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One Step Forward, Twelve Steps Back: Examining Alcoholics Anonymous and its Neo-Colonial Implications for Men in Cuenca, Ecuador

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Senior Honors Thesis

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Table of Contents

Abstract

This study, based on one month of ethnographic fieldwork and qualitative interviews, examines how Alcoholics Anonymous (A.A.) functioned at a drug and alcohol rehabilitation facility for men in southern Ecuador. I argue that, because A.A. has its roots in the United States and in distinctly American interpretations of Judeo-Christian doctrines, many of the key features of the twelve steps and its therapeutics are irreconcilable with aspects of Ecuadorian culture with regards to cultural identity, issues of masculinity and *machismo*, and religion. Many of the twelve steps and the goal of ultimate abstinence in A.A. do not align well with these cultural factors. Because success in A.A. relies on an identity transformation into a particular kind of "alcoholic subject" and because members must reconcile their identity with the culture of A.A., I contend that, in the Latin American context, the program acts as a neocolonial practice that attempts to refashion the body and "self" into an Americanized way of being. In making this argument I demonstrate that merely because a healthcare program is American or Western does not entail ultimate success internationally; rather, a system of therapeutics must take into account the culture and individuals that it is serving to best care for the patient.

Keywords: Alcoholics Anonymous (A.A.), Ecuador, machismo, cultural identity, neo-colonialism

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Introduction

Day One

My first day working at *Twelve Steps*, a drug and alcohol rehabilitation clinic in Southern Ecuador, the director of the program, Andrea, proposed a quick trip to *la tiendita* at the end of our lunch break. Two of the psychologists and the two interns joined us on this short walk to the convenience store, a side-of-the-road spectacle that consisted of a small counter and a covered area with a picnic table. We all settled in, discussing a patient's outburst in the morning therapy and wrapping scarves around our limbs; another Monday afternoon. Andrea eventually excused herself and went to the counter, exchanging a few coins for a cigarette. We watched as she inhaled, exhaled, sought solace in the smoke, let the fire flush her cheeks. Andrea let it burn to her cherry-red fingertips before she took a breath mint out of her purse. She noticed us watching her as she tongued the mint, before she exclaimed: "What! The patients can't know that I just had a cigarette!" We all laughed, tugging on our sweaters in the alpine air. The irony inherent in her statement at once became very clear to her, and her expression reflected this realization; she suddenly turned solemn, her lips turning downwards. "I guess we all have our addictions, don't we?"

The Nation of Ecuador

Ecuador is a small country in South America with a population of 13 million people (INEC 2015). It has both urban and rural areas, and there are four distinct regions in the country: the coastal zone, the *sierra*, or highlands, the Amazon rainforest, and the Galápagos Islands. Each of these regions has a unique culture, with its own set of

traditions, histories, and cultural ideologies, but there is also a widely understood shared *Ecuadorian* identity.

The majority of the nation racially self-identifies as *mestizo*, or mixed (Price 2003); as expected, the corresponding culture is rife with both remnants of Spanish colonialism as well as the traditional Andean worldview. For such a high rate of *mestizaje*, or mixing of races, though, the government still prefers *blanqueamineto*, or progressive "whitening" of the population in both culture and goals: essentially, the actions of the government imply that they would prefer the population to be more European than to preserve its traditional, indigenous roots. Governmental programs that aim to reduce distinctiveness or that celebrate *mestizaje*, especially in urban areas, persist (Price 2003:213). This is seen through the system of medical plurality as well—there is the pervasive idea, both supported through governmental means as well as in general society, that Western biomedicine and therapeutics is more efficient and overall better than traditional Ecuadorian systems of care. Patients who use Western remedy techniques can actually elevate their social class, while using traditional forms of care may suggest to others that the individual is of a lower class (Price 2003).

Demographically, the country is conservative, with Catholicism as the established national religion. As a result, 80.44% of the population identifies as Catholic; the next most prominent religion is Evangelical Christianity, comprising 11.30% of the total population (INEC 2015). The people do not simply identify with the religion; rather, the country is marked for its religiosity. For example, it is common to cross oneself while walking in front of a church or saying, "may God bless you" whenever someone leaves the house. Another remnant of Spanish colonialism is *machismo*, or "the emphasis or

exaggeration of masculine characteristics and the belief in the superiority of males" (Giraldo 1972). *Machismo* takes many forms, including the importance of heterosexuality, aggressiveness (especially unto women), the lack of emotions and feelings, and "the capability to intake large amounts of alcoholic drinks without necessarily becoming drunk" (ibid.).

Problems with Consumption

The consumption of drugs and alcohol, in Ecuador as in the rest of the world, represents a large problem for public health—in terms of physical as well as mental health. Harmful use of alcohol is one of the leading causes of morbidity, disability, and mortality worldwide (WHO 2014). According to the World Health Organization statistics for Ecuador (WHO 2004), the excessive consumption of alcohol had a prevalence rate of 8% in males older than fifteen years old; moreover, in individuals aged twelve to forty-nine, the probability of consumption of alcohol was 76.4%. This is in comparison to 6% of identified substance use disorders for all of Latin America (Sojo 2011:6; WHO 2014) and a rate of 7.4% for both men and women in the United States (WHO 2014). The availability and accessibility of alcohol is a crucial factor that explains, to a certain extent, the high rates of consumption: the majority of stores in each town—from the Amazon to the coast, in the urban sectors and the rural—sell beer by the *jaba*, or in cartons of twelve liters, for $11-15 USD. I have observed various teenagers, still dressed in their high school uniforms, buying a *jaba* and a pack of cigarettes at one o'clock in the afternoon, in the middle of the week; also, it is common to see adolescents drinking liquor directly from the bottle during the day in a public park. According to Leonore

Cavallero (2015), an intercultural specialist from Ecuador, "it is a country where alcohol is typically an integral part of the culture; the men, many times, especially teenagers but not only them, consider it an essential part of their relationships with other men."

Alcohol addiction is not only a problem in Latin America; rates of substance use disorders from alcohol in the United States are the highest among any other drug, making it "the most prevalent drug problem in the United States" (Wilcox 1998:3). 64.5% of all Americans with a substance use disorder are addicted to alcohol, with the next drug of choice, marijuana, claiming 15.7% of that population (SAMHSA 2014).

Although I will discuss the social meanings and models of addiction in further detail, recent studies have shown clear correlations between brain processes and the causes of addiction (Camí and Farré 2003). Drugs, like alcohol, that lead to addiction are characterized biologically through the activation of parts of the brain that cause a feeling of subjective pleasure (ibid.). Addiction works in a cycle of motivation, reward, withdrawal, and a return to motivation. Within the motivation cycle, dopamine is the neurotransmitter that is most highly involved (ibid.) When exposed to a reward so frequently, an individual will begin to experience a withdrawal and crave the reward, increasing their motivation towards actions that will lead to them receiving this reward (ibid.) Motivation will continue to increase until the brain interprets this reward as no longer something pleasurable and hedonic, but rather a necessity for survival and a vital aspect for maintaining homeostasis within the body (ibid.)

However, addiction is not only biological. Ecuadorian culture plays a large role in the onset of addiction; as Guillen and Nascimento (2010:600) note, "children and adolescents can be exposed to diverse risk factors, whose interaction influences the abuse

of drugs [and alcohol], such as the familial environment, an individual's own personality traits, the influence of partners, and the social environment." This form of consumption, especially in a culture noted for its *machismo* and religion, engenders a cultural and medical crisis in which relatives of the addict or the addict himself seek out professional help. However, for a rehabilitation clinic to function, it must adapt its therapeutic practices to the culture in which it finds itself.

Modern Ecuador still bears the scars of its colonial past: the main religions, Catholicism and Evangelical Christianity, only exist in situ because of conquistadors enslaving the indigenous and forcing conversions. The language that is spoken, Spanish, is a constant and subtle reminder of the nation's imperial history. Even the currency conjures the notion of modern neocolonialism in the country: after a financial collapse in 2001, the country adopted the United States dollar. Consequently, every monetary transaction recalls the fact that Ecuador is still, by some means, controlled by the West.

Illness Management in Latin America

Illness management is highly socialized, and the significant conception is that *the best* systems of care are those that have Western roots. However, anthropologists argue that the best healthcare system takes into account the culture that it is serving, relying on local understandings of illness, health, culture, and society to inform the best therapeutics (Bennett and Cook 1996:248-9). How are individuals treated as patients in a society that believes that what is Western is better—especially when discussing healthcare?

In terms of treatment for substance use disorder—more commonly described as *alcohol addiction* or *alcoholism*—these same trends apply. Alcoholics Anonymous

(A.A.) has arguably spread so rapidly and extensively due to the belief that Western forms of care are inherently more effective than local understandings. However, several core features of A.A.'s therapeutics and mentality are irreconcilable and incongruous with Ecuadorian values or the worldview of its populous. When the program is merely translated into the context without addressing any of these disagreements, it is necessarily done so with an imperialist nature. A.A. acts as a colonizing force to "Westernize" the body, or transform the patient into how the West believes an alcoholic *should* act, so that it then can treat him through Western therapeutics and methodologies. This is potentially culturally dangerous, as the program relies on an identity transformation from a drinking non-alcoholic into a non-drinking alcoholic (Cain 1991; Wilcox 1998:111), and by proxy, from their previously conceived cultural and ethnic understanding of self into one that is defined and controlled by Western ideology.

Alcoholics Anonymous

The twelve steps of Alcoholics Anonymous, a popular and internationally implemented North American organization, is the most commonly accepted system of care for addiction treatment around the world. It boasts having over two million members in more than one hundred thousand groups worldwide (Alcoholics Anonymous 2014a). It is based off of the ideology as determined by Bill W. and Dr. Bob, the co-founders of the organization in 1935. As the story goes, Bill W. had a spiritual awakening in a hospital room after a night of excessive drinking, and realized that his addiction is not a moral failure but rather a disease (Alcoholics Anonymous 2001). Only by the help of God and admitting his own powerlessness under the substance was he able to remain abstinent. He

worked with Dr. Bob, another self-proclaimed alcoholic, in Akron, Ohio, and they both recognized that sharing their stories with others helped them with their own sobriety (ibid.) In 1939, with the publication of the book *Alcoholics Anonymous*, the fellowship began to spread across the country, and eventually, internationally (ibid.)

As alcohol-use disorders became more recognizable abroad, many new A.A. groups were formed to deal with individuals who needed and desired support. Like the conception in Ecuador, as determined by my fieldwork and other researchers (Price 2003, for example), there is often an idea in developing nations that Western forms of care are inherently more successful than the care provided locally. I argue that a key impetus for the spread of A.A. is this conceptualization of Western healthcare. This is demonstrated through membership worldwide: by 1986, two-thirds of A.A. members resided outside the United States (Vaillant 1995:268). Moreover, in Latin America specifically, there are three times as many A.A. groups per capita in Costa Rica and in El Salvador as in the United States (ibid.).

The therapeutics of A.A. is managed by the twelve steps and the twelve traditions, both of which date back to early conversations with Bill W. and Dr. Bob in Akron. Both of these are delineated in the Appendix.

Twelve Steps Therapeutic Community

The "therapeutic community" where I did my fieldwork was located in the city of Cuenca in the south of Ecuador, the third largest city in the country. The rehabilitation center, which I have named *Twelve Steps*, is located in an urban zone of the city. The center is for males of all ages, and the patients that were there during the time of my

fieldwork ranged in age from their 20s to their 80s. In fact, a patient celebrated his 84th birthday while I was working present. The clinic is completely privately funded, and all of the patients going through treatment must pay for their stay. The patients live in the clinic without the possibility of leaving and receive treatment for six months. As part of the clinical staff there are psychologists, psychiatrists, doctors, "experiential" therapists, and social workers. The patients receive psychological therapies, as well as experiential-based, sport-based, and spiritual therapies in an individual setting, group setting, or familial setting throughout their six-month stay. The men at *Twelve Steps* suffer from addictions to all types of substances, including but not limited to alcohol, marijuana, cocaine, and heroin. However, the majority of men were addicted to alcohol, and the clinical techniques are based off of the ideology of Alcoholics Anonymous rather than other twelve-step programs such as Narcotics Anonymous.

The clinic itself is a four-story, nondescript building on the outskirts of Cuenca. It is gated, and for the majority of the day, the entrance gate is locked so that the patients remain inside the facility at all times. The staff offices are located on the lobby floor along with a waiting room, kitchen, and the therapists' offices. In between that floor and the next, there is a heavy padlocked gate so that the patients stay only on the top floors. There is only one set of keys, and it is kept on guard by one of the staff members on the lobby level.

The third level has some of the patients' rooms along with the main therapy room. The patients share their rooms with one or two other patients, and the living conditions are meager and dingy. The therapy room is dim and musky: even though it has three large windows, heavy bars and thick tinted window shields obfuscate the light. It is impossible

to make out anything through these windows, which are replicated throughout the upper levels.

The therapy room is a long space with chairs arranged in a lopsided semicircle around a podium at one end. It is completely grayscale; aside from a few signs on the walls, it is wholly monochromatic. The podium is in front of a whiteboard, which is often used to demonstrate key concepts or to write daily meditations. Along the walls are signs with motivational quotes, the only colors in the space, that are meant to inspire the patients to have the strength to continue the therapeutic process. These quotes are emblematic of the Alcoholics Anonymous model and invoke both inner fortitude as well as reliance on a higher power, or God, for assistance. Examples of these signs include: "Speak and you will save yourself;" "One step at a time;" "Shared pain is less pain;" or "Even though we are not responsible for our illness, we are responsible for our recovery." They were placed haphazardly and slanted across the walls, lilac against overwhelming gray.

The men had a strict daily schedule that involved waking up early, eating breakfast, having therapies for eight to nine hours a day, eating dinner, and going to sleep. Each day was routinized and relatively invariable. On Monday, Wednesday, and Friday, the patients had two hours of sports, in which they were able to leave the upstairs levels of the clinic and go outside. Aside from this, outside time was extremely limited. The majority of the day was spent in the main room engaging in different therapies. The "group leader," a patient who had been there for a significant amount of time and showed promise within the group, often led the other patients in daily meditations, activities, or the Serenity Prayer, which is a custom within all Alcoholics Anonymous programs

worldwide. Other therapies included an experiential therapy, in which a recovered addict shared his story and wisdom about staying abstinent and following the twelve steps, or a spiritual therapy, in which a religious leader from the community came to preach about how the Bible can help in therapy.

The men who sought rehabilitation at *Twelve Steps* arrived at the clinic through various means. Several of them chose to attend the clinic voluntarily, but many others were coerced by their families, either with their hesitant approval or against their will. I spoke to a number patients who shared stories of being roused in the night and transported to the facility by mysterious men, to be locked upstairs for some months. The scene conjures up images only out of nightmares.

It is important to recognize that a key aspect to Alcoholics Anonymous' program is willingness, as well as abiding by the twelve traditions. These are violated, in many respects, by the practices at *Twelve Steps*. For example, it ignores the third tradition ("The only requirement for A.A. membership is a desire to stop drinking"), as many of the patients at the clinic felt like they did not have a problem and did not want to stop their behaviors (Alcoholics Anonymous 2001). The lack of willingness that is a key aspect of both the twelve steps and the twelve traditions is a significant impediment for rehabilitation in A.A. and remains grossly against the mission statement of the fellowship. Furthermore, the sixth tradition strictly mentions that an A.A. group should never "finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose" (Alcoholics Anonymous 2001). Because the clinic is privately funded and associates itself markedly with A.A., it again disrespects another one of the traditions. These are

major concerns with how *Twelve Steps* functioned in relation to the policies and procedures of A.A., and certainly should be considered when reflecting on the efficacy and success of the program for Ecuadorian men.

Cultural Psychology

What quickly became clear to me during my time at *Twelve Steps* was the importance of a therapeutic program that addressed the culture that it is serving rather than attempting to transform the patient to fit the program. This idea is the central theme of "cultural psychology," or the theory that cultural context influences an individual and that it is necessary to adapt the therapeutic practices for the society. Stephanie Fryberg argues that cultural psychology "acknowledges the powerful role that cultural contexts play in understandings of self and identity. That is, cultural contexts provide important cues and messages about what it means to be a 'good' or 'healthy' person" (Fryberg 2012:442) Moreover, an inherent ideal within this theory is that "our psychotherapeutic practices depend on culturally specific concepts and values" (Kirmayer 2007:223). As one of the patients at *Twelve Steps*, Yayo, said, in comparison with North Americans, Ecuadorians "lack discipline, we are of a different race." Even though I perhaps would not consider this comment as a generalized truth, I agree that it is necessary to take a culturally relativistic perspective when we talk about culture and mental health. This academic perspective is very interesting in the context of *Twelve Steps*, given the fact that the program originated in the United States. The idea of a therapeutic program whose main aim is to transform the identity of the patient into its own Western conception of an

"alcoholic" is both necessarily neocolonial as well as against the ideals of cultural psychology.

