SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

Women, addiction, and rehabilitation: Reflections from the northwestern border of Mexico

Mujeres, adicción y rehabilitación: Reflexiones desde la frontera noroeste de México

***Galaviz Granados**, Gloria*[1]

[1]*Bachelor's degree in History. Ph.D. in Social Sciences. Postdoctoral Researcher, El Colegio de la Frontera Norte, Mexico. gloria_galaviz@hotmail.com*

ABSTRACT Since the recognition of addiction as a mental illness, studies concerning treatment and therapeutic models have tended to focus on its psychiatric and psychological dimensions. The aim of this article is to highlight the centrality of the social dimension, not only as potential trigger of addictive behaviors and of stigma regarding these behaviors, but also as a variable that permeates diagnosis and treatment. The reflections are based on fieldwork carried out in rehabilitation centers for drug-consuming women in the border city of Tijuana, northwestern Mexico. The results show that the predominant therapeutic models in the city are based in and reproduce the traditional role of women. The social implications of this finding are analyzed, and it is suggested that these centers could be better utilized in the process of building a society with greater gender equality.

KEY WORDS Women; Substance Dependence; Rehabilitation Centers; Anthropology; Mexico.

RESUMEN Desde que la adicción adquirió reconocimiento como enfermedad mental, los estudios relativos al tratamiento y modelos terapéuticos han tendido a centrarse en sus dimensiones psiquiátricas y psicológicas. El objetivo de este artículo es destacar la centralidad de la dimensión social, no solo como potencial detonante de comportamientos adictivos y estigmas sobre ellos, sino como variable que permea también su diagnóstico y tratamiento. Las reflexiones parten del trabajo de campo realizado en centros de rehabilitación para mujeres consumidoras de drogas, en la ciudad fronteriza de Tijuana, al noroeste de México. Los resultados arrojan que los modelos terapéuticos predominantes en la ciudad se basan en el rol tradicional de la mujer y lo reproducen. Se analizan las implicaciones sociales de este hecho, y finalmente se sugiere que esos centros podrían ser igualmente aprovechados en el proceso de construcción de una sociedad con mayor equidad de género.

PALABRAS CLAVES Mujeres; Adicción a Sustancias; Centros de Rehabilitación; Antropología; México.

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

INTRODUCTION: WOMEN, ADDICTION, AND REHABILITATION

Although in other countries[1,2,3] several research studies have been carried out in connection with rehabilitation centers for people who consume problematic amounts of drugs, in Mexico this is an issue that has not been deeply studied, and that deserves closer attention by the academic community. The study of rehabilitation centers is particularly relevant in the Baja California border region, because of the increased number of drug users over the last years,[4] as well as the number of centers registered with the state that are committed to address addiction problems.[5]

In 2012, an interdisciplinary and inter-institutional team of researchers, aware of the need to have in depth knowledge about the social implications of these facts, started a diagnostic study about the therapeutic offer on that matter in the Baja California border region. This paper shows the findings and reflections resulting from the study of centers for women in the city of Tijuana.

This analysis is relevant for several reasons. On one hand, there is little information about an issue that has experienced an important growth in the last decades. According to the results of the National Addiction Survey (ENA, from the Spanish *Encuesta Nacional de Adicciones*) from 2002 to 2008,[6] the number of women who admitted having used illegal drugs at some point of their lives has duplicated in Mexico (from 1 to 1.9%), whereas in Baja California the number registered in 2008 was 5.1%, two and a half times higher than the number reported nationwide. Furthermore, the survey showed a gender disparity in the current regional therapeutic offer: as it will be mentioned later, about three quarters of the centers in Baja California do not admit women. The analysis of these centers contributes to the understanding of a growing, and poorly explored, phenomenon, and helps to visualize the centrality of the social dimension in the diagnosis and treatment of the addiction. The purpose of this paper is to highlight the importance, and the advantages of considering social factors in therapeutic models to render a better medical care service. Given its transversal feature, gender[a] is one of the main factors to be taken into account.

METHODOLOGICAL ASPECTS

The research team is made up of sociologists, anthropologists, demographers, communicators, and epidemiologists from El Colegio de la Frontera Norte, Universidad Autónoma de Baja California, and University of California, in San Diego.[8] The empirical material analyzed resulted from a field work that took a year and a half (from February 2013 to August 2014), and was carried out in Tijuana in rehabilitation centers for women with problematic drug consumption.

In a certification course delivered by the Institute of Psychiatry of Baja California (IPEBC) [*Instituto de Psiquiatría del Estado de Baja California*], a Participant Observation was made in five centers for women from February to July 2013, and an interview was conducted with the directors of these centers. Furthermore, intensive field work was carried out in two centers; the first center follows the Narcotics Anonymous model, and the other center is "Christ-centered," which means that the treatment undergone by patients is based on the figure of Christ. The latter center will be referred to as "Christian" or "religious center." The field work consisted of regular visits to both centers (once or twice a week for five months) as well as an inmate stay for one week in each center by myself. Those visits enabled researchers to live with more than ninety female inpatients, some of whom have been admitted to several rehabilitation centers in the city, and the state of California (USA), thus providing a panoramic view of the therapeutic offers in the region, and their characteristics.

