DOI: 10.1590/1413-81232018248.22192017

Medicalization and Indigenous Health: An analysis of the consumption of psychotropics by the Xukuru de Cimbres indigenous people

Valquiria Farias Bezerra Barbosa (https://orcid.org/0000-0002-8200-2274) [1]
Luana Beserra Cabral (https://orcid.org/0000-0003-1009-2845) [1]
Ana Carla Silva Alexandre (https://orcid.org/0000-0002-5754-1778) [1]

Abstract *Objective: To investigate the process of medicalization among the Xukuru indigenous people of Pesqueira (PE), Brazil following the 2003 conflict. Method: This is a descriptive, cross-sectional, quantitative study developed with the indigenous attended at the Xukuru de Cimbres basic center. The final sample consisted of 75 individuals who used psychotropic drugs. Data were analyzed by SPSS version 18.0, using the chi-square test. Results and Discussion: We observed that 8% of the studied population use psychotropic drugs, and the most used is BZD (78.67%). Regarding age, 68% are young adults and 26.67% are elderly. The income of 81.33% of households is more than one minimum wage. As for marital status, 50.85% and 66.67%, respectively of the indigenous group using BZD and other psychotropic drugs are married. Conclusion: The study outlined the profile of the Xukuru de Cimbres indigenous people who used psychotropics and showed a fragmented mental health care focused on the disease and the use of medication. Results reveal a socioeconomically vulnerable adult population, a pattern of chronic use of psychotropic drugs and distancing from traditional indigenous healing, typical of the health medicalization process.*

Key words *Mental health, Indigenous health, Traditional medicine, Medicalization*

[1] Instituto Federal de Pernambuco – Campus Pesqueira. Loteamento Portal, Portal. 55000-000 Pesqueira PE Brasil. valquiria@pesqueira.ifpe.edu.br

Introduction

Medicalization is the process by which non-medical problems are defined and addressed as medical problems and translate into diseases. Thus, the paradigm used is biomedical, predominant in Western societies, according to which health is understood as lack of disease. Consequently, this model is centered on reductionism, individualism and technologization[1].

The process of medicalization of individual and global health issues builds on the ability to define and frame everyday issues in relation to the disease. It involves health care models and care and treatment strategies that focus on individual behaviors. This process finds strong support in the pharmaceutical sector and at the same time disregards the contexts of subjects and community, reducing explanations of problems and ignoring the social, cultural, psychological or environmental factors that influence the phenomenon[1].

In addition to being expensive for both individuals and society, because it depends on normative ways of thinking, medicalization favors subjects' loss of autonomy, devaluation of their context and depoliticization of social issues. It disregards the complexity, relativity and multiplicity of health experiences[2].

Thus, this process must be investigated and it is necessary to think about its non-medical effects, a reflection of the process, such as difficulties of incorporating mental health problems into a global health agenda[2].

From this perspective, it is important to analyze how medicalization of suffering can influence indigenous people. The concept of health for these people is related to land and harmony with nature, understood as a collective construction, inserted in a proper organization system that considers body balance. Thus, some elements, such as autonomy, full citizenship, land ownership, exclusive use of natural resources and integrity of specific ecosystems[3] are fundamental to health.

If professionals who work in health basic centers (equivalents of primary care facilities) do not hold this understanding, they may have the misconception to consider the process of mental suffering of the indigenous people as a mental disorder without distinction.

In 2001, the Xukuru de Ororubá people lived an internal battle, motivated by land and power, which resulted in the separation of two groups, namely, the Xukuru de Cimbres and the Xukuru de Ororubá. In 2003, with the death of an indigenous Atikum and one of the Xukuru de Ororubá, both allies, the Xukuru de Ororubá violently expelled the Xukuru de Cimbres from the village, which divided the community and fragmented kinship relationships[4]. The Xukuru de Cimbres migrated to the outskirts of the city of Pesqueira (PE), where many families still live and are exposed to poor life and work conditions[4].

Since this village separation was a profound rupture for the Xukuru de Cimbres, we are interested in understanding the implications of their psychic suffering for the medicalization of their health. In view of the above, this study aimed to investigate the medicalization process involving the indigenous people of the Xukuru of Pesqueira after the 2003 conflict.

We understand, therefore, that research like this one contribute to question and stimulate reflection on the singularities and pluralities of the indigenous people. The novelty of this research lies in the fact that, in the literature, there are no studies concerning the medicalization of indigenous populations in Brazil, as this is the first study that focuses on the indigenous community of Xukuru de Cimbres, Pesqueira (PE).

