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REFLECTION

THE TERRITORIALITIES OF CARE: INTERDISCIPLINARY REFLECTIONS ON THE USE OF DRUGS AND SOCIOCULTURAL CARE

AS TERRITORIALIDADES DE CUIDADO: REFLEXÕES INTERDISCIPLINARES ACERCA DO USO DE DROGAS E O CUIDADO SOCIOCULTURAL

LAS TERRITORIALIDADES DEL CUIDADO: REFLEXIONES INTERDISCIPLINARIAS SOBRE EL USO DE DROGAS Y EL CUIDADO SOCIOCULTURAL

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ABSTRACT

The objective of this article is to discuss the use of drugs as a sociocultural phenomenon and, from this approach, work on the constitution of a territoriality perspective of care, aiming to widen the perspective to a sociocultural model of care to drug users. It is a study of theoretical reflection, which problematizes the importance of thinking about the relationship of the individual with the use of drugs in different sociocultural aspects, including economic and social spaces, meanings, culture, the creation of networks and lifestyles. In this sense, we introduce the idea of care territorialities based on a sociocultural model, in which the importance of a dynamic/dialogic established between professionals and users in the living space of care is recognized.

Keywords: Drug Users; Mental Health; Comprehensive Health Care; Anthropology.

RESUMO

O objetivo deste artigo é debater o uso de drogas como um fenômeno sociocultural e, a partir desse enfoque, a constituição de uma perspectiva de territorialidades de cuidados, visando ampliar olhares para um modelo sociocultural de atenção aos usuários de drogas. Trata-se de estudo de reflexão de natureza teórica, que problematiza a importância de se pensar a relação do indivíduo com o uso de drogas em diferentes aspectos socioculturais, incluindo espaços econômicos e sociais, os significados, a cultura, a formação de redes e estilos de vida. Nesse sentido, introduzimos a ideia de territorialidades de cuidado baseada em um modelo sociocultural, em que se reconhece a importância de uma dinâmica/dialógica estabelecida entre profissionais e usuários no espaço vivo do cuidado.

Palavras-chave: *Usuários de Drogas; Saúde Mental; Assistência Integral à Saúde. Antropologia.*

RESUMEN

El objeto de este artículo es discutir el uso de drogas como fenómeno sociocultural y, desde ese enfoque, constituir una perspectiva de territorialidades de cuidados con miras a ampliar la visión para un modelo sociocultural de atención a los usuarios de drogas. Se trata de un estudio reflexivo de naturaleza teórica que problematiza la importancia del pensar la relación del individuo con el uso de drogas en diferentes aspectos socioculturales, incluyendo espacios económicos y sociales, los significados, la cultura, la formación de redes y estilos de vida. Por ello, estamos introduciendo la idea de territorialidades de cuidado basada en un modelo sociocultural en el que se reconoce la importancia de una dinámica / dialógica establecida entre profesionales y usuarios en el espacio vivo del cuidado.

Palabras clave: *Consumidores de Drogas; Salud Mental; Atención Integral de Salud; Antropología.*

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INTRODUCTION

The phenomenon of drug use accompanies the history of mankind, and its consumption is related to different interpretations throughout the ages. In prehistory, the drug was used for recreational, therapeutic and ritual purposes, which culturally demonstrated its non-association with a risk condition, and it could even be deified.[1]

It was also observed that drug use can be considered the manifestation of a group of people and their lifestyles. As, for example, the Hippie movement in the 1960s, in which the drug use represented ways of altering the consciousness as an element of protest along with music, literature, clothing, and sexuality. In this way, the drug use was associated with a liberation posture.[2]

It can be said that, with the Industrial Revolution, the expansion of the urbanization and the technological transformations facilitated the communication and transportation of drugs. There were also changes in the lifestyle of the population, in the behaviors and in the work dynamics. This can be perceived by a more individualistic lifestyle, with the demand of great productivity at work and the increase of the consumption, which made the use of drugs an element of abstraction and sociability.[3]

Given this, drugs have been a phenomenon associated with cultures, the formation of lifestyles, interconnected to the daily life of the subjects and their sociocultural contexts. The use of drugs is perceived as a ritual of socialization and strengthening of relationships, also as a territory of recognition, since it delimits a place of coexistence and interaction.[4]

Lifestyles are understood as a social, global construction that incorporates social, economic, cultural and relational aspects that bring individual risk only as an additional variable in the dynamic health/disease process.[5]

However, for the health field, the drug use is still discussed from a perspective focused on a hygienist point of view, in which the view of dependent/sick individual prevails. This perspective approaches that the drug is a vector of physical dependence, representing threats and damages to the functioning of the organism and mental disorders.[2]

Traditional therapies still see abstinence, which is the total cessation of drug use, to be the best treatment strategy. This view corroborates a model of treatment based on hospitalizations in specialized services, such as hospitalization units, psychiatric emergencies and the so-called therapeutic communities.

