Neoliberal Care: Intimacy, Romance, and Drug Use in Argentine Dispossessed Populations

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Resumen

Basado en el estudio etnográfico que he desarrollado por una década en barrios marginalizados de la Región Metropolitana de Buenos Aires, este artículo examina los cambios en los procesos de formación de parejas heterosexuales, el desarrollo de las prácticas localmente categorizadas como "cuidado" y sus relaciones con el consumo de drogas y supervivencia de los usuario/as de drogas. Partiendo de los desarrollos en Antropología y Ciencias Sociales sobre la problemática del cuidado en general, y cuidado de la salud en particular, el objetivo de este artículo es analizar los modos en que la formación de las parejas heterosexuales implica una solución de compromiso entre diversos procesos sociales (aislamiento territorial, vulnerabilidad en salud, encarcelamiento y muerte de jóvenes). A través de la noción de privatización del cuidado, el análisis muestra las consecuencias de estos procesos en la convivencia de estas parejas y en el refuerzo de los estereotipos de género patriarcales. [antropologia social, Argentina, genero, salud, urbano]

Abstract

Based on ethnographic research carried out in shantytowns in the Metropolitan Area of Buenos Aires, this article examines changes taking place in the process of the formation of heterosexual couples, the development of practices locally conceived as "care," and their relationship to drug consumption and the survival of drug users. It shows how this trend in the formation of heterosexual couples entails a compromise among multiple social processes (territorial isolation, health vulnerability, the incarceration, and the death of young people). The analysis demonstrates, through the lens of the privatization of care, the consequences of these processes for these couples. It also shows how such

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processes reinforce patriarchal gender stereotypes. [Argentina, gender, health, social anthropology, urban]

Anthropological and social science research between the late 1980s and the present has examined how neoliberal reforms in political economies have contributed to changes in the everyday lives and health vulnerability of marginalized populations. While some of these studies have shed light on how these transformations in Latin American countries differ from those taking place in North America and Europe (Camargo 2014; Commaroff and Commaroff 2012; Wacquant 2003), only a few have examined how these changes have promoted the development of informal care strategies, which affect in various ways the well-being, health, and survival issues they attempt to address (Epele 2011; Han 2012).

Based on ethnographic research carried out in shantytowns in the Metropolitan Area of Buenos Aires (2001–6), this article examines the changes taking place in the process of heterosexual couple development, including drug use, during the last two decades (1985–2005). The objective is to analyze links between particular changes in everyday life within dispossessed populations, changes in heterosexual couple development, and the growth of informal practices locally categorized as "care," which relates to drug consumption and the survival of drug users. The article also explores how these modifications are linked to a rise in sexually transmitted diseases in disadvantaged populations. More specifically, the emergence of a pattern of relationship that includes a male drug user and a female nonconsumer between 1985 and 2005 in Buenos Aires shantytowns is understood locally as a form of "romance," which has become an informal form of care aimed at changing drug consumption and improving survival chances among male drug users (Bourgois and Schoenberg 2009).

Starting with theoretical perspectives on care in general, and health care in particular (Kleinman and Hanna 2008; Tronto 1993), I examine how this trend in the development of heterosexual couples has progressively taken shape as a compromise between multiple social processes (a rise in poverty and social inequality, the growth of illegal and informal economies, changing social mobility, deepening territorial segregation), and increasing local health vulnerabilities, incarceration, and death among male drug users. Second, linking care practices and couple formation in the context of a neoliberal political economy also offers new insights into the increase in HIV/AIDS and the spread of syphilis infection (Santis et al. 2007; United Nations Reports 2012). Through the notion of privatization of care (Han 2012; Tronto 1993), the following work shows the consequences of such processes on cohabitation among this type of couple and how they reinforce patriarchal

gender stereotypes, deepening the precarious state of women's health, rights, and survival (Epele 2011).

Finally, the suffering, friction, and tension associated with the social transformations that result from structural reforms generally become public and gain visibility once intimacy issues are classified as "domestic," "family," "medical," or "emotional"—both by experts and people in need of therapeutic intervention by state and nonstate institutions. Due to the neglect, abandonment, and low level of effectiveness of expert actors conducting interventions in judicial and therapeutic domains, this type of romance and couple pattern promotes new forms of suffering, precariousness, infections, violence, and even death, especially for the women.

