

Reports of cohesion and manifestation of the madness social imaginary by family members and users of mental health at the time of admission

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Objective. To understand the social imaginary of madness and its manifestation at the time of referral to hospitalization of users of mental health by their families. **Methods.** Case study, qualitative, conducted in a mental health service in the city of Belo Horizonte, Brazil. Data collection was through non-participant observation and interviews with semi-structured to eight service users. Data were analyzed using content analysis proposed by Bardin. **Results.** The results indicate that the mad man speech is still denied and has no space due to the social imaginary of madness. Therefore, the hospital appears as a solution for the family, since they do not understand the mental illness process, designing the patient as bum. Since the mad man speech is not recognized, the family's demand prevails and becomes coercive. **Conclusion.** The conclusion of this study is that the social imaginary of madness is still associated with unreason and social inadequacy of the subject in psychological distress,

which leads families to choose the hospital psychiatric hospitalization.

Key words: coercion; hospitalization; mental disorders; mental health services; qualitative research.

Relatos de coerción y manifestación del imaginario social de la locura por familiares y usuarios de salud mental en el momento de la internación

Objetivo. Comprender el imaginario social de la locura y su manifestación en el momento de hospitalización de los pacientes de salud mental por sus familias. **Métodos.** Es un estudio de caso, de naturaleza cualitativa, llevada a cabo en un servicio de salud mental de la ciudad de Belo Horizonte, Brasil. La recolección de información se realizó por observación no participante y de entrevistas semiestructuradas a ocho usuarios de los servicios. Los datos se analizaron mediante análisis de contenido propuesto por Bardin. **Resultados.** Los hallazgos indicaron que el discurso del loco sigue siendo negado y

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no tiene espacio debido al imaginario social de la locura. Por lo tanto, la hospitalización se presenta como una solución para la familia que no entiende el proceso de la enfermedad mental, considerando al paciente como un vagabundo. Como el discurso del loco no es reconocido, la demanda de la familia prevalece y se convierte en coercitiva. **Conclusión.** El imaginario social de la locura aun está asociado con la irracionalidad y la inadaptación social del sujeto en sufrimiento, que lleva a las familias a decidirse por la hospitalización psiquiátrica.

Palabras clave: coerción; hospitalización; trastornos mentales; servicios de salud mental; investigación cualitativa.

Relatos de coerção e manifestação do imaginário social da loucura por familiares e usuários da saúde mental no momento da internação

Objetivo. Compreender o imaginário social da loucura e sua manifestação no momento do encaminhamento

Introduction

The imaginary of a society is something imponderable, difficult to precise in time and space to its origin and development, but it is real in its complexity and “materiality”. There is a social force that emanates from the imaginary, a collective mental construction, which runs through individuals, but does not end at them, surpassing them.¹ Since it is collective, the imaginary is partaken, shared and passed on culturally. The imaginary works as a collector of memory, experience, affection and perception of the routine. That perception of the individuals in relation to themselves and others determines the membership of a social group, and in a contradictory but complementary way, detects enemies and violators of this social imaginary.²

If the social imagination relates to the collective, the individual pieces that build it and approach, bind: the imaginary is social cement. Thus, permeated by affection, by rational and irrational aspects, the imagination gives an image that substantiate practices.¹ For example, the social

para a internação de usuários da saúde mental por seus familiares. **Métodos.** Estudo de caso, de natureza qualitativa, realizado em um serviço de saúde mental na cidade de Belo Horizonte, Brasil. A coleta dos dados se deu por meio de observação não-participante e por entrevistas com roteiro semiestruturado a 8 usuários do serviço. Os dados foram analisados mediante análise de conteúdo proposta por Bardin. **Resultados.** Os resultados indicam que o discurso do louco ainda é negado e não tem espaço, devido ao imaginário social da loucura. Assim, a internação aparece como uma solução para a família, uma vez que esta não entende o processo de adoecimento mental, concebendo o doente como vagabundo. Como o discurso do louco não é reconhecido, a demanda da família impera e torna-se coercitiva. **Conclusão.** A conclusão deste estudo é que o imaginário social da loucura ainda está associado à desrazão e inadequação social do sujeito em sofrimento psíquico, o que leva familiares a decidirem pela internação psiquiátrica hospitalar.

