

From manicomial logic to territorial logic: Impasses and challenges of psychosocial care

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Abstract

The present study describes Psychosocial Care as a new paradigm currently operating within the Brazilian Psychiatric Reform, emphasising one of its key elements: the provision of mental care within a network and a territory. To this end, the social and cultural diversity of each territory is taken as fundamental aspects to enable appropriate care for mental suffering, overcoming exclusionist thinking patterns that recently have taken on worrying conservative manifestations, and eliminating misconceptions about what defines a mental health sufferer, as well as those who choose alternative ways of being.

Keywords

community health promotion, disability, epistemology, mental illness, public health psychology

Introduction: psychosocial care, an interdisciplinary perspective on a complex subject

The work here presented was written by a psychiatrist and two clinical psychologists, although it could well have been written by occupational therapists, nurses and social workers. Our objective is to define Psychosocial Care irrespective of professional affiliation, prompting an intense dialogue between distinct and diverse academic fields of study, drawn in by the complexity of the subject. We offer an interdisciplinary perspective, result of careful observation of everyday care provided to the mental health patient community.

The Psychiatric Reform process has brought with it an important change in the way we see and understand the strange and complex human

experience of insanity. Its epistemological dimension is defined by a group of questions that aims to ascertain how knowledge is produced. It calls for the deconstruction of the founding concepts of psychiatry, such as mental disorder, alienation, isolation, therapeutic, cure, mental health, normality and abnormality.

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This is not simply a new perspective on the same subject, but an epistemological turning point that unveils a complex field of reality dimensions, that inspires us to produce new knowledge about new potential relationships. It is the production of new concepts for new problems and new objects (Yasui, 2010), in line with current debates on contemporary science, which highlight a possible 'new alliance' between the humanities and the natural sciences, as illustrated by Prigogine and Stengers (1992, 1996, 1997). This leads to a new scientific paradigm: Prudent knowledges for a decent life, as proposed by Boaventura Souza Santos (1987, 2001, 2004), a paradigm about complexity, as described by Morin (2002, 2003), or a new ethico-aesthetic-political, as defined by Guattari (1992).

Psychosocial Care offers a new paradigm within the Psychiatric Reform, opposing the notion of mental abilities as being exclusively a brain process, completely explained by *neurobi-chemical* language, as in psychiatric rationality. According to psychiatric rationalisation, mental ability variations are known as mental disorders. In contrast, Psychosocial Care takes into account the human suffering in its complexity, as well as its relation with reality. Paraphrasing the title of Nelson Rodrigues (2015) chronicles, it proposes to see 'life as it is'.

In Psychosocial Care, those who seek mental care, commonly referred to as 'users', are seen as an integral part of a network of relationships, making them social players rather than carriers of signs and symptoms. Their symptoms, although disruptive in nature, are seen as an inherent part of human existence and as such, something concrete and consistent, within given mental and sociocultural conditions.

Psychosocial Care also provides a fresh look on insanity, based on the concept that the associated suffering is seen as an inherent human experience. This introduces a radical difference in conventional ways of evaluating this phenomenon, markedly as it defines suffering as a complex event, placed within a broad social reality, where conflicts and contradictions constitute both the individual and its surroundings.

Human suffering is no longer considered merely an inner and ontological individual state, but the result of social interactions that lead an individual to a state of nonadaptation, mental confusion, loss of senses, decentralisation, and a feeling of emptiness and powerlessness. In a *non-adaptive* state, the *self* is experienced through others, consequently disrupting daily life.

The suffering of service users is marked by socially determined events that occur over time. Even so, users are believed to be able to handle their condition and bring about change because of the perception that they are implicated in their own suffering. Hence, the notion of health in Psychosocial Care includes the active participation of people in the continuous search for improved living conditions and better health-care provision.

Profound epistemological modesty is required to accept the complexity of life as an object, as it implies that there is no field of knowledge that in isolation is sufficient and necessary to contemplate such complexity. New ways of observing, listening and caring are a result of the profound and intense dialogue between different and diverse disciplines.

Words such as 'uncertainties', 'challenges', 'risks' and 'curiosity' are often used to discuss complexity. They also illustrate the feeling experienced by those seeking to understand insanity. They help us initiate the thinking process when looking to build bridges that prompt dialogues about this 'complex human experience'.

