

## De-institutionalization experiences in the Brazilian psychiatric reform: a gender approach

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This paper discusses gender issues present in the mental health field in Brazil developed during the de-institutionalizing process of psychiatric reform. It develops a data analysis from an ethnographic study conducted between 2010 and 2011, in the Brazilian cities of Joinville-SC and Barbacena-MG as well as in Turin, Trieste and Gorizia in Italy. The guiding questions for these discussions relate to the significant presence of gender in the experiences launched by the deinstitutionalization process along the psychiatric reform in Brazil, regarding the care practices and the modes of subjectivity of women and men as users of the services that substituted the psychiatric hospital.

*Keywords:* Gender. Modes of subjectivity. Mental health. Psychiatric reform.

### Introduction

This article aims to discuss some experiences of deinstitutionalization in the context of the Brazilian psychiatric reform through a gender approach. To do so, it develops an analysis of the data of an ethnographic research performed in the years 2010 and 2011, in the Brazilian cities of Joinville and Barbacena, and in the cities of

Torino, Trieste and Gorizia in Italy, aiming a critical analysis of the Brazilian psychiatric reform from the point of view of people who use or have used mental health services.

The problem that guide this text is the significant presence of gender issues in the experiences of deinstitutionalization triggered by the Brazilian psychiatric reform process, the care practices and in the modes of subjectivation of women and men attending the services that replace the psychiatric hospital.

These and other issues demonstrate the complexity and relevance of addressing gender within the framework of the Brazilian psychiatric reform, since their developments are significant both in the modes of subjectivation and in the institutional and unique practices of experiencing psychiatric care in Brazil.

### **Methodological path**

The ethnographic fieldwork was developed during nine months of the year 2010 in the city of Joinville/SC, and also in small ethnographic incursions in the city of Barbacena/MG (2010) and Torino, Trieste and Gorizia, Italy (2011). It is not a comparative study, we search in different realities elements that may increase the capacity of critical analysis of the Brazilian psychiatric reform.

We chose the ethnographic approach for its potentiality to emphasize the different social discourses and practices present in the context investigated. During the fieldwork, we used participant observations, narratives and semi-structured interviews. Data were registered in field diaries.

The fieldwork was not carried in a specific group or location. We follow the subjects in different activities, linked or not to mental health, in the cities in which they live. When talking to the first respondents about the survey, they indicated people who they thought could participate. These persons, in turn, indicated others and invited them to participate in other activities. Thus, the work was developed along the lines of social networks, as suggested by Bott<sup>1</sup>.

The subjects of the research were adult women and men, generally belonging to the popular classes, who attended or had already attended mental health services.

Many were former inmates of psychiatric hospitals and some, for different reasons, were still inmates in psychiatric hospitals in Brazil. All of them were using or had already used psychotropic drugs.

### **A brief overview of the Brazilian psychiatric reform**

The Brazilian psychiatric reform is recognized as both an innovative, original and prolific process<sup>2</sup> and as a plural and ongoing work<sup>3</sup>. This process began in the 1970s and was triggered by a social movement carried out by workers, family members, users, politicians, artists, among others, who demanded a transformation in the psychiatric care given to those considered "mentally ill".

It developed in a broader context of psychiatric reforms that were taking place in other countries, with a counter-hegemonic conception of the current model based on the custody and isolation of the "crazy ones" and their "madness". Such a model was recognized as incapable and inefficient, in its practical and theoretical aspects, as discussed in the works of Foucault<sup>4</sup>, Goffman<sup>5</sup>, Cooper<sup>6</sup>, among others.

In his analysis of the different movements of Psychiatric Reform in the world (Italy, France, the United States, among others), Desviat<sup>7</sup> shows how the post-war context, coupled with other events such as the advent of psychotropic medication and psychoanalysis, were driving forces behind these processes that, in each country, occurred in different ways. For the author, these movements were permeated by the characteristics of each country and by what he called different historical moments of the psychiatric reform movements, which had as their common conditions a favorable political and social climate and a favorable administrative legitimacy.

Desviat<sup>7</sup> considers two historical moments of the psychiatric reform movements in the world. The first was developed in France, Italy, England, the United States and Canada and the second was developed in countries like Brazil and Spain. For the author, this second moment would be influenced by previous reforms. In his evaluation, the risks of this processes of changing mental health care as an alternative public psychiatry are situated, "on the one hand, in the crisis of its mainstay – the

health, social and community services of the so-called Welfare State – and, on the other hand, on the drug-dependent and rudimentary biological evolution of psychiatry" (p.157).