The project was assessed and approved by the Ethics Committee of El Colegio de la Frontera Norte. Moreover, informed consent was given by the interviewes for the purpose of research studies. As sensitive information is involved, participants remain anonymous.

This paper is divided in four sections. The first one addresses diagnosis and treatment aspects in the addiction field, related to socio-historical factors and problems. In the second section, after providing a general context of the studied centers, the characteristics of the treatment are analyzed, highlighting how the accepted ideas about the feminine gender affect medical care models. In the

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

third section, some limiting conditions of the rehabilitation centers under study will appear, which are due to the treatment and to inpatient characteristics. Finally in the last section it is proposed to take advantage of these rehabilitation centers to build a more gender-equal society.

SOCIAL ASPECTS IN ADDICTION DIAGNOSIS

Addiction, defined as and considered a disease from the biomedical perspective, appeared in the 20th century,[9] as well as the social recognition and characterization of what an addicted person is. As Ignacio Lewkowickz stated:

> The figure of the addict – apart from medical, legal, and psychic classifications that are specifically detectable – is socially instituted, it is a recognizable subjective type. [...] Addiction is universally recognizable because the social logic where subjectivities occur makes this type of practices possible – and necessary."[10 p.76] [Own translation]

Apart from the social factors that lead people to develop an addictive behavior, it is possible to be clinically and socially diagnosed as an addict, and to admit such addiction because of the socio-historical conditions that appeared in the 20th century. Among these conditions, large scale production and business globalization are outlined.

The conditions that shaped the 20th century have enabled human beings to obtain a wide range of consumer goods and to establish relationship patterns with the goods consumed. One type of relationship consists of the development of negative or pathological behaviors. In theory, the pathological nature of consumption is determined by specialists in mental health, a field where addiction has been included.[b] However, parallel to the clinical perspective, there are other types of diagnosis. Two of them, widely spread in Mexico, and particularly in Baja California, are related to the types of diagnosis offered by Narcotics Anonymous and religious groups, mainly from the Christian-Evangelical denomination.

Despite the diverse therapeutic offer in Mexico, the findings of a survey conducted by the research team in the state of Baja California revealed that from 141 active rehabilitation centers that were reached when the survey was made (71.5% of the total amount of officially registered centers with the state),[c] 64.5% rendered services following the Narcotics Anonymous model; 27% confirmed that their treatment was explicitly religious-oriented, with a predominance of the Evangelical type of treatment; and only 8.5% out of the total offered clinical therapy.[12 p.259-262]

The previously mentioned findings show that, although there seems to exist a varied therapeutic offer, the truth is that those who require addiction treatment have a limited number of options, at least concerning the variety of medical care models.[d] The spectrum is even narrower when it comes to diagnosis. The three identified alternatives (clinical, religious, and Narcotics Anonymous) differ about the etiology and treatment of the disease, but all of them diagnose addiction through a social symptomatology.

In the *Diagnostic and Statistical Manual of Mental Disorders*, the bedside book of clinical specialists known as DSM-IV,[13] the term "addiction" is not used. Instead, the term used is "substance-related disorders," which are caused by abuse or dependence. These substances include legal and illegal drugs.[e] Substance abuse disorder is defined as "a maladaptive pattern of substance consumption that entails clinically significant malaise or deterioration, which causes a change in an aspect (or aspects) of the patient's [behavior] for a 12-month-period."[13 p.188] These changes include: a) failure to meet work, school or home responsibilities; b) consumption that puts physical integrity at risk; c) recurring legal problems for substance use; d) Failure to stop consuming despite the frequent social, and interpersonal problems that are caused or worsened by the substance taken.[13 p.188-189]

Substance abuse disorder differs from the disorder caused by dependence because, in the latter, the addict suffers from tolerance, abstinence, and compulsive behavior. These symptoms involve deeper physiological and social changes in the addicts by progressively increasing the amount of drugs they can consume (substance tolerance), causing physical discomfort after diminishing or ceasing the consumption of the drug (abstinence),

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

and restructuring their lives around the process of drug consumption and acquisition (compulsive behavior).[13 p.186]

Despite etiological differences, the symptoms identified in DSM-IV are similar to the symptoms shown in the criteria adopted by Narcotics Anonymous and religious groups to diagnose a person as an addict. In the latter two, the addict is also considered a person that causes social and interpersonal problems due to drug consumption. Problematic consumption involves losing control over the drug used, which does not enable them to fulfill both individual (personal care) and social responsibilities (family care and maintenance, work, school, etc.).

The clinical picture described helps specialists of every treatment to identify potential addiction cases. However, unlike other mental disorders diagnosed because of social symptoms, deep-rooted prejudices in the western society fall on "addiction," mostly when dealing with drug use.[14,15,16] These prejudices are based on social stereotypes which are continually strengthened by a prohibitionist policy against drugs that criminalizes both the seller and the buyer.[17] A real conscious and constant effort is required to achieve a critical view about the public policies related to this issue.

