ARTICLE

The spatial dimension and the social place of madness: for an open city

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Abstract *The Brazilian Psychiatric Reform (BPR) process proposes a break with the asylum paradigm in several dimensions. Thinking about care spaces and the right to the city are important flags for this issue. Bearing that in mind, a theoretical-conceptual framework was constructed, aiming to discuss and systematize the relationship between the architecture of care spaces geared toward madness and the production of subjectivities and relationships. Thus, based on archeo-genealogy, a dialogue was organized between concepts and authors that approach space and architecture as devices for the production of subjectivities and relationships, such as total institutions and self-mortification (Erving Goffman) and space-behavioral syndrome (Mirian de Carvalho), as well as experiences such as those by Maura Lopes Cançado and Lima Barreto. It is also the aim of this study to discuss and draw, through the lens of different fields of knowledge, an ideal city that will aid in facing the asylum paradigm and strengthening the BPR process: the open city, that which includes difference. Locating the importance of discussing the architectures, spaces, and the city built for the BPR process, this article proposes to build and add a new dimension of analysis of such a process to those that already exist: the spatial dimension.*

Key words *Cities, Architecture, Mental health, Healthcare reform*

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Introduction

Mental illness among spaces and technologies of power

As described by Foucault[1], madness is a social construct immersed in a power discourse. Architecture as a field, together with its spatial expressions, may also be a part of this discourse, as they produce power relationships that support a given paradigm. Throughout Western-European history, these two discourses ran hand-in-hand and passed through changes. The most important time of transformation for these discourses and their associations took place during Modernity. Madness, as seen through the lens of emergent modern psychiatry is the rupture between the subject and rationality, and the mean through which to treat this was through hospitalization in a mental institution. By means of the architectural space called an asylum, madness gained a new place in the social imaginary, and at the same time, it became a new location in the city. Relegated to this specific part of the territory of the city, the mad were forced to occupy this space as their natural place of existence.

For Venturini[2], asylums are places for hospitalization which take away the subjects' autonomy, with an architecture in which there is "(...) the convergence of multiple intentions or incarcerating, separating those inside from those outside, creating barriers (...)" (p. 119) The modern city is conceived to be ample, organized, and beautiful, leaving at its margins (or within barriers) everything and everyone who does not correspond to such ideals. The cities as objects of medical intervention and the medicalization of madness itself created fertile ground so that different social problems could be defined as madness and could be removed from the city to be placed in asylums[3].

The dynamics between madness, hospitalization in mental institutions, and exclusion from the city has gone through modifications and adjustments, but the tactic of this tyope of hospitalization was not questioned until after World War II, half way through the twentieth century. This tension between the psychiatric paradigm that had been built by modern society and the new paradigm which seeks to overcome it, began in the countries which were at the center of WWII, but that tendency spread and reached Brazil in the 1970's. Brazil was a country in political effervescence, passing through a military-civilian dictatorship, but which found space to contemplate both Sanitary Reforms as well as a Psychiatric Reform Movement.

While Sanitary Reform proposed a rupture with the model of the natural history of disease and proposed that health-disease was in fact a process with social determinants and, therefore, was a right of the society and an obligation of the State[4], Brazilian Psychiatric Reform (BPR) proposed to shift the focus on madness to the subjects who experienced it. Therefore, at the end of the 70s and the beginning of the 80s, Brazil was at the core of its democratic rebuilding and of the movements which arose within that period, seeing the individual as a citizen who has rights to the city. As important as arguing for such a right for the mentally ill – those who are had already been hospitalized and those who would still suffer mental illnesses - is the understanding of the city, the caring spaces within it and what kind of city occupation should be promoted along the BPR process. After all, what is the importance of the care spaces? What is the role of the architecture of such places? Are such spaces capable of producing and providing specific subjectivities, such as the citizen-subject or the subjected-subject? What role does the city play in this context? What proposal of a city, which takes care of the different subjective experiences, should we build during the BPR process?