One of the results of this model of treatment has been seen in the mass opening of psychiatric beds, in therapeutic communities and in psychiatric hospitals, the latter being places of non-care under the Brazilian law. The use of compulsory hospitalizations is determined by the judges as the outcome and solution to the problems that often occur without the assessment of a mental health team. It can be said that this is the phenomenon of counter-desire, which means despair to immediately solve the problem of "uncontrolled desire" (strong impulse to use more substance), in which a simplified way of understanding and treating complex problems involving multiple factors is created.[6]

This produces moral panic in society and anxiety in families, which end up seeing the compulsory hospitalizations as the only form of access to treatment. However, attention should be paid to the fact that many drug users, after hospitalization, return to their territories of life and to the use of the drugs. Therefore, drug use is a complex phenomenon in our contemporary society, which encompasses the urgent need to include an approach of interdisciplinary care that recognizes the subject involved in their territories of life, cultures, political and economic contexts.

Thus, this article aims to discuss and reflect on the use of drugs as a sociocultural phenomenon and, based on this approach, constitute a perspective of territorialities of care, which aims to broaden the vision for a sociocultural model of care to drug users.

DRUGS, A SOCIOCULTURAL PHENOMENA: INTERDISCIPLINARY REFLECTIONS

Territory is understood as the multidimensional space of power, not only of the political power, but also of the economic, symbolic, cultural and natural power. In this space, there is the formation of territorialities, which are the attempts to control the subjects, building their relationships, demarcating identities and symbolic appropriations. The space, when occupied by the man in his history and in his affections, expands from a physical and geographic matter only to the creation of a social territory of life. In this way, we perceive living spaces, qualified by the subject based on their life history, work, social relations, power and identity.[7]

In the health field, the term territory is still linked to the occupation of the services and the delimitation of the physical space for the organization and control of the population to be served. However, in an innovative proposal, we state that it is not possible to dissociate the discussion of the care of a territory that is experienced by the subject in their history and in their affections. Thus, the idea is to surpass the geographic space, providing the visibility of a territory that is social, place of life and history.

The territories of drug use are marked by a series of events and experiences that form these living spaces: the consumption, relationships, identities, opportunities, social, economic, work and life history issues.

When we incorporate the vision of a social territory, we understand that care in drug use must be thought from sociocultural elements. That is, to analyze that the drug user has a life history, a personal trajectory that can be marked by the economic and social territories, the meanings and culture of drug

use, the formation of social networks and common lifestyles, the vulnerability, prejudice and stigmas they face in our society.

The relationship of drug users with their economic and social territory is an important element for their own use. It is observed that young people living on the street affirm that their life project, for the most part, is the street survival, with drug trafficking and underemployment as a form of income generation. This brings the notions of "normal" and "abnormal", "acceptable" and "unacceptable" as irrelevant, while being understood in different ways in these social spaces, since most people use drugs every day and are involved in trafficking, naturalizing this relationship between drug use and people.[8]

In a study[9], it is assessed that the problem is not the dependence on the drug, but the social problems people face that lead them to use the drug. Their study shows that from 80 to 90% of people who use crack or heroin do not see themselves as dependent, because when the choice between the drug and another possibility (like money, goods, employment, leisure) was offered, most of the time they decided on the "other possibility".

It is understood that the drug use should not be seen merely as an individual experience, but as part of a set of social and cultural manifestations of groups that build lifestyles around the use.[3]

Culture is like a map, a prescription, a code, whereby the people of a group think, classify, live, modify the world and themselves. By sharing this code (culture), this set of individuals, with different interests and capacities, become a group and can live together, feeling themselves as part of the same totality.[10]

Thus, when talking about "codes", the drug, through a sociocultural and anthropological understanding, is permeated by the culture of the people and society in which people are inserted, therefore, it is related to the historical and symbolic construction of values, beliefs and networks of belonging and affection.

