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Stigma and violence in dealing with madness: narratives from psychosocial care centers in Bahia and Sergipe, Northeastern Brazil

ABSTRACT

OBJECTIVE: To analyze stigmatization processes and types of violence experienced by individuals with mental disorders.

METHODS: A qualitative study was carried out, based on individual interviews with users and focus groups with family members and professionals at five psychosocial care centers in the municipalities of Itaberaba, Lauro de Freitas, Salvador, Vitória da Conquista, and Aracaju, Northeastern Brazil, in 2006-2007. The analysis categories were constructed based on the stigma concept proposed by Goffman, and four types of violence were systematized: interpersonal, institutional, symbolic and structural.

RESULTS: Users and family members recounted examples of disqualification, reprimands, embarrassment, humiliation, negligence and physical aggression that had the aims of domination, exploitation and oppression. Professionals reported that people who suffer from mental disorders remain the target of prejudice that is culturally ingrained and naturalized. The main consequence is continuation of their isolation from social life as a form of "treatment" or as an excluding attitude manifested by discriminatory reactions in the form of rejection, indifference and verbal or physical aggressiveness.

CONCLUSIONS: The various ways of expressing stigma denote a sociocultural situation of violence against individuals with mental disorders. It is proposed that state monitoring bodies capable of planning and evaluating countermeasures against stigmatization should be set up.

DESCRIPTORS: Mentally Ill Persons, psychology. Professional-Patient Relations. Professional-Family Relations. Stereotyping. Prejudice. Hostility. Violence. Mental Health Services. Qualitative Research.

INTRODUCTION

Much of the effort directed towards changing the care methods and social inclusion strategies for individuals with mental disorders has had the perspective of ensuring a new place within society for them. This is because experiences of psychological distress have major implications for these individuals, regarding their means of social interaction, the possibilities for social acceptance and, more dramatically, the production of social stigma.

Although these consequences are implicit, they are not always explored in current studies, especially those developed within the sphere of substitutive

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services. Some of the studies that come closest to this interest deal with the question starting from concepts and representations about mental disease,¹⁸ while setting aside the experiences of subjects who are the target of these types of representation.

At the same time, investments are being made in new types of healthcare technology for the psychosocial care model, banking especially on so-called light technologies.¹⁴ Very positive results are being observed with regard to changes in interactive patterns, with interpersonal relations involving greater dialogue and more sensitivity.¹⁶ This opens up the possibility that members of society might accept and interact with such differences. Despite this investment in a national mental health policy, cultural transformations within society do not take place immediately, in response to legislative changes, and therefore the effects of new mental health practices on users' lives are insufficiently known. There are even difficulties in delineating the relational dimensions of users on which greatest effort should be concentrated in order to overcome the stigmatization processes. This has been seen in several studies, in relation to educational models,¹² expressed emotions,⁸ transcultural dimensions^{10,20} and cultural value scales.⁹

The present study had the aim of analyzing the stigmatization processes and types of violence experienced by individuals with mental disorders attended at psychosocial care centers.

METHODOLOGICAL PROCEDURES

This study formed part of a broader investigation evaluating psychosocial care centers.^a Interviews were conducted with users, focus groups, family members and professionals at five type II psychosocial care centers (CAPS II) located in five municipalities of Northeastern Brazil: four in Bahia (Itaberaba, Lauro de Freitas, Salvador and Vitória da Conquista) and one in Sergipe (Aracaju), in 2006-2007.

Out of 11 psychosocial care centers chosen according to macroregions of Bahia and Aracaju, the data relating to five type II psychosocial care centers were analyzed. These data consisted of ten focus groups including all of the professionals, five groups with family members and eight interviews with users. Family members who were not seen at the service were sent an invitation on the first day in the field, arranging a date for the focus group, which would coincide with the rotating scheme of family meetings. This invitation was emphasized among family members who were seen in person. The users were contacted during the activities and, when we spoke about the interviews, some of them wanted to take part, thereby creating an empathic relationship. For

this reason, we considered that individual interviews would be more appropriate for better comprehension of the subjects' singular characteristics. Each interview and each focus group followed a sequence that was appropriate for the subjects in each segment investigated. Broadly, there were questions relating to four main lines: technologies used in the service, management and administration practices, presence within the area and participation by family members.

The overall results from the survey were presented in separate groups to family members, professionals and users, with the aim of discussing their reactions to our interpretations. There were no significant divergences within the topic of stigma.