In Brazil, the psychiatric reform began its process concomitantly with the democratization of the country and reformulation of its health system, through the health reform. It began to question the knowledge and psychiatric practices besides a radical critique of the psychiatric hospital as a local of treatment.

Because of mobilizations, disputes and negotiations between sectors with diverse and divergent interests, after twelve years of proceedings in the Brazilian National Congress, the National Mental Health Policy (Law 10216/2001) was approved. Such a policy establishes rights for persons referred to as "people with mental disorders", regulates care for long-term inmates of hospitals and redirects psychiatric care in the country, indicating the creation of a network of community services to replace psychiatric hospitals .

Since the adoption of the law, various services and practices have been created in a heterogeneous manner throughout the country, which means that there are many Reforms, not only in the diversity of practices and theories as in what they intend to reform. Considering their heterogeneity and complexity, we could call this process as "the" psychiatric reforms instead of "a" reform, as presented by Fonseca et al.<sup>3</sup> and also suggested by Andrade<sup>8</sup>.

Other works had also pointed to the diversity of the processes of psychiatric reform as well as their complexity. Rotelli et al.<sup>9</sup>, from the Italian experience, commented that the transformation of psychiatric care is a dynamic, conflictive and non-resolving process. These authors allude to the saying of Franco Basaglia – one day after the approval of Law 180 in Italy in 1978 – that "by its internal logic and by the characteristics of the terrain on which it acts, this law opens more contradictions than it resolves." (p.49)

Whether due to the complexity of the process or the aspects that make it up, the contradictions and paradoxes of the Brazilian reform extrapolate the field of health. It

is a broad and complex process, full of tensions and crossings that put in evidence different issues. Gender is one of these issues.

We will discuss the aspects that emerged with greater vigor in the research carried out, considering gender as an important element in the context of the Brazilian psychiatric reform.

### **Considerations of gender in the Brazilian psychiatric reform**

The Brazilian national mental health policy resulting from the psychiatric reform has produced subjective and objective changes in the lives of men and women who have their life experiences crossed by it. Such a policy brings together some levels, which can be situated between the institutional level and the level of the singular experiences, in which the gender has been shown as an important political dimension configuring the relations of power. We start from the understanding of gender as a sociocultural, historical and relational construction that establishes hierarchies, configures relations of power and constitutes modes of subjectivation.

In the entanglement of subjective (re)positioning triggered by such transformations, it is possible to perceive the articulation of certain modes of subjectivation<sup>(c)</sup> that allow or not ruptures with the places hegemonically instituted to men and women who have their experiences in the field of mental health. Gender is understood here as a regime of subjectivation, as a form of constitution of subjects that configures power relations, as proposed by Judith Butler, Joan Scott and Teresa de Lauretis.

As some studies<sup>8,10-12</sup> indicate, women are the majority in most mental health services created in the process of Brazilian psychiatric reform, such as health workers, users and / or relatives and, above all, consumers of the psychiatric drugs prescribed in these services. However, there are some particularities regarding the greater or lesser presence of women in these services. While in services focused on basic health care, the presence of women is significantly higher, in services aimed at alcohol and

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(c) We understand by modes of subjectivation the processes through which individuals become subjects, as proposed by Michel Foucault.

other drugs, the larger clientele are men, which indicates socio-cultural differences in the ways men and women seek relief for their sufferings.

In the context of the research developed, we noticed that in Psychosocial Care Center type III<sup>(d)</sup> the clientele was distributed between the sexes, as perceived in the day-to-day of the service and also by the information given by the coordinator. Yet in the service that returned their actions to the questions of work and income, the women were not majority. In the other services, such as the Mental Health Clinic and the Psychosocial Care Center type II, women predominated as users. Such data evidence gender configurations that tend to reproduce historically constituted places for men and women and reveal that "the issues generating psychic suffering are rooted in gender stereotypes"<sup>13</sup> (p.245). Moreover, they demonstrate that the search for relief for such sufferings is marked by sociocultural determinants, as discussed by Silveira<sup>14</sup>.