Proposing the building of a theoretical-conceptual background, which may help us think about and analyze these questions throughout the BPR process, this article aims to discuss and systematize the relationship of spatial architecture – specifically spaces geared toward the mentally ill – with the production of subjectivities and relationships. It also seeks to construct a theoretical discussion and produce an ideal city that can help fight against the asylum paradigm and strengthen the BPR process. Hence, from the view of archaeogenealogy, this study organizes a dialogue between the concepts and the authors who examine space and architecture as a means through which to produce subjectivities and relationships. After, the context is explored according to different fields and conceptions of the city.

Over time, it became clear that approaching the issue of spaces, architectures, and the discussion of the city in the context of BPR is more than a necessary, relevant challenge, since it focuses on a theme that is often left to peripheral discussions. Such a process, understood as a complex[5] process that is alive, dynamic, and connected with different aspects must be always under analysis, and it should provide centrality to the architectural and spatial discussion as one of the pillars that helps to overcome the asylum paradigm. Therefore, as an organic development in the construction of this work, our study proposes adding a new dimension to those that already exist and those proposed by Amarante[6,7] to analyze the BPR process: the spatial dimension.

Spaces producing subjectivity and relationships

This study begins the construction of the theoretical background concerning the spaces, architecture, and production of subjectivities and relationships through the most extreme space or architectural experience: the *total institutions*, among them, the asylums. When Erving Goffman did his field study between 1955 and 1956 at the St Elizabeths Hospital, a federal institution with a little more than 7,000 patients in Washington D.C, his aim was primarily to understand the world and the experience of the patient. In other words, he wanted to understand the social world of the patients and how they lived and experienced that world. That field study originated "Asylums, prisons and convents", in which Goffman[8] reminds us of an aspect of modern society: we perform a series of activities such as sleep, play, work, in different places, with different co-participants and under different authorities. The institutions which do not follow this separation among the three spheres are referred to by the author as *total institutions*. The author claims that:

A total institution can be defined as a place of residence and work where a large number of individuals in similar situations are separated from society for a considerable period of time, living an enclosed and formally managed life.[8] (p. 11)

One of the characteristics of the total institutions is their situation of "enclosure" and separation from the social world, imposing barriers, including physical ones (high walls and locked doors, for instance), which keep the interns from relating with the outside world. Such institutions are destined to those who society considers useless or as representing some type of threat to the community – hence the prisons, but also the asylums. The people admitted into such institutions, go through a subjectivation process defined as the *mortification of the self*[8].

I was admitted to the Psychiatric Institute. My first impression was of panic. A door was open, and I walked straight into the cafeteria. The greyish stone tables, some patients with hair in disarray, made me step back. A nurse held me by the arm: "You can't leave anymore". They changed my dress for the uniform and put me in the yard. Only in the movies can one see what the Psychiatric Institute is like". (p. 195)

When speaking about her own experience with being an intern in Psychiatric Institutes in the states of Minas Gerais and Rio de Janeiro between the late 1940s and 1950s, Cançado[9] describes a process of loss of identity which occurs in total institutions. This process follows the intern from the first time he/she enters the institution. Therefore, they took away her dress and made her use another outfit, the same as the other interns, and they said the sentence: "You can't leave anymore".

In total institutions, it is common, from the moment of admission, to begin the process of *mortification of the self* by changing the intern's clothes for the uniform of hospital admission, by issuing the identification number, by losing the right of owning personal objects and having personal space, by losing the right to eat the food you want at the time you want, by losing the right to take a shower when you want, by losing the right to sleep when you want, to go where you want and when you want, resulting thus in an individual with a *mortified self*.

The degree of interference of those total institutions on the daily lives of the interns is extremely expressive, regardless of how much we want to build and live in a given space, thus creating our own "personal space"[10], that interference is so strong that all the personal spaces are invaded and prohibited from existing - as in the case of owning personal objects or in determining that some activities must be done at pre-established times. The *personal space*, as defined by Sommer[10], would be, at the same time, a portable territory, since we can take it with us and would also be "(...) an area within the invisible limits which surround the body of a person, in which strangers may not enter"[10] (p. 32).