For Rotelli et al. (2001), if the object is no longer simple (the illness), it is necessary to create or invent institutions. Such institutions must be renewed every time a user is met, because each individual story raises awareness of the complexity of life. Care is no longer therapeutic isolation or Pinellian moral treatment, but the creation of possibilities and the production of sociabilities and subjectivities. The user is no longer an object of knowledge, excluded from citizenship and unable to act, but the subject experiencing insanity.

Accordingly, when users experience intense suffering and are unable to fully exercise their subjective capacity, they are still treated as

capable of realising, feeling, thinking, making judgements and decisions, and of looking after themselves. Individuals are taken to a place where it is possible to build new subjectivities and new meanings for their lives.

Psychosocial Care embraces the existence-suffering relation of individuals. The problem-solution relation is dismantled with such notions even disregarded or abandoned. For Basaglia (2005), classic psychiatry removed the mental health sufferer from its social context and restricted its existence to abstract and naturalised diagnoses, thereby placing the subject in parentheses and focusing solely on the illness as a natural phenomenon.

As in Basaglia (2005), Psychosocial Care suggests a switch in this approach, whereby the illness is placed in parentheses and the focus is shifted to the existence-suffering of the subject. It supposes the de-naturalisation of pre-established concepts, judgements and everyday life truths that are built on the perception that reality happens before and is detached from consciousness:

Placing the illness in parentheses does not represent its negation, as if it did not produce pain, suffering and malaise, instead it implies refusing to accept the capability of psychiatric knowledge to fully explain and understand insanity and mental suffering, thus limiting the concept of illness. An illness in parentheses brings to light the duality of mental illness while offering an epistemological rupture, it represents what is not inherent to being ill, but of being institutionalised. (Amarante, 2004: 65)

Before, we continue to determine the dimensions of the mental care network and territorial care, we need to look at the close relationship between insanity, mental illness and urban living.

Insanity, mental illness and urban living

The relationship between psychiatry/mental health, society and urban living has always been close and intimate, and serves specific

purposes. For Foucault (1979, 1983), this relationship is a prime example of a disciplinary society device to normalise people and for Deleuze (1992), for social control.

Machado et al. (1978) and Cunha (1988) infer that the institution of mental health facilities as an integral part of the organisation of urban spaces, and of the maintenance of social order. This was a founding principle of Brazilian society in the 19th and beginning of the 20th centuries. In 1830, the Brazilian Medical Society adopted the motto 'asylums for the mentally ill', aiming to bring to light the conditions in which mental health sufferers were found at the Santa Casa de Misericórdia Hospital, and to request that new differentiated spaces were built specifically designed to treat mental illnesses more adequately. It was believed that in order to be treated effectively, specific disorders required specific facilities designed and driven by medical knowledge. This request was met years later, in 1854, when the Pedro II Asylum for the Mentally Alienated was built. Most asylums in Brazil were similarly built, away from urban conurbations. Their architecture and location reflected one of its main purposes: to exclude individuals who resist or are unable to adapt to social order.

In the 1920s and 1930s, the Brazilian League of Mental Hygiene advocated racial sanitation through a national regeneration project as reported by Costa (1981). In a preventive speech of eugenic nature, the league broadened the field of psychiatry to include other social instances, such as the family, work and schooling. Birman and Costa (1994) analysed the 1960s American proposal of preventive Psychiatry, which had a strong bias on control, although displayed no eugenic connotation. They describe society as its privileged locus, and aim to prevent mental illness through the detection of deviant or risky behaviours.

In recent years, the controversial fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), widened the number of diagnostic possibilities, trying to encompass a huge variety of behaviours, classifying them as deviant or as a disorder.

The idealistic belief that science can achieve anything, and that it should do so, led western society to the common misconception that living with the possibility of suffering is unacceptable, as if mankind could overcome suffering. Psychiatry, as all other human sciences, is called upon to present immediate solutions that identify and eliminate or minimise any manifestation of distress or pain. Psychopathology is applied to everyday life: emotions, sensations, distress and depression become objects to be dissected, analysed and quantified. A competent discourse takes place and tells us of what is right and wrong in the human soul (Chauí, 1980).

