleg Shuplyak.

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 when empathetic relations had formed within the smaller groups. Or did he?

While everyone seemed to agree 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. 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. We have a group of clowns, and the municipal government asked us to send them, it was for the campaign for, what is the campaign for 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 change (staff meeting November 8, 2015).

Obedience, rules, therapy as the most important objectives in order to generate empathy and the will to function properly in society: the process and its representations influence the way behaviors are interpreted. There are rules, and one must obey them. 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 therapeutic goals, Juan had the difficult task of making everything work while responding to the ministry's demands, orders, and expectations, as well as those of the staff and the patients. Had he been a part of the psyche's 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 began slowly started to close. Visits were scheduled by the psychologists, with one visiting day

designated for the patients of each. May, the occupational therapist, explained: “For example, on Mondays, I believe it’s the day all of Alejandro’s patients have their visits” (interview, May 9, 2016). Psychologists were the core of treatment but, at the same time, they were placed in a position of authority which made it difficult for transference to flow. The public center resisted, but inertia operated against it.

Psychiatry

Private clinics were mostly run by former addicts. A few had a psychiatrist attending for a few hours a week, but most used sinogan, a strong tranquilizer, on their patients, especially after capture, when people were desperately trying to resist confinement. A physician wasn’t required to administer it. Force did the trick. Still, psychiatry remained an important voice in addiction issues, even when its position was unclear. Physicians represent the unquestionable knowledge thought to accompany any hospitalization process. Sometimes the simple 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 put more emphasis on the psychological rather than the medical approach. Still, the meeting with the psychiatrist was a required step for entering the therapeutic process at the public clinic. The assessment looked for detoxification needs, as well as for the presence of other pathologies. If the case was severe, the person would remain under the psychiatrist’s care. May, the occupational therapist, explained the process.

May. If he needs detox, generally it won’t be handled here, the psychiatrist will deal with it, with *sueritos* [‘little intravenous,’ a colloquial way of saying 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 (interview, December 3, 2014).

Since the regulations required a psychiatrist for each center, Juan hired one when he put his team together. Jane, a Cuban psychiatrist, explained that the psychiatric approach was always unique, as each patient was different, and that decisions regarding treatment depended on the team's assessment.

Jane. There are standard medications, fluoxetine for depression, the antipsychotic risperidone..., and so on. We conduct a psychological assessment, a medical evaluation, and a psychiatric one, and this is how we determine which medication a patient will receive, if any. We take into consideration the psychologists' opinion because they can identify if the patient is borderline, things like that, and so we modify medication according to these criteria, if they can't sleep, etc. The psychologist can also suggest things which allow us to regulate the dosage (interview, December 2, 2014).

Patients at the public center mentioned that they found it easy to manipulate psychiatrists into prescribing something that would get them high. Albert and Francisco agreed upon the ability to fool the doctor to receive prescriptions. Jane explained that she never prescribed addictive medication to patients at the public clinic.

Jane. I have been a pioneer here of not prescribing psychotropic medication. Benzodiazepines for the patients? No, not unless it is strictly necessary. Sometimes the patient needs it, and if he needs it, ok, well, but we try not to, the physicians and I, not to give any medication which could lead to dependence. If it were necessary, unavoidable, it is prescribed for a limited period of time, just as specified, so that we don't risk the development of dependency (interview, December 2, 2014).

Jane's concern with patients' development of further addictions was based on the characteristics of the medications and, especially, of the patients. People like Albert had been hooked on pills for a long time, and her worry about the medicine being worse than the disease seemed understandable. For her, addiction was a disease, a disorder which made patients put drugs into the body to alter the mind.

Jane. There are people who have used drugs at parties, all of their lives, but it never becomes problematic drug use. And this is the thing; we treat problematic drug use only. An addict is someone who has a problem with drug use... Not everyone who uses drugs requires treatment. Not everyone develops problematic drug use. 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 (interview, December 2, 2014).

Differentiation between drug use and drug abuse or dependence had not been a concern when private clinics were the only rehabilitation alternative. Whether or not a person 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 changing this trend. Drug use alone was not sufficient to diagnose addiction, much less treat it. Being a public center, the clinic wasn't after profit, it didn't need the business. When a patient entered inpatient treatment, drug use was out of the question. Jane mentioned harm reduction as an international trend worthy of review.

Jane. It is preferable for a patient to use something less toxic. Or if he manages to reduce frequency and dose, we must recognize that as an achievement. But any patient coming in here cannot use. Period. This is a specialized center, and the people who choose to be admitted are not forced to do 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 who are inpatients and in intensive outpatient treatment. We do toxicology controls frequently, to be sure, to rule it out (interview, December 2, 2014).

At the public clinic, addiction is defined as a disorder: the person cannot control her intake of a substance, she needs the psychotropic or narcotic effect. But control is what was expected when someone was admitted into the program. Since the doors were open, abstinence was not forced upon them. It was voluntary. But just in case, to be sure, it had to be verified through testing with the possibility of being asked to leave

the clinic. The medical authority required no explanation for a relapse, simply test results. But breaking the rules didn't always result in the person's exit. The team's assessment left room for discretion and exceptions could be made. However, this didn't exclude scrutiny through testing.

Jane. They have therapeutic outings, recreational activities, to pools, to nice places, walks, with the objective of making them feel that we trust them, that they are not locked in here. But almost always, after a family leave for the weekend, we conduct a toxicology exam. And if they have used, the approach is different: the team meets and decisions are made, because right now, there are many patients on the waiting list (interview, December 2, 2014).

Contradictions are not necessarily evident. In fact, most of the time we lack a full understanding of what we are saying or doing. The public center was no different; contradictions abounded but they weren't obvious. Some stood out more than others, like the old building hosting new therapeutic approaches. Nevertheless, they affected the course of treatment which, in turn, produced a sad sensation in the staff, not only Iván, as a former addict, but many others.

I found everyone gathered near the nurse's station, and asked what the commotion was about. Patricio, one of the patients, was upset because his drug screening came out positive for marijuana, but he insisted that he hadn't smoked on his days off. He was demanding a new test, as the consequence for using during treatment is usually expulsion from the program. Someone else said it had happened to him as well, but when they did a retest, it came out negative. 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, people chatting in the halls mentioned Carlitos, a patient who had already left the program voluntarily but was readmitted. The public center allowed a new admission only for those who completed the program and then relapsed. However, Carlitos was charismatic, and everyone liked him. The team decided to give him another chance. I was in the meeting in which Carlitos, a young man in his twenties, was reintroduced to the group.

He had abandoned treatment after a month and gone on a drinking binge. His main problem was 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.

Patient, 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.” He was followed by another, who said, “I want to observe Carlitos: dude, you get too angry. Listen, we are all going through this. I ask you to think about the way you treat 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 (patients’ meeting, December 17, 2014).

Others addressed him in similar terms. 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 decision to leave, he wasn’t allowed back into 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 was 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 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.

The team eventually concluded that Carlitos’ problem was 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. Like Dr. Luis, Jane believed addiction was a matter of understanding.

Jane. 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's father, a humble person, asked me if it was true that I had an IV to cures his son's addiction. I told him I wish I had, that would fix everything (interview, December 2, 2014).

The definition of addiction remained ambiguous. Was a cure dependent on understanding the doctor's explanations, and was this the much-needed responsibility-taking Lorena had referred to? Is the addict a deviant by choice? I asked Jane what factors were involved in the development of addiction.

Jane. Basically, personality, family, the age of first use, friendships, social background, everything. It depends on many things, and no two persons are alike. We are all unique. Otherwise, everyone who got divorced would use, or everyone who had bad parents would use. The sad part is that it's three months [of treatment] against a lifetime. 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 [for some] while others had everything... and so on (interview, December 2, 2014).

Jane went on explaining that uniqueness is what justifies individual therapy in addition to group processes. Even though people might open up in a group, 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 interview process in order to try to understand what was going 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 had been released from his

first inpatient process after many months, since the staff didn't feel he was ready to leave; but when he finally did, he had a job and had rented a room. However, after making a little money, he paid his landlord for four months in advance. This gave him a sense of security and he decided to stop working. Telemarketing was boring. He wasn't good at it.

Up to then Albert had only worked for his dad, Jim, a Korean American who moved to Ecuador when he was a teenager. Jim began a 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 consisted of being a crew member for Jim when he performed. He had also played with him a few times, but mostly, he carried stuff. Going from life in musical circles, with stages, parties, hotel rooms, and drugs, to a telemarketing job was a major letdown.

Albert soon found himself spending his savings while still living at the public center. He quit his job, and even though he was searching for something else, he really wasn't doing anything. He described the months before coming back to the clinic.

Albert. 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 mopped the floors, I made the bed, I mean, I kept it the way I wanted it, I washed the dishes. When I fell [into drug use], then, a disaster." Was it like the worst times with your father?" I asked. "Exactly. But now it's 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 fill it with water and cook potatoes and eat them (interview, September 9, 2015).

I asked him what he spoke about during his individual therapy sessions, if he talked about depression: "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" (interview, September 9, 2015).

Occupational Therapy

May was one of the star workers at 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 director of the Dermatology Hospital. May was an occupational therapist, a profession she described as dealing with all of an individual's occupations. She organized the therapeutic process starting from the most basic activities (or occupations) that a person performs in her day-to-day life: "Brushing their teeth, bathing and dressing, eating, basic activities that every well-adjusted person performs daily. These activities are individual; each person does them for themselves" (interview, November 12, 2014).

Indeed, people who had been lost in drug use, like Paul, Allie, or Albert, arrived skinny and dirty. After a couple of months, they seemed changed: being at the center cleaned them up. They all looked healthy: there was a nutritionist who planned the menus (certain things are believed to trigger addiction, coffee and sugar, for example); patients took a shower every day, and their clothes were washed. The socialization process began with these most basic activities. When these had been mastered, the process moved on to what May called advanced life activities.

May. We call them instrumental daily activities, and these occur with other people, daily: taking a bus, looking after children, looking after the elderly, handling money, shopping, activities done every day. We work on these through dynamics with other people, cooking, that sort of thing (interview, November 12, 2014).

Even though Albert survived on boiled potatoes when at his worst, his second stay at the clinic 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 like the telemarketing gig. So, he began making turnovers (dough filled with cheese or meat) and selling them to the staff; after a while, he added sandwiches to what he had on offer. He used the occupational therapy kitchen. Cooking was no longer just a part of 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 do every day. Then there is work, or the exploration of jobs: what do I want to do; what am I good at; what are my resources, studies, abilities; what kind of job could I perform well in” (interview, November 12, 2014).

According to May, it was not only a matter of finding a job, but finding something the person is good at, 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 a social network, and when he found the telemarketing gig, the clinic agreed. But he never sold a single insurance policy. All he earned was a part-time salary, with no sales commissions. It was enough for a few months’ rent. But it was bound to fail.

Education, social life, and free time activities were also considered part of a person’s daily occupations. May aimed to assist each patient in achieving an occupational balance.

May. Some people work too much, and that could be an occupational dysfunction, because we must learn to balance all of our occupations. This brings us to the [patients’] routines and habits. 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 (interview, November 12, 2014).

For May, addiction was a habit. If it was a habit, I wondered if it could be considered one of the occupation groups she described.

May. No, it’s not categorized, I mean, these are habits we acquire depending on the context around us, so it’s not categorized among 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 themselves 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 balance comes automatically (interview, November 12, 2014).

Being a center that depended on voluntary admission (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 achieve. Addiction was commonly seen as a logical matter, something the patient could be educated about. But it was obvious in the meetings that everyone knew addiction was harming them, physically, socially, work wise, and so on. 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 that if a user acquired sufficient knowledge of what addiction produced, according to the definition of the discipline in question, the therapeutic process would be a success. However, if problematic drug use is unique, with a different meaning due to different factors in the life of each person seeking help, then maybe a therapeutic process based on teaching them something was silencing the possibility of discovering what made each case tick. Nevertheless, there were plenty of individual spaces, and group therapy could also facilitate identifications through which each patient could support their own recovery. Three years after the therapeutic community began, Juan estimated that they had a relapse rate of about 40%. Many patients, then, seemed to improve. But almost half did not.

The occupational therapy period was a good time to speak with patients, even though sometimes the music was a little loud. I found Paul sitting at a table outside of the room, on the porch overlooking the patio. The area assigned to May had previously been the dining room for Hansen patients. It reminded me of a classroom, perhaps in a preschool or an elementary school. 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. Next to the back door was May's desk, and to the left, the kitchen. On special occasions, the group would cook traditional meals: *fritada* (fried pork), *colada morada* (a beverage prepared for All Souls' Day, November 2), fried fish, it depended on who knew how to make what, and they all helped.

On December 15, 2014, the patients weren't cooking. Some were listening to heavy metal; others were playing *Mortal Kombat* at 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 have come from an elementary school. He was encouraged to work on this project; everyone agreed about his impressive ability to make detailed paper objects. "They gave us a class some time ago. I liked it, I like doing this" (interview, December 15, 2014).

While addiction can be defined 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 use.

Paul. In my case, I couldn't spend ten minutes without getting drugged. I wouldn't get desperate, like many people. But I carried the stuff 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 stop for two days at the most, but then I couldn't (interview, December 15, 2014).

While logic, responsibility, and knowledge regarding drug mechanisms seemed to have nothing to do with 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 hit bottom, or so he believed.

Paul. I was at the peak 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 first came here, they had to put me to sleep; I was in such bad shape that they had to sedate me. And now, there is a desire, but there are also other thoughts that keep me going (interview, December 15, 2014).

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 he mechanically added bits 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.

Social Work

If psychology carried most of the therapeutic weight, social work appeared to be the least visible of the addiction definition and treatment components. Eve explained her job at the public clinic.

Eve. 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 after another, and they haven't received the help they need. Mostly, the people who come by are family members, who don't know what to do (interview, October 5, 2015).

When the public center opened as a therapeutic community, it was advertised as a state-sponsored service. People started coming for information, looking for an option for a relative, but they did not receive attention without a referral from a health center. It was May, 2016, I was sitting in the secretary's office with the coordinator, when a man came in. "Excuse me, where is social work? I would like to know if I can be helped. You see, I have a problem with addiction, but when I came, they told me I couldn't get treatment here." Juan asked him if he had been evaluated by the staff. Two women, his wife and his mother, came in and explained that he was using to the point of threatening his 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's doing drugs. He came here, but they told him he couldn't be admitted."

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 a health center, 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's willingness to be accepted: the team needed to make sure that the person wanted to undergo addiction treatment, and was also willing to face addiction and its consequences. In 2016, other public addiction treatment centers had been opened and new protocols were established: evaluation became the task of intensive outpatient centers, and the public center required that evaluation. But evaluations weren't necessarily detailed, and the clinic continued to do their own. The initial assessment at this center considered this, and if they found that the person needed to work on her demand for addiction treatment, they would refer them back to the intensive outpatient units.

Juan reviewed the file and advised the family to get an appointment for a reevaluation. It had been many months, and he didn't understand the psychologist's handwriting. Hopefully, the family could get an appointment with Iván, and the team would consider admission after the review. 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 using except for a couple of weeks, and they weren't getting answers from anywhere. Juan understood. If they could go back to the entrance and get an appointment, that would allow them to reenter the admission process at the public clinic. "Do you want to be treated this time? Because admission depends on willingness, and if you were not 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 people dropping out 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 success rate.

Eve. Referral has to come from the intensive outpatient program, because this is something which affects the high dropout rate 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 occurring at that time. Perhaps the family told them they wouldn't help anymore, or maybe a legal issue had come up that scared the person into treatment. But after starting, maybe he discovered it wasn't what he wanted, and this increased the dropout rate (interview, October 5, 2015).

In theory, after spending a few months in intensive outpatient treatment, the patient would feel more aware of what inpatient treatment means, and he might have a better chance of continuing with the process. This was the idea when the Therapeutic Community first opened, but the state ordered the outpatient area closed, and people were referred to the newly opened units. Nevertheless, Juan kept the evaluation process for the inpatient clinic. The social workers' first duty was to give people information about the process. Admission included opinions from the psychologist, the physicians, and the social worker. They worked with the family or the patient's social network to evaluate the person's living situation, and their options for reinsertion. But social work didn't include any form of treatment, per se. From the social work perspective, drug use is a public health problem, not a crime.

Eve. 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 where I believe the country has made some progress. Because, obviously, [drug use] 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 (interview, October 5, 2015).

While Eve believed the country had moved forward in defining addiction as a public health problem, she also believed that addiction was beyond the medical approach, because it included other aspects.

Eve. 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...problems that they have. From what I have seen, in the families

we deal with, there are multiple problems, not just one problem. Maybe the parents split up and that wasn't properly managed, and the child has an abandonment issue, and tries to become part of 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 people to notice this situation, that the problem is not just a matter of drug use (interview, October 5, 2015).

The social worker's approach is to look 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? In many cases, Eve says, she needs to educate the patient about the process of admission, but also about the sharing of responsibility. The process, as described, can't be reduced to a psychological/educational session (or two), because each case is unique, and family support can also generate a failure in the responsibility process. Social workers have to learn about the individual circumstances surrounding each case and, based on their findings, make 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 were based on who spent the most time in therapeutic activities, or at least, that was my impression. Since social workers 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: "The area which has been called social work, we are last in terms of importance. 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..." At that point, Eve interrupts him: "We are looked upon as the psychologists' assistants!" (interview, October 5, 2015).

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 take their suggestions into account. Eve continued.

Eve. We are not looking for ways to integrate the different areas, and if our perspective is minimized... The psychologists' role, obviously I understand that the strongest work at a therapeutic level is the psychological, but the other areas are supposed to complement that, and our opinions are not being considered (interview, October 5, 2015).

Roberto felt they were treated as if they were someone's personal assistant: "They tell us, 'You need to call to tell someone they have therapy.' And that's how they see us. I mean, a social worker is no one's secretary, I mean, family contact is part of our job, but this is the way they make us feel" (interview, October 5, 2015).

