Living the pointless biographies of mentally ill in Galicia

Manuel Torres Cubeiro 1, IES Campo San Alberto; GCEIS 2; USC.

INTRODUCTION

This report describes the social complexity of mental illness in Galicia in March. I collected the biographies of forty-four people directly associated with Mental Illness (MS). They are grouped into three groups, each group linked differently to MS. First, a group composed of those who live a diagnosis of MS in first person (19 interviews and other data 270). A second group consists of those with a family link with EM (9 interviews, data from 270 families) live within MS in private. Our third group is formed by Mental Health professionals from three mental health units and other hospitals (16 biographies). Using the data from these biographies are re-constructed three biographical profiles or moral careers of their relationship with MS. Each line defines a biographical profile of a patient, family member or a mental health worker in Galicia. These profiles reconstruct social processes in which it is built on the complexity of MS office in Galicia.

HYPOTHESIS: MEDICAL SOCIOLOGY LUHMANIANA.

The German sociologist Niklas Luhmann (1927-1998) built a theoretical framework to describe the social complexity 4. Understanding complex as the situation in which the elements of a system can not relate all together, forcing a biased or selective the system itself. On this concept of complexity Luhmann constructs his sociology has two stages. First, human beings are separate from society. They are not part of a social system are its surroundings. Luhmann therefore focuses on sociology in the study of communication. The second premise of sociology leaves out any ontological concern. Therefore, there is an ontological entity EM, only communications on it. Luhmann's theory describes how the whole social construction gets and keeps sense of social systems.

A social system works by communicating improbable probable. Communication is a complex operation, based on a triple choice. An ego chooses first information. With the presence of alter, ego makes a second choice: choose to communicate. At this point, alter choose whether to accept (or not accept) the communicative intention of the ego. Social systems have previously generated expectations between ego and alter. These expectations increase the likelihood of a successful communication. Ego selects between a set of meanings in semantics offered by social systems. From face to face interactions to the current global society, a growing process of semantic differentiation has occurred. In face to face interaction in traditional societies the likelihood of increased communication increased with the expectations produced by social differentiation by segments, layers, territories or by kinship. If our egos were in a traditional society, could alter accept (or not) their intention to communicate, but the likelihood would increase if both belonged to the same social stratum, the same family or territory or the same segment of society. These social systems work increasing the likelihood of communication and continuity. Contemporary society has emerged from a process-based differentiation, not in face to face interactions, but through organizations and social systems. Both have emerged thanks to a functional differentiation. Social systems become complex over social evolution through diversification of its functions

to facilitate communication. Medical systems, scientific, economic and educational systems have emerged as distinct. Have been formed based on their function. For example, and now focusing on medical sociology, medical systems are differentiated by function, the latter being detected as healing the sick. The medical system does not work only with communications but their work is primarily outside (environment Luhmann's terminology) the social system: it covers the body and mind (soul in previous medical system). A disease can be (or not) an ontological entity to a physician.

The biographies of those associated with MS are complex biological, genetic, chemical, psychological, emotional and social (to name a few) are involved. But neither the biochemical nor the psychological components, or social components provide a complete picture. Mental illness affects the body, psychology and social relations. This complexity must be simplified to be reported to a doctor, a friend or family member. This simplification is an option communicative semantics of a social system. Schizophrenia is a physiological entity. By choosing the word schizophrenia has been elected a socially created meaning. Schizophrenia simplifies the complexity to select a meaningful element of communication. In the sociology of Luhmann called this semantic cultural pool where you select meanings and expectations with communicative possibilities of success. Our working hypothesis was that the three different groups use the same words to communicate, but each uses them in different senses. It is this difference, presumably because they speak the same thing, what gives it its social significance. What is a MS from a sociological point of view? Without entering into detail, for a biologically oriented medical MS is a brain chemical imbalance psychoanalytic training or have a bad psychological learning. For a family could be an embarrassment, a reason to blame or maybe an insurmountable burden. For the patient, MS is a disease, an illness or crisis may be an alleged passenger. The sociologically important is not who these groups is the truth. The sociology describes, as we saw, communication in the case of MS stems from the complex interweaving of all these definitions.

PURPOSE: DESCRIPTION OF THE COMPLEXITY.

If our working hypothesis is that the social system is complex. And it probably also works for communication when the meanings ascribed different and contradictory. The aim of this study was to describe the complexity of these contradictions and differences. In that sense we have collected biographies of the three different groups. Once collected we have extracted the profile of the development on the go professionals, families and the mentally ill. Each profile describes the evolution of the meaning attributed to MS and it changes over the life of each of the groups interviewed. In so doing we will help the reader understand the social, not acting as doctors, including family or sick.

