

# Social representation of users of a Psychosocial Care Center and those in their social network on mental illness and social inclusion<sup>1</sup>

## Representações sociais de usuários de um Centro de Atenção Psicossocial e pessoas de sua rede sobre doença mental e inclusão social

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### Resumo

Ao viver na comunidade, as pessoas com transtornos mentais enfrentam o desafio de construir a sua inclusão social. No presente estudo, buscou-se identificar e analisar as concepções expressas pelos entrevistados sobre inclusão social e doença mental. Utilizou-se a abordagem qualitativa como metodologia de pesquisa. Os sujeitos desta investigação foram pessoas com transtorno psíquico, usuários de um Centro de Atenção Psicossocial (CAPS), e pessoas da sua rede social. Para a coleta de dados, foram realizadas entrevistas semiestruturadas e, para apuração dos dados, foi utilizada a análise do discurso, que permite refletir sobre as condições de produção e apreensão de significado dos textos. A percepção sobre inclusão social dos entrevistados está alinhada com a literatura, valorizando aspectos como trabalho, educação, renda, poder contratual e ser aceito na sua diferença. Porém, a comunidade apresenta associações negativas em relação ao adoecimento mental, que são introjetadas pelas pessoas ao longo do tempo. O modelo manicomial ajudou a criar o imaginário de que a pessoa com transtorno mental é perigosa, incapaz e deve ser excluída. Assim, as pessoas com transtornos mentais enfrentam preconceitos e discriminações que dificultam seu processo de inclusão social. Neste contexto, é preciso lidar com a herança cultural que estabelece o conceito de que estas pessoas devem ser temidas e excluídas. Os avanços nas concepções sobre inclusão social são um forte aliado para transformar as concepções sobre a doença mental, já que a inclusão social pressupõe uma sociedade inclusiva para todos, sem exceções.

**Palavras-chave:** Saúde mental; Serviços de saúde mental; Estigma social; Preconceito e inclusão social.

## Abstract

By living in the community, people with mental health problems face the challenge of building their social inclusion. This study aims to identify and analyze the conceptions expressed by the interviewees about social inclusion and mental illness. The research methodology used was the qualitative approach. The subjects in this investigation were people with mental health problems, users of a Psychosocial Care Center (CAPS) and people in their social network. For the data gathering, semi-structured interviews were conducted and discourse analysis was used for examining the data, allowing reflection on the conditions of production and for the meanings of the texts to be grasped. The interviewees' perception of social inclusion is in accordance with the literature, valuing aspects such as work, education, income, empowerment and being accepted in their differences. However, the community shows negative association in relation with mental illness, which are introjected by people over time. The asylum model helped to build the idea that the people with mental health problems are dangerous, incapable and must be excluded. Thus, people with mental health problems face prejudice and discrimination that makes the process of their social inclusion difficult. In this context, it is necessary to deal with the cultural inheritance that establishes the concept that they must be feared and excluded. Advances in conceptions of social inclusion are a strong ally in transforming conceptions of mental illness, since social inclusion assumes an inclusive society for all, without exceptions.

**Keywords:** Mental Health; Health Services; Social Stigma; Prejudice and Social Inclusion.

## Introduction

Historically, the mentally ill were excluded from life in the community, marginalized in social life, whether through expulsion from life in the city and confinement in an asylum, or through the discrete exclusion due to the stigma of mental illness, impossibility of finding work and devaluing the subject.

As an issue of social policy, health care policies in general and mental health policies, social exclusion/inclusion is inherently contradictory with regards different approaches to psychiatric care (Silva et al., 2002). Thus, conceptualizing social exclusion/inclusion is essential to understanding the psychosocial rehabilitation process of an individual with psychiatric disorders and the differences in mental health models of care.