Social workers did have to contact the family, but not to remind them of an appointment. Instead, their job was to find the 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 sensitive about their role mostly because one case triggered conflict within the team. The problem had to do with the definition of addiction, even though that didn't come out clearly.

Eve. I had already said in the meeting, I believe our opinion is not being considered, because we provide information from home visits. The problem was that a woman wanted her son to be here, admitted 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 a health center, 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, the other patients had to look after him, and the nurses' aid team also ended up in charge of him, and this generated conflict (interview, October 5, 2015).

The case in question involved a young woman who had lost custody of her son to his grandparents on his father's side. What the psychologists were suggesting is that the infant come to the addiction treatment hospital, because the woman said that if they didn't let her be with her son, she would start using again, as Eve recalled.

Eve. Patients, are very manipulative, and they demand things from the psychologist and the psychologist just says ok, and so we had to explain this to the psychologist, and to her, to Lorena. There was a confrontation with her because we disagreed with the child being brought back here, because it has already happened with the same patient, that she brought the child but she didn't look after him, it was the other participants, her fellow patients, and the staff who did (interview, October 5, 2015).

For the social workers, while addiction is a complex problem which involves not only a mental disorder but also the environments in which people live, addicts were manipulative and the staff had to be cautious of how they responded to their demands, especially when they were used 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 their children. Women wanted to be in constant contact with them, but admission was bound to a set of rules and regulations. She believed this was the reason why treatment for women never really worked.

One thing that was clear from the social workers' perspective, and which was echoed in 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.

Eve. The substance will still be there when they come out, and they will have the same problems, maybe even worse. What we do is prepare the person for a new form of life, we aid in the acquisition of new habits, new aptitudes, new behaviors, and this implies that they distance themselves from the factors which increased the risk of a relapse (interview, October 5, 2015).

Sexual Control

The first public addiction treatment center was developed as a therapeutic community for adult males. Treatment was intended for males willing to stop substance use. However, soon after it became 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 treatment in the public sector. The women's wing opened in the area furthest from the men's, with a barred door 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 women in treatment will also reveal power relations in Ecuadorian society.

In public addiction treatment, abstinence is a day-to-day phenomenon related not only to drug use but to many other areas of the patient's life. While the public center has been an experiment, the first of its kind, a trial-and-error arena, it was designed as a treatment clinic for males. However, the demand for therapeutic spaces for women 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 with women: the creation of a specialized space which takes gender into account. In the meantime, the door with the metal bars is now open, and what was once a meeting room is now a classroom. The bedrooms are empty, and the hospital beds are stacked and mattresses are stored in one of them. The silence and the stack of equipment look like more debris in the abandoned, still to be renovated, rooms throughout the clinic.

Male patients explained during a conversation on July 21, 2015, that any form of relationship between males and females was forbidden, including looks, smiles, or any other type of flirting. There were certain exceptions, as Paul and his girlfriend were both patients at the public clinic and they hugged, kissed, and interacted every chance they got with no consequences; after all, Paul agreed to be admitted as long as Allie was as well. But for the rest, interaction was not allowed. "Since it's forbidden, it's tastier".

The male patients were discussing a conflict which arose. It was common practice for males and females to exchange love letters, something the staff failed to prevent from occurring. While there were intermediaries who cooperated (girls that men run into by chance or even staff members), contact with patients of the other sex could have consequences, such as having to wake up earlier for a week, washing dishes for a week, that sort of thing. Patients who were caught repeatedly

risked expulsion from the program. On one occasion, a man received a letter from a female patient, but one of his peers noticed and reported it to a psychologist. The psychologist confronted the offender: “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 reveal who the girl was. His buddies added: “We don’t know what consequence the girl had, but David was forgiven.” Confession was added to abstinence: the men were expected to express no sexual or romantic interest in the girls, but they did; confessing and identifying their forbidden interest could lead to a pardon. Private clinics had their own version of this kind of disclosure, usually involving an obligatory, abject confession of the gruesome details of the individual’s drug use. Here, the value of honesty overcame the value of solidarity. David ratted his girl out.

Confession was linked with addiction treatment as a way to show interest in the therapeutic approach: testing for drug use was another way. If someone relapsed, they had a better chance of staying in the program if they confessed, as opposed to being discovered through testing. Suspicion, on the other hand, characterized the gaze of the staff. After all, addicts manipulate, commit crimes, steal, lie... Confession was one way the center differed from private clinics: it didn’t involve 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 leave 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 at the center. Confession was an option extended 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 suffer the 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 shop at the clinic where it was sold to patients.

Also, there were love stories all over the place. Some patients 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 that remained secret. At least until the girl came back pregnant and using again, and then everyone found out. Sexual control by locking down the women had at least two effects. First, they were made responsible for whatever happened between them and the males. Regardless of how conscious this was, when David disclosed his girlfriend's name, she was punished. Second, this reinforced the view of women as the difficult party. Why were they locked up for their protection? Treatment for women was much less successful than it was for men. And the staff constantly referred to women as problematic: always fighting, complaining about everything, used to selling their own bodies for drugs. Protecting women also revealed complex views of the feminine.

Juan explained that at the beginning female patients were an exception, but that it eventually became necessary to open a wing. The regulation was clear: No mixed clinics for men and women and no mixing adults with adolescents. The public clinic broke the rules.

Juan. There is a need, and you have to decide between leaving them in the street or admitting them. So, we are opening a wing for adolescents. I am asking for a meeting [with the Mental Health Department], because treatment is different: first of all, they don't come as a result of spontaneous demand, most of them come with a court order; when they are admitted they often break the rules, and while they can leave, 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 (interview, November 10, 2014).

Juan was aware of the failures the program was experiencing, especially with adolescents. He wanted to consult experts, including the police or professionals who worked with minors, in order to create a new therapeutic program or adapt the existing programs. He was also seeking expert advice for the women's program.

Juan. 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 has to be thought through. But there is a program for women. Because many have been pressured by their partners [to use drugs], it hasn't been a free choice, like when they do sex work to get pills. It is very complicated, and so women's empowerment and gender violence need to be addressed (interview, November 10, 2014).

The treatment of women seemed paternalistic. This was evident in the discourse, which came from other women as well as from men, and in the management of space, issues like the bars on the door, the control, and the fact that confession didn't do them as much good as it did the men. And patronizing women was not a male thing. Everyone patronized the female patients. Female psychologists complained of their attitudes, social workers discussed their wickedness at staff meetings, nurses' aides informed of rules broken in the women's wing. And as they were criticized and patronized, the possibility of taking responsibility for their life choices diminished. What therapeutic effect could control have, along with subtle degradation by simple comparison with the better-behaved males? With the men, treatment was something that could be handled. They cooperated, they adapted, they identified, regardless of the results (after all, the cure is a result). But the women were women.

Iván. I read once that among a lady's needs, the main one is to be admired, and this is something we need to be aware of in the process. 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 feminine issues, a different way of thinking, they even fight over hair bands, and the way they resolve conflict is different. It's a gender issue (interview, December 1, 2014).

For Iván, 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 in the female condition which needed to

be addressed differently in therapy. And even though for Lorena the unconscious doesn't have a gender, the female patients, or the patients identified as female, 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 addiction.

Lorena. 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, that's something that doesn't come out, ever, 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 (interview, December 1, 2015).

Sexual issues came to bear when the user in question was a female. Women are considered fragile, victimized, and mistreated; they had entered 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 easily influenced, which meant they were somehow released from the need to take control over their lives. How can someone take control when the door is locked?

The definition of addiction is evolving. The constant changes respond to different factors. One of those factors is the discipline within which the definition is built. But even though each professional brings their own mode of understanding drug abuse and dependence, everyone operates within the war on drugs, which hasn't ended. The patients represent the roles implicitly assigned to them, and reinforce the beliefs surrounding their behavior.

The practitioners of each of the disciplines within the therapeutic community contribute to the complexity of defining addiction. While the contribution of each is based on some form of scientific knowledge, all manifest a hidden set of representations which end up maintaining,

and sometimes even reinforcing, the practices which the public clinic was created to counter.

At the same time, the therapeutic process unfolds amidst a set of preconceptions, perhaps unconscious, which are visible in the contrasts that the old space selected presents with the new project it hosts. There are many cases which require hospitalization, or at least, which benefit from it. But, in practice, substance use 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 creation of a female wing demonstrates the way in which society sees women and how this affects the therapeutic approach. Representations are the strongest when it comes to women, which leads to treatment becoming the most difficult, or the least effective. There is a social debt in terms of recognizing the views that limit the assistance which can be given to addiction patients from a gender perspective. Mostly, there seems to be confusion regarding the definition of gender issues which also influences the way treatment is handled.

Throughout the time spent at the public clinic, I kept feeling I wasn't paying enough attention to the women and their situation, either as addicts or as patients. I kept asking staff members about the women, and I always felt that the answers were evasive: their treatment wasn't a part of the plan; the current situation 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; women 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, 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 press for more clarity.

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 was reluctant to fall into simplifying ideological categories, but I now believe I ended up deciding that the women's situation could not really make a full chapter. I now wonder if I gave in to subtle pressures – everyone avoided in-depth discussion of the women and their treatment.

Chapter 4

Addiction Treatment and Bureaucracy

So, if someone comes wanting to see a psychiatrist, are you going to see them? [If so,] leave, please give me your resignations, go home, because, you have not understood anything. I'm sorry, but I can't accept this. We have this huge need in the country, but not here, no; in here, yes, this is the only hospital where people's rights are respected, because anyone who comes and asks for anything, they get it. Forgive me for getting angry. I wish I didn't have to get angry here. But I see a total lack of respect for the fact that we have policies. They are not being followed. I can't accept that, I cannot accept that, there is a directive from the President of the Republic which is not being followed here. It's great that you are humane, let anyone come for treatment, but this is not the treatment model in our country. It's not like that. There are clear directives, ministerial agreements with which we must comply. I would like to have what you are doing here audited, because you are wasting the Ecuadorean state's resources, you are misusing them, that is what you are doing, and I can't accept that.

—Carina Vance

Minister of Health, during her visit to the public clinic

Addiction treatment in the public sector involved more than the public clinic. It was developed within the context of the political change in which it was created: that of the Citizens' Revolution, led by a left-wing

government, which proposed the return of the state and an end to privatization. In the minister's visit to the center, we can see the way the state relates to that entity and those who work there.

A visit by an authority such as the minister, a direct representative of the executive branch, is not a spontaneous event; it takes weeks of preparation on several fronts: while patients help clean up the physical space, the psychologists work on treatment protocols, and the coordinator fulfills requirements specified by the minister's advisors.

This chapter begins with the visit followed by an analysis of the public addiction treatment center's relationship with the state. The space in which the clinic operates, the old leper asylum with its architectural design and location, is relevant, as it is a traditional site of exclusion. At the same time, it operates within a legal and administrative limbo, as it is a project,¹ a fact that affects the lives of employees who lack long-term job stability.

The physical space, a complex of old buildings later deemed structurally unsound, mirrors the instability of the staff and the clinic's lack of legal status. All of these aspects emphasize that addiction remains a matter of exclusion.

The clinic shared space with the Dermatology Hospital, which was later closed, and this led to power struggles, which also tell a story about addiction and its place in society. At the same time, those seeking attention at the public clinic were trapped in the red tape and disciplinary practices that characterize the public health system.

Finally, the chapter looks at the power struggles within the multi-disciplinary team, and the way the notion of "team" dissolves in disagreements over the handling of cases.

The Visit

Although everyone seemed excited, the tensions surrounding the minister of health's visit had also left them exhausted. Ministry officials had announced her visit on at least three previous occasions,

¹ The public addiction treatment center began as a pilot project rather than a permanent program with a permanent budget.

but each time the event was postponed. During that entire month of cancellations, Minister Vance's assistants requested reports, statistics, descriptions, and other documents in order to brief her on the first public addiction center. And it wasn't just the information that had to be gathered; the minister's presence on the premises required adjustments in different areas, ordered by her staff at the Department of Mental Health, her personal assistants, and the director of the Dermatology Hospital.

A few weeks prior to her arrival, news about the minister's visit had everyone busy with tasks in addition to their regular chores. The men undergoing inpatient treatment were cleaning and organizing the first floors of two buildings that used to be part of the leprosarium and which had not been used for years. These structures were scheduled for renovation and use by the public center in order to increase the rehabilitation clinic's capacity. At the same time, the staff had organized itself into groups to coordinate and implement the demands the official visit generated. Some of the psychologists were preparing the reports and treatment protocols requested, while the occupational therapist was making sure all requests from the Dermatology Hospital were fulfilled. 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 others involved in the event.

Not that any other day went smoothly. But the visit had everyone working, filing paperwork, cleaning unused buildings, organizing things. It was an unusual day, they had to satisfy the demands of the ministry, to produce the information that the minister would need, to make the place look nice. Cheliotis (2014) proposed the use of art to hide suffering within prisons. But the clean-up at the public addiction treatment center seemed more like an effort to attenuate the contrast in forms of exclusion through confinement, between those applied to Hansen patients compared to those applied to people locked in private recovery clinics and the modern therapeutic approaches to addiction proposed by the state. It wasn't just the arts and crafts produced during occupational therapy; for this visit, everything had to look nice: *que se vea bonito*.

Minister Vance had pushed for regulation of private clinics. Abuses had gone as far as offering behavioral modification and dehomosexualization: a fantasy that seemed to have been inspired by *A Clockwork Orange*, an Anthony Burgess novel, cheating ignorant, desperate families confused not only by the prejudice against addiction but also against homosexuality. In reality, there were no changes; many private clinics offered only torture, starvation, rape, and, in some cases, death. The public clinic was an alternative to the neoliberal abuse that the addiction market had produced, and the team was making an effort, with pressure from ministry employees, to make it look nice: the processes, the paperwork, the premises.

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 patients confined in private clinics that had been closed. 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 to what were 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, is not a crime in Ecuador. But private addiction treatment clinics were mixing drug users, homosexuals, and people with impulse-control disorders together. This wasn't limited to private clinics. On the contrary, even the Citizens' Revolution's first set of regulations for private addiction treatment centers did it: article 9, which prohibits centers for men and women, also stated that different groups – teenagers, males, females, adults, elderly persons – have to be treated separately. At the same time, it reads:

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 identity or primary sexual orientation disorders, along with impulse control disorders, such as pathological gambling (F63.0 DSMIV-TR) and other addictions and non-pharmacological dependencies (Ministerio de Salud Pública del Ecuador 2012b, 4).

The same document also states, in article 25, that, in recovery centers, people coming for reasons other than those defined in the regulation cannot be admitted, and that “practices known as ‘dehomosexualization interventions,’ behavior modification, among others, which infringe upon their dignity, sexual identity, gender expression, and physical, psychological, sexual, and spiritual integrity, are prohibited, including for patients with HIV” (Ministerio de Salud 2012b, 10).

In the years following the inclusion in the Constitution of addiction as a health problem, the Ministry of Health began a slow process of identification, regulation, inspection, and control of private addiction treatment centers, especially after Minister Vance took over (Ministerio de Salud 2013). As I learned from interviewing the technical coordinator and the psychologists who had worked at the public clinic from the time it opened as a contingency center, the ministry identified clinics that had to be closed for malpractice, lack of regulation, and even human rights violations. The legitimacy crisis regarding drug policy was an emergency that, when addressed, produced other crises that needed to be dealt with. Many people in these clinics had substance abuse problems that they could not manage on their own, thus requiring some form of addiction treatment. At the same time, many parents and spouses didn’t feel confident enough to take a family member home. 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 assigned the status of therapeutic community. This was an opportunity not only to experiment with a form of treatment that addressed the disorder, but also to demonstrate the superiority of the new socialist state-run clinic over previously dominant neoliberal clinics. At the same time, the public clinic responded to an increasing demand for decriminalization and provided a place that 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 2014: Juan, informally known as the director, was a psychology professor with years of experience in therapeutic communities.

Juan's first task was to hire 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 center's psychologists, the process of building-reconstructing the center began. Protocols and theoretical perspectives, previously outlined, were reviewed and enriched with medical, psychiatric, and other contents. In practical terms, the center opened a female ward due to increasing demand, extended services to underage patients, and outlined a three-month inpatient treatment option. In the architectural domain, previously abandoned spaces and those being used by Hansen patients were reorganized: what was once the dining room for the former asylum became the occupational therapy room; an area that had been used by men was converted into a separate area for women, with a barred door added, while the men were assigned to the building that housed the offices. The new treatment protocols were implemented as a reactive strategy, a way of dealing with concerns generated by scandalous reports from private clinics, which had become public.

The minister's visit, then, was not only an honor, as she was a member of the president's cabinet, but also represented the power of the state supervising the application of new practices resulting from the definition of drug abuse and dependence as a medical problem rather than a crime. On that day, instead of exchanging the usual greetings, people commented about the visit, the stress it had caused, the long wait that family members who had been invited were forced to endure, and so on. Everyone seemed busy, concerned, or annoyed. Except for Albert, one of the clinic's long-term patients. He approached me as I waited for the event to begin. 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 people around him were excited or nervous or both, he was indifferent. He was just having his usual day, heading to the occupational therapy room to play the guitar, almost as if he were enjoying being so calm about what had everyone else stressed. The chaos gave him more time to hang out.

Like many patients who lived at the public center, Albert was just happy to talk, even if it was about his addiction and his therapeutic

process. Had he not been in the clinic, he would have been homeless, 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 a change, something that hadn't happened to him in other clinics where he had spent time. We chatted for a few minutes until the minister arrived and the tour began.

It reminded me of a *procesión*, a Catholic procession with the figure of a saint carried around town while everyone prays and sings. Just like a religious gathering, the highest authority arrived, accompanied by her close advisors and collaborators, and was greeted by people from the Mental Health Department, a branch of her ministry. The Dermatology Hospital's director, Dr. Ochoa, and his own crew were also ready for the tour, as were Juan, the addiction clinic's director, and some of the staff. There were also some extras, people who just happened to be there, like me. They may have been family members or patients from the Dermatology Hospital. A small crowd formed and the tour began.