Methods

This is a descriptive study, with a quantitative approach, developed with the Xukuru de Cimbres indigenous community located in the municipality of Pesqueira (PE) from February to June 2016.

In indigenous health care, the Special Secretariat for Indigenous Health (SESAI) is part of the Ministry of Health and is responsible for coordinating the National Indigenous Health Care Policy, as well as managing the Indigenous Health Care Subsystem (SasiSUS). The Special Indigenous Health District (DSEI) provides primary and referral care services in a decentralized way and is part of SasiSUS. This organization is guided by a dynamic ethnic, cultural, geographic, population-based and administrative demarcated space. Each DSEI organizes services in articulation with the Unified Health System (SUS). Brazil has 34 DSEIs, and one of them is in the State of Pernambuco[3].

The indigenous community is served by multidisciplinary teams at the basic centers, which provide coverage to villages and receive strategic support from health posts. In Pesqueira, the management of the basic centers is the responsibility of the Maternal and Child Institute of Pernambuco, intermediated by the DSEI-PE. If

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indigenous people have to perform treatment outside their residence, they can use the Indigenous Health Support House (CASAI)[3].

Indigenous Health Workers (AIS) are critical in delivering primary care services in the villages. They provide a differentiated treatment that is sensitive to pluralism and cultural diversity, ensuring the right of community participation, individually or collectively in the planning and evaluation of services[5].

The AIS is the foundation of this new paradigm of indigenous health, since it plays a strategic role in the articulation of traditional knowledge and the official health system to this intercultural communication[5]. AIS coverage of indigenous people registered at the basic center of Xukuru de Cimbres is 100%, equivalent to 949 indigenous people followed-up. In the study area, indigenous people are distributed by five AIS, according to their subgroups, in order to ensure their right to health.

Of the total number of indigenous people that make up the Xukuru de Cimbres tribe served at the basic center, indigenous people that met the following criteria were included in the sample of this study: using psychotropics during data collection, being registered by the AIS and followed-up by multiprofessional indigenous health teams. Subjects who abandoned treatment with psychotropics without medical advice and those who were not found in the area during data collection were excluded. The final sample consisted of 75 users.

Data was collected using a tool applied to AIS, with objective variables related to the consumption of psychotropics by the indigenous people served at the Xukuru de Cimbres basic center and under their responsibility. Collection was performed with a date pre-established by the AIS, in a suitable place for the application of the questionnaire, by means of signing the Informed Consent Form. The questionnaire was submitted to a pre-test in order to evaluate its clarity and replicability through its application to SUS network health professionals who were not part of the study sample. Following data categorization, users were divided into three groups: patients using Benzodiazepines (BZD), those using antidepressants and those using other psychotropics.

Data were stored in the data editor of the Statistical Package for the Social Sciences (SPSS), version 18.0, a free access program, which was also used as an analysis tool. The chi-square test was used to compare qualitative variables, with 95% confidence interval.

Because it is a study with a special population, the project was initially submitted to the local health council of the Xukuru de Cimbres community for approval. Subsequently, it was submitted to the appreciation of the Indigenous Health District Council, by which it was unanimously approved. Finally, it was forwarded to the Human Research Ethics Committee of the University Center ASCES-UNITA and the National Commission of Ethics in Research that issued its approval pursuant to Resolution CNS 466/2012.

Results

This study analyzes the consumption of psychotropics by indigenous people enrolled in the Xukuru de Cimbres basic center. Of the total analyzed sample, we observed that 8% (75) of the indigenous population studied uses psychotropic drugs. Among psychotropics consumed, 78.67% (59) use BZD; 17.33% (13) antidepressants and 4% (3) consume other psychotropics such as barbiturates, antipsychotics and lithium compound.

Table 1 shows the sociodemographic characteristics of the indigenous people of the sample. Regarding age, we note that adults in the 30-59 years age group account for the highest percentage of BZD users (72.88%), 46.15% among those using antidepressants and 66.67% among those who use other psychotropics. The income of the group that uses BZD and antidepressants, 84.75% and 76.92%, respectively is more than one minimum wage. Regarding marital status, the group of indigenous people who use BZD (50.85%) and other psychotropics (66.67%) are married, while most of those using antidepressants (61.24%) have other types of relationships. We observed that female indigenous people are predominant in the use of the three groups of psychotropics, more representative for those who use BZD (72.88%).