The process of social exclusion/inclusion is multi-dimensional and determined by diverse factors. It is important to recognize that it is not an intervention or treatment, but rather a set of values and principles which guide policies, culture, attitudes and practice (Friedli and Gale, 2002). Social inclusion is a process of promoting rights, access, choice and participation. For individuals with mental health problems, this also means access to the best possible forms of treatment. Social inclusion is related to the possibility of the individual achieving more self-actualization in life and forming part of the community (Greatley and Ford, 2002).

In addition, social inclusion is about empowering individuals with mental illness to define and manage their own lives. The focus needs to be on the individual, with the aim of coordinating the opportunities available in the community with what is most appropriate for the individual in question (Bates and Repper, 2001).

Everyone, including those with mental health problems, is entitled to good health, to be able to develop their skills, to receive a salary and live a satisfying life within the community. Citizens have a right to a good quality of life, with what modern society can offer (Bates et al., 2002).

According to Huxley and Thornicroft (2003), the concept of social exclusion has two aspects: on the one hand, citizenship, on the other, the community, with shared values, identity and belonging through

participation as a member of groups or in social communities.

Although integration into the community is essential, constructing citizenship is very effective in the process of social inclusion. Some indicators of citizenship are social security, a job, a home, health care, education and access to community services (Huxley and Thornicroft, 2003).

Social inclusion can also be defined in terms of a circuit which increases the right to access to the economic and social world, to new opportunities, to recovering their place in society and to reducing the impact of disabilities (Sayce, 2001).

Citizens' rights and access to the opportunities present in society are indicators of social inclusion and also the objectives of Psycho-social rehabilitation, a question of being treated by mental health care services.

In this context, mental health care services should attend not only to symptoms but also to issues such as home, work, education, free time and networks of relationships with friends, neighbors and family (Bates et al., 2002).

After falling mentally ill, there is a break with normal life; often, social relationships and day-to-day activities change or simply cease to exist. Therefore, mental illness can be viewed as impossibility and emptiness, related to the loss of everyday life as it was before. The processes of psychosocial rehabilitation and social inclusion seek to recover, together with the people with mental health problems, important activities and relationships, constructing an aware and satisfactory everyday life.

Individuals suffering from mental health problems need to deal with the problems they face in all areas of life, keeping control of their lives, being able to make decisions and follow their interests. It is necessary to deal with a variety of losses provoked by mental illness, to deal with the process of sadness and the challenge of lack of hope. Everyone needs to have a meaning to their life, to feel valued and have a positive self-image (Perkins and Repper, 2003).

When living in the community, people with mental health problems face the challenge of creating social inclusion, a complex process which involves different aspects of everyday life.

Summarizing the concept of social exclusion/

inclusion schematically, below are shown the basic concepts which characterize the process of social exclusion/inclusion. The "dimensions of social inclusion" are the principle axes in identifying the process of social exclusion/inclusion; the singular level is related to how this axis influences the individual's everyday life; whereas the collective level refers to the relationship of this axis with social organization, the productive system and the legal system.

This separation between the singular level and the collective level is not a water tight metaphor but rather illustrative, as the everyday lives of the subjects are directly related to social organization, the productive system and the legal system. Moreover, the different dimensions of social inclusion are related and linked between themselves.

Social representation of social inclusion and of becoming mentally ill demonstrate the way of thinking of social groups, which reflect the way in which the relationships with people with mental health problems are established.

Social representation, concerning the ideas, conceptions and world views the social actors have of reality, are of fundamental importance in understanding and analyzing social reality, in which they produce social inclusion/exclusion. The way of thinking is a form of society's expression, which determines both positive and negative effects on everyday life.

Whether the masses follow, or not, an ideology is the way in which the historicity of the way of thinking is verified. The philosophy of an era represents the history of that era, and history and philosophy are inseparable (Gramsci, 1978).

Everyone develops an intellectual activity, participates in a conception of the world, possesses a line of moral conduct, contributing to maintaining or modifying the way of conceiving the world, i.e., encouraging new ways of thinking. Each social group which appears in history finds pre-existing intellectual categories, a historical continuity which is uninterrupted even by the most radical changes in the existing social forms (Gramsci, 1989).