Besides the significant presence of women in mental health services, during the research it was also possible to perceive the reification of the place of subalternity occupied by them. Such reification can be perceived in institutional discourses and practices and also in the speeches of some interlocutors who, when referring to the experiences of some women, made comments like "this is whim, give her something to do ...", "it's that hormone-ridden every month....", among many other revealing expressions of a way of thinking about the perceived differences between men and women. Comments with this content became frequent and were stated by both men and women. They demonstrated, in a certain way, sociocultural, historical and relational aspects.

During the fieldwork in Barbacena - MG<sup>(e)</sup>, we learned that one of the editions of the Festival of Madness, held every year in the city with the purpose of discussing madness, had as its theme the madness of women and as slogan "Festival of Madness:

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(d) The Caps (Psychosocial Care Centers) are constituted in different modalities, according to the population criteria of comprehensiveness, operational capacity, hours of operation and clientele. Caps III works every day of the week, 24 hours a day, and serves men and women with "mental disorders." On the other hand, the CAPS type II, has reduced functioning in days and times.

(e) Barbacena-MG has an experience considered paradigmatic in Brazilian psychiatric care. It was considered for many years the "city of the crazy ones" to have had seven psychiatric hospitals, of which three still remain. With the beginning of the process of psychiatric reform in the country there was in the municipality the creation of some mental health services aimed at replacing psychiatric hospitals, of which the residential therapeutic services where men and women who are from the psychiatric hospitals of the city stand out.

their madness ...". This slogan was inscribed on a pink shirt worn by a woman who worked at the reception of a tourist service in the city and who told about her impressions of this edition of the festival. It had been a unique opportunity for her to discuss the suffering of women since she understood that they suffered differently from men. "It's different, you know, we have something that is woman's ..." she said, arguing about the specificity of female suffering.

It was possible in this and in other circumstances to perceive how much gender notions constitute speeches and practices of the agents of the State, professionals that act in the public services (not only in the health area, as seen in the example), as well as users of these services. Notions of gender establishes norms that define and configure the relations between men and women and both with their experiences of suffering, illness and care. Both the worker's arguments about suffering that would be specific to women, as well as the color and slogan of her T-shirt are the expression of a discourse of difference and power relations configured and established by gender conceptions.

However, it is not just about women that such gender configurations weigh. Men are also affected by the idea that, being the "mental suffering" of a "feminine nature," those men who suffer are displaced from the traditional places conferred to them, as the account of Daniel, one of the interlocutors, showed. While talking about mental disorders during one of our talks, he said: "Bipolar disorder is gay thing [homosexual]." For him, there were disorders that were specific to women and bipolar disorder was one of them.

As Laqueur<sup>15</sup> points out, gender has been present in conceptions of Medicine in a significant way since the 18th century and the set of knowledge that comes from this knowledge has instituted a series of interpretations related, in particular, to reproductive questions and to gender historically built asymmetries. Such conceptions are also included in the interpretations of suffering and of psychosocial afflictions, and cross their etiology and therapeutics.

In her analysis of the construction of gynecology as a science of difference, Rohden<sup>16</sup> argues that it is possible to say that

theories of insanity and nerve disease in women, based on the predominance of reproductive function, were predominant in the nineteenth century because women also 'experienced' their reproductive lives as problematic. (p.30)

Such conceptions persist today through the conception, consolidated by hegemonic knowledge and contemporary subjectivation regimes, of a natural relationship between the reproductive life of women, their hormones, that something that "belongs to the woman", "this madness of the hormones", and their afflictions and sufferings. As Butler<sup>17</sup> suggested, gender is produced by a discursive complexity, which is responsible for producing bodies of men and bodies of women. For the author<sup>17</sup>,

Gender is the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame, that congeal over time to produce the appearance of substance, of a natural sort of being (p. 59)

As the social construction of madness pointed out by Foucault<sup>4</sup>, gender also has its genealogy, as showed as well by Laqueur<sup>15</sup>. In analyzing the conceptions of the categories sex and gender, Laqueur<sup>15</sup> argues that sex would be more than a discovery of a truth of nature; for him sex is a social construction that corresponds to the values of a given time. For the author, sexual dimorphism was a non-existent category until the birth of medicine, and sex, as we conceive it today, would have been invented in the eighteenth century as a foundation for cultural and social gender conceptions. Sex was invented, just as mental illness was invented: both being grounds for practices of subject's control.