Spontaneous Demand and the Reorganization of Health Care

At the gate of the public center, in the security guard station, two flat screen TVs were connected to security cameras. Rather than an ordinary security system with cameras aimed at borders or expensive equipment, here they were aimed at places used by addiction treatment patients. Voluntary admission, praised as one of the clinic's key differences from 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, below the nuns' residence, next to the coffee shop, was the dentist's office, the statistics and administration offices, and the Dermatology Hospital building. This is where the confusion began. While the dentist is a maxilla-facial surgeon, which, according to Juan, makes sense in a Dermatology Hospital, the minister asked why the hospital had a dentist. Dr. Ochoa replied that the dentist worked for the addiction clinic, not the hospital. Juan was shocked: while the dentist checked the recovery unit's patients' teeth, she was on staff at the hospital.

The minister was disturbed with this reasoning, as it seemed a waste of human resources for a center specialized in addiction. But the confusion was only beginning. While using statistics to explain the admission process, a staff member mentioned that admission to the addiction treatment center is the result of *demanda espontánea* (spontaneous demand). The minister found this unacceptable. Had they not read the *Manual de atención integral en salud* (Integral Health Attention Manual, MAIS)?

With the return to democracy in 1978, the Citizens' Revolution argued, the country had adopted a neoliberal logic that resulted in reduced spending on public services, which turned health into a commodity to be acquired through the market, a practice "recommended" by international financing organizations (Naranjo Ferregut et al. 2014). The Citizens' Revolution, which came into power in 2007, was characterized by its strong anti-neoliberal discourse, and after the 2008 Constitution was adopted, it turned to health care reform, aiming to counter the effects of neoliberalism, particularly those related to reduced access to health services for lower income persons (Constitution of Ecuador 2008; Secretaría Nacional de Planificación y Desarrollo 2007; Ministerio de Salud 2012a). This implied a reorganization of health services to change the focus from disease and treatment to a broader perspective, with an emphasis on prevention, and that involved gathering statistical information in order to calculate probabilities and costs.

A key aspect of the new model was the division of medical services into three types. At the first level are public health centers, where most minor illnesses are treated. At the second level are the general hospitals, better equipped for emergencies and more complex medical problems. Finally, the third level is made up of 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, means that clinic workers send newcomers to the neighborhood health center to get the referral. The minister understood, mistakenly, that spontaneous demand meant skipping the referral step. In terms of health care, the sovereign power over life had been organized through laws, norms, and protocols that could not be ignored.

Spontaneous demand meant something entirely different. President Correa utilized the phrase *la larga y triste noche neoliberal* [the long and sad neoliberal night] in reference to neoliberal policies that, he claimed, diminished the role of the state while favoring the private sector. In terms of health, for example, he explained:

What did neoliberal fundamentalism tell us? That we had to have tax neutrality, we all had to pay equal taxes, and the lower the taxes, the better, and that the state had to be reduced through an aggressive privatization plan, among other things. This means that even a human right as fundamental as access to health care had to become simple merchandise provided by the private sector (Correa 2012).

Indeed, addiction treatment at the time was violently imposed by family members and center owners: at the request of and paid for by the family, private clinic personnel hunted down the suspected addict in a process called “rescue” – also known as capture. He or she was then locked up for months, and, in many cases, years. For family members faced with the problems associated with conflictive use, these clinics seemed to offer an option to imprisonment, homelessness, delinquency, or whatever. Paul’s impatient treatments, for example, gave his parents some peace: at least they knew where he was, even if he hated it. On the day of the minister’s visit, they were invited to be part of the welcoming committee.

When 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 confinement in clinics throughout the country. The endless treatments he received as a teenager didn’t seem to cure his addiction but, for his parents, at least confinement kept him safe, or so they believed. The clinics offered salvation from the threat of jail or violent death in the streets. They offered non-consensual confinement combined with torture, violence, surveillance, humiliation, and so on. Families didn’t fully understand or know what happened inside, but were convinced that it couldn’t be worse than being outside on the streets or in jail. Paul’s parents finally gave up on this option when he set a clinic on fire: he had been captured and returned soon after escaping,

and he couldn't take it anymore, so he burned it down. Jorge decided it was enough: Paul had demonstrated that he could be a danger to himself and to others if forced into treatment. Before he came to the public clinic, Paul had been at home after some weeks on the streets. He asked his parents to find him a psychiatric hospital, but was referred to the specialized center, where he chose to stay.

In a context in which private clinics operated through force, with the law encouraging confinement of anyone who used drugs, *demanda espontánea* referred to the individual's interest in treatment for his problematic drug use. However, when demand came from the family rather than the user, intensive outpatient treatment was the option, during which patients "worked on their demand," so that, when admitted, it was because they wanted to be there. For the first time ever, Paul voluntarily admitted himself to the public clinic through the reference and evaluation process, but not before going to the bathroom and smoking his last joint, as well as negotiating his girlfriend's admission. He had to spend at least three months inside, and his therapist, after the technical team's evaluation, would have to recommend his release. He could leave if he chose to, but he risked losing the opportunity for further treatment. If someone decided to leave before the evaluation process, and wished to return, they had to return to outpatient group meetings until demonstrating a genuine interest in readmission, that is, after the outpatient technical team found the patient's request to be genuine.

Avowal, at this point, didn't respond to torture or violence, common in private clinics that followed their own interpretations of Alcoholics Anonymous programs. Nor did it resemble a process of naming the condition for it to disappear: in 1846, French psychiatrist François Leuret published what seemed a revolutionary therapeutic approach to insanity: moral treatment (Brigham 1847). It consisted of a series of practices designed to produce pain or discomfort in order to prevent or cure the condition he wanted to remove from his patients. After asking the patient to describe his delirium, Leuret made him promise not to believe in it anymore, while punishing him with a cold shower. This moral approach is repeated until the patient stops insisting that his delirium is real or that he is being forced to deny that it is real (Foucault 2014). At the public treatment center, denial

of delirium was replaced by demand for treatment, while the cold shower was replaced by expulsion from the recovery program. The moral psychiatrist is now a multidisciplinary team that decides if a person should stay longer, or if she can be readmitted after leaving before finishing treatment.

The confusion about spontaneous demand only deepened as the minister walked through the men's ward and the therapists' offices. She was greeted by the smiling psychiatrist. A foreign specialist, Jane had been hired as part of the technical team, following the ministry's specifications. The minister asked who she was. She explained that she was in charge of psychiatric treatment. At the time there were 40 patients. One psychiatrist for 40 patients, in the minister's mind, was another waste of resources. Jane explained that she saw every person who came to the clinic, not just the 40 inpatients. Rather than clarifying anything, this confirmed the minister's suspicion: "spontaneous demand" meant skipping other steps in the process of accessing public health care. People needed to be referred by public health centers; they needed to follow the manual. Somebody was going to be fired for this, the minister promised, while continuing the tour, on her way to the Hansen patients' area.

The psychiatrist hadn't been able to explain herself clearly because, when the tour began, she was in her office seeing patients and had missed the confusion created in regards to spontaneous demand. In fact, the psychiatrist saw people who were undergoing inpatient treatment, those who were in the intensive outpatient program, newcomers who needed to be evaluated for admission, people who had 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, the ministry assigned her to a level two general hospital. She now had to divide her time between the public addiction recovery center and the new job.

Hansen patients received the minister in their communal room, where they held special events, such as Christmas celebrations or wakes when one of them died. The clinic's team 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. Though she said that she had to leave, people expected to participate. Most patients expressed gratitude for the creation of the public clinic. Many referred to experiences in private treatment centers, where they were mistreated, some even tortured. The stories included hunger, abuse, violence, and fear during forced confinement, which the law permitted. For the first time, some said, they were treated as human beings, and they were thankful for the chance to work 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 had not happened in the private clinics in which her son had spent time. Everyone applauded, identifying with her suffering.

Towards the end, someone made a demand, backed by many of the patients. This is all great, the place, the treatment, it's all perfect. But patients needed jobs. Rehabilitation was made more difficult by stigmatization, and jobs were hard to find for people who had been confined for years and didn't have a stable work history. Also, some of them, like Paul, hadn't 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 reintegration into society. The minister agreed and made some promises before leaving.

Albert didn't speak at the meeting. Nor did Paul or his parents, who were sitting nearby. Albert had told me on several occasions that he didn't feel as if he could 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 kept a low profile during the minister's visit.

After the dialogue, the minister had lunch with the Dermatology Hospital's director, the addiction clinic's technical coordinator, her own crew, and, again, a couple of extras. Juan told me that, during lunch, he had been able to clarify the 'spontaneous demand' confusion. He felt relieved as she showed her approval of the work being done, especially after hearing patients speak of their experiences and their gratitude to the government of the Citizens' Revolution.

Sharing Space

The decision to place the addiction treatment center in what had once been the leper asylum was part of a long-standing, deeply rooted confusion about who or what was in charge of the clinic. While the clinical aspect has individual and group spaces, the administrative aspects function according to a different logic responding more to the demands of the Ministry of Health than to the needs of patients. Juan, the coordinator, explained the current legal situation of the clinic: the minister had stated that private centers which “are doing things right” should be licensed (interview, July, 2, 2015).

The Ministry of Health, rather than the Ministry of the Interior, a security institution, was now in charge of the clinics. When the public clinic opened, it began as an experiment at the Julio Endara Psychiatric Hospital, with pilot project status under the Office of Mental Health. Yet, because it was next door to the Dermatology Hospital, there was confusion as to who was in charge. This confusion was not limited to people working at the addiction center, but the ministry itself did not know where it belonged, 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 clarification 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 to what entity they belonged: *The clinic was in a legal/administrative limbo.*

While it still had project status, the plan was to use all the buildings, fix all the rooms, and add beds for a capacity of 90 patients. CONSEP, which was providing some of the project’s funding, requested a meeting with the coordinator. It was December of 2014, only a few days before Christmas. I attended to the meeting and was surprised to see the director of the Dermatology Hospital there. Not only that: he presented the plans for increasing addiction treatment center capacity. Later I asked Juan why. He laughed. He had found that life was easier if he confronted people less. Juan knew he was the coordinator, the boss of the addiction clinic. But he didn’t feel he had time to deal with the Dermatology Hospital director’s need to control. And, just as he hadn’t argued against

the surveillance system, he also let slide the director's display of power at the meeting. After all, he knew that the hospital was going to close, and that the specialists were going to be moved to a second level entity. Hansen's disease was no longer a threat, and the Dermatology Hospital was an unnecessary expense for the state.

When the clinic opened, the hospital had already been there for decades. It represented a historic change in the treatment of leprosy patients. A period of exclusion was merged with confinement: after Dr. Gonzalo González managed to restore some form of citizenship to Hansen patients, the dynamics changed while the hospital remained. When addiction patients started coming, hospital staff felt they owned the place, and they also 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 said you could use it?" None of the girls looked directly at her. She left, not before making us all feel uncomfortable. Allie 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 scold us about" (interview, December 9, 2014).

I asked May about the issue. The gym was built with money from the addiction clinic's budget, and its purpose was to aid in the rehabilitation of problematic drug use through exercise, more of a pastime for patients, nothing obligatory. Yet, hospital staff assumed the gym was theirs, and there had been other incidents. Juan had to speak to the Dermatology Hospital's director, budget from the addiction project in hand, to clarify things and politely request that people stop harassing patients when they just wanted to work out. Apart from this particular issue, the problem wasn't limited to a circumstance or a misunderstanding.

On the day of the outing to El Tingo pools, I was chatting with the clinic's driver. He had been working at the Dermatology Hospital for some time and, since the Psychiatric Hospital had donated a bus to the

addiction clinic, his duties included driving it whenever necessary. Since he worked for both entities, I asked him how he perceived the relationship between the hospital's staff and the clinic.

Clinic's driver. Oh, they're scared of them. I'm not, 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're afraid of them. You can tell (interview, July 21, 2015).

He was right. The valley had hosted many clinics, including clandestine ones. One of my closest friend's youngest brother, 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 admitted by force into many clinics. He was 27 when we spoke about it. He was working, had married, and the couple was expecting a baby.

JP. In all the centers in the valley they get tortured, this is where most clinics are located. And I tell you this as an addict, the addict does not recover, unfortunately, it's an incurable disease. I asked if 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 asks 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 shaken many things off but this anguish, I just can't. Even though I'm older, 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 patients (interview, July 21, 2015).

When JP's mother decided to lock her son up in a clinic, she was acting on a belief about addiction shared by employees at the hospital and even some at 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 way addicts were treated, that they didn't deserve it. Juan believed that social workers needed to be empathetic in order to be

able to perform well within a therapeutic community. However, the belief that addiction is a moral rather than a health problem was still widespread, as indicated by the doctor who reprimanded the girls.

Administratively speaking, the relationship with the hospital was not bad, from the perspective of the occupational therapist: 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: men in treatment lived on the premises, and they moved from one activity to the next, joking and speaking loudly. May described the discomfort this produced for the hospital's staff.

May. They are here, confined, so, when they go out, they joke around, just like any group of boys, because most of them are young. That bothers the hospital staff, they are always criticizing the way they walk, the way they yell, what they look like, I mean, they have this idea of a hospital, a hospital is silent, quiet. 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 unfamiliar, perhaps, for a hospital to also have a community. It doesn't add up for them, it clashes a lot, and that's the problem we have, we try to stay in our own spaces, because shared space produces conflict (interview, July 21, 2015).

While for May the conflict was due to shared spaces, the fact that the clinic could not function on its own because of a lack of legal status made it subordinate to the hospital from the beginning. The Psychiatric Hospital, with which the therapeutic community was associated in administrative terms, was not close by, so that arrangement never worked well. Distance made it easy for the hospital to forget about the clinic. However, patients needed medication, supplies, food, and accounting support to manage the budget. Thus, to "make things easier," the Dermatology Hospital ended up "helping" the clinic. In practice, this meant that the hospital director had too much power over a project that wasn't his, that wasn't even

under the auspices of the same division of the Ministry of Health. Mental health was a whole different field, but the director assumed that 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 Mental Health director to step in and set some boundaries, draw some lines. The hospital was eventually going to close, and it made no sense to fight with people who were going to leave soon anyway.

According to Juan, the main problem 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 specific institution, and they are still debating about that. We are no longer linked to the Dermatology Hospital, because it is in the process of closing, it has, in effect, already shut down."

Juan summarized the center's trajectory through its status within the public health system. The addiction clinic began as a project with resources, which included a budget and a spending schedule. But after the project had been consolidated, it required a change of status in order to guarantee its sustainability, from pilot project to government program for which the state had to provide regular funding. Until mid-2016, the therapeutic community still had project status, which meant it could be cancelled at any time. In May 2016, the staff was beginning to worry about their job situation, because there were no signs that the clinic would be included in the national budget and contracts were due to expire the following month. A major earthquake had hit the coast, and resources were being channeled through emergency decrees to the affected areas. Juan explained: "Since nature didn't help us, with the destruction of the coast and all, things got complicated. You need to know that resources have been assigned on a permanent basis. So, the money is not there, we are three months in arrears" (interview, May 7, 2016).

Juan had been doing follow-up with the Mental Health Department and they kept telling him not to worry: "They say they are doing the paper work at the Ministry of Finance to change the status of the clinic, so that it moves to current expenditures, and the second legal step this would generate is that job positions would be filled on the basis of applicants' qualifications." Regulation, needed to ensure job stability, also meant that people might lose their jobs. Everyone was worried. The

clinic was scheduled to be placed in the current expenditure category on June 30. Juan had already been through this the previous year:

Juan. I imagine what's going to happen is what always happens, I guess we will get a three-month extension while this is being settled, because the money is there in the Department of Mental Health, but 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. Don't get stressed. Why is everyone getting stressed?' That's what happened before, that is, the payments come late, they're at the Ministry of Finance, they're there, but they are missing the 254th signature, but they're there, don't worry (interview, May 7, 2016).

Bureaucratic control was exercised primarily through the uncertainty that people had to deal with in terms of their jobs and in terms of the very existence of the clinic. Six months earlier, before the extension as project was granted, the coordinator was trying to solve this matter. Similar projects in health had already shifted to the programs category, with a regular budget. But bureaucrats were taking their time with the addiction treatment center. There had been changes in the Department of Mental Health; the director I had met when I began was long gone. I never met his replacement. And by 2017, there was yet another director. The process seemed to depend on someone doing the paperwork, correcting mistakes, filing paperwork again, calling, asking... follow-up took so long that persons in key positions kept changing with no resolution in sight.

After a while, the district took over administrative responsibility for the clinic. But budgetary administration remained a problem that worsened with time, as May explained: "There is no disinfectant, no toilet paper, and no napkins, there is nothing, and the district has returned [unspent] 25,000 dollars." Juan, the coordinator, corrected her: "It's 250,000 dollars." In the Ecuadorean system, if an institution does not spend its entire annual budget, unspent money is returned to the Ministry of Finances, and the following year's budget is based on the amount that was spent. The limbo in which the addiction clinic was

stuck threatened its very survival. People began complaining, because juice was being prepared without sugar, May explained.

May. If it was orange juice, you drink it, right? But if it's guava juice, it's terrible. So, 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 could not just bring sugar for him, and she decided to bring a quintal of sugar (interview, May 7, 2016).

Besides cleaning supplies and other basic items, the problem with being linked to the district was that, since the clinic was not a health center but an administrative institution, according to the law, it could not get a permit to purchase medication. For an addiction clinic, this was problematic.

Juan. We have fixed this temporarily. The medication is ensured through zonal administration, but just so you see what kinds of problems we have. On the other hand, since we are a third level center, we should be linked to the zone, but that means we must hire 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 (interview, May 7, 2016).