Thus, this article aims to identify and analyze the conceptions expressed by people with mental health problems and those in their social network

**Table 1 - Dimensions of social inclusion on singular and collective levels**

Dimensions of social inclusion	Singular level	Collective level
Material possibilities	Quality of life Food Clothing Paying monthly bills Self-esteem	Home Income Social care
Work	Inter-personal contact Status and social identity Structured way of passing time Feeling of self-actualization Salary	Formal employment Casual work
Significant activities	Maternity Sport Environmental activism Joining a church Arts Other	Leisure Hobby Voluntary work School
Social support network	Friends Family Neighbors Conjugal life	Church NGO Commerce Local institutions
Citizenship	Access to services Health care Education Social security Welfare Right to vote Freedom of expression Religious freedom Right to enter and leave the territory Right to be different	Civil rights Political rights Social rights Home Income
Conducting your own life	Reconstructing a meaningful and satisfactory life Having a goal in life Feeling valued Engaging in roles, relationships and activities which they deem important Making personal choices Be the subject of their own narrative	Deal with the limits and make use of the possibilities offered by the social context

on social inclusion and becoming mentally ill, from the perspective of how they perceive the possibilities of social inclusion for individuals suffering from mental health problems.

## Methodology

The methodology used in this research was a qualitative approach. Ágnes Heller's Theory of Everyday Life was used as the philosophical framework supporting the development of the research. In

modern life, the human condition lies in everyday life, composed of constant and variable models. Regularity, uniformity and repetition give order to life and come to characterize themselves as models of links between living beings. If the models change, everyday life will also change (Heller, 1991).

In everyday life, the activities with which we make up the world and the activities which we make up ourselves coincide. For the majority, life is everyday life (Heller, 2002).

The subjects of this investigation were people

with mental health problems, users of a CAPS II (Psychosocial Care Center) in the west of São Paulo, who were living in the community and facing the challenge of social inclusion and constructing a meaningful life.

The director of the service was asked to identify CAPS actions which aimed to encourage social inclusion. Four workshops were identified; the Baking, Recycling, Secondhand Shop and the Creative group workshops. In total, 24 users attended these workshops.

Of the CAPS users who took part in these activities, the following were selected: those who had been registered with the institution for more than one year; those who were aware, oriented in space and time, without moderate to serious cognitive deficiency, able to understand and respond to questions; who agreed and were willing to participate in the research and who were present on the days on which data were collected. Thus, 17 interviews took place with CAPS users, aged between 29 and 71 years old.

Each interviewee was asked to indicate one person in their social network to take part in the research, excluding members of the CAPS team. These individuals provided reports on the social inclusion of the users from the point of view of the community.

Of the 17 CAPS users interviewed, two did not want to identify anyone to be interviewed, two reported not having anyone available to be interviewed and one of the indicated individuals declined to participate in the research. Thus, 12 interviews were carried out with individuals from the users' network of relationships, aged between 36 and 68 years old. In total, 29 interviews took place, 17 with users and 12 with individuals from their social network.

Semi-structured interviews with the CAPS users and the individuals who were part of their social network were used to collect the data. The interview aimed to obtain information contained in the dialogues of the participants as subjects and objects of research living in a specific reality which being focused on. It is a means of collecting data on a specific scientific topic (Cruz Neto, 2004).

The project was approved by the Research Ethics Committee of the Municipal Health Department, which authorized the study to be carried out. The interviewees signed a consent form, authorizing

the use of the data collected in the research, and the confidentiality of participants' identities was guaranteed.

Data were assessed using discourse analysis, which takes into account linguistic material: what is said, how it is said and the circumstances in which it is said. Based on the raw material, a discursive object is constructed in which what is said in the discourse is analyzed in relation to what is said in other discourses, in different conditions, influenced by different discursive memory (Orlandi, 2007).