As addiction is a strongly stigmatized and stereotyped disease, the subjectivity of the person who diagnoses the condition plays a central role. It is worth considering, for instance, whether the social problems identified in the "addict" are related to the consumption pattern or to stigmas and prejudices about consumption the specialist may have. Do diagnostic parameters vary between a man and a woman, or between an adult and an adolescent?

If the answer is affirmative, it can be stated that an addiction diagnosis runs the risk of being much more subjective than other types of health problem diagnoses and, therefore, it is essential that specialists of any therapeutic model make sure that their diagnoses are not influenced by their own social prejudices and paradigms.

This situation is not new. For instance, from 1970s onwards in the US, there has been a "model of cultural competence" with a strong focus on raising awareness and training people who work at health institutions to deal with the cultural differences shown in the population undergoing the treatment. Such differences had to be recognized and considered when offering services.[18] Regarding social sciences, it has been noted that this phenomenon needs to be analyzed from a wider perspective that involves the far-reaching historical and social process.[14,16,19]

Although the importance of the sociocultural dimension when understanding, and treating addiction is not a new discussion in the clinical and academic spheres, specialists still do not thoroughly consider this aspect as part of the whole picture. They tend to privilege the psychological and medical dimension of the disease,[19 p.172] thus limiting the social influence to the family (mostly to the so-called "family disintegration"), and the socioeconomic (in general, lower classes) context. Moreover, specialists rarely make a self-analysis to assess if their diagnosis is mediated by their own training and social values or prejudices.

A key factor that is necessary to increase awareness is gender importance. Although addiction makes no gender distinction, this factor influences the way people become addicts, and face their problem, both in social, and therapeutic matters.[16,19-21] This is more evident when the substance used is a drug, legal or illegal, because the social parameters, and stigmas differ when the addict is a man, a woman or a homosexual person.[15,19,20] Consciously or not, social and therapeutic judgment is conditioned by gender.

In Mexico there is still a long way to go, since there is the need to have research studies that show the importance of considering gender differences on this subject. In the next pages, a description is included about the way in which some accepted ideas about the social role of women guide therapeutic models in rehabilitation centers for women in Tijuana, Baja California. Then, the implications of that reality will be analyzed. The purpose of this description is to show how the absence of a conscious social perspective about the phenomenon, and above all, gender, may cause a therapeutic mistake in a concrete reality. The aim of this research study is to show that the visibility of this reality helps to understand the phenomenon, and improve the treatments provided.

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

REHABILITATION CENTERS FOR WOMEN IN BAJA CALIFORNIA

According to the Public Directory of Addiction Treatments Centers (*Directorio Estatal de Establecimientos Especializados en Tratamiento de Adicciones*), the state of Baja California has 197 rehabilitation centers for drug users (Table 1).

In the summer of 2002, the first rehabilitation center for women in the state was created in Tijuana by the initiative of a woman who was looking for rehabilitation centers for women. She only found all-gender Narcotics Anonymous centers. The founder considered that the way women were treated in all-gender centers was not appropriate, and described degrading activities involving women, as well as love relationships that diverted people's attention from the treatment purposes. These were the reasons why she decided to open a Narcotics Anonymous center ran exclusively by, and for women.

Since then, more than a dozen rehabilitation centers for women have been opened in Baja California. Most of them follow the Narcotics Anonymous model, and the rest follow the self-proclaimed Christian model.[12] Due to their pre-eminence, the following analysis will be focused on these two types of centers.

Each center has its own characteristics, which makes it difficult to generalize. Nevertheless, there are common patterns in the women who are admitted to these centers, and in the role that gender plays in the therapeutic models. This paper will then be focused on the common elements identified in the rehabilitation centers visited in the city of Tijuana. The differences between Narcotics Anonymous, and religious centers will be subsequently analyzed.

Admitted women's profiles go from women who have been consuming for a long time, and suffer from severe physical, mental, and emotional health conditions to women who consume from time to time, especially marijuana. There were cases of women under legal age who have never used drugs but that were considered by their relatives to be hostile towards an authority figure, and were sent to rehabilitation centers with the hope that, through discipline, a potential problematic consumption could be prevented. This is an important fact because it means that women who do not have a clear addictive behavior receive a therapeutic treatment to avoid a potential addictive behavior.

Although there are women with a brief or null consumption history, since these centers are mainly characterized as a low cost treatments (from 1000 to 1500 Mexican pesos on a monthly basis) or free, most addicts are adult women who belong to a lower socio-economic status or that were taken there because they were homeless. Two religious centers declared that their main strategy

Table 1. Rehabilitation centers for drug users registered in Baja California, by municipality, according to the population admitted to these centers, 2013.

District	Men	Both	Women	Total
Tijuana	73	7	8	88
Mexicali	34	14	1	49
Ensenada	37	5	5	47
Tecate	5	2	0	7
Rosarito	5	1	0	6
Total of the state	154	29	14	197

Source: Own elaboration based on data from the Public Directory of Addiction Treatments Centers, created by the Public Board against Addictions (Consejoestatal contra lasadicciones), which is dependent on the Institute of Psychiatry of Baja California, July 2013.[22]

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

to attract people is based on a recruitment carried out by Christian preachers in highly marginalized areas. These preachers encourage people to undergo rehabilitation treatments, for example, by offering parents advice to get their children back after suspension of parental rights and duties.