Juan is a problem solver. He is constantly thinking of the program's components, the woman who comes to teach yoga, the relaxation periods. He created the intensive outpatient program, and he managed it for a while, until it became an element of addiction treatment. He maintained a political relationship with the hospital's director, even after the director had the surveillance equipment connected to his cell phone in order to watch what they were doing from the comfort of his own home. Juan now had to deal with budget cuts. Disinfectant was something they couldn't do without. He was thinking about asking the patients if someone could bring some from home. "Even if it's only a little bit, we need to figure this out." While the coordinator was trying to figure out how to solve issues resulting from the lack of a budget, he was constantly pressuring Mental Health (interview, May 7, 2016).

Juan. Sometimes, they just do not answer phones or emails. During day-to-day activities we find out that we are out of something, or that we have it but they aren't giving us permission to use it. So, I have to ask the person in charge of supplies, 'Hey, man, how are we doing?' And then you find out, aha, this is the problem: we are out of something because they didn't buy it. And the thing is that the state is not buying for the clinic, it's buying supplies for the district, and they have certain protocols. But I just can't wait for the process to work itself out. Toilet paper, those things, you need them now. So, on family visits we ask them to please bring a roll of toilet paper. Now each patient has their own toilet paper, their own towel, and other things the state is no longer providing. And Sandy, the secretary, on her own initiative, brought some trash bags for the patients because we are also out of those (interview, May 7, 2016).

When the Dermatology Hospital closed, and its professional staff relocated to second level hospitals, the district office ended up overseeing the clinic. In 2013, the Ministry of Health reorganized health services management by dividing the country into zones and districts, according to the Citizens' Revolution's national development plan, for institutions under the executive branch (Ministerio de Salud 2013). The division aimed to decentralize resources and distribute them equitably throughout the country, a process begun with the signing of 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 clinic's administrative issues without a training process. The first few months were chaotic. Eventually things began to get organized. Still, something else needed to happen so that the center could administer itself. Regardless of minor setbacks – the lack of toilet paper and cleaning supplies –, Juan felt that things were improving.

Juan. We have made progress in terms of what level we are at, whether it is first level, second level of attention, that has been settled. According to a resolution, we are a third level, specialized center, 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 gaps (interview, May 7, 2016).

Staff contracts had been moved to the district. People were on the district's pay roll, but their salaries still came from Mental Health's project funding. Everyone was still under a project contract, creating job insecurity. Too much time had passed, the coordinator explained, and the issue remained unresolved. On top of that, the question of who should be admitted to the clinic had not yet been answered. "Someone from the Psychiatric Hospital comes here and says that they decided at a meeting that patients who are unfit to enter a plea or cannot be charged [because they have been found to be not guilty by reason of insanity] should come here, that debate continues, those matters are still being resolved." Bureaucrats kept trying to take the public addiction treatment center, a therapeutic community, into the repression realm. The lack of clear definitions regarding its legal status worked against the center as a project for addiction treatment, an alternative to repressive policies. There were bureaucrats who wanted to send persons declared unfit to stand trial by reason of insanity to the addiction clinic.

Juan. Not here, come on, because those people are deprived of their freedom [the euphemism for referring to prisoners was *personas privadas de libertad*, as decreed by the Citizens' Revolution], they need follow-up and, theoretically, the main aspect for them would be the reason why they were declared unpunishable [not guilty by reason of insanity]. But it seems they are eager to optimize resources. There are psychiatrists here, psychologists, physical space, that's not the issue, so, this judicial limbo has these things, someone from the Technical Secretariat [the institution which replaced CONSEP] comes and tells me they are looking for another place to move us to, but then people from the Department of Mental Health come and say that they [the Secretariat] have no place for us, 'We have decided you are staying here.' I don't really know what to make of all this (interview, May 7, 2016).

Those against the privatization of health services, with the rhetoric of emancipation through the creation of an omnipotent, omnipresent state, came up against difficulties in defining who was in charge and what their duties were. Aside from creating a place where addiction

wasn't treated as a crime, with spaces for individual and group therapy, the main treatment component, and based on the patient's desire for treatment, public clinic staff had to deal with the lack of toilet paper, sugar, and basic cleaning supplies. Beyond these issues, which, because this was a bureaucracy, seemed to be nobody's fault, the concerns of employees experiencing job instability came together with those of patients and their need to understand their symptoms and behaviors, as well as this therapeutic opportunity. And in addition to all of these matters, there were those who wanted to turn the clinic into a center for the criminally insane. Juan and the staff resisted these outside pressures.

Procedural Therapeutics

In addition to the bureaucratic issues produced by the absence of clear definitions, clinic staff had to deal with the fact that everyone – neighborhood residents, the Dermatology Hospital staff – was annoyed by the clinic and its patients. Fear motivated most of the annoyance and justified disciplinary practices: reprimands, memos to the ministry, and complaints were day-to-day occurrences. May's perceptions were reinforced.

May. They [hospital staff] are resisting, they think that [the patients] are going to steal from them. For example, sometimes the kids help me take things from the storage room [at the Dermatology Hospital]. We go there, and since they are strong and all, I take them to help me, but the guy in charge of the storage room goes: 'Stop there! Have them stay right there! Don't come any closer!' Those things are annoying, and I try to keep calm and all. I get along with them all right, except with the doctor [who yelled at the girls]. I can't talk to her because she gets too upset (interview, November 20, 2014).

Part of the occupational therapist's job was to educate the staff of both the Dermatology Hospital and the clinic, reassuring them that the patients were not prisoners, nor criminals, and that they were safe sharing space with the rehabilitation clinic. Perceptions of most people

at the hospital, she believed, had slowly changed and they were more relaxed about the population living next door. At the same time, the therapeutic community staff had learned to control the space better. During the first days of functioning as a therapeutic community, someone stole the toilet tank lids, heavy ceramic pieces. Everyone was surprised, and it led to certain changes. When I went to the bathroom, I had to ask one of the therapists for their keys. Open spaces were slowly and subtly closing. Moving outpatient treatment to another location also helped with the security feel around the clinic.

Juan believed that, even though certain things still needed work, the system was slowly moving away from the dominant prohibitionist path. For one thing, there was an addiction treatment clinic within the National Health System, transforming treatment from the commodity that it was within the private clinic world to a right. Private clinics existed because of policy, he argued: “I’m not saying all have been bad, but there have been excesses” (interview, May 7, 2016). Yet the shift from a security to a health perspective was complicated by inertia resulting from decades of the war on drugs.

Referral procedures, apart from establishing new mechanisms, were marked by beliefs surrounding addiction. On a few occasions, this resulted in the arrival of patients who needed an emergency room rather than a therapeutic center. The police once brought a man who was drunk on alcohol.

Juan. 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 least. Plus, there are other patients there, my guess is that 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 (interview, May 7, 2016).

Indeed, the addiction center was not prepared to take care of these kinds of emergencies. Nor was that its purpose. The medication, the equipment required to make sure that patients are taken care of during that crisis, the clinic had none of that. There were some reagents to test for drugs in the patients’ system, but for disciplinary reasons, and there

was some psychiatric medication. But this was not an emergency hospital. Yet, members of the police, staff at the first level health centers, judges, sometimes politicians, kept sending random people who needed to be treated elsewhere. The National Health System had a protocol, as the minister highlighted during her visit. But people throughout the entire system failed to understand and apply it.

When the clinic first changed from a contingency area to a therapeutic community, the referral protocols were confusing and ambiguous, not only for 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 bureaucratic referral procedures, especially after the state opened new outpatient treatment centers and centers for females and adolescents. But this was also a process which involved individual choices; each staff member was solving the issue from their own perspective. Everyone agreed that the referral process was not yet working right. Should they evaluate prospective patients at the clinic? Should they send people elsewhere for evaluation? What if the person needed to be admitted but other centers missed that? Participants at a team meeting addressed the matter.

Occupational Therapist. We can keep on evaluating patients, and sending them directly to the health center, and they send them back to us. We should send them already evaluated, so that when they get to a health center, staff should understand if the patient needs to be admitted and so sends them here, but they are doing it backwards.

Social Worker 1. Since this center was created first, before the outpatient centers, we are doing it backwards.

Social Worker 2. What I am doing now is asking people who come requesting information where they live and then I send them either to the Guamaní outpatient center or the Calderón center, or to Chimbacalle. And if they decide the patient needs 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 red tape, because this becomes very bureaucratic.

Psychologist. The person should first be referred to a place where they will be evaluated and then sent here. Instead, we evaluate and send them back there (team meeting, September 14, 2015).

After the state opened addiction treatment centers in other provinces, demand dropped in Quito: there were centers in Guayaquil for people from coastal provinces and there was a center in the eastern Amazon region. Before the new centers were opened, the public clinic in the capital had 70 people on the waiting list for inpatient treatment and they had to wait for up to three months. Teen centers were also opened in Quito and Guayaquil, which allowed the clinic to focus on its main, original purpose: treatment for adult males.

Male adolescents who had been admitted due to the lack of a specialized center for underage patients would now go to the new adolescent center in Guayaquil. The center for teenagers in the coastal city was in response to a growing concern over heroin use there among high school students. And while the female ward opened in response to increasing demand for addiction treatment for women, once the excitement over the new public center died down, demand for treatment for females diminished and the ward was closed. Juan believed that this was problematic because adult women with drug abuse issues had no place to go.

In general, the practice of medicine is ambiguous. While there are statistical manuals for diagnosing diseases and disorders, people prefer a second opinion; there is always space for mistakes. Problematic drug use is no different, and it seemed that the staff at the public clinic feared that other health workers lacked the knowledge to differentiate among symptoms and thus, to prescribe the type of treatment required. Their concerns were based on the types of cases they received through referral. The conversation during the meeting continued:

Occupational Therapist. There is an information problem with other institutions. They don't know that outpatient centers exist, so they send everyone here.

Social Worker 1. Right, because the only outpatient centers are those in Calderón and Guamaní (team meeting, September 14, 2015).

The introduction of new centers offering outpatient treatment alleviated the flow of patients coming to the public addiction treatment clinic, but referral was still problematic, and 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 drugs. Could someone please help them? The established procedures didn't always serve the people seeking help. Instead, they generated confusion and delay in treating disorders.

The confusion extended to within the clinic. While the entire system rearranged referral and treatment procedures, clinic staff worked to improve efficiency and efficacy. After all, their numbers were being checked by the ministry. The following year, 2016, the process was divided into phases and the definition of each took some time. The main focus for the first phase, then, was compliance with the program; during the second phase, patients focused on skills; in the third phase, they could start going out into the real world looking for work and becoming independent. The occupational therapist worked on a schedule for each patient. Each phase required a physical space, and by this time, the clinic had already extended to the renovated buildings.

Over time, the use of spaces had been reorganized: the hacienda-like building where the male wing had been located became the third phase area. Those who were closer to finishing treatment were moved there, because, according to Juan, they required less supervision. The offices were moved to the back buildings, and the rooms for the first and second phases were located near the office area. The old male wing was closer to the main entrance, and there were no offices in that area. The location of treatment phases was based on experience: "People are going to drop out during the first two weeks, so we concentrate the majority of the staff there," that is, near the new patients so that they could be monitored more closely (interview, May 6, 2016).

While at the beginning everyone did all activities together, the division in phases separated newcomers from longer-term patients. This allowed for differentiated focus on each person's progress, rather than everyone having to go back to the beginning every time a new patient arrived.

Juan. Before, patients were confused, they were all undergoing the same therapy, and they said, many times, that they were bored. Even in occupational therapy they were doing the same activities and they kept saying they were tired of it. Now they work on different topics and this helps them see the light at the end of the tunnel. The activities both motivate and prepare them (interview, May 7, 2016).

I wondered how effective this was. Studies have found that those in addiction treatment have the same recovery results as those who don't undergo any therapy whatsoever (Vaillant 2005). In fact, brain studies suggest that psychological approaches are not effective because pleasure centers activated by drug use are not located in the cerebral cortex, but in the primitive, reptile part of the brain. Yet, addiction treatment is a cultural phenomenon, something provided by the state or private entities. It is something families need. It may also be a way for patients to relieve the guilt they feel as a result of their actions, their choices. In Alcoholics Anonymous, the belief in a higher power serves the purpose of addressing guilt, an emotion otherwise responsible for relapses: alcohol, aside from being an 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 series of procedures, to advance in phases. Juan explained the mechanism.

Juan. We move someone to the next phase, but we do it based on a mechanism: they present a letter, there is a grade... I mean this person, great if someone tells them: 'You deserve to go to the next phase.' But there are kids who get around the rules. The house says: 'Hey, but you didn't participate in activities, or you're late.' Those people don't give the staff any trouble but they are poorly perceived (interview, May 7, 2016).

As a result of the switch to phases, decisions at the clinic would no longer be made solely by a group of experts. The bureaucratic changes in the therapeutic community were turning patients into members of the decision-making process. Juan continued: "It's just that it's valid, that someone tells them directly, 'No, you can't go to the next phase.' If that is the opinion, then no, that's it. Because you do get the sense that

there are people who the kids [other patients] say shouldn't be here or shouldn't leave yet" (interview, May 7, 2016).

The decision was based on the idea that peers should reinforce behaviors that everyone considered desirable. For Juan, this new mechanism allowed for closer monitoring of each patient's behavior, relieving the staff of some disciplinary responsibility. It now depended on the patients; they shared the weight of decisions with the team. A person who wants to climb the therapeutic ladder has to make that request, and it is reviewed not only by the attending psychologist, but by the multidisciplinary team and, ultimately, by the other patients. If the decision is negative, the patient has to reapply two weeks or a month later. The process felt like a way of placing responsibility for therapeutic failure on the patient, a failure which assumed that addiction treatment was, indeed, a moral issue. Are they making the effort? Are they admitting that they are at fault? Are they cooperating in the psychological education and occupational training process? Are they getting along with their fellow patients? Compliance became an indicator of improvement, even if it wasn't a known predictor of relapse or continued abstinence. The therapeutic process was increasingly disciplinary, regardless of the obvious differences between the public clinic and private, traditional forms of addressing addiction.

Staff changed other things, after some debate. One was the issue of family visits. At first, families could drop by anytime, though weekends were official visiting days. This was something Paul's parents liked, because they could just come over, for example, to bring his soccer shoes for the tournament for hospital and health center teams that the patients had signed up for. When their son had been in private clinics, his parents hadn't been able to see him for months at a time. On Saturday and Sunday, someone from the team was on duty, but there were no therapeutic activities. Staff weekend meetings addressed administrative issues, paperwork, things patients needed the family to bring. The process didn't include the families, though the team felt it should. The clinic switched to a controlled family visit model, scheduling one day a week for family members of each psychologist's patients.

Juan explained the decision: "We realized that what families really need is a space where they are listened to. Families always have had

family therapy; this has been strengthened by giving psychologists more time to focus on family therapy” (interview, May 7, 2016).

The clinic had a 50-patients capacity. The expansion to 90, in the plan presented by the Dermatology Hospital’s director to CONSEP in 2014, never occurred because of budgetary issues. Thus, each of the five psychologists had ten patients and their families, as well as patients in follow-up. Patients had the same psychologist during the three phases. Family visits were now limited to a specific day of the week. Another change was the inclusion of self-help groups: Alcoholics Anonymous (AA) and family members of alcoholics (AL ANON) were now meeting at the clinic. Juan explained this addition.

Juan. Families are required to attend the self-help groups, the ladies [from AA] come. I think one of the most positive aspects of the self-help groups associated with Alcoholics Anonymous is AL ANON, because they work a lot to differentiate 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 that well (interview, May 7, 2016).

People who attend Alcoholics Anonymous events do so voluntarily. The entire process depends on the desire to stop drinking. Narcotics Anonymous has applied the model to other substances. But in private clinics, and now in the public clinic, it is a mandatory aspect of therapy, as if people can be forced to want to participate. Of course, there are differences in the way private clinics applied the 12 steps, compared to the public center. Meetings in the latter didn’t last all day; usually they were scheduled for a few hours once a week and they followed the same format used with groups who were not confined. In the third phase, or after finishing the program, the patient was required to choose a group to join as part of the follow-up process, because their daily activities sometimes conflicted with the clinic’s schedule.

I had attended just one Alcoholics Anonymous meeting, while I was doing my master’s degree in Forensic Psychology in Washington D.C., an assignment for a substance abuse counseling class. It was one of the strangest experiences I’ve ever had. I felt like an intruder. Only now, many years later, I can understand a little better the importance of the

desire to participate. People with alcohol abuse or dependence problems forced to attend these meetings probably feel as awkward as I did. Back then, I was working as a bartender in order to pay tuition, which now seems kind of funny.

Even though many years have gone by, I remember the meeting, the feeling. I had trouble concentrating on people's stories. Everyone knew each other, as it was a rather small group, and there were constant subtle suggestions for newcomers to participate, you know, don't be afraid, tell us your story. I couldn't wait for it to be over. For the class, I read the AA 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 stayed sober throughout their involvement in these groups. What I remember most about my understanding of the AA model was the need for voluntary attendance. Going to AA meetings could not be required. Effectiveness depended on the person's own desire to take control. Yet, in Ecuador, use of the model was a pretense; voluntary participation in anything was virtually nonexistent in private clinics. Most patients had been forced into treatment. Most of them could not wait to get out. According to one study, at least 20% of patients escaped from a private clinic at some point (Geoplades 2012).

Team Issues

The creation and improvement of a public addiction treatment center was a complex process that went beyond fulfilling the needs of patients. The clinic had to comply with state requirements, applying the National Health System's manual on patient attention, while trying to deal with the absence of norms. At the same time, it was a therapeutic community offering treatment for drug abuse, and people came expecting results, even if these were minor. Patients and families came from all over the country searching for answers to substance abuse problems.

The clinic had to deal with the Dermatology Hospital, which housed district offices after it closed, and with the community. It had to coexist with the remaining Hansen patients as well. The first public addiction treatment center had to work with a multidisciplinary team, merging

different perspectives into a model with a degree of efficacy while satisfying everyone. This complexity occasionally generated conflicts that the team had to address.