Palavras chave: coerção; hospitalização; transtornos mentais; serviços de saúde mental; pesquisa qualitativa.

imagination of a crazy person makes him/her to be what it is. Worse, by its historical development, creates and maintains segregating image of madness and corroborates with the institutional practices. The crazy person becomes incapable. Imaginative becomes real. The recognition of difference and devaluation of the crazy person for being different underpin the social construction of stigma and prejudice, concepts present in the lives of people in mental distress and historically constructed. The legal framework of the Brazilian psychiatric reform was Law 10.216/2001 redirected the mental health policy in the country, but only in 2011 the network of psychosocial care was established, though there are network services initiatives undertaken in this timeline and movements after the law's processing and approval. The Brazilian psychiatric reform is the result of a social movement of certain specific sectors of society and not of political front, which marks its uniqueness.³

The 3088/2011 ordinance that created the network of psychosocial care in the country also defined the psychosocial rehabilitation as a

theoretical framework that supports their actions. However, although legal frameworks that govern by law where, when and why should occur a change in the design of care to the person in mental suffering, it would be naive to think that by operation of law in the reorganization of the care model implies in changing the social imaginary regarding crazy figure. This occurs over the conception of the care setting in which the crazy one is part, because it is a historical context that was woven in different contexts in the country and the world.⁴⁻⁶ From this understanding and analysis of historical facts of the Brazilian psychiatric reform which is still ongoing and weakened by political issues, subjects with mental disorders living in a symbolic limbo, something these individuals generates the misunderstanding and leads to differentiation, in which there is no place for expressing their wishes, demands and speech.^{6,7} If, according to the prevailing social imaginary of the madness, there is no speech to the crazy people, how they manifest their desires and demands in society?

Demand means the “needs” of a subject, the particular individual, and therefore should be expressed in a special way, facing a crisis of difficulty. In the context of mental health, the interpretation of the demands of the suffering subject is complex. How to differentiate if the demand, in fact, is the subject’s or imposed by others?⁸ Such differentiation and demand identification are given at the patient’s reception. Thus, the reference technical - nurse, psychologist, psychiatrist - must first listen to the patient, and only then hear the familiar story. The nurse, by providing direct care and spending more time near the patient in the institution, is a privileged professional to build demand along with the suffering subject. Usually, regarding mental health, the extra office conversations, once they are not identified as formal consultations, make the patient feel more comfortable to present his/her subjectivity, demand, in contrast to family’s demand. However, if the nurse-patient relationship is grounded in the madness imagination, what remains is to make the other parties’ demand, supposedly, the demand of the suffering subject.

Thus, if it is imposed by other parties, how can the person with mental disorders have an autonomous position opposite to his/her own life?

The express demand consists of a web of subjective and objective aspects related to the subject’s life history, his/her social interactions and living conditions. Thus, the demands are the result of a social construction, which involves all aspects of this process: the user, as well as his/her family and professionals who accept this demand.⁸ Construction demand is given by daily actions experienced by the subject, and each one experiences a situation differently. Demand, therefore, can only be unique, particular. It is not possible for other parties to present the demand of a individual.⁸ Although social imaginary and demand are socially constructed, the first is a collective elaboration, while the second is individual. The pressure of the collective often stifles the individual. In this case, it is almost natural for patients with mental disorders to succumb to social imaginary history about madness and conform themselves to have their desires and “needs” expressed by other parties.

If demand is unique, even if socially constructed, it is the mental patients who should decide how to seek health care, why look for it. When someone decides for the user, depriving his/her autonomy, there is the manifestation of the third party’s demands, which may or may not coincide with the user’s. Thus, the design of the treatment plan will be based on the actual user’s demands, but on the concerns and difficulties of others. Based on these, this article aims to understand the social imaginary of madness and its manifestation at the time of referral to the hospitalization of mental health users by their families.