Regarding treatment characteristics, both types of rehabilitation centers demand that the residential treatment lasts at least from three to six months. It is legal to put people in a rehabilitation center against their will,[23] no matter if they are minors (either at their parents' or at their guardians' request) or adults, if their relatives have previously served notice to the respective authorities [*Ministerio Público*]. It is assumed that the people who are admitted against their will are not mentally capable of making decisions.

During the residential treatment, inpatients are not allowed to leave unless directors allow them to take part in family, work or center-related activities that take place outside the establishment. These permissions are only granted if the inpatient has shown to be reliable. Otherwise, escaping from the center is the only way out. This is why centers have fences and boundary walls with different levels of safety, as well as security guards that watch over the doors, and reprimand inpatients who do not comply with the regulations. As inpatients gain guards' and directors' trust, different tasks and greater responsibilities are entrusted to them in the center, from coordinating activities to becoming guards. This is how inpatients are encouraged to play roles in the new social circles where centers intend to include them once the residential treatment comes to an end.

In these centers, women have a routine of daily activities at specific times. In general, they start between 5:30 and 6:00 a.m., and finish between 8:00 and 9:00 p.m. These activities include personal hygiene and establishment cleaning tasks (which takes from two to three daily hours), food (three daily hours), group conversations (from five to six daily hours), and regular activities for visitors. Among these activities, they communicate a message to motivate rehabilitation, either by music, by living together or by informative talks (with a variable regularity and duration). Family visits are only allowed on Sundays and psychological treatment is occasionally provided. Unless any activity related to occupational therapy or sports is scheduled, or any support group visits them, inpatients have the rest of the day free (around four hours throughout the day).

Psychological care in these centers is sporadic due to several factors. On the one hand, it is due to the lack of resources to hire on-site psychologists; on the other hand, it is because of the differences between these care models and the clinical, mostly regarding the relapse concept and the use of medicines in the detoxification process. In these centers, the use of medicines is considered harmful and that they substitute drugs instead of helping inpatients cease their consumption. From a clinical perspective, to relapse is to fall back into the use of drugs in a repeated and uncontrolled way. However, from the Narcotics Anonymous and religious centers perspective, it means using drugs again, even if it just happened once, and is considered an extremely severe misconduct that is heavily penalized even if they had been sober for a month, a year or a decade.

For these kind of differences, several directors do not consider that psychological-clinical intervention is essential. They constantly remark that they value psychologists' and psychiatrists' knowledge but that their academic studies cannot be compared to the knowledge they have acquired through their own experience. Their therapeutic model is based on mutual assistance accomplished by conversations and meetings. Listening and sharing are the basis of the treatment.

In Narcotics Anonymous centers, between five and six daily hours spent in three compulsory meetings. Conversations are centered in the Narcotics Anonymous bibliography,[24] and in rehabilitation stories and experiences of the staff leading the process. The first meeting is held at wake-up time and lasts for an hour, during which inpatients express the emotions they face the day with. The second meeting consists of the guided reading and reflection of the book *Just for Today* by Narcotics Anonymous.[25] The third and last meeting is called "stand," which lasts two hours. During this time, two or three inpatients share a part of their lives as a testimony.

On the other hand, activities in religious centers are focused on the study of the Bible, prayers and attendance to religious services. In the center where the field work was conducted, around five hours per day were spent on these

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

types of meetings. When inpatients woke up, they spent half an hour praying individually; then, they spent two hours reflecting on the book of Proverbs and singing praises. At midday, they spent an hour studying the Bible and, when visiting religious groups arrived to talk to the inpatients about any evangelical topic, the meeting could last at least two hours. Moreover, during the day, inpatients memorized new biblical verses. It is mandatory to recite a verse to have the right to eat.

As it can be observed, most of the day is spent in group conversations that may vary their dynamic but not their purpose. Each activity is oriented to influence and change inpatients' perception and interpretation (subjectivity) of their disease as well as to foster the formation of new social and self-identification (identity) networks.

In both cases, the identity promoted implies the acknowledgement and reproduction of traditional gender roles. In most rehabilitation centers the ideal image of women after rehabilitation goes hand in hand with the image of the virtuous woman described in the Bible, in the book of Proverbs. Ester Espinoza[26] makes a very good summary of the virtuous woman and the opposite image, the "bad woman" or "whore" (Table 2).

Although Narcotics Anonymous centers are not governed by any specific religious group, they are strongly influenced by a Christian religiousness and morality because of the regular visits of religious groups to the rehabilitation centers. These visits are considered useful because they encourage a relation with a supreme power. Although the actual behavior of inpatients and directors is quite far from the proposed ideal, adoption of a "decent" behavior which corresponds to God's will is fostered.