Table 2 shows the association of social variables and the use of psychotropics. We observed in this research that the number of inhabitants per household is around 3 to 5 indigenous people in the three groups of psychotropics' users, representing 49.5% (29) of those who use BZD; 76.92% (10) of those using antidepressants and 66.67% (2) of those using other psychotropics. Regarding the number of children, in the BZD user group, more than 2 children (38.98%) prevail. Most psychotropic drugs user groups are homeowners.

Table 3 shows the trend towards chronification of the use of psychotropics and the relationship with traditional healing. Regarding as-

sociation between different therapeutic methods, 52.54% (31) of users who use BZD and 66.67% (2) of those who use other psychotropic drugs only use prescribed medication, while 53.84%

Table 1. Sociodemographic analysis according to the consumption of psychotropics in the indigenous population registered at the Xukuru de Cimbres Basis Center, 2016, Pesqueira (PE), Brazil.

Variables	Benzodiazepines nº (%)	Antidepressants nº (%)	Other Psychotropic nº (%)	P
Age				
Less than 18 years	0 (0)	1 (7,69)	1 (33,33)	
Between 19 and 29 years	1 (1,70)	1 (7,69)	0 (0)	
Between 30 and 59 years	43 (72, 88)	6 (46,15)	2 (66,67)	0,007
60 years or more	15 (25,42)	5 (38,47)	0 (0)	
Income				
< 1 minimum wage	9 (15,25)	3 (23,08)	2 (66, 67)	
> 1 minimum wage	50 (84,75)	10 (76,92)	1 (33,33)	0,075
Marital Status				
Single	15 (25,42)	2 (15,38)	0 (0)	
Married	30 (50,85)	3 (23,08)	2 (66, 67)	
Other	14 (23,72)	8 (61,54)	1 (33,33)	0,085
Sex				
Male	16 (27,12)	1 (7,69)	0 (0)	
Female	43 (72,88)	12 (92,31)	3 (100)	0, 201
Total	59 (100)	13 (100)	3 (100)	

Table 2. Social analysis according to the consumption of psychotropics in the indigenous population registered at the Xukuru de Cimbres Basic Center, 2016, Pesqueira (PE), Brazil.

Variables	Benzodiazepines nº (%)	Antidepressants nº (%)	Other nº (%)	P
Inhabitants per Household				
Between 1 and 2	21 (35,59)	2 (15,38)	1 (33,33)	
Between 3 and 5	29 (49,15)	10 (76,92)	2 (66,67)	
More than 5	9 (15,25)	1 (7,69)	0 (0)	0,431
Total	59 (100)	13 (100)	3 (100)	
Number of Children				
None	14 (23,72)	1 (7,69)	1 (33,33)	
Between 1 and 2	22 (37,28)	6 (46,15)	2 (66,67)	
More than 2	23 (38,98)	6 (46,15)	0 (0)	0,461
Total	59 (100)	13 (100)	3 (100)	
Home Ownership				
Home owners	52 (88,13)	12 (92,30)	2 (66,67)	
Rented house	7 (11,86)	1 (7,69)	1 (33,33)	0,467
Total	59 (100)	13 (100)	3 (100)	
Profession				
Family farming	16 (27,11)	2 (15,38)	1 (33,33)	
Retired	18 (30,50)	4 (30,67)	1 (33,33)	
None	11 (18,64)	3 (23,07)	0 (0)	0,949
Other	14 (23,72)	4 (30,67)	1 (33,33)	
Total	59 (100)	13 (100)	3 (100)	

Source: authors' elaboration, 2018.

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(7) of those who use antidepressants take the prescribed medication and seek follow-up of DSEI-PE mental health team.

Most of the psychotropic users of the three groups do not seek the shaman, corresponding to 93.22% (55) of those who use BZD and 100% of antidepressants' users (13) and users of other psychotropics (3). In terms of time of use, most of the groups studied had been using psychotropic drugs for more than 2 years, a result consisting of 83.05% (49) of those using BZD; 76.92% (10) of those using antidepressants; and 66.67% (2) of those who consume other psychotropics.

Discussion

BZDs are the most commonly used drugs worldwide, mainly to combat insomnia and anxiety. Of note in this group are Alprazolam® and Diazepam®. The effects of BZDs are sedation, hypnosis, decreased anxiety, muscle relaxation, retrograde amnesia and anticonvulsant activity. Despite their low cost, it is important to note that prolonged use of BZDs produces tolerance and, consequently, dependence. Treatment abandonment, in turn, results in withdrawal symptoms, such as anxiety, agitation, hypersensitivity to light and sounds, paresthesia, muscular cramps, myoclonic concussions, sleep disorders and dizziness[6].

