


Body limits and failure: the access to treatment of female crack users at a CAPSad from Rio de Janeiro


Limites e falência do corpo: o acesso ao tratamento de mulheres usuárias de crack em um CAPSad do Rio de Janeiro

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Abstract

Crack abuse evidences a complex public health problem to be confronted. In this context, crack use by women exposes them to vulnerable situations. This article aims at identifying and describing the motivations to access to treatment of female crack users in a Psychosocial Care Center (CAPSad) for people with alcohol and other drug problems. This is a qualitative study that used participant observation and in-depth interviews with nine female crack users examined by thematic analysis. The results indicate that the body is used as a reason to justify the seek for treatment. Body issues directed them to treatment, such as the experiences of physical tiredness, pain, sleep deprivation, weight loss, exhaustion, fear of dying and the violence on the streets. Many of them felt these needs due to crack abuse and showed that by requesting medication and night care from health professionals' team. In conclusion, body must be understood as an important tool used by female crack users on access to treatment.

Keywords: Patient Care; Social Vulnerability; Mental Health; Crack Cocaine; Gender Identity.

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Resumo

O abuso de crack evidencia um problema de saúde pública complexo a ser enfrentado. Neste contexto, o consumo pelas mulheres as coloca em situação de maior vulnerabilidade. O artigo tem como objetivos identificar e descrever as motivações para o acesso ao tratamento de mulheres usuárias de crack em um Centro de Atenção Psicossocial (CAPSAd), voltado ao atendimento de pessoas com problemas com o álcool e outras drogas. Trata-se de um estudo qualitativo, feito através de observação participante e realização de nove entrevistas em profundidade com mulheres usuárias de crack, submetidos à análise temática. Os resultados indicam a presença do corpo como o argumento usado pelas mulheres para justificar a procura pelo atendimento no CAPSAd. As questões ligadas ao corpo, tais como, as vivências de cansaço físico, dor, sono, emagrecimento, esgotamento, medo de morrer e da violência das ruas, direcionaram as usuárias para o tratamento. Muitas delas sentiam essa necessidade em decorrência do abuso do crack e precisavam de ajuda dos profissionais de saúde, por meio do pedido de medicação e acolhimento noturno. Assim, é fundamental reconhecer o uso do corpo como ferramenta de acesso ao tratamento por parte das mulheres usuárias de crack.

Palavras-chave: Assistência ao Paciente; Vulnerabilidade Social; Saúde Mental; Cocaína Crack; Identidade de Gênero.

Introduction

Social and public health repercussions around the use of crack are directly perceived in the strategies aimed at care within the Brazilian National Health System (SUS). This scenario highlights a complex public health problem to be faced.

National and international estimates characterize the magnitude of the problem of crack use/abuse. In the United Kingdom, the number of adolescents under the age of 16 arrested on suspicion of supplying crack, cocaine and heroin has increased (UNODC 2018). Crack use is associated with several disorders in the clinical and mental health of users, such as: respiratory infections, sexually transmitted diseases, depression, and suicidal behavior (UNODC, 2018). In addition, crack has been an important drug of choice among multiple drug users, which should be considered in the treatment of this population (Eastwood; Strang; Marsden, 2017; Heidebrecht; MacLeod; Dawkins, 2018).

In this context, women are more subject to social and health inequities, which makes them more vulnerable to the use of drugs, including crack. Estimates show that the problems associated with drug use by women in street situations are greater when compared to those of men in the same conditions (UNODC, 2018). As an aggravating factor, female crack users are subjected to prejudiced and stigmatizing social judgments that affect the various situations of vulnerability of women and hinder access to treatments at the Psychosocial Care Center (CAPSAd) (Monteiro; Villela, 2013).

In Brazil, studies on topics related to women, alcohol and drugs show important processes of social discrimination that give rise to different forms of violence. This violence is linked to gender, but also to race, ethnicity and sexuality as social processes connected to broader structures of power and domination, which have repercussions on the various situations of vulnerability regarding health (Monteiro; Villela, 2013).

The use of crack among women, therefore, is not usually well accepted socially, generating stigma, prejudice and its relation with discrimination, as well

as some of the main sufferings in health, diseases, segregation and violence directed at users (Fertig et al., 2016; Parker, 2013).