Therefore, the purpose of the rehabilitation centers studied is to change deviated females and guide them towards the social ideal of women. It is intended that, through self-control and the gift of service to others, women stop consuming and recover their social function, two of the main problems associated with addiction. Most of the activities and conversations are aimed at raising awareness about the importance of being mothers, wives and daughters. Rehabilitation is motivated by the constant reminder (reinforcement) that their presence and work is needed at home. Thus, it is expected that women stop both drug consumption and the social practices that make their interaction with others more complicated.

This rehabilitation strategy clearly shows the relational characteristic of gender. Being a woman is only possible in relation to others, not only to men but also to every person who has a role in her life (parents, children, siblings) and that, at the same time, allows her to play and live her own role. In the case of women, serving others is mainly related to house-keeping and tasks connected to being mothers and wives, while for men it relates to serving other mates, outside

Table 2. Good woman vs. bad woman.

Good woman: virtuous woman	Bad woman: whorish woman
Trustworthy, respects her husband and loves him as well as their children; chaste and faithful.	Unfaithful and adulterous.
Hard-working, makes efforts, makes profits, foresights and saves money; cares about her home.	Rambler, cannot be at home.
Merciful and generous, honest and not a slanderer; does good deeds.	Quarrelsome, irritable and liar, flatters with her words but with a bitter purpose, has a long tongue.
Wise and fears God.	Clever heart, stubborn, imprudent, simple and ignorant.
Dresses with modesty, decency and propriety.	Seductress and conceited, dresses up and wears perfume. A man is brought to a piece of bread.
Learns in silence, is moderate and prudent; of an incorruptible heart, placid and friendly spirit.	Rowdy, looks for men, attention seeker.

Source: Espinoza.[26 p.90]

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

the home, especially those who suffer from the same disease.[27] This partially explains why there is more proliferation of rehabilitation centers for men who are "more prone" to the vocation of public service than for women, in the state.

It can be said that in both types of centers the rehabilitation process encourages the internalization of individual and group identity in order to change the consumption patterns and influence the creation of a life plan. This is to be followed once residential treatment is over, and it corresponds to the identity proposed during the treatment. In Narcotics Anonymous centers, it is expected that inpatients recognize and accept themselves as addicts since it will be their identity for the rest of their lives, as it is considered a chronic disease that cannot be cured, just controlled. In Christian centers, it is expected that the person accepts and professes the doctrine of the center, which is generally Evangelical Christian, and that they join a church at the end of the hospitalization period. In both cases, this new identity starts with the acknowledgement of their role as women and, as this role is accepted and played, they have the possibility to integrate into the circle in which they are being treated.

The rigidity of the profile/role of woman promoted in these centers is variable. There are rehabilitation centers where this role is quite flexible, it is even accepted that women have lesbian relationships in them. However, there are other centers where recovering their femininity through esthetic care is seen as part of the rehabilitation process. In these cases, it is mandatory for inpatients not to cut their hair, to use makeup and dress themselves according to what is socially considered right for women.

The main difference between Narcotics Anonymous and religious centers is the freedom of interpretation and performance that inpatients have according to the information/training received during the residential treatment.

As long as it helps to stop drug consumption, control is mainly exercised over the information inpatients receive in Narcotics Anonymous centers. However, emphasis is not made on the result of derived interpretation. On the other hand, in religious centers, control is exercised over the information inpatients receive and the way they understand that information. Efforts are made to narrow the scope of interpretation (freedom). In this sense, it was discovered that the more religious the nature of the rehabilitation center, the more the therapeutic model tends to focus in the social field. This means that it is intended to have major influence over all social dimensions of the inpatient, especially in their subjectivity and the way they see each other in the future.

While in Narcotics Anonymous centers the emphasis is put on women assimilating information and experiences that help them be sober and live a functional social life once the residential treatment is complete. Religious centers propose a femininity model to recover sobriety and social functionality and a concrete salvation plan, as in any Christian church. The difference, in this case, is that the functioning logic in rehabilitation centers gives directors major control mechanisms to catalyze processes of religious conversion due to having 24-hour control over them.

This research project did not assess the effectiveness of the analyzed medical care models. However, it was possible to identify women capable of changing consumption patterns once admitted to both types of rehabilitation centers. The rehabilitation cases that were considered successful by the directors were those in which stopping drug consumption for long periods of time (six or more months) was achieved, as well as the creation of new life projects, related to the identity encouraged in each center. These cases – constantly narrated in the form of testimonies – are often related to long residential treatments, along with the presence of women in social relation circles associated with the center and, then, to reference communities.

From this perspective, the work and effectiveness of rehabilitation centers are understood, as well as the dilemmas that directors and inpatients have to face in their attempts to put into effect the plans and techniques created for the purpose of rehabilitation.

ADVERSE EFFECTS TO THE PROPOSED REHABILITATION PROCESS

The directors of these centers face several difficulties to achieve the rehabilitation of inpatients

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

when using the proposed method. The first problem detected is that the stricter the therapeutic model, the smaller the impact on the inpatients is. The paradox of the treatment in rehabilitation centers is that what makes the treatment effective is the same as what hinders the treatment follow-up in a greater number of women. That is, the clear directivity of beliefs and actions women have to assimilate and practice for their rehabilitation. This proposal is effective for those who manage to accept it, internalize it and put it into practice, but it turns out to be problematic for those who do not accept it or those who may accept it but have difficulties putting it into practice.