Garcia (2010:9) argues that the "Hispano addictive experience is closely related to history and not merely cultural or personal pathology, as is so often described;" therefore, it is not only obligatory that one considers how A.A. fits within an individual and cultural space, but one also must recall Ecuador's history of colonialism and dispossession in order to fully understand how substance abuse functions. This must also inform the type of care that is offered. I argue that A.A. ignores several key cultural aspects of the Latino experience, specifically the concepts of *machismo*, the role of religion, as well as the history of the Andean region. Instead, it acts more as an imperial force upon the people rather than a healing one.

Methodology

General Methods

I first encountered *Twelve Steps* while choosing a site for a month-long fieldwork project I completed as part of a study-abroad program in Ecuador. Due to my interest in mental health care and therapeutics, I wanted to find a site that negotiated with the Ecuadorian healthcare system on a unique cultural level; the option to conduct fieldwork at an addiction rehabilitation facility that utilized the twelve step program from Alcoholics Anonymous was an intriguing option for me. My academic director contacted the site director, and my placement was arranged.

To complete my project at *Twelve Steps*, I utilized several forms of observation and interviewing: I observed the therapeutic practices by different clinicians; I led a writing workshop as a form of therapy; and I conducted formal and informal interviews with patients and staff, with their written consent. All of the data I present was obtained after informed consent was given to all participants in the study.

My attire and choice of dress was an important aspect of my daily life at *Twelve Steps*. All of the clinical staff either wore a uniform that bore the emblem of the clinic or they donned a white coat, while all of the patients wore a blue or gray sweatsuit with the clinic's logo emblazoned on the front. My individual choice to not wear a uniform, neither that of the patients nor of the staff, made it possible to differentiate myself from the therapists while maintaining the identity of someone from the outside. It was apparent to the clinicians as well as the patients that I occupied a unique role at the clinic, which was vital for completing my fieldwork.

I also attempted to differentiate myself during my observations of the therapies. While the leader stood at a podium at the front of the Therapy Room, all of the patients sat in a circle on wooden upright chairs. I chose to sit on a chair outside this circle of patients. This permitted me to observe everything during the therapies while interrupting the natural order as minimally as possible. I did not participate directly in the therapies, but I instead observed and took notes.

Writing Workshops

For the writing workshops for the patients, I prepared six distinct lessons that I instructed over a period of two weeks. I explained my role in the clinic (that I was a student from the United States doing a study about therapeutic practices), and that I was *not* a psychologist or a doctor. Moreover, I told them that I was not going to collect their work nor force them to share what they wrote unless they wanted to give it to me or share it publicly with the rest of the cohort. I wanted to separate myself from the staff so that they could be honest with me; perhaps if they had thought that a psychologist was going to read their writing, they would have been dishonest or would have tried to manipulate the reader through their writing. Every day, I reminded them that I was only a student and that I had no relation to the staff or any effect on their stay at the clinic.

During the workshops, I attempted to explore the genuine feelings and emotions of the patients. I observed that, sometimes, the patients did not feel comfortable sharing their true emotions in the presence of the therapists; as a result, I wanted to foster a space in which they had the liberty to express themselves honestly. The first workshop was aimed to be a fun exercise to start the writing process: each patient began a story with one

sentence, and passed their story to their neighbor; each patient added a sentence to create collective stories. The second exercise explored the feeling of happiness; each patient wrote a story that started with the phrase "A través de mi adicción, me di cuenta que…" ["Through my addiction, I realized that…"] and ended with the phrase "….y yo sería feliz" ["…and I would be happy"]. The third workshop was centered on regret: the patients wrote about events in their life that they regretted, and how they would change the situation if they had the opportunity to relive those moments. The fourth workshop was an exercise in which the patients wrote letters asking forgiveness to people that they have hurt through their addiction to explore the idea of repentance. In the fifth exercise, they wrote about a moment in their life through the perspective of someone else that they may have hurt, which was meant to assist in empathy. Finally, in the sixth workshop, they wrote "the story of their life" in the space of a quarter sheet of paper; after that, everyone wrote "the story of their addiction" on another quarter sheet, and afterwards we discussed the different identities within each story. In this last exercise, I hoped that the patients would recognize what key moments or memories were part of their lives in general and in their lives as addicts, and how to reconcile the two and engender positive change moving forward in sobriety.

I envisioned these workshops functioning in the specific group that they were to be delivered to: for a group of Ecuadorian men. Due to the *machista* complex inherent in society, it is generally uncomfortable for the men to be open about their emotions, and as a result I did not coerce anyone to read his writing if they did not desire to do so. Additionally, I structured the workshops so that they would be beneficial to the process of rehabilitation. I used, as a basis for the exercises, scientific studies that examined the

importance of writing as a form of treatment for mental illness. One study notes that "language, narrative, or storytelling is an essential element in the construction of a coherent identity, sense of self, and connectedness to others, and therefore, a powerful tool in creative therapy" (King et. al. 2013:445). Essentially, "the process of narrative therapy involves creating an alternative story by searching for exceptions to the dominant story, which then open up possibilities for the person in therapy to re-author their life" (ibid.:446). Moreover, an incredible finding for me was that "a key component of the success of the workshop was that it was conducted by a person whose expertise was in creative writing, rather than in mental health. This enabled participants to identify as writers, rather than people affected by mental illness" (ibid.:450). This was a key aspect of my role as a student observer, and I made a concerted effort to ensure that my role was clear to all the patients present.

In general, I believe that the writing workshops worked well; the patients who took advantage of the space without judgment told me that the workshops gave them the opportunity to express themselves openly. Nevertheless, there were some difficulties: given the fact that Spanish is my second language, when I explained the instructions there were often misunderstandings. Also, due to the fact that the patients ranged in ages from 20 to 80 years old, some of whom were illiterate, and ranged in physical ability and levels of education, it was more difficult for some patients than others to engage meaningfully in the activities. Some patients did not have the physical capability to write, and others were unable because they had never learned how. Moreover, as all of the patients were obligated by the program's director to participate in the workshop, some did not want to dedicate themselves to the exercises. If the patients had had the possibility to choose

whether or not they wanted to participate, perhaps it would have only been with individuals who truly wanted to devote themselves significantly to the process.

Interviews

Another essential form of obtaining information for this project was through interviews, which included informal conversations as well as formal interviews. The informal conversations were with psychologists and patients and occurred without specific questions in mind. On the other hand, formal interviews were based on questions that I had developed previous to the conversation. Nevertheless, I allowed the interviewee to stray off subject and did not always stick to my prescribed questions. I invited some psychologists to eat lunch outside the clinic to conduct the interviews with them; for the patients, I had my interviews during the sports period, in which they had free time. The lack of true free time for the patients limited the source of individuals that I could interview, and as a result, the majority of the participants that I interviewed were men who did not play sports during their 2-hour long break for physical education. Many of the men who did not participate in sports were more advanced in age, and, in order to have a broad variety of participants, I had to work around tight schedules to interview men of all ages and backgrounds. This occasionally led to interviews being cut short or continuing over the course of multiple days. However, one benefit to the sports break was that informants were able to speak openly and honestly without the fear that a psychologist could hear something disagreeable, as the recreational break was largely unsupervised by clinicians. Many of the interviews with the patients were very personal, and I utilized therapeutic techniques that I learned as a peer counselor such as validating

and normalizing their experiences as well as communicating empathy for their hardships, which assisted me greatly in building rapport with the patients.

Wilcox (1998:28) offers an interesting perspective on trusting the validity and truthfulness of alcohol addicts as informants in an anthropological work. He argues that even though there is good reason to suspect that the data provided by the informants may no be wholly accurate, especially with respect to recalling specific aspects of health-seeking behavior and social interaction, this "should not and cannot preclude the use of such information." An individual's memory may equivocate, especially when that individual is in an altered state of consciousness such as drunkenness, but it is vital that we recognize this limitation and continue forward. Moreover, he claims that the "drinker's story" has often been identified as an integral perspective within a culture and social community, but it is often overlooked in academic anthropological work. This is an opportunity to give a voice to those who otherwise may be silenced.

The patients that I interviewed gave me very personal anecdotes about their history with addiction, intimate details about their family, and delicate information; I did not want to use the real names of the informants because I did not want to publish their personal information for the world to see. Furthermore, members of the Alcoholics Anonymous program have the tradition to not identify themselves by their full names, but rather solely by their first names. To keep with the motif of anonymity, I asked all of the patients if they had a pseudonym that they would prefer me use instead of their real names. Some authorized me to use their real names; others chose nicknames, middle names, or fake names. All of the names of the patients that I use in this study are the names that they elected I use.

Moreover, as a final note: I have chosen to use the pronouns *he*, *him*, and *his* to describe the population I focus on throughout this work. This is intentional, as *Twelve Steps* was a therapeutic community that focused specifically on the rehabilitation of Ecuadorian men from their addictions. Although many of the themes discussed can generalize to women as well, I do not want to overextend the data I collected and instead hope to focus on the experiences of the men I followed.

Models of Addiction

To best understand the nature of addiction, including alcoholism, within the Latin American context, it is beneficial to understand the American conception of addiction on a historical continuum. Ecuadorian values and beliefs of addiction are largely assigned as a result of colonialist tendencies that infiltrated pluralistic healthcare systems abroad. As a result, a nation thousands of miles away still largely experienced a similar conceptualization of addiction across unique periods.

Historically in the United States, alcoholism has been interpreted through the lens of many disparate models. Although different models were popular during different epochs of the past, many of these conceptualizations overlapped with one another and were appropriated by different groups of people with distinct belief systems. However, a general timeline emerged in Western understandings of addiction.

What can be termed a moral model of addiction was the first significant comprehension of alcoholism in the United States (Miller and Kurtz 1994). It was heavily promulgated by religious institutions, but was widely accepted by American society starting in the late 1700s with the rum trade and following through until Prohibition was repealed in 1933 (Bennett and Cook 1996:246). This model was centered on the ideology that drunkenness is a personal choice and moral flaw, representing a religious sin and vice. Different religions, including Protestantism and Catholicism in the mid-1800s, blamed alcohol consumption as a character flaw and a key proponent of the decline of the family unit (ibid.). Men of this era, products of a newly industrialized urban landscape, could facilely get drunk quickly in bars after work; this flagrant form of drunkenness was blamed for rising levels of crime and domestic abuse. Even though urbanization and the

forcible navigation of a novel, industrialized world most likely contributed a significant amount to the "moral decline" of America, alcohol was made culpable in the moral conceptualization of alcoholism. As a result, men who drank were perceived as having moral failings, harming the no longer cohesive family unit and engaging in criminal rampages across cities (Miller and Kurtz 1994).

Perhaps not surprisingly, what followed was a temperance model, whose proponents argued for the complete prohibition of the sale of alcohol (ibid.). Churches, as well as many organizations across America during the Progressive Movement of the mid-1800s, understood alcohol as being the cause of female and child suffering, and called for the wholesale ban of the substance (ibid.). The Anti-Saloon League formed in 1913, which contended that bars were masculine arenas in which men congregated and which engendered misogynistic beasts that tore apart families (ibid.). The Volstead Act of 1920—a Constitutional Amendment that arose out of the wishes of the temperance movement—called for a total prohibition of alcohol until it was repealed in 1933 (ibid.).

There is disagreement over whether the temperance movement was successful in its mission to keep individuals from drinking, and thus improve the morality of the general American population. Some historians (i.e., Hanauer 2009), along with a solid societal perception, suggest that prohibition was repealed because it failed in this goal; however, others (i.e., Blocker 2006; Hall 2010) argue that prohibition destroyed the alcohol industry, closed saloons, and massively reduced drinking rates during the temperance movement (Blocker 2006). The constitutional amendment may not have been repealed due to inefficacy or for public health reasons, but rather because the government needed tax revenue from the sale of alcohol during the Great Depression (Blocker 2006).

Furthermore, historical data suggests that deaths from alcohol-related disease actually decreased overall and arrests from drunkenness were halved during the Prohibition era (Hall 2010).

The Disease Model of Alcoholism

The most significant model, especially in terms of how general society currently views addiction and alcoholism, emerged in the 1930s once Prohibition was repealed: the disease (or medical) model of alcoholism. The origins of this model are in the Alcoholics Anonymous literature from its inception, and represent the conceptualization of alcoholism as an illness that naturally occurs within the human body rather than an individual's personal moral failure (Alcoholics Anonymous 2001). The storied foundation for one of the most influential organizations of the 20th century revolves around Bill W., a failed stockbroker who had a propensity to drink two quarts of whiskey a day, a habit he was unable to break. When he was finally hospitalized, he had a spiritual epiphany with the help of God: he experienced a flash of light and a feeling of serenity. He proclaimed that alcohol dependence, and by proxy, substance abuse in general, is an illness rather than a moral failing—making this a cornerstone ideal when he eventually founded Alcoholics Anonymous one year later (Glaser 2015). The original publication of A.A. used the words "illness," "malady," and "habit," while using the term "disease" to refer to "spiritual disease." (Cain 1991:213). This departure from the moral model of alcoholism represents a huge shift in public perception, and frames our modern understanding of addiction in general.

The disease model of alcoholism truly took shape with the help of E. M. Jellinek after World War II with the founding of the Yale Center for Alcohol Studies. In his book *The Disease Concept of Alcoholism* (1960), Jellinek identifies alcoholism as "a progressive disease with clear symptoms and certain recognizable, inevitable phases" (Bennett and Cook 1996:246). The book was immensely influential, and the American Medical Association began to classify alcoholism as a "disease," with patients being admitted into the hospital for the illness (Keller 1976:1697). This illness can be compared to schizophrenia, due to the fact that it can manifest itself in different forms with an unknown cause and site of origin (ibid.:1703).

Substance Use Disorders and the DSM-5

The disease model also works in tandem with other conceptions of alcoholism that are widely recognized by the medical community. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) is the champion source for the diagnosis of mental and psychological conditions, standardized and utilized by every practicing clinician for mental illness in the United States. Although the understandings of addiction have been altered throughout the several iterations of the manual in its history, science and practice has informed new developments. For example, the authors of the DSM-IV refrained from using the word "addiction" in fears that it would engender stigmatization of people with substance use disorders through its arguably pejorative nature. As a result, the manual adopted the word "dependence" to refer to compulsive drug-seeking behaviors (O'Brien, Volkow, and Li 2006). In practice, however, the term dependence—which was meant to refer to losing the ability to control desires and urges

for the drug—became confusing in the clinical setting and was associated with "physical dependence," or adaptations that emerged as consequence of drug withdrawal (ibid.). Dependence does not have to be linked to addiction; rather, it can merely be the body's normal response to a substance. Many (O'Brien, Volkow, and Li 2006; Miller 2006) argued for a change in the diagnostic language as well as a revision of the criteria, and the DSM-5 addressed those concerns (APA 2013).

The DSM-5 now promotes a revised conception of the disease through adapted diagnostic criteria. While earlier versions separated substance abuse and substance dependency, and a diagnosis of substance abuse only required meeting one symptom, there is now a continuum for "substance use disorder" that ranges from mild to severe and additionally requires meeting two to three symptoms out of 11 for the most mild diagnosis (APA 2013). Those 11 criteria, according to DSM-5, include: using larger amounts of the substance than intended; unsuccessful efforts to cut down; excessive time to obtain, use, or recover; craving or strong desire to use; failure to fulfill role obligations; continued use despite recurrent social or interpersonal problems; important activities reduced due to use; recurrent use in physically hazardous situations; continued use despite a physical or psychological problem caused by the substance; tolerance; and withdrawal symptoms. A "mild" diagnosis suggests that an individual meets two to three of the criteria; a moderate diagnosis suggests four to five; and a severe diagnosis suggests six or more (APA 2013). As the volumes of the DSM evolved, so did the standardized and clinical understanding of addiction: the more recent editions have provided a "clear way of defining addiction as compulsive and drug-seeking behavior using criteria that

turned out to have excellent interrater reliability and applicability to all forms of drug addiction" (O'Brien, Volkow, and Li 2006:764).

An interesting reading of the diagnostic criteria in the DSM contends that the disease of addiction is not due to medical factors, but rather relies heavily on the social nature of addictive tendencies (for instance, in Wilcox 1998). For example, two of the factors are "failure to fulfill role obligations" and "continued use due to a problem caused by the substance," implying that not only does an addiction constitute harm to oneself but also to others (APA 2013). Although the DSM attempts to standardize a diagnosis as much as possible, clinicians are unable to use fully objective and observable data to foster a conclusion. Rather, the subjective nature of addiction requires that the individual negotiate with his surroundings and the social system that he engages in to both clinically diagnose and self-identify as suffering from a substance use disorder.

Modern Interpretations Within A.A.