The presence of female crack users in the scenes of use, frequented mostly by men, reinforces inequalities, exposing them to different problems related to a persistent gender hierarchy that organizes and institutes relationships (Fertig et al., 2016). In these spaces, we notice the maintenance and reproduction of historical relations of domination between men and women – men are “allowed” to be in crime, and women in prostitution (Romanini; Roso, 2013).

The absence of female users in CAPSad health units (Malta et al., 2008) should be problematized in view of the historical predominance of sexual and reproductive health care of women in Primary Health Care services, in the scope of prevention, care and promotion. The reproductive health domain has greater participation in the care of women in correlation with other health problems, women being more assiduous than men in public health units (Barata, 2009; Botton; Cúnico; Strey, 2017). Conversely, when the problem is alcohol and drugs, women are more absent than men in health units.

We consider the hypothesis of discrimination of users as one of the reasons for the difficulties of them reaching CAPSad, resulting from the feeling of shame and the fear of being mistreated as drug users, linked to the social scruples related to the cultural identity of the “*mulheres cracudas*” (crack junkie women). In addition, there is the strongly masculinized culture of the scenes of use and the discriminatory practices that are reproduced in relation to female users, which must be understood and fought, especially in the context of health care. In this sense, this study sought to describe and analyze how access to treatment of female crack users in a CAPSad unit is constituted.

Methods

This is a qualitative study conducted with nine female crack users who accessed a Psychosocial

Care Center for people with problems with alcohol and other drugs (CAPSad III), located in the city of Rio de Janeiro.

Participant observation and in-depth interviews were used as a strategy during the seven-month fieldwork period. The use of these methodological tools provided immersion in the daily life of the unit, allowing us: to know the users, the dynamics of care of the unit, their routines, obstacles, and challenges in the issues related to access to treatment.

The nine women included in the study correspond to the total number of users who had crack as a preferred drug and accessed the service during fieldwork. Two women were excluded from the study: one who had bacillifera (Koch bacillus contamination) and another who we contacted at the scene of use and did not attend CAPSad as invited for the interview. After the consent to participate in the study, the reports given by the women were recorded and their names coded, replacing them with fictitious ones, so that the secrecy of the information was maintained.

After systematic and exhaustive reading of the interviews and field diaries, the collected material was included in the research database in order to define the analytical thematic axes. A qualitative data analysis software – Nvivo version 820 – was used to support and organize the material. Then, the information obtained was submitted to the stages of the thematic analysis (Minayo, 2014). This research was sent and approved by the Research Ethics Committee of the Universidade Federal do Estado do Rio de Janeiro (CAAE: 51280515.7.0000.5263; Opinion: 1.526.402).

Results and discussion

Regarding the reasons female crack users seek care in CAPSad III, we identified the body that needs care as the main reason from two elements: the limits of the failed body and the stigmatized body. In addition, they resort to access to treatment from the request for medicalization to contain and deal with crack abuse and night care as a protective measure.

The failed and stigmatized body in access to treatment

We found, in the women's statements, that access to treatment occurred in the circumstances of the limits imposed by a sick body. For them, this limit appeared from the radicality of crack consumption and which, in the issue of access to treatment, became evident as the main theme, because of a body that needed to be taken care of. We observed in the narratives that they identified the signs of physical exhaustion and that the decision to access related to the feeling of this exhaustion, represented by the supplication for food, a bed to sleep and a place to shower.

Regarding the consequences of crack use, the women reported bodily symptoms as an effect of uncontrolled crack use: "*it's like this all day, all night, until we feel sick*" (Gicélia, 33). The many narratives described these effects as devastating: "*Blood coming out of my mouth, my nose, in the feces, [we were] really almost dying. I couldn't walk, I kept falling, it was horrible*" (Renata, 34 years old).

In a broader logic, we understand that women's access to treatment occurred when the exhaustion of their bodies replaced the satisfaction provided by the use of crack. The users described a moment called "*all or nothing life stage*", which exemplifies the meaning that Denise (30 years old), one of the interviewees, attributes to her own trajectory with the use of crack in relation to her current moment.

We notice in this case that the satisfaction produced by the drug was no longer so rewarding. Rosane, for example, expressed the motivation to look for CAPSad as follows: "*What motivates me is my own life, I've had enough with only using drugs [...] Because in this world, in this little space where there's only addicts, you have no friends [...] you are no one, no one even sees you*" (Rosane, 30 years).