Discourse analysis was used to reflect on the mentally ill individual's way of thinking and living, developing a work which encompassed the human being, their history and their social context. Based on the discourse analysis, we sought to uncover the essence of conceptions of social inclusion/exclusion and of mental illness.

The analysis process begins by establishing a corpus, which is composed depending on the nature of the material and the organizing question. When configuring the corpus, the limits are set and shaped, in the same way as a first draft of an analysis is made, revising concepts and notions (Orlandi, 2007).

In the discourse analysis methodology, repeated readings of the discourse take place; the structure of the text is analyzed; the subjects' values, beliefs and concepts are identified; arguments present in the discourse are identified and empirical categories emerging from isolated themes are identified (Florin e Savioli, 1999). In this study, the following empirical categories were identified: the inclusion/exclusion process, social networks and mental health care. This article deals with the first empirical category: the process of social inclusion/exclusion.

## Results and discussion

### Social representation of social inclusion

In the course of the interviews, it was possible to uncover the subjects' concepts of what social inclusion is. They reported how difficult it is to identify the threshold between being included or excluded, which is consistent with the concept of social inclusion as a process, and which individuals experience being excluded to a greater or lesser extent, or partially included, during their lives.

Social inclusion is dynamic, in addition to being multi-dimensional, and changes over time; it is both objective and subjective, at the same time (Huxley et al., 2008). The “social inclusion/exclusion dialectic produces specific subjectivities which range from feeling included to feeling discriminated against and rejected. This subjectivity cannot be explained merely by an economic determination”, they manifest themselves in everyday life as identity, sociability and affection (Sawaia, 2007, p. 9).

The following sentence exemplifies this dynamic, between feeling included or excluded, experiencing a non-linear process:

*U12 ph 15<sup>2</sup>: [on feeling included in society] This is so difficult, it is so difficult to be included in society, it seems like we are, it seems like we're not, you know? It's difficult.*

When trying to conceptualize social inclusion, the users reported that participation in the job market is a central element of social inclusion. According to Xiberras (1996, p. 28), those who refuse or are unable to participate in the job market are perceived as excluded, “unemployment underlines inability to participate in the market of production”.

Work is fundamental to social inclusion and for life, for the majority of people. For the excluded, due to mental illness, work is even more important as it can decrease isolation, giving meaning to the day and an identity to the worker (Perkins and Repper, 2003).

*U11 ph 16: [On social inclusion] A good job. A profession.*

*U9 ph 87: It is important to have a good job. It helps... Because in society... If you work, if you are a professional, you are included.*

In addition to work, the study also identified how important education is to social inclusion. Xiberras (1996) stated that education establishes an itinerary of normality; at each stage, if the required level is not reached, poor performance at school leads to special classes - and this is the first category of exclusion. Thus, opportunities to study can be the focus of Psychosocial Rehabilitation, seeking to increase

and make use of the possibilities of the context according to the users' singular therapeutic project.

*U9 ph 80: [On social inclusion] It's not about intelligence, it's about whether he studied, whether he went to university.*

*U13 ph 28: [if I were included in society] I would be studying, getting better results.*

Another aspect which came out of the discourses on inclusion was the importance of having an income, bearing in mind that the society we live is considered a consumerist society, and that income allows a life of dignity, independence and access to the possibilities available in the context. Bertram (2008) states that mental health service users consider having their basic needs met as one of the criteria for social inclusion.

Poverty represents the inability to participate in the consumer market, “the first form of exclusion consists in breaking the economic tie which faithfully, or normatively, links the participants to the model of society” (Xiberras, 1996, p. 28). Moreover, income is an element which multiplies opportunities for the user to participate; by having an income, an individual has access to leisure options and other activities, opportunities for social inclusion unfold.

