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Insanity and culture: an approach to the gender relations in the speeches of psychiatrized patients

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Abstract

The scope of the present work was to point out how the gender values and stereotypes socially established in our culture are evidenced in the "psychic loss", that is, how the culturally established roles for male or female individuals appear in the experience of the so-called "insane" people. From the quanti-qualitative analysis of the speeches of psychiatrized patients, the results point to the prevalence of relationship-related complaints among the women and, on the other hand, to the valorization of the virility among men. In the relationship-related complaints of women, the object of complaint is, in most cases, family and love life. In the male virility speech, active sexuality, work, money and fame were the most expressive topics.

Keywords: gender relations; insanity; psychic loss; culture

Insanity is commonly understood as a "deviant behavior, product of mental and psychic instabilities" (Cherubini, 1997:2), and its definition is permeated by social and cultural aspects that undergo changes over the ages. In these terms, each society prescribes concepts of "normality" and, consequently, designates everything that is not in accordance with the standard behavior as being "abnormal". Historically, the so-called "insane" have not only been interpreted, but also defined in different ways (Foucault, 1982). In other words, the very definition of insanity has undergone changes. Moreover, the experience of insanity in the Western world before the 19th century proved to be very polymorphic at each historical moment (Foucault, 1975), until its inclusion in the concept of "mental illness".

During the Classical Antiquity insanity was seen, among other approaches, under the perspective of a mythical-religious model, whereby insanity would be a visitation attributed to the individual due to a supposed affront to God (exceeding the *métron*). Pessotti

(1994) emphasizes the active position of the "insane" individual, in this view, responsible for his or her condition.

In the Middle Ages, the cause of insanity was mainly related to demonic possessions. Thus, the treatment for the "possessed individual" was attributed to the priests, through exorcism. Catholicism has chased the heretics (deviant behavior individuals) and burned those accused of witchcraft at the stake.

From the seventeenth century on, rationality gradually acquired greater credibility, occurring a devaluation of the mythical and religious explanations. In the Western tradition, in which rationality is valued, insanity was disqualified in its ability to tell the truth (Machado, 2009). The insane individual, banished from society, was confined to general hospitals, along with other marginalized people, such as poor incapacitated individuals, patients with venereal diseases, libertines, etc. (Foucault, 1975). The criterion for asylum according to Foucault (1975) would be an "alteration" in relation to morality. He points out that those institutions had no "medical function; the individuals were not there to receive a treatment, but because they would not be able to live in society" (Foucault, 1975:79).

The insane individuals only reached their specificity as individual/object to be studied and treated in the nineteenth century, period of creation of the psychiatric clinic. They were then separated from other marginalized groups and confined to specific asylums. This represents the beginning of the appropriation of insanity by medicine, as it is until today. In this sense, Pinel was one of the pioneers in the understanding of insanity as a "disorder" or "mental illness" and its respective treatment. Pinel's method suggested the isolation of the patient from society and family in order to assure a systematic and prolonged observation of the behavior of the "insane", also aiming at a moral rehabilitation.

Important debates on the nosological classification of the types of alienation begin to occur. The insane individual, turned into a patient, now separated in his/her specificity ("mental illness"), is treated as an object of study, bringing the indicial semiological logic to the field of mental health (Martins, 2003; Zanella, unpublished). In this historical moment, insanity begins to be converted into "mental disorder". One of the important contributions of Foucault (1982) in *History of Madness* is the indication of how "mental disorder" is a produced entity, and not a discovered truth. The role of the doctor has become more related to an ethical control than to a therapeutic intervention: "the insane individual had to be observed in his/her gestures, demoted in his/her ambitions, contradicted in his/her delirium, ridiculed in his/her error" (Foucault, 1975:82). It is a moral and repressive context. A discussion about insane people occurs, but the insane individual does not have the opportunity to speak about his own condition.

In general, the manicomial model, introduced through the creation of the specific asylums for "mentally ill" people, became increasingly characterized by the mistreatment of the patients, involving electric shocks, cold showers, tying them up, lack of care with hygiene and

nutrition, lobotomy, etc. Such mistreatment practices were considered as being “punishments” for the moral rehabilitation of the patient. There is a “confusion within a single moral regime, where some of the techniques presented a precautionary nature while others presented a medical strategy nature” (Foucault, 1975:83).

The discoveries of neuroscience and the development of the pharmaceutical industry in the twentieth century also contributed to the concept of insanity as a “mental disorder” [1]. The “chemical gag” allowed the liberation of several “insane individuals” from the asylum, maintaining the permanence of the medical control, but now with more invisibility. The insane individual is silenced again, and his/her “abnormal” symptoms are suppressed. The perception of insanity has become a recognition of the “illness”, and this was transferred to people’s daily lives. An increasing medicalization of the existence was established, constituting a new form of social control, present until today.

In our view, the representation of insanity as a “mental disorder” does not favor the individual in severe psychological distress or provide an approach to a knowledge that the voice of the insane might present. Szasz (1980) points to the disqualification of the conflicting human values, aspirations and needs promoted by the idea of “mental disorder” due to its negligence to the aspects of subjectivity. The author considers that the use of this concept by the psychiatry does not make the necessary distinction between neurological and existential problems, limiting the interpretation of the causes of the “mental disorder” to the physiological field, as a brain disease (body).

In the twentieth century, these criticisms and the atrocious treatment in the asylums led to protests in several countries and to the appearance of reformist initiatives in the field of mental health that resulted in the anti-asylum movement.

In Brazil, the Psychiatric Reform emerged more substantially only in the late 1970’s, as an opposition to the national subsystem of mental health and to the structure of the knowledge and of the traditional psychiatric institutions (Tenório, 2002). The Reform presented the proposal of reformulation of the mental health care model, pointing to the necessity of reorganization of the services.