Many of the narratives of these women expressed that their bodies, their lives almost often reached the boundaries between life and death: "*Now, my use, if you want to know, is extremely suicidal*" (Almerinda, 61).

To understand this perspective, we can start from the concept of body described by Le

Breton (2017), which is always an operator of socialization. It is through it that we see the statutes of inequality, especially those relating to men and women and their respective processes of individualization.

We emphasize that, for women who use crack, the body is opposed to exclusion, as it appears as a motivating factor for access to treatment and is therefore a tool for social inclusion. Le Breton (2017, p.30) when talking about the body, describes it as marked by the limits of the person, "where the presence of the individual begins and ends."

A second point that marked the reasons leading them to seek treatment was the stigma about the woman and her body. We found that stigma is one of the terrible negative effects of crack use. Thus, the reports of the interviewees repeated the statements regarding the female body that suffered changes, among them, the lack of appetite and the consequent slimming.

Ribeiro, Sanchez and Nappo (2010) state that, among female crack users, slimming is the most reported problem about their body. The authors report that "the factors that contribute to slimming are: appetite suppression, psychomotor restlessness and long walks in search of crack in moments of craving" (Ribeiro; Sanchez; Nappo, 2010, p.213).

We observed the devastating effects of crack in the narratives of the interviewees through their observation of the changing image of their bodies. We also observed, in the accounts given in tones of lament and regret, how rapturous the image of the female crack user was: "*My godmother took me there where she was [referring to the place where her mother, who is a crack user, was]. My mother used to have the nicest body, but the last time I saw her, she was very, very thin. I cried, I told her: come home*" (Daniele, 18).

The crack marks on their bodies impressively wore down their image of themselves. The interviewees knew that their image was of an abandoned body that was no longer cared for, but attacked by drugs, and this impacted them. They knew that their body was completely outside social standards: "*Then, on the second day, I woke up like a beast to use it*" (Renata, 34).

A fundamental and striking occurrence in the life of the stigmatized subject is the fact that they become discreditable mainly by those who know them, when they are treated as “insane” (Goffman, 1988). In the words heard, the fear of people noticing the difference in their bodies prevailed and, consequently, of them being labeled and stigmatized: “*A 61-year-old woman being an addict*”, is the speech of a son about his mother (Almerinda, 61, commenting with regret the criticism made by her son).

It is extremely important to understand how much a woman like Almerinda can harm herself or benefit from the reaction of others to the fact that she is a crack user at the age of 61. We have said before that when a user thinks that she should resort to a health service it is because she has a previous concept about her state, her limits, her risks, especially about what the health field and health professionals can do for her. This concept, whatever it may be, not only determines the manner and type of help she chooses, but also influences the entire course of treatment she will accept and be willing to do (Chiozza, 1987).

With clear language, Almerinda reported the magnitude of the effects of prejudice that fall on her and the suffering of being considered the “*vovó do crack*” (crack junkie granny, the nickname Almerinda received in the scene of use). The “illness” of users cannot be considered as a banal thing that erupts, since, despite everything and although it does not look like it, the gaze of others has repercussions on affections and emotions and can hinder access to services. It is appropriate to examine the prejudices in the social consensus that can essentially limit the approach of users to health devices. It is necessary to recognize the presence of the anguish of the stigma that falls among the users, evidenced in Sônia’s speech: “*When I went to the street, went for a walk, people began to notice how different I was. I lost weight, I no longer combed my hair*” (Sônia, 31 years old).

Stigma and discrimination are patterns of social interaction that result in disrespect and violence and, in the case of health, have repercussions in situations of social vulnerability (Ayres, 2009). They are concepts defined by political and power

relations, based on inequalities and social exclusion (Ayres, 2009). In the case of female crack users, the stigmatized female body was the one that underwent changes, changed shape, was noticed by others and, therefore, excluded.

Medication with fundamental supply in access to treatment ”

The women interviewed go to CAPSad in search of medication that can help them control and reduce crack abuse. The medicine is also requested with the aim of reducing anxiety arising from the restriction of the abusive use of crack.