The decision to divide the therapeutic process into phases responded to many of these factors. The main issue was to avoid repeating therapeutic content, and to make the process clearer for newcomers. When the group was being treated as one, newcomers were confused, while those who were already in the process got bored with the repetition of things they felt they already knew. The model provided for the division of patients in phases, but the clinic had to assign different spaces to different groups first. Before the phase model was implemented, it was reviewed and approved by the ministry, where a brochure on the approach was published. As May explained, this caused some hurt feelings: “We made [the brochure], but they [Ministry of Health personnel] put their names on it. On one occasion they asked Mercedes for help... but her name wasn't on it.” May explained that people from the Ministry of Health were taking all the credit for work they didn't do on their own. The staff would work on something, but their names would not be included as authors (interview, May 6, 2016).

Recognition was an issue in dealing with other institutions and sometimes within the team. The staff members were also human. As for the new spaces the state opened for addiction treatment, the staff from the clinic noticed that they were not offering services in an effective manner. This meant that, while according to the norm, patients were to undergo outpatient treatment first, some had to be admitted because they would not follow outpatient processes.

May. We need to be realistic. The people who need residential treatment go [to outpatient treatment] for a day and then they disappear... So, it's not realistic, but that was in the brochure, that outpatient treatment was required before inpatient treatment was allowed. That's absurd, if you are an outpatient and you are doing ok, what's the point of becoming an inpatient? So, it's illogical, but it's the norm, you must send them to outpatient first. But there have been cases, complicated ones, of patients admitted [without prior outpatient treatment] (interview, May 6, 2016).

Mental health and health in general cannot be treated by decree. Many cases respond to complex circumstances, and some present acute symptoms that require more than an ambulatory process. Albert, for example, was at risk of becoming homeless, on top of his addiction. Paul had already been in the streets before arriving. Intoxication was a possibility. Admission had to be determined on a case-by-case basis, but there was a norm. The staff used discretion. They made decisions they believed served patients, even when this meant skipping steps or failing to comply with the manual. The first phase was useful for generating a demand for treatment, even in cases where that was not clearly defined when the person arrived. The process of moving into subsequent phases, with a written request and evaluation by staff and fellow patients, strengthened the patient's commitment to the therapeutic process. The team developed guidelines for phase change, with objectives for each.

The checklist for moving from one phase to the next included recognition of norms and principles, rules and codes of conduct. The evaluation of each patient involved social workers, psychologists, psychiatrists, physicians. Did the patient adapt to schedules and community activities? Yes or no. Is his participation positive and motivated? Does he treat fellow patients and staff with respect? While the process was an attempt to monitor progress objectively, it was, in fact, subjective, a combination of personal opinion and ideas about the merits of therapy. Conflict was inevitable.

The division into phases was also designed to deal with conflict caused by perceived differences in treatment, staff's perception of patient preferences. The team would constantly hear from patients: "Why is he leaving?" "Why do you help him and not me?" Requirements for moving from one phase to the next narrowed the options for patients. It made it harder for random preferential treatment. It helped maintain a sense of fairness. But this didn't prevent some team members from feeling that certain colleagues had preferences. Eve, the social worker, explained: "I see this difference, with some patients, yes, and others, no. For example, if there has been any form of drug use, some are allowed to stay. And this is very serious... It depends on the psychologist you have" (interview, May 6, 2016).

The phase approach was developed to limit differences and arbitrariness in treatment, as well as decisions regarding patients but not specified in the norms. Thus, the phases worked as a control mechanism not only for patients, but also for staff members, to protect the credibility of the process, an aspect of therapeutic relevance. If one patient broke the main rule, abstinence, and there were no consequences, while for others there were, this threatened the disciplinary aspects of the process.

A multidisciplinary team brought different perspectives to each case, and each had to negotiate his/her point of view. Sometimes, however, 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. The social workers felt annoyed, as Roberto explained.

Roberto. There is also this fear of saying anything, I mean, for example, sometimes I hear team members say, “Well, I have my reasons, but I can’t say anything because of confidentiality.” I mean, as though they were dealing with the cleaning staff. But we are a multidisciplinary team. So that also kills me (interview, May 6, 2016).

If coming to an agreement about the definition of addiction was difficult, team work also presented challenges. “There is a difference between confidentiality and team work, there are certainly some things you don’t need to disclose, but not everything, and if this is what you’re going to say, it’s better to remain silent.”

Team members felt a lack of trust among themselves. They also felt undervalued, especially those who weren’t psychologists. Comments like these increased the sensation of conflict within the group, disillusion.

Eve. They make you uncomfortable, obviously, like when a psychologist said, “I can’t tell you any of this but this is very serious.” I mean, so much secrecy. But, in the end it’s like they do tell us, to show us they know something we don’t. We joke about it, and I have wondered, “Did I do something wrong?” Because you don’t know who they’re talking about, maybe the kids [patients] are even lying [to the psychologist], but you can’t defend yourself (interview, May 6, 2016).

Conflict among team members revealed discrepancies in power sharing, related, apparently, to the field of each member. Psychology was the main discipline, because the psychologists spent the most time with patients. It seemed they had knowledge (regarding theory, and also regarding each patient) other staff members lacked. They also seemed to have certain privileges: they called the shots, made the decisions, and reported to the coordinator if they felt someone did not agree with them. This, at least, was how the rest of the team seemed to interpret the situation.

Because the clinic offered a therapeutic approach to suffering (from addiction and everything that came with it), 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,² I was familiar with the concepts of compassion fatigue and burnout, the stress affecting psychologists and people working in the care professions, especially in contexts of trauma and suffering.

Studies have found that self-care strategies can lower the possibility of developing secondary stress (Burnett and Wahl 2015). I asked the coordinator what strategies, if any, the team was using to protect staff from compassion fatigue and burnout in a context of trauma, suffering, and frustration. He said that they had been to a 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* (teammates) didn't like to socialize, and most didn't attend when they made 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.

The public addiction treatment center was a proposal allegedly based on evidence, an application of a logic of care, in which patients were considered ill, as opposed to the logic used by private clinics, which could be thought of as within a logic of choice, the choice of using substances. Yet a closer look showed something different. Private addiction treatment clinics were not about patients' choice but, instead,

² I was the national program director of an NGO that gave psychological assistance to Colombian refugees; I trained people working at the Commissioner's Office for Women and Families which dealt with cases of family violence; I taught crisis intervention at the Catholic University.

the choice of desperate families who did not know what to do about drug use. After addiction was defined as a health problem, the Ministry of Health took over providing addiction treatment based on a 'logic of care,' which, according to Mol, is not concerned with the patient's will but, instead, with his or her actions (Mol, 2002). Yet, from the very start, addiction treatment in the public sector revolved around the will. It could not be offered to someone who did not want it. At the same time, Mol describes the logic of care as a matter of various persons working together toward a result; the multidisciplinary team seemed to fall under this logic. However, power struggles within the team showed something other than interest solely in the result. Again, perhaps it was because addiction treatment hadn't yet become a health service but remained in the disciplinary realm.

Recognition was an issue not only within the team, but also in regards to the distribution of different types of attention. The model finally approved by the Ministry of Health placed follow-up in other institutions. This caused discontent among team members. Why would others finish the work the clinic had begun? May explained the psychologists' objections.

May. They don't want to send them [to first level health centers; they say] "I'm not going to trust my work to the first level health centers." For example, there is a guy who has been a patient for a year, Santi, and he is already tired of coming. He was admitted for five months, and he has been doing follow-up for seven months, but the problem is that follow-up is an individual as well as a group process. But imagine, if [the psychologists] already have their patients, they won't be able to manage additional patients (interview, May 6, 2016).

May proposed a three-month limit for follow-up, a differentiation between personal psychological therapy and an element of the therapeutic community's process, two different approaches to therapy which needed to be established for practical reasons, but which the psychologists resented, she felt, because of the fear of losing credit for success stories. Bureaucratic discipline and the creation of more and more regulations for the therapeutic process were ways of addressing conflicts within the team and also a mechanism for controlling staff.

The failure to integrate perspectives through the multidisciplinary team can be seen in the power struggles that occur. Rational, evidence-based argument is replaced by statements such as “He is my patient,” or the command “Stay away from my cases.”

Conflicts within the team were increasing, which members attributed to lack of experience, frustration over therapeutic failure, lack of self-care tools, lack of clinical analysis of cases, and the tendency toward the punitive. In addition, bureaucratic obligations blurred the line between working with patients and working for the ministry, further complicating the staff's roles. All of this occurred while the issue of job security awaited a permanent solution, as the program was subject to cancellation.

Staff believed that the clinic's rules were necessary in order to help patients accept the need for treatment. The demand for treatment, they believed, can sometimes be a matter of self-deception, as people left inpatient treatment voluntarily but continued to come for physiotherapy and medication. For the staff, this implied the need for norms for leaving and returning for treatment (director, interview, August 18, 2015).

Three stages were proposed: the initial stage of complete confinement; a second stage of controlled visits to family; and a third stage of reinsertion in society. The 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 gaming the system by leaving and returning at will (interview, October 5, 2015).

The coordinator had to deal with two more directors before the Dermatology Hospital finally closed. Personnel from the district seemed a lot easier to deal with.

The lack of job stability caused unrest among employees. Some applied to other, more secure jobs with the state and two psychologists left. Employees talked about this amongst themselves. “My friend was telling me to apply to the Sangolquí Hospital. That's where Al applied.” I asked if he would leave the clinic if he was hired. “Yeah. But from having nothing, to having a job appointment, anyone [would take that]” (conversation, June 30, 2016).

They felt vulnerable, as contracts would expire at the end of the following month, and no one knew yet if they would be rehired. The paperwork was complete, but the main office at the ministry claimed that, since the last page was missing due to a scanning error, they would need to redo the entire process, thus prolonging the uncertainty.

Some, like the psychiatrist, moved to the United States. And the rest waited. In 2016, the clinic's status got sorted out, sort of, when it was included in the district's budget. District offices were moved to the clinic's premises, while the Dermatology Hospital was closed and a first level health center was relocated there. Being a part of the district was 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 in its own right within the National Health System.

In any case, some of the services previously offered, in response to increased demand, had been reassigned to other clinics. Those in intensive outpatient treatment no longer came to the clinic, and this lowered the volume of neighborhood protests; they went, instead, to a psychiatric center in Calderón opened for patients who did not require inpatient treatment, or who needed to work on generating desire for treatment. Also, 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 might have been a secondary symptom. The women were sent to a different location but that soon closed, which left the coordinator again feeling that he owed them. The door to their wing was now always open, the meeting room had been turned into a classroom, and furniture had been removed from the bedrooms, except for three where hospital beds and mattresses were stored, so that they looked like new versions of the old debris rooms in the abandoned buildings.

In November 2015, Minister Vance resigned and a new minister took over. The clinic had been informed of her desire to visit the center to understand its functioning. Juan felt it was more of a public relations thing than a work-related visit: the Department of Mental Health ordering the minister to visit. In any case, a date had not been set, but Juan already knew what would happen. History was repeating itself; nothing to worry about. He was curious to learn what her thoughts were on addiction: "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 drugs are only news when someone dies, that's when you get answers from authorities and you can see what the position is" (interview, May 6, 2016).

Public addiction treatment is affected by different forces, including authorities representing the state and dominant political perspectives, as well as by the individuals for whom treatment is designed and their families. It is also affected by what professionals are on the multidisciplinary team.

Governmental authorities see themselves, and are seen by many others, as deities or religious figures. I had experienced this up-close and personal when Mount Cotopaxi reactivated and those of us living in the lahar risk areas demanded risk management. Whenever we had the chance to speak with an "authority," people displayed a reverence 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. 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) in the clinic and among the neighbors. The visit, however, involves patients and families who desperately seek humane attention and, especially, an answer to their prayers. While relief is not always the result, people appreciate being treated with respect.

Therapeutic approaches end up taking second place to bureaucratic procedures, and the clinic struggles to treat people in need of attention not outlined in policies and manuals. This is done amid pressure from a ministry wanting to control excesses affecting a small portion of the population, the addicts, regardless of the abuses and exclusions which they have suffered at the hands of private clinics. At the same time, objectivity gets lost amid team members' need for recognition.

The public clinic, opened in 2013, remains in a legal vacuum that affects budget, supplies, and the team's job stability. While some staff members have left, most remain working for the center and hoping they will have a job next year.

The introduction of phases and the division of activities in relation to the progress each patient is making reflect a disciplinary approach that places guilt on the patients themselves, while turning moral values

into indicators of therapeutic progress. Avoiding failure, then, depends on compliance and obedience. At the same time, procedural therapeutics limit discretion and arbitrariness by multidisciplinary team members, thus controlling differences in power relations among staff.

The addiction treatment center was created as a response to abuses suffered in private clinics during the long neoliberal night. Treatment was to be humane, as opposed to the repressive measures applied in private clinics where addicts were treated like criminals. However, inertia remains a factor in the public clinic, and is slowly transferring control and a moral approach to those with substance abuse or dependence disorders. Addiction treatment slowly becomes behavior control, a disciplinary approach more than a therapeutic one.

In spite of the constitutional mandate defining addiction as a public health problem requiring medical treatment, the therapeutics of problematic drug use have not yet entered a logic of care. Rather than being medical, those therapeutics retain the characteristics of the disciplinary.

Chapter 5

The Individual User

Rather than a clearly defined medical category, addiction is a sort of scapegoat for anything related to mental health. Granted, psychiatric disorders, especially psychoses, generate anxiety in families, as I learned when studying psychology, and observed in cases of psychosis I have seen as a psychologist.

Addiction became the easiest explanation for anything deviant, anything abnormal. María is an example of the way families give in to the compulsion to diagnose addiction. This is what made private rehabilitation clinics in Ecuador so profitable. In this last chapter, I look at the construction of the addict as a subjectivity influenced by others – from family members to therapists and fellow patients in a public addiction treatment center.

People in the clinic struggle to define who they are against, what others have to say about them. They have to find the right balance amidst other voices also attempting to describe them.

Albert is one of those 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 he has not yet been able to find in society. He is locked in a therapeutic loop: after being admitted to the public center on three different occasions, Albert was sent to a public center in a different city, mainly because norms prevented the public center in Quito from admitting 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 other patients.

Addiction patients are generally depicted as lying and manipulative, but this description doesn't always come from others. They, too, see themselves as deceptive, especially when using depends on their ability to pretend. Manipulation, however, is not something limited to addicts; the entire system is susceptible to different degrees.

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

Addiction on the Outside

The management of substance-related disorders and mental disorders in general is not a matter limited to protocols or bureaucratic procedures. There is much more involved than a simple decree, a ministerial agreement, or even a norm, as María's case shows. At 39, she suffered a psychotic episode characterized by paranoid ideations surrounding her mother's identity. María had been kidnapped several years before this happened, and when she spoke of her beliefs regarding her mother's involvement in the conspiracy, she explained that it all began when she was in the hospital recovering from the event. 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.

María's condition slowly worsened: she started noticing that her computer didn't connect to the internet, or that there was something anomalous about the wireless signal affecting only her equipment. Her boyfriend, she explained, was upset when she started talking about all of this, and they broke up after a relationship of many years. According to her son, the separation from her boyfriend triggered the acute phase of María's delirious disorder. She began building walls around the house, started confronting her mother more, and began going through every single piece of paper from her parents, her childhood, any old

documents, anything she could get her hands on. María's father 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 several times, until she decided to leave the house and her daughter. María's son, frightened by her violent behavior, also left her and moved in with his dad.

Both María and her mother were unemployed. María would stay for a few days with a relative and then move to someone else's home. She could no longer afford to pay the bills at her house, and soon found herself without water service. She lost weight for lack of food, and received help from random people on the street: car watchers,¹ security guards, anyone willing to give her a little something. Her teeth deteriorated because, according to her mother, her saliva pH was off and this, along with malnourishment, was affecting her teeth. She didn't shower. María seemed to have been left to die when she called me. She and my brother had been friends when they were teenagers. 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 asked him to see her as a personal favor. It all seemed odd, but forensic psychologists are trained to doubt our first impressions.

The lawyer said that there were no indications of foul play, no evidence of identity theft. Nothing. He looked at all the documents she had collected. 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 told him that she seemed to need assistance. In response, he told me of rumors that she was into crack cocaine, and that she had borrowed money from him but never paid him back. Nevertheless, he offered to check in on her. When he saw María, he tried to convince her to go to a psychiatric hospital. She agreed. But on the way there, she changed her mind. He later told me that her teeth were black and that she didn't weigh more than 90 pounds. He was certain this was all due to addiction. "It is exactly like *Requiem for a dream*."²

¹ In Ecuador's larger cities, people self-employ as car-watchers: they make sure cars are not broken into, and receive whatever car owners offer them.

² *Requiem for a dream* is a movie directed by Darren Aronofsky, released in 2000.

That's exactly what's happening." I hadn't seen her, but the symptoms pointed to a psychotic breakdown. Neither her mother nor her son knew of any drug use. If she was going to get 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 breakdown, would need to be treated for that first. But our friend decided that it was addiction. He called her mother, said that her daughter was a drug addict, and recommended admission to an addiction clinic. He knew of one in a rural area, far from the city. Perhaps she could go there. He even offered to pay for it.

Addiction, or drug use, is often taken by family and friends as the reason a person is exhibiting anxiety or anguish. Psychotic disorders are very difficult to understand, and everyone, from her son to the friend mentioned, believed that María needed to be told that her delirium was delirium. It was a matter of the way not only addiction but any mental disorder was represented, that is, as a moral failing, and since María refused to accept that her problem was delirium, the easiest thing to do was admit her to an addiction clinic. I 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 information and guidance. But she was also much more comfortable with the addiction idea, even when she knew her daughter's teeth were damaged from a previous pH imbalance disorder. Granted, her daughter's mental illness had changed her life and affected everyone around her. But by attributing her condition to addiction, María was at risk of being sent to a place that would harm her, considering her state of mind.