The removal of the insane individual from the asylum, restoring his/her life in society, is only a small part of this proposal. Listening to the individuals considered insane are especially important in our view. Restore their voices. And also, listen to the specificities of our culture in these speeches. As said by Foucault (1975:71), the illness only “has reality and value of illness within a culture that recognizes it as such”. Therefore, it is necessary to know how “our society expresses itself in those morbid forms in which it refuses to recognize itself” (Foucault, 1975:74).

Thus, questioning a biologizing and reductionist conception (biomedical speech) within the field of mental health, we believe that the analysis of the notion of gender generates a

new field of reflections, which emphasizes the participation of socio-cultural factors in the experience of psychic distress. In other words, culture, in its fundamental nature, privileges ways of subjectivation in which the gender relations represent an important factor. This means that what the society establishes and requires from a "man" or a "woman" interferes in the subjective experience of each individual, and therefore influences if this individual happens to "break" [2] into severe psychic distress.

The idea of cultural values permeating the severe psychological distress gain consistency in the epidemiological studies that point out variations of prevalence of certain "disorders" in the population, with strong evidences of differences in the distribution of such disorders in relation to men or women. In addition, the symptoms go through changes according to the values of the time and the society. Such plastic nature of the symptoms was named "metabolics" by Van den Berg (Van den Berg, 1965).

Epidemiological data regarding "mental disorders" [3] point to a higher incidence of depression and anxiety disorders between women and, on the other hand, a prevalence of the use of psychoactive substances and anti-social behaviors between men (Andrade, Viana & Silveira, 2006; Rabasquinho & Pereira, 2007; Santos, 2009; Zanella, 2010).

Currently, the interpretation of these data is performed by two important guiding currents that lead to essentially differentiated understandings. On the one hand, the biological current, consolidated by the acceptance of insanity by medicine and by the development of the pharmaceutical industry. In this vein, there is an emphasis on the symptoms and the illness, rather than on the subjectivity, disqualifying the material and existential conditions of the individuals in psychological distress (Zanella, 2010).

Regarding the women, for example, the anxiety and mood disorders frequently associated to them are explained in terms of their menstrual cycle and of the existence of hormones in the female body that exert influence on their mood (Andrade, Viana & Silveira, 2006). Thus, the biologizing perspective reduces the being of the woman to the body.

A second current opts for a socio-cultural interpretation, showing psychosocial indicators that influence the expression of mental health. Thus, the socio-historical perspective seeks to explain the insanity as a symptom of our culture, emphasizing risk factors in the social field that interfere in the psychic "break", including the gender (differences in the gender relations). "In this perspective, more than a consequence of an unregulated body, the psychic distress would be understood as a result of social roles, gender relations and their pressure on the individual" (Zanella, 2010:310).

In a research conducted in Florianópolis, for example, Maluf (2009) points, from the reports of "female users" of mental health public services, how the experiences of affliction, distress, etc. experienced by women in severe psychic distress are previously present in the trajectories and social contexts of their daily lives. In his reports, the women surveyed

emphasized the family conflicts, household daily life and the relationship with husband and children as the main source of tension and psychic distress. Thus, an experience not addressed by the speech of female health and mental health public policies nor by the speeches of the health professionals, who justified such tensions according to a biomedical conception based on the female reproductive cycle (adolescence, pregnancy, delivery, puerperium and menopause) or simply in the biological, was demonstrated (Maluf, 2009).

Ludemir (2000), in turn, emphasizes risk factors related to the common mental disorders (depression and anxiety) that primarily affects women. These are some of the risk factors reported: informal labor and household responsibilities (homemaker, mother, wife responsibilities). That is, invisibility of work, low remuneration and the "obligations" undertaken as moral obligation related to family care are concepts that represent culturally and historically located constructions related to gender relations.

Therefore, the reinterpretation of the field of mental health from the perspective of gender relations assumes a distrust about the ideological and historical nature of the approach to insanity by the psychiatric speech that selects certain "data", assigning a "natural" (biological) and a-historical character to them. Casares (2008) points out: "(...) no reconocer ni denunciar el androcentrismo que caracteriza una disciplina forma parte también de un proyecto ideológico y político" (Casares, 2008:32).

Thus, the present study aimed at a reflection on insanity from a psychosocial perspective, considering it as a severe psychic distress (Costa, 2010)^[4], pathic possibility constituted in the relations and in the social context. With this interpretation, we approximate the "insane individuals" of all the "normal" people that suffer from psychic distress as well, filling the "gap" claimed in certain terms like "mental disorder", which isolates the "mentally ill" from the "healthy people" society. Thus, we aim at pointing out a continuity of the human experience and how the severe psychic distress evidences certain aspects that appear in the ordinary distress of our daily life and in the clinical practice of the so-called "normotics". This is a Freudian teaching: The "abnormal" teaches us about the "normal" and vice-versa (Freud, 1905).

The present study aimed to investigate what the "psychotic break" reveals about the gender relations and roles present in our daily lives, how the constitutive social roles of the genders appear in the distress of the psychiatrized patients called "insane men" and "insane women", and how the understanding of the phenomenon may contribute to a more appropriate intervention method. Prior to the approach to the specificities of the research, it is necessary to clarify the concept of gender adopted here.

Gender relations

The concept of gender emerged from the feminist movement as "an important category of description and analysis of social interactions" (Couto-Oliveira, 2007:7), in contrast to the biological determinism implicit in the use of certain terms, such as "sex" or "sexual

difference" (Scott, 1990), which restricts the analysis of the individuals to the differences of the "body" (genitalia).

According to Lima (2008), the gender is marked by the patriarchal cultural system of the western societies, in which women are historically left on the sidelines. "Gender cannot be decontextualized from its patriarchal base, gender refers to a relation of hierarchy in which the female is constantly subjugated to the male" (Lima, 2008:1).