*U10 ph 26: If I had a large income, then I would be able to go out and have fun, to travel, then I would be included in society. But the way things are, I don't think so.*

*U16 ph 13: [To be included] An individual needs at least an income to survive with dignity, to be able to buy the things they need and be more independent.*

Income was also reported as a possibility for social inclusion, not only because it provides access to material goods and to activities, but because it enables autonomy, not depending on others to survive. According to Rodrigues et al (2006, p. 243), it is evident that autonomy is intrinsically linked to the source of income, that the subject may receive a “quantity sufficient to feel they have the contractual power enabling them to participate in social exchanges, in which the subject is perceived as having positive characteristics”, which are indicators of credibility.

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<sup>2</sup> The letter U refers to the users, and the letter R to members of their social network. fr refers to the sentence and the number of the sentence in the interviewees statement. Thus, U12 fr 15 signifies user 12, sentence number 15.

Financial autonomy is especially valued by those in the social networks of users who, due to advanced age or to changes in life, at some point can no longer help the user. Thus, the possibility of becoming a professional is considered a relevant aspect, taking the user away from being financially dependent on family or on individuals in their social network.

R8 es 114: Because I think he can get a place. To support himself, because we [aunt] are here today, but we don't know if we'll be here tomorrow, you know?

It was also reported that the possibility of going to different places is something that has a positive influence on the process of social inclusion. Xiberas (1996, p. 22) states that the excluded is someone who is "rejected from our spaces, from material and symbolic markets, outside of our values".

*U10 ph 28: Meeting new people, going out, travelling. I would like to go to new places, travel, know Brazil a bit better. I would really like that.*

*U11 ph 17: [On social inclusion] I think that's it [work]. And wanting to go out, to have fun, you know? To have an active life. To visit new places and meet new people.*

Social networks were also described as important aspects in constructing social inclusion. The possibility of having friends and living among others was something the interviewees considered a factor which positively influenced social inclusion. According to Bertram (2008), one of the aspects which defined social inclusion for mental health care users was belonging to a social network, having the support of others and, at the same time, being needed by others.

In the social inclusion project, the social distance between those considered "healthy" and those considered "crazy" or "strange" diminishes. Individuals learn that having a mental health problems does not mean that that person can no longer contribute as a friend, colleague, boy/girlfriend or parent (Sayce, 2000).

*R4 ph 29: Inclusion is living among everyone else; participating in life and in society, being there.*

*R15 ph 45:[On social inclusion]I think that it is important for him to feel wanted in his surroundings.*

Another issue highlighted as significant in the social inclusion process was the possibility of the individual feeling important, capable, someone who has contractual power in exchanges, who can decide things about their own life and enjoy the possibilities provided by the social context. When constructing social inclusion, social participation and the possibility of living autonomously is important.

True social inclusion will only be reached by valuing the contribution that individuals make to society, because the fact of someone suffering a mental health problem does not mean they cannot contribute (Stickley, 2005). For the user to feel truly included, they need to believe in their own value to society (Bertram, 2008).

Individuals in the users' social networks exemplify that the hegemonic thinking, that all individuals with mental illness are incapable, is contradictory to the concept of social inclusion.

*R16 ph 53: [On social inclusion] You take a citizen who had nothing and show him what he is capable of. Make him believe in himself, that he has hidden potential.*

*R13 ph 59: I think that the individual has to be viewed as someone who is important within their social, political and economic context; in the community in which they live, you know?*

Accepting difference between individuals was also reported by the individuals in the social network as an important factor in encouraging inclusion. This social change may occur as a result of decreases in stigma and prejudice regarding mental illness. Thus, the way society deals with difference needs to be worked on, constructing an embracing social context which allows and facilitates life and free movement for everyone. Bertram (2008) found that users believing that they have value for what they are, and acceptance of difference, are important topics in social inclusion.