This escalated into a kind of family madness in a matter of days. A cousin forwarded to María a voice message from an aunt explaining that María was a drug addict, and that addiction was the cause of her paranoia. María now knew her family was conspiring against her to admit her to a hospital where, she believed, she would disappear. The family was contributing to the worsening of her condition, increasing the risk that she would act out.³ I explained to her mother that a specialist, not

³ Acting out refers to impulsive, violent, aggressive, or criminal behaviors which come from a representation or tendency attributed to the act itself.

a family member, needed to determine what María's problem was. A friend or an aunt was not equipped to provide a diagnosis. María needed assistance, but as time passed it seemed more and more unlikely that this would happen. Meanwhile, she was surviving on food her friends gave her every now and then. The lawyer decided to wait and see what would happen when her son arrived, before reporting her situation to social services.

Addiction treatment is the first choice in everyone's mind when it comes to dealing with disorder. It simplifies reality, makes people feel less frightened about something complex and difficult to grasp, such as a psychotic breakdown or schizophrenia. Moral blame ensures that whatever is happening to the person suffering the breakdown is occurring because of her own poor choices. At the same time, addiction functions as a representation that makes the unfamiliar – the paranoid breakdown – familiar, regardless of the absence of knowledge about addiction, a phenomenon known as “anchoring” (Hoijer 2011). Everyone has heard of it; everyone knows about some clinic. Paranoid schizophrenia⁴ or the Capgras⁵ syndrome sound much weirder and even more ominous. So, her aunt opted for the representation she ‘understood,’ and told everyone that María's problems were due to her drug addiction.

The representation of addiction became a form of objectification. María's delirium, something disorganized and difficult to understand, could now be grasped as a condition: drug addiction; and something could now be done about it: admission to a private clinic. A single word explained the complexity of her behavioral changes, relieving family members of the obligation to explore the matter any further. And because the state was making admission to public psychiatric hospitals increasingly difficult, and private hospitals were expensive (for María's case, the cost of the psychiatric hospitals her mother was considering ranged from USD80 to 200 per day), a private addiction clinic was more affordable.

⁴ Paranoid schizophrenia is the most common form of this disorder, and it is mostly characterized by delusions/hallucinations which make the patient suspicious of others.

⁵ Capgras syndrome is characterized by the belief that a family member has been replaced by an impostor.

María's story took place outside the clinic. Hers was an isolated occurrence that does not illustrate who the subjects of addiction really are, or the way addiction and its representations affect individuals. In order to understand this, the public addiction treatment center becomes a privileged space for ethnographic study, as it condenses the political, economic, medical, cultural, and moral aspects that shape the milieu in which the addicted go through life. The creation of a multidisciplinary approach made it possible to learn what becomes of the subject of addiction in a therapeutic context characterized by a political ideology. An ethnography of the clinic offered a look inside this "unfinishedness" (Biehl 2013).

Addiction Truth

There were many fronts for the production of truth regarding addiction that could be grasped much better from within the public addiction clinic. The center was created because of reports of rights violations by private clinics and state intervention in those clinics after addiction was defined as a public health problem in the 2008 Constitution. The legal framework within which the first public addiction treatment center was created was a contradictory one: it proposed a health approach to drug use while maintaining repressive measures against drug trafficking, amidst unclear thresholds for differentiating one from the other. By differentiating drug use from drug trafficking, the principle of proportionality was applied, but sentencing parameters set by the new Integral Organic Penal Code, in 2014, were changed again in 2015 back to more punitive responses. The meaning of addiction, as determined by the state, remained ambiguous, subject to modification based on public opinion (see chapters 1 and 2).⁶

⁶ Counter reform was a shift back to the dominant perspective in force for decades. The country saw signs of change in the way drug issues were addressed: the pardoning of drug mules in 2008; the inclusion of addiction as a health problem in the 2008 Constitution; withdrawal from the ATPDEA and cancellation of the Manta Base concession in 2009; the chart created by CONSEP, the security organism in charge of drug issues, in 2013; differentiating between drug users and traffickers by establishing a list of maximum quantities that could be legally possessed, and its inclusion in the COIP in 2014. However, the following year, the president spoke of heroin use by

The dialogical truth⁷ held by the public had been shaped through decades of the war on drugs and its campaigns, linking drug use with criminality almost automatically. The first social worker hired by the center didn't understand why the state was giving so much to this undeserving group; her view reflected the position of Ecuadorian society: fear, concerns, memos regarding safety, and the constant reprimands the addiction center's patients received from the Dermatology Hospital's staff were not-so-gentle reminders of popular beliefs about people with problematic drug use.

Iván, a psychologist who worked at the addiction center since its founding as a contingency area, said that the minister liked things empirical, evidence based, scientific, and that they built the therapeutic model with these characteristics in mind. The team claimed to be working with objective, validated facts, empirical 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 the unintended purpose of keeping some form of forensic truth in mind. The clinic had different forms of surveillance: the security system, with cameras pointing at patient areas, was the most obvious. The line that formed at the clinic after weekends, for patients to receive medication and to drop off urine samples for drug tests, also showed a way in which the clinic built its truths regarding its population through body fluids surveillance.

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

children and ordered a review of the "*malhadada table*," the evil chart that, he claimed, encouraged drug use. A change in quantities permitted came with a change in sentencing. See Paladines (2016) for more information.

⁷ The Truth and Reconciliation Commission, established after apartheid ended in South Africa, involved public hearings throughout the country to gather the stories of perpetrators and victims, in order to generate awareness and forgiveness (Dhunpath and Samuel 2009). The report the commission produced 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 narratives of those experiencing the events reported. Dialogical truth came from society: public understanding of groups and individuals evidenced through oral discourses, spoken and written media, life histories. Finally, restorative truth referred to the restoration of dignity through the reconstruction of lives. Using this model for understanding truths displayed in the therapeutic context of an addiction clinic makes sense in light of the criminal connotations attached to traditional interpretations of drug use.

Nurse: Someone smoked in 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 María José. I confronted her but she denied everything.

Coordinator: Who is María 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 she has ignored the rule. We need to make a decision, because apparently she was making the other girls smoke.

When the phase model was adopted, the burden of truth was placed on the patients. It was up to them to determine if a person was ready for the next phase or not. Surveillance was no longer a matter of the authority from above; the camera pointing from the ceiling was replaced by the eye-level gaze of patients at themselves. In private clinics, the more a patient cooperates or complies, the sooner they earn privileges, including going along for the "captures" ("rescues," as they are called) of other addicts. Persons who resist are punished by other patients. The public clinic didn't use physical punishment or capture; everyone was free to leave. The patient had to find his own truth in order to be released from dependence, but that truth had to be validated by his peers as well as by the team. In a context in which relapse is generally expected, the objectives, or the therapeutic goals, overlap with compliance and avowal, making it unclear if the patient is genuinely improving or just obeying. At the clinic, addiction lost its clinical interest as it became a matter of obedience. Nevertheless, the clinic also allowed for a patient to make a personal journey through his/her trajectory: a realization of his/her own experiences through narratives of what he/she had been through as an addict. Each had the chance to address personal issues, even though the clinical setting also had its share of disciplinary mechanisms.

At the public addiction treatment center, avowal, a situation that involves the relationship between truth, subjectivity, and first-person speech (Foucault 2014), added peers to the equation as guardians of the truth about the self that each patient described. The other patients became witnesses for their peers' process of subjectivity building; as a group, they were made to testify, corroborating or contradicting each patient's avowal of who he is. Avowal in private clinics seemed a little more primitive in

the sense that it occurred as a compulsory form of focus on the crime, that is, drug use. Private clinics, as distortions of Christian self-mortification practices turned into torture mechanisms designed to force disclosure of the worst acts committed during drug use, seem to aim more for the *jouissance* of the symptom than for the construction of a subjectivity in recovery. But the public clinic's attempts to avoid the logic of disorder found at private clinics, in order to enter one of health care, becomes a penal logic instead with the inclusion of peers as judges and witnesses.

In researching something as obscure and ambiguous as addiction, a biographic methodology has the advantage of allowing for the observation of "the interplay of society, history, and biography" (Niehaus 2006, 53). In other words, the way discourses and practices surrounding substance use, 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 drugs, which are allowed, which are prohibited, how contradictory positions give form and meaning to life experiences in the addiction treatment clinic with the eventual aim to re-enter society, in some cases with no family bonds or social network, without job skills or education, hoping merely to become something other than an addicted subjectivity – all of this is subject to ethnographic inquiry through biographical construction. Self-representation can also be seen through a life history, the way it is influenced by subjective processes operating in an addiction treatment process.

Life histories have been criticized for being open to exaggeration by an informant narrating his or her own life experience. However, the methodology can also be used to reveal history and culture as lived, as an individual life happens, as a kind of *topos*, or a place grounding history and culture on a common plane of existence. At the same time, the methodology allows for a look into the multiple relationships that, on a day-to-day basis, human groups experience and to which they are linked due to different needs (Mallimaci and Giménez Béliveau 2006).

In addiction treatment, histories unfold throughout the process of change, which implies the need for a narrative to be created and re-signified in order to achieve recovery. The path to recovery, whether in a private clinic or the public center, begins with recognition of

a problem. In psychotic disorders, such as those treated by François Leuret, experts now recommend that the professional treating the patient allow the delirious construction to play out rather than contradicting him or her, until medication stabilizes thought processes and the risk of acting out diminishes.⁸ But in addiction, now considered a public health problem, being accepted by the program depended on the person's willingness to undergo therapeutic inpatient treatment; each patient had to present a spontaneous demand.

Compulsion to Treat

Albert had been in the clinic longer than any other patient. He wasn't a leader, but he got along with everyone. He obeyed the rules and he stayed out of trouble. Due mostly to his history, everyone considered him an important case. Juan, the coordinator, pointed him out during one of my first visits: "If I took a third of the pills Albert takes, I would die, something 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 to tell me more. We met several times afterwards: between 2014 and 2016, he was admitted to the public clinic three times and stayed for over six months each time. He told me about his drug use during our first meeting, when I asked him why he had been admitted.

Albert. 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 ask myself, 'Now what?' I would spend the entire day like that, asking myself, 'Now what?' And I would get money for more. This is when I realized I was bad, and getting worse, and with liquor, worse yet.

⁸ While substance related disorders are not necessarily psychotic, the therapeutic approach mentioned resembles the type of treatment that this population has received. There is a trend toward de-hospitalization.

I would shake and needed a sip of liquor to calm down, and to calm my nerves. So, what started as a way to just chill, so to speak, a little drink, ended in a weeklong drunken binge. I realized I had problems. I wasn't drunk, I could talk, just like now, but with alcohol. Always, all the time, all day I would spend it like that. And if I didn't have a bottle, I would get desperate, I needed to see it in front of me so that I wouldn't panic. That's when I knew I was really bad (interview, November 18, 2014).

Albert always specified that his memories were confused; he constantly apologized for not being able to tell a chronological story of his life. He came from a family of artists; his father was 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 knew him. "You're talking about Albert, Chin-Fu's brother? They used to come to our house to rehearse with Sergio's band" (a band my brothers' friends had formed, but because they didn't have all their instruments yet, they rehearsed at my brothers' studio, as he had instruments they could use). Albert remembered my three brothers – they had been friends long before he began drinking – and our house. His parents were well-off, but they were always arguing. Albert's dad was famous and his mom was jealous. They sometimes spent entire weekends 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 drinking.

Albert. 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 [of school], I preferred to be home or on the street rather 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, you’re not to be trusted,’ she said, ‘I don’t trust you. I know that at some point you are going to become an alcoholic, a *marihuanero*, with that attitude of yours.’ She would say those things, and I was so angry (interview, November 18, 2014).

Clinic staff saw Albert much like his mother saw him. Very little hope, not many expectations, his mother had made up her mind regarding her son from the time 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. The doctor checked him at one year of age and his hearing was fine. He was always seen as clueless, lackadaisical. His father used to say he was naïve when he was little.

Albert. I was careless, I remember. My shoelaces used to be untied, and I used to fall. When the family got together, I’d spill my juice, always, and they’d say to me, “Hey, you’re exactly like *El Chavo*,”⁹ and hey, I was so resentful, I felt so angry, but I was careless, 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” (interview, November 18, 2014).

The relationship Albert had with his father seemed like a normal identification process; his mother also compared him to his dad from an early age. Perhaps unknowingly, I thought, 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 getting people’s attention,

⁹ El Chavo was a 1970s television character created and played by Chespirito, a Mexican comedian whose artistic name means “little Shakespeare” (he was short). His show gained worldwide popularity.

I don't understand it, I'm simply telling you about it." He constantly felt the need to do something, to move around, to get people's attention. At the same time, he became an extremely shy teenager: the first girl he ever fell for was a classmate, and Albert couldn't bring himself to approach her. Instead, he created a fantasy world where he spent his happiest times with her.

Albert. After school, instead of hanging out with my friends, I would lock myself in my bedroom to think about her while listening to music. This was a pattern I had, maybe a part of some personality, maybe you can explain this, but that's what I did. And this made me more of a person who didn't relate to friends (interview, November 18, 2014).

Albert believed that it was his obsessive personality that hooked him on drugs. He was obsessed with his classmate, but couldn't tell her, and later he got obsessed with drums, particularly after performing without having practiced and making a fool of himself. Albert also told me that at age 15, his relationship with reality was strongly mediated by fantasy, and the difference between the real world and the imagined one produced anguish.

Albert. We were forming a band. We were at a friend's house, in his backyard, and they had their guitars, it was just my brother, his friend, me supposedly with a drum set, but I didn't have a drum set, just some jars. And supposedly I played, and my brother, well, he had enrolled in an evening program at a community high school to finish his senior year, and anyways he says, "There's 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 behind a drum set, in front of an entire school. I was a kid still, I didn't know, didn't know drums had sets of pedals. Imagine that! I fell off 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'll get better. And that's when I really began to dedicate [myself to music] (interview, November 18, 2014).

Albert sold his piano, bought a drum set, and began skipping school in order to practice. Around the same time, he started drinking and

smoking weed. He was obsessed about the girl, then about the drums, and then also about alcohol: “I said to myself, ‘Hey, this is what I need in order to feel good.’” Albert was intimidated by people and what they thought of him: reality was hard to bear. Drugs made everything more tolerable. At the clinic his history began to make sense. He confessed: “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” (interview, November 25, 2014).

The drugs Albert developed a problem with at this point were mostly alcohol, base cocaine, and, over time, heroin. Base was 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. Their affection for one another was forged in part by shared drug use. His father gave him the freedom to use drugs, he claimed, perhaps because he needed a partner in crime, someone to be an addict with.

Albert. 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 [high]. 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 penal,¹⁰ they used to cook the coke, with sodium bicarbonate and water: it was crack (interview, November 25, 2014).

Albert believes that he got seriously hooked on drugs when his father was in prison. Visiting him every day meant living his life, sharing his drugs. After visiting his father, Albert would hang out with his girlfriend in the evening. She didn’t know about his drug use for the ten years they dated. “I don’t blame him. It’s just life,” he said. 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

¹⁰ Albert’s father spent almost a year in prison, at the ex-penal Garcia Moreno. The use of base in the prison was common knowledge.

an entirely different person when he was with his father. After his dad's release, his theatrical existence continued: he adopted different personas in different scenarios. Prison guards would deliver the drugs to his house, something which made sense with what Núñez Vega (2006) had found regarding prison systems in Ecuador. Prison guards were part of the corruption within prisons; they provided the illicit substances while pretending to control them. Albert moved back in with his dad, and they spent hours smoking base and playing the same card games they had learned while he was in prison.

Juan and I talked about the demand for treatment. Did the patient want to stop using drugs? He believed that most patients tend to blame their parents or experiences they have had: "I haven't seen people one hundred percent convinced that this is harming them, because drugs produce pleasure.... Among other things, we work on the subject's position in regard to drugs. Drugs have you. It's difficult to leave them" (interview, November 10, 2014).

It appeared that the subject's position in regard 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 activities, and continued inexorably towards the more sophisticated of technologies of the self. These are described by Foucault (1990, 48) as the operations on one's body or soul, thoughts or behavior in order to transform and reach a "certain state of happiness, purity, wisdom, perfection, or immortality". These are carried on either by the individual or with the help of others.

Albert was well along in coming to grips with where he stood in relation to drug use, but he was already 38 years old. He had only recently realized that he had a drug use problem, he claimed, even though he had been forcibly admitted to private clinics. It became clear that the hook from which he was suspended had to do with avoidance of unpleasant realities; a sort of defense mechanism so deeply 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, it seemed, almost happy. I never observed him suffering from withdrawal, yet he did speak about wanting to use.

Albert. It's like they tell you, come on Albert, chill out, change already, *hasta cuándo*,¹¹ 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 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" (interview, November 25, 2014).

Albert explained that being told to change didn't make any difference. Discipline didn't work for him, regardless of where it came from. I thought of a forced process of identification, like the one described by Freud in *Group Psychology and Analysis of the Ego* (1921), with an authority figure or a therapist in place of the father with whom the patient should identify in order to change. I thought perhaps experiential therapists might feel that they have a better chance of generating identification processes because of the supposed shared understanding they have of drug use. Perhaps this is why the clinic required a desire for change as the prerequisite for admission to the program. The will to change may facilitate identification with an ideal, a process reinforced and sustained by identification with others' narratives, or perhaps by the clapping of participants in group meetings (see chapters 2 and 3). If so, in any case, it would seem to be an unconscious, two-way process of identification between the individual and the group. But identification as a therapeutic mechanism was never mentioned by anyone. The ego ideal¹² didn't seem to operate that way. Even if it was the minister herself telling Albert to change, he explained, he didn't care. And recidivism rates reflected failure.

¹¹ When will it end?

¹² Freud (1921, 110) described the 'ego ideal' as the instance in charge of "self-observation, the moral conscience, the censor of dreams, and the chief influence in repression. We have said that it is 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; 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." 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.

Most patients came from therapeutic histories that compelled them to define themselves as incurable addicts – with the disciplinary stick in the hands of the authority. According to Iván, addiction patients came believing they were misfits – malicious people, sorely deserving punishment. At the same time, this identification with the incurable operated as permission to use again. In the end, families agree to admit their relatives because they don't know what else to do to manage the problem, similar to what Biehl (2013) found in Catarina's story of psychiatric illness.