Another problem is the significant rotation of people in the centers. Most women leave before the minimum period of residential treatment is over due to gender-related reasons. Some of these reasons are related to their relatives, who request that the inpatients assume their responsibilities towards their children or partners; others, to the decision of escaping or to the request for discharge by inmates based on their necessity of "being with a man."

The hypothesis is that the roles these centers consider that women should play strongly contrasts with the inpatients' lifestyle. Besides, this role implies a different way of processing life experiences, which makes it difficult for inmates to play this role in their daily life because it differs from the conditions they used to live in and will return to once they leave the center.

Although the degree of vulnerability and marginalization of their origin vary, in general, inpatients share problematic economic, social and emotional lives and lack formal resources to face such problems. These characteristics have led them to learn, adopt and develop practices that are not socially accepted. They use these practices as tools to survive the dangerous and precarious situations they live in. In this regard, their life experiences do not follow accepted, or even legal, social parameters, and they have made hazardous decisions, which are not aimed at or associated with a definite and clear project to achieve goals. In other words, their actions are not oriented to specific purposes in medium or long terms, as it is proposed in the described therapeutic models, but follow more immediate motivations, interests and possibilities. If a forced and brief treatment is added to this profile, the possibilities of an efficient treatment – regarding modification of consumption patterns – are scarce. There may be less success in the religious model in inpatients with this profile because they have difficulties following a normative experience which is strictly attached to the Christian morals.

A particular and individualized use of the principles understood can be observed. This use goes beyond the strategic convenience for survival. The incorporation (appropriation) of daily life conversations is observed, but in their own ways of processing the experience. For example, an inmate of a Narcotics Anonymous center, ex devotee of Holy Death, listened to a visiting Christian leader saying that just by merely naming Holy Death, evil was invoked. After this, she would be worried that she could lose self-control and attract evil unintentionally, so she constantly controlled and corrected her words. However, the same inmate, after taking part in many sessions where the same Christian group talked about prostitution as an activity contrary to God's will, continued considering such activity as a life option once the treatment was over, because according to her own arguments, it is a common way of subsistence in her life environment and circumstances outside the center.

The experience of this woman shows that the femininity model encouraged in these centers is far from the type of femininity many of them have experienced. Regarding the constantly repeated discourses, several inpatients feel guilty when they acknowledge that they are not the good woman they were supposed to be. However, other inmates are not interested in sticking to the proposed femininity model and decide to continue living as they did before starting the treatment.

The example described above allows to see how the body is both the resource they use to obtain drugs and, at the same time, the recipient of its effects. Furthermore, due to the relation they establish with their bodies, drug consumption is severely sanctioned by Christians because it does not only situate them out of the ideal woman, but also makes them sinners for attempting against what is considered the temple of the Holy Spirit: the body. However, not using the body as a tool, which goes against Christian logic, is depriving themselves from resources in the risky and precarious situations they are constantly exposed to.

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

To conclude, the rehabilitation processes and the stereotype of women that define these processes, which are in turn intended to be instilled in inpatients for their recovery, are useful for those who succeed in incorporating them and regaining sobriety and social functionality through them. But for other inpatients, this is not very feasible, partly because the life circumstances they face after residential treatment makes follow-up difficult. Therefore, these rehabilitation strategies are just effective for a minimum number of inpatients.

CONCLUSION

Through their rehabilitation models, the existing rehabilitation centers in the state reproduce the gender-related roles and stigmas that exist in relation to addiction. Moreover, the role of women through which centers intend to reintegrate inmates to their social functionality contrasts with the international efforts adopted by the Mexican state to promote gender equality.[7] Considering that the government allocates resources to partially support the work of these centers, an open contradiction is observed in its actions because, on the one hand, the state is involved in gender equality projects and, on the other hand, it finances projects that ratify the traditional role of women with its subsequent inequalities. The latter is the real problem, mostly if it does not give women the possibility to recover their social functionality out of such traditional roles. This is more evident in Christian centers, where the only legitimized model of femininity is the Biblical model, which follows the evangelical interpretation.

The characteristics of rehabilitation centers follow a widespread social gap/necessity, which is that of being sensitive about the importance of gender differences that define and direct most of our behavior as social beings, and about the inequalities resulting from differences. This means that the directors of the centers studied cannot be held responsible for this in the cases in which their actions and omissions are influenced by a social pattern that is so rooted that it interferes with the recognition and transformation of social inequalities.

Changing that social inertia demands a consciously targeted effort. It is feasible that rehabilitation centers, which currently reproduce women's traditional role, may help inpatients gain awareness of the social disparities to which they are vulnerable on account of their gender and that becoming aware may help women understand their present and past circumstances, make decisions and, ultimately, have a fuller life.