The understanding of addiction as a disease is a basic, integral tenet of the A.A. program: the first two steps of the twelve steps relate to the individual being "powerless" over alcohol and believing that a "Power greater than ourselves" will restore the individual to sanity (Alcoholics Anonymous 2001). Not only is this wholly unique from earlier interpretations of addiction, which argued that the individual has the power and responsibility to control his alcohol intake yet instead falls to the hands of vice, but it also functions well with the DSM classification of addiction. A piece of Alcoholics Anonymous literature describes the diagnosis of alcoholism as such:

> Whether or not you are an alcoholic is not determined by where you drink, when you started drinking, how long you've been drinking,

> with whom you drink, what, or even how much. The true test is in the answer to this question: What has alcohol done to you? If it has affected your relationships with your family, friends, former or present employers; if it has influenced the way you schedule your days; if it has affected your health; if it determines or affects your nondrinking moods or your state of mind; if you are in any way preoccupied with alcohol—then the likelihood is that you have a problem." (Alcoholics Anonymous 1979)

Similar to the DSM's conceptualization of a substance use disorder diagnosis as being negotiated by one's social experience rather than a fully medicalized and objective list of criteria, A.A. focuses on how the individual functions within society to determine their version of a diagnosis.

Vaillant (1995) also argues that the modern diagnosis of alcoholism should be assigned through a social lens, and that it is adaptable depending on the circumstance. It is inherently hard to define and standardize because it completely depends on the situation. He gives a fabled example: "A drinker may worry that he has an alcohol problem because of his impotence. His wife may drag him to an alcohol clinic because he slapped her during a blackout. Once he is at the clinic, the doctor calls him an alcoholic because of his abnormal liver-function tests. Later society labels him a drunk because of a second episode of driving while intoxicated" (Vaillant 1995:24). This demonstrates that, even though the DSM may have a more empirical method for determining a diagnosis, alcoholism is still inherently socially determined.

While the etiology and criteria of the diagnosis may continue to be revised and negotiated among the individuals and the social system that surrounds them, one aspect of the conceptualization that remains unchanged in A.A. parlance is the disease nature of addiction. Members of A.A. must accept this tenet as the first basic truth, inherently altering the way that addiction may otherwise be discussed or interpreted. The literature

asserts that the A.A. member "must learn that alcoholism is a *disease* that can happen to anyone, and she must learn the appropriate evidence for it" (Cain 1991:219; Alcoholics Anonymous 1967; Alcoholics Anonymous 1968; emphasis mine). The educational pamphlets have characters that typify their addictions as "a disease…just like cancer or diabetes" (Alcoholics Anonymous 1967). The Big Book, the reigning document of A.A. composed by its founders, mentions that its members must "continue to speak of alcoholism as a sickness, fatal malady. Talk about the conditions of the body and mind which accompany it" (Alcoholics Anonymous 2001:91-93).

The disease model is not only present in the literature; it is inherently referred to in many practices that have been adopted as tradition within the A.A. canon. In my own fieldwork, each therapy session concluded with the men gathering together in a circle in the center of the room, their arms huddled over one another's shoulders, their voices rising in anticipation. They would then chant the Serenity Prayer, an internationally recognized staple of the A.A. meeting. The "leader" of the group—in this case, the patient who has both had the longest stay and has become the most significantly acculturated into the A.A. philosophy and tradition—began by exclaiming: "Who brought us here?" to which the rest of the men would respond in unison, one voice into the still air: "God! Grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference." In this prayer, there is an implicit understanding that what they are suffering from is a disease that is unchangeable and incurable, and that the only way to move forward is to accept this, and instead of giving up hope, change their behaviors towards substances and remain abstinent.

Other Models of Alcoholism

There are several other models that are worth mentioning, as they continue to contribute to the public's understanding of alcoholism. The biological model has been a recent effort within the scientific community to quantify and objectify addiction by identifying, neuroscientifically, how brain chemistry can provide clues to understanding the nature of addiction. In his article "Addiction is a Brain Disease, and it Matters," Leshner (1997) notes that addicts and non-addicts have scientifically observably different brains. However, this science has not yet translated into public opinion or policy due to the stigma that continues to surround addiction from the era when the moral model governed the ideology. He argues that addiction, regardless of how it begins, is a brain disease of chronic compulsion and should be treated more like HIV than a moral or criminal issue.

Finally, alcoholism can also be considered within the premises of the chronic illness-care model. This goes hand-in-hand with the disease model but refocuses the emphasis on the incurability and interminable aspect of the illness (Garcia 2010:14). For both patients and clinicians, the chronic illness-care model is disheartening and inspires hopelessness; there is tacit acceptance and anticipation that even a patient who completes an addiction treatment program will inevitably return, as it is something that requires constant treatment rather than entailing an eventual cure (ibid.). Even though the patient may want recovery to be a unitary circumstance, it unfortunately is a struggle for every day for the rest of one's life (Garcia 2010:15). This ideology is laden within Alcoholics Anonymous language and tradition: for example, each day at *Twelve Steps* began with a meditation and a challenge called "Just for Today." The patients would acknowledge that

they had to take their recovery one day at a time, *solo por hoy*, because today is the only day they can be responsible for. As Yachetty, one of the patients at *Twelve Steps* noted, "I am living *solo por hoy*, only for today, otherwise I'd die." This linguistic marker, a feature common within Alcoholics Anonymous worldwide, signifies the ceaseless nature of the disease. Similarly, Garcia (2010:80) recounts the sentiments of Alma, a heroin addict, who notes that she "knew [she] would be back. What [she has] has no end."

Even though there are distinct models throughout history, these all continue to exist contemporaneously within the public's understanding; Brandes (2002:96) recounts the story of when a member recognized this concept for the first time:

> He states that at first he thought his alcoholism was inherited, that it had a biological origin, because both his father and grandfather were alcoholic. Then he thought he was the victim of witchcraft. Finally, the truth came to him: alcoholism is "una enfermedad" (a sickness) and only with the help of God and his compañeros in A.A. could he hope to stop drinking. "They say that dogs don't open their eyes until two weeks after birth," he states, "but I didn't open my eyes until I was thirty-six and a half." That was when he discovered AA.

This member's account demonstrates the unique conceptions of alcoholism that are rife among public understanding: that it is inherited genealogically, passed down like brown hair or blue eyes, and dooming a baby at birth; or that it is somehow related to morality, that vice has infiltrated a body through the devil or through witchery because of a sinful lifestyle. Yet, the acceptance of alcoholism as a sickness that *can* be treated is immensely reassuring to many A.A. members, as it removes the responsibility of illness away from character but provides the autonomy for that individual to change his or her behavior and eventually stop the addiction.

However, even though this model has become more popular with the advent and growth of AA, Bennett and Cook Jr. (1996) argue that American society has not completely rejected the notion of the moral model. Rather, it "has superimposed the disease model upon the moral weaknesses model in popular understanding of the etiology and nature of alcoholism," and as a result, "alcoholics can be held responsible for their addiction based on personality features while at the same time be excused based on a presumed physiological predisposition" (Bennett and Cook 1996:246). In other words, modern society still holds onto the idea that addiction is not merely a disease but also a function of someone's character. These models are not disparate and distinct, but rather interwoven and understood through each other.

The patients and psychologists at *Twelve Steps* also exhibited an understanding of addiction that was a mix of several different models. Hernán recognized that it was "an illness without a cure," but only understood treatment through a spiritual and religious lens: "it's difficult to have faith and hope. But it is easier with God and cooperation." He acknowledged the power of the disease model but did not believe that a medicalized model of treatment was sufficient in assisting in the healing process.

None of these models is without criticism or praise. One of the main benefits of a medicalized model, especially in contrast with the moral model of past centuries, is that individuals suffering from addiction can actually become more responsible for self-care. Opponents of this model assume that if they are taught to see alcoholism as a disease, someone suffering from an addiction can use this as a reason to drink or as an excuse to never seek responsibility in their recovery: that they are, as the first step of the twelve steps mentions, "powerless" over the substance, in the most futile sense. Yet A.A. finds

that it actually generates significant value for its members, and that they no longer view themselves as "wicked, weak, and reprehensible," but rather a patient with a diagnosis (Vaillant 1995:21). As Vaillant (1995:21) argues, "there is an enormous difference between diagnosis and name calling." For many, a diagnosis can be reassuring through the normalization of their sentiments and actions, but also through a vindication of their own self-responsibility.

Furthermore, many argue that a medical model should have implications on the way the governmental and public healthcare systems perceive addiction: treatment should focus on psychopharmacological and therapeutic methods instead of relying, as it often does, on the criminal or justice system. Leshner contends that, too often, we treat individuals suffering with addiction or substance use disorders as though they did something wrong, which completely ignores both a biological and cultural basis of a mental illness for which they are not responsible for (Leshner 1997). This argument fits wearily within the context of *Twelve Steps*: the men followed the disease concept of addiction by accepting the precepts of A.A. as truth, but were confined to prison-like conditions, often times against their will. The barred windows and padlocked door were clear signs of imprisonment, implying to the patients that they are at the clinic for moral failure rather than a natural, biological illness.

However, there are significant problems to a medicalized model of addiction that affect an individual's sense of personhood, patienthood, and self. Although a novel focus on the biological nature and medicalization of substance use does have its benefits, especially in a history fraught with judgment relating to religion, morality, and the failing of the individual, an illness diagnosis can cause an individual to feel like his life is

suddenly out of his control. For example, in her book *Bipolar Expeditions*, Emily Martin explores the loss of autonomy and personhood through the diagnosis of bipolar disorder (Martin 2007). Although she specifically refers to depression and mania, any diagnosis has the potential to engender feelings of worthlessness, inevitability, and loss of identity. Martin argues that individuals struggling with mental illness still have experiences that belong to the human condition—they should not merely be confined to their diagnosis, or expected to behave in a certain manner as a result of their diagnosis.

Additionally, studies have shown that a medicalized model may actually contribute to fewer feelings of empathy towards the patient from clinicians. Lebowitz and Ahn (2014) demonstrated that doctors provided more empathy to patients who struggled throughout their life and thus developed a mental illness in contrast to those who were born with it. This has implications on the genealogical, biological, and etiological explanations of addiction: even though it could reduce the stigma through normalization and science, it also has the potential to provoke fewer sentiments of genuine care from a clinician. A doctor who views an addiction as a result of negative life circumstances is more likely to empathize with a patient who has had a fine life, except for poor luck biologically.

Finally, some criticize the disease model of addiction for misattributing substance use as an illness when there is little evidence to support that. Heath (1988:117) argues that "If alcoholism is a disease, it is a most unusual one inasmuch as an individual can often bring an end to it by modifying his/her behavior even in the absence of any other intervention. Most of the reasons commonly given for calling it a disease are fallacious." Moreover, the World Health Organization claims that alcohol problems do not

necessarily follow a distinct pattern or pathogenesis throughout the general population, attributing the ideology that it is not a recognizable disease such as HIV or cancer (Bennett and Cook 1996:247).

Abstinence and A.A.

Cain (1991:214) notes a phenomenon in which members of A.A. are unable to divorce themselves from their diagnosis, contending that "since alcoholism is an incurable disease, once one is an alcoholic, one remains an alcoholic for the rest of one's life. The A.A. member comes to see not only his drinking as alcoholic, but his self as an alcoholic. The disease is a part of one's self." This also relates specifically to the idea through the disease model of A.A. that a diagnosed "alcoholic" is completely "powerless" over the substance and cannot even imbibe one sip of a drink in fear that he will completely relapse (Alcoholics Anonymous 2001). Merlín, a patient at *Twelve Steps*, admitted that through his experience in the twelve step program, he has acknowledged that he "will never be able to stop being an addict, but [he] can stop consuming for a long time—hopefully [his] whole life." He has embodied the understanding of "alcoholic" and, in the manner of the chronic illness-care model, must toil to recover from it every day of his life.

Although the television program *Seinfeld* attempts to make light of the situation, the appearance of this ideology on the famed show's repertoire of daily life occurrences illustrate how pedestrian this concept has become:

Elaine: No, no, no, this is just cranberry juice.
Jerry: Oh, uh, I think maybe Dick picked up yours.
Elaine: Dick? He can't drink. He's an alcoholic. I told you to hold it.
Jerry: I didn't know you meant *hold* it, I thought you meant hold it.

Elaine: One drink like that and he could fall right off the wagon.
-*Seinfeld*, "The Red Dot," (David 1991)

Other members of A.A. also view this ideology with chagrin, often citing it as an excuse to binge. Glaser (2015) discusses the experience of J.G., a recovering individual suffering from alcoholism, who said that because "there were no small missteps, and one drink might as well be 100," he could drink as much as he wanted for a few days before attempting to return to abstinence. This understanding of addiction is clearly antithetical to progress and treatment. Dr. Ulloa, a psychologist at *Twelve Steps*, felt analogously: he argued that "the twelve steps are a manual for how to live life: they can help. But there are contradictions. Abstinence should not serve as the basis for recovery—it should not mean that a relapse means that the treatment failed." It can be unbelievably disheartening for someone suffering from a substance use disorder to remain fully abstinent, or otherwise feel like they have failed as a patient and as an individual if he relapses.

Moreover, many studies have been conducted that suggest that "normal drinking" behaviors can be achieved after a patient recognizes his addiction, which attributes to the belief and contestation that abstinence does not necessarily need to be the end goal. For example, Davies (1962), along with later research that supported his view, argued that in some cases patients can relearn how to drink in non-problematic ways. Similarly, Sobell and Sobell (1973) suggested that alcoholics can be trained to control their drinking through work with inpatients at a California state hospital. However, these are not without criticism: Vaillant (1995:218) argues that these studies have methodological flaws, and even if it is possible, it is not a return to normal or social drinking but rather "only controlled or asymptomatic drinking."

Regardless of which theory is most accurate, it is important to clarify that most studies recognize the "bio-psycho-social" complexity of alcohol use and abuse (Wilcox 1998:7). This is the notion that there are many factors that lead to an individual's first drink and his consequent continuation of drinking into abuse: namely, the biological, psychological, and social aspects of consumption. However, even though Jellinek's concept of alcohol abuse as a disease has been reinterpreted and reunderstood by modern research, it continues to be one of the most important and influential considerations in any discussion of alcoholism (ibid.).

Negotiating Models of Alcoholism and Treatment

This does raise the question: even if there are observed flaws to the disease model, we still conceive of substance use disorder and addictions as illness rather than moral failure or personal choice. Why do we not treat it using medical techniques, or even consider using a scientifically-reviewed treatment program? Glaser (2015) cites G. Alan Marlatt, a prolific addiction researcher, who stated that "despite the fact that the basic tenets of [AA's] disease model have yet to be verified scientifically, advocates of the disease model continue to insist that alcoholism is a unitary disorder, a progressive disease that can only be arrested temporarily by total abstention." Glaser devotes the full article to explaining the "Irrationality of Alcoholics Anonymous," contending that "the problem is that nothing about the twelve step approach draws on modern science: not the character building, not the tough love, not even the standard 28-day rehab stay" (Glaser 2015). She examines several more medical models that have proven helpful, including

pharmacological treatments or more bio-social-cultural approaches that rely significantly more on the scientific method.

Even though A.A. is not scientifically backed, it still presents the lofty promise of full recovery, as long as the individual going through treatment is compliant. The Big Book clearly states this promise:

> Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way (Alcoholics Anonymous 2001).

A.A. does not hide their ideology: although individuals in their program fail, they are the only ones who remain culpable for their lack of success. At *Twelve Steps*, these feelings were replicated by Mr. Carrillo, a recovering addict who had been a patient at the therapeutic community before but has since remained abstinent. He argued that "the person who created A.A. was a blessing. It is so perfect—there is no space for doubt. A person who honestly practices the twelve steps will not ever relapse."

Why, then, do so many people relapse? Dr. Orellana at *Twelve Steps* intimated, with a palpable sense of chagrin, that "there is a larger number of patients who relapse than those who stay sober." Dr. Sánchez was also frustrated with the operations at *Twelve Steps*, arguing that at her old clinic "they used methods that were more bio-psycho-social-spiritual" and significantly more successful at preventing relapse. However, "here, there is a focus on the twelve steps and nothing more." She was especially concerned with the program because "sometimes the educational level of the patients is low:" a significant understatement, as, for example, several of the forty men even identified as illiterate.

Why is a program that is clearly flawed, whose intention is to be a one-size-fits-all endeavor, continuing to function as the chief and sole method of treatment?

In the end, identifying a perfectly proper model to satisfy our lexicon is futile. Addiction will remain, regardless of public perception or the way that we discuss it. As Garcia (2010:201) suggests, "It isn't a matter of using or not, of testing dirty or not. This was the life [an addict] was born into." Addiction exists outside of these models; they are inherently intertwined with one another. We cannot divorce the biology and neurology from society, structure, and culture. Similarly, we cannot separate a treatment program from the inherent biology, the larger societal structure, or the culture that it exists within. An individual can only begin to be treated once a holistic approach is identified for him specifically: for his unique biology, his social system, his culture. A one-size-fits-all model will inevitably fail if his own experience is ignored, for what motivation does he have to treat himself if he is merely a cog within a hopelessly colonial, patriarchal machine? A twelve step approach can function if an individual adapts his identity to fit that model—but what are the ethics inherent within that ideology? Should an individual change to fit the treatment, or should the treatment be adapted to fit within his life?