Depression and anxiety disorders are the mental diseases that widely affect the world population, about 10-15% during lifetime. Regarding treatment of depression, antidepressant users can respond in a few days or up to four weeks. Among the main adverse effects of antidepressants, taking as an example tricyclics, are increased blood pressure, tachycardias, arrhythmias and, in extreme cases, heart attack, cardiac arrest and strokes. It is also worth noting the loss of libido, impotence and testicular edema[7].

In view of the various side effects and adverse effects secondary to the use of these drugs, good practices in prescription and therapeutic follow-up are required, especially in the elderly, since body drug absorption changes over the years, leading to an increased half-life. Thus, the multiprofessional team must be attentive to the specificities of each individual, especially in the onset of use[8].

This study points out complex issues that are cross-sectional to the suffering medicalization process, such as those that contribute to abuse, self-medication and indiscriminate prescription of psychotropics. Thus, conscious user-oriented prescription and guidance regarding self-administration of these drugs will prevent use chronification, enhancing therapeutic effects[9].

However, national and international studies indicate that we are moving against what is proposed earlier on. In a study conducted in the U.S.,

Table 3. Analysis of variables according to the time of use and type of therapy used in the indigenous population registered at the Xukuru de Cimbres Basic Center, 2016, Pesqueira (PE), Brazil.

Variable	Medicamentous Therapy			P
	Benzodiazepines nº (%)	Antidepressants nº (%)	Other nº (%)	
Other therapy				
Only the prescribed medication	31 (52,54)	4 (30,76)	2 (66,67)	0,492
Indigenous traditional healing practices	10 (16,94)	2 (15,38)	0 (0)	
Psychological accompanimenton DSEI	18 (30,50)	7 (53,84)	1 (33,33)	
Search for thes haman				
Yes	4 (6,77)	0 (0)	0	0, 564
No	55 (93,22)	13 (100)	3 (100)	
Time of use				
Less than 1 year	2 (33,89)	0 (0)	0 (0)	0,761
Between 1 and 2 years	8 (13,55)	3 (23,07)	1 (33,33)	
More than 2 years	49 (83,05)	10 (76,92)	2 (66,67)	
Total	59 (100)	13 (100)	3 (100)	

10% of respondents reported having used BZD annually, with around 20 million prescriptions[10].

In 2011, the National Health Surveillance Agency observed that 44% of the drugs sold in Brazilian pharmacies and drugstores were indicated for the treatment of mental or behavioral disorders. Again, in this research, it was verified that about 10 million boxes of psychotropic Clonazepam®, of the BZD pharmacological class were sold, which resulted in a cost of R$ 92.4 million to the Brazilian population with this drug alone[11]. The irrational use of psychotropic drugs in Brazil has been described as a relevant public health problem[12].

This picture points to the importance of studies related to the profile of Brazilian psychotropic consumers, which are still scarce, mainly in recent years, including indigenous people, since this study shows that consumption of psychotropics is also a reality in this ethnic context.

As to the income of indigenous people participating in the study, it is important to highlight that, their main economic activity was family farming when they lived at the village. However, living in an urban area entails greater financial resources. In addition, it is necessary to consider sharing, characteristic peculiar to community life, typical of villages and rural communities, which is hardly noticeable in the hostile urban ambience.

Low family income influences the health-disease process and generally favors suffering's medicalization, since several non-psychic problems related to socioeconomic factors are addressed through prescribed medication as an immediate solution to suffering. Thus, factors conducive to illness, such as unemployment or underemployment, leading to the consumption of psychotropics[13] are invisible.

Different evidence on the relationship between marital status and consumption of psychoactive drugs can be found in literature, ranging from a positive association between being married, having a family history of mental disorders and using BZD[12], to that found in another study, which is a positive association between being single and consuming BZD and antidepressants[14].

A study carried out in the municipality of Coronel Feliciano (MG) indicates that most users of psychotropics are women[15]. In Sorocaba (SP), 75% of psychotropics' users were women[12]. In Recife (PE), in the Chico Mendes Family Health Unit and in the Ximboré Health District, women using psychotropics accounted for 71% of the study sample[13].