After the regulatory process started by the government in 2000, through Official Mexican Standard NOM 028,[23] many directors of the centers showed they were willing to collaborate with the government to improve their service. This willingness may be used as a platform to raise awareness in directors and program staff regarding gender equality, which could affect the therapeutic processes currently in place. For these purposes, the professionalization process already started by the state may be used, which currently focused on training employees and employers to understand addiction from a biomedical perspective.[12]

It is clear that not only the directors of rehabilitation centers need to gain awareness and take gender as an important factor of analysis, but also the government officials who work with them. As Maier points out,[7 p.226-224] government officials in Baja California are hardly aware of the need to incorporate the gender perspective in the design and operative management of the efforts involved. Therefore, it is necessary that both the government and those in charge of public rehabilitation centers become aware of the stereotypes and stigmas that influence the phenomenon of addiction in women, so as to create better therapeutic models, and whenever possible, collaborate with the transformation process of gender inequality in our society.

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

ENDNOTES

a. Gender is understood as a category formed by assembling two intertwined aspects that intervene in the creation of male and female identities: the cultural interpretations about the biological differences of the body, that is to say, sex; and power relationships that organize such differences: "thus, gender is a relational category that refers to a sexual division of labor that is both historically and culturally flexible and it is protected by complex cultural, social, economic and political processes that turn biological differences into social inequalities."[7 p.212]

b. According to the World Health Organization, drug or alcohol addiction is the "repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use [...] The term addiction also conveys the idea that such substance use has a detrimental effect on society, as well as on the individual."[11 p.13] Currently, it is recommended to use the term "dependence," as it is more connected to the reality studied.[10 p.11] However, the term most frequently used by people is "addiction." In this paper, the term addiction is kept because it is used in the centers studied to refer to the disease they treat.

c. All centers registered with the state were contacted by telephone (197), but only 141 provided precise information, mainly because the phone numbers of the rest of the centers had been changed, phone calls were not answered, or because the person who answered refused to take part in the survey.

d. The fact that therapeutic offer in Baja California is ruled by two therapeutic models that give priority to spiritual and religious principles to cure inpatients drastically reduces the possibilities of treatment for people who do not believe in God or in a supreme power or for those who believe but prefer real alternatives of a different kind. In this regard, although violation to human rights just as commonly described in the media, such as physical abuse, were not detected, the fact that more than 90% of rehabilitation centers in the state offer a spiritual or religious treatment indirectly violates the human right to have access to a secular therapeutic offer. This is an extremely important aspect that deserves to be studied and discussed in depth and that exceeds the limits of this paper, but it is necessary to at least mention it. Its implications were partially covered in a previous paper.[12]

e. Drug, in medicine, "refers to any substance with the potential to prevent or cure disease or enhance physical or mental welfare, and in pharmacology to any chemical agent that alters the biochemical physiological processes of tissues or organisms [...] In colloquial language, the term often refers specifically to psychoactive drugs, and often, even more specifically, to illicit drugs."[11 p.33]

ACKNOWLEDGEMENTS

We would like to thank the Consejo Nacional de Ciencia y Tecnología for having financed this research study through project No.166635 and for having granted us a postdoctoral scholarship to continue our research work. Moreover, we would like to thank PhD Olga Odgers for her accurate comments on the draft this paper, and all the directors and inpatients of the centers that accepted to be part of this project.

REFERENCES

1. Van der Meer Z, Nappo SA. Religious treatments for drug addiction: an exploratory study in Brazil. Social Science & Medicine. 2008;67(4):638-646.

2. Hood D. Addiction treatment: Comparing religion and science in application. New Brunswick: Transaction Publishers; 2011.

3. Vederhus J, Laudet A, Kristensen Ø, Clausen T. Obstacles to 12-step group participation as seen by addiction professionals: comparing Norway to the United States. Journal of Substance Abuse Treatment. 2012;39(3):210-217.

4. Salazar I. El consumo de drogas ilegales en Baja California: Una perspectiva desde los determinantes de salud [Tesis de Maestría]. Tijuana: El Colegio de la Frontera Norte; 1997.

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

5. González P. Diagnóstico situacional de los organismos de rehabilitación de adictos a drogas en Baja California. Mexicali: IIS-UABC; 2001.

6. Comisión Nacional contra las Adicciones. Encuesta Nacional de Adicciones 2008. Cuernavaca: Instituto Nacional de Salud Pública; 2009.

7. Maier E. Diagnóstico de conocimiento, actitudes y estrategias de equidad de género en servidoras y servidores públicos de primer nivel en Baja California. Frontera Norte. 2011;23(46):211-223.

8. Oferta terapéutica religiosa en los Centros evangélicos de rehabilitación para farmaco-dependientes, Proyecto Conacyt 166635 [Internet]. 2014 [cited 18 oct 2014]. Available from: http://proyecto166635.wix.com/166635.

9. Torres MA, coordinador. Historia de las adicciones en la España contemporánea [Internet]. España: Gobierno de España, Ministerio de Sanidad y Consumo, Secretaría General de Sanidad, Delegación de Gobierno para el Plan Nacional sobre Drogas; 2008 [cited 20 oct 2014]. Available from: http://goo.gl/eU85ix.

