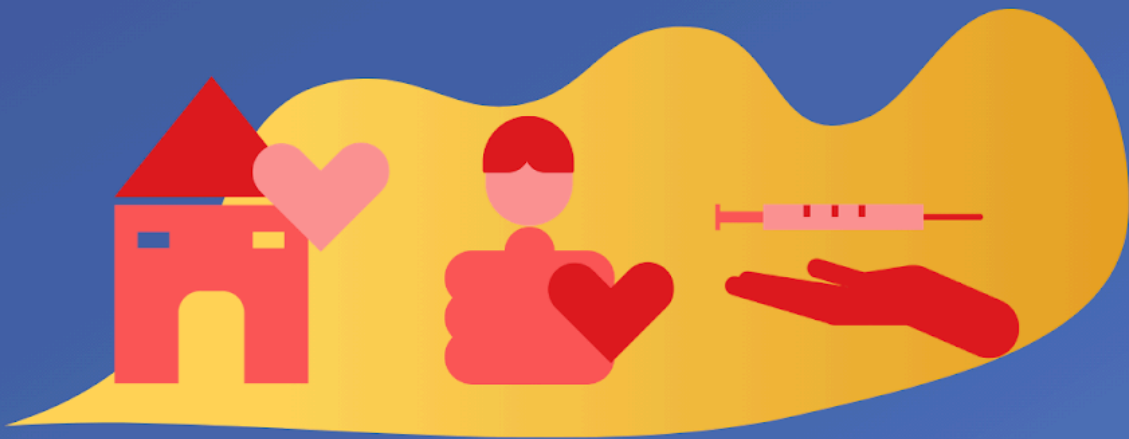


STIGMA & DISCRIMINATION

Related to Substance Abuse



2021

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Stigma & Discrimination related to Substance Abuse

Deconstructing sophisms towards Humanitarian Public Policies

EN / Abstract: Over the past few decades, international research has documented that stigma and discrimination is one of the major barriers to care in the field of drug abuse worldwide. Objective: To show the findings of the international literature about specific populations that experience stigma or discrimination as one of the main barriers to care for substance abuse as well as to account for the development of public policies against stigma in mental health and addictions in consonance with goals 3, 10 and 16 of the Sustainable Development Goals.

Keywords: *Substance Abuse, Stigma, Discrimination, Mental Health, Human Dignity*



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INTRODUCTION

In 2019 it was recorded that, about 271 million people around the world, consumed some type of illegal drug, one in 20 adults between 15 and 64 years old has used at least one drug in their lifetime, in addition to that about 35 million people suffer from substance use disorders and only one in seven receive treatment, hence the importance of addressing in research on these issues (UNODC, 2019).

International research has documented that stigma and discrimination as one of the main barriers to care in the field of addictions (Room, 2005; Kulesza et al., 2014; Krawczyk et al. Al., 2015; Cama et al., 2016; Yang et al., 2017; Volkow, 2020). Drug users are socially perceived as people incapable of self-control, responsible for their own behavior (Corrigan et al., 2009) and this perception could impact their recovery process and emotional well-being. Exclusion, rejection and other discriminatory practices such as physical and verbal abuse have been identified in drug users attending treatment (Redko et al., 2007; Gueta, 2017; Mora-Ríos et al., 2017, Rafful et al., 2019). Likewise, it has been reported in research that stigma and discrimination come not only from the general population, but also from health personnel working in the field of care in this area (Ford, 2011; van Boekel et al., 2013). Persons deprived of liberty, minority groups, migrants and displaced persons also face additional barriers to treatment due to stigma and discrimination (UNODC, 2020).

Substance abuse refers to the harmful and hazardous use of psychoactive substances, including alcohol and illegal drugs (WHO, 2020). The health impact of substance abuse can lead to dependence syndrome as well as a high incidence of health care costs due to the comorbidity of substance abuse problems with physical conditions such as infectious diseases such as HIV and hepatitis C, chronic degenerative diseases, cardiovascular, respiratory, cancer and mental illnesses (NIDA, 2017).

At the social level, the implications of substance use are observed in different "forms of violence that can be associated with organized crime, linked to the purchase and sale of drugs in the illegal market or induced by intoxication with psychoactive substances" (Medina-Mora et al., 2013, p.67). Hence, the strategies that countries have adopted to address this problem have been characterized by being based mainly on the punishment and criminalization of individuals (Volkow et al., 2017).