Although the notion of gender has emerged from feminist studies that primarily focused on the social roles and the subjection of women, currently the concept of gender is emphasized as a relational category, that is, it emphasizes the impossibility of studying men and women separately. This is due to the fact that the gender roles and the categories related to them are complementary, superposed, belonging to the same mode of social functioning; in this case, to a binary mode of understanding of human beings and to the compulsory heterosexuality. In other words, the deconstruction of the female "essence" necessarily leads to a deconstruction of the male "essence" and vice-versa, as well as to the possible emergence of new gender categories, such as transsexuals, transvestites and transgenders. For this reason, the gender studies and the feminists currently refer to this category as "gender relations".

The reflections about this concept have been historically produced from the contestation of social interests and, particularly, political and economic interests that designated the social roles and the behavioral patterns to be supported by men and women. In this sense, Santos (2009) points out that what seems to be related to the subjective experience of each individual as man and as woman is, as a matter of fact, subjected to rules and values formed by the society and the historical moment in which they are inserted. Casares (2008), when referring to the gender roles, values and stereotypes, says: "(...) los elementos simbólicos rigen también nuestras vidas, aunque no siempre seamos conscientes de su alcance (...)" (Casares, 2008:232).

This is the definition of gender roles according to Casares (2008): "son las actividades, comportamientos, y tareas o trabajos que cada cultura asigna a cada sexo" (Casares, 2008:50). According to the author, they constitute social skills and "appropriate" ways of living to the members of that society, depending on the sex in which they are classified. Generally, they consist of social values evidenced in the gender stereotypes. These are presented as efficient tools against the equivalence of people (Casares, 2008:52): they represent "um conjunto de ideas simples, pero fuertemente arraigadas em la conciencia que escapan al control de la razón". They have psychological strength and create material reality! They are present, for example, in the discriminatory remuneration between people of different sexes, even when performing the same task. The stereotypes support the dissimilarity and the hierarchical power relation between the genders. Moreover, they reaffirm the social values and constitute a privileged space in the identity formation of people in a society: people who do not adapt themselves to the gender stereotypes are considered anomalous, marginalized. Thus, Casares (2008) affirms: "la

adecuación personal a los estereótipos responde, en gran medida, a la necesidad de las personas de sentirse socialmente integradas" (Casares, 2008:53). Therefore the gender stereotypes would be cultural and artificial categories that exaggerate the physical differences, making them symbolical, acquiring a condensing dimension of the emotions as well. That is, in the case of the gender stereotypes, "(...) la simbolización de los sexos se convierte casi en un pensamiento normativo lleno de valores sobre 'lo que debe ser', ocultando por completo 'lo que es' y 'lo que podría ser'" (Casares, 2008:231).

Couto-Oliveira (2007) points out that the establishment of the behavioral patterns, as well as the exercise of the roles attributed to women and to men, implies in world experiences and distinct realities for both the sexes, having influence on the different aspects of life, individually and socially, including the psychological and physical functioning and development.

These are some of the stereotypes culturally assigned to women and that we had the opportunity to find through another survey previously conducted (Zanello & Gomes, 2010): sexual abstinence/containing, characteristics of relational nature (caring for the other, dedication to the other) and the ideal of beauty.

Regarding the female modesty, Perrot (2003) says: "The woman, especially the young, marriageable one, should mandatorily present moderation in her gestures, looks, expression of the emotions, which she should not make explicit unless when done with full consciousness" (Perrot, 2003:15). Psychiatry, as a part of medicine in the nineteenth century, has significantly contributed to the affirmation of this stereotype, providing "scientific" strength, becoming established as bourgeois hygienization of the behaviors.

The women who stayed in society were not less observed from the psychiatric perspective, but suffered a distinct and punitive supervision (...). The cultural rules of society have created an image where the women were idealized as home angels, guardians of virtues. Moralists and physicians formulated the rules and the anatomical target, considering them especially suitable for motherhood and household duties (Garcia, 1995:57).

The affirmation of sexual restraint by women is also related to the affirmation of motherhood and to a supposed female "essence" ("natural") of care for the other. According to Bordo (1997), the "femininity", formed in the androcentric logic, sets the woman as the main physical and emotional nurturer for the others: "The rules of the formation of femininity require the women to learn how to feed other people instead of themselves, and to consider as greedy and excessive any wish for self-feeding and care for themselves" (Bordo, 1997:25). That is, women are required to develop a kind of emotional economy completely devoted to others.

In relation to the ideal of beauty related to the woman, the body acquires, at this historical moment, the status of central element to be cared for, well-shaped^[5], especially regarding obesity and overweight. According to Novaes (2006), beauty is a value and an

exchange currency, being of paramount importance in the affirmation of the woman in this sense: "Culturally, the image of women is intertwined with the image of beauty. This is one of the most emphasized points in the speech about women: she can be beautiful, she must be beautiful, or she will not be a complete woman" (Novaes, 2006:85). According to the author, what is normative for women in the current social context and moment is not only the imposition of beauty standards or that she must be beautiful, but that she can be beautiful. That is, if the woman is not beautiful, it is her choice, and she will be judged from a morally biased perspective ("laxity", low self-esteem, etc.). Thus, instead of an aesthetic obligation, beauty became a female moral obligation. It is related to the affirmation of the self technologies, well pointed by Foucault (1977:136): "the efficiency of the disciplinary practices is higher when they are not experienced as external demands to the individual, but as self-generated and self-regulated behaviors". That is, the ideal of beauty as a moral obligation began to compose women subjectively, leading them to think that the pursuit of beauty is a personal choice.

These three stereotypes, as we will have the opportunity to demonstrate later, are also present in the severe psychic distress experience, and appear both in the female complaints and in the protective factors against distress.

The constructions of the male stereotypes are similarly affected by social elements. According to Azize & Araújo (2003), the representation of man in our culture has become increasingly attached to the representation of virility. Therefore, it is necessary to point out the historical and social nature of the construction of male virility and what is considered as virile as such. According to Azize & Araújo (2003), what counts here is the excellence of performance: "This excellence of performance expected from every "real man" has a specificity: it is not only a matter of achieving a virile standard assumed as dominant, but it is also related to appearing, making it visible, demonstrating such situation" (Azize & Araújo, 2003:41). Here, the performance is related not only to sexual capacity, but also to labor capacity. (Zanello & Gomes, 2010). Or, according to Casares (2008), to the provider and breeding male stereotypes.