In the turn of the millennium, urban living produces isolated and disconnected subjectivities, easily controllable and often keen to be included in the restricted and inaccessible group of the privileged. Birman (2001) points out that narcissism and exhibitionism, characteristic contemporary behaviours, have created a subjectivity model where the possibility to reinvent the subject and the world was silenced. Ideals and behavioural standards are totalitarian and all encompassing.

As a result, neither time nor space are spared for pain and suffering. There is always a magical pill at hand to silence what does not want to be silenced, waved with promises of fast and immediate relief. However, what is seen is simply a lonely and desperate search for peace, leaving the unsettling feeling of helplessness, restlessness and general unwellness.

Within this context, psychiatry, or mental health, serves the social purpose of producing *consumist* bodies who are docile, useful and amenable. It becomes a form of power over life, coined as *biopower* by Foucault and from which he derived his concept of *biopolitics* of the population. *Biopower* concerns understanding, regulating and controlling birth and mortality rates, public health, life expectancy of segments of the population and all factors that may affect the variability of these processes. With *biopolitics*, a surveillance and control mechanism has emerged, from which populations are organised and divided into groups with similar characteristics and personality traits.

Furthermore, subjectivities, living and settling patterns are produced. Segregation, sectionalism and *hierarchisation* are increasingly becoming strong characteristics of urban spaces, all of which establish invisible boundaries, delimiting circulation rights. Take the gentrification process as an example, the result of regeneration and urban redevelopment of dilapidated areas within the city. Such changes to urban living may bring affluence, but they also push out less privileged residents further afield. This has been seen in the cities that hosted the 2014 World Cup in Brazil, as well as in Rio de Janeiro, host of the 2016 Olympic Games: whole communities being dislodged to accommodate new roads, heritage buildings being demolished, stadiums being built in towns and cities with no football history. For Gaffney (2013), gentrification establishes neo-colonialist socio-spatial standards: spatial adequacy to stimulate global trade, in other words, a clean-up of urban spaces to improve its market value. For Gaffney (2013), one of the consequences of this trend is the homogenisation of landscapes around the world, in order to replicate a process of psycho-spatial familiarities. Accordingly, the docks at Edinburgh, Dublin and Puerto Madero in Buenos Aires, all resemble the Barcelona waterfront.

Gentrification produces networks of capture and exclusion, where social diversity is scrutinised and constricted in broad daylight.

Manicomial logic

Within the Brazilian Psychiatric Reform, the institutional logics of mental care is known as *manicomial* logic; it outlines operating practices that sustain the need for mental health institutions in our society, and is widely employed by its workers and users.

It is possible to state that *manicomial* logic is the exercise of *biopower*, instituting knowledge and duties, restricting access to urban spaces and determining where and how groups marked by exclusionism interact, sometimes resulting in confinement. It is a set of managerial strategies that not only exclude and suppress, but

regulate, control, subject and enforce surveillance. It is strengthened by urban policing, as well as by having control over individuals through the detailed analysis of the territory it governs and its intrinsic elements, and above all, by its continuous exercise.

Manicomial logic is devised to survey and control those who do not conform to common norms of good conduct, who evidence or express a diverse way of living. Therefore, it goes beyond those considered insane, reaching homosexual and transgender individuals, homeless people, drug addicts that inhabit the streets of cities and many other actors who, in each area and territory, cross over the boundaries of good conduct.

The power exercised by manicomial logic becomes embedded and influences everyone involved. It is seen when local residents request state intervention to remove and constrain crack users from urban spaces, demanding compulsory confinement, or when same-sex couples are attacked or harassed and are criticised by the media for demonstrating affection towards one another in public, or when protesters demand changes to the legislation to reduce the minimum age of criminal responsibility.

More specifically in mental health services and facilities, such power is evident when health professionals are unable to deliver effective care, particularly during crisis episodes, resorting to prescribing or administering drugs and admitting patients into hospitals as the alternative solution. More subtly even, when professional interventions are guided by moral judgements that advise users to behave properly or on how to act in face of life's uncertainties.

We emphasise that the indiscriminate and extensive use of psychotropic drugs has become a naturalised practice in the health service. As previously mentioned, subjectivities produced in the modern time and space do not tolerate the demands and impasses of life. The search for the unreachable ideal of full and constant happiness is imposed on everybody. Anything that does not fit or escapes the mould, as distress or sadness are no longer feelings relating to

subjective challenges and tribulations: they become psychiatric diagnosis. As a result, we are experiencing a widespread epidemic of depression, anxiety and hyperactivity.