I. PREJUDICE, STIGMA AND DISCRIMINATION

Due to the various disciplines that have been interested in the issues of exclusion, stigma and discrimination, the development of research on stigma and substance abuse suggests a transdisciplinary approach (Greaves et al., 2015). Social psychology, promoted pioneering studies through the proposal of Gordon Willard Allport (1955) The nature of prejudice, enunciates some characteristics of the stigmatization process. He gives an account of the historical origin of the word prejudice: for the ancients (Greeks) *praejudicium* meant precedent or a judgment based on previous decisions and experiences; the consideration of facts: a premature or hasty judgment. The term currently in use refers to a favorable or unfavorable state of mind that accompanies such a prior and unfounded judgment, i.e., to think ill of others without sufficient grounds. In this sense, he defines prejudice as "a hostile or anticipatory attitude towards a person who belongs to that group, thus assuming that he possesses the objectionable qualities attributed to the group" (Allport, 1955, p. 22). For the author, prejudice constitutes a personal attitude that is based on generalized beliefs, endowed with a moral value load, expressed through different negative acts ranging from bad language, avoiding contact with the group, discrimination, physical aggression and extermination of the population -genocides-.

Almost simultaneously, Sociology through Erving Goffman (1963) developed the first work addressing mental health and the processes of social interaction between subjects in his book *Stigma: Notes on the Management of Spoiled Identity*. The origin of the word, says Goffman (1963) comes from the Greek, they created the term stigma - stigmata - to refer to bodily signs, intended to show something unusual and bad about the moral state of the wearer. The signs were engraved or marked on the body and informed that the wearer was a slave, an evildoer or a traitor, a corrupt, spiritually impure person who had to be avoided, especially in public places.

Goffman defines stigma as "a deeply discrediting attribute that makes one person different from another" (Goffman, 1963, p.14). He also classifies stigma in three dimensions: a) abominations of the body, comprising physical malformations or deformities; b) defects of the individual's character; and c) tribal stigma characterized by race, nation or religion. The character defect of the individual is perceived as lack of will, tyrannical or unnatural passions, rigid and false beliefs, dishonesty, in this parameter appear people with mental disorders, reclusions, drug addictions, alcoholism, homosexuality, unemployment, suicide attempts and extremist political behavior.

Decades later, the proposal of Bruce G. Link and Jo C. Phelan incorporate important assumptions in what they call modified labeling theory. Link and Phelan (2001) assert that the experience of stigmatization is personal and as such is part of the social world. "Stigma is a dynamic and changing process that begins with the construction of differences in skin color or gender, producing labeling, linking with defined prejudices and

stereotypes, causing social distancing or segregation between those inside "us" and those outside "them", the above results in the degradation of the individual (loss of status) and discrimination of labeled people, at all times there are asymmetrical relationships" (Link & Phelan, 2001, p.367).

Labeling theory considers that a psychiatric label can set in motion a series of cultural stereotypes and negative images about mental illness that are applied to the individual suffering from it, by others, but also by the person him/herself (Link, 1987). Likewise, in the modified theory of labeling Link et al (1989), refer that making visible the devaluation and discrimination generated by labeling interferes with people's access to social, economic and welfare opportunities.

On the other hand, from Anthropology, Raybeck (1988) criticizes the theory of labeling, speaking of the deviance of the social and cultural. Throughout society, social practices, structures and institutions are created to control, contain and repress certain types of behavior considered aberrant or deviant from the norm; these same institutions and practices lead to social exclusion and stigmatization of the disease. For this author, one of the results of the labeling process is always directed at the "deviants", who find themselves in an "outsider" or "outside" position, where the availability to interact with other groups in society is limited.

The author proposes that the size and scale of the social unit are important factors that come into play in the labeling and stigmatization processes. "The social and family structures historically found in pre-industrial societies and prevalent in poor countries may exert a comparatively benign or protective effect on those with mental illness" (Raybeck, 1988, p. 37).

In more recent years, Pedersen (2005) was interested in developing the concept of stigma from a mental health perspective. The author's proposal understands stigma "as a dynamic concept given by temporality, it is constructed from interpersonal relationships anchored in the context of individuals. Stigma is a social product related to the regulation of institutionalization and the ideologies that sustain them, as well as to the decisions made by individuals, societies and states" (Pedersen, 2005, p. 2).

Returning to Raybeck's proposal, stigmatized behaviors will vary from one culture to another, and this in turn is defined by temporality. In this regard, Pedersen (2005) says that exploring psychiatric stigma in "traditional" or "non-Western" societies has a certain complexity because there is a different classification of mental illness, where the distinction between "psychiatric" and "non-psychiatric". Illness is often blurred or simply does not exist in the same way as it does in cosmopolitan Western societies.