Methods

This is a case study of qualitative approach, which focus takes place in contemporary phenomena linked to any real context.⁹ The study was conducted from 2011 to 2013 in a Reference Center for Mental Health (CERSAM) located in the city of Belo Horizonte / MG. This service caters to

a population of 400 000 inhabitants, has eight beds for night hospitality and welcomes every day, on average, 50 patients in day stay basis. Regarding the physical structure, in addition to six offices for individual care, CERSAM has a large outdoor area that can be used for performing sports activities and / or workshops and an internal garden which have been gardening workshops offered. The service offers individual and group consultations for patient's family members, for they to be inserted into treatment and assisted in understanding the nuances that permeate the health / mental illness and decrease / change the social imaginary of madness.

Data were collected through interviews with semi-structured script to service users and non-participant observation of CERSAM dynamics (1- You have been sent to psychiatric services? How was the referral? How did you feel?; 2- How and with whom you came to CERSAM last admission? How did you feel being brought in this way?; 3- Would you like to have been brought otherwise? Which?; 4- How do you see that your hospital CERSAM have you ever noticed the otherwise?; 5- What is the proposed treatment to you? What is your perception of treatment?; 6- What activities do you play in CERSAM? How often do you perform them? How do you feel to participate in these activities?; 7- Do you think the way you were brought influence on their involvement with the proposed treatment? How / Why?). We interviewed eight patients of the service that will be identified as P1, P2, ..., P8 and observation notes will be identified as NO. These patients have an average of nine years of follow-up in CERSAM. To determine the number of study participants used the criterion of saturation of dados.¹⁰ Later, the data were analyzed as content analysis proposed by Bardin.¹¹ In this article, the following categories with their respective sub-categories will be addressed: "Family Mental Health" and "Old habits never go out of fashion" (Disrespect legitimized and intimidates Madness). With regard to ethical principles, the study was approved: ETIC 539/11 and Opinion 0539.0.203.410-11A. All participants signed a consent form.

Results

Which influences the family can establish in the lives of the mentally ill?: *They don't understand that I am mentally ill, my family do not understand. (...). So they think I'm a bum, I'm a dishonest (...). The family finds it difficult to understand that when I'm fine, I'm fine, but it's not because I'm good that I'm healed, I'm not cured, because there is no cure, only treatment [P2₁]. The family's speech becomes the speech of the patient; the family's demand suffocates, cancels and becomes the demand of mental patients: Because there family really interrupted my treatment because I had no voice, the family, in hospice, has the voice instead of us (...). Every time I was hospitalized in the psychiatric hospital my aunts were who took me. They came there and spoke well, she is like that, like that, then they gave me a way to be hospitalized [P3₁].*

As the madman's speech does not enter the accepted symbolic wheel, it is not only the family which cancels and transposes the demand of mental patients: *Torture is to be stubborn. Torture is: Do you have it? I do not have and they say, he has! [P3₂]* Then Paulo, from SAMU, said so ... *handcuff him because he is super changed, and can attack me. Then I said, I'm fine, I'm calm, wait a minute ... You can handcuff me, it's fine for me, if you may tight it, tighten [P2₂]. The discursive and symbolic clash between the supposed to be-know (society) and being object-not knowing (crazy) impacts and tightens the still possible socio-affective relations of the mentally ill: I think horrible, because my mother, she exposes me. Christmas for me is over. I do not want to go home, I'm disappointed because of that [P1]; I'm the same person I was before, only my wife was filling me patience until the time I could not take any more. 50 years of torment, of exchanging the words, to step, to offend, to humiliate and everything [P6].*

The social imaginary of madness, played strongly by the family, is part of the construction of the

social imaginary of the carrier of mental disorder against the psychological distress: *I was afraid of the patients here (referring to CERSAM) [P5₁]; And when I got here, I was nervous because I had never dealt with so many people with more serious mental problems. And that left me shaken [P4₁]. Thus, the different scares ... And even more crazy: User of the CERSAM approaches and begins to talk with me and two other members. The patient says she is not a person, but an animal, once she has body hair. If animal does not use clothes, she, as an animal, also should not wear clothes. The other two members are frightened, go out and says "What is this? That one is too crazy" [NO₁].*