The theoretical reference point taken was stigma from the perspective of Goffman.⁷ In 1963, Goffman⁷ developed the topic of stigma starting from the concept of social identity, in which an individual who was liable to be stigmatized would present attributes that "would make him different from others who might be found in a category within which he could be included" (p. 12). Thus, such individuals would be reduced to a status of "damaged and diminished", presenting a "defect, weakness or disadvantage", or a "depreciative attribute". However, Goffman⁷ observed that the attribute in itself did not lead to stigma, but did so when put into relational language. Thus, "an attribute that stigmatizes one person may confirm normality in another, and thus the attribute in itself is neither honorable nor dishonorable" (p. 13). The process of stigmatization would therefore always require a context and a relational situation for interpreting the attributes. This would always lead to a process of excluding or marginalizing the individual with the disorder.

However, this production of stigmatized identities is not a monolithic process. It is influenced by counteraction from stigmatized individuals or other social players. Thus, attitudes such as great efforts made to access closed spaces, searching for secondary gains, positive resignification of distressing experiences or relativization of defects starting from the recognition of problems within people who are said to be normal are attitudes that may diminish or relativize the effects of stigmatization. Goffman⁷ emphasized the beneficial effects of maintaining social interchange with others, which is manifested through mutual help networks, collective homes or occupation of certain social situations such as that of "professionals campaigning against stigma". This campaigning status may allow such individuals to go beyond the limited space for interchanges between equals, thus enabling them to interact with people who are said to be normal.

^a Nunes MO. Articulando experiências, produzindo sujeitos e incluindo cidadãos: um estudo sobre as novas formas de cuidado em saúde mental na Bahia e em Sergipe, Brasil. [Research report to *Conselho Nacional de Desenvolvimento Científico e Tecnológico*].

Goffman's thinking⁷ leads to three dimensions for the stigmatization process:

1. the production of a stigmatized identity, including the tendency to characterize the whole entity through just part of it: a person through his "defect"; a family through a sick member of the family, thus producing the effect of "contagion" of the stigma; the process of disqualification and dehumanization of the stigmatized person; introjection of the depreciated image by the stigmatized person (the "career" of sickness, for example); and the need to create spaces for exclusion and isolation of stigmatized individuals;
2. the process of stigmatization, delineated in values and attributes that are contextually and relationally attributed or interpreted, and not as absolute facts or reality itself;
3. the processes of counteraction against the stigma, developed by individuals who suffer stigma or by people who have a close relationship with them. These processes may have a political nature (advocacy), socializing nature (breaking the isolation or expanding sociability between different parties), experiential nature (resignification of the disease in positive terms) or relativizing nature (equals living together, thereby enabling freedom of expression, without control).

By taking these dimensions as a means of analyzing situations that involve the lives of individuals with mental disorders today, questions can be asked about the type of stigma and discrimination to which they are subjected. Consequently, the social spaces or types of experience that are marginalized can be investigated, and whether such stigmatizing relationships can be understood as violence.

This analysis was based on the processes of stigmatization among individuals with mental disorders, and on certain aspects of the production of stigmatized identities, with analysis of counteractions against stigmatization. Reports by individuals with mental disorders relating to discrimination, exclusion or social marginalization were given special attention.

Stigma anchored in social imagery of madness is manifested in the form of various types of violence, committed within different spheres of peoples' lives. From the informants' reports, we defined four main types of violence that were reported, corresponding to the following analytical categories: 1) interpersonal violence, 2) institutional violence, 3) symbolic violence and 4) structural violence. The processes of stigmatization were linked to types of violence and systematized from an ethics perspective (categories found in the literature regarding violence in general) and from an emic perspective (descriptors learned from narratives).

Margins, stigmatized identity and violence

The production of stigma relating to madness in the Western world was studied by Foucault,⁵ who identified an epistemological change in the 18th century that started from classifying madness as a mental disease, in the records of psychiatric care and its forms of treatment grounded in isolation and segregation. Castel² attributed a political designation to this innovation that was congruent with the important social and political transformations produced by the French Revolution. Within this context, madmen were freed from the project that was constructed from the ideal of a social subject who was free, rational, autonomous, self-sufficient, responsible and capable of participating in the social contract.

Today, Godoy & Bosi⁶ have emphasized the "social construction of stigma", associating this with the process of isolating the madmen: "An action of violence and multiple segregations is imposed on madmen: from reclusion to abandonment, naked and filthy in the yard of the lunatic asylum, thereby constructing the concept of madmen as dangerous, disgraceful and incapable beings, i.e. "non-beings", and legitimizing the condition of "non-citizen" or "non-subject"" (p. 294).