In the reports of the interviewees, we noticed especially the request of the “medicine” for the “restoration of normality”. Therefore, the norm referred to a certain logic of an “ideal” that the “medicine” would work for their case, and that it related directly to their treatment history.

They all used psychotropic drugs and understood that medication was a resource to deal with emotions and the desire to use crack, that is, a tool of self-control. In the testimonies, it is possible to realize that their expectations were of a mastery over their own thoughts, their reactions and emotions: “*I wanted to use the drug every day. Now that desire is fading. I’m taking the medicine right. I’m sleeping*” (Gicélia, 33 years old).

Medication became an important resource to keep without using crack: “*I’d ask others for Haldol. I wanted to give it some time, but I couldn’t*” (Sonia, 31 years old). We observed that it was essential for them to be in a state of sedation: “*I’m on a very strong medication, really strong. [...] When I’m doped, I don’t think about drugs. I sleep, I eat, I sleep. I don’t have time to think about drugs*” (Denise, 30).

Between crack, which produced a state of “*pancação*”, and the medicine, a state of “*doping*”, they chose the latter: “*It’s much better, this state of doping, when I feel I’m doped [effect produced by medication], than the state of pancação [effect produced by crack], when I feel I’m high*” (Gicélia, 33).

We observed that the promise that they would have the medicine available in the unit was a tool for access to treatment. Also, we noted that this was a resource used by some professionals in the

description of how treatment is constituted to deal with the effects of crack. Daniele and Rosane, interviewed, talked about how the team of the practice in the street used this way to show the type of treatment available in CAPSad III. In this sense, the women reported that their expectations of access were that they would find the medicine as a form of treatment.

Denise explained that, when she felt tired and knew that she would have to take two buses to get to CAPSad, she faced “laziness”, because if she did not do it, she would run out of her medicine: “*I’ve to come and get the medicines that are weekly*” (Denise, 30 years old). For those women, the promise of medicine is just as important as so-called “conversations”.

Symbolic relationships with medicines are evident in various social and health instances. The studies of Peter Conrad help us understand the process of social construction regarding the practice of medicalization. The author says that, in the last 50 years, there has been an increase in the social impact of the concepts of Medicine and, consequently, an increasing number of products intended for health care invading the markets. For said author, this is the way we use to deal with the problems in terms of disease and disorder. He states that we define these concepts from a medical picture and treat them from a medical intervention (Conrad, 2007).

Medicalization occurs in the most varied plans that include the medicalization of deviation, such as: alcoholism, mental disorders, opioid dependence, eating disorders, sexual and gender differences, sexual dysfunction, learning difficulties and sexual and child abuse (Conrad, 2007). Peter Conrad (2007) pays attention to the fact that one must worry when medicalization transforms aspects of everyday life into a pathology, narrowing the scope of what is considered acceptable.

The women started from the premise that in CAPSad III “*there is a doctor and medicine*” (Daniele, 18 years old). About this, Boltanski (1989, p.20) states: “the disease, thus defined, is then entirely qualified by its relation, first as a sign and, secondly, with a medication.” For him, there is a kind of popular nosography that defines diseases, and the

object that we abandon in the hands of the specialist is our body (Boltanski, 1989).

It is known that the process of access to the treatment of people in street situations occurs, mainly, from the units that are directly linked to work in the territory. On this aspect, some authors realize that, in the Family Health Strategy, mental health medical consultations are very related to the issue of Pharmacology, that is, the act of giving the prescription of psychotropic drugs again (Mielke; Olschowsky, 2011). These authors emphasize that one must break with the structure of medicalizing and prescribing, valuing construction and production health spaces (Mielke; Olschowsky, 2011).

It is perceived that biological knowledge is socially constituted as a reference for these issues. For Sarti (2010), this is a difficult field, since it is marked by power relations instituted by the social place that holds knowledge in our society.

For these women, medicalization associated with the possibility of curbing their impulses and emotions, an instrument of containment of the desire to use crack. In this case, it approaches the appointment that Ferreira (2007, p.292) makes about the function or status of social operator of the body: “where the social becomes possible and where, consequently, the effectiveness of the social on the individual is revealed”. In the women’s attempt to seize the social and reproduce the order of the world, they needed to contain, under any circumstances, crack abuse. So the question remains: how to break with the structure of medicalizing and prescribing, valuing the construction of spaces of health production in the face of user demand?