We call this EM to what in our society and social specialists called in detection, identification, care and treatment: psychiatrists. Before the advent of medical science and psychiatry healers attended each region and culture, detecting and treating ailments equivalent 5. With the emergence of psychiatry in the nineteenth century these local medicines do not disappear. In Galicia the possessed and still have their places of healing rituals and treatments with herbs and incantations. In the nineteenth century a German physician Emil Kraepelin 6 classifies mental disorders on symptoms assuming that doing so would be detecting the underlying physical causes. This raises the biological psychiatry where MS has a physical cause in the body, still to be defined

precisely. At the end of XIX a Viennese physician, S. Freud, mental health problems associated with childhood trauma, suggesting a cure through speech in which he called psychoanalysis. Along with the birth of psychology as a science, the MS is defined here in its psychological components. In the mid-twentieth century discovered several drugs that calm the acute symptoms of MS or help stabilize mood swings. Psychotropic drugs are added to the biological definition of MS by adding a chemical mechanism is not fully understood but "works" (side effects). Already in the sixties and seventies spread the idea of MS clearly has a social component, calls for closing psychiatric and create "community networks" where are addressed. We have therefore four defining elements of MS in our society, and local medicines: those provided by biologist psychiatry, drug therapy, community psychiatry and psychological therapies (more or less psychoanalytic). MS is in this complexity which must be understood and studied.

In this paper we offer a small part, to the three profiles in question, the description of the complexity of our original research in July. He did also: (1) a history of semantics of the medical system to the differentiation of psychiatry, (2) a history of the semantics of medical anthropology and sociology, (3) a history of the various institutions and organizations have differentiated in Galicia since the nineteenth century to meet the MS or equivalent, (4) a description of daily life in one of the NGOs managing MS in the present, and finally (5) a description of the communication two mental health units in Galicia in the 90s. Luhmaninao The theoretical framework was also discussed more fully there. Here are just a small part of the description of the social complexity that arises from the social interaction of all these elements.

METHODOLOGY: REFLEX TIME AND AWARDS.

"Our task as researchers is to produce not only knowledge but also help others understand the limits of the knowledge we have produced" 8.

A medical sociology of mental illness must bear the consequences of the proposed theoretical approach. You must meet certain requirements to be thoughtful and coherent. We note here five. First, our methodology should include self-awareness of their limits. If this is a description of social complexity, an obvious limit is the impossibility of a complete description. Therefore, you have to lower expectations, becoming humility in the key of our research. Since there is no single description of social complexity, the solution is to make explicit our methodological choices, our inevitable simplifications. In this sense in our original research in September described the semantics of all theoretical systems used in medicine, psychiatry, anthropology and sociology.

A second key methodological is the inclusion of time and diachronic perspective. Luhmann does not understand a social system without observing their change and evolution of their communications. Weather has been introduced in our research in two ways: first, collecting biographies to describe the evolution of the meaning of mental illness in each interview, secondly, we have included a history of complex institutional framework of health system Galicia.

A third requirement is the adoption of a constructivist approach. Leave behind any ontological nostalgia in sociology means assuming that there is no single reality, but a multitude of socially constructed communication. Thus, each respondent's comments

are constructions in the selection of meanings offered by the social semantics. Each person talks about mental illness in a different sense, and yet the social system ensures that communication can proceed.

The life stories selected here comprise both the complexity and change over time. Evolution and complexity are key tools for a methodological viewpoint. A biography is the story of all "life experiences of a person." 10 But far from being simply assigned based on authenticity, the biographical genre in itself is a form of observation and communication. Biography is one of the ways in which a social system observes a human being extrapolated and 11 Luhmann literary theory to sociology. Human beings have learned to repeat models which give an account of his life to others. These models have biographical meaning precisely because we accept the meaning they assume. The sociological question is not about the authenticity of the story told in a biography, not a cruel history from the margins. The sociological question is how to construct meaning within a biography in communication with the sociologist. The biographical accounts we offer researchers the opportunity to observe both the construction of meaning as its evolution in the same elapse of time. Our profiles show the emergence of complexity and movement.

A fourth methodological condition is the adoption of a functionalist perspective. Far from the exclusive prejudices of some quantitative sociology, the function is here a methodological sense. A function is "a logical regulatory scheme that organizes" 12 a set of options, and meets normally distant to the senses. A social function establishes equivalences. A significant organizational role. Mental illness has different meanings for parents, for patients or health workers. These "three" meanings of MS are functional equivalents to provide order and meaning. A doctor and a patient communicate precisely because they do about the same (even when used exactly the same word). And this brings us to our fifth methodological premise:

The purpose of sociology as a science is to observe the differences, not to draw analogies or similarities. When the sociologist offers a simplification (like mine here), helps the reader (or not) to make your own reflection. Our sociological approach aims to rebuild the complexity in the eyes of the reader to understand (or not) social complexity.

RESULTS: CONTEXT AND THREE biographies.

In Galicia overlap various administrations to meet the MS. In the twenty-first century free public assistance Charities was organized in the municipalities. At the same time worked for payment of medical services, mainly in the urban core for the scattered Galicia serve its population scattered. In January 1885 it opened in Santiago de Compostela will be until 1959 that the only psychiatric hospital in Galicia. I founded the bishopric Compostelana but quickly signed agreements to meet the "insane" that local councils by law must meet the Charity. The Psychiatric Conxo be until mid 1959 at the founding of another hospital, the only place that specializes in psychiatric care in Galicia. During this long period we have two systems of psychiatric care: a charity or poor in Conxo litter, and one private beds with mattress also in Conxo. The first funded by the County, the second with direct input from families. Even today in Galicia Conxo talk is talk of discrimination, poverty and madness.