In the context of the mental health services investigated, it was possible to perceive how gender has marked the experiences of the subjects and the assistance practices. The research data found resonance with data from another studies, such as those of Santos<sup>18</sup> and Silveira<sup>14</sup>, that also emphasized the effects of gender in the practices of care. These effects can be observed in the search of women and men for the relief of their sufferings in health services, and in the relationship they establish with their peers in their daily lives, in their places of coexistence and sociability. Thus, we share Maluf's argument<sup>19</sup> that:



In the case of the generic theme "mental health" and distress, including the issue of "nerve disease", gender has appeared in its ethnographic relevance – both quantitative, i.e., the high rate of women suffering from this type of disturbance, and qualitative, by the way in which representations and ideologies of gender difference conform social experiences of illness and psychological, physical moral and nervous suffering. (p.24–25)

As we could see in the analyzed data, both the ways psychiatry and psychology fields define the experiences of suffering and the conception of gender difference have constituted regimes of subjectivation that unfold in public policies and in the ways of caring for and seeking care in mental health services. Being a woman or a man and / or receiving a diagnosis of psychiatric disorder are experiences that define conceptions and ways of feeling and thinking on the part of users and of health professionals.

### **Gender and its effects in practices**

From the ethnographic data, it was possible to understand some effects of gender in practices that tend to reinforce the asymmetries based on the discourse of sexual difference. One of these perceptions is related, according to the reports obtained in the fieldwork, to the triggering of what, roughly speaking, could be defined as the experience of "illness" in the field of mental health.

The narratives analyzed show that, even in the hegemonic conceptions, the dichotomy between the private and the public, the world of the house and the world of work and subsistence do not necessarily is reproduced in the investigated context. According to women's narratives, alongside experiences such as the loss of a child or a loved one, marital separation and family relationship difficulties, issues related to work, household support and women's double or triple shift of work were present, demonstrating that the public/private dichotomy was not homogeneous and was dissolved in women's confrontation experiences with the "public" world.

The debate about public and private worlds in feminist studies is old and will not be deepened here. However it is necessary to observe that both the public and the private have undergone changes in face of the transformations produced by the insertion of women in the world of work and in other areas of public life, as revealed by the fieldwork.

Nilza, an interlocutor belonging to the urban popular classes, with a history of psychiatric hospitalizations and treatments in the substitutive services, reporting her experience of illness, showed how these two domains (public and private) appeared simultaneously in her life. According to her, her difficulties had started when, at a very young age, she began to work and, given the pressures of this work, such as the intense and extensive workday, she fell ill "in the head". However, talking about her crises, she said that they were related to work conditions, to maternity and to terrible marital conditions, being thus configured in difficulties in public and private spheres. In one of our conversations, she told the following story:

"Alberto (husband) did nothing, I had to pick up the sickle and cut the bush because it looked like a capoeira [capoeira means, in this context, high bush] here, and take care of Tiago and the house as well. And Tiago eat nothing, and cried of hunger, but he couldn't suck the baby bottle ... It was getting difficult because Alberto and I did not have acquaintanceship, he never could do anything at home ... So, I talked to a neighbor and she said that they needed people to work in an industrial kitchen. After I got married I had not worked any more. Thus, I went and found a nursery and put Tiago. It was near the house but one of them said that he could not stay there because his development was not normal.. I went there to talk to her because I thought he could, but she said no, because he was too skinny, that I did not feed him. They sent me to the tutelary council and I had to go there to explain that he was [premature born at] 8 months. Then I had to take him to the other side of the city very early, and then came back here to work, and at the end of the day I had to pick him up. That's what I was doing, running from one place to another. How can I not go crazy? Working, married with a husband who beats and scolds, having to take care of the son [...]"

In this narrative, the articulation of the public and the private is evident, demonstrating the dilution of their differences in the experiences of the subjects. Nilza shows how sociocultural demands related to domestic tasks ("Alberto and I did not have acquaintanceship, he never did anything at home") and motherhood ("they said that I did not feed him") contributed to the beginning of her illness.

The report also anticipates other aspects related to gender, such as the perpetuation of domestic violence, often invisible due to different circumstances, and the responsibility of women in child care.