In the Latino context, these questions reveal the scars of colonialism that still exist in Ecuador. A Western program that has no official scientific evidence—that, in fact, has been demonstrated to be scientifically flawed—is still considered the optimal therapeutic method for addiction treatment, merely because it is American. Ecuadorians are expected to contort themselves into this model, sitting through Evangelical Christian preaching or never addressing issues of *machismo* that, for many, led to their patienthood in the first place. The A.A. model only works when they manipulate their own narrative to fall

within the identity they are expected to maintain: just as their ancestors did when Pizarro landed in Tumbes and crossed the Andes, the red and gold of his nation's flag no more red than blood and no more gold than the minerals he exploited.

Ecuador is a country of *mestizos*, or mixed race. Just as the biological model states, addiction is a brain disease: there are genetic factors that encourage its manifestation in the population. The mixed blood that has forever stained the *pachamama*, the indigenous conception of Mother Earth; the mixed blood that has been inherited genealogically, passed down like brown hair or blue eyes: this continues to fester within the nation, and cannot be fueled by further imposing its reign.

The twelve steps were created in the North American context, using its understandings of disease and substance culture of the epoch. Anthropologists and alcohologists insist that "alcoholism is a complex phenomenon, perhaps having predisposing factors (genetic and physiological) in combination with a series of precipitating factors (including psychological, social, and culture) contributing to etiology. The need for a biocultural synthesis of studies of individual and cultural variation is compelling" (Bennett and Cook 1996:247). Furthermore, anthropologists have claimed that comprehending cultural variation in substance use and abuse patterns, in tandem with the greater cultural context, is integral in planning and executing proper prevention, intervention, and treatment programs (Bennett and Cook 1996:248). Anthropologist H. K. Heggenhougen (1984:3-5) has examined how acupuncture as a healing technique in Hong Kong functions better than Western twelve step programs that completely ignore Eastern ideology. His findings do not seem shocking, yet abstinence-based programs such as A.A. still predominate the therapeutic community worldwide

merely due to its Western origin, a constant emblem that colonialism continues into the 21st century. The etiology of addiction departs from the conception of A.A. that strives to rebrand the individual's identity to meet the needs of the therapy, and additionally, attempts to serve a population outside the bounds of its own culture.

Identity Transformations Through Narratives in A.A.

The Confessional

Mr. Carrillo, one of the therapists at *Twelve Steps*, was insistent on the fact that "La felicidad está en compartir:" Happiness is in sharing. We release our inner burdens by sharing them with others; we are able to heal through admitting our faults and moving forward. There is power in sharing: we can influence others by our narratives, and we can also benefit from releasing our encumbrances.

Therapeutic "sharing" is a form of confessional discourse (Foucault 1976:67). The confessional has been integral in Western custom, both religious and otherwise, for centuries. Foucault (1976) discusses the role of the confessional in Western societies, since the Middle Ages, as a necessary ritual for producing truth in others:

> …the confession became one of the West's most highly valued techniques for producing truth. We have since become a singularly confessing society. The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites; one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell. One confesses in public and in private, to one's parents, one's educators, one's doctor, to those one loves; one admits to oneself, in pleasure and in pain, things it would be impossible to tell to anyone else, the things people write books about. One confesses—or is forced to confess […] Western man has become a confessing animal. (Foucault 1976:59)

In other words, Western individuals have been socialized to share—we share burdens, secrets, truths, desires.

Not only has the West used the confessional to produce truth, but it has also been utilized in the rehabilitative process of self-actualization and self-emancipation: "[confession] exonerates, redeems, and purifies him; it unburdens him or his wrongs,

liberates him, and promises him salvation" (Foucault 1976:62). That is, the act of confession is not only for the elucidation of truth from an individual but also for his self-healing: he is able to learn more about himself and his own reality while also freeing himself from the burdens of that experience.

Consequently, the confessional has been utilized as a key aspect to rehabilitation and plays a vital role in different therapeutic methodologies, one of which includes Alcoholics Anonymous. Foucault speaks of this too, and argues that the process of obtaining and the effects of the confession has been medicalized and "recodified as therapeutic operations" (Foucault 1976:67). The "truth" is thought to have healing effects, and the process of speaking about one's experience in relation to one's illness is vital in being a participant within A.A.

I contend that the confessional is quintessentially Western, with its roots in Judeo-Christian religion and early-modern historical thought (Foucault 1976). Its incorporation into A.A. practices is fitting for a Western society; however, when implemented abroad, pushes a foreign ideology onto the participant. I will use the life histories and linguistic analysis of patients at *Twelve Steps* to demonstrate how using confessionals and narratives as therapeutic techniques transforms the body into how the West perceives of an "alcoholic:" as someone who has hit rock bottom, is powerless over alcohol, and must abstain from the substance.

The Importance of Narratives Within A.A.

As part of A.A., members tell their own narratives of their illness to others in order to heal themselves within the A.A. tradition, but also in order to redefine their own

personal identity as a drinker within that of a Western-conceived "alcoholic." A.A. requires, as part of the twelve-step process, that the program member admit his own defects—in the process of defining their own truths and retelling his illness narrative—so that he can begin the healing process. Part of the A.A. literature insists on the confessional as a therapeutic technique:

> The practice of admitting one's defects to another person is, of course, very ancient. It has been validated in every century, and it characterizes the lives of all spiritually centered and truly religious people. But today religion is by no means the sole advocate of this saving principle. Psychiatrists and psychologists point out the deep need every human being has for practical insight and knowledge of his own personality flaws and for a discussion of them with an understanding and trustworthy person. So far as alcoholics are concerned, A.A. would go even further. Most of us would declare that without a fearless admission of our defects to another human being we could not stay sober. It seems plain that the grace of God will not enter to expel our destructive obsessions until we are willing to try this. (Alcoholics Anonymous 2012:56-57)

This tradition has been a part of A.A.'s program ever since Bill W. overcame his compulsion to drink by sharing his personal story of addiction with Dr. Bob in 1935. They claimed, and members who have come since argue, that sharing their stories with other alcoholics, and thus helping other alcoholics achieve sobriety and full recovery, is an important part of maintaining their own sobriety (Cain 1991:222). The confession has its basis in Western religious and social society, and has been appropriated into a therapeutic ritual. Its role now in the A.A. context abroad suggests a possible Western basis and neo-imperialist agenda of its therapeutics, as not only is the practice itself inherently foreign but it also refashions the patient, through the "A.A. confession," into the type of person that the program identifies as an "alcoholic."

Cain (1991) writes about how through the process of accepting the term "alcoholic," as A.A. defines it, a patient actually adopts a new identity that has been

predefined for the individual and thus reestablishes himself as a drinker. Cain argues that this transformation of identity not only requires a particular understanding of the world, through the A.A. mindset, but also a "new understanding of their selves and their lives, and a reinterpretation of their own past" (1991:210). Alcoholics Anonymous has a particular comprehension of an "alcoholic" as an individual who has no control over his alcohol intake, and who follows a generally repeated life history. This new label of "alcoholic" also requires the refashioning of identity from a drinking non-alcoholic ("normal drinker") into an alcoholic, which, by proxy, requires "a radical reinterpretation of who one is, of 'self'" (Cain 1991:212). Consequently, not only does a member of A.A. reinterpret his identity into what the program conceives of as an "alcoholic," but he also transforms into a distinctly colonially controlled body, whose identity is governed by the rules of the West. This process of identity transformation, as Cain contends, occurs when the A.A. member learns the "A.A. story model," in which "he learns to place the events and experiences of his own life into the model, and he learns to tell and to understand his own life as an A.A. life, and himself as an A.A. alcoholic" (1991:215).

Storytelling in A.A. is almost equivalent to the confessional: one speaks about one's experiences in an honest, earnest light, not hiding any defects, in order to heal oneself and find some form of salvation. Both forms of narrative also have their religious and spiritual implications, as well as their place in Western ideology and values. Thus, how members of A.A. interpret their own illness and talk about it, and their further identity transformation into an A.A. "alcoholic," is necessarily a further suggestion of the neo-colonial nature of the program and its therapeutics. When individuals tell their life stories through the A.A. story model, they have been socialized into being Western

bodies and selves in a Western system of healthcare management, regardless of their culture or social background.

A significant portion of the A.A. literature is stories of different A.A. “members,” or archetypes of different types of alcoholics, who are all finally finding treatment and recovery through AA. These stories are sensationalized narratives of different types of people that illustrate that *anyone* can be an alcoholic: no matter if you are Black or African American, Native North American, an “Older Alcoholic,” a woman, gay or lesbian, a professional, or someone “too young” for alcoholism. What is shared between these stories of “real people” who have suffered from alcoholism and sought recovery through the program is the A.A. story model. This model becomes understood as the proper way to *be* an “alcoholic,” as defined by AA, and those who hear these stories reinterpret their own path to addiction through the lens of the A.A. story model.

The A.A. story trope has a particularly defined arc to it:

> The A.A. story usually begins with the teller categorizing his early drinking as either normal social drinking, or alcoholic from the start. The story then goes on to describe how the drinking progressed, leading to negative effects such as loss of jobs, domestic problems, arrests, car accidents, or hospitalizations. Still, the drinking continues, even gets worse. The drinker justifies it by blaming it, and its negative effects, on circumstances or other people, or by explaining what drinking did for him. Perhaps drinking provides escape from pressures, or perhaps it makes him feel confident in situations in which he is usually insecure. People begin to point out that he might have a drinking problem, and perhaps they suggest that he try AA. He rejects the suggestion, though he may go to an A.A. meeting or talk to some A.A. members. He believes "alcoholics" to be hopeless drunken bums, and since he is not that, he thinks A.A. has nothing to offer him. His drinking continues, and with it, the negative effects. His struggles to control it fail. Finally, he "hits bottom," recognizes that he is powerless over alcohol, and gives A.A. an honest try. He finds out that members are really just like him. His definition of an "alcoholic" changes from the drunken bum to the everyday person afflicted with a disease. The story ends with a

> description of what A.A. has done for him, and what his life is like now. (Cain 1991:225)

In summary, the narrative arc includes the "first drink," negative effects of drinking, progression of drinking from "normal" or "social" drinking into problem drinking, suggestion (by others) that drinking may be a problem, denial, attempts to control drinking, entering AA, giving A.A. an honest try, and finally becoming sober (Cain 1991:235). This narrative is common to practically all members of AA; even if it is not, their own experiences are reinterpreted to fit this mold. They are socialized into believing that this is the story of the alcoholic, as the public confession is a key part to the rehabilitative program: a member hears the story of another, who has identified himself as an alcoholic in his introductory statement (through the universally recognized presentation, "My name is *x*, and I am an alcoholic"), and he then understand himself as an A.A. alcoholic. Rehabilitation in A.A. is not only behavior-based, from drinking to not drinking, but rather identity-based, from a drinking non-alcoholic into a non-drinking alcoholic.

"A.A. Speak"

Another key way that people conformed into the A.A. conception of an "alcoholic" was through specific speech markers. The redefinition of ordinary words for A.A. concepts has been observed by other researchers: for example, Wilcox (1998:29) argues that "When A.A. members refer to such concepts as surrender, acceptance, pride, powerlessness, control, resentments, a higher power, or God, these terms may have a much different meaning to members of the A.A. culture than they generally convey to other members of American society […] it is through the acquisition of this new language

that Alcoholics Anonymous enculturates new members into the group and perpetuates itself as a viable and unique cultural community within American society."

I noticed this phenomenon at *Twelve Steps* as well. The patients used phrases that are part of A.A. literature or aspects of the rehabilitation program; one example that I heard often was "*solo por hoy*"—one day at a time—which is used by A.A. members to focus on just the present twenty-four in the process of their recovery, and is based on daily meditations read each morning at *Twelve Steps* provided as A.A. literature. Many patients feel that dwelling on past mistakes or constantly worrying about the future provides more of a reason to drink, and thus, a focus on the present assists in recovery. For example, Yachetty, a patient who had been at the clinic for over two months, often incorporated the phrase "solo por hoy" into his everyday, pedestrian conversations; for instance, when speaking with me about his time at the clinic, he said, "I have become more humble, accepting the first step, living *solo por* hoy—one day at a time—because if not, I would be dead." Similarly, many of the patients would end a conversation with the phrase "*veinticuatro horas*," or "twenty-four hours," in order to reinforce the sentiment that their disease should be focused on one day at a time. Both of these phrases are prominent within the A.A. literature and comprise of "A.A. speak."

Moreover, many of the patients adopted new linguistic features into their lexicons that were rife within the A.A. literature. For example, all of the literature, including the twelve steps and traditions themselves, incorporate the pronoun "we" so that no member feels alone in his addiction. When speaking, especially when narrating part of the story of their addiction, many of the patients reverted to this "we" (with the pronoun *nosotros*) even though it is not a common speech pattern in Ecuadorian Spanish.

Patients used this sort of "A.A. speak" to communicate in a common language about their addiction and their recovery, and through utilizing these phrases, they also understood their addiction through the A.A. conception. It is commonly understood that language affects thought and informs the way we comprehend our world (i.e., Whorf 1941); consequently, conversing utilizing these new expressions inherently reaffirms the identity of an "alcoholic" as determined by AA. The longer that a patient was at the clinic, the more exposure he got to this way of speaking, and the more he incorporated it into his language; that directly correlated with his identity transformation into more of an "A.A. alcoholic."

Narratives and Identity Transformation at *Twelve Steps*

As part of the writing workshops that I led, I strove to help the patients better understand their identities, with and without their addiction. During the final writing workshop, I handed out quarter-sheets of paper and asked them to write "the story of their lives" on the page. I said they could write about anything, as long as they fill the sheet but do not write more than that. We had a short discussion about what they wrote: many of them wrote about difficult childhoods, being in tough financial situations, or growing up with the wrong crowd. Very few of them talked about their addiction, or their time in rehabilitation, though, on their sheets. Afterwards, I handed out another quarter sheet and asked them to write "the story of their addiction" on it, with the same rules. A significant portion of them followed the A.A. story model; several of them were uncannily similar to the model and could even be excerpts from published A.A. pamphlets. For example, this

patient's story describes the first drink, the progression from "social" drinking into problem drinking, suggestions from others there may be a problem, and seeking help:

> At 17, I for the first time learned what 'alcoholism' is. It started off slow but I soon turned into a full 'alcoholic.' When I was in school, I drank on the weekends with a professor. My friends and I drank during the day on the weekends, and then during Mondays and Tuesdays too. During Carnaval [a holiday involving a lot of partying], I began to drink with other alcoholics. Seeing this, my brother and son told me that I should get better and seek help. At this clinic, I am in recovery, slowly, thanks to the help of God and my higher power.

This narrative also includes an appeal to the patient's higher power in response to being helped through the recovery process, which is another inherent aspect of "A.A. speak."

Other narratives also discuss how individuals became "powerless over alcohol." Another patient recounted:

> When I was 13 years old I began to drink alcohol for the first time. I drank at every party, and I drank in order to talk to girls. I would drink three or four glasses because it was the only way I could feel comfortable and strong. I stopped drinking at 33 until I turned 48. During that time, I lived very happily. But after I returned to drinking and my life was uncontrollable until I arrived at *Twelve Steps*. From this point on, I will not drink and I will follow the program because I don't want to fail in these twelve steps, so please help me God.

This excerpt contains the notion of having an "uncontrollable" life during drinking, which is a key aspect of the definition of alcoholism as determined by AA. Although it leaves out a few of the stages represented in the A.A. story model, it demonstrates how his identity changed from drinking socially into not being able to control his drinking and becoming a non-drinking alcoholic.

An interesting conclusion that can be drawn from this workshop was that very few of the patients mentioned their alcoholism as a key part of their life stories. The majority of the patients waxed poetic on their upbringings, interests, relationships, and

work histories while never admitting that they had an addiction. Those who did mention it only did so briefly, almost always at the end of their stories, as though it was an afterthought. This implies that being an alcoholic is still not how they identify themselves: their life stories can function aside from their alcoholism. This is wholly distinct from AA's understanding of alcoholism, in which people self-identify as alcoholics upon introducing themselves, as though it is their surname. The patients at *Twelve Steps* were not yet wholly transformed into the Western conception of what it means to suffer from addiction: they were still remotely divorced from their illness; they have a life separate from the disease they have inherited.