Informal Care at the Urban Margins

Several authors have suggested ways in which care and care practices have become invisible and undervalued in western societies because of the association with women, the world of intimacy and emotions, and disadvantaged sectors of society (Held 2006; Kleinman 2009). In other words, in exploring who takes care of whom, social subordination patterns are revealed. Privileged classes have the resources to pay others to take care of them; lower class, migrant and/or ethnic minorities, and women often cease to take care of their own people in order to work as caretakers for members of other social classes (Tronto 1993). Debates about care also raise a number of western epistemological, political, and moral assumptions that are involved in the development of well-being, health, and citizenship in our societies: that is, such discussions tend to draw on the dualisms of body/mind, nature/culture, individual/society, for example. In addition, the notion of care directly challenges the oppositions and tensions between autonomy/dependence, control/care, knowledge/practice, facts/values (Mol 2008). Lastly, unlike views that prioritize the rational, the instrumental, and choice in the health–disease domain, the logic of care is a complex and continuous process that requires time, energy, material and human resources, knowledge, technologies, emotions, activities, tasks, and people. Rather than being focused on biomedical rationality, care involves uncertainties, fragilities, emotions, tiredness, and conflict (Kleinman 2008).

There are, of course, different types of care: institutional (biomedical and psychological, for instance), self-care, and care among close relations (family and social networks; Blomqvist 2002; Glick Schiller 1992; Kleinman and Van der Geest 2009; Larkin and Griffiths 2002). For instance, there is a dissociation between biomedicine and psychological knowledge, on the one hand, and "care-takers" (social workers, occupational therapists, members of the family, and friends), on the other; this may reflect the dissociation (and privilege) of the technical rationality of biomedical knowledge over care, daily commitment, and assistance.

In addition, the knowledge and practice of self-care has been analyzed in relation to new modes of medicalization, standardization strategies, and unique ways of control that include the delegation of responsibility to individuals for their own well-being, health, and survival (Foucault 2010).

The object of the present research is to review the change in patterns of social and health vulnerability within sectors of society that have been significantly affected by neoliberal reforms, through an examination of heterosexual couple development and the knowledge and practices considered as "care" categories in these groups. In addition to the social transformations that have resulted from neoliberalism in Argentina (unemployment, an increase in poverty, a growth of informal and illegal economies, a rise in social marginalization, limited access to education, and poorer educational outcomes), the public health-care system has also undergone change (privatization, outsourcing, working flexibility for professionals, multiple access barriers, emergence of waiting lists in care services, and a reduction in the number of hospital beds; Basualdo 2001; Escudero 2003; Iriart and Watzkin 2006; Svampa 2005). During the 1980s and 1990s, while these structural reforms were taking place, not only did illegal drug consumption rise in these affected groups (specifically, cocaine use), but the numbers of people caught up in the HIV/AIDS epidemic also increased across the same population.[1] According to epidemiological data, from the onset of the disease, most of the HIV/AIDS cases (around 40 percent) during the 1990s were attributable to syringe sharing, specifically for cocaine consumption. Since 2000, however, a progressive drop has occurred in the number of cases attributable to injectable drug use, alongside a growth in the number of women who have been infected through unprotected sexual intercourse among heterosexuals (Grimberg 2003; Pecheny et al. 2013).

Despite a significant reduction in vertical transmission rates and a fall in the number of reported cases, other health-related issues have recently emerged. Over the course of the new millennium, a growth in the rate of other infectious diseases has been recorded in the poorest communities (INBRIS 2014). For example, a steady rise in the number of cases of syphilis, including congenital-type syphilis, has been reported.[2] Some policies and programs have been developed regarding social issues (e.g., unemployment and gender diversity) in this geographical area since the beginning of the new millennium. Since the 1990s there has been a struggle among the government, NGOs, activist organizations, health researchers, and policy makers concepts, policies, and programs. This struggle has engendered a set of fragmented and contradictory strategies regarding drug use and related infectious diseases. Given the mixed trends and the limited scope of health care services, informal knowledge and practices locally categorized as "care" have progressively gained greater relevance over the years among marginalized populations.