Among the determinants and conditionants of this process among women described in the literature are attendance in health services, inequality in gender issues that is so strong in the Brazilian context, stressful lifestyle and burden in several aspects of being a woman in a sexist and non-egalitarian society. These are some elements that are closely related to use and, consequently, increased demand of these women, mainly for BZDs[13-15].

As discussed by Rose[16], the medicalization process focuses more on women than on men and works differently in different social classes in many countries and regions around the world.

In the context of the Xukuru de Cimbres, one perceives a departure from the values and practices originating from their cosmology. In the village, indigenous people was close to nature and could resort to herbs, roots, flowers and ancestral knowledge: a complex, collective and intergenerational transmission process. The shaman was a spiritual leader who heals body and soul diseases[3]. However, the results of this study point to the loss of the reference to the shaman and other subjects that dominate the practices of traditional healing among the Xukuru de Cimbres indigenous people.

Although there is no statistically significant association between the use of drugs and the use of traditional methods of indigenous healing in this present study, the effect of removal from the village, deterritorialization and acculturation on the predominant allopathic therapeutic practices typical of the biomedical model, to the detriment of indigenous traditional healing practices, with rituals, prayers, baths, teas and beverages[3] is perceptible.

When administered properly, psychotropic drugs facilitate care, but they should be used for a short or medium period, taking into account the damages that their use can cause in the long term. On the other hand, they are not always the best choice and should not be considered as the only treatment[6-7].

This reality is also found in the context of primary health care. In the Family Health Facilities, mental health care is often conditioned to medical consultation and prescription of medicines, sustaining and strengthening the biomedical therapeutic behavior for the mental disorder diagnosed. This kind of experience favors the medicalization process and does not meet the desires of individuals in their singularity and complexity[17,18].

When Peter Conrad, among other social scientists, analyzes the medicalization process

according to which non-medical problems are understood and addressed as medical problems[19], they do not do so in order to assign them social value, so that underpinning changes and phenomena should not be considered a priori as good or bad[20]. On the contrary, Conrad establishes a clear differentiation between "over-medicalization" which could be translated as over, super or excessive medicalization, which carries negative effects and "medicalization" which should not be initially considered bad[20].

To this end, it is necessary to analyze in each specific context the influence of the medicalization process on individuals and communities.

The limiting aspects of this research were the fact that it was not possible to access indigenous people's medical records in order to compare the medical diagnosis with prescribed treatments and with the main complaint of users, relating them to the indication of psychotropics. Another limiting factor was the non-distinction between children and grandchildren of the people who suffered directly from the conflict, data that could have enriched the research with the study about the consequences of traumas suffered for younger generations.

Conclusion

This study revealed the profile of indigenous psychotropic users served at the Xukuru de Cimbres basic center. Results evidence high rates of psychotropics' consumption by the Xukuru de Cimbres indigenous people and, in contrast, a distancing from traditional healing practices. Findings also showed a socioeconomically vulnerable adult population and a trend towards chronic use of psychotropics and pointed to a life medicalization process in a unique ethnic context linked to a fragmented, biologicist health care model focused on prescription drugs. Silencing and invisibility of psychic suffering of the Xukuru de Cimbres indigenous people before the sociocultural, political and economic rupture process experienced are among the consequences of this medicalizing model that distances itself from the advances of the Brazilian psychosocial care model.

Investments in new studies on medicalization that take into account the diversity and specificity of ethnic-racial issues found in the Brazilian population are required. Such studies will increase understanding on areas such as mental health, where the global health agenda and its formulation of problems shift to medical and technical solutions, neglecting the necessary social, community-based or political action[2].

Collaborators

LB Cabral and VFB Barbosa were responsible for the design of the research. ACS Alexandre was responsible for planning data collection and quantitative analysis. All authors participated collaboratively in the development of the research and paper drafting.