Iván. It comes to the point where families only want to get rid of the addicted son. They go from one place to another, 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 (interview, December 1, 2014).

Manipulation

Francisco had already been in the clinic for two months when I met him. He joked about me being in intensive outpatient care after seeing me at the meetings a few times, even though everyone knew that I was doing research. He was a leader: he organized others for house activities, designating tasks and writing them down on the board; he proposed themes and activities for special holidays; he always participated actively in group meetings. He behaved like a regular person, someone who was visiting a patient at the addiction clinic. One day, the group meeting was devoted to a particularly sensitive issue: Jorge had been out on a weekend release, he came back to the clinic with pills, and gave one to Pedro. Patients admitted to the clinic for treatment were not allowed to use drugs and, in this case, they had done so at the clinic, aggravating the situation. The psychologist addressed the matter at the morning meeting and announced that Jorge was to be expelled from the

program. If he wished, he could join the intensive outpatient program. But he would no longer be permitted inside. For Pedro, weekend leaves were suspended pending 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 used Jorge's example to speak about his own drug use.

Francisco. 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 got someone else to do it. I mean, if you are going to die, then die on your own, not in a house based on certain values. There's a huge difference between him saying "I did use," and them having to ask him and test him to see if he used or not (interview, November 18, 2014).

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 – fellow patients, family, authorities, and the multidisciplinary team itself. Still, most patients shared an even broader set of reasons for being there. For Francisco, having his urine tested to check if he did consume any drugs excluded the possibility of him taking charge of his own process.

Francisco. 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." Yeah, we have to leave this place and start over. But there's another voice that says, "If you have a hit, nothing bad will happen, no harm in that." It's a daily struggle between the one and the other, that's all there is to it. 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 (interview, November 18, 2014).

Contrary to Francisco's description, I was under the impression that the clinic was designed for regular observation and judgment: from the psychological-educational practices to the occupational therapeutic approach, or the decisions regarding leaves and the various forms of surveillance, the patients were there to be evaluated. Assessment implied a judgment regarding demand: "Do you really want treatment?" translated to "Are you willing to become abstemious?" Spontaneous demand was part of the triage: the patient had to desire treatment in order to be accepted for it, a voluntary quest to cure what the coordinator described as a disease of the will. In any case, nobody on the team seemed concerned about Francisco. He was cooperative, he was charming, and he played the guitar for every special event. His drug use didn't seem to worry anyone; he was never the subject of team discussions. He mentioned that, during his time in private clinics, he had learned to manipulate psychiatrists into medicating him. He felt capable of deceit. Albert, on the other hand, generated fewer optimistic expectations among staff members. It almost seemed as though no one expected him to recover.

Albert. 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 the end I became so addicted to pills that I would go to pharmacies owned by people I 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's 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, finally, I had to think about what to spend my last 50 cents on, not food, but drugs, so I kept thinking, 50 cents – how much of this, that, or the other can I get with some change? (interview, October 10, 2016).

While addiction is depicted as the disorder affecting the will, there is a contradiction in the belief that the addicted manipulate. Is the will really affected? Carl Hart (2014) indicates that meth and crack addicts

can make rational choices. Nevertheless, most clinics, private and public, have adopted therapeutic approaches based on submission, as if what the addict needs is a taming of uncontrollable impulses, while considering them fully accountable for relapses (or any other forbidden behavior). Albert went through a number of different phases, besides different forms of treatment at the clinic. His three admissions led to insights regarding his self, the slowly developing understanding that he was addicted, and the realization of other problems that directly affected his adjustment to the “real world.” Albert looked forward to meeting with me, as if speaking about his past led to understanding his own life, his current situation.

Albert. I wanted to talk to you, to tell you about this new phase, because you have been following my history for a long time, right? My latest phase was no longer using, it was something deeper, insecurity, questions about what I’m going to do. And since I didn’t know, I got depressed, I didn’t know that depression is staying at home in your pajamas all day watching TV and waking up at three in the afternoon, but I felt really bad, I mean, with my conscience (interview, October 10, 2016).

Albert had gone through the therapeutic process twice at the public clinic. He followed all the steps, spoke with his therapist, looked for a job, and when he didn’t find one, he began a small business selling sandwiches and similar food items at the clinic and on the street. He rented a room and moved in. And then he came back to the clinic. He did all of this twice. But after the third admission, the team could no longer treat him at the clinic; regulations prohibited a fourth admission. When he was once again homeless, Juan called the El Puyo clinic, a public center opened in Ecuador’s Amazon region where other clinics, mostly private, were also located. Juan asked for Albert to be admitted. 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?

Although the public clinic addressed addiction as a health problem, as prescribed by the Constitution of 2008, in practice, staff treated patients as deceitful and surrounded them with surveillance techniques

and technologies. The path to redemption thus involved characterization as a poor defenseless addict as well as a manipulative liar. Juan tried to make sense of this contradiction.

Juan. The pathology of addiction is really complicated, because among other things, it is thought that addicts are manipulative, but instead, they are very smart. You find one of them outside, and ask him what he's doing, "Ah, May sent me to get something." But when you ask her, she says she hasn't seen him all day. So now, everyone [the staff] has a radio, and if we find them walking down the hall, you ask her then and there, "May, did you send so and so? No?" Ok then, you're screwed (interview, July 22, 2015).

Just as 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 the pursuit of truth leading to emancipation or the willing submission to a truth regime. Instead, it becomes a matter of convincing those with decision-making power over release that one is ready to overcome this disorder of the will, because one *a priori* already has the will to do so. At the same time, when the phases were already in operation, Albert remained in treatment because he had nowhere to go, as May explained.

May. He is in the third phase, but we can't sign his release because he has no place to go.... Patients [like Albert] are in different situations and, in spite of the rules, in spite of the program, we have to bend [the rules] a little and look for alternatives, [and] in his case, that means letting him stay for a month or two until he finds a job and has some money (interview, October 10, 2016).

The staff had given some thought to Albert's situation, because even though he had found a job, they felt that rushing into recovery had been a mistake. Having just any job, out of necessity, was not working for Albert (though it might work for someone else); he needed to find something he liked. Greater organization of therapeutic procedures was a way of controlling not only the patients, but also staff's differentiation

among cases. On the other hand, Albert's therapeutic failure after he had complied with requirements was a criticism of 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 knowing what medications were commonly prescribed for what symptoms.

Francisco. I had a psychiatrist at a private clinic prescribe Meleril, 200 milligram tabs,¹³ he gave me one in the morning, and then I got one in the evening. Meleril is a very strong med, so, obviously, I knew the symptoms, I would say that I couldn't sleep, or that my hands were sweating, or that I felt anxious, or about to explode (interview, November 18, 2014).

Certain anxiety drugs, such as benzodiazepines, cause dependence by diminishing the production of neurotransmitters which control the production of dopamine, a neurotransmitter that activates the brain's reward system (Rosas-Gutiérrez, Simón-Arceo, and Mercado 2013). Francisco's lies sounded like something he had made up based on stories heard from addicts, but I wondered if the medication he referred to actually made him feel better by preventing his own brain from controlling dopamine release. I asked Francisco if he invented the anxiety symptom.

Francisco. I talked about anxiety. So, when I got the pill, I would go back and explain, you know, I'm here for pills, you could give me twenty and nothing would happen. So, they would say, ok, we can't give this man a baby Tylenol. And they would give me this pill, and I found out that I didn't want to stop [taking it], I wanted to keep on getting high. But then I discovered that by jogging I could overcome myself [control the need for medication] (interview, November 18, 2014).

¹³ Meleril is an antipsychotic medication used in acute psychotic outbreaks. It is also used for anxiety and depression disorders. It is usually recommended for inpatient processes and follow-up outpatient treatment.

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.

Francisco. Sometimes they [the patients] say they want to see their families, but it's an excuse, they only want to go out and smoke. You don't realize that you are manipulating yourself and leaving the clinic is not necessarily voluntary. I sign out, but how do I deal with anxiety and with being conscious that I need to change? But if a person is forced to be here, well, that won't work either, because no matter how long they are here, they are never going to change (interview, November 18, 2014).

When Francisco finished inpatient treatment at the public clinic, he got married, the couple had a baby, and, with the help of his family, he began a catering service that later became a restaurant. Regardless of the truth surrounding addiction, the contradictions or the "unfinishedness," this is what seemed to have worked for him: having something meaningful such as a family and a work-related objective. And yet, he didn't describe his goal as a life of abstinence. He just wanted to achieve some form of balance between drug use and daily activities. He left the treatment center and continued with outpatient therapy for several months. He didn't have a relapse, at least not during the following two years.

After stays in many private clinics, Paul's last recourse seemed to be the public addiction treatment center. Though he left of his own free will, telling his mother he needed a psychiatric hospital, having been admitted to the clinic was beneficial in legal terms. He had been charged with robbery. When the Judge learned of his addiction treatment, she agreed to suspend sentencing as long as he signed in at the prosecutor's office on a weekly basis. Paul's father, Jorge, explained:

Jorge. It's a miracle that he's free. I had to find out the date of his trial. I knew my son had been arrested, so I told the prosecutor that I was his dad and that he has problems with drugs. She said, 'Ok, I'll help you. Bring your son to me if you can find him.' When he came back from

Colombia, the judge made him sign as if he had shown up five different times (interview, December 12, 2014).

The addict was not alone in practicing manipulation and deceit. The entire system seemed to be designed to allow, and even encourage, manipulation. Paul had mugged people. He mentioned that the rush of mugging someone was the thing he missed most, even more than smoking base. He was charming, everyone liked him at the clinic, and his charisma also seemed to help him in the legal system. Luckily, the prosecution had no evidence against him and, after appearing at the prosecutor's office for a few months, the case was dropped. For Paul's parents at least, this was a miracle. But they longed for a bigger one: that he stop using. Paul wondered what he would do if he could not mug people. He had not finished high school, and even though he was a piano player, he felt he had no survival skills beyond mugging, which he knew he was good at.

Paul. I was very skilled at mugging when I was a kid; I made a lot of money that way. With that shit, and being able to have a reasonable life style level, we [he and his girlfriend Allie] were very close to living really badly, to being homeless. We were hurting each other. This is hard to explain, watching her use, it affected me. Love began to change into annoyance. It's like this, when you begin to get high, everything is pleasurable, sex, drugs, 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 (interview, December 9, 2014).

Paul had learned to gain attention and affection from his peers by being reckless: drugs, gangs, street fights, these were all part of his skills. In the clinic he was clearly a favorite. Everyone liked him and they admitted his girlfriend so that she could undergo therapy. For Paul, giving up a life of drug use also meant giving up the recognition he had achieved in the streets. He was admired and appreciated; his luck was actually his charm, and the way he knew how to use people for personal benefit. Whether or not that made him manipulative remained unclear; he had learned to survive on his own at an early age, because he was

always alone. The need for recognition also appeared at an early age, when he felt undervalued in his own home. His dad was always angry. His parents were always working, and their marital problems occupied the rest of their attention. Paul found recognition elsewhere. He was very skilled at making friends wherever he went, including at the prosecutor's office.

Social identities were part of the struggle within the therapeutic spaces, and the presence or absence of a social network made a difference. Albert didn't have one; all he had was his ex-girlfriend's parents inviting him over for weekends, with no expectations of recovery on their part or anyone else's. Francisco had his girlfriend, the baby, and his parents. The staff felt that had helped him redefine himself.

Paul, on the other hand, fell straight through the cracks of his therapeutic process and would have a relapse. He was readmitted to the program, a practice the staff struggled to avoid because that made it seem like rules could be broken, and the therapeutics were all for naught. Paul responded by stealing the clinic's PlayStation video game console. He disappeared for over a year. He subsequently returned to the therapeutic process as an outpatient. His psychologist explained that, after breaking up with Allie, he met a woman who was a medic, began a relationship with her, and went back to high school. He found a job and seemed to be doing great. But a few months later, he broke up with her and went straight back to binge-smoking cocaine base.

Pasteurization of Addiction

Addiction is defined and understood as compulsory drug use that affects the life of the addicted: the person continues to use the substance regardless of significant problems associated with it (American Psychiatric Association 2013). It remained unclear if it was an impairment of the will or a form of disobedience. The disorder was also confusing in terms of what the patient needed to know about addiction and behavioral expectations after being *educated*. Education had been described, along with actions of 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 whites (Kingman 2002). Through *mestizaje*, differences are toned down, but superior-inferior dynamics remain in practice. The complex process of truth-finding at the clinic had shaped the therapeutic program into a civilizing process of pasteurizing subjects: the steps to a cure shed some light on the way the disorder was understood.

People arrived at the clinic in a state of disorder: they came disorganized, dirty, and malnourished; most chronic drug users were thin and generally unkempt. At the clinic, they were slowly trained to be acceptable citizens. The process began with personal hygiene, with patients learning how to perform basic daily activities such as showering and brushing their teeth. There followed a stage of development and potentiation of skills that would give patients access to the productive world, that is, undeserving addicts, so viewed by society, were to become productive members of it. Albert believed that this was the most difficult aspect of his recovery.

Albert. 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, and move in, 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 part of me 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 I can tell you that sometimes, carelessness wins. 'Now, I'm gonna go hang out somewhere, nobody is going to tell me anything, until I organize myself, until I get myself a family.' I boycott myself; I manipulate myself (interview, December 23, 2014).

Albert's concerns about recovery were mostly about facing the process on his own. Having a family seemed to have worked with Francisco; he had someone next to him balancing the two characters Albert referred to. But Albert didn't. Neither did Paul. When he left the clinic, he had Allie, a girl with the same issues he had. While he was with her, he had been inclined to favor drug use and theft. But when he met his new girlfriend,

a well-adjusted citizen, a professional, a medic, he was able to redefine himself. The balance shifted and Paul stayed clean for a while. Breaking up with her also broke the fine lines holding his recovery in place.

The path toward social reinsertion was described as free, open, and voluntary by the staff at the public addiction center. Iván explained that “we have around forty people who come because they want to, and you can see that they do a very good job of managing abstinence and conflict.” 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 on anyone.

The outings functioned as a way to teach patients to deal with the outside world, no longer having to numb reality through drug use. May took patients to different places, and there was always someone in the group who associated the site with their drug use. One day, the group went to downtown Quito, to the Panecillo.¹⁴

May. We had a guy who, it turns out, used at the Panecillo, and when we got there, he had an adverse reaction, he became nauseous, he vomited, he got bad, but this also helped him grow stronger. He was with the group, he was with the other guys, and he was able to talk. Those things are very satisfying here. In fact, you see changes and you see patients expressing themselves (interview, November 18, 2014).

Sometimes, the process of recovery extended to other areas, to experiences lived during addiction and therapy. One patient 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 carry a weapon. May worried that the freedom patients enjoyed at the clinic made it easier for him to find something he could use it as a weapon:

May. The need 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

¹⁴ El Panecillo is a hill located in Quito’s colonial center. A statue of the Virgin Mary stands at the top. The site is known to be a hot spot for selling and using base.

beyond his control, he feels he needs it for protection. But this has diminished, and he has turned in the things he had, like spoons and stuff (interview, November 18, 2014).

May's mention of the spoon made me smile. There had been a complaint 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 popsicles raised concerns, once again, revealing absurd representations of drug users. Still, the staff was involved in a civilizing process intended to reassure the clinic's neighbors: The addicts would eventually leave behind their primitive ways in order to become well-adjusted citizens. May explained: "They become adjusted here, they see other attitudes, and they adjust to them, the way they look at themselves." May was referring to a process of referential construction of the self through observing others in the same process. Addiction seemed to be related to the way people defined themselves. Not everyone used drugs; among those who did, not everyone developed problems. And among those who did, the problems were not permanent for all, some were able to stop using.

Paul's parents were satisfied with the process of self-reconstruction. After so many experiences with private clinics, finding a place where Paul received humane treatment made a difference for them. Gaby, in tears, explained: "At every other clinic, he has been treated like scum. But here, they treat him with respect. They don't look at him as if he were scum. His self-esteem has improved; at every other clinic it was destroyed." Jorge, Paul's dad, agreed:

Jorge. The way he is treated is different. But also, at the private clinics, there are practically no psychologists. Even at the best ones. It's really just a business, where mistreatment is the rule, typically with food, punishment. Sometimes I think they don't know how to treat patients, or they consider them untreatable, people with problems, dangerous. I do admire the staff. It must be hard to open a clinic, and these are people who, typically, were addicts themselves... just trying to do something to prevent these people from being on the street (interview, December 11, 2014).

Paul's parents noticed a difference when their son started his medication, something which he hadn't done in the past. Given their experience with the violence in private clinics, they felt that the public clinic operated according to professional standards. The medical perspective was a relief. On admission, their son had been "skin and bones," but after some weeks in the clinic, they could see the improvement. Because addiction treatment didn't involve submission through violence, Paul had the chance to think of things besides escaping or using. At the public clinic, he was wondering what he might become.

Paul. I'm a good cook. I've always loved cooking, but I don't think I want to be a chef, no. There's something else, I mean I love music [he had played the piano from an early age], but I don't like the bar atmosphere. Now 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 myself to music production, or maybe I could study psychology. Believe me, studying psychology would be very helpful, because I have good analytical abilities. Besides, all the bullshit I've been through, and still go through, it's like I've had good experience. But life is life, I'm 22 years old and this is the good thing about all this, there is a life ahead (interview, December 9, 2014).

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 at a clinic. The public addiction treatment center gave him a chance to reshape the way he looked at himself and at his life. It gave him a time to stop, to calm down, to think. He no longer felt like he was in a hurry; he was beginning to generate a desire for things other than drugs. It wasn't a matter of taming the abstinence alone. It wasn't just abstinence. It involved finding meaning in his life, beyond abstaining from the things which activated his reward system: mugging and using drugs. He could envision himself in a future that, in the past, he didn't think existed.

On the day the minister of health visited, Julio's mother spoke. She was simply thankful; her son had been consumed by the evil disease of addiction, she said, which caused her family years of suffering. She was an older woman, from humble origins. She held back tears as she spoke.