*R15 ph 60: I think that it depends on the tolerance of other people. In social life, people can go to clubs...*

*R8 ph 110: Because lots of people don't yet understand this, you know? That a person with some type of disability has to have a place in society like in any other place.*

The interviewees, users and individuals from their social network, showed a perception of social inclusion which was in line with the literature, valuing aspects such as work, education, income, social networks, contractual power and accepting difference. The concept that everyone could participate in community life was found. This evinces advances towards social inclusion for all individuals in society.

However, it is worth remembering Spandler (2007)'s criticism on being careful that the concept of inclusion not be the next regulator of behavior for individuals with mental health problems. According to the author, common sense on social inclusion assumes that those with mental health problems want to be involved and participate in society, and that this is undeniably good.

It is necessary to be careful not to focus on transforming individuals' choices instead of focusing on transforming the social context which had limited their ability to choose. Social inclusion must not impose choices which are more desirable than other; for example, overvaluing work as something which all should aspire to. It is necessary not to turn social inclusion into another form of treatment which is imposed on users for their own good; social inclusion must not become a new form of normalization (Spandler, 2007).

### **Social representation of mental illness**

Despite familiarity with the concept of social inclusion, the interviewees, especially those from the users' social networks, highlighted the lack of knowledge of mental illness, demonstrating that the topic is still not widely discussed by society. Other research has also found this data, such as Pereira (2003), who reported that, for families, there is an unknown with regards mental illness; no one really knows what it is, and this lack of knowledge results in the idea of being adrift, with no chance of constructing a better life.

Thus, contact with people with mental health problems often means entering into contact with a stranger; which can generate fear, apprehension, distress and anxiety.

Stigmatizing attitudes towards people with mental health problems "are based on stereotypes which

grow up where there is inadequate knowledge" (Leff and Warner, 2006, p. 69), or where there is little contact with individuals suffering from mental health problems, which would correct them.

Considering that the majority of people with mental health problems live for a long time excluded from society, institutionalized in asylums, many people in the users' social network have no past experience or reference with which to deal with the situation. In these cases, there are no "precedents". According to Heller (2000), precedents are important in having knowledge of a situation, being an indicator for behavior and attitudes; it is the use of examples and experiences which occurred in the past. However, the lack of precedents is not necessarily negative, as it leaves space for the new, to create something different to that which has already occurred.

*R4 ph 16: Mental illness was always something distant. Because I never knew anybody who had this problem. It was like it was made up.*

*R5 ph 53: I never heard anything about it, I didn't know anything [on treatment for mental illness].*

*R9 ph 27: When he suffered his first crisis and I didn't know what was happening, and we went to the doctor and the neurologist; and no one knew what it was, and they told us it was this, it was that...*

The users revealed the prejudices toward mental illness encountered in society. Thus, it is possible that there is a tendency for the lack of precedents and lack of knowledge about mental illness to become prejudice, or that the reference to mental illness being based on the asylum model. According to Heller (2002), prejudice is a category of thinking and everyday behavior, it is an ultra-generalization, a provisory judgment based on belief. In ultra-generalizations, we take on stereotypes and schemata created by others, imposed on us by the media in which we grow up. Every ultra-generalization is a provisory judgment or rules of behavior.

Provisory judgment anticipates possible activity and is not always confirmed in practice. Provisory judgments may show confidence affect, based on knowledge, which can be refuted by thinking or by experience, and are not prejudices. On the



other hand, provisory judgment may show belief affect, “the belief is in conflict with knowledge, it withstands shocks to the thinking and experience which control it” (Heller, 2000, p. 48). We assimilate prejudices from the environment and apply them spontaneously to concrete cases.

In the struggle against prejudice towards mental illness, Sayce (2000) states that we should be careful how we use the word stigma, which implies that there is something wrong with the individuals, and prefers the word discrimination, which places the onus on the person, or group or people, who have the discriminatory attitude. The “shame” should not be on the users but rather on those who behave unfairly towards them.

