
THE STIGMA OF MENTAL ILLNESSES AND THE THERAPEUTIC RESIDENCES IN THE TOWN OF VOLTA REDONDA-RJ

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ABSTRACT: This research aims to characterize the stigma experienced by patients with mental disorders and health professionals during the implementation process of the Therapeutic Residences, as well as to analyze the nursing staff's performance in overcoming those obstacles and implementing those Residences. A qualitative socio-historical research was undertaken. Its primary sources consisted of written documents and six interviews. The theoretical reference that supported the result analysis was the author Erving Goffman. It was observed that the social stigma resulted in some social actors' resistance against the implementation and permanence of the Therapeutic Residences, involving not only neighbors of the therapeutic residences, but also the effect on property rentals. Additionally, a professional identity crisis was observed. It was concluded that the nurse played a key role by interfering in the stigmatization process of mental disorder patients and of mental health professionals, showing that changing the form of care delivery could represent an innovation.

DESCRIPTORS: History of nursing. Assisted living facilities. Social stigma.

O ESTIGMA DA DOENÇA MENTAL E AS RESIDÊNCIAS TERAPÊUTICAS NO MUNICÍPIO DE VOLTA REDONDA-RJ

RESUMO: Os objetivos desta pesquisa são caracterizar o estigma vivenciado por portadores de transtorno mental e profissionais de saúde, durante o processo de implantação das Residências Terapêuticas; e analisar a atuação da equipe de enfermagem para a transposição destes obstáculos e implantação das mesmas. É uma pesquisa qualitativa de cunho histórico-social. As fontes primárias foram constituídas de documentos escritos e seis entrevistas. O referencial teórico para análise dos resultados foi o autor Erving Goffman. Observou-se que o estigma social resultou na resistência de alguns atores sociais para implantação e permanência das Residências Terapêuticas, tanto por parte dos moradores próximos as mesmas quanto para o aluguel destes imóveis. Também se evidenciou crise de identidade profissional. Concluiu-se que o enfermeiro teve papel fundamental ao interferir no processo de estigmatização ao portador de transtorno mental e aos profissionais de saúde mental, mostrando que a mudança na forma da assistência prestada seria uma inovação.

DESCRIPTORIOS: Historia da enfermagem. Moradias assistidas. Estigma social.

EL ESTIGMA DE LA ENFERMEDAD MENTAL Y LAS RESIDENCIAS TERAPÉUTICAS EN LA CIUDAD DE VOLTA REDONDA-RJ

RESUMEN: Los objetivos de esta investigación son caracterizar el estigma vivido por portadores de trastorno mental y profesionales de salud durante el proceso de implantación de las Residencias Terapêuticas; y analizar la actuación del equipo de enfermería para la transposición de estos obstáculos e implantación de las mismas. Se trata de una investigación cualitativa de cunho histórico y social. Las fuentes primarias fueron constituídas de documentos escritos y seis entrevistas. El referencial teórico para análisis de los resultados fue el autor Erving Goffman. Se ha observado que el estigma social resultó en la resistencia de algunos actores sociales para implantación y permanencia de las Residencias Terapêuticas, tanto por los residentes cercanos a la misma como el alquiler de estas propiedades. También se demostró crisis de identidad profesional. Se concluyó que el enfermero tuvo papel fundamental al interferir en el proceso de estigmatización al portador de trastorno mental y a los profesionales de salud mental, mostrando que el cambio en la forma de atención prestada sería una innovación.

DESCRIPTORIOS: Historia de la enfermería. Instituciones de vida asistida. Estigma social.

INTRODUCTION

As they do not permeate the human premises of reason, mental disorder patients have long been treated as mad, dangerous, libertine and, therefore, severed from society and family contact, often turning into beggars or living in hospices.¹

This view on mental disorder patients contributed to the development of a stigma, making them different from other people. Thus, it interfered in their relations with society, in different social contexts. This phenomenon is still perceived today. Stigma can be understood as “[...] the situation of the individual who is disqualified for complete social acceptance”.^{2:11} Hence, it is used to refer to a depreciative attribute.