According to Sartorius (2006), it can be summarized that stigmatization can result in negative discrimination, which in turn leads to numerous disadvantages in terms of access

to care, poor health service, frequent moments that can damage self-esteem as well as additional stress that can worsen the condition of the "labeled" person and, therefore, the "label" becomes even greater, making the person more prone to be identified and stigmatized. In this sense, discrimination is defined as "actions taken by a dominant group or by a member of the group, with the aim of harming other individuals who are part of less dominant groups" (Huddy et al., 2013).

2. STIGMA AND SUBSTANCE ABUSE

In the international review of stigma and substance abuse, research in the Netherlands, Canada, Australia, England, and the United States has documented how health professionals develop stigma and discrimination against people who use drugs.

The systematic review conducted in the Netherlands by van Boekel et al. (2013) found that negative attitudes of health professionals toward patients with alcohol or other drug addiction take the form of poor communication between professionals and patients, resulting in decreased therapeutic alliance and misattribution of physical illness with symptoms of substance use. In Ontario, Canada, Heskell et al. (2016) compares an urban community with a rural one, how drug users and their family members report negative attitudes on the part of health professionals, attributing responsibility for inadequate care to the health team due to stigma and lack of knowledge about how to care for people with problematic drug use.

In Australia, a qualitative study on nursing staff (Ford, 2011) shows how caring for patients who use illicit drugs represents an emotional and potentially unsafe challenge for health professionals, due to the perceived existence of violence, manipulation and irresponsibility on the part of patients. Similarly, in a research conducted with general practitioners in London, England, McGillion et al. (2000), expose how patients with drug abuse problems are often perceived as manipulative, aggressive, rude and unmotivated. Complementarily, the study by Meltzer et al. (2013) conducted with 128 internal medicine residents in a New York hospital, addresses attitudes towards different types of patients through the Medical Condition Scale and it was found that first-year residents are those who have limited resources to care for people who use drugs, in addition to manifesting a reserved way to improve their attitude towards this population.

In North American countries, particularly in Canada, research has been developed that shows that stigma occurs around opioid use. This type of research comes as a result of the so-called opioid and injection drug crisis where the Ontario region has the highest prevalence of overdose deaths (Fischer & Rhem, 2017; Hadland & Kertesz, 2018). McCradden et al. (2019) show that how opioid stigma is reproduced depends on the

context of use, the social identity and networks of the person using the opioid, as well as the type of opioid used, including non-prescribed forms of treatment.

According to the review and analysis of 49 articles on the subject, it was determined that there are four typologies related to opioid use:

- (1) interpersonal and structural stigma toward persons seeking opioid agonist therapy (OAT);
- (2) stigma related to opioids for the treatment of chronic pain;
- (3) stigma in health care settings; and
- (4) self-stigma.

"Opioid-related stigma permeates intrapersonal, interpersonal, structural, and societal levels, and people who use opioids are marginalized at all levels, this typology may serve to have considerations for reducing stigma in health services" (McCradden et al., 2019, p. 205).

Current research has been conducted on people who inject drugs (PWID) in countries such as Australia, Russia, and Estonia using scales that measure self-stigma, Cama et al. (2016), conducted a study where they recruited people who inject drugs in a needle and syringe program located in the city of Sydney. In this research, the Internalized Stigma Scale for Mental Health (ISMI) is adapted and suggests that there is an association between self-stigma with depressive episodes, low self-esteem and severe injecting drug use during the past month, furthermore internalized stigma among people who inject drugs has an implicit impact on the individual's mental health.

In the Northeast region, Burke et al (2015), developed a comparative study between two cities in Europe, people who inject drugs were recruited through targeted sampling, as well as those who indicated to be HIV positive were included in the sample 381 participants in St. Petersburg (Russia) and 288 in Kohtla-Järve (Estonia). The research shows how people who inject drugs are frequently discriminated against, associating their physical and mental health with being possible HIV carriers.

In Latin America, the country that has developed more research on people who use cocaine base (crack) is Brazil, showing strong evidence, Krawczyk et al. (2015) conducted qualitative research in two cities (Sao Paulo and Rio de Janeiro), used semi-structured interviews to explore the perceptions of regular crack users to understand how social and environmental factors, including stigma and marginalization, influence initial use, as well as a range of social and health problems that may arise temporarily or permanently.