There was one individual I met at *Twelve Steps* who quickly self-identified as an alcoholic, and that was Mr. Carrillo. He was the "terapista vivencial," or the experiential therapist. Mr. Carrillo had gone through addictions with both drugs and alcohol, and found himself in jail six times before seeking help through AA. He now works at the clinic and speaks about his own experience as a practicing addict, in recovery, and in abstinence; by sharing his story, he provides hope to those in recovery as well as propagating the A.A. story model. In my personal interview with him, he described his life story as such:

> I am Mr. Carrillo, and I am an alcoholic. I started drinking at eleven years old. I drank socially, at parties. At fifteen, I started to come home drunk. My family permitted it, and I did it whenever I wanted to. I drank every day in high school. I didn't recognize that I had a problem because I didn't do bad things. I started doing drugs in law school—crack cocaine. I changed jobs, and started working with prostitutes at a nightclub—with low quality people. I lost everything because I consumed drugs every day. I went to jail, six times. I kept drinking until complete indigence. When I was twenty-one, I went to an A.A. group, who had their doors open, but it didn't interest me. At thirty, I finally wanted to change myself. After only fifteen days, though, I wanted to consume again. But a friend introduced me to the word of God. I had a lot of conflicts, but what I learned in A.A.

> helped me to not relapse. I stopped doing drugs and drinking. I cut ties with my old friends, and I don't go to the places I used to go.

He has been a member of Alcoholics Anonymous and Narcotics Anonymous, successfully, for over ten years now. He has not only internalized the lexical and narrative features of AA, but he has also fully transformed his identity into that of an "A.A. alcoholic" after a significant amount of time with the program.

It is fascinating to consider this process of identity transformation by AA. The patients at *Twelve Steps* recognized that they needed help, even using "A.A. speak" to discuss their illness; and although they reinterpreted their own histories with their addictions into the A.A. story model, they were reluctant to self-address as an alcoholic. That is, the men at *Twelve Steps* were in the process of identity shift: none of them had been with the twelve step program for longer than three months, and thus had not yet completed this transformation, like Mr. Carrillo has done. However, this narrative process—which has its roots in the West, and is a key aspect of AA—is assisting in this form of neocolonial transformation, turning the addict into the form of alcoholic that is conceived of by the West, not by the society and culture that it remains in.

Implications for Masculinity Through Addiction and Sobriety

"The men of my family didn't cry"

Tú me dijiste: no lloró mi padre;	You told me: my father didn't cry;
Tú me dijiste: no lloró mi abuelo;	You told me: my grandfather didn't cry;
No han llorado los hombres de mi raza	The men of my family didn't cry;
Eran de acero.	They were steel.

-*Peso Ancestral,* Alfonsina Storni

Alfonsina Storni, a renowned Argentinian poet, understood her position as a woman in Latin American society. Her poem, *Peso Ancestral* (Ancestral Weight) discusses the idea that femininity is only valued as a conduit for the emotion that men cannot show, and that their masculine counterparts must be steel, or have hardened hearts. This is a key component of *machismo* in Latin America. Men are perceived as *macho*, virile, and sexual, hiding the emotions they may feel but socially cannot show—that is, until alcohol enters their systems. This legal and widespread drug alters what would normally be considered socially permissible, allowing for culturally constructed and accepted deviance among men who are then not only allowed but expected to show emotion. But what happens when the goal of a therapeutic program is to stay sober, effectively rejecting a substance that allows them to be released from the highly structured and monitored bounds of their society? Should the goal for a rehabilitation program for men in Latin America be sobriety if drinking is a fundamental aspect of social and masculine life?

In this chapter, I argue that Alcoholics Anonymous' goal of abstention from alcohol is unrealistic and does not take into account how significant consumption is for masculinity. Drinking provides the sole escape for men from the rigid bounds of the *machista* culture; to aim for complete sobriety removes a necessary aspect of male life.

Furthermore, consumption assists in male bonding behaviors, and is a major way for men to interact without judgment of their behavior. Moreover, the treatment program in A.A. has significantly anti-*machista* ideologies, which I suggest are irreconcilable with how men view their livelihoods, personalities, and selves.

Machismo among Latinos is a widespread and well-accepted cultural phenomenon. Many (Giraldo 1972; Ingoldsby 1991; Lewis 1961; Stevens 1973, among others) claim that there are several principal characteristics of *machismo* and differences in how it affects masculinity among Latino men. One is that he must be aggressive; "each macho must show that he is masculine, strong, and physically powerful. Differences, verbal or physical abuse, or challenges must be met with fists or other weapons. The true macho shouldn't be afraid of anything, and he should be capable of drinking great quantities of liquor without necessarily getting drunk" (Ingoldsby 1991:57-58). He also should be hypersexual, as it is the "woman who loves but the man [who] conquers—this lack of emotion is part of the superiority of the male" (Giraldo 1972; Ingoldsby 1991:58). These themes are recounted repeatedly throughout anthropological and Latino literature; Lewis (1961) shares the story of a man who opened up about how masculinity is fostered in Latin American culture:

> The thing is that we started to see life in such a way that we had to learn to have a lot of self-control. At many points in my life I had things that drove me to an intense desire to cry. Nevertheless, life taught me to show only a mask; when I am suffering inside, I am laughing. And for others I don't suffer, I don't feel anything, I am cynical, shameless, I don't have a soul…for the mask that I show others. But inside I react to everything that others tell me. I learned how to hide fear by showing the contrary reaction […] so when I carried a lot of fear inside, on the outside I made it seem like I had none, that I was calm. And it worked, because I wasn't criticized like some of my friends who shook visibly. Because if I come in silent, or if I come in with teary eyes, or if I come in shaking, like I say here, good

> luck to me! Immediately everyone jumps on the bandwagon" (translation mine, Lewis 1961:35).

These sentiments are common among men, but it is nearly impossible to hear a man express his concerns about the system due to the restrictive nature of the culture.

One interpretation for why *machismo* continues to endure and be recapitulated within society is that environmental stressors as well as tacit cultural and biological ideals engender a system of oppression and suppression. Environmental stressors include socioeconomic status or job insecurity, both of which encourage feelings of inferiority among men that result in aggression, displays of masculine virility, and the subdual of emotions (Ingoldsby 1991:59). Cultural and biological markers include parenting styles, or the values that men are taught in their own households. Dr. Sánchez, a clinician at *Twelve Steps*, explained that "all of this is generated within their homes, from their mothers when they were children," which is inherently a *machista* ideal in itself. It is a reinforced cultural theme from within a man's own family as well as in his community at large.

Machismo and masculinity in the Latin American context has developed historically and has arguably become more pervasive as the political and economic situation has shifted (Diekman et al. 2005; Viveros 2001). Many Latin American countries have experienced globalization, westernization, industrialization, and democratization in the past century, and have thus become more open to women occupying roles that have traditionally been considered masculine. As a result, men may feel the need to appear even more stereotypically *macho*, adopting characteristics of masculinity such as independence, assertiveness, quantitative skills, and muscular

capacity at an ever-increasing rate (Diekman et al. 2005:221). Viveros (2001:238-40) argues that this is a "crisis of masculinity," in which men are responding to this changing environment through the reification and strengthening of their masculine qualities. Their behavior has transformed into absolutes: they must *never* cry; they must be the *best*, they must *always* compete with others (ibid.). With a changing Latin America, perceptions and stereotypes of masculinity are shifting as well, continually further into the extremes.

Alcohol and Drunken Comportment

However, under special circumstances, men are socially permitted to deviate from these strict cultural boundaries and act in a behavior that would otherwise be unacceptable. In their book *Drunken Comportment* (1969), a groundbreaking anthropological and sociological work on how alcohol affects the human body, MacAndrew and Edgerton argue that our perception of how individuals act while intoxicated is skewed. Although we often believe that all humans respond similarly to alcohol—for example, drinking in a party setting brings about general relaxation, laughing or joking, and disinhibition—it is actually the culture that the individual is in which determines how he or she is affected. Essentially, the individuals within a certain society must learn how to "do" being drunk; "getting drunk the wrong way—which might be too often, too much or violating the unspoken rules of drunken comportment—is sanctioned, and the drinker quickly learns to keep himself, or less usually herself, in check" (Bancroft 2009:58).

For instance, MacAndrew and Edgerton (1969) describe the behavior of the Mixtecans, an indigenous group living among Hispanic Mexicans in the state of Oaxaca,

Mexico. The Mixtecans live a considerably poorer existence, both financially and socially, in comparison to their Hispanic counterparts. They show no aggression while sober, and even while drunk, do not deviate from this mannerism. MacAndrew and Edgerton interpret this as an interesting case, as even though their Spanish-speaking neighbors use alcohol as a way to release aggression and act *macho* in a socially acceptable form, the Mixtecans do not engage in drunken violence. Their intoxicated comportment is much more mellow, and they recognize that: they identify that alcohol does *not* have the capability of producing aggression amongst themselves, even though it is common among their counterparts (MacAndrew and Edgerton 1969:35; Romney 1966:611). Although the toxins in alcohol affect the human body in a similar manner physiologically, it is clear through this example that drunken comportment is actually a "*learned* affair" (MacAndrew and Edgerton 1969:88).

Moreover, not only does alcohol have socially determined effects, but it also creates the opportunity for the drinker to escape the usually strict cultural bounds that they reside within. MacAndrew and Edgerton contend that "the state of drunkenness is a state on societally sanctioned freedom from the otherwise enforceable demands that persons comply with […] For a while—but just for a while—the rules (or, more accurately, *some* of the rules) are set aside, and the drunkard finds himself, if not beyond good and evil, at least partially removed from the accountability nexus in which he normally operates" (MacAndrew and Edgerton 1969:89-90). Essentially, drunkenness allows for the individual to remain in a period of "time out" in which they can act in a manner unique to how they must normally behave. Many cultures have actually created

specified roles for the intoxicated individual, giving recognition and space to the idea of intoxication.

Much like the notion of the Shakespearean fool, the role of the "drunkard" is seen clearly in an account from an Oaxacan village in Mexico (Dennis 1975). In this community, everyone is aware that an intoxicated man will behave in a certain manner that would normally be unacceptable—for example, he does not comply with the polite and passive air that he otherwise would, but instead is permitted to speak freely and without filter about his opinions. The community does not always resent this type of drunken comportment, but rather appreciates the transcendent nature because the intoxicated individual experiences no shame or fear in speaking about how the community actually feels. If a visiting dignitary comes to town, the community is forced to keep their genuine sentiments to themselves lest they offend their guest of honor; the drunk, however, is free to publicly exclaim his views which coincide with the community's beliefs without the negative repercussions. One man's release from the oppressive social norms actually benefits others in the community, indicating that even though it is deviant behavior, it does not necessarily foster negativity. It could be argued that the drunk in this community is not deviant at all, but rather fulfilling an essential role in society through the means of alcohol and under the guise of intoxication (Dennis 1975:860). Essentially, alcohol provides a convenient social explanation for deviant behavior, and men often take part in drinking to transcend the oppressive cultural bounds that they would otherwise be shackled to.

Specifically in relation to male identity and *machismo*, alcohol can provide an escape from the society that dictates that men must remain within this "cult of virility"

(Stevens 1973:315). The intoxicated disinhibition, or transcendence from the otherwise restrictive cultural bounds, that men experience allows men to break taboos; Bancroft (2009:52) suggests that "anthropological evidence indicates that many taboos […] usually remain in place whatever the supposed disinhibiting properties of alcohol may be […but] those taboos that are broken tend to be broken in a socially acceptable, carefully defined manner." This alcoholic disinhibition is often "used deliberately and creatively to facilitate the fulfillment of a social role, as when young men demonstrate the ability to engage in violent, confrontational masculinity" (ibid.). However, the opposite may also be true: men may utilize drunkenness to show their more tender, stereotypically "feminine" sides. In a personal interview, Leonore Cavallero, an intercultural specialist residing in Ecuador, claimed that men want to surpass the *machista* restraints placed on them and show emotion or weakness; as a result, many men release the emotions they so often hide through the assistance of alcohol. In a personal interview with the author, she argued that "it is not acceptable to cry in front of other men. But, if you're drinking—then yes, no one says anything."

The Bar

In noting the geography of deviance, it becomes clear how the bar can become, in some ways, a physical space of nonconformity in the Latin American context. Alcohol provides the opportunity for escape; a man who parties with his *compañeros* or *panas*—essentially, his drinking buddies—can rest assured that he is outside the bounds of machismo that exists exterior to the bar's walls. The bar is a privileged space for male socialization where men can reassess their understandings of being masculine and how

their gender identity affects their familial life, occupational endeavors, and general personality (Viveros 2001:249); it is also where men can challenge the norms by which they otherwise are controlled. Brandes (2002:110-111) notes that he observed drunk men become so disinhibited that they became "downright amorous with one another, uttering propositions that would be inconceivable for these men when sober." Homosexual behavior is a pervasive taboo within the *machista* Latino culture, but under the influence of alcohol, some men completely disregard this. Brandes continues, contending that trust and intimacy amongst males also have the ability to be cultivated while intoxicated (ibid.).

In other ways, the bar is a place where a man can reify his masculinity in front of other men: the close proximity to his *compañeros* engenders the bar a performative setting, in which a man can validate his worth as a male. Gutmann (1996:178), for example, observed men who were usually mild-mannered transform into violent aggressors after drinking, affirming the ideal that intoxication for some men leads to a visible demonstration of their virility. Especially in circumstances where the man does not live up to the *macho* ideal—for example, he is trying to find work, underemployed, poorly remunerated, or feels emasculated by his wife—the bar may provide some men with the opportunity to demonstrate to others that they are, indeed, *macho* by finishing many shots of liquor in quick succession or drinking until they black out. In fact, Singer et al. (1992) engages critical medical anthropology to explore a connection between male employment, gender identity, and drinking patterns, essentially arguing that masculinity and problem drinking can be closely tied for some men. This was particularly evident in the life story of a patient I interviewed; Luis, a man in his mid-60s, remembers

developing a reliance on alcohol "not only because [he] liked to drink—it was also [his] socioeconomic position." Intoxication assisted Luis in both personally dealing with his negative financial situation as well as reasserting and reaffirming his masculinity identity to himself and others.

These key effects of intoxication underscore the connection between masculinity and alcohol or alcohol abuse, in which men either use drinking as a way to escape the chains of machismo or flaunt their masculinity to validate their own personal gender identity. Gutmann (1996:178) maintains that alcohol has the ability to transform a man into a raging aggressor or engender "tender confessional moments." These two effects of intoxication foster an invaluable state of being, one that can readily drive men to problem drinking in Latin American society, as "the parties involved are capitalizing on the belief that drunks should be held less responsible for their words and actions" (ibid.). In other words, drinking gives men a space to try on different ways of being men and negotiating their masculinity.

The Male Addict

Although manhood and intoxication are intricately intertwined—to the point that Latino men begin to associate alcohol and inebriation with masculinity and the male gender identity (Brandes 2002:111-2)—this does not mean that the only drinkers in these societies are males, or that all males are drinkers. However, while it is not shameful for a Latino man to drink, especially to the extent of inebriation, Latina women struggle with being accepted while under the influence of alcohol (Brandes 2002:100). Women still can drink and achieve drunkenness, but it is significantly less socially permissible than for

their male counterparts (ibid.). One possible interpretation for this is that the patriarchal nature of the *machista* society precludes women from achieving the same rights as men, to the extent that they are monitored and judged for the substances they imbibe. Another could be that intoxication historically has been so interconnected with the masculine identity that the role of the drunk within the society is only permissibly held by a male figure. Christine Eber, a specialist on gender and alcohol, argues (1995:23) that since ancient times, men were given "more leeway to drink" than women were, and that has persisted through today. It has become ritualized within the perception of manhood that exists in society, and often differentiates between the two genders during religious or life-cycle rituals. Additionally, Brandes (2002:100) cites a survey of physicians in Mexico City that reports that "despite the occasional exception, it is men, rather than women, who mainly suffer from alcohol problems."

Furthermore, there remains the idea that the addict in Latino society is always male, completely ignoring the possibility of a female deviant in the form of a substance user. In her discussion of heroin users in the majority-Latino Española Valley in New Mexico, anthropologist Angela Garcia (2010:113) maintains that the language used to talk about addiction reinforces the stereotype that it only affects men. The word to describe a heroin addict in Spanish is *tecato*; there exists no feminine form of the word, only the linguistic masculine. Additionally, the physical manifestations of heroin addiction cause the body to morph into a skinny, flat-chested frame, essentially transforming into a more masculine figure. Brandes (2002:105) also notes that, on a global scale, A.A.. is considered more appropriate for males. Its counterpart, Al-Anon, is seen as the program that is more acceptable for females, as it covers topics related to

living with an addict or how to support someone through the recovery process. It is also interesting to note that "the two founding members of A.A. were men, most of the A.A. literature is written by men," and men still make up the majority of the members worldwide (ibid.). Moreover, until recently, much of the language in A.A. literature was also very gendered and masculine (ibid.)