Gender, Intimacy, and Drug Use

Given the rapid changes in social and health vulnerability from the early 1990s to the present among these populations, it is important to examine the social, economic, and political transformations of contemporary capitalism, and the changes taking place in the microdynamics of everyday experiences and relationships in which such "care" practices and knowledge may be observed. To that end, it is necessary to include "intimacy" and the characteristics of emotional ties in the development of heterosexual couples, as well as the native perspectives that characterize these bonds as forms of "care," specifically in relation to young male drug users (Epele 2011).

It is also necessary to explore how changes in social mobility, territorial segregation, bond characteristics, and size of local social networks have modified the content and boundaries of the space of intimacy in close relations. This article problematizes how growing territorial segregation and a limited or descendent social mobility, as well as health issues, law enforcement, and legal actions that criminalize drug use, have pushed the transfer of roles and activities—previously undertaken by other public and private institutions and practices—toward the world of intimacy, that is, toward close relations in general and couple relations in particular. Drawing on prior research in this area (Butler 2004; Connors 1996; Giddens 1992), this study refers to "intimacy" as a social space, the materiality of which is defined by a set of practices, activities, and experiences of different types: corporal, emotional, relational, care related, and violence. The privatization of care is a process that transfers to intimate relations and couples the responsibility to mediate and resolve conflicts that are generated in other areas of everyday life, including the promotion of well-being, health, and the survival of its members (Han 2012; Tronto 1993).

The emergence and progressive normalization of this type of heterosexual couple in poverty settings in which the use of drugs is involved has, as a common denominator, the union between a male drug user and a female nonuser, although occasionally this may be reversed. The spread of free base cocaine (FBC; *paco*) in these social scenarios during the 2001–2 crisis deepened the social and health vulnerabilities among these populations (Epele and Pecheny 2007). Because of its high level of toxicity and compulsive mode of consumption, FBC/paco engendered extreme survival strategies among female users (e.g., sex for drugs exchange, prostitution, and drug dealing) that made them less desirable partners outside of drug-using social networks.

The territorial isolation, the concomitant reduction of the surrounding world, and the multiplication of risks to life of this low-income young population have burdened women with additional responsibilities, activities, and roles and have turned the intimate world into a space of tension and conflict that

originated in other areas of social life. Hence, this type of couple not only reestablishes an existing traditional and patriarchal gender pattern, but also promotes new forms of discomfort and vulnerabilities (disease, violence, death)—specifically for women. In other words, when the private becomes public and political, and when the politicizing of suffering, violence, and the death of women occur in a public space, the restructuring of social spaces, conflicts, and tensions has already taken place.

Methodology

The ethnographic study of dispossessed populations, the results of which provide the basis for this article, was carried out in three fieldwork phases in five shantytowns in the metropolitan area of Buenos Aires. The research was undertaken in three key areas. First, it explored social networks of intensive drug use in three districts of the Metropolitan Area of Buenos Aires (2001–6). Second, a study was undertaken of general health care systems and of treatments for drug addiction in particular (2008–11). Lastly, from 2013 to the present, I reviewed the psychotherapeutic technologies in the public health system that are targeted at the marginalized populations of this area. In the present article, however, I include only the data from the ethnographic fieldwork carried out in the first research stages in everyday settings and shantytowns where the drug users live. Here, the focus is on informal care knowledge and practices in relation to heterosexual couples; expert knowledge and practices will be presented in future work.

The fieldwork mainly consisted of participant-observation development in everyday contexts (housing, public spaces, streets, parks, and community centers, for instance) and at health care institutions (health centers, public hospitals, and rehabilitation systems). I also carried out interviews with health care professionals (physicians, psychiatrists, psychologists, social workers), active drug users, and members of their families and social networks, as well as with community residents and local leaders. The studies were approved by the Ethics Committee and informed consent was sought among participants. Therefore, all the names and places have been changed in order to preserve anonymity.

The participants included the following categories: (1) 40 subjects (24 men and 16 women), all active drug users. Ages ranged between 18 and 45. Most made a living through diverse strategies combining informal practices (e.g., recycling, street vending, selling wares at open markets, and cleaning windshields at traffic lights), illegal practices (e.g., shoplifting, mugging, and minor drug sales), and occasional precarious short-term work or odd jobs in the formal job market; and (2) 20 family members, specifically mothers, wives, and siblings. I also interviewed members of social organizations, such as soup kitchens and neighborhood leaders, among others.