Some research findings addressed common concerns among users, including excessive crack use, engagement in risky habits, infrequent use of health services, marginalization,

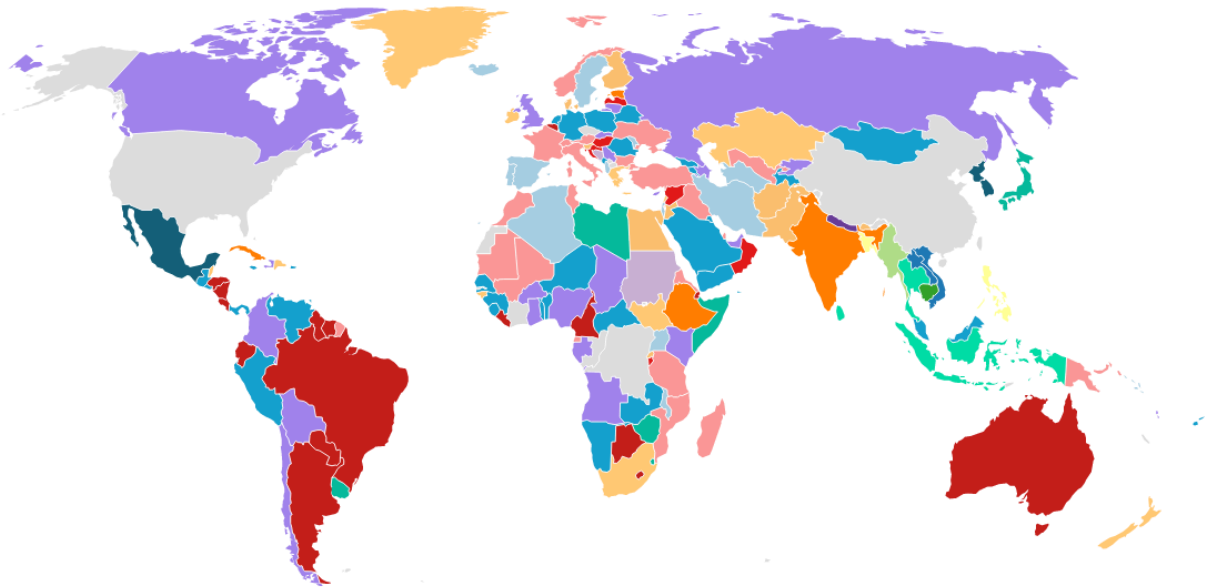
and difficulty in reducing use. Likewise, in Porto Allegre, Bard et al. (2016) point out that crack users suffer the consequences of being labeled and stereotyped as undesirable and unproductive beings, which promotes a lower position in the social hierarchy, which can have a negative effect on their opportunities as citizens, loss of status, becomes the basis for discrimination, which generates stereotypes and separation.

In Mexico, research on stigma in the general population shows that people with a mental disorder are subject to greater stigma and discrimination, substance use and schizophrenia are the most stigmatized conditions (Mora-Ríos et al., 2013) due to the fact that people who use drugs are considered responsible for their condition (Mora-Ríos & Bautista, 2014). At the federal level in Mexico, research has been conducted on the presence of stigma in people who use drugs. A study of the female prison population shows how substance abuse affects female inmates to a greater extent than other women and that their situation makes them more susceptible to influence and prevalence of substance abuse behaviors. "Aspects such as low educational level, limited job skills, exposure to stigmatization and discrimination accentuate this vulnerability, which represents difficulties in accessing treatment for this type of problem" (Romero et al., 2010, p. 599).

In a study on addiction-related stigma conducted by Mora - Ríos et al. (2017), a subsample of 9 alcohol and drug users, 10 family members and 16 health professionals was analyzed, it was found that the greatest generators of stigma are family, health professionals, self-help groups, classmates, other drug users and treatment centers. In addition, research findings show that the most common practices toward drug users include indifference, rejection, distancing, overprotection, physical abuse, and psychological abuse. One of the themes that emerges is the internalization of stigma, which occurs when the person who uses alcohol and drugs takes on the stereotypes associated with addiction and applies them to him or herself.

Percentage of population with mental health and substance use disorders.

The map shows the relative change from 1990-2017 of the percentage of the population with any mental health or substance use disorder; this includes depression, anxiety, bipolar disorder, eating disorders, schizophrenia, alcohol and other drug use disorders.



Because of widespread under-diagnosis, these estimates use a combination of sources, including medical and national registries, epidemiologic data, survey data, and meta-regression models. As of the date of publication of this document, there are no data available on the effects of the COVID-19 pandemic.