The Social Nature of Drinking

Several scholars (Brandes 2002:110; Lomnitz 1977:175; Gutmann 1996:177; Wilcox 1998:13) draw the connection not only between masculinity and intoxication, but also between male bonding and friendship and alcoholic consumption. Even from a young age, entirely sober boys "wobble down the street with arms around one another's shoulders, pretending to be drunk" (Brandes 2002:110); this represents that the ideal male-to-male friendship is one reinforced by a drunken stupor. Lomnitz (1977:175-80) described construction workers in Mexico City who developed exclusively male friendships from their job which came to be known as a *cuate* friendship, or literally, "twin." Lomnitz (as discussed in Brandes 2002:112) contends that:

> *Cuates* are first and foremost drinking buddies. Although *cuates* potentially share a number of activities—among others, card playing, viewing television together, playing soccer, going for walks, or simply conversing—their most significant activity from a symbolic point of view is drinking…Lomnitz found that it is "the act of getting drunk" (Lomnitz 1977:176) that above all brings about this bond, since "getting drunk together represents a high degree of trust" (ibid.:177). As one of Lomnitz's informants put it, 'getting drunk is a liberation, people get rid of their inhibitions. When you are sober you cannot say the kinds of things you can say when drunk; these are your truths.'

Alcohol is almost always seen as a social act; even though the drunken comportment may differ once the individual is intoxicated, it still remains a highly prosocial activity. Friendships and intoxication work in reciprocal ways: friendships are formed as a result of alcohol, and alcohol is imbibed in the context of friends. The social aspect of substance abuse tacitly makes the deviant behavior more culturally permissible and socially acceptable, promoting its use among the majority of men within society.

Arguably the most intriguing characteristic of intoxicated comportment within the Latino context is how the culture dictates that men who drink can transcend the otherwise strict boundaries of machismo and emulate contra-masculine tendencies. These range from the innocuous affinities to build trust and familiarity among a man's *compañeros* that he drinks with to more blatant disregard of taboo, such as engaging in amorous homosexual behavior (Brandes 2002:110-1). For many of the men that I personally interviewed at the rehabilitation center in southern Ecuador, their impetus to begin drinking had social determinants that stemmed from a desire to escape the restrictive nature of everyday machismo. Merlín, a man in his early 20's, shyly admitted that his addiction began thanks to "friends in the neighborhood and a girl;" he continued, stating that he "entered the world of drugs to feel the same as [his] friends and to be with them." In a society that values inter-male aggression and competition, intoxication was the only way that Merlín could feel close to his *panas*, or his friend group. Without the substance, he felt that he could not demonstrate affection for those close to him. It was only under its influence that he was able to socially acceptably engage in meaningful relationships with other men.

Two other patients, Luis and Hernán, commented on the social aspect of drinking, especially in the context of coworkers and the pursuit of women, that led to their eventual addictions. Luis remembers that he worked in a group of men, and "the pressure from [his] *compañeros* was strong. Four, five drinks, sometimes until [they all] passed out." They would go to dances together, and while there "it was necessary to drink in order to dance with girls." Hernán, another man in his mid-60s, also recalls: "I drank—I started my alcoholism—drinking with my *compañeros* from work. We looked for girls and drank. I thought I was only a social drinker, but then began my illness." Both of these men note the social nature of intoxication, specifically in regards to building friendships with coworkers and building up the courage to speak or dance with women. They escaped the *machista* bounds of gaining trust and constructing new inter-male relationships through intoxication, at the same time that they demonstrated their virility and sexual prowess by engaging women in conversation or dance. These two examples illustrate how alcohol can often work to both release the man into a "deviant" state as well as reaffirm his masculine identity among others.

I noticed this firsthand when I experienced the Ecuadorian nightlife. On one particular occasion, I ventured out with a group of late-adolescent men that were friends with my host sisters. At the start of the night, they challenged themselves into out-drinking each other, most likely in an attempt to seem as masculine as possible for the girls. The girls abstained from drinking and rather watched the boys imbibe drink after drink, bottle after bottle. They did not offer each other drinks, implying the option to refuse; rather, cups of beer were handed out with the intention that the recipient finish it all. As the boys became more intoxicated, their comportment changed; they became more

liberated, sitting on each other's laps and freely embracing each other. They then all moved towards the dance floor, gyrating their hips to the quickening merengue beats and cat-calling different women until they secured a dance partner. Once they had begun dancing, they ensured that the other men in their cohort noticed their "conquest" by whistling or making grand attention-grabbing gestures, clearly challenging each other's masculinities. Both the demonstration of masculinity as well as deviant, contra-masculine behavior was exhibited throughout the night, as the drinking continued more heavily.

Due to the positive cultural and social consequences that come out of intoxication, it begs the question: should a rehabilitation program focus on complete abstinence from alcohol if it has an integral place in society? How do men respond to a program such as Alcoholics Anonymous that relies on the explicit sharing of emotions and fraternal bonding, if previously the only way to achieve those deviant behaviors was under the influence of a substance? Moreover, how can a program like A.A. function if it relies on admitting powerlessness over alcohol and that a man has character defects in a society that promotes ultimate strength and shames defection?

Staying Sober

There is significant evidence that the use of alcohol amongst males in Ecuadorian society has positive aspects to it: men feel more at ease and can bond with other men; they enter a socially acceptable form of deviance where they can show emotion and affection. Because drunkenness has these benefits, and there are no other substitutes for it, should total abstention from alcohol be the goal of a therapeutic program? Or, should a

rehabilitation program accept that sobriety may cause negative repercussions and encourage or teach better drinking behaviors instead?

Glaser (2015) demonstrates through various forms of evidence that complete sobriety may not be necessary for all "alcoholics." Although A.A. claims that "alcoholism is a progressive disease that follows an inevitable trajectory," the National Epidemiological Survey on Alcohol and Related Conditions illustrates that nearly one-fifth of those who had alcohol dependence are able to drink at low-risk levels with no symptoms of abuse after treatment programs (ibid.). Moreover, a recent survey of nearly 140,000 adults by the Centers for Disease Control and Prevention discovered that nine out of ten heavy drinkers "are not dependent on alcohol, and, with the help of a medical professional's brief intervention, can change unhealthy habits" (ibid.).

Furthermore, under the new conception of substance use disorder in the DSM-5, alcoholism can now be interpreted on more of a continuum rather than in binary terminology. According to the American Psychiatric Association, using this new diagnostic criteria, only fifteen percent of those with alcohol-use disorder are at the severe end of the spectrum; everyone else diagnosed with the disorder fall between the mild to moderate scale (ibid.). This implies that an abstinence-only therapeutic program may not be necessary for all drinkers—although some individuals undoubtedly should refrain from alcohol use, there is evidence that individuals can be taught to drink at a more mild or moderate level. Because there are significant positive social and cultural factors intertwined with alcohol use for Ecuadorian males, perhaps a better goal for rehabilitation should be teaching a man how to drink more responsibly, if he falls on the more mild side of the substance-use disorder scale. However, this is completely

antithetical to A.A.'s main tenet, in which the only requirement for membership is the desire to stop drinking (Alcoholics Anonymous 2001). This suggests that A.A. may not be the best approach for men in the current state of *machista* society in Ecuador, as it removes a crucial actor in men's lives that is irreplaceable and renders the man, according to Leonore Cavallero, "more tense, nervous, and uncomfortable."

Sharing Emotions Through the Confessional

I have already discussed the confession as a therapeutic technique within Alcoholics Anonymous, especially as to how it relates to the neocolonial power dynamic. However, another key aspect to the confession is the sharing of emotions through personal narratives in a group setting. At *Twelve Steps*, this was very uncomfortable for the majority of men. Yet, the psychologists disregarded the *machista* environment and adapted the way that emotions were shared so that, although the practice was not eliminated, it was more fitting for the male patients.

The psychologists that I interviewed maintained that they created their therapies to combat the *machista* ideals that are promulgated in society. I observed that a large part of the therapies were based on the liberal sharing of personal stories and purportedly true sentiments; participation in these therapies with personal stories was encouraged by the therapists and also by various motivational signs and posters that hung around the therapy room: "Speak and you will be saved," or "shared pain is less pain," for example. At first, I mused that this form of therapy was ironic, given the fact that Latino society is founded upon *machista* ideals in which the mere admittance of a man's emotions is basis for ridicule. Even though all of the clinicians agreed that it was necessary for the process of

treatment and recovery to admit to one's feelings, share emotions, and discuss the past, they attempted to normalize this for the patients and encourage open and honest discussion both in group and individual therapies.

For example, Dr. Orellana told me that the sharing of emotions is "very good, appropriate, and adequate. It is important for the channeling of accumulated energies within the body. If we laugh more than we cry, what we repress are the tears. Everything in moderation is better." Mr. Carrillo, the experiential therapist, also noted that when a man shares emotions, he can "undrown himself and liberate himself. Also, his stories and emotions help the others in the group."

One key difference between the traditional A.A. approach and the approach of the clinic in southern Ecuador is that individual therapy alongside group therapy was used to assist in the recovery process. The psychologists recognized that, without alcohol, men had a tough time deviating from the norms of masculinity that are so ingrained in their beings; although many men attempted to stay strong during the group therapies and show little emotion, the clinicians admitted that many exhibited more emotion during the individual therapies. Dr. Sánchez argued that:

> It is a culture that represses a lot, in which men are prohibited from crying. There is the belief that the man is the stronger sex, that he can't cry […] In individual therapies, they can exteriorize all of their feelings, sentiments, and experiences that they've had. Many times human beings just need another person to listen to them. Individual therapy is a catharsis, in which nothing is repressed, so that the person feels more free and equipped with the tools to confront the negative experiences that they have lived.

She recognizes that in the group therapy, the men are more subdued and repress more because they fear being judged by their male peers; even though she encourages free expression during all the therapies, she really attempts to utilize the space of the

individual therapy to facilitate the expression of emotions. She did admit, though, that it can often times be ineffectual to expect the men to be genuine while sharing emotions in a group setting because of a fear of judgment or shame.

The benefits to sharing emotions and pain are clear; the dilemma, however, arises: should A.A. attempt to change the way that men interact with their surroundings through the deterioration of *machista* ideals? I argue that a program whose goal is to reform the society that it is serving embodies the definition of imperialism. Brandes (2002:119) suggests that the A.A. program in Mexico that he observed, Moral Support, had as one of its main missions to redefine masculinity for its members and attack *machismo* head on; he claimed that a main goal was

> to redefine family relationships so as to maximize equality and mutual respect between spouses. This endeavor naturally involves a redefinition of what it means to be a man. The men of Moral Support know that, as recovering alcoholics, they have to abdicate as authoritarian rulers at home. They should share in household tasks and take responsibility for their children. To signal the new form of relationship, the men have dropped the common Mexican label "*esposa*" to refer to the wife. Instead, they make a point of referring to their wives as *compañeras*. This designation, they believe, automatically elevates their wives to a position equal to themselves. (2002:119)

Although it is difficult to argue that there are no flaws with *machista* ideology, A.A. as a American organization that intends to impose Western conceptions of gender equality and masculinity is laden with a neocolonial agenda. A rehabilitation and treatment program should work with the culture that it is serving, opposed to attempting to change that culture and its ideologies.

Machismo and the Twelve Steps

Upon considering the twelve steps of A.A., one recognizes that there are critical aspects to the therapeutic process that remain incompatible with *machista* ideology and masculine culture in Ecuador in general. When a man reconfigures his identity, through the first step of A.A., and admits that he is an "alcoholic," he also acknowledges that he is "powerless under alcohol" and has character defects that contribute to his alcoholism (Alcoholics Anonymous 2001).

The definition of "alcoholic," as defined through A.A., does not coincide with the vision of masculinity that many Ecuadorian men find themselves needing to uphold. One first interprets oneself as an "alcoholic" through the completion of the first step of the twelve, which is: "We admitted we were powerless over alcohol—that our lives had become unmanageable" (Alcoholics Anonymous 2001). This powerlessness is antithetical to the notion of possibility and omnipotence rife within *machista* ideology. Jensen (2000:96) states that "as the persona of the practicing alcoholic is discarded, which begins with the first utterance of 'I am an alcoholic,' a newcomer moves from thinking that he or she is one of the most important individuals in the world—remember that Bill W. likened his alcoholic self to Napoleon when his drinking was most severe—to a sense of humility." This sense of self-importance is heightened within the *machista* context; during personal interviews with many of the patients at *Twelve Steps*, they also admitted that the first step was the most difficult to overcome because of the necessary admittance that they were not as powerful as they were expected to be.

The second step also proves to be an obstacle for many men, as it requires them to surrender themselves to a higher power (Alcoholics Anonymous 2001), which tacitly

concedes that the man does not have ultimate strength as is anticipated under the rules of *machismo*. This surrender is both a complete loss of autonomy in terms of personhood as well as in regards to his masculinity, as he must admit that he is lacks the fortitude and power that is expected by being a man. During his fieldwork with members of A.A. in Texas, Wilcox (1998:80) often heard that "most members really believed that to be dependent was to be weak." This idea was echoed among the men at *Twelve Steps*, who found it difficult to give up complete control over their bodies, selves, and recovery because it would require further acknowledgement of imperfection and weakness.

Even traditions like the Serenity Prayer, a mantra that is said at every A.A. meeting worldwide, has the potential to be emasculating for men who are expected to have complete control and autonomy over their own lives. The prayer—"God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference"—essentially concedes that the man does not have power in his life over many aspects, which demonstrates a lack of strength and control.

These early steps are interpreted differently for men and women in Ecuador due to the gender differences and expectations from *machismo*. Yachetty, one of the patients at *Twelve Steps*, maintained that "the steps are the same, but we [men and women] have different thinking about them." In other words, although both men and women have the same goals in the steps, they are different—and, he continues later by claiming they are much more difficult—for men because of the way males are enculturated into understanding gender roles within their own society.

Also, the fifth and sixth steps, in which the alcoholic must determine his wrongs that he has committed and plead to God to remove his character defects (Alcoholics

Anonymous 2001), present challenges for men in Ecuador. Along similar lines, admitting that a man has erred in the past and has defects is inherently anti-*machista*; this shows weakness in character and does not represent a strong-willed, emotionless man that he is expected to be.

Alcoholics Anonymous has key aspects to its therapeutics that are not in accord with the ideology of *machismo* that permeates Ecuadorian culture; many of these facets of the program present significant obstacles for men in treatment. Men in Latin America largely drink to make connections with other men and to share emotions with one another. Yet, with the main goal of A.A. as remaining abstinent, a man loses this one opportunity to escape the rigid boundaries of *machismo* and be liberated through socially acceptable drunken comportment. Moreover, the idea that men should share emotions without access to alcohol as part of the therapeutic process is extremely difficult for many men, and often times, they remain afraid to do so lest they are judged or shamed by their male peers. Lastly, several of the twelve steps require the men to admit powerlessness or defect and surrender their autonomies to a higher being, which causes many men to feel weak. This weakness is harder to accept for men in Ecuador, as it is antithetical to the expectation that is set for them under *machismo*.

The process of rehabilitation through A.A. largely ignores these cultural obstacles and expects the men to readily transform their identities into an "alcoholic," with the laden connotations associated with that term. This expectation that a man should conform to the therapeutic process, rather than the opposite occurring, reaffirms the neocolonial nature of A.A. abroad as well as acting as an impediment to treatment.

Religion and Addiction

Three Scenes

1. I know that I'm running late. It's 9:17 in the morning, and even though there is no formal public transit schedule, I know that leaving any later from the apartment will cause me to be late to my class. My host mother knows this as well, but she still insists that we engage in *sobremesa*, the Latin American custom of having conversation at the dining table post-meal. The plates remain unwashed, the table still set. I look at my watch in the hopes that she will end the dialogue, but she doesn't seem to notice. I do it more frequently, a panicked look resting in my eyes. Even though this happens each morning, we do the same dance—I finish my coffee and a Pavlovian instinct causes me to internally worry about missing my bus. I prepare my legs for the run to the stop.

She finally terminates the conversation with an exasperated glance towards the clock on the wall. "You're going to be late!" she starts, as though I haven't been keeping track. She readies my coat as I maneuver my way towards the door. No matter how late I am, though, she blocks the doorway before I am able to leave and closes her eyes. "*Qué Dios te bendiga*—May God bless you," she whispers as she places her hand on my head. She reaches on her tiptoes to do this and holds it, suspended in the air, our pulses aligning and the energies coordinating between our bodies.

She knew that I was of a different faith than she was, but did not let our conflicting ideologies stop her from this ritual. "It doesn't matter which God blesses you," she continued one morning, "your God or mine. As long as you go blessed through the day."

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2. I was surprised to hear that there was a Christian church in the small town of El Capricho. The town of one hundred residents straddled the border of two Amazonian provinces, noted solely for a minimarket, soccer field, and Internet café along the highway. There certainly shouldn't be that many Evangelical Christians in a region noted for its still-preserved indigenous traditions, where shamans still cure illness and where families arise before dawn to sit under the stars and interpret the dreams they experienced during slumber. However, I also knew the history of this religion in the country: within the past few decades, the number of individuals who identify with Evangelical Christianity has slowly been rising, even against the strong roots of Catholicism that have guided the nation since the sixteenth century.