In the set of data analyzed it was also perceived a naturalized discourse subjugating women, which does not take into account their unique experiences and the different ways in which each subject gives meaning to them. The interpretation of a supposed "feminine nature" was present in the speeches of some interlocutors who attended the mental health services visited during the research. As pointed out earlier, it was one of them who, referring to the experience of women, said: "there's no way not to be crazy right?!? Imagine they get that hormone-ridden every month". From their point of view, women would be predisposed to mental disorders due to a biological condition, that is, their menstrual cycle.

The naturalization of these discourses, as discussed by Rohden<sup>16</sup>, is articulated to the conception of a feminine nature linked to biological determinants. As the author<sup>16</sup> says: "From this would derive the idea that the diseases of women are nothing more than the very expression of their nature. Insofar as they are women, they are also sick and ill because they are women" (p.16).

In the context of public policies on mental health for women, such naturalization also appears in a significant way in the concerns related to reproductive rights and to the notion of the "life cycle" of women defined by the phases of their biological cycle, such as pregnancy, partum, postpartum, and menopause, as Maluf<sup>19,20</sup> pointed out.

We understand that efforts to a broader understanding of the articulations between gender and experiences of suffering in the field of Brazilian psychiatric reform are still limited. This may be related to the fact that even with the proposal of

overcoming the asylum model, somehow, there is still a reproduction of some characteristics of this model through the maintenance of asymmetries, in this case those related to gender. Moreover, we perceived that, as Maluf<sup>19</sup> suggested

[...] Although there is no explicit and consolidated gender policy on mental health in official programs, it is noticed that in the application of health policy, in the daily life of the health units and the Psychosocial Care Centers, a politics of difference and a discourse of gender difference is present. In practice there is a policy being implemented or reproduced, a policy that involves the medicalization and medicamentation of women users of the public service. (p.35)

The effects of such a policy are evidenced by the majority presence of women as users of mental health services, by the hypermedicalization of their experiences and its articulation with gender asymmetries. At the same time, they indicate possible limitations in accessing and attending to men's mental health demands in these same services. As pointed out in Andrade<sup>12</sup>, the fact that gender issues are not part of the concerns of psychiatric reform demonstrates the invisibility of their effects in this context and indicates the reproduction of a culture strongly marked by gender inequalities.

### **Modes of subjectivation and its unfolding experiences**

As discussed so far, gender as a regime of subjectivation has exerted a great influence on the ways of thinking and intervening in the scope of the Brazilian psychiatric reform. As shown, misrecognition of complexity of this process has had effects especially on women seeking relief from their suffering in mental health services, effects linked to the centrality of drug therapy prescribed to women.

It is worth noting that suffering is understood in our analysis as a subjective experience crossed by the models and meanings of the process of illness and healing,

permeated by the sociocultural contexts in which they develop and that cannot be reduced to a nosographic category, a biological event or a set of symptoms.

As we could see, the phenomenon of (hyper) medicalization is articulated with invisible gender issues present in this context and it is an issue that goes through speeches and practices of professionals, of family members, of users and users in different perspectives.

As pointed out by several authors, women have been prominent in the consumption of psychotropic drugs, especially benzodiazepines (see, for example, Diehl et al.<sup>11</sup>), which are among the psychotropic substances most widely consumed indiscriminately around the world. This prominence is "justified" by prescribers for the balance that such drugs would offer to women. These, having their anxieties relieved, would maintain their functions in the context in which they live, although such prescriptions may mean a chemical gag that makes it impossible for them to discover other ways of dealing with such sufferings.

With regard to the use of psychotropic drugs among women<sup>(f)</sup>, the complaints we've heard revolved around the body stiffening, decreased ability to articulate words many times as a result of the slowing of thinking and of corporal modifications resulting from the use of the medication. In general, women complain about weight gain, as did Mariana, an interlocutor, about the fact that she gained 136lbs during one of her psychiatric hospitalizations.

In chorus with most women and men who complain about the effects of psychoactive drugs on their bodies, she said: "When I entered São Pedro [referring to the psychiatric hospital in Porto Alegre / RS] I was 88lbs and I left with 224lbs. It was one injection a week and 18 tablets a day." Through his account, she tried to make visible the magnitude of such modifications and the bodily effects of excess medication.