Julio's mother. How can we ever thank you? We can't, but God will pay you for your kindness, the heart you have shown towards my son and all these people, many of them live sick, abandoned in the streets, Madame Minister. To my sons, my family said, forget about him, leave him in the streets. But he's my blood, *doctorcita*, please help us. Not only me, but all of us here, and just as you came 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 repay you, Miss Minister (meeting, December 9, 2014).

For the families, understanding addiction wasn't yet associated with the right to health care discourse. They saw the clinic as a favor provided by the government, after finding only dead ends in the private recovery labyrinth. In spite of disciplinary measures, technologies of the self, or concerns about patient compliance, the public clinic offered a different approach to problematic drug use, something that needed research, and that could definitely improve, but that broke a pattern of systematic violence towards drug users, who had been left with two options: a private clinic or prison. The pasteurization of addiction was being pulled by inertia, as it wasn't really planned, but it gave a different feel to a disorder difficult to grasp.

In light of Latour's *Pasteurization of France* (1988), I wondered if the new agents in this form of social control were the substances, as the microbes were for the hygienists. From my point of view, it was the treatment provided in private addiction treatment centers that was the illness that needed to be pasteurized, that needed to be controlled, even more than drug use itself. The structure of treatment hadn't changed, just as foods and beverages are unchanged through the pasteurization process. Instead, the dangerous components, capable of harming consumers, are removed. The same thing was true of 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 that had been eliminated through pasteurization.

Dramaturgy

No studies have been done in Ecuador on addiction or addiction treatment. Instead, knowledge is borrowed from different contexts in order to generate a dramaturgy, an interplay involving health workers, made into bureaucrats by prioritization of procedures over care, who perform the theatrical work needed to remain employed, and patients who need a place to live in order to avoid homelessness or prison. Compliance solved some of the difficulties patients had with family members, exhausted from years of compulsive drug use and avoidance of responsibility.

The gradual increase in surveillance and disciplinary measures was revealing concerns about job security. Dividing the therapeutic process into different spaces, together with assigning responsibility for spontaneous demand determination to the intensive outpatient centers, improved the public clinic's success rate. Results were monitored, regardless of the difficulty in defining the health problem in question. The clinic was trying to reach a balance that worked for everyone: on the one hand, the public addiction treatment center workers, who needed their jobs, on the other, patients looking for housing and food. I asked Albert, during his first stay, why had he come to the clinic.

Albert. Because I had nowhere else to go. They told me I had to leave the place I was staying at. 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 get in. When I was in outpatient, I partied on weekends and that wasn't working. I was becoming more irresponsible and my social life was being destroyed completely. I was left with nothing (interview, November 14, 2014).

The following year, Albert was at the clinic for the second time. He was tired of the scheduled therapeutic activities, he no longer enjoyed structured meetings, and he was bored. But he still needed a place to live.

Albert. 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 just a process of reciting stuff that made no sense but that made everyone happy. I remember one day a doctor came to 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 that attracts more attention and so on. I swear to you, sometimes they seem retarded (interview, September 8, 2015).

Nine months into his second stay, 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's easier to just do that" (interview, September 8, 2015). Albert began to play the role of a compliant patient, but he couldn't find a job or an apartment. When he did, he left for the second time, only to fail again and return to the clinic. As noted, after his third admission, Albert was sent to another clinic where, per Juan's request, staff did not require him to perform as a patient as there was no reason to expect that the new clinic in the rainforest could make a change in his life.

Private clinics encourage a performance in which the addicts confess their problem over and over, their most horrific experiences, read the Bible, show remorse. Beyond the walls of these clinics, however, the outside world becomes the backstage where they reveal their true self, acting out vengeance towards those responsible for their confinement in the private clinic, performing failure through binging. The public clinic is subtler: even though there are dramatic spaces, patients are more tightly controlled in the sense that performance calls for something else: the manifestation of an engagement with individual processes, the acceptance of treatment. Expectations of recovery focus on the individual's manifest behaviors. Albert is an example of a well-adjusted actor who, regardless of playing the role expected of him, fails to adjust 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 based on ambiguity. Shaped by moralistic slogans, such as “say no to drugs,” the war on drugs remains in force even though the reasons for its existence have been contradicted by its own guiding principles. While some drugs are framed as such and treated as evil, drugs remain essential actors in society; from medicines to coffee, virtually everyone uses them. Yet, those framed as evil are the center of violent approaches, with an entire war fought to combat them. In practice, the years between 2007 and 2016-2017 witnessed great changes in drug policy, shaped by harm reduction discourses, but culminating in a return to a security rhetoric – which never actually disappeared and allowed for the return of prohibitive measures and punitive policies. Amidst this contradiction, Ecuador has introduced a public health perspective to its approach to illegal substances.

While public health has been celebrated as a key aspect of drug policies, and rhetoric emphasizes the unfairness of repressive policies, the country has reinforced the penal approach by building more prisons and introducing the concept of maximum security within them. Perhaps unwillingly or unwittingly, policies have also increased corruption within the prison system. Addiction is not avoided in prison; in fact, some prisoners become addicted while serving their sentences. Meanwhile, public perception of addiction is linked to criminality, which can be seen even in health centers, such as the public addiction treatment center. In a vicious cycle, imprisonment ultimately feeds what it is supposed to fight, while markets are left untouched.

There has been no public debate in Ecuador about illegal drugs and the factors leading to their use. This raises new questions about drug war democracy, its meanings, and its practices. Social movements opposing prohibitionist logics were silenced and blocked from public debate, leaving only those voices aligned with the prohibitionist stance, a practice seen in other areas of social struggle during, for example, the Constitutional Assembly of 2008. Those who were able to participate went in with an illusion of being able to implement changes from privileged cultural and political spaces. Yet, this form of “citizen participation” seems decidedly unrealistic; as anti-prohibition movements object to new drug policies, they often find they themselves blocked from expression or influence in the political arena, while their own ideas are still influenced by that which they oppose. The marginalization of anti-prohibition forces has delegitimized them in the eyes of the public, and certain movements have grown to accept the exclusion of others, a process which might be called “silencing of debate,” which risks their very existence through isolation. Only Diabluma and Ecuador Cannábico, for example, have publicly debated drug issues, while the LGBTI movement has been virtually alone in raising awareness regarding private addiction treatment centers. Still, the movements mentioned began with a discourse which suggested the removal of cannabis from the list of forbidden substances, while leaving the prohibitionist approach unquestioned.

In recent years, we have been offered a series of speeches that seem to please official audiences: CONSEP was so obedient that it became an exemplary institution copied by other Latin American countries, while at the same time it began producing research that questioned the status quo. In the end, the president of the Republic decided to close CONSEP, replacing it with an institution that answered to the executive branch and lacked the independence enjoyed by its predecessor. The Secretaría Técnica de Drogas responded only to the president, as opposed to CONSEP, which was composed of several institutions. In 2018, this Secretariat was closed and its functions were divided among the Ministry of Health and the Ministry of the Interior, respectively.

The contradictory nature of drug policy allows a degree of arbitrariness to thrive within the judicial system, including the police, courts, and prisons. A history of the laws shaping the way illegal substances and

substance use is represented demonstrates continuity in the change from addiction defined as a crime to addiction defined as a health problem. The idea of dangerousness as well as the need for confinement as the therapeutic approach remain fundamentally intact. Criminalization prevails, and drugs are considered malevolent agents, capable of generating a disease that impairs the will. The effects of this ideological view would seem to reproduce the approach that characterized the security paradigm, while the expected results, such as a decrease in prison rates, have been only temporary (Paladines 2017). Emancipatory measures, such as drug regulation or legalization, is no longer discussed in the halls of government; any attempts to propose new policies within this paradigm, even when they come from the state, are silenced from within.

By defining addiction as a public health problem in article 364 of the 2008 Constitution, the state is required to offer treatment for all users, from the occasional to the problematic. Once again, this locates the disease in the behavior and the substance, rather than within a historical context or interpersonal dynamics: drug use is enough, there is no need for differential diagnosis processes as even the occasional user is considered in need of treatment. The 2015 counter-reform, moving back towards a more punitive approach to drugs in general, meets with 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 from 2007 to 2017.

However, these changes, which were viewed as hopeful by many, face a complex set of relations that intertwine different aspects of society, 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 illegal substances, making of addiction studies a privileged space for the study of culture, politics, and society. Yet, drug use is still approached primarily from a security perspective.

As the state attempts to regulate addiction treatment, the new addiction rehabilitation centers are more than medical treatment entities.

At the public clinic, the multidisciplinary approaches are intended 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 range of behaviors society allows. From this “realistic perspective,” medical discourses become reflections of the political, moral, and epistemic orders established by those in power. Addiction subjectivities show not only the relation of the individual with a substance, but also reveal a complex life experience that interacts with society’s social, economic, moral, epistemic, and legal regimes.

Public addiction treatment implies actions by the state, a welfare state trying to save the lives of its citizens – the state’s actions are performed by individuals, such as health workers, and observed through official rationalizations that justify them. The rehabilitation clinic is an institution that condenses a series of power relations that take shape in the day-to-day realities of addicted subjects, reworked in the form of medical, family, legal, or religious discourses.

The concept of addiction – its definition and therapeutic approach – is based on representations which result in human rights violations in the name of healing, while creating a profitable market for behavior modification. Through ethnography, the subject of addiction becomes 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 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, and epistemic frames that shape it. This study, therefore, offers a starting point for understanding the complexity of addiction and its treatment as a space for reflecting on power relations in Ecuador.

As Ecuador’s domestic policies shape new ways to address the relation people have with certain substances, public centers for the treatment of addiction open new spaces for relevant social research. My ethnography has brought together different, methodologically distinct ways of approaching the experience of people going through rehabilitation for 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 findings with participants implies the right to become more than they are typically reduced to by a specific discourse, whether legal, medical, or otherwise. Ethnography opens the door for complex analyses of human matters, including fulfillment, suffering, abandonment, belonging, and everything that is part of the act of living through addiction.

While study of the public addiction treatment center can be used to identify major elements put into play in the power relations generated through moral and knowledge discourses, it also poses more questions than answers. However, one important outcome of ethnographic work is the possibility of questioning the "evidence-based medical approach" through practices that occur during day-to-day existence at the clinic, as an exception that reaffirms the rule.

New discourses reveal themselves to be versions of the old, put into play through the coexistence of surveillance and control exercised by the sovereign power that decides who lives and who dies. The study of addiction treatment in the discursive context of state anti-neoliberalism, depicted as progressivism but maintaining conservative perspectives, serves as a magnifying glass of what happens beyond the unfettered capitalist apparatus, and in the lives of those governed by it.

Addiction treatment's failures and abuses are not the result solely of neoliberal policies that pervert therapeutics for profit. The problem goes beyond the market issue, as the inclusion of addiction as a medical category in the 2008 Constitution ultimately fails to generate a model of care. The emphasis placed on the will, whether it is on impaired functioning resulting from drug use, or as the requirement for accessing 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 that is never fully resolved in therapeutic spaces alone. Those who do "recover" have a reasonably well functioning social and familial network, and are less

dependent on the way they are perceived by the outside world. Those who lack such networks face reduced possibilities for successful social reinsertion.

One of the clearest aspects contributing to abuse in addiction treatment is the “behind closed doors” policy found at private clinics. The hope that these abuses can be eliminated with surprise visits and regulations from authorities is a mistake. Not only is this type of control and assessment unsustainable, it is also susceptible to corruption. The entire system risks the return of practices reported by the LGBTI movement and corroborated by the state, as indicated in the “Mental Health Policy” of 2014. Indeed, by reporting the conversion therapies applied in private addiction treatment centers, the LGBTI movement was able to unmask businesses profiting from family fears and social stigmatization, by offering punitive practices in spaces other than prisons. The pressure generated by the LGBTI movement forced the state to intervene in private clinics, which in turn resulted in many being shut down and many more being regulated. This is where the public clinic came into being, as it was originally designed as a contingency area for those admitted to private centers that had been closed.

In practical terms, what would work best is the self-regulation of private clinics, which would be possible if an open-door policy were instituted. This process would need to include families, as their own beliefs and representations are the main supporters of closed-door policies, due to the stigma associated with drug use. And since the family that decides to commit a member to a private clinic finances that individual’s treatment, “coming out” as families of addicts should be encouraged, just as it has been for those living secret lives amidst sexual diversity. Silence reinforces stigmatization and allows abuse to occur. Drug policy should focus on this aspect in order to improve the situation of private clinic patients.

Stigma is not solely responsible for family silences and complicities. Rather, it is also the result of laws, policies, and institutions that shape the way society relates to drug use. This largely unspoken ideology on which they are based affects not only the private clinic realm, but public addiction treatment centers as well.

Whether or not addiction is a medical problem is not clear in practice. And while medical components are involved in addressing addiction, the

public clinic has not been able to escape punitive responses to addiction. Technologies of the self are still the key components of the therapeutics involved in addiction treatment.

While the most recent law defines addiction as a socio-economic problem (Asamblea Nacional 2015), I doubt that drug use is the result of the lack of a job. In the course of this research, I came to realize that the way drugs and users are depicted is problematic, one of the many problems related to drug use. Panic regarding drug users is ever present in official discourse. Ecuadorian society hangs on to a rhetoric born in the war on drugs.

It is therefore necessary to face down these discourses critically, asking ourselves about unproblematic drug use and debunking drug myths in spaces other than the clinics. Research on largely unproblematic drug use is necessary to rework the way drug use is 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 which include those who use illegal substances. Moral panic, criminalization, and medicalization – all have worked to stigmatize and silence people who use drugs. Drugs are part of culture, and drug users are part of society.

The inclusion of addiction as a health problem in the 2008 Constitution does not automatically generate a health care model of treatment. 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 viewed in large part as criminal. This could be compared to other countries (and currently, Ecuador) where courts have ruled against chronic mental health problems as an emancipatory strategy against unnecessary commitment. The matter is too complicated to be resolved by a single policy or decree. The consequences of assuming that emancipation is something which comes from above, in these cases, can be dramatic, such as homelessness or abandonment in hospices.

While I haven't given enough attention to women in public addiction treatment, their situation will not improve by simply including gender components in treatment plans. Women, and how they are treated in clinics as well as in society in general, involve sets of representations

or theories defining not only their behaviors in relation to addiction, but their very nature. More than working on gender components, I believe that the first thing that needs to be addressed relates to the unconscious theories of the feminine operating in everyday practices. Again, what comes to mind is an idea that treatment is the illness that needs intervention.

The redefinition of addiction as a public health problem, in the Constitution of 2008, and the creation of a public center for addiction treatment demonstrate how representations are not changed by decrees or regulations coming from above. Instead, definitions of reality should be the result of rational, public debate. Most people agree that dehomosexualization practices and conversion therapies are wrong, as these matters have been publicly debated. Given the opportunity, Ecuadorian society is just as capable of rational public debates about addiction.

Policy recommendations are always well received, I understand. NGOs and the state itself usually pay for research leading to recommendations for policymakers. But I do not know how this research should affect policy when it comes to drug use. What I do know is that policy must not be designed from above, drawing from specialized knowledge used in a form that ends up legitimizing the reproduction of repressive practices.

I hope that, rather than generating specific policy changes which end up maintaining the status quo, this kind of research will contribute to a growing public debate regarding drugs and the way we relate to them. The debate should be open, just as private clinics should, and not limited to political authorities, academics, and representatives of religious groups. The debate should include drug users, both occasional and problematic, and their families, both men and women.

The objectives for any debate should be more than policy-making. The main objective should be the generation of a more nuanced understanding of drug use, addiction, and subjectivity, and it should include a reflection on this compulsion to treat through coercive mechanisms. Indeed, I believe society, as a whole, needs to be treated for what private addiction treatment centers have become: a symptom of our society's acceptance of the torture, starvation, and humiliation administered with the tacit approval of families, police, doctors, and judges, with

nearly everyone else looking the other way. We should be more ashamed of addiction treatment than of addiction itself.

Public addiction treatment does offer the opportunity for different modes of engagement with addicted subjectivities. But its existence alone 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 in these spaces, which is a reflection of what goes on in society. Private clinics require self-regulation. If the objective in a therapeutic approach is that people with conflictive drug use self-regulate, treatment facilities also need to do so, and this will only be possible with public awareness of what goes on inside. Ethnographic studies help unveil these practices, shedding light on complex social relations that affect not only patients, but society as a whole.

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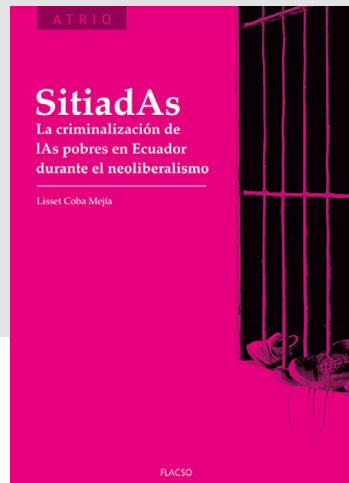
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Ana Isabel Jácome-Rosenfeld's *A Question of Will* is a gift of moral acumen, providing the world with ethnographic insight and conceptual clarity. Pundits across the political spectrum can debate the pros and cons of drug prohibition and its fifty years of policies, but it took a scholar trained in the art of ethnography and the science of psychology to engage, face-to-face, those people affected most by the criminalization and medicalization of addiction.

The short story is that the 2008 Constitution of Ecuador defines addiction as a health problem, and this marked a shift from a prohibitionist approach to drugs to the rise of public addiction treatment centers. These centers have not only become privileged spaces to understanding the transition from criminalization to medicalization, but also the many contradictions that the medicalization process advances. One of the most beautiful elements of this book is that Jácome also engages the employees of these centers and the families of these patients. They, too, have become embroiled in addiction.

Beautiful, timely, and yet also timeless, this book invites the reader through its stunning prose to enter the public addiction treatment centers of Ecuador—to understand that addiction must not be reduced to a question of will.

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