The networks of belonging and affection are fundamental to think about the use of drugs, in the sense of what brings the study of Draus and Carlson[11], which argues that the wider social networks of people who use drugs have less exposure to addiction due to greater social interaction and the amount of support. On the other hand, networks that are "tighter", that is, with little social contact, have an amplification of similar behaviors, whose group finds it easier to use drugs, because they do not feel judged and have the same cultural values.

It is important to mention that in some therapeutic approaches this experience of informal networks is often seen only in an "etiological" sense by the health team, that is, how these relationships influence the continuity of the use, being negative for the treatment and, in that case, the strategy is to think about the removal of these affections and friends. However, it is important that health professionals can recognize and incorporate these networks and cultures to think of strategies of care beyond prescriptive and normative simplifications.

The consequences that the drug use brings to users living in extreme poverty, such as stigma, prejudice and vulnerability, are also observed. For example, in a study conducted in a city in India known for its drug trade, poverty, and prostitution points, it is observed a strong stigma and prejudice linked to these images, as a consequence, people have difficulty obtaining a formal employment. The stigma related to drugs and prostitution makes vulnerable families have little access to other perspectives of social insertion and work, which strengthens the organization of life around the drug, since the possibilities of income usually end up being limited to trafficking and the sexual work of women.[12]

Still regarding the stigma, there are drug users marked by the discrimination and by the absence of perspective of life, which makes the momentary pleasures of the drug use an artifice capable of filling this emptiness. However, not all users have the compulsive pattern; there are also those who make use sporadically, as a means of sociability, as well as users of multiple drugs and those who only use at night, as a strategy to control the consumption.[1]

Given this, it can be observed that drug users may have different use/consumption profiles, as well as different scenarios, life histories, meanings and contexts of use. However, they have something in common, which is the organization of a lifestyle around the use of drugs, in which the drug has social, symbolic and cultural value; and from this value, built historically, users create relationships/networks and organize themselves at work and in their lives.

These forms of living are, then, dimensions that allow a perception of the drug in its complexity, considering it as a sociocultural phenomenon related to many factors and collective experiences that must be incorporated in the construction of new ways of providing care related to drugs: recognizing these territories of life in their production, seeking the participation of the subjects and understanding the territory of health as a lived experience, which is individual and collective.

A SOCIOCULTURAL CARE APPROACH: THE TERRITORIALITIES OF CARE

The concept of territorialities of care is referred to as a new possibility of care, which aims to broaden the perspectives on a sociocultural model of care for drugs.

The scenario of public policies and care related to drug use in Brazil is still marked by a dichotomy: prohibitionist policies and harm reduction. Prohibitionist policies have as their basis a model based on the moral/criminal issue and on the disease. From a moral/criminal point of view, the drug coping is directed towards the punishment/imprisonment. As a pathological problem, drugs cause addiction, disease and need treatment focused on abstinence.[2]

There are in our society examples that demonstrate the strong performance of the model based on morality and disease, such as the actions of repression and sanitation of social spaces, such as the Cracolândia (Crackland), in São Paulo, Brazil, in which street people are removed from their territories of life, with the justification of drug use and crime. These people end up being associated with the image of "sick" and often "tramps", having dismissed their sociocultural contexts of drug use.

On the other hand, the harm reduction model (HR) questions the prohibitionist policy of the drug use, because the actions of repression did not contain the phenomenon in any part of the world, since it is a phenomenon associated with life experiences, social and economic conditions, and cultures and networks of affection. The HR aims to demystify abstinence as the only treatment strategy, redirecting the focus of care to strategies that minimize the risks, sufferings, problems, and social damages of the drug abuse.[13] We believe that the HR in Brazil may represent a device for the implementation of a sociocultural model of care.

The sociocultural model is known in Europe and has as its approach the phenomenon of drugs from a range of elements and factors that are related: the individual, the substance, the context.[3] The drug use, from the perspective of the sociocultural model, is part of a life history, and it is necessary to perceive the environment in which the group and the person experience this use.