*U14 ph 45: In that way, people don't know us properly and have a bad opinion of us. They think we're all crazy and not to be trusted. That's how it goes...*

*U11 ph 20: They call those of us with mental illness crazy, that sort of thing. It's a pain to find yourself in a situation like that. I get irritated, but I stay calm, I go, avoid the situation.*

Prejudices are provoked by social interactions in which man lives, serving to consolidate and maintain the stability and cohesion of the given integration. “Looking down on the ‘other’, hatred of what is different, are as old as humanity itself”. Those predisposed to prejudice label what is around them and place it within a group stereotype, unable to correct provisory judgment formulated based on previous experience (Heller, 2000, p. 55).

All prejudice reduces freedom of choice, as it twists and narrows the real margin of individual alternative. Prejudices cannot be totally eliminated from social development, “but it is possible to eliminate the rigidity and - most importantly - the discriminatory effects of prejudice” (Heller, 2000, p. 59).

Prejudiced provisory judgment, not based on reason, gives us the idea that the mentally ill are dangerous and aggressive. This concept has been widely divulged in society by the media, establishing itself as common sense.

The image of the disturbed killer, “psychotic”, is repeatedly given a vehicle in newspapers and films, suggesting the link between craziness and danger, forming a group of “others” who need to be feared

(Sayce, 2000). The information generally presented in the public domain emphasizes the danger of violence from individuals with mental disorders, to the exclusion of practically any other aspect of these individuals (Thornicroft, 2006).

*R4 ph22: It was something we were afraid of [segregation of the user]. Because I was one of those people who was scared of them [people with mental health problems].*

*R16 ph 83: For the community, he is crazy, a psychopath, a rapist. That is how they see him.*

*R9 ph 32: Because he's had psychiatric treatment, they think he's crazy, mad, that he will go around attacking, causing fights and I don't know what. So, it's important that there's no discrimination.*

Despite this ultra-generalization, established in society, that everyone with mental illness is potentially dangerous, this information is not confirmed in academic studies, ratifying that it is an idea based on belief, not knowledge, in other words, it has the characteristics of a prejudice. According to Leff and Warner (2006, p. 51), only “a tiny proportion of the mentally ill commit violent crimes, only a small amount of these commit homicide, and their family and friends who run much more risk of being attacked” than strangers.

Thus, the public perception that people with mental health problems are dangerous is a perception based on common sense, constructed over a period of more than two hundred years of institutionalizing and imprisoning the mad. For centuries, psychiatry isolated the mad as they were considered dangerous, constructing an ideology that all people with mental health problems were dangerous.

Psychiatric hospitals originated from the concept that people with mental health problems were dangerous, created based on the prevailing ideology and reaffirmed and divulged in society, establishing itself as common sense. According to Basaglia (2005, p. 47), the function of the psychiatric institute is not to treat the ill but to “protect the sane from the excesses and dangers of the mad”, the mentally ill are considered a danger to themselves and to others and the rules of psychiatric hospitals are built on this dangerousness.

However, despite the concern created in society

on the aggression of the mentally ill, it is much more likely that these individuals are themselves victims of aggression, rather than aggressors; studies show that they are more frequently the target of verbal or physical aggression than the general population (Thornicroft, 2006).

*R16 ph 89: Because, normally, someone with a psychiatric problem, who takes their medication, I never heard of one attacking someone, trying to kill or rape someone. I never heard of that happening.*

Moreover, it was also reported how the concept of mental illness brought with it the idea of incapacity and incompetence. According to Perkins and Repper (2003), the majority of the population has negative images of mental illness as shown in the media: people with mental health problems tend to be viewed as incompetent, incapable of participating in society and making their own decisions. According to Sayce (2000), over the last few years it has been possible to transform the location and organization of mental health services; thus, opportunities are given to people with mental health problems; however, the idea that these individuals are inferior has still not been challenged, impeding access to complete citizenship.