In the search for normality, even drug therapy opens wide the abnormality spread by society: *Because I feel ashamed. Living in other's home is very bad, I peed in bed. The remedy is so strong that I do not get up to pee. I get upset [P5₂]. Between normal and pathological, social appearance resembles the real madness: Physicians comment on the appearance of a patient in day stay: Do you see J.? Look at her hair height, it is like a lioness. She stuck the comb on the head, when she does it...you may know, it is nocturnal hospitality for sure [NO₂]. A week later, the standard technician for this patient says: Did you see saw how J. is better? She took the comb off the head, the hair is more straightened out and the clothes are clean. She is almost ready to leave the night hospitality [NO₃]. Social discourse and coercion confuse even health professionals that should retreat to the ideal of madness and advance to the respect for human rights of the suffering subjects: There were a few strong guys that came in, tied me. Even, in my opinion, (pause), criminal. Terrible, very bad [P4₂]; Once, this year, my mother called the police and the police was truculent and SAMU staff was truculent with me, I did not like it. Because I said I would pick up a cigarette and he took my pants here, as if I were a criminal [P2₃]; SAMU has already threatened to intubate me, if I were to stay. SAMU does it with us. I felt bad. When I came here (CERSAM), I felt freed [P3₃].*

Discussion

The route of mental patients in their life is usually challenged by unexpected constructions, for example, the crisis, or by subjects who walk, in parallel, this trajectory with the subject in distress, especially family. This cloudiness against the mental disorder causes a difficulty for the family to understand the multifaceted character of suffering. Thus, as shown by P2₁, the family, sometimes, assumes a disbelief behavior towards treatment, because, sometimes, the individual, following the drawn therapy, gets well and, at other times, in crisis, creating fear and instability. The family sees the mental disorder as an incurable, unpredictable and uncontrollable phenomenon, and, therefore, complicated to handle in social life. Thus, the admission emerges as a relief, a temporary solution to the discontinuation of normality, a transfer of responsibility to the health team.¹² Hospitalization emerges as a response to the social imaginary, a solution to family demand. While the family's demand is accepted, the autonomy of the individual is denied.

Autonomy is understood as the ability of an individual to freely decide about his/her own actions and outline his/her life story. Similarly, the concept of happiness, according to Greek philosophy, transits good fortune, excellence front of "self" and decision-making potential of this self. In other words, it is "to be his/her own master." Applying the concepts of autonomy and happiness to the field of health: they are the domain of individuals regarding the demand, the determinants of their own health.¹³ According to the previously mentioned social imaginary of madness, the psychiatric crisis is a dead end street for the subject in suffering. In the absence of the crisis, it is still acceptable to discuss the restoration of social ties. However, when the signs of crisis arise, they awaken the symbolism of unreason and the loss of decision-making capacity.

The mad man, subject of the unreason, the unexpected, is expropriated of his ability to express himself, his desires and perceptions.

There is no insertion in the discourse.¹⁴ Seizing the speech while speaking, when denying the power of the word to the subject, the life empowerment of that individual is denied. An individual without speech and without power becomes a mere object to the other, becoming the target of speech and the power and others demand. Individuals with mental disorders tend to be disqualified in their testimonies, including by health professionals. There is a pessimistic belief about their ability to recognize the implications of the problem and the need for treatment. They are often considered incapable, with an expendable point of view.¹⁵

In addition to the denial of the speech, the social imaginary of madness is so pervasive that even in present days, the crazy is still and also seen, by nurses, as an unpredictable individual, violent, more likely to commit crimes.¹⁶ Such negative stereotype, linked to the imaginary, directly impacts on the type of care provided by nursing. Thus, when considering crazy people as violent, physical and/or chemical restraints become the first “therapeutic” resource, annulling the speech and link between nurse-patient. The speeches of P3₂ and P2₂ indicate the need for health professionals to approach the subject in psychological distress, in fact, as a subject and not as an object to the other. It is, therefore, necessary that the nurse, during the graduation, has disciplines that provide new insight on this subject and sickness, to dilute the crystallized social imaginary of madness.