Mariana is a young, white woman who belongs to the lower classes and, although she is from a generation that could have had access to another kind of psychiatric

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f) The women we talked to had been diagnosed as having severe and persistent mental disorders, especially depression, schizophrenia, and other psychotic disorders, and therefore used antidepressants, antipsychotics and other medications commonly prescribed in the treatment of these types of disorders.

care, she felt subjectively and objectively the effects of hospitalization in a psychiatric hospital. She has increased more than double of her weight in addition to other adverse effects triggered by the medication. Her indignation during his reporting concerned not only body issues but, above all, the effects of psychiatric hospitalization on his life.

Marta, another interlocutor who attended a substitutive service to the psychiatric hospital, in one of our conversations complained about the excess of prescribed and administered medication. For her, who had had her first "crisis" due to the demands of the world of work and had gained many pounds from psychiatric treatments over the years, her complaints were justified by the fact that she did not agree that medication was good for her and help her feel better. "I'm not good tonight. I do not like CAPS anymore, ... to stay here at CAPS. They give us a lot of medicine", she said. But even though she resisted verbally against the medication and warned about its effects, she was taking the medication prescribed to her.

As discussed previously, the naturalization of women's suffering is emphasized in view of a supposed vulnerability related to what would be their reproductive function<sup>19,20-21</sup> and unfolds in a corresponding therapeutics; to an alleged suffering of organic etiology, correspond a supposedly effective drug therapy.

We understand that the discussion of psychoactive drugs is not limited to prescription, their use and abuse, but it is related to broader issues of power and control. In a paper discussing the use of anxiolytics among women in a health unit, Carvalho and Dimenstein<sup>22</sup> argue that, at health services, "there are a kind of naturalized discourse that subjugates women, insofar as it does not take into account their particular modes of existence, their singularities and the different ways of feeling and thinking of each subject" (p.121).

Silveira<sup>14</sup> also refers to the use of benzodiazepines as a therapy for nervous women and shows that "at least from the perspective of patients and their families, medicalization of social problems has worked as a solution for the physician, since patients, despite the use of tranquilizers, continue to have crises" (p.80).

These aspects involve the relations between prescribers and claimants and the contexts in which they are inserted, since they are marked by regimes of subjectivation that reify differences and places of power. For Basaglia<sup>23</sup>, the discovery of psychotropic drugs may have determined the relationship between patients and institutions, but it did not mean changes in relationships themselves, since the "madman" continues to be "crazy" and his experiences are always interpreted from a psychopathological reason. As the author argued:<sup>23</sup>

The drugs exert an undeniable action, from which we can see the results in our homes and in the reduction of the number of patients "partners" of the hospital. But, a posteriori, one can begin to see how this action works, both at the level of the patient and the doctor, because the drugs act simultaneously on the sick anxiety and on the anxiety of the one who cures it, evidencing a paradoxical picture of the situation: through the medicines which he administers, the doctor calms his anxiety in front of a patient with whom he does not know how to relate or find a common language. It compensates, therefore, for using a new form of violence, its inability to conduct a situation that it still finds incomprehensible, continuing to apply the medical ideology of objectification through its own perfectionism. (p.128)

It is possible to recognize that somehow, amidst the transformations in Brazilian psychiatric care, it is no longer the madmen that are controlled through the asylum apparatus, between the walls, but it is the madness that is controlled through the imperative of medication.

However, as medicalization takes place in relational processes, different knowledges are articulated in different ways by the subjects who attend the mental health services. Some reports and observations were quite significant in this articulation and possible subversion of such prescriptions (of remedies and places), as that of Nilza, who, telling of his experience, said:

"Ok, I came home, but here I did not take the pills anymore, I kept it behind my tongue and I did not take it and in the psychiatric ward I did not take it either, when I

was going to have breakfast I would do it, but I would throw it away." Why? "Because everything is so hard (gestures to show me the rigidity of the arms and legs), the person can do nothing. I came home and could not do anything, I wanted to do some dishes, I wanted to want to walk and I could not...".

Finally, it was in this context of hypermedicalization of experiences that it has been possible to understand how the subjects, especially the women interlocutors of this research, exert despite these prescriptions a certain agency, through which they create lines of flight that, subverting the hegemonic regimes of subjectivation, produce new meanings for their experiences with suffering.

### **Collaborators**

The authors participated equally in all stages of the article.

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