Map: Knowmad Institut gemeinnützige UG (haftungsbeschränkt) | By: Martin Ignacio Díaz Velasquez •

Source: PREVALENCE - MENTAL AND SUBSTANCE USE DISORDERS - SEX: BOTH - AGE: AGE-STANDARDIZED (PERCENT) Variable time span 1990 – 2017 Data published by Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017.

• Created with Datawrapper

3. STRATEGIES FOR FIGHTING STIGMA AND DISCRIMINATION

The issue of stigma and discrimination has gained momentum in the last decade, in January 2020, the United Nations Office on Drugs and Crime (UNODC) held a meeting called "Inclusion not exclusion" in which 50 experts participated, including researchers from countries such as Canada, Australia, Uruguay, Mexico, as well as members of civil society, which addressed the social implications of stigma for people who use drugs, which represents one of the priority issues on the international agenda (UNODC, 2020).

Among the practices proposed at that meeting to combat stigma and discrimination, education of health professionals and other service providers as well as a careful and appropriate understanding of scientific evidence (Corrigan, 2016b), modifying the language when referring to substance use and abuse (Kelly et al., 2016; Corrigan, 2018), supporting the meaningful participation of people with lived experiences for the development of policies and services (Corrigan, 2018), as well as expanding contact with the population of drug users (Ronzani et al., 2017) stand out.

In relation to anti-stigma interventions, Mascayano et al. (2019) propose the need to expand research in this line, mainly in Latin America due to the gap between low- and high-income countries, which implies employing cultural adaptation processes, better research designs, with longer follow-up periods and more appropriate strategies to incorporate relevant cultural characteristics of each community.

Canada is currently the pioneer country in focusing its efforts on a health policy that seeks to eradicate stigma and discrimination in several intersecting conditions: racism experienced by First Nations: Inuit and Métis peoples; racism experienced by Africans, Caribbean and Black Canadians; stigmas experienced by LGBTQ+ people (sexual stigma and gender identity stigma); mental illness stigma; substance use stigma; HIV stigma; and obesity stigma (Tam, 2019).

In order to showcase an example of anti-stigma public policy, Jacob & Skinner (2015) critically analyze a public strategy to reduce stigma towards mental illness and substance use in the general population, the campaign was developed in Toronto, Canada, through the Centre for Addiction and Mental Health (CAMH). The authors explain that CAMH launched the first stage of the three-part Defeat Denial campaign in June 2012. "The campaign began with an initial promotion at public transit stops in late May 2012 in which CAMH, was not named, targeting the Greater Toronto Area, the campaign formally began in early June 2012 with advertisements in movie theaters, as well as billboards, subway, radio, newspaper and online ads.



With the goal of encouraging a broader public conversation, the campaign included an interactive online component, through the social networking sites Facebook and Twitter, as well as through a dedicated website. The goal of the campaign was to challenge the stigma associated with mental illness by encouraging the public to rethink their perceptions of mental illness and addiction, as well as to raise awareness of CAMH's work" (Jacob & Skinner, 2015, p.7-8).

Prevalence of mental health disorders (2017).

Estimates on the prevalence of mental health disorders and associated disease burden. Data show that by 2017, at least 792 million people were living with a mental health disorder. This accounts for just over one in ten people globally (10.7%).

Disorder	Percentage of the world's population suffering from a disorder (2017). [difference between countries].	Number of people suffering from the disorder (2017).	Percentage of women with the disorder (2017).	Percentage of men with the disorder (2017).
Any mental health disorder	10.7%	792,000,000	11.90%	9.30%
Depression	3.4% [2-6%]	264,000,000	4.10%	2.70%
Anxiety disorders	3.8% [2.5-7%]	284,000,000	4.70%	2.80%
Bipolar disorder	0.6% [0.3-1.2%]	46,000,000	0.65%	0.55%
Eating disorders (clinical anorexia and bulimia)	0.2% [0.1-1%]	16,000,000	0.29%	0.13%
Schizophrenia	0.3% [0.2-0.4%]	20,000,000	0.25%	0.26%
Any mental or substance use disorder	13% [11-18%]	970,000,000	13.30%	12.60%
Alcohol use disorder	1.4% [0.5-5%]	107,000,000	0.80%	2.00%
Drug Use Disorder (excluding alcohol)	0.9% [0.4-3.5%]	71,000,000	0.60%	1.30%

Mental health disorders are complex and can take many forms. The underlying sources of the data presented in this table apply to specific definitions according to the WHO International Classification of Diseases (ICD-10). This broad definition incorporates many forms, such as depression, anxiety, bipolar, eating disorders, and schizophrenia.