The imaginary dilution would provide, for example, a receptiveness, by the nurse, of the subjectivity of mental patients, considering the demand of that individual, not the family, as shown by the study participants. The speech of crazy people would be current and non-cloistered in the individual himself, as historical imaginary construction. Since the Middle Age, the speech of a crazy person in the one that cannot stay in the same space of other speeches. Since it is not considered true, the word spoken by the mad cannot be accepted and heard by others, is void. The discourse of madness sets up a

distorted noise, constantly silenced and without value.¹⁷ What is not recognized as plausible and acceptable, becomes symbolic crack, which will be filled by imagination and demand of others. Curiously and, apparently, contradictory, even worthless, it is through the subject’s speech that the madness is established and recognized. The exclusion and segregation stem from the discourse itself, which defines the boundary between reason and unreason.¹⁷

It is said that isolation by speech was overcome and that, currently, the crazy person is heard, but what is the real purpose of this listening? It is given the possibility of talking to P2₂ and P3₂, and, theoretically, both were heard. Words were heard, but the reason of the words was superimposed on an alleged irrationality of individuals who rendered the decision. Again, imaginary overlaps subjectivity. Demand is synonymous with hetero-subjectivity. A qualified hearing may be masked by a dominant know, aimed to identify normal or abnormal elements. In stealth mode, the listening censorships the speech and remains focus of segregation, coercion, guided by a knowledge-truth, the discourse of truth. There are three systems of exclusion that affect the speech: the forbidden word, segregation of madness and the truly will.¹⁷

The three systems minimized the speeches of P2₂ and P3₂. When stating that one has nothing the other state, on behalf of the subject, he/she has, the word was spoken, but denied and prohibited to the ears of the other. There was a search, in the speeches of P2₂ and P3₂, for aspects that would enable segregation that the own craziness legitimizes and, finally, the real will of the other, crossed the speech, putting in vogue desire and right to know-power forward craziness. A knowledge-power institutionalized in society.¹⁴ The search for the institutionalization of mental patients reflects a significant burden of the family. The presence of a crazy person at home forces the family to change their routine life. There is, when living with the crazy person, a physical and mental exhaustion of the family, that feels like carrying the burden of madness alone.¹⁸

In this context, the family seeks the psychiatric hospital and asks for the hospitalization of the mental patient. This request, closer to a plea, consists of a family trying to regroup, rest, feel free of a problem apparently without solution.¹⁸ What, at first, is configured as a distress demand, over time, becomes a forgotten and solved problem. The role of the mental patient in the family and the spaces allocated for him/her are rearranged in his/her absence. The family reorganizes from the absence of the crazy person who, when leaving the hospital, is unwelcome and moved away from the family environment.

In psychiatric hospitals, the family is responsible for determining the appropriate time for hospitalization, given their difficulty in dealing with the crisis, as explained by P3₁. The family's contact with health professionals happens at the moment of delegation of custody and care to the institution, in some cases, by coercion, without the consent of the subject in suffering. At that time, the family desires to move away from the sick person, as well as he/she desires to move away from the family.¹² If the family does not understand the illness condition and its resulting suffering, how will they seize the moment of crisis and listen to the demand of the subject? In this difficult time for both sides of the dyad family - mental patient, respecting the individuality and the space of the other becomes difficult.

Disrespecting the difference becomes a habit, a socially accepted practice supported by the imagination. Changing attitudes and thoughts requires a great investment of anyone planning to know the new. Keeping what is already established and known is much easier and less painful. The effects of the discourse and social imagination of madness in "normal" individuals are not new, are an everyday fact. However, would the mentally ill him/herself produce these same effects? It is easy to understand that the fear and the feeling of strangeness about the madness are present in society. However, the mental patients exhibit this same sense of alienation when faced with the madness of another, wide opening the power of the social imaginary of individuals.