*R9 ph 55: There are many people who do not have this opportunity, or "Imagine, that one there the stuff doesn't go in", and it does go in, slowly, but it goes in. slowly, but they get there.*

*R12 ph 15: [On being able to rely on the user] For the things needed in life... Erm... It is something I discovered recently, because, to be honest, I saw it like this... As a person I had to look after, you know?*

Society has negative associations with mental illness, which have been introduced over time, forming concepts of mental illness. The asylum model which, for a long time, was prevalent in psychiatric history, encouraged this way of understanding madness as something which was purely negative, by separating people with mental health problems from society, declaring them incapable of social living. This form of treatment helped to create the image of someone with mental health problems as someone to be feared and excluded.

Even as the process of decreasing beds in psychiatric hospitals was advanced and people with

mental health problems are more and more frequently living in society, the legacy created by those years of exclusion and prejudice towards the mentally ill still persists, a negative and hopeless vision of the mentally ill having been established in society.

The images of madness in Western culture make it clear that mental illness should be avoided or denied, as it is difficult to view someone as "crazy" and, at the same time, as someone with value and with a future worth living (Sayce, 2000). An individual diagnosed with mental illness can expect to suffer discrimination, and this expectation in itself can cause disabilities, evinced in the negative consequences of the labels received by psychiatric diagnosis (Thornicroft, 2006).

*R4 ph 17: Since I was a child... I lived in the countryside. And there was a train which passed once a month, and it had a carriage with bars. And I was scared of that train. Because the adults said that it was the crazies' train, the train of death. This train went to an asylum in Minas Gerais. And every time that train went past people said, "Ah, that one there's not coming back". And I grew up thinking that mental illness was something to do with dying. Until it appeared in my family, in my son. And the first thing that we, my husband and I, thought about was not to segregate M. We were so scared of him being segregated. For us, he was going to get on the train of death [cries]...*

It is worth remembering that perceptions of the world are characteristic of each era, they are not unchangeable, but rather change over time. Therefore, it cannot be said that these concepts of mental illness are fixed, with no chance of being changed; the seed of change may already have been sown.

According to Gramsci (1978, p. 40), what each individual can change is very little in relation to their efforts; however, "as the individual can associate to everyone that wants the same change; and; if the change is rational, the individual can multiply themselves" a great number of times, obtaining a much more radical result than what seemed possible.

## Final considerations

In order to construct the social inclusion of people with mental health problems in society, the cultu-

ral legacy which established the concept that the mentally ill should be feared and excluded needs to be dealt with, facing up to prejudices and creating new possibilities of understanding mental illness.

Advances in concepts of social inclusion, which are becoming established in society, are a strong ally in transforming concepts about mental illness, as social inclusion assumes a society which is inclusive to everyone, with no exceptions. This advance in concepts of social inclusion should be used as the basis for mental health care policies and to construct practice which would increase the possibilities of social inclusion for the mentally ill, in the context within which they live, always taking into account their choices and their personal life project.

In addition to this, another form of contributing, of changing conception of the possibilities of social inclusion for this population, is using successful people with mental health problems as examples, those who have, in one way or another, experienced social inclusion making it evident that they are people capable of studying, working, having friends and looking after their children. Thus, it is possible to encourage a new social representation of madness, created based on rationality and experience.

This is a strategy that could also be used in training CAPS professionals. According to Leão and Barros (2008, p. 102), they observed “difficulties in the day-to-day aspects of the service, due to lack of training on the part of the mental health care professionals in acting from a psychosocial care perspective, requiring greater knowledge”. The mental health care professionals and service users need to believe that people with mental health problems are capable of constructing a meaningful everyday life, to, in fact, follow paths which lead to social inclusion.

On experiencing this process of social inclusion, these individuals may become examples who influence the individuals around them to transform their social views of mental illness. Moreover, health care professionals will be empowered to multiply actions which encourage social inclusion of people with mental health problems.

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