If, on the one hand, unreason confers the negative attributes relating to an incapacity to answer for oneself and a need for protection, along with attributes of childishness and dangerousness fundamental to a disciplinary society; on the other hand, in a present-day control society of consumption and wild capitalism, the denial of madmen's condition of humanity is congruent with social exclusion processes. Goffman⁷ emphasized that reducing people to their stigmatized traits, with the supposition of defective or incomplete humanity, legitimized "various types of discrimination, through which we effectively and often unthinkingly reduce their chances of life" (p. 15).

Stigmatization processes are referred to and conceived as being among the greatest impediments against advances towards attributing another social space to madness and towards enabling madmen to have citizenship. These projects are central to psychiatric reform. Despite some movement that has been produced, the social place of madness generally still remains one of situating it at the margins of society.

Kleinman et al¹¹ advocated that the position "on the margins" of the field of healthcare is occupied by problems that are situated at the border between medical and social issues. These authors made particular reference to phenomena that they included within the term "social suffering", defined as the set of human problems that originate from the devastating damage that social forces may inflict on experience.

As put forward by Goffman,⁷ the process of stigmatization (and the consequent social suffering) not only encompasses people who experience intense sociopsychological distress but also may extend to members of their families. Recently, in a study¹⁶ conducted in a psychosocial care center in which a professional used the word “limbo” to describe the situation of isolation and abandonment by the municipal healthcare administration, we hypothesized that this could also affect such individuals’ caregivers.

Not only may the stigmatization process affect different social players who are involved with individuals with mental disorders, but also the interpretation of this process takes on a variety of connotations. Estroff³ emphasized the difference between the aspects of stigma expressed by caregivers and users. Thus, among these authors’ interlocutors, while caregivers tended to focus on aspects of stigma relating to the disease, users were more concerned about their rights as citizens.⁴ The latter protested “much more strongly against the affront of the treatment than about the disease; against the humiliation and loss of self; against economic poverty and rarity of opportunities rather than about auditory and visual hallucinations”. This means that users preferred to “fight discrimination and promote equality of civil rights” than to complain about the burden of the disease (p. 495).

Estroff also emphasized that a good proportion of the stigma relating to individuals with severe mental disorders is explained by the question of “violence associated with mental disease”, i.e. by its (supposed) dangerousness. However, studying the factors really at play in triggering such reactions of violence or threats from these individuals, this author drew attention to the interpersonal and contextual contributions that especially triggered experiences of hostile relationships, financial dependence and perceived threats, either from family members or from other social players.

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ANALYSIS AND DISCUSSION OF THE RESULTS

Stigma and violence form part of the spectrum of social representations. Stigma may be expressed as a generic condition of prejudice that is rooted and naturalized in our culture. It is summarized in this phrase from a professional: “*society is not ready to receive the users*”. This prejudice remains particularly related to the concepts of dangerousness and childishness that are attributed to madness, and related to reduction of the subject to the disease. Starting from the family, it constitutes a situation of double bind:

“I know a user who said: ‘I don’t know what to do. If I keep quiet, my sister says: ‘You’re not well: I have to take you to the psychiatrist’. If I’m cheerful: ‘You’re not well: we have to take you...’ What do I do?’” (Nurse)

The main result from the reduction of the person to the disease relates to the rationalization that, to treat madmen, the best approach is to isolate them. This is strongly delineated by the principles of moral treatment, which is not only manifested through segregating them in a closed space. In one psychosocial care center, a situation involving a priest was cited: after feeling he had been harassed by a user who was undergoing a crisis, he prescribed in a mass that “whoever has madmen at home should leave them there”.

Violence in interpersonal relationships, a category that was inspired through the study by Oliveira,¹⁷ consists of “situations in which a relationship of inequality is presented, delineated with authoritarianism. It is made explicit through disqualification, reprimands, embarrassment, humiliation, negligence and even physical aggression, with the aim of domination, exploitation and oppression, thereby treating the human being as a non-subject”.

Among the types of violence relating to the intimate sphere (relationships within families and friendships), the types most frequently reported by professionals were: lack of acceptance of the user, and even his expulsion from his own home; exploitation of the user’s retirement pension; and domestic violence that goes beyond gender relationships. There were also records of home-based restraint practices or private incarceration and, in some cases, intervention from the Public Attorney’s office or from the Guardianship Council was required.

Some family members also admitted that the family undertook unethical practices, such as appropriation of the user’s retirement pension, diversion of inheritances, cowardice, truculence and lies, among other situations, with the aim of obtaining advantages of all types.