The reports of the patients P4₁ and P5₁ show that they do not recognize themselves in other people's madness. Just as society places madness as belonging to a parallel reality, the crazy person, when glimpsing in the other something of his/her own subjectivity, takes the same approach of the social imaginary. The image reflected by this mirror returns a familiar figure, but distorted. Madness intimidates. This strangeness of the own subject in distress in relation to madness is due to the experiences that this individual has developed in relation to his/her own mental suffering. By harrowing personal experiences, the subject knows, with property, that madness triggers significant changes in the other front of the patient. Thus, those experiences cause, unconsciously, distortions in the way the mental patient sees him/herself and his/her position in the world.¹⁹ The suffering individual knows the reaction of others to the label of madness and progressive loss of status, of self-management of his/her own life. There is the deterioration of the identity of the subject, making him/her the target of manipulations of others' demands.¹⁹

Faced with constant losses and subjugations from the experiences with the disease, patients with mental disorder, when witnessing the madness of the other, expresses the same strangeness of society, reproduce the imaginary and social discourse. Even understanding their own disease, they do not want to belong and feel recognized in this stigmatized category imposed by madness. The society expects the mental patient to act and behave in certain way. This expectation towards the mental disorder reflects in the way the patient experiences and expresses the disease. Thus, the individual tries to express his/her anguish considering ways culturally acceptable.¹⁹

The society does not accept the madness. For an adult, regardless of the cause, bedwetting, as explained by P5₂, is also not a socially accepted phenomenon. Hence, the strangeness about their own body and behavior emerges. Restlessness does not relate to intense suffering, but to the judgment of another in relation to oneself. Thus, the mental patient begins to establish normal parameters to

be able to confront and meet the impositions of the social imaginary. It is an extreme attempt to belong to the current discourse. Keeping neat and good hygiene itself indicates the clarity and emotional status of an individual. A messy presentation in a mental health service is acceptable by the normal parameters of the location, but those parameters are not the same established and consecrated by society.¹⁹ Moreover, disorganization in appearance reflects the level of psychic disorganization of the individual and how much he/she is displaced in the speech. The appearance is an important variable in the characterization of the person's normal state before the illness, during and in his/her recovery.¹⁹ The other imposes and exposes the weaknesses of the mentally ill between the normal and the pathological.

The way the individual "chooses" to be treated sets different types of coercion. When the decision is not up to the individual, there is an informal coercion, that is, to be forced by pressure, as explained by P4₂ and P2₃. The decision to treat can also be by involuntary coercion, when the individual is forced to get treated by threats of negative sanctions, exemplified by the report of P3₃.²⁰ Regardless of the type of coercion and by whom it is held, the practice presents as the configuration of the social imaginary and other's demand. The family environment and the social bond do not mean security. Interestingly, in the report of P3₃, that she felt free in CERSAM. Even considering the suffering and anguish when threatened by professionals from SAMU, a health service should not represent security and, much less, freedom to an individual. Those feelings should be present in the patient's house, at work, interpersonal relationships, that is, unlinked health social spaces.

P4₂, P2₃ and P3₃ reported there was coercion at the time approached by teams of care for emergency and public safety approached them. Coercion occurs when there is a paternalism, a sense of responsibility towards an individual or by a social assessment in order to prevent or reduce undesirable behaviors.²⁰ It is noteworthy the preventive character of coercive practices, that is,

to anticipate a phenomenon not yet manifested. Coercion can, therefore, be characterized as a type of violence for it affects the physical, mental and moral assaulted, resulting in a weakening of the quality of life and health of that individual. In a comprehensive analysis, social violence unveils established structures of domination.²¹ Violence emerges as a historical-social phenomenon, representative of ideas and ideologies built by a society in the course of time.²¹ Thus, the psychiatric crisis is used as a device to validate coercion, demand, discourse and social imagination, not by the mental patient, but by others.

The conclusion of this study is that the social imaginary of madness is still associated with unreason and social inadequacy of the subject in psychological distress. This imaginary reigns active in the family who sees mental patients as incapable and permanently in crisis, preferring to refer them for hospitalization at a psychiatric hospital than for alternative services as recommended by the Psychiatric Reform.

Despite the limitations of this research, such as not being part of a historic series that can be compared to other times of the mental health policy in the country, the fact that it was conducted at a single place of the network services and have no similar studies addressing the topic to compare the phenomenon in other contexts, it is possible to make some observations on the theme. Advances related to mental health care network are notorious; however, it is clear that out of that assistance substitutive circuit there still is the imagination that mental patients have nothing to say and, therefore, do not need to exist in their uniqueness and subjectivity. Perhaps, the biggest current and future challenge is, in fact, to allow the existence of those subjects, so that their demands appear and become social discourse.

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