One of the horrors of any reclusion is that you can never be by yourself. In the middle of that crowd, there is always someone who comes to talk about this and that. At the asylum, I felt that problem, which can only be understood by one who has been to a prison; however, that one is worse than any other (...)[11] (p. 166)

Lima Barreto was institutionalized at the National Hospital for the Alienated, at Praia Vermelha, for periods between the decade of 1910 and the beginning of the 1920s. The feelings that Lima Barreto transferred to writing remind us that, whatever may seem simple and basic in our relationships may be completely ignored when we enter one of those institutions. The territory of the self is violated, "(...) the boundary that the individual establishes between his/her being and the environment is invaded and the incarnations of the self are profaned"[8] (p. 31).

Russel Barton, Goffman's contemporary, was an American psychiatrist who worked at psychiatric hospitals, and from his observations he created the concept of *institutional neurosis*. The option for the term Neurosis reveals his background as a psychiatrist (at the time, based on the structures of Psychoanalysis) and at the same time defines the author's objective, which is to understand institutional neurosis as a disease. Although it does not have a certain, defined cause, it is associated with environmental factors, such as the architecture of the place where the intern lives, and can be characterized by the following symptoms: apathy, lack of initiative, no expression of feelings, lack of interest in the future. Sometimes, all this apathy results in occasional aggression episodes, which are usually attributed to the "mental illness"[12].

If we observe, we will realize that there is a similarity between the symptoms of institutional neurosis and the symptoms of psychiatric diseases. Therefore, when those symptoms are defined as a consequence of living at a psychiatric hospital, we shift away from the idea of a relapse of the interns, to the realization that it is produced by the institution itself. Even though we move away from Barton in some instances of his categorization, especially concerning treating it as a disease - that would place the intern into another layer of medical power – this shift in understanding could be considered an advancement on the issue.

Franco Basaglia, in a Communication from the first International Social Psychiatry Congress held in London, when he was the director of the psychiatric hospital at Gorizia, in 1964, revisited Barton when he mentioned the effects of *institutional neurosis*.

So, as the patient goes into an asylum, alienated by the illness, by the loss of personal relationships, and therefore, the loss of one's self, instead of that patient finding a place where he/she can find freedom from the impositions of others and rebuilt his/her personal world, ends up facing new rules which compel that patient to become more and more objectivized, until becoming identified with the institution.[13] (p. 25)

What Basaglia is arguing about is the impossibility of treatment in an institution with asylum characteristics. At that time, he still believed that there was a possibility of reforming such spaces and making them into Therapeutic Communities. In the Triest experiment, such an idea became unviable. Therefore, there was a need to move beyond the idea of psychiatric hospitals. However, in 1964, he spoke of a system with "open doors", with no fences or gates which would provide to the patient "(...) the perception that one is living in a place where one can achieve, gradually, a relationship with the "others", with the caretakers, with the companions"[13] (p. 31). The question that was considered by Basablia in the following years is that which we still ask now: is it possible to provide a non-asylum treatment in an institution with the characteristics of an asylum?

This question, which was a concern of Basaglia, seems to be currently in the minds of many professionals, theoreticians and others in the field. One of those experts is Miriam de Carvalho, a doctor in Philosophy who developed studies with architects from the Architecture Post-Graduation Program of the Universidade Federal do Rio de Janeiro about the problems concerning the relationship between the built environment and spatial behavior. Starting from the hypothesis that the constructed space interferes in the behavior of those who use that space, Carvalho[14] conducted a participant observation in psychiatric institutions. One of the developments of that research indicated that there is a significant interference of those spaces on the behavior of the patients, something that he will define as *behavioral-spatial syndrome*.

The *mortified self* is the one who does not inhabit the space of the institution, and only lives in it. In fact, it is the opposite of the space of residence, "where the individual makes choices, modifies the environment, can go in and out freely (...)"[15] (p. 126). Asylums, as total institutions, are conceived as spaces which modify the subjects, and as something against the opposite notion as well. The spoken or unspoken rules are part of those institutions and part of the lives of the interns, and are capable of producing "behavioral responses related to poorly projected spaces"[16] (p. 322).