Table: Knowmad Institut gemeinnützige UG (haftungsbeschränkt) | By: Martin Ignacio Díaz Velásquez | 2021 •

Source: Hannah Ritchie and Max Roser (2018) - "Mental Health". Published online at OurWorldInData.org • Created with Datawrapper

4. REFLECTIONS ON THE STIGMA & DISCRIMINATION AGAINST PEOPLE WHO USE DRUGS

Through the survey of stigma and discrimination related to substance abuse, information was collected from ten participants. Four women and six men, with professional profiles oriented to Clinical Psychology, Psychiatry, History, Library Science, Economics and Chemical Engineering.

Eight of the participants affirmed that they knew about stigma and discrimination against people who use drugs. However, only five recognized that public stigma promotes a stereotype of people who use drugs, based on the association of illegal drug use with crime, as well as a negative image of those who use drugs as a bad influence on others who do not.

One participant recognized the existence of structural stigma, which has to do with a set of norms, policies and procedures of public or private entities that restrict the rights and opportunities of people with mental illness, legitimize power differences, reproduce inequities and social exclusion, since "it is aimed at making individuals invisible to the authorities".

Two participants expressed very concrete practices that define discrimination, one is family abandonment as well as physical and psychological abuse through indifference and underpricing of the person's basic needs, such as food restriction and neglect during treatment.

In a very specific way, a participant who works directly in psychiatric care services recognized the existence of intersectional stigma, which refers to the interaction of multiple conditions of vulnerability in drug use and its barriers to access treatment, such as: gender, physical and mental abuse, comorbidity, lack of social support, social and health inequalities, as well as migratory situation or belonging to minority groups.

Regarding knowledge about available public health services that address substance abuse, it was found that all participants are aware of the existence of health institutions at the public level (psychiatric hospitals) and at the private level (psychotherapists, psychiatrists), likewise, the services of mutual help groups such as Alcoholics Anonymous and Narcotics Anonymous, are referred to as easily accessible services, but represent a problem because they are violent with the community. However, only one participant referred to the existence of harm reduction services for people who inject drugs: "syringe exchange services" or "safe injection rooms".

It was also found that participants with a professional orientation to psychology (3) and psychiatry (1) have information about the diagnostic classification systems for substance use disorder. They comment that these criteria, are: The International Classification of Diseases and Related Health Problems, eleventh edition (ICD 11) proposed by the World Health Organization, as well as the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5), developed by the American Psychiatric Association. In addition, there was a mention of the existence of health care models based on the cultural system.

Regarding recommendations to combat stigma and discrimination against people who use drugs, participants expressed the importance of updating the curricular education of health professionals. Promote mental health and drug education to society in general in order to have a better understanding of the spectrum of substance use, i.e., to know that not all consumption is problematic or can generate a substance use disorder. Participants also expressed that in order to raise awareness about stigmatizing attitudes and their consequences in those who seek to stop using a substance, it is necessary to work together at the community level and with the media to have a better use of language and "detoxify the current narratives" that exist around the phenomenon.

5. DISCUSSION

Currently, the criteria for the evaluation of mental health are not fully disseminated and promoted in the general population. The now obsolete criteria have a biologicist approach, which proposes recommendations in the community approach through the so-called psychosocial interventions, which seek to standardize the strategies of care without enunciating the inequalities related to access to health according to the different regions and cultures. Specifically, Latin America has heterogeneous and mixed health systems, which incorporate a diversity of conceptions of mental health and, consequently, of status and priorities in public health policies.

Comprehensive approaches are required where consumption that becomes problematic for the individual or his or her community environment can be addressed by means of full-spectrum strategies. To this end, it is important to deepen the education of the general population and particularly to incorporate in the training of health professionals a comprehensive and critical perspective, with a view to geopolitical power relations at the local level and in relation to the countries of the global north, which must necessarily be accompanied by state policies consistent with a comprehensive, regional and human rights perspective, aimed at the development of non-pathologizing and non-violent interventions.

Likewise, there is a broad need to modify the narratives surrounding the use of psychoactive substances in order to remove prejudices and stereotypes that generate

stigma that relate people who use drugs with some psychophysical pathology or as actors that promote violence or crime.