In this sense, Badinter (1992) points out how much being a "man" is a construction that occurs in the imperative. According to her, virility should be "produced" and evidenced: "Obligations, tests, competitions, these words indicate that there is a real task to be performed to become a man (...). Thus, the man becomes a kind of artifact, and as such, he is permanently subject to failure. Manufacturing defect, failure in the virile machine, on the whole, an unsuccessful man" (Badinter, 1992:15). This virility required from men so that they can fulfill or perform their male "essence" promotes permanent tensions and conflicts, as it should be affirmed in any and all circumstances. Thus, men would eventually be oppressed by their own oppression (Bourdieu, 1998).

Welzer-Lang (2004) emphasizes the conflict concerning such virility when it is conflicted in different social situations, such as unemployment; the social andropause represented by retirement; or if the object of our study is in a situation of "forced" disability due

to the psychiatric hospitalization.

Therefore, there are social obligations and expectations for both the sexes. More than external, these values are constitutive of the subjectivation ways and are present in the experience of being a "man" or a "woman", establishing parameters under which the individual experiences and assesses himself/herself.

The qualification of gender relations as dynamic constitutive aspects of the individuals requires a reflection about the subjectivation process and how the psychotic break reveals gender contents privileged in our culture. Thus, the scope of the present study is a quanti / qualitative analysis of the speeches of psychiatrized patients from the perspective of gender relations. The aim was to show how the speeches of these patients are full of questions deeply marked by gender categories.

Methodology

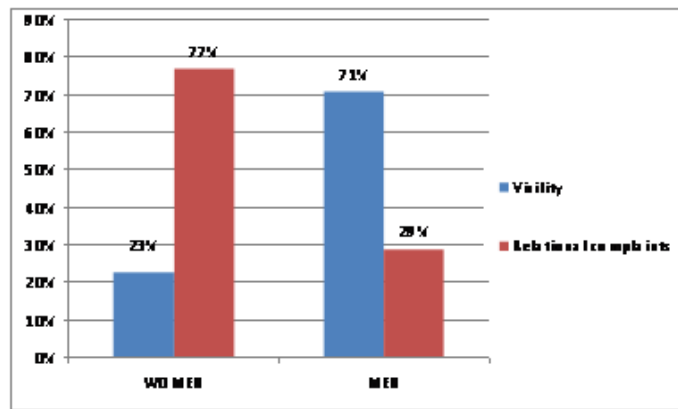
For the present work, 34 visits to the hospitalization sector of a public psychiatric hospital of a Brazilian capital were conducted during the period from February to June 2010. The visits occurred three times a week, in the morning, with duration of 4 hours per day. The target public were the inpatients of the hospital, generally evaluated in a situation of crisis (suicide attempt, seizure). Twenty-two open interviews and informal conversations in the yard were conducted with 10 male and 12 female patients during the visits. The interviews were conducted in one of the rooms of the institution in the presence of the patient and, opportunely, two or three psychology students. Interviews and informal conversations were registered for subsequent study of dialogues. An interpretative analysis of the speeches of the patients was carried out from a qualitative interpretation of the data relating to gender relations.

In the qualitative analysis, the topics (thematic axis) that appeared in the speeches of the patients during the interviews were classified through the content analysis (Bardin, 1977). Then, the frequency of the topics that emerged in the total of speeches of the patients was quantified according to the sex of the interviewee. All data that could identify the hospital or the interviewee were removed from the fragments used in the results. The purpose was to safeguard confidentiality and ethics.

Results and discussion

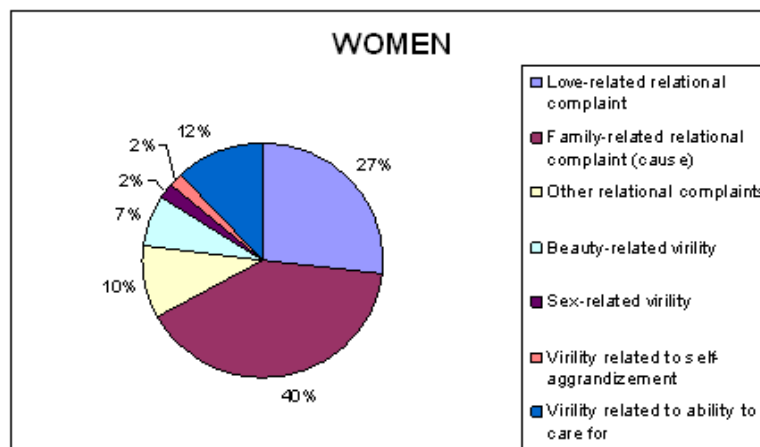
The quanti-qualitative interpretation of the speeches of the patients indicated a prevalence of relational complaints (77%) among women and a speech marked by virility (71%) among men. However, the speech related to virility also appeared in the speeches of the women (23%), as well as the relational complaints were present in the interviews with the men (29%).

However, the difference between the frequencies in the speeches of men and women is very significant, as shown in the chart below:

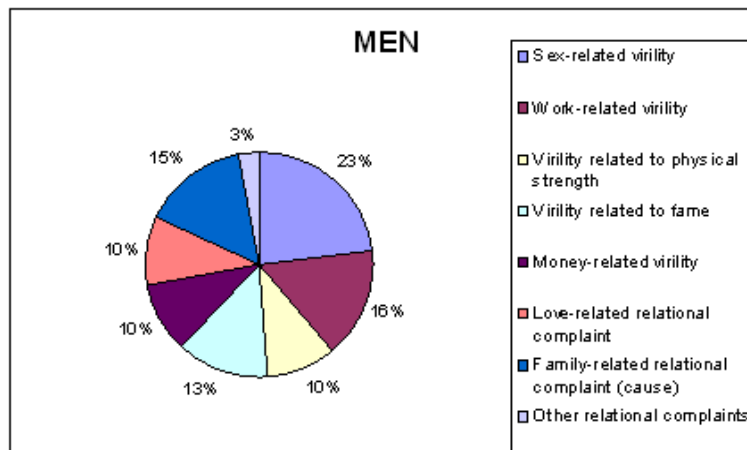


The prevalence of relational complaints in the speeches of women and virility in the speeches of men seems to point to different subjective positions in the experience of "insanity". Women tend to be in a position of complaining and resentment, while men prefer a defensive "reactive" position, in which the narcissist functioning appears expanded.