References

1. Clark J. Medicalization of global health 1: has the global health agenda become too medicalized? *Glob Health Action* 2014; 7(23998):1-6.
2. Clark J. Medicalization of global health 2: the medicalization of global mental health. *Glob. Health Action* 2014; 7(24000):1-6.
3. Conselho Indigenista Missionário (CIMI). *A Política de Atenção à Saúde Indígena no Brasil. Breve recuperação histórica sobre a política de assistência à saúde nas comunidades indígenas*. Brasília: CIMI; 2013.
4. Cavalcanti B. *No tacho, o ponto desandou: história de Pesqueira, de 1930 a 1950*. Recife: Editora Baraúna; 2007.
5. Diehl EE, Langdon EJ, Dias-Scopel RP. Contribuição dos agentes indígenas de saúde na atenção diferenciada à saúde dos povos indígenas brasileiros. *Cad Saude Publica* 2012; 28(5):819-831.
6. Mihic SJ, Harris RA. Hipnóticos e Sedativos. In: Brunton LL, Knollmann CBC, editores. *As bases farmacológicas da terapêutica Goodman e Gilman*. Porto Alegre: AMGH; 2012. p. 303-324.
7. Santos JES. Fármacos que atuam nos distúrbios emocionais: depressão e ansiedade. In: Almeida JRC, Cruciol JM, editores. *Farmacologia e terapêutica clínica para a equipe de enfermagem.* São Paulo: Atheneu; 2014. p. 307-339.
8. Terassi M, Rissardo LK, Peixoto JS, Salci MA, Carreira L. Prevalência do uso de medicamentos em idosos institucionalizados: um estudo descritivo. *OBLN* 2012; 11(1):26-39.
9. Alfena MD. *Uso de psicotrópicos na atenção primária* [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública; 2015.
10. Buysse DJ. Insomnia. *JAMA* 2013; 309(7):706-716.
11. Agência de Vigilância Sanitária (Anvisa), Sistema Nacional de Gerenciamento de Produtos Controlados (SNGPC). Panorama dos Dados do Sistema Nacional de Gerenciamento de Produtos Controlados: um Sistema para o Monitoramento de Medicamentos no Brasil. *Boletim de Farmacoepidemiologia da Anvisa* [documento da internet] 2011.[acessado 2016 Ago 10]. Disponível em: http://www.anvisa.gov.br/sngpc/boletins/2011/boletim_sngpc_2edatualizada.pdf
12. Naloto DCC, Lopes FC, Filho SB, Lopes LC, Fiol FSD, Bergamaschi CC. Prescrição de benzodiazepínicos para adultos e idosos de um ambulatório de saúde mental. *Cien Saude Colet* [periódico na Internet] 2015. [acessado 2016 Set 02]; 21(4):1267-1276. Disponível em: http://www.scielo.br/pdf/csc/v21n4/1413-8123-csc-21-04-1267.pdf
13. Lira AC, Lima JG, Barreto MNSC, Melo TMAG. Perfil de usuários de benzodiazepínicos no contexto da atenção primária à saúde. *Rev. APS* [periódico na Internet] 2014 [acessado 2016 ago 11]; 17(2):223-228. Disponível em: https://aps.ufjf.emnuvens.com.br/aps/article/view/1924/806
14. Souza ARL, Opaleye ES, Noto AR. Contextos e padrões do uso indevido de benzodiazepínicos entre mulheres. *Cien Saude Colet* [periódico na Internet] 2013.[acessado 2016 Set 05]; 18 (4):1131- 1140. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232013000400026
15. Firmino KF, Abreu MHNG, Perini E, Magalhães SMS. Fatores associados ao uso de benzodiazepínicos no serviço municipal de saúde da cidade de Coronel Fabriciano, Minas Gerais, Brasil. *Cad Saude Publica* [periódico na Internet] 2011 [acessado 2016 Set 04]; 27 (6):1223-1232. Disponível em:http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2011000600019
16. Rose N. Beyond Medicalisation. *Lancet* 2007; 369(9562):700-702.
17. Alvarenga JM, Giacomin KC, Loyola Filho AI, Uchoa E, Firmo JOA. Uso crônico de benzodiazepínicos entre idosos *Rev Saude Publica* [periódico na Internet] 2014.[acessado 2016 out 10]; 48(16):866-72. Disponível em: http://www.scielo.br/scielo.php?pid=S0034-89102014000600866&script=sci_arttext&tlng=pt
18. Bezerra IC, Jorge MSB, Gondim APS, Lima LL, Vasconcelos, MGF. Fui lá no posto e o doutor me mandou foi pra cá: processo de medicamentalização e (des) caminhos para o cuidado em saúde mental na atenção primária. *Interface (Botucatu)* [periódico na Internet] 2014 .[acessado 2016 Out 7];18(48):61-74. Disponível em: http://www.scielo.br/pdf/icse/v18n48/1807-5762-icse-18-48-0061.pdf
19. Conrad P. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.* Baltimore: The Johns Hopkins University Press; 2007.
20. Parens E. On Good and Bad Forms of Medicalization. *Bioethics* 2011; 27(1):28-35.

Article submitted 31/08/2017
Approved 14/11/2017
Final version submitted 16/11/2017