10. Lewkowicz I. Subjetividad adictiva: un tipo psicosocial históricamente instituido. Revista de la Asociación Argentina de Psicología y Psicoterapia de Grupo [Internet]. 1998 [cited 18 oct 2014];21(1):69-89. Available from: http://goo.gl/3kanID.

11. Organización Mundial de la Salud. Glosario de términos de alcohol y drogas [Internet]. Madrid: Ministerio de sanidad y consumo; 1994 [cited 29 sep 2014]. Available from: http://goo.gl/u90y3p.

12. Galaviz G, Odgers O. Estado laico y alternativas terapéuticas religiosas: El caso de México en el tratamiento de adicciones. Debates do NER. 2014;(26):253-276.

13. American Psychiatric Association of Washington. Manual diagnóstico y estadístico de los trastornos mentales [Internet]. Barcelona: Instituto Municipal de Investigación Médica, Departamento de Informática Médica; 1995 [cited 25 sep 2014]. Available from: http://goo.gl/c1bqMA.

14. Garrido F. La droga como figura contemporánea del mal. Gazeta de Antropología [Internet]. 1999 [cited 15 mar 2014];15(2). Available from: http://hdl.handle.net/10481/7525.

15. Paris MD, Pérez L, Medrano G. Estigma y discriminación hacia las y los usuarios de drogas y sus familiares. México: Consejo Nacional para Prevenir la Discriminación; 2009.

16. Marulanda MC. Un siglo de la política prohibicionista de las drogas. Revista Flora Capital [Internet]. 2011 [cited 12 mar 2015];11(1):87-105. Available from: http://goo.gl/eG1gbB.

17. Dana R, Aragon M, Kramer T. Culturally Competent California Mental Health Services: Model and Example [Internet]. Portland: Regional Research Institute for Human Services Publications; 2000 [cited 28 feb 2015]. Available from: http://goo.gl/Rr0kEF.

18. Romo N. La mirada de género en el abordaje de los usos y abusos de drogas. Revista Española de Drogodependencias [Internet]. 2010 [cited 10 mar 2015];35(3):269-272. Available from: http://hdl.handle.net/10481/22304.

19. Blanco P, Sirvent C, Palacios L. Diferencias de género en la adicción e implicaciones terapéuticas. Salud y Drogas [Internet]. 2005 [cited 30 sep 2014];5:81-97. Available from: http://www.redalyc.org/articulo.oa?id=83905205.

20. Jáuregui I. Una perspectiva cultural de la adicción. Gazeta de Antropología [Internet]. 2002 [cited 1 mar 2015];18. Available from: http://hdl.handle.net/10481/7394.

21. Castillo PI, Gutiérrez AD. Consumo de drogas en mujeres asistentes a centros de tratamiento especializado en la Ciudad de México. Salud Mental [Internet]. 2008 [cited 20 feb 2015];31(5):351-359. Available from: http://www.redalyc.org/articulo.oa?id=58231502.

22. Instituto de Psiquiatría del Estado de Baja California. Directorio estatal de establecimientos especializados en tratamiento de adicciones. Mexicali: IPEBC; 2012.

23. Secretaría de Salud. Modificación a la Norma Oficial Mexicana NOM-028-SSA2-1999, Para la prevención, tratamiento y control de las adicciones, para quedar como Norma Oficial Mexicana NOM-028-SSA2-2009, Para la prevención, tratamiento y control de las adicciones. Diario oficial de la Federación. México: Segob, Primera sección, 21 de agosto de 2009.

24. Narcóticos Anónimos. Narcóticos Anónimos [Internet]. 6a ed. California: Narcotics Anonymous World Services; 1991 [cited 20 feb 2015]. Available from: http://goo.gl/C2lhnI.

25. Narcóticos Anónimos. Sólo por hoy. 6a ed. California: Narcotics Anonymous World Service; 1991.

26. Espinoza E. Más que Evas y Marías: discursos y prácticas de feminidad en la Primera Iglesia

SALUD COLECTIVA. 2015;11(3):367-379. DOI: 10.18294/sc.2015.722

Apostólica de la Fe en Cristo Jesús en Tijuana [Tesis de Maestría]. Tijuana: El Colegio de la Frontera Norte; 2014.

27. García E. Renacer por la palabra: Identidad narrativa y experiencia espiritual de exadictos en centros de rehabilitación evangélicos en Tijuana, Baja California [Tesis de Maestría]. Tijuana: El Colegio de la Frontera Norte; 2014.

CITATION
Galaviz Granados G. Women, addiction, and rehabilitation: Reflections from the northwestern border of Mexico. Salud Colectiva. 2015;11(3):367-379.

Received: 29 October 2014 | Modified: 23 March 2015 | Accepted: 6 April 2015

http://dx.doi.org/10.18294/sc.2015.722

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Daniela Mazzeo and Daniela Pérez Valdéz, reviewed by María Pibernus and modified for publication by Anne Neuweiler under the guidance of Julia Roncoroni.