Changes in Social Mobility and Territorial Segregation

In the metropolitan area of Buenos Aires, the growth of low-income communities (slums, informal settlements, and buildings called monoblocks) over the past few decades has been accompanied by a growing consumption of drugs (specifically, cocaine). While these transformations have been taking place, HIV/AIDS has spread in these social spaces and this has had an impact on various social groups within these populations. According to the accounts of male and female users who have had a long history of drug consumption, as well as former drug users, a change has occurred in the last decades not only in the characteristics of substances, but also in the modes of consumption. For example, Luis, a 40-year-old ex-drug user explained:

> Everything was very different in the past. You cannot even imagine it. Perhaps I am just getting older, but we had a style in using drugs. We knew how to mix them and the best ways to achieve the highs, reaching the effects that we wanted. Since I got out of jail, I realized that we ended up like the Bolivians: taking cocaine became just a way to resist drinking alcohol all day. This is so depressing, so decadent.

At the end of the 1980s and the beginning of the 1990s, the dominant mode of use was by injection. Social networks of male and female drug users showed different characteristics, however:

> We were around 50 men and women. We controlled this part of our neighborhood. Nobody could get in without our permission, even the police. How many are still alive? Two . . . no, three are still alive and living around here. Only a few are still in jail. But the rest are dead. I got the HIV virus, but I quit taking drugs. It is amazing, but most of them died because of AIDS, many in prison. In 1994, 1995, and 1996 most of the youth of the Villa died . . . Well, some got killed in shootings with police or among gangs. Many of them died because of AIDS. The majority. You try. If you walk the neighborhood you can see that there are only a few people from 30 to 40 years old. They have disappeared. (Pablo, a 42-year-old ex-drug user)

Between the 1980s and the beginning of the 1990s, drug consumption networks were large: they were made up of many members, although the number of total consumers by population was lower than in the new millennium. According to the accounts of long-term drug users and ex-drug users, those social networks involved between 30 and 50 members, with two or three networks in each community. In addition, they also had different types of bonds with other social networks in the neighborhood. Belonging to one of these networks was not only a necessary condition to have access to drugs, that is, they needed to be "known," but it also worked as an informal mechanism to protect some of their members who were exposed to a variety of dangers, such as family expulsion or police persecution.

These networks included some dimensions of social experience that exceeded the consumption of drugs, such as belonging to a soccer fan club, large networks of family and local relationships, a particular music style, and occasional—or ongoing—illegal activities, and even an affiliation to political groups.

According to local accounts, the discriminatory practices and stereotypes between female drug users and nonusers were almost nonexistent, except in a few cases, in the 1980s when drugs had not yet become a "social problem." Although some of the women consumed a large amount of drugs, and took part in other illegal activities, stories show that most of the teenagers and young women who consumed drugs did so because they were involved in a couple relationship with a drug user. By the end of the 1980s, the first cases of HIV/AIDS had been reported in the shantytowns where I carried out the research, and the first deaths from the infection among drug users had been reported. Unlike other social classes, these groups learned about the spread of the disease through the deaths of young people around them. Subsequently, as an informal care strategy, most of the teenagers and young people entering the world of drugs chose inhalation as their preferred mode of use. Injection became a less frequent practice, as it was associated with disease, contagion, and death.

Unlike relationships with women drug users today (see below), interviewees talked about having relationships with young women who lived outside the neighborhood in the late 1980s and in the early 1990s. As Carlos commented, "girls would come from downtown and would stay here because nobody would fuss here, and they could do what they wanted. I had a girlfriend who had money; her name was Rosana, and she would run away from home and come here with a friend."

Although the neighborhood boundaries and socioeconomic differences were socially recognized obstacles, they were not considered insurmountable barriers to the development of relations, as they are today, nor to the possibilities for drug users and young people from these neighborhoods to move around the city. According to Carlos, the relationship with Rosana was not limited to sharing drugs. They could also go out together, go dancing or walking, and go to soccer games; in other words, they could move freely around different parts of the city: social class and territorial boundaries were more open than today.

According to their reports, for young women from the neighborhood who used drugs in the 1980s and the beginning of the 1990s, the relationship with a male drug user was the explanation for starting to consume drugs, as this created easy access to a drug supply. Similarly, the end of those relationships in many cases explained why some of these women stopped taking drugs and started other relationships outside of drug consumption networks. However, some of the women were infected with HIV/AIDS as a consequence of drug use. In a few reported cases, some of the women not only contracted the disease and died of AIDS; they also

had children who were infected with HIV/AIDS in the first years of the epidemic (Lusida 2001).