Based on the implementation process of the Psychiatric Reform in Brazil, which initiated in the 1980's, this reality started to be contested¹. This demands conceptual changes in knowledge and changes in the care model delivered to this clientele, as traditional psychiatric care practices have shown to be inhuman and outdated.³

As one of the alternatives to redirect this model in Brazil, in the 1980's, *Lares Abridados* were founded to humanize the treatment in asylum institutions and, thus, to get rid of the hospital characteristics and seek autonomy and new contacts in the social spaces. This initiative involved taking the mental disorder patients from the infirmary and including them into a Home, making the teams working in these spaces responsible for intermediating the relation between the Home, the local care network and the health professional in that network. Hence, this proposal did not characterize these devices as health care institutions but as housing.⁴

Over the years, this proposal has gained new names, such as: assisted housing; extra-hospital housing; therapeutic pensions, among others. Despite these name changes, one common point is that all of these models attempted to replace psychiatric internment by a housing alternative.⁴ The most recent model the Ministry of Health has established in Decree 106/00 is called Therapeutic Residence Services, better known as Therapeutic Residences.⁵

According to recommendations by the Ministry of Health, this service can benefit mental disorder patients discharged from psychiatric hospitals; patients discharged from custody hospitals by a court decision; people monitored by Psychosocial Care Centers (CAPS) with housing

problems identified by the team, and street dwellers with severe mental disorders. The therapeutic residences are houses, located in the urban area, whose functioning needs to be understood as a housing instead of a health service.⁵⁻⁶

The therapeutic residences are articulated with the other devices in the extra-hospital care network, including: beds reserved in General Hospitals; Family Health Strategy (ESF); Residents' Association; Community Centers and CAPS, with a view to guaranteeing comprehensive care to users.⁷ As opposed to this restructuring model of the health care model for mental disorder patients, this group has been confronted with stigma in function of the mental illness, which makes it even more difficult for these users to gain autonomy and practice their citizenship. The stigma is conditioned by the deviation from characteristics that were previously established by a majority group, whose members do not take distance from these characteristics and consider themselves normal.²

In that sense, the participation of people who seem weird to the eyes of those who hegemonically inhabit that social space allows those who identify themselves as normal to categorize the weird according to their attributes and characteristics, and thus establish their “social identity”.^{2:12}

In this context, in 2009, the implementation of therapeutic residences started in Volta Redonda, a city in the South of the State of Rio de Janeiro, as a housing alternative for patients discharged, due to the closure of the *Casa de Saúde Volta Redonda*, a private psychiatric institution affiliated with the Unified Health System (SUS).⁸

The implementation of the residences was possible as the other extra-hospital care network devices were already functioning.⁸ The municipal authorities and mental health professionals faced some difficulties though, as a result of the stigma raised against mental disorder patients, with a view to the implementation of Therapeutic Residences in Volta Redonda-RJ.

Therefore, in order to understand the historical phenomena surrounding the stigma against mental disorder patients referent to the reintegration in social life, this study is focused on: nursing actions in view of the stigma against mental disorder patients during the implementation of the Therapeutic Residences in Volta Redonda-RJ. The aims were to characterize the stigma mental disorder patients and health professionals experienced during the implementation process of the therapeutic residences in Volta Redonda and to

analyze the nursing team's actions to overcome these obstacles and implement the Therapeutic Residences.

METHOD

A qualitative and socio-historical research was undertaken. The latter is considered as a synthesis and permits reaffirming the principle that, in history, all approaches are part of the social context and are interconnected, with a view to formulating problems about the collective actors, which comprise the relations and behavior among different social groups, also emphasizing the social dynamics.⁹

The primary sources consisted of written documents, including laws, decrees and reports. In addition, interviews were held with six professionals who participated in the creation and implementation process of the therapeutic residences, using a semistructured script. The interview contents were fully transcribed.

To guarantee the interviewees' anonymity, they were identified by their function and a code: Social Worker (E1); Nurse, Coordinator of the municipal Mental Health Program (E2); CAPS Nurse (E3); Family Health Strategy Nurse (E4); Nursing Technician (E5); Recreation Professional (E6). All professionals were selected who directly participated in the implementation process of the Therapeutic Residences in Volta Redonda-RJ.

The secondary sources were papers indexed in the Electronic Library SciELO and in books on psychiatric care and psychiatric nursing.

To understand the collected data, they went through a process of consecutive reading and detailed analysis, in the attempt to establish a dialogue among the different sources. After analyzing the data and identifying relevant common points, the collected information resulted in categories.

The theoretical framework for this study was based on the author Erving Goffman, in his work: *Stigma - Notes on the Management of Spoiled Identity*,² in which the author presents the attitudes of people who consider themselves normal towards people with a stigma, and the acts towards them "are well known, since these responses are what benevolent social action is designed to soften and ameliorate. [...] On this assumption, we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life changes".^{2:14-15} These attitudes and reactions are disclosed when we place the implementation

process of the Therapeutic Residences in Volta Redonda-RJ in its historical context.