The content analysis revealed the following categories in relation to the relational complaints of women: family (40%), love (72%) and others (10%). Among the family-related complaints, we found the following subcategories: paternal (15%), maternal (10%), children (15%). Violence-related complaints were classified within the relational complaints and appeared in 41% of the speeches of the women interviewed. In the thematic area of "virility", the following categories were found in the speeches of the women: ability to care (12%), beauty (7%), self-aggrandizement (2%) and sex (2%). These categories are represented in percentage terms below:



In the speeches of men, the following categories appeared within the thematic area of virility: sex (23%), work (16%), fame (13%), money (10%) and physical strength (10%). Regarding the thematic area of relational complaints, the following categories were found: family (15%; composed by the following subcategories: paternal 6%, maternal 6%, children 3%), love (10%) and others (3%). The chart below shows each category represented in percentage terms:



Despite the prevalence of family and love-related issues in the relational complaints of both men and women, the frequency of such appearances in the speeches of men is low, 15% family-related and 10% love-related; in relation to the women, 40% family-related and 27% love-related.

The love-related complaints of the women were primarily related to the sexual act, love life forbidden by the family, betrayals, divorce, abandonment, threats or lack of financial provision. An example may be illustrated through the speech of the patient Fernanda. Her love-related complaint was related to how she felt in relation to the sexual treatment that she received from her husband.

“He treated me like a prostitute. How can a husband treat his wife like a prostitute?! When having sex... Open your legs and do it! Raise your head and close your eyes slowly... They want it easy... Oral, anal... Bestial! Bestial! He really treated me like a prostitute, I couldn't accept that, I suffered for 7 years, because he is my cousin, it would cause an annoying situation in the family, and that was what happened”.

Another example is the case of the patient Nara, who, in relation to the impossibility of “living a love story”, reported: “Hey! I have a boyfriend and my mother does not let me date. Is she right?” Then the interviewer asks: “Why doesn't she let you date?” Nara: “She says he is a miser, sam! That he will not... that he will not take me to the appointments. He said he will, sam! That he will come with me... But she doesn't allow it (...)”. Interviewer: “Have you ever talked to your mother?” Nara: “When my mother puts something in her head... But do you know who's to blame? My step father, who doesn't accept him there. And I hesitate about living with him, because things might not work, and I would have to go back to my mother's house (...)”.

Betrayal also appeared as a recurrent theme in the love-related complaints of women. This is the case of Ana, who told us that the father of her first son had left her for her younger sister, a sister that lived with them and that used to sleep with the couple at the time. Ana also

told us that the relationship that she had with another man, her cousin, had ended due to the abuse of alcohol and cigarettes and his involvement with other women. At the time of the interview, the patient was living with an "old man" (as she referred to him), who she considered a great man, who welcomed her with her children and managed to get her a job.

In the love-related complaints of men, the recurring themes were primarily related to the incapability to practice or have a love life and to the loss of a love. In relation to the incapability to practice the love life, we have the example of Wilian, who illustrated this very clearly. The interviewer asked him:

"Do you have a girlfriend?" The patient answered: "No, I don't. But I would like to have one, but I can't". Interviewer: "Well...what do you mean, you can't?" Wilian: "Because they don't want me to". Interviewer: "Have you ever tried?" Wilian: "Many times!" Interviewer: "I see...have you ever kissed anyone on the mouth?" Wilian: "I have never realized." Another patient, Hélio, reported in details during the interview the suffering over losing his girlfriend.

Although the theme of love loss is present in the speeches of both men and women, a qualitative difference was observed in their answers. In the speeches of the women, love became impossible generally due to an external agent. In general, family is felt as the "causer" of the separation or of the impossibility to live a great love. In relation to the speeches of the men, the emphasis was focused on the inability to have lived a certain love, on something the individual might have done (a betrayal, for example) that "caused" the impossibility. That is, the locus of control [\[6\]](#) in the speeches of men seems to be on the individual himself, while in the speeches of women it is perceived as something external to them. The application of a locus of control scale in the psychiatric hospitalization to better investigate such differences would be interesting.

According to Noriega et al (2003), the aspect of learned inability should not be excluded from the external locus of control, "that occurs when the individual identifies his/her lack of control over certain daily conditions, attributes the control to external forces and presents depression. It is assumed that a higher lack of control causes a higher rate of external attribution, and consequently, higher rate of depression" (Noriega et al, 2003:212). That is, the authors point out the character learned, constructed in the social interactions, from the locus of control and its relation with the possibilities of psychic "sickness". In this case, depression, as demonstrated, appears in the epidemiological data as a mental disorder that primarily affects women. The structure of the engendered character of this social learning, constitutive of the psychic functioning of the individual, should be investigated with empirical researches.

Maltreatment from the children (aggressive children, children that do not help) and, mainly, the concerns regarding the children's care (who is taking care of the children, impossibility of breastfeeding, interferences in the education given to their children, etc.) are present in the family-related relational complaints of the women. The following passage of the

interview with the patient Mara reveals her concern in relation to the care of her daughter. She said:

"(...) My little daughter... I have to take her to school. She is four, it is her first year in school". We asked: "Who is taking care of her now?" The patient answered: "Her brother and her father. But they are not taking care of her like I do. I prepare her food at the right time, I work from 7 to 9, when I get home I prepare her meal, I bath her, I dress her up, I comb her hair, I take her to school... I am suffering so much, it is very painful..."