We state that besides exclusionism, manicomial logics produces consumist subjectivities: users are absorbed in and keen to consume goods and services that are perceived to shape their identity.

Psychosocial care: the network and the territory

Psychosocial Care concepts were first described during international events that took place in the twentieth century, predominantly after World War II, evolving over decades and were influenced by events that took place in Brazil during and after the 1980s. The underlying theoretic support links different knowledge fields such as sociology, psychology, historical materialism, psychoanalysis, philosophies of difference, among others.

The deinstitutionalisation process that took place in Italy, namely the Italian Democratic Psychiatry, is possibly the most influential event affecting Psychosocial Care. It advocates the disassembling of the mental institution apparatus based on a tripod model. The first vertex stands for the development of new mental health policies, inside mental institution structures with contributions of all interested parties. The second vertex refers to shifting the therapeutic focus so as to enrich the patients' overall and concrete existence in its complexity – the extreme multiplicity of social relationships, such as the production of life, meaning and sociability – and the use of collective spaces for ample conviviality. Lastly, the third vertex proposes the construction of external structures to replace psychiatric hospital admissions (Luzio, 2010).

Hence, Psychosocial Care offers a radical change in concepts and practices. It refers to an inter and intra disciplinary gaze into the complexity of life as it happens in time and space. Thereby, care becomes intrinsic and inseparable from the network and the territory. Such care

network is fundamentally built around the people, space and time it is associated with.

Here, the idea of territory dialogues with the concept developed by geographer Milton Santos, for whom territory is a dynamic entity, alive with interrelations, therefore enabling a defragmented view of diverse social, economic and political processes, present in everyday life. It comprises the physical characteristics of a given location as well as those created by people, resulting in a structural, functional and procedural inseparability between society and the geographical space, which play an essential role in individual and collective life (Santos, 2002).

Territory is fundamentally a relationship: it is the construction and the transformation that takes place between the natural landscape and the social history of mankind, enabling us to belong, contribute, create and by which we are fabricated. Accordingly, territory is not simply a geographical space, but is made of demographics, epidemiologies, technologies, economics, social, cultural and political aspects. It is the output of a continuous process articulated by various political actors, who have needs, interests, desires and dreams. It is the memory of past events imprinted in the landscape, in the ways of living, in the manifestations that modulate the perceptions and the understanding of the space. This relationship emerges from space appropriation and alienation practices whereby social, economic and political values are formed. These are numerous, contiguous and contradictory. They produce space and assign meaning to where one lives and belongs through everyday events.

For Psychosocial Care to operate under territorial logics, as proposed by the Brazilian Ministry of Health, is it necessary to develop a network that looks at and listens to the life that beats where it is being built.

Consequently, to implement a care network in remote cities along the Amazon Forest is completely different from implementing care networks in the state of Rio Grande do Sul, in a suburb of Rio de Janeiro, or in areas of north eastern Brazil. They are distinct territories, with distinct features, such as the social, political and

economic influences they suffered during occupation and through the use of their spaces. Their history determines how spaces are accessed or excluded: affluent areas are not accessible to the unprivileged, except for those who provide basic services; commercial regions may have intense traffic, or be located in purpose built shopping complexes; parks and their sport equipment; poor neighbourhoods; prostitution zones; and so forth. This social heritage produces peculiar forms of language expression, developing local accents and colloquial speech. Cultural expressions reveal different cultural influences too, seen in parties and celebrations, local cuisine, dance and music.

Territories also differ in the dynamics of their economies and the forms through which people are exploited, affecting the way they live and choose to lead their lives. The supply, organisation, distribution and access to services and public institutions carry local imprints of the construction of public policies.

Herewith is the radicalism of territories, as the relation between the natural and the social. On one side producing imprisoned subjectivities, on the other causing potential disruption, creating new existential territories, and spaces where autonomous singularities can be affirmed. This means finding and activating existent local singularisation resources.