In summary, during the 1980s and the beginning of the 1990s, although there was a small group of women who used drugs intensively and took an active part in the reduced universe of illegal activities, most of them alternated between drug use and nondrug use. For example, they would start a relationship with a drug user but would then enter into a new one with a nondrug user. In other words, drug consumption and its consequences for women in couple development processes were marked by social and territorial flexibility and mobility. Also, within the neighborhood environment, the relations established between resident and nonresident drug users, and between drug users of the same or different socioeconomic levels, was not only a more frequent pattern than today, but also enjoyed higher social recognition. Participation beyond the boundaries of the neighborhood was considered to be an indicator of social status and capital, which was highly valued in drug-consumption circles, coupled with the possibility of experimenting with new substances or drugs that were different from those available in poor and marginalized populations.

New Social, Territorial, and Gender Boundaries

The characteristics of social networks that involved the use of drugs were modified as a consequence of the changes in local economies, labor structures, and strategies for subsistence, as well as by the rise in poverty and extreme poverty during the 1990s. Poor living conditions and the consequences of intensive drug use for young people from underprivileged populations (including the HIV/AIDS epidemic, incarceration, and the death of male and female drug users) resulted in a progressive reduction in the size of drug-using social networks, as well as a change in their characteristics. It is worth noting that the increase in the total number of consumers was intertwined with a greater dependency on illegal activities for drug supply, an increase in conflicts between local groups, and changing criminalization and law-enforcement strategies (Epele 2003).

With the gradual move toward territorial segregation—that is, living within the limits of the neighborhood—gender constructions linked to the use of drugs and the processes of couple development involving drug use adopted new modalities. The progressive territorial isolation has had two main consequences. First, the development of couples has been influenced by the abrupt reduction in relationships between drug users from inside and from outside the neighborhood; in other words, couple formation has become confined to the limits of the neighborhood. Also, a progressive polarization has occurred in terms of women now being categorized in one of two groups: "drug addicts" and "good girls." This classification

has become increasingly irreversible, which has had significant consequences for social integration.

Unlike the situation observed a decade before, in general, young drug users have been forced to enter into relationships with existing drug users. The deterioration in living conditions has also changed the level of women's involvement in illegal activities. In other words, developing a relationship does not guarantee that women will have access to drugs through men in the new millennium. On the contrary, the participation of women in intensive drug use has led to their gradual involvement in activities for the supply of drugs, in many cases through illegal activities (theft, robbery, and involvement in the drugs trade). Inside the social networks of drug consumers, however, this progressive gender homogeneity regarding activities for the supply of drugs shows some specific differences in the role women play today.

With the growth in the use of *paco* (low-cost cocaine paste) during the 2001–2 crisis in the poorest and most vulnerable populations, occasional or full-time sex work among women, and/or the trade of sex for drugs, rapidly spread as a result of the compulsive consumption of this substance. In other words, patterns of gender inequality and differentiation that characterize most intensive drug use environments have reemerged and become exacerbated:

> I found out that my brother, who is now 27 years old, was doing drugs. I mean his wife at the time would tell me, you know? But I would think: no, she's out of her mind, she's making it up . . . because I couldn't look beyond my own little world, my home, my kids and I thought he was, well . . . fine. He would go to work, he'd come home . . . Until one day it all blew up, um . . . he separated from his wife, he kicked her out of the house with the kids, their two girls were little at the time . . . he pressured her: so she left. He sold everything, all his stuff, he started selling off everything until he was left with nothing; he sold the house . . . and he went to live with my dad. So after that, one night he comes over and knocks on my door. I open; I was by myself . . . and . . . he runs in and hides under my bed, just like that. I swear I was so surprised and I asked: 'what's going on?' I couldn't believe that he actually fit under there. So he said: 'they're coming after me, they're coming after me, close the door because they're coming to take me away, they're going to take me away.' And I kept thinking: what's wrong with him? So anyway, this went on all night; he spent the whole night under my bed. He didn't want me to open the door. After that, they separated and he never went back to her, because she never wanted to get back together with him . . . because after that he was in so deep that because—first, they get started and it's like they cover it up, right? The family doesn't notice, and it's like they keep going along and they manage, but later when they reach a point when they're, let's say, so addicted . . . it's really impossible. There comes a time when they no longer bathe, um . . . they . . . they lose track

of time, they don't eat, they don't take care of themselves. (Patricia, sister of a drug user)

The steady growth in numbers of this type of couple in such social contexts can only be understood if we recognize the extreme marginalization in the lives of intensive drug users from the low-income neighborhoods of the greater Buenos Aires area.