It should be highlighted that, in compliance with National Health Council Resolution 196/96, this study was submitted to the Research Ethics Committee at *Escola de Enfermagem Anna Nery/Hospital Escola São Francisco de Assis* on March 18th 2011 and approved, as registered in protocol 015/2011.

RESULTS AND DISCUSSION

Resistance against the implementation and permanence of the therapeutic residences in the neighborhoods

The therapeutic residences were a strategy to reallocate the mental disorder patients hospitalized at *Casa de Saúde Volta Redonda*. Since February 1994, this was the sole psychiatric institution that delivered care to mental disorder patients in the city. As it did not comply with the Ministry of Health standards, as established in Decree 88/93,¹⁰ the institution spent many years under municipal intervention (1994-2009) and had to be closed in 2009 by a court decision.⁸

Therefore, to avoid that the patients discharged would be left to fend for themselves and to accompany the paradigm change from traditional psychiatry to a mental health model based in the extra-hospital care network, in 2009, three therapeutic residences were created in Volta Redonda-RJ.

The users' transfer process from a psychiatric hospital institution to the therapeutic residences requires that they are in mental conditions to establish new bonds, which permit their social reinsertion integrated in the cultural context and the community, as they are confronted with an organization of the city's space that differs from the period before their long internment.¹¹ Society also faces difficulties to accept this social transformation, due to the stigma and depreciative attributes linked to mental disorder patients. The following excerpts support this assertion:

[...] *people are very scared, prejudiced and face difficulties to accept these people's exit from hospital* (E2).

I think that what we faced most was the people's prejudice (E5).

In addition, other challenges permeate the new daily reality of therapeutic residence users, as they need to establish social relations with

their neighbors, with local commerce, and need to recognize daily trajectories through the city, thus creating a feeling of inclusion in that territory.

This issue with the end of the hospital, the closing [...], and then their distribution in these residences to really get rid of this psychiatric patient label, to see if they can have a 'normal' life like other people (E4).

The stigma the mental disorder imputes on patients shows "an undesired differentness"^{2:12}, that is, different from what those who are considered normal people anticipated. Hence, society, or part of it, imprints the reduction from a "whole and usual person" to "a tainted, discounted one" on the mental disorder patients.^{2:12}

During the implementation process of the therapeutic residences in Volta Redonda-RJ, one of the initial phases was the search for house available for rent. In accordance with Ministry of Health Decree 106/00, these should offer three bedrooms.⁵

After finding these houses in a location that offers easy access to the other health services, the professionals involved in this process are confronted with other difficulties, as the real estate agents were resistant to rent the houses to the municipal authorities, as rent payment delays could represent legal expenses against the municipal government. In addition, the owners of the houses were resistant to rent their real estate when knowing that the tenants would be mental disorder patients, as described in the following testimonies:

[...] there were great difficulties to rent these houses [...]. According to the real estate agents, the municipal government does not pay the rent on time and they could not cast them out due to delayed rent because they're a public entity and that's why this process was so difficult (E6).

[...] it was a tremendous difficulty to get a house with three bedrooms, airy, large. Difficult because the real estate agents did not want to rent to the city or when they discovered that mental health patients were going to live in the house (E1).

[...] we are facing great difficulties with the real estate agents and the owners. When the real estate agent accepts to rent to the public service, most owners do not accept because it's for psychiatric patients (E2).

In one of the neighborhoods, the neighbors expressed the desire to remove the new dwellers through an undersigned.

[...] so, they wanted to do an undersigned so as not to allow these people to move there [...]. (E2).

They [neighbors] were mobilizing through an undersigned to remove these users [...]. (E6).

The neighbors did an undersigned, the neighbors were staring at the gate, at the window, they stood at the stairs to look inside the houses, in short... [...] (E3).

In this circumstance, an inhuman logic of social relations is revealed, as the stigmatization mental disorder patients suffer reflect their difficulty to get accepted by the hegemonic group in society, besides the non-recognition of their abilities and rights. This fact can be analyzed when considering that society divided people into categories, identified by the attributes their members have in common.² Then, when a stranger is met, a social identity can be established for that individual.

In view of the relation between the principle of Therapeutic Residence and psychosocial rehabilitation, the need for investments is highlighted with a view to enhancing the individuals' abilities, "reducing their disabilities and deficiency, and, for the mental disorder, the damage as well".^{12:449} Thus, the estrangement society feels towards these patients can be reduced.

The implementation of the therapeutic residences, still in its initial phase, caused another problem for the nursing technicians and municipal authorities, which is the difficulty the neighbors of the houses announced, mainly when the users had a crisis, as illustrated by the following testimony:

[...] some neighbors do not understand, they think that we're mistreating them [...] because they [neighbors] do not understand it when the patient has got a crisis, they think that it is nursing that is mistreating them [...]. So I think it's a prejudice because, if it were a normal house, you could yell, you could fight because you're at home, but there's this prejudice with psychiatric patients in therapeutic residences (E5).