The interconnection between madness and architecture make it urgent to elaborate the space we create for the care of those who are undergoing psychological suffering; therefore, "(...) mental disease becomes an indispensable observatory for an architect and for those who want to analyze critically the progressive loss of social space and the spaces provided by the city"[17] (p. 57). Carvalho[14] reminds us of the importance in conducting studies in the BPR context, considering that the growing implementation of substitute care services must guarantee the definitions of such a process. We believe that those studies would collaborate with the development of strategies and policies which could break away from the asylum logic and had, in their core, the occupation of the city.

For a city where people who do not know each other can meet

Foucault[18] makes us think about space as an expression of the power technologies, which occurs in a given context and is not simply an expression of the technologies of the day. This premise is also defined by the French sociologist, Marion Segaud, who works with the intersection of sociology, anthropology, and architecture. The author claims that "space is not an homogeneous notion, measurable, existing *a priori*, regardless of the cultures, the historical contexts and the representations what people make of it"[19] (p. 20-21). This anthropological perspective considers that the relationship of the individual and the group with the space corroborates with the identity of each one. The pedagogy of space is the way to understand the spaces as the identities of each person, is the way to understand spaces as instruments of knowledge and power, which have social efficacy and are frequent in our society, and at the same time, problematic.

When the eighteenth century architecture went through a specialization as a field which interacted with the matters of society – health and urbanism – a shift was observed in the focus of power, from the sovereign figure, to the people, to their bodies and their daily lives. In so doing, architecture begins to affect the spaces which intertwine with life, such as the house, the school, and the hospital. Architecture becomes "the art which determines the space"[20] (p. 6). Hence, "architecture is, foremost, building – however building with the primordial purpose of ordering and organizing the space for a given objective and with a given intention"[21] (p. 246). What we notice is the association between disciplinary power and biopower, an interaction which in Brazil begins to occur intensely in the nineteenth century. In this relationship, the disciplinary techniques work as tools for the regulation and normalization of life, since biopower is a "power which has the function of taking care of life, and must have continuous, regulatory and corrective mechanisms"[22] (p. 134). It is this very relationship, or association between powers, that we will find in the specific spaces geared toward the control and normatization of those who are considered mad, as well as in the control and normatization of the city in which they live.

Madness in Brazil was not always related to asylum madness; that process is produced *pari passu* with the expansion and transformation of big cities into modern cities, based on bourgeois ideals. And it is in the name of those ideals that "entire districts began to be cleared out and demolished, pushing to the peripheral areas the poor classes and the minorities, for the privilege of the bourgeois class"[23] (p. 206). Such a rearrangement of the big cities in Brazil occurred in the nineteenth century, after the arrival of the Portuguese Royal Family, with the objective of transforming the cities according to the standards of the European metropoles. Therefore, medical knowledge has a fundamental role to perform in the normatization of the cities, transforming them into a space where medical practices will take place, and consequently, transforming the cities into an object of intervention[3]. It is in such a context that different social pariahs are defined as "unreasonable" and pushed to the asylums, which were also located in the peripheral areas of the "beautiful and organized city", following a dynamic of the medicalization of madness, which configures a social and hygienist matter, captured by scientific interest and by the discourse of progress[24].

Through that period of medicalization and exclusion of madness from the city, different spaces were occupied by the mad – although the objective of segregation connects with all of them. Therefore, since the opening of the Dom Pedro II Asylum in 1852, eight other similar establishments were opened until 1886 in other large Brazilian cities. Time passed, the asylums became crowded, and the medical power gained increasingly more centrality. With the advent of the Republican regime, new transformations occurred in Brazilian cities, and Rio de Janeiro, the capital, went through another urban transformation. In 1902, during the presidency of Rodrigues Alves, when Francisco Pereira Passos was the mayor, extensive urban and sanitation reforms were conducted. Again, seeking to become more like the European cities with their large avenues, the inhabitants of the old tenement slums from the center of the city and the harbor areas were expelled, with no financial compensation, for the purpose of restructuring. Most of those poor urban residents were black and unemployed, and did not fit into the new conception of the city.