We stumble upon the church like it was a site of ruins, the jungle overtaking its foundation and sprouting roots around its core. We file up the stairs into the open-air sanctuary, t-shirts and all; another Sunday morning. The rows of pews outnumber the congregants, especially after my host siblings leave in the middle of the service to play barefoot amongst the weeds growing behind the small baptistery. My host grandfather ordained himself the minister for the town, and the only members seemed to be his family. Nevertheless, he gives a rousing sermon and leads us in prayer. We hold Bibles from the 1980s with names inscribed in pencil, each one over another.

"It's been two thousand six hundred and sevety-two days since I have been saved," my host grandfather exclaims. "I saw God in a dream, and I have been saved ever since." He fails to mention the American missionaries who learned his native Kichwa and inspired him to reinterpret his own ideology into one that coincided with Christianity.

"With God's strength, we were able to build this beautiful church." He fails to mention the numerous foreign donors who contributed the necessary money for the task to be completed.

My host grandmother, a frail, illiterate woman, holds a Bible close to her chest and rocks back and forth, her mouth and eyes never opening, she rocks back and forth.

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3. A quarter of a million people pack themselves in alleyways and sun-splashed sidewalks in the Historic Center of Quito. The street is deserted, its black asphalt a stark contrast to the magnitude of bodies inching their way towards it. We watch hundreds of men in purple robes begin to march through the colonial-era avenues, the brightness of their costume an eyesore against the sixteenth-century architecture behind them. Church bells toll. The only sound, aside from muffled conversation, is that of struggle: these men tie chains to their feet and drag them for miles through the city; boys carry substantially sized crucifixes above their heads like tree trunks; men affix barbed wire around their naked chests and openly bleed, filing stoically but biting their lips against the pain. These men are known as "Cucuruchos:" they wear long gowns, masks, and tall pointed hats, often without shoes. They create a sea of purple, and to the Western eye would be mistaken as a Ku Klux Klan member. They march as acts of penitence and humility in the Procession of Jesus of Great Power (*Jesus de Gran Poder*) on Good Friday each year, and through this they demonstrate to the world their unequivocal devotion to their religion.

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It is hard to imagine this country before the Spanish: we can envision open plains in the *sierra* instead of the bejeweled cathedrals dotting the landscape, or indigenous traditions at the forefront instead of parades in honor of Jesus Christ. Colonialism, especially by means of religious conversion, has become ingrained in Ecuadorian culture, indivisible from our perception of it today. The culture is marked by the religiosity of its citizens who, for the most part, self-identify as Catholics. There are signs of the religion in many aspects of daily life: there are crucifixes in nearly every public bus or taxi; the historical center of Cuenca, the third largest city in the nation and where I did my fieldwork, has 52 churches in its several square-mile historical center ("Cuenca Overview" 2015). Even though "of the five largest cities in Ecuador, Cuenca has the smallest percentage of people who identify as Catholics," nevertheless, "in Cuenca, 74.36% consider themselves Catholic, 4.5% identify as Evangelical Christian, and 21.13% say they belong to other religions" (AGN 2015; INEC 2015). In fact, Ecuador is often considered by many scholars to be the most religiously conservative population in the Andean region, and possibly in all of Latin America (Lane 2003). Yet the religious climate in Ecuador is not as conservative as it once was; according to Leonore Cavallero, "there are people who are not religious but are spiritual. There are others for whom religion is part of their reality, almost solely due to tradition, and perhaps the spiritual aspect is less important. There are many contradictions, though—you can be a good Catholic and still drink significantly." Whereas in the past many followed religious practices dutifully, modern Ecuadorians practice in more diverse, liberal manners.

These statistics demonstrate that religion and spirituality are omnipresent and dominant aspects of Ecuadorian culture. Consequently, for a therapy to be effective for

Ecuadorian men, it is critical that it dedicate attention to religion and spirituality; according to Cavallero, to ignore this cultural phenomenon would arguably disregard the importance of religion to the livelihoods of the population (personal communication). But, even though the culture has been Catholic for hundreds of years, the still existing juxtaposition between indigenous culture and the more urban, Catholic society in Ecuador subtly and implicitly recalls the effects of Spanish colonization and Western imperialism, as many of the indigenous were forcibly converted under the guise of self-improvement. In the modern context, a focus on Catholicism as a key aspect of health rehabilitation does not only connote a restructuring of religious ideology, but also a reformation of the self and holistic improvement – corporeally, spiritually, and medically. The use of Western religion in the rehabilitation process, from this perspective, is a remnant of these colonial ideals: it can be seen as representing the Western conception of development, progress, and healing on an individual level. In this light, its use in the Alcoholics Anonymous Twelve Step program further reifies this, rendering the addict a more "perfect" example of what it means to be an alcoholic in the Western context.

In this chapter, I explore how religion has come to act as a remnant of Ecuador's colonial past, and how its use in A.A. subtly reaffirms imperialism upon the patients. Even though, officially, A.A. is not religious, the way that *Twelve Steps* intertwined Catholicism and Christianity into the therapeutics made it indisputably a core aspect to the program. Moreover, I argue that the type of religion that A.A. propagates, through its language and literature, is irreconcilable with traditional Andean cosmology, and thus when it is utilized in the A.A. context, it attempts to transform the patient more into a

Western being, in a direct evocation of the forced conversions of the indigenous of the 16th-18th centuries.

Colonial Roots of Catholicism

Whether one believes the opulent cathedrals are priceless jewels or, on the contrary, symbols "of centuries of physical and psychological oppression," as Lane (2003:92) argues, they both bring to mind "another of Ecuador's most durable colonial specters." Regardless of opinion, a large motivator for Spanish colonization of the Americas was an attempt to spread religious influence, just as much as it was motivated by economic and political means. The supposed treasure throughout South America was meant to fund not only royalty but also the Catholic crusade against other European religions (ibid.). Other factors of mass conversion in the New World was based around the view that preaching the gospel to native Americans would "bring about the millennium, the final, thousand-year reign of Christ on Earth" (Lane 2003:92-3).

In the Colonial period, it was widely believed by the colonizers that through religious conversion—especially conversion to Catholicism throughout Latin America—the individual could improve his life as a whole. Examples of this are rife throughout the history of imperialism in Ecuador: in an agrarian society, for example, this was demonstrated through the Salesians, a Roman Catholic order, who combined "peasant evangelization with human development." They understood "human development" as assisting peasant farmers in their struggle to obtain land and better maintain crops (Martínez Novo 2009:203-4). Similarly, even though many native Ecuadorians exhibited "great disdain" for religion, did not attend church services, and displayed no special

respect for religious figures, they still paid priests in gold, tobacco, and pita for prayers or weddings as part of the colonial system. The Church justified taking from their surplus by "alleging its social duty to 'civilize' them, and its religious mission to 'evangelize' them" (Muratorio 2009:88). It is clear that evangelization and civilization of the indigenous work simultaneously as a form of colonization throughout Latin America.

The system of *encomiendas* ,or "trusts," throughout the Colonial period also demonstrates the power dynamic at play between the Western colonizing forces, as represented by the Church, and the indigenous Ecuadorians. *Encomiendas* were given by the Crown to Spaniards who could be trusted to run the empire abroad; it was a grant of rights to "collect tribute from a carefully defined indigenous population" and was determined not by the amount of land a Spaniard owned, but rather by how many natives he enslaved. In exchange for converting his slaves to Catholicism, the indigenous individuals would provide him with agricultural services, cultivate crops, and offer other forms of menial labor (de la Torre and Striffler 2009:11). The Church also exploited the surplus of the indigenous in often "ostentatious" ways by building massive cathedrals or allowing clergymen to obtain opulent goods; this did not supply capital for the colonial economy but rather impeded capital formation, resulting in disadvantages for the general population (Bauer 1983:708). However, today, remnants of these systems are what are considered architectural masterpieces in the historical centers of colonial cities like Quito or Cuenca: shimmering domes dot the horizon and form the city skyline.

Throughout the history of imperialism in the New World, then, the Spanish Church managed to spread its influence into "every corner of the newly converted Indies" (Bauer 1983:707). Catholicism had such a profound influence on the population that it

was considered the only tolerated religion in the nation from its independence in 1830 until 1904, and attempts to separate the church from the state failed throughout the whole of the nineteenth century (Lane 2003:94). Even as it was a free, independent state, the Church acted like an imperial hand within the nation by requiring taxes and tithes on the people. Even presidents openly condoned Catholic practices: they marched in the Good Friday processions and sponsored missions to convert the indigenous of the Amazon (Lane 2003:94). It was not until the twentieth century that the power of the Roman Catholic Church was finally disassembled, and more liberal social practices like religious freedom, divorce, and public education were established. The country still bears the scars of its colonial past through its religious conservatism as it remains today: it is hostile towards women's and gay rights, for example, because of the religious undertones.

Despite Catholicism's reach, however, folk religions and indigenous practices have not been exterminated from Ecuador's common consciousness. Shamanism and traditional healing techniques remain as important facets of the pluralistic medical system—less so in urban areas, but nonetheless still encountered. Hallucinogenic plants like *ayahuasca*, although often appropriated for drug tourism in the modern context, are also still utilized in the traditional method to achieve altered states of consciousness and explore other aspects of self. Shamans and traditional healers meet important social and psychological needs, even within a modern society, and are not likely to disappear, even as newer biomedical resources become more available and popular (Price 2003:210-1). However, Catholicism and—more recently—Evangelical Christianity have become inculcated into society so much that, if an individual were to seek religiously-affiliated forms of healthcare, the modern Ecuadorian would seem *bien educado*, or (literally) well-

educated, if he sought out Catholic- or Christian-based healing methods; on the other hand, he would sacrifice this cultural identity and social standing by choosing indigenous remedies (Price 2003:214).

Religion's reach extends far beyond the walls of the cathedral: it inhabits a role in every aspect of life, from breakfast in the morning to the bus ride home. Even though it is culturally ingrained, I argue that it is a subtle, omnipresent reminder of imperialism, westernization, and Latin America's tough history of dispossession and loss of autonomy (Viñán 2011). Within the healthcare paradigm, this is paralleled—for forms of rehabilitation from addiction, the most prevalent programs are twelve step programs that rely on Western conceptions of religion, further pushing an imperialistic system upon Ecuadorians. Even though modern Ecuadorians are, undoubtedly, fundamentally influenced by the West, this process within the healthcare system further removes them from their own unique culture and traditions and attempts to make them into more Western beings.

It is important to recognize the distinctions between "Western religion" and those practiced by indigenous Ecuadorians. I do not intend to equate many different religions (for example, Catholicism, Evangelical Christianity, and Protestantism) by placing them under the same umbrella term "Western," but I rather hope to contrast the differences between monotheistic, Judeo-Christian conceptualizations of God and religion with the polytheistic, nature-based, traditional Andean cosmology.

Religion and Alcoholics Anonymous

Before Bill W. became one of the most revered men the world over, he was a failed stockbroker who had one too many shots of whiskey. In 1934, the man who would go on to found Alcoholics Anonymous found his way into a New York hospital and had a spiritual awakening after a plea to God: he saw a flash of light and a feeling of serenity, like none other that he had ever experienced. After that, he stopped drinking alcohol for good and founded A.A. (Glaser 2015; Alcoholics Anonymous 2001).

This story, fabled or true, provides exposition for why A.A. has been argued to have a religious basis: not only did Bill W. pray to God and feel immense serenity, which ultimately led him to abstain from alcohol, but he based the principles of the rehabilitation program on the evangelical Oxford Group, which claimed that sinners could right their paths through "confession and God's help" (Glaser 2015). In an era where alcohol addiction was viewed as moral failing, the disease model of addiction has an interesting twist here: Bill W. and the other co-founders of A.A. relied upon spiritual and religious actions, including prayer, accepting a higher power, and asking God to remove all character defects, to attend to what is *not* an issue of morality but rather a medical phenomenon. It is a natural paradox: issues of morality are usually solved through faith and spirituality, whereas Western conceptions of medicine tend to divorce themselves from those topics. This is a central tenet of AA, though, and guides the rehabilitation process.

As the A.A. program has evolved and spread both domestically and globally, it has had to grapple with how it defines the role of religion. A pamphlet titled "Members of the Clergy Ask About Alcoholics Anonymous" (Alcoholics Anonymous 1992:13)

clearly states how they want the public to perceive how religion is affiliated with the addiction treatment process:

> Is Religious Belief Part of the A.A. Program? A.A. does not inquire into alcoholics' religious beliefs—or lack of them—when they turn to the Fellowship for help. However, the A.A. program of recovery is based on certain spiritual values. Individual members are free to interpret these values as they think best, or not to think about them at all. Most members, before turning to A.A. , had already admitted that they could not handle their drinking—alcohol had taken control of their lives. A.A. experience suggests that to get sober and stay sober, alcoholics need to accept and depend upon a spiritual entity, or force, that they perceive as greater than themselves. Some choose the A.A. group as their "Higher Power"; some look to God—as they understand Him; and others rely upon entirely different concepts. Numerous alcoholics, when they first turn to A.A. , have definite reservations about accepting any concept of a Power greater than themselves. Experience shows that, if they maintain an open mind on the subject and keep coming to A.A. meetings, they will in time find an answer to this distinctly personal dilemma.

AA, as a program, insists that it is not affiliated with any sort of organized religion, and that it works for anyone who is willing to keep an open mind about spirituality. It argues that they have members who are "atheists and agnostics," and "people of every race, culture, and religion […] bound together in the kinship of a common suffering" (Alcoholics Anonymous 2014:4). However, "in practice, though, a religious tone became the norm within AA," and is still a noteworthy aspect of the program (Freedman 2014). It has definitely adapted throughout the years since its formation—for example, by adding the clause "as we understood Him" after mentions of God—but it still requires a belief in a God, and a male God at that. Even though much of the literature aims to illustrate that all religious and spiritual conceptions work with the program, its evangelical roots and faith-based aspects to the twelve steps remain problematic. It inherently relies on the Western conception of faith and religion, and in the Latin American context, forces this

ideology upon the person suffering from addiction, fashioning them a more Western-understood version of an *alcoholic*.

Out of the twelve steps, seven of them—more than half—refer to God or some aspect of spirituality. They are:

> Step 2: Came to believe that a Power greater than ourselves could restore us to sanity.
>
> Step 3: Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
>
> Step 5: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
>
> Step 6: Were entirely ready to have God remove all these defects of character.
>
> Step 7: Humbly asked Him to remove our shortcomings.
>
> Step 11: Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
>
> Step 12: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Alcoholics Anonymous 2001)

The fellowship of A.A. gives its members the flexibility to interpret this spiritual dogma for themselves, especially in their conception of "God, as we understood him." The Big Book offers several paths to better understanding God in relation to AA, depending on whether the individual *will not* believe in Him, *cannot* believe, or believes He exists but does not believe He will perform the miracle of abstinence from alcohol.

In the first case—the case of the man who is "belligerent" against believing in God—A.A. argues that it "does not demand that you believe anything. All of its Twelve Steps are but suggestions" (Alcoholics Anonymous 2012:25). It also argues that all an individual must do is keep an open mind, "to stop fighting," and they will understand how God's will functions (Alcoholics Anonymous 2012:27). This is also prescribed to individuals who feel as though they cannot accept God as a higher power.

A.A. also stresses that the person suffering from addiction must not need to accept a God-like figure as their higher power, but rather any being greater than the person himself. For example, "you can, if you wish, make A.A. itself your 'higher power.' Here's a very large group of people who have solved their alcohol problem. In this respect they are certainly a power greater than you, who have not even come close to a solution. Surely you can have faith in them. Even this minimum of faith will be enough" (Alcoholics Anonymous 2012:27). This apparent flexibility allows the patient in the program to feel autonomy in choosing a higher power and makes it seem as though it does not need to be religiously-based; however, because all of the literature uses the term "God" in lieu of "higher power," it engenders the implicit understanding that the most acceptable form of higher power is a Western conception of God.

For the man who believes in God but does not believe that He will help him, the Big Book suggests that "the answer has to do with the quality of faith rather than its quantity" (Alcoholics Anonymous 2012:32). Even though the program insists that it is inherently not religious, it instructs its members to reevaluate their faith in order to have a better relationship with God—a precept that would otherwise belong in a strictly theological setting. It is difficult to argue that this program, which argues for the rehabilitation of a medical disease, is not completely divorced from organized Western religion and westernized conceptions of spirituality. In fact, the literature later goes on to state that "every A.A. meeting is an assurance that God will restore us to sanity if we rightly relate ourselves to him," which moreover assures the patient that his treatment relies solely on his religiosity and submission to a higher power.

Other excerpts of A.A. literature are inherently religious in nature, and can even be mistaken for canonical religious texts. There are several claims that "prayer and meditation are our principal means of conscious contact with God," and that "we all need the light of God's reality, the nourishment of His strength, and the atmosphere of His grace" (Alcoholics Anonymous 2012:96-7). Beyond "suggesting" prayer throughout the twelve steps, the literature preaches that communication with God is a necessity for a successful completion of the therapeutic process. Furthermore, it emphasizes following the religious and spiritual guidelines of A.A. instead of one's own faith inclinations; a Jewish patient in the literature states that, after being a member for a long time, he was able to "recite the Lord's Prayer without feeling guilty since it was pointed out to [him] in 'How it Works' that [he has] to go to any length to get and stay sober" (Alcoholics Anonymous 2014b:9).