[...] They [neighbors] filed several complaints, complaints that patients were yelling inside the house, that they were probably being mistreated and it was very hard (E3).

Similar sociological characteristics are found among the different types of stigma, including mental disorder patients.² In this case, the individual who "[...] might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us".^{2:14}

The professional identity crisis during the implementation of the therapeutic residences

According to the Ministry of Health's recommendations, a caregiver needs to be present in type

I therapeutic residences, a professional without a health education background. That professional's function is to help with daily housework, besides stimulating the users' autonomy, without reproducing the practices and routines of a psychiatric hospital. It should be highlighted that these residences serve for more autonomous patients who are less dependent on clinical care. In type II, on the other hand, the patients are more dependent on clinical care, in case of physical limitations for example, and are less autonomous, demanding the presence of a nursing technician around the clock, besides the caregiver.⁶

These caregivers not necessarily had to be trained professionals [...]. The caregiver was [...] the person who would be facilitating social life and some daily activities in the residence (E1).

In the initial phase of the creation and implementation of the Therapeutic Residences in Volta Redonda-RJ, some houses were similar to type I and type II. Nevertheless, the residences were unable to comply with all Ministry of Health recommendations, due to overcrowding, as three therapeutic residences were created in the city when the actual need to respond to the demand discharged from the *Casa de Saúde Volta Redonda* was four. Therefore, the residences were not registered in the Unified Health System (SUS) and, at the time, were funded with municipal resources only.

There were 29 patients at the Casa de Saúde Volta Redonda and, according to the Ministry of Health, each residence could house between six and eight users. Thus, four therapeutic residences were needed [...] (E1).

They are not registered because the number of people is higher than established in the decree, precisely because we need another house, there is one additional user in each residence. [...] these residences are being funded by the city plain and simply because they are not registered (E2).

[...] what we found out is that the municipal government was not receiving any funds without the accreditation. So, but how could we apply for accreditation if we did not have the fourth house? They were overcrowded [...] (E3).

The professionals working at the therapeutic residences could be hired as nursing technicians, independently of whether they were more similar to type I or II. In this case, there would be no further harm for the hiring of the nursing technicians at that time because, at the time of the implementation, the residences were not complying with all standards set for registration in the SUS. Hence, some additional adjustments were needed to have

this new mental health network device comply with the Ministry of Health's recommendations.

[...] so, it [therapeutic residence] would be implemented without accreditation because, if it were accredited, these people were not going to be hired as nursing technicians inside the residence but as caregivers [...] (E1).

[...] one of the main problems were faced was that we do not have the function of caregiver in our city [...]. The ideal would be to hire all caregivers, but we could not do that officially. So, we ended up making some adaptations, which caused a lot of confusion and surprise among the professionals themselves (E2).

At the residence where only the caregiver was established, that is, more similar to type I, the nursing technicians' functions would not be in accordance with their professional background. Their actions should be based on support and supervision of daily activities, the stimulation of autonomy to develop activities of daily living, and social reinsertion. Hence, the ability to bond and be receptive to the other was highlighted for care to actually be rehabilitating.¹³ In this context, the professional identity crisis emerged and the stigma based on the reclassification of the category this professional was inserted in.

[...] need to establish these caregivers as nursing technicians, due to these therapeutic residence users' limited degree of autonomy (E3).

Some technicians were questioning: well, I'm a nursing technician and I'll be hired as a caregiver? As if it took away the merit of their profession [...] (E1).

The nursing technicians' resistance towards the possibility of being hired as caregivers can be understood as a stigma against caregivers without a professional degree. And, in this specific case, they are defined as part of a political care project to take care of people with mental disorder in a domestic context.

In addition, discomfort was revealed for those nursing technicians who could only be hired as caregivers, that is, a conflict between the real social identity - category and attributes that effectively belong to this group - and the virtual social identity, as external attributes allocated to someone or a group.² This discomfort could influence the professional's involvement and commitment, aspects that are considered of "great value and also facilitators for people in mental suffering to be able to reconstruct and return to their own course".^{13:660}

As regards the type II residences, the hiring of the technicians did not represent a discrepancy

from Ministry of Health recommendations. These professionals should develop actions according to their professional education but, as no caregiver was hired, the technicians ended up accumulating this function.