The Insane Colonies gained, therefore, more candidates. In the following years, the creation of Insane Colonies expanded and spread across other parts of the country. It is clear where that process would lead: to overcrowding, to countess violations of human rights, to iatrogeny, to extreme segregation, and ultimately, to the *barbacenas*. The Brazilian psychiatric reformation conducted in the 1970s by professionals, patients, and families, as well as by members of society, created a process of transformation in many aspects and instances, inspired by other experiences of psychiatric reforms throughout the world, all aimed at overcoming the asylum paradigm. One of the strategies for that breakthrough was the occupation and the recapturing of the city through the different dimensions of madness. Thus, local experiences of medical care came about as territory-based mechanisms. Projects of deinstitutionalization gained prominence in that period, which were implemented so as to provide people who had been institutionalized for a long period of time the chance to interact once again with the city, experiencing art, culture, solidarity, and economy. When we refer to the ideas of territory and territoriality, we are not referring simply to the interconnection of the concepts of distance, accessibility, and time, which are commonly dealt with in the analysis of the distribution of health services. We are proposing an idea of territory which covers the senses, the meanings, and the production of relationships in a given place. This territory is, at the same time physical and symbolic, it is in constant construction and disputed. Therefore, when occupying the city, it is necessary to consider which city we really want. Bearing this in mind, in this BPR process, we must revisit and (re)build ideal possibilities of the city which may serve as the guiding model.

Certainly, there are as many ways of conceiving a city as there are cities[25]. In that case, how can we know which city we want to build in the context of the BPR? Or what is the ideal of a city that is worth fighting for? Besides being endless, the different conceptions of cities are disputed by the fields of knowledge which conceive them. The most basic and accessible definition, available to everyone, comes from the dictionary. After searching in three different dictionaries - Aurélio, Michaelis, and Priberam – we found very close definitions, which emphasize the presence of a large number of people and focus on the fact that people work in factories and services, differently from what happens in the countryside. Considering that, Ferreira[26] defines a city as a "demographic complex, formed socially and economically by an important population concentration, non -agricultural, dedicated to mercantile, industrial, and cultural activities; urbe" (on-line).

However, the city has not always had as its main characteristic the agglomeration of people, much less their economic and industrial potential. In Ancient Greece, for instance, the concept of *polis* had to do with the fact that politics and city were interconnected, since that was the space where people were able to express a unit. Pagot[27] indicates that it was the Roman conception of a city that influenced the contemporary urbanization processes instead of the Greek conception, since the Roman city created the geometry of space not based on union, but rather on division.

If we steer into the field of Geography, we find the definition from Milton Santos who considers that "(...) the city constituted a particular form of organization of space, a landscape, while on the other hand, presides the relationships of a larger space in its surroundings, its influence zone"[28] (p. 7). The French geographer Pierre George brings a concept of a city which dialogues with historical time and society. Therefore, the city is, simultaneously, a geographic and historical event, and its format represents the connection between the past and the present.[29] Henri Lefebvre, a Marxist French sociologist, when referring to cities, seeks in philosophy something that the other fields were not able to provide: the totality of the city. Contemplating this totality, he states that:

A city projects on the ground a society, a social totality or a society considered as a totality, which comprehends its culture, institutions, ethics, values, and altogether, its superstructures, including its economic basis and the social relationships which constitute its structure as it is defined.[30] (p. 141)