Interviewee: When my son was born, I tried to "rescue myself." Every job requires a high school diploma. But it's hard; I can't catch a break. Why? I manage by doing odd jobs, but I don't know how long I can go on like this.
Interviewer: What does "rescue" mean?
Interviewee: It's something we say here. When you're going overboard, crazy, or fucked up, they tell you to 'rescue yourself' and it plants it in your mind that you have to get out—the drugs, the bad habits, the stealing, the police—because if you don't, you die. It means get a hold of yourself and get going.
Interviewer: What is rescuing yourself like?
Interviewee: It's in the head; they can lecture you, or lock you up, but that click is done on your own, on your own. (Nicolás)

The development of a couple relationship with a nondrug user is one of the few "care modes" available, which is desirable for those who wish to leave the circles of destructiveness that hinder not only the well-being, but also the health and survival of drug users from marginalized populations. These circles of deterioration are not only tainted by intensive drug use, and the emotional and bodily deterioration associated with it, but also by the multiple threats and dangers arising from drug use criminalization (including both assistance and law-enforcement actions), the difficulties involved in, and barriers to, treatment, the escalation of violence and local conflicts between groups involved in illegal activities, and limited local options for accessing other strategies to produce an income (in either the formal or the informal job market). The rare institutional alternatives for health care and treatment for intensive drug use are only accessible in a few cases, if they can pass through the filter of institutions that most often simply criminalize the drug consumption.

Accompanying the process of transformation of some neighborhoods into enclosed enclaves, police forces have changed and intensified their law-enforcement strategies, including more significant involvement and illegal collusion. Some of the low-income populations and slums have been placed under surveillance by special law-enforcement agencies (such as the National Gendarmerie), which control entry and exit movements. As a result of growing unemployment numbers and the dismantling of informal economic activities, drug users have become trapped over time in networks of illegal activities.

In summary, then, the progressive isolation resulting from a gradual reduction in social and territorial mobility has been accompanied by a change in traditional gender positions, that is, in a polarization of women into "addicts" and "good girls," and a growing homogeneity between men and women who use drugs in relation to ways of gaining access to resources. At the same time, the development of heterosexual couples involved in the use of drugs has adopted new forms. Among these relationships are couples formed by a female nondrug user and a male drug user. This relationship pattern tends to bridge the gap that used to separate drug users from nondrug users, but now has a specific gender orientation. The rescue rhetoric that characterizes these couples is a form of locally constructed "romance" that entails contradictions and conflicts produced by the trends and processes outlined above. In other words, this has become a solution for settling conflicts that has multiple consequences in the short and long term.

The Expansion of Intimacy

The gradual territorial confinement caused by limited social and territorial mobility, and the criminalization of drug use and poverty have led to a shrinking of social networks and the lived world, which have thus become confined to a few close friends and/or family relations, places, and routes. This change in activities, replacement of roles, and reduction in the places and spaces that may be occupied make close relations, particularly couple relations, one of the few ways to escape from the destructiveness and deterioration of local circuits.

According to the same social players, in these few close relationships—and especially in terms of couple relations—lie expectations for activities and functions that were previously performed by other institutions (e.g., work, health, studies, and leisure), or in other areas of life. Thus, intimacy as a social space has been redefined, extended, and modified in relation to its characteristics, content, and roles. The wide variety of meanings carried by the notion of intimacy correspond to the models of romance in which it is subsumed (Giddens 1992). In these cases, according to the residents, intimacy has a materiality that relates to a set of practices, positions, and bodily activities, ranging from distance, proximity, and body contact; verbal or nonverbal emotional expressions; care practices; and forms of aggression and violence.

The emergence and growth of this type of couple defines—through a biased focus on gender in local contexts (male drug users and female nonusers)—who will be considered loved and eligible for care (male drug users) and who will be considered as caretakers (female nonusers). It also defines those for whom drug consumption is a contingent state—or a state that can change—and those for

whom drug use is a substantial part of his/her identity that cannot be modified (female drug users).