From the process of drug recognition as a sociocultural phenomenon, we need to think about its repercussions in relation to care. And also recognize the need for a new care configuration, not only linked to Biopolitics and to the control of bodies, which aim at "treatments" carried out only in closed services, practices of hygiene of the social territory, including total drug abstinence and institutionalized care.

The Biopolitics aims to take care of living beings from interventions in the everyday life of individuals, their health, sexuality, body and diet. The "sick people" tend to lose the right over their own bodies, the right to live, to be sick, to heal as they wish. In this way, the institution is considered a place of control of bodies and diseases.[14]

In this new emergent configuration of drug care, we perceive the urgency of a contrary movement, which recognizes the importance of knowing and understanding the world of this drug user, inhabiting their social territories, having in their voices tools of interpretation of dissonances and contradictions about sanitary processes and their experience of the territory.

The territory is formed of territoriality, which is a procedural and relational movement of the subject with the space, appropriating and dominating this space. There is a symbolic-identity and affective appropriation, a construction of life history and social relations, which empower this user.[7]

In this context, the street is a territory territorialized by people who use the drug. The street, the house, the vacant lots and the construction of social networks are territories of identity, affection and power, where users inhabit, appropriate, build relationships and feel included. These spaces, often considered "vulnerable" and "unhealthy" by the society, help us to know the networks and lifestyles of the drug user, in order to think of strategies of care that are in accordance with the reality of life.

In order to move towards a sociocultural model, it is necessary to incorporate care in the roaming of the cities, from a new concept of mobility, in which one visualizes the non-separation between periphery - habitat of the poor - and the center of the cities - place of the rich. In addition, there is cultural heterogeneity in cities, based on the growth of large urban centers, and there is also the degradation of this space. In the large centers there are not only rich and private condos; there are also individuals who live in clandestinity and precariousness.[15] Thus, the forms of mobility and occupation of the urban space must interfere in the organization of care, since we live in a heterogeneous and dynamic territory, which implies cultural diversities.

Thus, we introduce the idea of territorialities of care based on the interdisciplinary concepts of social territory of life, urban mobility and sociocultural model. In these territorialities, there is recognition of the use of drugs as a socio-cultural phenomenon, working the territories of life and organizing the care provision according to cultures and lifestyles. Thus, the forms of embracement expand, since we no longer think of this static user in the health services, but of a population that is dynamic and questions the aseptic space and controller of the services.

We understand that the territorialities of care are not conditioned to a vertically and monological relationship with the health services, because the care provision is established in the dynamic relationship of the subject with living space. This new relationship of care questions a monological model and gives life to dialogic models. The monological models evaluate that health problems are merely biological and behavioral results, verifying and hierarchizing the care provision, in which the professional holds the knowledge and the power of organization of the system, and must "teach", "pass", "treat" the "patients".[5]

On the other hand, the dialogic models aim at the multidimensional perception of the phenomena, understanding that the subject is not only a result of their individual behaviors, but is enveloped in a diversity of contexts and cultures. It is a participatory model, in which one values the dialogical and symmetrical relationship between all the actors involved in the process.[5]

In the territorialities of care, the dialogic model is essential, bringing a new spatio-temporal relationship between caregivers/care, whose power moves, creating subjects involved in processes of care that permanently negotiate these powers and experiences, based on bonds created. Care can be built in and out of

the services, considering that it comes from the way professionals experience it, that is, how they perceive the subjects involved in their sociocultural processes. However, the exit of the services brings in the city and in the urban mobilities more possibilities of recognition of these fields as places rich in doing health.

FINAL CONSIDERATIONS

Recognizing that the drug use is not an individual and isolated experience of a merely pathological aspect, but closely linked to collective and social experiences, following the history of humanity, is to broaden the discussion on health. We approach the territorialities of care as a proposal of care model that includes a sociocultural perception. The health professional must recognize and work the use of drugs, which is marked by the life histories, relationships and experiences of the subject with their social territory.

Interdisciplinary research on drugs in contemporary society remains an epistemological and hermeneutic-dialogical challenge, since it is about knowing the lifestyles of the subjects and their relationship with drugs, subjectivities and social life in the plural urban spaces of our Latin American cities and the rest of the world. In a scenario still strongly marked by the prohibitionist and monological model, we conclude by the importance of investing in more interdisciplinary research that addresses the sociocultural character of the drug phenomenon in health. Thus, we can advance in new perspectives of dialogic and inclusive strategies of care.

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