Other complaints of women are related to the treatment that they received from their father (15%), accused of cursing, spanking, denigrating and insulting and, less significantly, from the mother, in this case accused of infantilizing, treating the individual as a child.

Complaints related to the father, principally those related to physical abuse, were also present in the relational complaints of the men. However, the frequency of this category was lower than half of the answers of the women (6%). Another relevant information refers to children-related relational complaint: in the case of the answers of men, the complaint was felt as a feeling of inability to provide for the family, due to the "illness" and the consequent interruption of the work activities due to the hospitalization. The report of Luciano is an example: "That cretin doctor did not discharge me... Will he see my son? Will he give things to my son? Will you?"

Besides the frequencies previously compared, the comparison between the answers of men and women emphasizes two points: the similarity in the figure identified as the offending agent in the speeches of both men and women (generally male individuals, often a relative, particularly the father or stepfather); and the differences regarding the children-related relational complaints. In the case of the women, the factor of distress is related to the impossibility of taking care of the children, a task that has been assigned in our culture to a "naturalness" of the female role, becoming a parameter for their narcissistic self-evaluation. Thus, a "real" woman should be a good mother and take care of her family. For men, another class of roles is culturally required: it is related to the provider role; a role that is conflicted during the period of hospitalization or in function of the psychic disturbance of the individual.

Concerning the assertion of virility, we observed that deeply patriarchal values and stereotypes continue to play a role of (self) assertion and (self) social acceptance. In the masculine speech, often delirious, this is presented as an important configuration factor, especially in the selection of the content of the delirium, pointing to gender specificities in the narcissistic functioning of the individual.

In the "sex" category (23% of the answers of men), regarding "virility", the emphasis was focused on the active role, the individual of the enunciation as a character who has sex with a high frequency and with a high number of women, including famous and desired characters.

As pointed out by Badinter (1992), the penis, as a symbol of power (love machine) or of the most extreme fragility, metonymy of man, is also his main obsessor.

Three passages from the interviews illustrate these aspects. In the first one, we asked Julio if he was married, and the patient answered: "I'm not! I have had a lot of girls (laugh).

Yes, yes... I have already had a lot of girls. Teacher (calling one of the interviewers): I have already got a lot of girls. I had a lot of girls. I have had five girls". Then the interviewer asked: "Do you have any children or have you ever got married?" The patient answered: "No, I don't, no, no. I just dated them, the five of them. I just dated the five of them. I did had a movement with them... You know what? You know what? I had sex with the five of them. Heeeee!!! (laughing) I had sex with all the five woman". Interviewer: "How did you manage to deal with so many women?" Júlio: "That was easy".

Mãrcio, another patient, cuts to the chase:

"I am mad... And I like it... Especially because my wife is Kelly Key, you see? So I really make a mess. She gets angry with me. She gets really angry with me. But I don't care! Do you think I care?! I was cheating on her with Angelica... But that's no problem..."

A last example, among several others, was found in the speech of Everton. When the interviewer asked him if he was married, he said:

"I'm engaged! But I have nearly 40 children spread all over the world, just waiting. And several virginal women. And my blood test shows that I don't have any kind of disease. I know which area I get in the woman. I look at her face and I know that she's not sick... If she is not, I date her, I seduce her... even marry her, and I am cheating on my wife. A lot! Because she does not want another child". The interviewer asked: "How can you have so much power over the women?" Everton answered: "A lot of hard muscles, a lot of nerves here" (pointing to his penis). Interviewer: "Do these women fall in love with you?" Everton: "No! They get angry because I don't live with them".

Job-related issues appeared in the second position (16%) in the speeches of men, followed by issues related to symbols of personal and professional success (fame, 13%; money, 10%). Physical strength, another way of assertion of virility, also appeared as an important category. As previously mentioned, these are stereotypes and values related to masculinity in our culture.

For the patient Junior, for example, virility appeared in the report of the exercise of multiple roles that, according to him, granted him social prominence. His speech indicated that

the performance of such roles and the relationships with famous people seemed to be, in his perspective, something ordinary, and therefore, treated as irrelevant. The patient reported to be a former player of the Brazilian soccer team; a computer technician, function fully performed by him, who considers as "easy" any activity to be performed on a computer; that he had served the Brazilian Army, where he had been a sharpshooter; that he had worked as a teacher, that he used marijuana, but only a stronger variety of the substance, called skank; that he produced ether spray, but he did not sell it by himself, because other people were selling for him; that he used to steal cars in order to demonstrate his "power", and that the girls liked that. He also said that his uncle was a judge, an "important name", who would never allow his nephew to go to jail for involvement with drugs, besides, his father had been a police chief. He also reported to be a member of the rap group Racionais and that he had been the singer Bruno of the duo Bruno and Marrone when he was fat.

Another patient, Luciano, reported to dominate several professions:

"I am a woodworker, mason, electrician, painter, plumber, I work with handicraft, with sales, I do many things. The best wall of that place (referring to the city where he lives) was made by me".

The case of the patient Edson, another example, evidenced the grandiosity attributed to everything that he performed. He was not only a soldier of the Brazilian Army, but a sniper. He did not travel to just anywhere, he went to Mars, and accompanied by none other than the famous Brazilian singers Martinho da Vila and Martinália. He said that he was the father of the famous actress Susana Vieira, and his work partner was the international producer Steven Spielberg. Also, Edson told us that he was the character of the TV series Dungeons and Dragons, Dungeon Master, keeper of all knowledges.

Regarding the exploration of virility through the physical strength and other attributes considered as symbols of masculinity, such as courage and heroism, the identification with super powerful fictional characters was common among men. The patient Vitor believed to be turning into the character Vegeta of the cartoon Dragon Ball Z. He told us about his insuperable physical strength and how he could use it to blow up and throw objects and to annihilate powerful enemies.