According to those interviewed, the development of this type of couple is linked to complex domestic conditions that compromise health and/or survival, and where a rapid life change is necessary. Far from being the result of a rational calculation whereby an explicit strategy is defined, entering into a relationship with a "good girl" has become an informal way of escaping from circles of deterioration, danger, and destructiveness. Contrary to a popular view of codependence, based on the notion of the couple as a monad—where the search for intensity, violence, and need of the other are the basis for this type of bond—these couples are not only the product of a set of processes of social, economic, territorial, and gender restructuring and survival in local contexts, they also, in most of the reported cases, claim dependency, intensity, and violence as the reasons for separation and breakup:

> I was never into drugs; I always worked and raised my girls on my own. I met Claudio in the neighborhood ... He was sick and had HIV when we met. He didn't have any money; he was down on his luck. So, I would take him to the doctor, get his medication and even make him take it. But with the drugs, it was a mess. I would tell him to stop and he would quit for a while ... Then, he would lie again and say that he had everything under control. But he could not stop ... he would hide and drink, cry, get mad. He would also leave for a few days and come back looking like shit; it was bad, very bad ... But one day I had had enough, so [I] kicked him out. He keeps on coming now and he is always mad at me. He sometimes comes like crazy, yelling and he wants to tear the door down, usually at night. (Beatriz)

Thus, instability, tension, and emotional conflict in the life experiences of drug users enter the intimate world of the couple, giving it an emotional intensity and rhythm, which, if not solved, leads to breakup, forced separation, or repeated violence. As Laura states in relation to her partner, an intensive drug user: "you know how they live: they don't care ... they are up when drugged and then terribly low; they sometimes have a lot of money ... and others they have nothing to eat ... I tried to help him but could do nothing."

One of the assumptions of this type of relationship is that the woman, who is usually a nonuser, has the capacity to "take care" of others and therefore "cure," change, and heal the suffering of her partner through love. Although care is one of the most common female assignments, care in this process of couple development also entails a wide variety of activities and functions that exceed the traditional patriarchal relationship. Here, it includes solving complex emotional states (anxiety, fear, anger, anguish) and subjective states (dissociation, alienation, bodily effort, total devotion, and separation from the other), corresponding to the

patterns of experiences that the drug user goes through due to their consumption of drugs, which they face in conditions of extreme vulnerability.

Thus, intimacy in this couple development pattern appears to be invaded by these aspects, and by the emotional and subjective states of previous bonds, as well as by a series of activities and roles that make "care for the other" a central task of the woman in the present bond. Women are expected to reduce and/or limit drug consumption, make their partners stop undertaking illegal activities, heal the pain and suffering experienced in other domains of everyday life, prevent disease, and enable survival by providing order and stability to the emotional state of the male so that they may leave the destructive circle and enter instead a constructive circle of work, family, and legality. However, everyday life and intimacy in these couples ends up being affected by the intensity, rhythm, and emotional and bodily states that are typical of circles of deterioration and destructiveness in contexts of poverty and social and health vulnerabilities.

Expert Interventions

The emergence and steady growth in the numbers of this type of couple involves a set of processes relating to the consequences of neoliberal reforms in the societal groups considered: limited mobility, territorial isolation, descending social mobility, growth of illegal economies, accelerated increase in drug consumption, stronger gender stereotyping accompanied by illegal economies, difficulty in gaining access to health care and addiction treatment, government neglect, and accelerated growth in the number of men facing legal issues, incarceration, and even death in their adolescence and youth:

> In most cases, I do not know what to do. Not only did the drugs change, people have also changed. I have been working in this neighborhood for the last 20 years, but now things got rough! Everything is about violence. I am not sure if there are more cases than there were years ago, or if women complain now more than before . . . perhaps both situations run together. Anyway, we do not have resources to deal with such high levels of violence against women. There is only one shelter for women under risk. The judicial system in the poor neighborhood does not work well. Police . . . bah! Most institutions do not do anything in the place and at the time when they are needed. We regret many times because almost always it is too late (Mariela, psychologist in a local health-care center)

The privatization of care shows the process by which activities, practices, and knowledge relating to well-being and health care, developed in other areas of social life and other institutions, are transferred and integrated into the intimate environment of close relations and couples. The conflicts, tensions, and suffering

originating in other contexts are also transferred to the intimate world of the couple, as a new domain for expression, recovery, and resolution. However, in most cases, not only does this care fail in terms of expectations for the men involved, it also promotes new conflicts, social and health vulnerability, and threats to survival, among the women whose tasks are framed in a patriarchal logic of care, in this case, for the male drug user.