In this sense, the problem of drug trafficking cannot be thought of as separate from the discussion, since the illegality of certain substances increases the inequalities of those who use them. The geopolitical segmentations of each region, the socio-cultural inequalities surrounding the guarantee and preservation of basic rights such as access to land, decent housing, health, education and work, in addition to the military, paramilitary and political conflicts in the different countries of Latin America and Africa, are not problems that should not be taken into account when thinking about the stigmas and discrimination that people experience in relation to the consumption of psychoactive substances.

We assert that access to drugs of varying quality standards will depend on factors such as social class, gender, markers of racialization and the geopolitical location in which communities and individuals find themselves. As well as whether the substance being produced is for domestic consumption or for export.

Some Mesoamerican countries, for example, designate responsibility for prevention and (coercive) treatment to entities dependent on public security apparatuses. This contributes to the deterioration of the authority and credibility of the entities responsible for public health.

The geopolitical instability of Latin America in particular, shows the deep socio-cultural inequalities regarding the guarantee and preservation of human rights and dignity; added to the armed and political conflicts of different characteristics and intensities are problems that must be taken into account when thinking about the stigmas and discrimination that people suffer in relation to the consumption of psychoactive substances.

6. RECOMMENDATIONS

- ❖ The Sustainable Development Goals seek, among others, to preserve the ethnosphere, for which it is necessary to recover community strategies for self-care and responsible self-care of people, as well as to make visible and confront repressive policies towards the most vulnerable sectors of society such as children, women, youth, as well as minority groups due to migration, class and health conditions.
- ❖ Promote the practical action of communities to build policies that promote, strengthen and form a public health system according to their social environments based on the needs that the community itself identifies according to the different ages of its members. In this way, channels for the exercise of citizenship can be enabled, which will challenge the states to develop and deepen comprehensive and participatory policies. The appreciation of community knowledge and experiences is vital in order to approach these objectives.
- ❖ The development of pragmatic tools is required to raise awareness of one's own stigmatizing attitudes and their consequences on the individual. These tools should allow the person to sustain him/herself as an active and valuable member of his/her social environment, so that his/her fundamental rights are not blatantly disqualified. Factors that determine the contexts of consumption and its purpose, and allow us to move away from the pathologization of substance use.
- ❖ Working together with the media to have a better use of language is fundamental to "detoxify current narratives" and deconstruct the legitimized sophisms that exist around substance use.
- ❖ Raising awareness about People Who Use Drugs (PQUD) also consists of recognizing that the current view of PQUD is based on stigma and discrimination and that it is the result of a web of interpretations that come from the community where people live, as well as from biopsychosocial teams. If we take up Goffman's (2006) idea mentioned above about stigma, it is possible to state that this (stigma) emerges when the group to which an individual belongs identifies elements (or a single element) that makes him/her different, whether at a physical, tribal or psychological level, in this case, consumption is the element that makes him/her different from others, and they associate this element with other aspects that are interpreted as negative, harmful, pathological, unpleasant, among others. But stigma, from this notion, not only represents a differential actor, but also an element that fosters a special kind of relationship, a relationship that is characterized by a specific attribute (consumption and the attributions to it) and stereotypes.
- ❖ Promoting a vision away from stigma and discrimination, merits delving into the interpretations and networks of interpretations that emerge from a series of assemblies where previous knowledge is present, for example, and that are lived in everyday life and are present in social reality. Inquiring into the processes of

subjectivation (Guattari, 1996) will be necessary, both from the processes where individuals who consume some type of substance assume themselves and identify themselves with different stereotypes, stigmas and even forms of discrimination among them. As well as the processes of subjectivation related to other social actors of equal importance due to their interaction with people who consume some type of substance, such as medical health personnel, for example. Subjectivation is a "Set of conditions by which individual and/or collective instances are able to emerge as a sui-referential existential Territory, in adjacency or in relation of delimitation with a subjective otherness" (p.20).

- ❖ These processes of subjectivation and then of protosubjectivation allow us to understand that stigma and discrimination are part of the framework that emerges from and in society through its "social machines", which are the result of a chain of historical events. In the words of Guattari (1996), the relevance of analyzing the processes of subjectivation is expressed, the author comments that "For this reason they must take an eminent place within the conformations of subjectivation, called in turn to relieve our old social machines, incapable of following the efflorescence of machinic revolutions that make our time explode everywhere" (p.72).
- ❖ The understanding of discrimination and stigma, from the work of Chaosmosis in Guattari (1996) specifically in his multicomponential cartographic method allows us to understand the coexistence between the process of subjectivation and the possible reappropriation, and result of it, "an autopoiesis of the means of production of subjectivity". This allows us to explore how the aforementioned categories represent the superimposition of multiple layers of subjectivations, heterogeneous and hegemonic layers, which extend in different universes, professional and non-professional, and which sustain a consistency in their variables: the attributions resulting from stigma and discriminatory response. This superimposed on family and community subjections, but also focused on understanding that current practices are the result of a social system based on hegemonic medical models and nominal and normal categories cemented in a historical process characterized by power relations through biomedical knowledge, since the time of the classical episteme. In the interpretations of people who use substances, there are flows and "abstract machineries" that not only permeate the unconscious structure and language, but also everyday praxis, materializing in the continuity of stigma discrimination.
- ❖ From this traditional and somewhat canonical notion about people who consume some type of substance, the processes of subjectivation start from a base idea where these people not only move away from the stereotypes or visions of "normal" and desired by society. But it also promotes a representation that contributes to the persistence of actions, discourses, based on an interpretation that undervalues