According to Lefebvre's ideas, we project on the city our culture and our relationships, yet we are also projecting on the city our segregation. Therefore, women, blacks, LGBTQI+ people, the poor, and the mad and their intersections occupy places at the margin of the city (metaphorically and concretely). Even though we know that this is not the main issue in this study, it is important to emphasize that, historically, the minority groups have been more likely to be taken to asylums and psychiatric hospitals - not to mention prisons - in a perverse action of *cloistering*, by means of medical authority, all kinds of people who are undesired by the industrial, bourgeois society. Barros et al.[31], in a study about the patients of psychiatric hospitals in São Paulo, noticed that, considering the demographic census of the state, there is a higher proportion of blacks in psychiatric hospitals, since they often do not have an income or a place to live. This indicates that

black populations historically suffer an uninterrupted processes of exclusion and social distancing. The ultimate place for exclusion and segregation is the asylum, as well as the other total institutions. The consolidated data proved that the black population has the unfair position of priority in the ranking of social exclusion in the psychiatric hospitals in the state of São Paulo.[31] (p. 1.240)

Therefore, if the city reserves a place at its margins for the excluded since the creation of the first psychiatric hospitals, we have the distance from the urban centers, as a condition. That was the case of the Bicêtre Hospital, directed by Philippe Pinel, and the Dom Pedro II Asylum when it was created. If Sennett[25] defines the city as a "human group where it is likely that people who do not know each other, meet" (p. 39), such models of planning and building cities are promoting quite the opposite. Thus, as they become full of walls, barriers, and real or imaginary divisions, the cities are not prepared for differences.[2]. In his most recent book, *Building and dwelling: ethics for a city*, Sennett[32] discusses the possibility of the buildings promoting more meetings between people, in what he defines as an *open city:* a city that is permeable, with inviting spaces and which includes the differences. Thinking about the challenge of building a city that is able to promote such encounters, Sennett[32] divides the city in two: the city in its built format, the *ville*, and the city in its format of a lived experience, the *cité*. The author calls attention to the duality and the antagonism of those two definitions of a city, and raises a question to himself, arguing if the answer to create an open city could be that of providing more power to its inhabitants. As McGuirk[33] argues, it becomes clear that:

Building and dwelling" is Sennett 's attempt to respond to this question. And he has an almost Taoist attachment to harmony and equilibrium. If you provide to the architects and planners too much power, the cité suffers; if you trust too much the citizens, the ville succumbs. The open city that Sennett imagines is one which requires that we accept difference, even though we may not relate to it. (on-line)

From Sennett's ideal city[32], we can think of a city which is a magnet, a city that is "a great magnetic field which attracts, unites and concentrate men"[34] (p. 12), but that at the same time, it is also a city that

(...) is the source of the collective labor of a society. In it, we find the history of the people materialized, their social, political, economic, and religious relationships. Its experience throughout time is determined by the human necessity to congregate, interconnect, and organize around common welfare, of producing and exchanging goods and services, of creating culture and art, of manifesting feelings and desires which can only become real in the diversity that urban life provides.[27] (p. 23)

In short, what we propose is a city which promotes contact with the unknown, with the different, which accepts it. A city which is a collective construct, permeable. We believe that the concept of open city is that which encompasses most of all those ideals, and we therefore propose that we adopt that open city as our guideline when considering the strategies and policies for mental health in the different dimensions of the BPR – in favour of meeting; in favour of an open city.

Final considerations: building the spatial dimension of the Brazilian Psychiatric Reform

If we can manage to build and show the potential of the architectures and the spaces in the production of relationships and subjectivities; if we are capable of understanding that the analyses, the policies, and the creation of strategies must discuss that potentiality; if we can think of an ideal city which would help us and guide us in both practical terms and epistemological terms to overcome the asylum paradigm, would it not be interesting if this discussion could be structured as an analysis tool? How can we provide centrality to this discussion, in the context of BPR?

As we mentioned in the introduction of this article, we understand the Brazilian Psychiatric Reform as a permanent and continuous process based on social mobilization, on what Rotelli *et al.*[5] – when referring to psychiatric reform – called a complex social process. Such a process has been analyzed and categorized by many theorists in the field from different views and analytical categories. Amarante[6,7], among the influential and important authors in the field, looking for a systematic reflection on the BPR process, proposes to analyze it through dimensions. In the end, "(...) a complex social process constitutes itself as the intertwining of simultaneous dimensions, which at times support each other and are at times conflicting; which produce vibrations, paradoxes, contradictions, consensus, tensions"[7] (p. 63).