Specifically, some of the dimensions of the increase in drug use among women, as well as the spread of HIV/AIDS, the vertical transmission of the virus, and the concurrent growth of syphilis not only in women, may be articulated with this new logic of relationality. It changes the modes of production of subjects, highlights the limits of caring for oneself and caring for others, and promotes conflict in the realm of the rights and reproductive health of women in these social groups.

In addition, the burdens transpiring in the intimacy of these relationships leads to the failure of most couples, either abruptly or not; they show cycles of union and separation, which may be caused by external intervention. Only in a few cases are men able to reinsert themselves into the labor market and lead a life outside illegality and intensive drug consumption.

Conclusion

Given that privatization of care has been taking place over the last twenty-five years or so, the more recent expert interventions and treatment (including in areas of the judiciary, law enforcement, biomedicine, psychology, and social work) occurred after the transformations outlined here had already changed the life conditions of such populations. In a few cases, once tensions and conflict have reached an extreme level, some state institutions (police, justice, health), which in part generated these conflicts in the first place, have taken action to try to resolve situations of violence, abuse, neglect of children, and even murder in the home. However, when these events happen, such institutions treat these conflicts as part of the private life of individuals—that is, they hold the members of the couple responsible for their occurrence, and indirectly blame the women. In other words, expert interventions classify the hardships and conflicts experienced by this type of couple as health related and/or social problems (in terms of the legal situation, access to and continuity of treatment, and violence). They explain conflicts on the basis of the intimate relationship, the vulnerability of bodies, and on material life conditions. As a result, interventions usually arrive late in the process, or focus on aspects of everyday life, ignoring the complex processes that have caused them.

Finally, as processes that govern patterns of couple development, romance models classify people as those who may be loved and desired, and those who may not. Furthermore, the category of being desired and susceptible to being loved

opens up the possibility of entering a care circle—that is, being eligible for couple development. The gender orientation assumed in this process of heterosexual couple development shows one of the ways in which gender inequality relates to the possibility of being desired, loved, and cared for, and of surviving in these social environments.

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Notes

[1]A growth in drug consumption levels among marginalized populations of the Metropolitan Area of Buenos Aires has been documented (with some variations, depending on geographical area) since the 1980s. Cocaine stands out as the main drug used, but other substances are also used in these social groups (Epele and Pecheny 2007). Regarding modes of cocaine administration, the first generation of users preferred injection. Following HIV/AIDS infections and deaths among those drug users, injection was gradually abandoned and was limited to a reduced number of drug users; inhalation became the dominant practice in this social context. With the new millennium, and during the economic and political crisis of 2001–2, the spread of *paco* (freebase cocaine), a highly toxic substance that is smoked, led to more fragile health outcomes and a lower survival rate among teenagers and young people in these societal groups. "The AIDS epidemic in Argentina is concentrated on IDUs (intravenous drug users) and on gays, transgender, bisexuals and other men who have sex with men. After Brazil and Mexico, Argentina has the third highest AIDS figures in Latin America, with 127,000 estimated people living with HIV and 31,900 cumulated AIDS cases, 32.9% of them IDUs. During the 1990s, IDUs constituted almost half of AIDS cases and were the main category of transmission. Since 2000, the weight of IDUs has decreased and heterosexual transmission has increased: in 2004, 50.8% of new AIDS cases were attributed to heterosexual unprotected sex, 18% to unprotected sex between men and 15.8% to injecting drug use" (Epele and Pecheny 2007:344).

[2]In relation to the increase in cases of syphilis from 2001 to 2006, and considering that this disease is not generally reported or recorded, Latin America and the Caribbean together have the highest rate of cases worldwide. Regarding the seroprevalence of syphilis in Argentina, the national percentage is 1.32 percent and congenital syphilis is 1.12 percent. According to epidemiological studies, both types of cases have recorded a steady growth. Between 2011 and 2012, there was an increase of 30 percent in reported cases of syphilis (United Nations Reports 2012; INBRIS 2014).

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