In turn, users indicated that there were problems with their families, which some of them called “disturbances at home”, and mentioned that they were fenced off from the possibilities of having a social existence, such as going to school. The feeling of abandonment was also mentioned, associated with fear of being forgotten and of losing their ties to people who were dear to them. They complained of progressive isolation from their circles of friendship, along with reactions of exclusion or situational rejection from family members and friends:

“Yesterday, I was discriminated against. It was a sister... I’m evangelical (...) I was at a little party that the psychosocial care center took me to, and when the people from the center got there, she saw me with them. I went to give “Peace to the Lord” to her and

she responded by looking away. She didn't look at me. And whenever she was serving someone, she looked the other way and didn't look at me... And she's from the same cell; she's my sister before Jesus Christ and I always see... people discriminating against me". (Female user)

The stigmatization process may reach cruel situations that come close to the most radical stage of social exclusion, thereby causing dehumanization of the other person as a way of symbolic distancing and producing gestures or feelings of annihilation,¹⁵ as attested in this statement from a mother: *"I'd rather see this girl dead than have her put me through the shame that I'm going through with her"*.

Stigma also, by extension, affects the patient's family, thereby leading it to progressive isolation from social life. The consequence is that the burden of care becomes an overload, often on a single member of the family and support link. This has frequently been mentioned as a reason why members of these families have become ill, or have been left with the feeling that they had sacrificed part of their lives.

A second type of interpersonal violence belongs to the public sphere and goes beyond relationships with neighbors or strangers within the space of the street. Such violence, in the words of members of the families, was characterized by stigmatizing comments, humiliation and totally gratuitous mistreatment, such as throwing stones or scaring individuals with mental disorders. The professionals reported frequent conflicts with neighbors, which was associated with absence of a support network in the district. Users complained of indifference, which is another face of the discrimination and rejection that they suffer in the ordinary social world: *"Because everyone here [at the psychosocial care center] is treated as equals, aren't they?! No one is indifferent, but out there, they're indifferent to us"*.

The second type of violence studied was institutional violence, which especially includes discrimination in the healthcare sector itself, in situations in which individuals with mental disorders are insulted, ignored, neglected, denied care or led to worsening and inevitable death. This type of violence extends to cases in which there are regulatory failures within the service network due to stigma, or in which there is deficient supervision of very poor conditions of care, or even cover-ups of negligent actions. Grouped with this is violence produced by the healthcare professionals themselves and violence that characterizes services as a whole, thereby delineating an institutional culture.

The professionals at the psychosocial care centers mentioned violence produced by healthcare professionals in other services. This functioned as a barrier against accepting these individuals within institutional spaces, with attitudes of distancing and even repulsion, hidden in

the euphemism of lack of preparation. This reached the extreme of denying care to individuals in severe clinical conditions, which even led them to death.

"So we generally seen that it really exists, doesn't it? Because of lack of information or unawareness even among the professionals themselves: doctors who are on emergency duty; the nurses or the technicians: well, they are afraid, aren't they? We had a case here of a user who had been run over and the service... Everything was badly done, wasn't it? He had a cut, and to do the suture, it seems that it was done at quite a distance, you know. It must have been very rapid... The Emergency Mobile Care Service, sometimes they... sometimes they are afraid and, depending on the case, they call a police officer to accompany them". (Psychiatrist)

Discriminatory attitudes were also manifested among the mental health professionals themselves. For example, we found the opinion that with the psychiatric reform, *"they are giving a lot of rights to madmen"*.

With regard to institutional violence that in a general manner delineates the culture of different types of service, that of psychiatric hospitals can be highlighted. This stands out, in the words of users and members of their families, as a space where abusive, anti-therapeutic and antisocial practices are perpetuated. Whenever users and members of their families were discussing the evaluation of mental healthcare, comparisons appeared between the treatment provided at the psychosocial care centers and the treatment at the hospital or clinical to which the user had been admitted.

Regarding psychiatric hospitals, users indicated the limitations on movement, such as mechanical containment and the impossibility of leaving; the interactions consisting of iatrogenic socializing solely among sick people, along with mistreatment caused by technicians; and the treatment centered on medication use, with the absence of workshops and lack of autonomy. Members of their families were more restrained in their criticisms, but even so, they mentioned the users' idleness, the prison-like characteristics and the excessive use of medications.

When the psychosocial care centers were the subject of analysis, most of the points made were positive. Members of the families emphasized the quality of the attendance, the multidisciplinary team, the activities to occupy minds and which provided socialization (arriving home with new things to talk about) and the facilitating effect of the use of medications. Users mentioned the interactive aspects of the care (autonomy, closeness to the physicians and nurses and motivation, thereby ensuring improvement), movement aspects (free movement inside and outside of the institutional space) and technological aspects (participation in workshops such as "improvement systems"). The users generally believed that the psychosocial care centers

were satisfactory both for themselves and for members of their families. Among the negative aspects of the centers, the users indicated that the food was repetitive and poor (“poor for poor people”) and that there were attitudes of induction and suggestion.