those who consume psychoactive substances, as it categorizes them as unpleasant and even pathological for society.

- ❖ From the multicomponential cartographic method by Guattari (1996) it is possible to understand the pathic subjectivation in the discourse of the participants, since at the root of all the modes of subjectivation there is hidden a rationalist and capitalist subjectivation that is eluded through an almost dogmatic appropriation of the concepts that emerge from the biomedical model about "consumption", "mental health", "health", "substances", among others. The discursive links not only reflect these universes proper to the dominant formation and discourse in Western cultures, but also the way in which science is understood over and above the factors of subjectivation, as the expression of a unique and all-encompassing discourse.
- ❖ It is important to understand the constitution of the individual who consumes psychoactive substances, legal, illegal or illegitimate, depending on his or her culture, is in itself the anatomy of a complex series of subjectivation, where it is possible to evidence individual-group-machine-stigma-society-community-interchanges-multiplicities-culture-discrimination-economy-system-paradigm-science-disease. These complexes offer people different possibilities of living their condition and even their existential corporeality on a daily basis, as they live through a series of repetitive "impasses" that do not always facilitate the process of resignification and resingularization. It is here where subjectivities prevail that are crystallized in "structural complexes" and potential structural complexes that are evident in the discourses of this research, and that depend on dominant paradigms and power structures that define and re-define people who consume substances, according to particular interests and cultural inertia, which is based, on the one hand, on the absence of critical thinking and, on the other hand, on the presence of a dominant model, then, when new modalities of understanding this subjectivation are proposed, resistances are formed that aim to return to the traditional model, over and over again, as a kind of eternal return, in a Nietzschean sense.
- ❖ From this analysis, the proposals should focus on understanding the process of subjectivation not only in those who consume substances, but also in the society and culture that surrounds them. It should focus on processes of subjectivation between those who consume and the systems that surround them, paying special attention also to the processes that Guattari (1996) calls "machinic" and that are more than human, since they contain abstractions, systemic, structural formations, even with animals and with discursive formations, in those who suffer from some kind of illness, in significant social actors, but above all in an even more important and underestimated class, to which many of the discourses found in this research

belong and which Guinsberg and Oury define very well: the normopaths (Guinsberg, 1994; Jean Oury, cited Guattari, 1996).

- ❖ Normopaths and their relationship with accepted normality, without further analysis, and with solemn passivity, have long presented "the new subjectivity", offering individuals who transgress this normality, guilt, stigma and discrimination. This marks an essential part of the devices that sustain social structures and systems, based on subjugation and pathologization, but which in reality are a return to old empires and practices, those machines of subjugation coming from old feudal orders, and reterritorialized visions of normality and abnormality.
- ❖ Given the cultural inertia that this situation represents in some countries, it is common to find the presence of a hegemonic medical model, characterized by the promotion of a medicalization of everyday life, consequently, labeling individuals who use substances is not only a common practice, but a welcome and even desirable one. Therefore, promoting a vision from an intercultural perspective will be important, as it allows us to return to the ontological foundations through which all the existing domains around people who use substances have been valued. For example, not all cultures have the same vision of consumption, nor of what is "normal" and what is "abnormal", much less of categories that are understood in the West as binary and separate, such as illness and health, physical and mental. The understanding of consumption should start from understanding it as a social-cultural and historical fact, understood from the multiple levels of subjectivation, which allow us to see beyond a simple typification, this opens new debates and recovers old questions, but above all, provides a vision of consumption that has a starting point from interculturality, from the individual, from society, from the community, from the human and the non-human, from their relationship with nature, from their worldview, from a disciplinary pluralism, but above all, from a new vision of humanity, one where understanding, empathy and respect for diversity prevail.

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