Night care as a facilitator of women’s access to CAPSad

We noticed that, when the women arrived at the night care, their bodies were in a high degree of physical exhaustion and needed several types of care. To cope with an exhaustion of this order, they needed a place of intensive care. The sensations in their bodies were so intense and urgent that they wanted to feel protected 24 hours a day. About this,

Renata's speech (34 years old), who arrived at CAPS after spending many months in the use scene, is expressive: "*Because I'm monitored 24/7 by people, right? If I have a withdrawal crisis, if I want some medicine. It's a different job, right? It's better*".

In addition, the request for care was related to the intensity of the symptoms perceived by them. Gicélia (33 years old), when she sought night care, lamented the effects of crack: "*It's horrible. I had a headache, Monday. I arrived with a horrible headache, didn't sleep right, vomited. I felt very bad because of the drug.*"

In this context, the users wanted to rest their bodies. Therefore, the beds were the place of shelter where they understood that they could get an immediate response to the suffering caused by crack abuse. In this sense, it is noted that the description of the care was related to a clinical device to meet the demands of the body.

The night care beds were also described as a place of shelter that gave them security in situations in which they felt their lives at risk. Thus, for them, night care also became a strategic response to the fear of the streets, violence, humiliation, and the imminent panic of dying. To understand this meaning of night care is inevitably to include it in a context that re-signifies it, so that the patient, the body, and the disease can be treated. The request for night care is a form of language, a sense that erupts, an inseparable part of the request for help (Chiozza, 1987).

The story that is hidden behind the request for night care, the understatement is the women's request for restraint in the health unit as a way to get rid of the harsh reality of the streets that they feared. The idea of being free and unprotected on the streets frightened some women, as Denise (30) stated: "*they said that the CU [Care Unit] you can be free to do whatever you want. If so, I want to continue here because I'm terrified of going out alone.*"

This also related to the situations of violence which some women experienced. The story of Gicélia, recorded in the field diary, testifies that she resorted to night care because she felt unprotected in her home. In addition, women hoped that from the treatment received, they could stay away from

crack: "*I'm getting used to being without it. I'm not missing drugs as much as I was [...] It helped me a lot to stay away from drugs and return home without it*" (Gicélia, 33).

It is important to realize that some women have resorted to the night care because they say this is the way found to not give in to the desire to use crack. We could say that, like Teresinha (33 years old), many users would like to be "confined" in a health service to receive attention and affection: "*A lot of attention, a lot of affection, talking to people who use [drugs], giving attention [...], playing, if you can lock the door, do it, so you can't leave. If I try to break out, they open [the door], talk to me.*"

However, experience shows that there is a paradox between the length of stay in the bed defined by Ordinance No. 130 and the need shown by women. According to the ordinance, the period they can stay in night care is a maximum of 14 days, which does not seem to be enough. Gicélia, during her night care, glimpsed staying longer and told, with a certain air of excitement, that her mother would enter with a request for compulsory hospitalization so that she would spend more time in CAPSad III – "*I want to be here for a month!*" (Gicélia, 33 years old).

Renata, during her night care, also said that her father would enter with a request for compulsory hospitalization: "*Now they found out that my father is in court to get a compulsory hospitalization. So, he put me here, I'm here for the compulsory, but I'm going to stay here indefinitely, I don't know when I'm going to leave*" (Renata, 34 years old). Rosane, who had not gone through night care, had an expectation of "*being admitted for at least six months*" (Rosane, 30).

The stories we show try to highlight and clarify an important issue, an inseparable problem related to the treatment of female crack users. Empirical experience teaches us that night care is a tool that is consistent with the precepts of psychiatric reform (Pereira et al., 2017). Ordinance No. 130, of January 26, 2012, highlights the issue of night care beds, through the financial incentive to implement CAPS III (Brazil, 2012). Said Ordinance makes it clear that these should be intended for night shelter based on the needs of detoxification and psychosocial rehabilitation, such as the need for observation,

rest and protection, conflict management, among others (Brazil, 2012).

We could say that the fact that this resource responds immediately to the basic needs of users, such as: sleep, food, bath, rest etc., it relates to a fundamental way of empirically understanding their need. The use of comprehensive care beds in a CAPSad III has as objectives “relapse prevention, harm reduction, protection in conditions of social risks and extreme vulnerability, treatment of mild abstinence and shelter in case of intense fissures” (Brazil, 2010, p.9) and this is enough to show a practical need.