In the speeches of women regarding virility, as pointed out, we found the following themes: ability to care (12%), beauty (7%), self-aggrandizement (2%) and sex (2%). In the theme ability to care, children appeared as the main factor. The patient Laura told us, for example, about the power of her prayers. According to her, her prayers made her daughter gain weight and become healthy enough to breastfeed her granddaughter. They had also made her brother stop calling his wife a "prostitute", "bitch", and other similar words. The patient showed a distinct pleasure when reporting about her power of prayer. It is important to note that, differently from the male speeches, virility is expressed in the exercise with the other one, and not only to be

enjoyed by the patient herself.

In the category of beauty, the main points reported in the speeches of the female patients were related to their own physical beauty, as well as the desire generated in men, and consequently, the envy of other women. A patient, for example, called Amanda, reported that her beauty had always attracted men, and that despite the HIV her skin was still beautiful. At that moment, she showed her skin to the interviewer and emphasized the beauty of her legs. She also said that she had decided to not go to parties anymore, because when she danced all the men went crazy about her, while the women were angry, jealous. This speech clearly evidences the fact that the assertion of virility of the patient is based on the claim of being an object of desire of men. Differently from the male speeches, in which the active aspect in the sexual and love life were emphasized, for the women we observed as assertion through the other's desire, the power of seduction and charm, characteristics "naturalized" in our culture as a supposed female "essence".

The patients Maria Paula and Rebeca are other examples: Maria Paula showed to be careful about her appearance during the whole interview, often saying and asking the interviewer if she was beautiful. Rebeca, in turn, categorically stated several times in relation to her beauty: "I am beautiful, other people are jealous of me." Being an object of male desire is not enough, it is important to emphasize the comparison with other women in order to emphasize the qualities of beauty of the individual herself.

The theme of sex had only 2% of the answers, that is, it appeared only in the speech of one of the interviewees. The patient Lucia reported her sexual affairs, saying: "Crisis begins... Pleasure, lust, manipulation." In this case we observed the assertion of sexual desire of women, but the frequency of the answers was inexpressive, evidencing a prevalence of an extremely patriarchal standard regarding the position of women in relation to desire: Desire of being desired.

The category of self-aggrandizement (2% of the answers) was also inexpressive, however it was interesting when considering the object by which the patient boasted: the wedding party. Rebeca told us that she had always had the best things and talked about her wonderful wedding party, worthy of a princess. According to her, the wedding took place where the President used to stay, and that her dress had been designed by a personal stylist. The patient showed a particular pride when reporting the grandiosity of that day, with an emphasis on the feeling of having been "chosen".

Based on the data survey presented here, we point out the evidence that the gender values and stereotypes are present in the situations of insanity, considered as severe psychic distress. However, there are certain questions to be answered by further studies: how and to what extent gender relations favor privileged ways of subjectivation and psychotic break in our culture? How can gender relations lead to a reinterpretation of the field of mental health and of

metaphysical concepts that mediated our understanding of insanity from a perspective of clinical psychology? And finally, how to use the knowledge acquired from the gender studies in order to reconsider the mental health intervention?

The two first questions will remain open in order to guide future possibilities of research. However, regarding the last one, we have some ideas and evidences of data from other researches conducted by us. The first one refers to a music and dancing workshops program that we developed in the female wing of the hospitalization sector of the institution (Zanello & Souza, 2009). The title of our article is very illustrative, "More music, less haldol", and it was suggested from the speech of one of the patients. For the workshops, we selected songs characterized by a kind of "turnaround" in the love life condition after being left, that is, we emphasized the passages in which the protagonist could overcome abandonment, disappointment, betrayal (the main example is the Brazilian country song called "Chora, me liga, implora", -national success at the time). Those were extremely mobilizing moments, with participation of a great number of patients, singing (sometimes yelling) and dancing. Catharsis was evident, not only through the gesticulations and grimaces while singing (as if they were saying that to someone), but through the speeches collected from these women after the workshops. In the days of workshops, we observed a reduction in the number of contentions and in the need of the use of strong sedative drugs. Although a palliative intervention, it meets the idea of harm reduction[7]. It was an initial idea that, in our view, can lead to a reconsideration about other possibilities of intervention in the moments of crisis and possibly in other moments of preventive nature or life promotion[8].

However, we observed a particularly expressive data: these workshops did not work in the male wing. Different kinds of songs were demanded: The men revealed a preference for rap music, containing social themes, such as social exploitation, slavery, work, etc. Since these songs, according to the nurses, were inciting violence and aggressiveness in the patients, these workshops were cancelled. Another possibility, developed by the trainee Carlos Barreto under supervision, was shown to be helpful. This student developed a project of playful workshops to work on improving the self-esteem of the patients. The activities were found highly specific for each wing (male and female). A particular issue stands out in the male wing: the activities performed that involved a larger number of patients worked on a kind of virility not exercised. Higher therapeutic effect was observed in certain activities, such as hitting the ball into the basket, winning a ping pong game, creating their own musical instrument, among others. Here, as mentioned earlier, we clearly observed the intensity of the importance of the assertion of the internal locus of control, or self-management in the male universe, in the configuration of masculinity in our culture and in the reconstruction of a sense of identity in the male universe. These were the first series of approximative, interventional experiments that we performed from this reinterpretation of insanity under the perspective of gender relations. The field seems to be beneficial, and new ideas and researches are necessary to give continuity to these early works.

To conclude this part of the article, we would like to emphasize, based on the data

presented, how the narcissistic functioning of the individual is engendered. In other words: the gender relations lead us to a reinterpretation not only of the psychotic break in a different manner, but also to a reconsideration about the intervention methods in which the engendered values may be used.