The author, therefore, proposes four essential dimensions: the theoretical-conceptual, or epistemological, through which the rupture with the basic precepts of classical psychiatry and the reductionist biological view of the natural history of the disease, builds its own conceptual-theoretical field, which seeks to dialogue with the different fields and disciplines related to the care for madness. There is the sociocultural dimension, which seeks to transform the historically built, social imaginary of madness, in which the mad individual assumes a disqualified place and is often categorized by the stigma of peril. There is also the juridical-political dimension, seeking to build new agreements of power through the actions of protagonists and different actors in this process who can, through politics and the judicial sphere, both propel and substantiate a social transformation. Finally, there is the technical-care dimension, which is related to both practice and theory, that is, with the praxis, which proposes a new organization of services that can promote a support network, provide spaces for sociability, as well as generate income, housing, and the production of life[6,35]. As everything indicates, the discussion about spaces would be more connected with this last dimension. Even considering that the dimensions are dynamic and not static, we believe that only this dimension and no other is capable of handling the necessary centrality that the discussion concerning the spaces geared toward madness deserves. Bearing this in mind, we propose that a new dimension be considered in the discussion of the process of Brazilian Psychiatric Reform: the spatial dimension.

This dimension involves all that has been discussed throughout this article. Therefore, to work with the spatial dimension of this reform, it is necessary to understand architecture as a field of knowledge capable of conceiving spaces that produce relationships and subjectivities. Subsequently, it is necessary to contemplate which relationships and subjectivities we are trying to produce and facilitate. It is necessary to understand that the spaces themselves and their physical, concrete architectures are part of subjective processes, and therefore deserve attention. The spaces for caring for mental health must be thought of together with the ideal city that we want to construct, and it is essential to build the two in a dialogical manner. The physical and symbolic territory must be taken into consideration; the spaces for madness must go beyond the building of mental health facilities, following an intersectoral and integral logic in health.

Therefore, the spatial dimension seeks to transform the asylum paradigm of care for mental health by breaking with the centrality of the spaces for care that are exclusively health related, containing asylum architectural structures. It is worth mentioning that, in order to accomplish the spatial dimension, we must not only change the architectures and spaces, but we must also develop the other dimensions in order to truly break from the asylum paradigm, so that asylum-style practices are not produced in the substitutive services.

There are many singular ways to experiment madness, and there are multiple possibilities for building the spaces to care for madness. Therefore, we should not fall into the trap of seeking a space model built in a predefined manner and restricted by some law or public policy. That would result in the end of creativity and would disrespect the senses of each territory, where the madness experience and the meanings of assistance and care are specific to that place. Of course, we must further develop the parameters in order to reach what we define as substitutive dispositions, which is of utmost importance, especially today, when psychiatric hospitals are returning to the network of Psychosocial Care and the concept of substitute service is being suppressed.

But why introduce a new dimension if we can debate and analyze the questions of the spaces for care through others that have already been proposed? In addition to enabling a productivedebate on the issue, with more specificity, we would also be placing the issue of space in a place of importance, calling attention to the field of mental health and collective health, which is a fundamental part of our reform process. This is a factor that often goes unnoticed or that is left at a peripheral place in discussions. So what are the challenges of this dimension? The biggest challenge is certainly the overcoming of the architectural asylum paradigm.

If the process of the Brazilian Psychiatric Reform is complex, and therefore alive and dynamic, so are the dimensions chosen and created to analyze it. Taking that uintonder consideration, we hope that this discussion and the explanation of the spatial dimension are not restricted to this article. We will continue to develop it, and we hope that the articulations established here unfold as an invitation for other researchers to take interest in them and expand this dimension, consequently strengthening the fight against asylums.

Collaborations

L Paladino participated in all the phases of the research. PDC Amarante participated in the construction of the article's argument, the analysis and discussion of the bibliography, and the writing and revision of the manuscript.

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