Nurse activities during the implementation of the therapeutic residences

To minimize the stigma that marks mental disorder patients in the city, nurses and other health professionals involved in the negotiation process to put the rental of the houses in practice held meetings with the owners of these houses and oriented them about the changed paradigm in the mental health area. In addition, they demonstrated that the mental disorder patients were able to live in an urban area and were entitled to exercise their citizenship. This initiative is evidenced through the following testimonies:

[...] the secretary of health intervened, a meeting was held with the residents' association in these neighborhoods for them to understand a little, collaborate also with the users' arrival in these neighborhoods (E5).

[...] we talk to all of them [owners], we explain and show. One of the houses that is rented today, the owner came to us with everything ready, just missing his signature, saying that he did not want those people living in this house because they were going to destroy, they were going to break it. Those things everyone has because of a lack of knowledge. I talked to him, I showed pictures and after this whole process he decided to rent, but not everyone decides to rent after this knowledge interaction process, this conversation (E2).

To overcome this obstacle to the users' stay at the residences, meetings were also held with the neighborhood residents' association, with a view to demonstrating the need to maintain these establishments, explain their functioning and emphasize that the presence of these inhabitants would not devalue the neighborhood and should be understood as an innovative strategy implemented there. The following testimonies illustrated this phenomenon.

[...] as we were already working, we intensified this work through different meetings in the community, using the space of churches to calm down the people from the community and get to know the patients a little (E2).

We are working with the community service secretary, secretary of sports and leisure, we're now going to start working with the secretary of culture,

we are doing educational activities. [...] because this issue of dealing with the mad is not that simple for the population and, today, there are already people in the community defending the cause, people from the community, there's a residents' association we are involved in. So, we took on this case because we believe that an individual who remained isolated from society for years can be reestablished (E2).

[...] and then there was this whole work with the community that had to be done [...] the patients started to go for walks in the neighborhood, have contact with the neighbors and they started to perceive that, like, this contact is possible (E3).

Another strategy the municipal coordination of Mental Health adopted was aimed at the direct action of the nursing technicians in the therapeutic residences, as they were accustomed to an asylum care model, which was therefore incompatible with the proposal of the Therapeutic Residence Services. In these services, contact with citizens in society is not the only desirable attribute for mental disorder patients, "but contact free from the prejudice that still hovers over mental illness today".^{14:169}

The nursing technicians got help from the CAPS and ESF nurses, with a view to receiving support, supervision, orientations and stimulation to cope with the difficulties deriving from the stigma in this process of change and adaptation to the new care model, defended in the principles of the Psychiatric Reform.

[...] it is a very new experience for all of us, for nursing mainly, which moves from task execution to a creative and innovative practice (E3).

[...] because then they [nursing technicians] are seeing that we're together as well, it means valuing the work. [...] So this work is also done inside the service, this awareness raising about this responsibility. And we really charge them, we're there together with them (E4).

[...] so, the coordinator herself of the Mental Health Program was giving this support, she was doing the visits, she and the Program Coordinator in Volta Redonda. They were giving this support, they'd go every day. She [Mental Health Program coordinator] is a nurse too (E6).

In that sense, it can be affirmed that the nurse helped to cope with the stigma and explored the reclassification of the professional category the nursing technicians were submitted to, as something that could benefit them and the therapeutic residence users. This assertion is supported by Erving Goffman: "[...] when normal and stigmatized do in fact enter one another's immediate

presence, especially when they attempt to sustain a joint conversational encounter, there occurs one of the primal scenes of sociology for, in many cases, these moments will be the ones when the causes and effects of stigma must be directly confronted by both sides".^{2,23}

CONCLUSION

The stigma placed on mental disorder patients can reduce their chances of bonding with society and sharing other social environments. The attitude society adopted towards the mental disorder patients, as a hegemonic majority, made it difficult to establish a social relation in Volta Redonda-RJ during the implementation of the therapeutic residences. This conduct can minimize users' possibilities to have their abilities and other attributes perceived by society, which often envisages only the disease and its limitations, instead of individuals and their potential.

The change involving the members of different categories in the city also affected the nursing technician, who went through an inquiry process about the social category he belonged to, that is, a caregiver or a nursing technician. Thus, he needed support and orientation, which he received from the CAPS and ESF nurses.

Hence, nurses played a fundamental role in the stigmatization process of mental disorder patients. This happened through orientations and clarifications provided to different social segments, like sensitizing the house owners, the real estate agents, the neighbors of the residences about the new comprehensive care model for mental disorder patients and their rights as citizens. In addition, they also mediated the nursing technicians' professional identity conflict, showing that the change in care delivery would be an innovation and not discredit their profession.

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