The A.A. literature also recognizes that the mentions of religion, spirituality, or God can push away several members that would otherwise seek its assistance. Many have a "misconception" about A.A. that it is a religious organization, and some struggle with trying to accept a sense of faith that they do not believe in (Alcoholics Anonymous 2014b:4). The literature attempts to quell this idea by providing stories of others who "felt at odds with what [they] perceived to be a religious approach to A.A. or pressure to adopt certain religious or spiritual concepts in order to remain in AA" (Alcoholics Anonymous 2014b:6). For example, the story of a Sioux/Blackfoot woman is recounted, in which she felt relief that she could believe in "the Great Spirit" instead of a God determined through "the white man's world" (Alcoholics Anonymous 2014b:8). Another individual's story is told, who is a Catholic—he mentions that he is "perfectly okay with

others referring to Buddha, Mohammed, Yahweh, or whatever name they call their higher power," but would get uncomfortable were someone to cite "the Bible, the Koran, the Talmud, or any non-A.A. literature as the truth in an A.A. meeting" more than just a quote or reference (ibid.).

This begs the question: how does A.A. function in Latin America, where the population is devoutly religious but still adheres to its Andean cosmology?

Latin America and A.A.

In the Latino context, by calling to a Western conception of God through a medical healing process, as the Alcoholics Anonymous program promulgates, it further demonstrates how colonialized the region remains. Furthermore, by nature of the program, the person suffering from addiction is modeled into the Western conception of an alcoholic, regardless of his cultural background, and is thus fashioned into the Western process of treatment. The twelve-step program does not easily allow for the Andean polytheistic and nature-based cosmology, and actively works against several facets of Ecuadorian culture. Just as the Spaniards infiltrated Latin America in the sixteenth century and abolished any sense of individuality, the medical system in place for addiction rehabilitation attempts to engender the addict into a more Western, colonialized being that can fit seamlessly within this form of healthcare treatment.

One significant way Andean culture is irreconcilable with the twelve-step program is through the insistence on a monotheistic, Western conception of God or *a* higher power. The traditional Andean religious concept is inherently polytheistic, involving idolatry, sacrifice, and open communication with deities not recognized in the

Judeo-Christian model of religion. The gods that are traditionally part of the Andean pantheon include *Viracocha*, the creator deity; *Pachamama*, the goddess of the land and nature; *Inti*, the sun deity, and *Illapa*, the Lord of Thunder, Lightning, Hail, and Rain (Kolata 2013:164). These nature-based deities do not coincide with the Western conception of one omnipotent and omnipresent God or higher power that is common throughout Western religions. Moreover, the socioreligious nature of idolatry and oracles are at odds with the system of organized worship in the Judeo-Christian tradition, in which generally men constitute the principal religious practitioners as rabbis, priests, and imams (Kolata 2013:170-1).

The Spanish conquest of the sixteenth and seventeenth centuries attempted to eliminate all remnants of indigenous spirituality; as colonizers, the European officials enslaved workers to construct monolithic cathedrals praising a foreign God and coerced them to convert. The indigenous were resilient, though: they continued to practice their traditions and rituals in the face of imperialism. For example, when they were forced to practice Catholicism, they reinterpreted the image of the Virgin Mary and instead affixed her the incarnation of Pachamama, the indigenous concept for mother Earth, femininity, and fertility (Merlino and Rabey 1992). Even though the colonizers attempted to "destroy all practices associated with native religious traditions, including healing rituals," the current atmosphere in the Andean region—both in terms of tradition as well as healthcare—reflect the resilience of the indigenous (Alchon 1991:131). The modern day system of health incorporates Western medicine as well as the Catholic and indigenous traditions; "Catholic-based miracle cures are not disparaged, as are those of diviners or certain other healers," such as shamans, who have their basis in pre-colonial times (Price

2003:226). How modern-day Ecuadorians seek out healthcare is a microcosm for how they view religiosity: although Western conceptions of religion, such as Catholicism and Christianity, are the most prominent, there is still a significant indigenous influence.

Consequently, as many anthropologists have previously argued (e.g., Bennett and Cook 1996), any treatment program for a specific culture should address the cultural context, such as the religious or spiritual nature of the population, in order to be successful. In many respects, A.A. promulgates a single understanding of religion that is incongruous with the Ecuadorian context; as a result, the treatment program at *Twelve Steps* struggles with fully connecting to its patients on a spiritual level and significantly loses efficacy. By using the twelve-step program of AA, the treatment regimen at *Twelve Steps* forces the patient to believe in only one *higher power*—essentially, a Christian manifestation of God—that may not align with how the modern-day Ecuadorian man actually comprehends religion. This further reflects the neo-colonial nature that A.A. has in Ecuador, as it rejects any indigenous understanding of spirituality and attempts to refashion the alcoholic into a more Western conception of patienthood.

The language in the twelve steps excludes any possibility for the traditional Andean cosmology, as it propagates the notion of a monotheistic higher power that has an omnipotent locus of control upon the body. Although this linguistic feature is arguably minor, it inherently rejects a key aspect of traditional Ecuadorian religion and forces the patient to accept only one concept of God, thus engendering him a more "Western" being. Because the Andean idea of spirituality includes multiple higher powers that work in conjunction with one another to govern human beings, the language of the twelve steps that only allow for *one* higher power works against this understanding. For example, the

twelve steps argue that an alcoholic must believe in "*a* Power greater than ourselves" to restore us to sanity, or that an alcoholic make a decision to turn his will and life over to the care of "God as we understood *Him*." The words "a" or "Him" necessarily entail a monotheistic understanding of a higher power, not allowing for multiple God-like beings such as Viracocha, Pachamama, Inti, or Illapa, who all have control over the body in Andean cosmology. Furthermore, the capitalization of Him and God demonstrate the specifically Western ideology of religion in the form of traditional Biblical translations.

Twelve Steps followed the A.A. ideology when incorporating religion into its therapeutic practices. All of the clinicians used some form of spirituality as part of their rehabilitation regimen, and all of the patients that I interviewed were receptive to this being an aspect of the program. As David, one of the patients, argued, "the program is more spiritual than psychological. It would be impossible to cure yourself with only psychology." The clinicians use flagrant signs of religion in their practices: Dr. Sánchez uses the Bible because "the messages from the parables are clear. God, or a higher power, is the only one who can cause someone to rise from his illness. Spirituality helps people be freed from their problems." She expressed her belief that religion alone can cure someone, sharing a story with me from her work at another clinic: "I had a patient who was antisocial. There was an intervention with a Christian group, with an Evangelical pastor. He taught [the patient] to read the Bible. The patient changed dramatically. Religion is very powerful. The word of God helps us to self-reincarnate. The love of God does not judge or criticize. It is a God of love." Furthermore, Dr. Sánchez—who has clinical training in psychology—claimed that psychology alone cannot cure a patient;

rather, it must be complemented with spirituality. She said that "we need to complement therapies with other theories that we have," namely, religious belief.

It is also important to note that every patient I interviewed at *Twelve Steps* believed that the ideology of the program was religious-based. There was no denying that the program followed Catholic and Christian precepts, and many admitted to me that the pervasive religious tone was a key aspect of the therapeutic methodology. This is completely antithetical to the majority of American members of A.A., including the literature, the quickly asserts the notion that the organization is not religiously affiliated whatsoever (Alcoholics Anonymous 2014b; Alcoholics Anonymous 1992; Alcoholics Anonymous 2001, to name a few).

Not all of the clinicians at *Twelve Steps* relied as heavily on religion as Dr. Sánchez did. Dr. Orellana, for example, focused less on the religious aspect and more on spirituality, claiming that "it doesn't matter what the patient believes, but that they stick to what they believe and strengthen his self-motivation and self-discipline." This coincides with the traditions and steps of Alcoholics Anonymous, as she does not force one specific religious tradition upon the patients but rather encourages spirituality as a basic concept to help in the rehabilitation process.

Although not every clinician based their therapies around a specific religion, each week at *Twelve Steps* an Evangelical Christian pastor came to preach at the *terapia espiritual*, or "spiritual therapy." This weekly practice took place at 8 o'clock at night on Wednesdays, after all of the daytime staff had departed. This was fundamentally religious: Luis, the preacher, opened up the session by saying that the goal "is that we get to know God better, and to remember that God wants you all to be here." This conception

of God is exclusively one from an Evangelical Christian standpoint, and the preaching that Luis gave for the hour and a half period was all framed around Christian teachings. Part of his lessons required that each patient had a Bible, for the word of God "is going to help you a lot" throughout the process of rehabilitation. He argued that "only He can raise us up," and that before the patients arrived at the clinic, they were "without light."

Essentially, Luis is acting as a colonizing body in conjunction with Alcoholics Anonymous to fashion the patients into more westernized beings. Just as A.A. promotes a Western conception of spirituality as a means of rehabilitating the patient, Luis argued that his main goal was to have the patients see the "light" of his conception of God—a necessarily Western conception, at that—in order for the patients to successfully complete treatment and stay sober. Luis further claimed that "Christ is the only one who ahs the power to give life when you are in a world full of wrong and sin," which wholeheartedly rejects any other conception of a higher power as a rehabilitative force. Moreover, in relation to the second of the twelve steps (accepting a higher power), Luis said that "it is fundamental that we know God as the higher power. The power is *not* the group, or this desk—we must recognize Him by His name." This illustrates, doubtlessly, that the rehabilitation program at *Twelve Steps* did not allow for any other conception of a higher power; it forbid the traditional Andean cosmology and pushed strongly for the Western understanding of God.

An more baffling aspect of Luis's spiritual therapy is that he relied on the teachings of Evangelical Christianity in a country that is still majority-Catholic. Most of the patients had strong Catholic roots, and during the therapy itself, were outwardly bothered and resentful of the Christian teachings. When asked about this dichotomy

between the two religions, Luis responded that "it is difficult for Catholics to listen to someone preaching Evangelical Christianity. Yes, it is tough. It is hard for the patients here. In a Catholic country, when someone preaches Evangelical ideas—people confront you, they argue with you. There is a clash. But it still helps them." Luis recognizes that there is a significant conflict between the two teachings, but still hopes to use the twelve-step platform as a form of conversion. This is profoundly neo-colonial, and is a visible analogy for how A.A. as a program internationally works to convert the patient into the Western conception of an alcoholic to then by treated by Western means. Although A.A. does not promote a single understanding of a religion, the themes are understood abroad as fundamentally Western, and the clinic felt as though the only way the twelve step process could work successfully was through the integration of Western religious ideology.

Catholicism and Christianity, as institutions, are inherently markers of colonialism in Latin America. Even though these themes are ingrained in modern culture, remnants of the indigenous cosmology still exists in daily life as well as in the healthcare system. At *Twelve Steps*, and in Alcoholics Anonymous in general, however, this lack of recognition of traditional roots is a constant reminder of the imperialist nature of religion in the region. The history of colonialism includes forced conversion to these Western religions, and this is still a strong aspect of Ecuador's collective memory. By preaching these Western concepts of religion and using A.A. as a rehabilitation method, which does not allow for indigenous understandings of spirituality, the patients are essentially enduring colonialism again and being fashioned into more Western concepts of "alcoholics," being treated by a necessarily Western program.

Conclusion

As we walked back from the quick post-lunchtime break at the *tiendita* on my first day at *Twelve Steps*, Andrea ensuring that she smelled like spearmint rather than cigarette, we walked past a pile of empty beer bottles on the sidewalk. This sort of scene was common and pedestrian for the others, but I stopped in my tracks. At least fifteen one-liter bottles lay there; the remnants of *una fiesta* by the river, right outside the gates of the clinic.

The most popular and traditional brand of beer in Ecuador is *Pilsener*, and it is sold at nearly every convenience store in the country—from the coast to the Amazon. It is sold beside popsicles and chocolate candies, next to cigarillos and chewing gum. The beer has produced in the largest city in Ecuador, Guayaquil, since 1887, and is a weak lager with its roots in the *Pilsner* style ("Cervecería Nacional"). Pilsner beers are originally from the Czech Republic, but the style has since spread internationally. They are still remarkably European, though, and the crisp style remains an integral part of Central European culture and cuisine.

Like almost everything else in Ecuador, this is a sign of the imperialist nature of the West upon their culture. The national beer, a fundamental aspect of society and a source of pride for the population, is inherently Western. When Ecuadorians drink too much of it, they are then subject to treatment by Western means. Their own autonomy as Ecuadorians and Latin Americans, with their own form of popular culture and tradition, has been violated by this more subtle form of neocolonialism, with arms outstretching into the everyday life of the citizens. A *fiesta* by the side of the river is not their own doing—the way that they consume is intrinsically controlled by the West.

Alcoholism in the modern context is understood not only by biological means or as a disease; it is fundamentally socially and culturally constructed, and its treatment programs should fit the culture that is serving. Alcoholics Anonymous, as an American-based program, does not necessarily address issues of identity, masculinity, or religion in the Ecuadorian context, which makes it arguably a less successful therapeutic program. The notion of cultural psychology and the ideas of many modern anthropologists support the claim that therapeutic programs function best when they aim to address the culture it is in.

When A.A. is implemented in the Latin American context, it clearly exists as an American program with Western ideologies and conceptions of identity, gender, and religion. A crucial aspect of the program is that the patient knowingly transforms his identity from that of a drinking non-alcoholic into to a non-drinking alcoholic; in Ecuador, this identity transformation is more than just one involving an understanding of self, but it necessarily forces the patient to negotiate with issues of masculinity and religion that do not align with his native context. By accepting the label of "alcoholic," an Ecuadorian man must reconfigure his life story into one that fits the A.A. story model, work around the *machista* culture and admit powerlessness and imperfection, and accept a monotheistic, Judeo-Christian conception of God to help overcome his disease. In this way, A.A. transforms the body into a more Western characterization of what an alcoholic should look and act like, removing the patient from his own culture and into a novel, more Western one. This is another, more modern and subtle iteration of colonialism that continues to impact Latin America.

One presiding belief that I heard throughout my fieldwork was that, because A.A. is an American program, it is inherently "better" than any Ecuadorian program or other form of healing. However, I argue that the success of a system of care is *not* determined by its origin, but rather by its ability to be cultural competent. One's culture is an intrinsic aspect of one's self, and especially in the healthcare context, a culture must be reaffirmed rather than negated or subverted. A.A. is a program that was constructed within a Western culture *for* members of that culture; if it does not possess the ability to remain culturally competent, it may lack success. A therapeutic program works best when it is adapted to the culture it is meant to serve; there are flaws and ethical dilemmas when a program attempts to perform the opposite and conform the patient for the medical system.

Anthropologist David Levinson (1983), for example, argues that cultural factors influence the alcoholism treatment process, and it is vital to address that culture when building a therapeutic program for a specific population. He claims that behavior modification treatments of alcoholism are the most successful because they "do less damage to the cultural identities of the individuals receiving treatment," and thus allow the patient to have a continued sense of self during recovery (1983:256). He contends that Alcoholics Anonymous "implicitly requires members to give up their cultural identity and adopt instead the identity of A.A. member or recovered alcoholic," which is often irreconcilable with other aspects of self (ibid.). He pushes for behavior modification treatment programs because they have showed empirical success as well as a lack of interference with one's culture (ibid.).

Other specific cultures have found competent methods of alcoholism treatment that specifically negotiate the cultural factors most important for the population. One

significant example is how Navajo people use peyote, a hallucinogen, to assist in a transformation of self, a revitalized sense of community, and a new vision of the future that leads to treatment from alcohol abuse (Garrity 2000). Religious leaders use the drug in conjunction with the Native American Church to help sufferers refocus on the harmony and beauty of their culture, in the hopes that a return to their specific understanding of the world will assist in treatment. Because it was developed by members of the Navajo community for other community members, it is inherently culturally competent and reconfigures the autonomy of healthcare onto the population itself.

I do not intend to say that Alcoholics Anonymous has no place in Ecuadorian society, or in society in general. Rather, I hope to demonstrate that there are flaws with the ideology that, merely because it is Western, it is inherently better than a traditional approach to treatment or one that is more fitted within Andean culture. A.A. has been demonstrated to assist many out of the depths of alcoholism, and there are surely many in Ecuador who have found solace in the twelve step approach. I do suggest, though, that the patient is considered when developing any form of treatment, as he is the sole individual who needs to benefit.

As I stood in front of the discarded beer bottles, dew overtaking the opaque glass, it was impossible to divorce the substance from the addict. I turned and faced *Twelve Steps* directly across the street from me. Even though the windows were barred, the glass tinted, on the upstairs levels, I could still see the outline of a young patient, his hand on the window, making every effort to make the first step forward.

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Appendix

The Twelve Steps

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs

Twelve Traditions

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever nonprofessional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.