Final considerations

The understanding of the severe psychic distress according to the perspective of gender relations allows us to consider how the culturally constructed roles take the subjective experience of the individual. Thus, gender values and roles represent not only causes of distress (constitutive ideas and standards of the individual and by which he/she evaluates himself/herself, evidenced in the complaints), but also a privileged "outlet for frustration" by and through which the defenses of insanity are constructed (virile speech). In the relational complaints, these roles and values were observed as a driving cause of distress. In the case of women, most of these complaints are related to love life (if the family-related complaints are classified in paternal, maternal and children), indicating the impossibility of living a great love story. Generally, the impossibility was due to an external factor, and not to the patient herself. Love-related complaints were also present in the speeches of men, but in this case the impediment factor was observed to be the patients themselves. That is, in the case of women, the locus of control seems to be external; in the case of men, internal.

The prevalence of relational complaints among women, in contrast with the prevalence of a virile speech among men, seems to point out different subjective positions among men and women in the psychotic break, or "insanity process". Women, in general, remain in a complaint position, while men build a defensive position, markedly present in a virile speech in which the delirium often seems to play an important role.

Thus, with regards to the speech of virility, the values by which men build their delirium transcends those values culturally assigned to them: sexual activity, work, money and fame. The male "Self" is inflated through these parameters, pointing to specificities of narcissism that should be more deeply investigated in a work incorporating psychodynamic clinic and gender relations. That is, the relation between the changes of the "Self" in the cases of psychotic break and the engendered character of the narcissistic functioning would be interesting as a future possibility of study. We believe that the perspective of the gender relations may change our own psychodynamic view of the so-called "insanity".

In the female speech of virility, the gender values by which women attribute values to themselves are those referred to them in our culture: beauty, ability to care, sex, self-aggrandizement.

Therefore, we may affirm that gender relations are significantly present in the speeches of psychiatrized patients. Or even that in the extreme distress or radical experience that insanity is, we emphasize the importance of gender relations and how they are constitutive of the

subjectivities. A deeper study about how gender relations create privileged ways of subjectivation, present in the psychotic break and reflected in the epidemiological data related to the mental disorders, remains open for further investigations.

One of the consequences of the present study is precisely the emphasis on the need to consider the gender relations in the mental health public policies. The gender, as a constitutive parameter that may lead to psychic distress, intensify it or just configure it, may also be used in the methods of therapeutic intervention. It is a matter of trying to get an antidote from it. Researches are currently being developed in this sense (Zanello & Souza, 2009). In this kind of work, the paradigm is the idea of harm reduction instead of "healing". In other words, we seek to improve the quality of life of the patients during hospitalization, through a reduction in the need for drugs and, mainly, in the use of physical contention methods, often excessively violent. It is also important to reflect about how the gender values could be used in preventive interventions or as promotion of life.

In conclusion, considering the socio-cultural nature of the psychic illness under the perspective of gender relations, it is possible to "denaturalize" the distress, opening new possibilities of reflection on the methods of treatment and intervention.

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[1] And other synonyms, such as "mental illness", which has currently been used in a privileged way in international compendia for the classification of "insanity".

[2] Term used in a psychoanalytical approach of psychopathology. It refers to the so-called crystal principle, metaphor created by Freud to approach and understand the diversity of the types of psychic distress of the individual. According to him, the human being is not randomly "broken", it occurs according to his/her psychic structuration – an structure that consists in his/her personal history, in a single process of subjectivation and that points to the experiences of childhood sexuality. It is a matter of emphasizing how the "break" of the individual is related to his/her way of behavior. In epistemological terms, the use of the term "psychic break" is based on the definition and interpretation of "insanity" under the perspective of subjectivity, opening ways for the use of the concept of insanity as "severe psychic distress" and the use of a symbolic semiology. That is, under this perspective, the participation of culture and social context is essential. Thus, the definition of insanity as a "mental disorder" is proposed, whose presupposition is the idea of syndrome and an emphasis in the indicial semiology, typical of medicine. See Martins (2003; 2005)

[3] We needed to use this term in this part of the article because the psychiatric epidemiology is built on the medical logic of the syndromes, in which, as previously mentioned, we observed an importation of the semiologic logic of medicine to the mental and existence fields. There are no epidemiological studies that are not based on this definition of insanity as a syndrome, that is, as a correlated set of signs and symptoms. In this sense, the definition of insanity provides a look and a report on the so-called epidemiology. Such report, due to the fact that it is based on specific epistemological presuppositions (biomedical model), supports a biological interpretation, that is, a "naturalization" of the differences of frequencies of the so-called "mental disorders" between men and women, and opens the field for the growing pharmaceutical industry. Regarding the perversity of this logic and the "development" of licit dependence on anxiolytic and antidepressants among women, refer to Zanella (2010).

[4] The author proposes the use of the term "severe psychic distress" to refer to the process of insanity, that is, the crisis. According to her, the term "severe psychic distress" leads to the reflection about the distress as something essentially human (as a possibility), of an order that is not merely organic or physical and, above all, with a "severe" character in the sense of the intensity and difficulty of management. In this article, we will consider insanity more related to this idea of severe psychic distress. This concept seems to point to the possibility of "limit situations" that exist to all of us as humans.

[5] Term used in the medical environment to designate the healing of diseases and that would become visible in the suppression of the symptoms. Expressions such as "having a well-shaped body" point to the metaphorical character of the use of the term and, also, to the form of life of which it is part and creates. In this case, it shows the medicalization of the bodies and lives, and how obesity is now seen as a disease to be healed, in the assertion of a moral and ideal aesthetic of "good health". According to Novaes (2006), our culture would be "lipophobic".

[6] Concept developed by Julian Rotter. It is the degree in which an individual believes that his/her life is under his/her own control or under the control of others. When an individual

believes to be responsible for his/her own fate, the individual has an internal locus of control; and when the individual believes that what happens to him is merely a result of chance and luck, the locus of control is external.

[7] Proclaimed in the public health policies related to the use of drugs. We used the term metaphorically, by analogy.

[8] We had some difficulty to express this idea because "prevention" is a term frequently used in health, with medicine and biology as the base model. In this case, it refers a model of potentialization and deconstruction, that is, of intervention practices that consider the well being or mental health with uppercase "H", taking into account the historical, social and material existence of the individuals involved. See Farmer (1996).