For instance, establishing alliances with peer groups, art movements and work cooperatives maximises the opportunities for affirming singularities and fosters social inclusion. It is all about creating a network of intense articulation and porosity between services and the resources around them. It also means creating other resources, to invent and produce spaces, especially in precarious and homogenised places, or to occupy territories within a city. From asylums, where no social exchanges happen (Rotelli et al., 2001), to public spaces as places of care, of intervention, of permanent facilities, where users can discover new ways of dealing with their suffering and to experience the world.

Another example is provided by therapeutic residences, restored spaces located within cities to house those who lived for several years, or

even decades, isolated in psychiatric institutions. Residents are required to relearn everyday activities such as cooking, tidying up, shopping, gardening and opening a bank account.

Territorial logic: permanence and transformation

Territorial logic offers a backdrop for personal exchanges, fostering processes that produce subjectivities and autonomies to occur in time and space, and where actions are produced prompting care to be articulated within a network.

It is also a huge effort to build an alternative logic, opposed to hegemonic rationalities and globalised capitalist logics, hence creating a new social space for insanity. Unsurprisingly, it poses multiple challenges of distinct natures and varying degrees.

How can relations be transformed in territories and areas where life is governed by financial interests that determine the way people live and consume? How can we stand up and face the mechanism that produces sad and lonely subjectivities, fascist and intolerable of differences, finding ways of living and interacting with our urban surroundings guided by solidarity and collaboration (experiences of art, of cooperative production, of resistance)?

As stated by Venturini regarding the rehabilitation of people and cities:

The real problem, in fact, always seemed to be to rehabilitate the inability of psychiatry, the reductionism of practices; the first step of a sensible rehabilitation strategy always seemed to be to rehabilitate the rehabilitation institutions. (Venturini et al., 2003: 5)

Besides, there are other risks. To create an alternative logic carries its own threats:

When the symbolic, yet concrete, boundary that exists between society and its mentally ill becomes hazy, under the pretence of accepting the difference, are we not simply abolishing it? Are we not, like a tender bear hug, distancing ourselves from the dangers represented by the insane? Are we not, gently and lightly, through

soft technology, domesticating the beast that lives within the mentally ill and eliminating the eeriness that they transmit? To put it more bluntly, would not the liberation of the insane really correspond to a strategy to homogenise society? (Pelbart, 1993: 104)

Modern rationality depicted by Pinel by releasing the insane from their chains, has also been a liberating force for the deranged. Here is a great challenge: to build a place that does not blur boundaries, homogenise, domesticate or tame insanity, stripping it from its disruptive potential. On the contrary, to build a place where unreasonableness, this radical difference, can live in all its provocative plenitude, permeable and porous to a strange dialogue with our 'square' rationality, but without which we still do not quite know how to live. To build such a space means to reinvent our relationship with this new place. To think, feel and live in an intensely different way.

The concept of territory is therefore a complex object that must be approached also from the perspective of liberating local knowledge, born from local necessities and realities.

For Boaventura de Souza Santos, knowledge is local, because it is constructed around topics that

[...] are adopted as local life projects by concrete social groups at a given moment in time, may they be to recount the history of a place, to look after a green space, to setup a computer that fulfils a local purpose, to lower infant mortality rates, invent a new musical instrument, eradicate a disease, etc. (Santos, 1987: 47–48)

Seeing the territory as a process and a relationship breaks away from the need to scrutinise society, of defining scope, of considering only the cold map of a city. Instead, it means constructing or inventing a space that can be subjectivised.

In short, a powerful territory-based network the fabrication of the user as a social subject, with greater social contractual power and autonomy coefficient; it enables subjective repositioning of the user, to himself and to the

world. This repositioning assumes that a singularisation process takes place, during which subjects are able to share their active utopias with one another, build life projects, to participate and enjoy all aspects produced socially, that go beyond basic needs.

We can think of it as an emancipation process, as per Venturini et al. (2003), understood as the capacity of liberating oneself from alienations produced historically by social, cultural and economic contradictions, which reach everyone, one way or another, but that on the user are experienced more intensely.

Actions on the field of Psychosocial Care are radical bets on the production of subjectivities that are more autonomous and have a greater contractual power. They are also investments on the production of a collective emancipatory process. It is possible to say that these actions can become strategies and devices of local knowledge expressed in the everyday, heterogeneous practices of the territory, contributing to the production of new meanings living connotations.

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