The third type of violence found related to symbolic violence, as formulated by Bourdieu.¹ In this, the individual is considered to be “a second-class citizen”. In the case of individuals with mental disorders, this refers to those who are subjected to supervisory and disciplinary measures, control over sexuality and strict surveillance. For this violence to occur, the individual suffering it has to have incorporated the domination structures imposed by society. Among the subtypes of symbolic violence, there is one that, because it is more veiled and often takes on a pedagogical or preventive nature, is not always seen as a problem. This relates to control over users’ experience of sexuality. In all of the psychosocial care centers, there was a concern (ambivalent in relation to users’ desires for autonomy) that amorous relationships developed between them might lead to sexual practices inside the institution, along with pregnancy. A further important concern related to homoeroticism, which was tacitly understood as an additional pathological condition.

Included among the subtypes of symbolic violence was also what we called civic violence, through which the possibilities for individuals with mental disorders to participate in civic functions were restricted because of the supposed limits imposed by unreason. These were translated into legal implications, sandwiched between guardianship and users’ autonomy. This type of violence extended to all the practices that surrounded the steps towards giving the users autonomy and that kept them hostage to vigilance and guardianship:

(...) The question really is about the benefit that users receive, isn't it? They are under guardianship and don't receive anything. The guardian is the one who receives it and passes it on in the way he sees fit. And here, we preach and work towards autonomy, and we hear judges phoning here and saying: “What madness is this, that you want the user to have his own credit card?”. (...) Well, social inclusion goes through this, too. A truly structural change in society”. (Psychologist)

Finally, we observed structural violence that was generated by social determinants in the social structure. These were consequent to the way in which society is organized economically and politically-ideologically, thereby producing situations of inequality and social tensions.¹³ Among them, we could basically distinguish those that were manifested through the work process and those that related to living conditions and socio-economic situation. The first of these were especially represented by exclusion of individuals with mental disorders from the labor market.

“Because, for example, inclusion of an individual with... with mental disease in the labor market is much more difficult than inclusion of someone with a mental disability! As incredible as it seems, isn't it? (...)” (Psychologist)

Socioeconomic violence was described by the professionals as a type that related to a much broader condition of social misery, which reinforces the situation of stigma attributed to the family and to users themselves. This was also reported among people living in the streets or among users living in very precarious situations whose homes did not have any sanitation at all and consisted of plastic shacks. It was recognized that a large proportion of the users’ problems stemmed from social suffering, thereby in turn generating an enormous feeling of impotence among the professionals.

Although separated for heuristic purposes, many of the types of violence described earlier frequently appear in combination in people’s experiences of life. This produces complex situations that sometimes are difficult to reverse, considering that they have the effect of mutually reinforcing each other. It is within this complexity that solutions may be devised for the effects of stigmatization on human existence.

FINAL CONSIDERATIONS

There is polysemy in the processes of stigmatization suffered by individuals with mental disorders, regarding the perceptions and experiences of users, members of their families and the professionals at the five psychosocial care centers studied.

Identification of the distinct social spaces within which these stigmatization processes are manifested and the various forms taken by such violence makes it possible to outline action strategies of greater specificity, with a view to facing up to this. Many of these strategies are present in public policies (the economic solidarity program, the “*De volta pra casa*” (“Back home”) program and the equipment of the service networks, among others) and in actions that are developed within healthcare services (such as therapy based on ties, the quest for comprehensiveness of care and actions aimed at social inclusion).

Thus, systematization of reports on stigmatization, with regard to types of violence, may serve as a reference point for monitoring actions that have the aim of mitigating stigma, and for mapping out situations in which such actions are denied. An effort along these lines may culminate in proposals to create posts for monitoring violence committed against individuals with mental disorders.

At the same time, another aim is to refine the analyses that identify which efforts have been more successful in producing counteractions against stigmatization.

Even in countries that have already been using a psychosocial care model for longer periods, television campaigns and leaflet distribution have been insufficient to produce a cultural transformation that would modify the collective imagery of and practices aimed at individuals who are experiencing intense psychological distress. Nonetheless, concrete engagement with people going through such situations, thereby expanding their visibility and political, moral and educational space, seems to be giving rise to better

results than is neuroscientific progress (e.g. treatments using medications, diagnostic technologies and genetic mapping).¹⁹

Actions developed within day-to-day micropolicies, involving relationships between subjects full of new directions and resignification of blind points that were fed by old stigmas have been shown to be the greatest resource for social inclusion among individuals with mental disorders.

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