Several authors discuss the social and health vulnerability situations which crack users associate with the exhaustion described by the women included in this study.

The vulnerability for the users lies in: being dirty, with torn clothes, poor hygiene, thinness and apparent skin problems, ranging from cracks and wounds apparently infected (Zeferino et al., 2017). In addition to these conditions, one cannot ignore other aspects contained in the idea of vulnerability, for example: risky sexual behavior, overdose, slimming and insomnia (Ribeiro; Sanchez; Nappo, 2010). Similarly, there are conditions such as: “exposure to climatic variations, unhealthy housing and food conditions, and repression actions by public security policies, which negatively affect the health condition of individuals in street situations” (Hallais; Barros, 2015, p.1501).

We understand that, among the structures necessary to expand access to treatment for female crack users, it is important to implement care points. These points should offer the possibility of food, rest, health promotion activities and harm reduction (Brazil, 2010). It was clear that the women included in the study were unaware of these structures and demanded from CAPSad III this offer of care.

Some authors justify the search for prolonged hospitalization as a protective measure. The crack user, in general, maintains a compulsive pattern of use, associated with some harms such as illicit activities, violence, prostitution and legal problems. Thus, prolonged hospitalization would

be the preferred form of treatment sought by family members and the users themselves; although, in addition to this, there are other modalities of treatment (Picoli, 2013). The search for hospital care was mentioned by other authors in cases of overdose. Death would be a risk inherent in the use of crack, but which, when avoided, allows the maintenance of addiction for many years (Ribeiro; Sanchez; Nappo, 2010).

Finally, in relation to the request for the cessation of crack use, this is repeated in other studies. Pedrosa et al. (2016) highlights that the participants of their study showed a desire to get out of the situation in which they were, and that they associated this with the need to remain abstinent in order to be able to start over.

It is true that some authors have criticized the fact that CAPSad bases its practices on a biomedical model, which aims to “cure” through abstinence (Paula et al., 2014). For Romanini and Roso (2013, p. 493), abstinence is a concept that is related to the very conception of who crack users are: “if we conceive the drug user as a chemical dependent, as a victim of the substance, only abstinence and the prohibition of contact with the drug can produce therapeutic effects.”

Final remarks

In this study, from the concrete perspective of women, the desire to have a body that could be cared for is an important motivation to seek help from the users.

Under the aegis of a bankrupt and stigmatized body, with signs of deterioration and exhaustion, feeling by their own the limit of life imposed by the radicality of crack consumption, they, despite everything, expect help from CAPSad for their problems.

The female perception of the stigma that falls on them derives from the signs that are noticeable in their bodies because of crack abuse. In the lived experiences, the women considered their situation serious, seen from the physical and subjective sensation of fragility and deterioration of the body. This was signaled through the desire of having

their previous body, gaining weight, improving appearance and feeling more interesting.

We demarcate that there is an issue that retains our greatest interest: the users had the expectation of shelter and medicalization. At this point, it must be said that the professionals in a certain way evaluated how the medication could respond to the ailments of their bodies. Thus, while in other health devices women experienced as reality the difficulty of access to drug therapy, they saw that in CAPSad their demands would be answered. In the women's discourse, medicalization was a containment tool. The request made by them was that the medication could provide them with a state of self-control, to deal with crack abuse.

In addition to the drug perspective, the women hoped to find in CAPSad a structure that would provide them with rest and protection for a body that gave signs of exhaustion. Thus, they asked for night care, which would respond to the fear of the risk situations which they experienced on the street and those imposed by the abuse of the substance itself.

Finally, based on what has been exposed, it is essential to recognize the elements that characterize access to treatment for women who use crack. CAPSad needs to be prepared to deal immediately with the consequences generated by the sick and bankrupt bodies of these women. It is important to recognize that stigma is an essential symbolic piece that should be seen as a part that integrates the problem of access and reception of users.

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Authors' contribution

Vernaglia participated in the conception, design, analysis and interpretation of the data and the writing of the article. Cruz participated in the discussion of the results, critical review and approval of the final version of the study. Peres participated in the discussion of the results, critical review and approval of the final version of the study.

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