With Franco (1936-1975) created the Social Security and free medical insurance for all workers. Coverage of the EM will have to wait, on paper, the Health Act 1986 and Democracy and the Socialist Party in power. During the sixties and seventies have opened four other state psychiatric hospitals in Galicia while several "sanatoriums" private. The Chair of Psychiatry, Faculty of Medicine Santiago also got to have a specialty in Psychiatry Unit in Hospital with child psychiatry team. At the same time created twelve mental health units at different clinics, health centers and hospitals throughout Galicia. To this have to join the mental health clinics set up in the military hospitals in the Hospital del Mar and drogodepencias units created under the casuistry of each professional and each council. Therefore Democracy and the end of Franco diversify and multiply the devices of attention to the existing MS. From the seventies until the late twentieth century this complex network joins a network of private psychiatric consultations, also associated with their private sanatoriums in all Galician towns. The private network and public network to flourish thread s laws protecting the coverage of MS on paper but in practice not carried out.

Already in the early twenty-first century the administration of the Galician Autonomous Community legislation takes a unifying Mental Health. And thus begins to unify all these clinics, hospitals and units under the heading of "Service Galego de Saúde" or SERGAS. This coincides with the supposed closure of psychiatric hospitals psychiatry advocated 13, and the defense of the so-called Community Psychiatry. So, coinciding with the legal unification with mental illness and their families are beginning to join up to 25 associations to cover another area in which the law will not attend: the chronicity of their illness (Pergola is one of them). These partnerships will in turn create a network of private care funded by grants and European funding: rehabilitation centers, supervised apartments, businesses to provide employment for the sick.

From Charity to the nineteenth century XXI SERGAS the different systems integrated into the medical system have fueled the semantics in which they work managers, family members and patients themselves in Galicia. We have briefly defined the evolution of the institutional context.

I. DEALING WITH THE MEANINGLESS: LIVING A DIAGNOSIS OF MS.

All Mentally Ill had a life before diagnosis. They get confused and idealized memories of what life was like before, seldom draw a clear distinction between personality and MS. In most cases the presence of MS is found in adolescence to increase the number of problems and conflicts. Most remember the first serious crisis ends with an in income and in adult life. The dividing line between childhood happy, normal young adulthood with an increasing number of problems with others, is generally clear. Many of the interviewees reported at this time the use of alcohol and other illegal drugs (heroin, cocaine, hashish ...). A large majority said the cause of their current state to alcohol and drugs.

All interviewees narrate a race with thousands of therapists before going to a psychiatrist. The case mix is varied but in general, the advice of someone carrying a healer, a specialist in the capital of the community or region, or doctor nephew of a neighbor. If the drugs becomes a central theme the different detox programs, public or private, are then either follow the advice in this or that. The advent of psychiatry as a specialty is in general a first visit to a private psychiatrist. It is worth noting here that

not one of all respondents has remained the same psychiatrist, all have gone through more than three psychiatrists to have as your psychiatrist today. Most users Pergola today are treated with Melon in the public USM. But none have had him as the only psychiatrist. All users have gone through a long list of psychiatrists and specialists of various kinds: acupuncturists, curandeiros, herbalists, Albéitar 14, psychologists, psychoanalysts, psychiatrists of all schools thinkable, and so on.

Sometime during this pilgrimage a psychiatrist who understood and remain a season given a diagnosis of a serious MS are prescribed a medication. Usually coincides with a major crisis in which the core of family members or relatives and not take any more and there is a first deposit more or less long. Dominate the public sector income, but also here in a first psychiatric admission, abundant use of private practice. The case mix varies greatly here depending on employment status, family and staff of each case. After this first entry, the list is long, through all Abstracts available, depending on the presence or absence of free beds. None of the interviewees, without exception, tells less than ten revenue over the years. In many cases you do not remember exactly the exact number or you can establish a clear chronology of them.

Upon receiving a diagnosis of MS after meeting with a psychiatrist who understood, recounted a long pilgrimage to find the exact dose of anti psychotic pills and side effects. They tell stories of trial and error in a complex evolution with its crisis, income and family situations varied. All accounts have been periods when the medication stopped "feeling better". The reasoning is similar in all mentioned cases. "If I run as well, because I keep taking these pills." 15 As for medication, few remember exactly the names and quantities of pills taken. Most receive them in Pergola or they give their families at every meal. Many receive an injection for the acute symptoms, with six to seven pills to complete the treatment and avoid unpleasant side effects. It follows that the doses that have theoretically made by their psychiatrists, but the families with whom they live, supervising or supervised flats themselves or fellow workers Pergola, change or advise them to change the doses at the onset any crisis.

In at least three cases occurred at the time of the stability of diagnosis and medication, a strong crisis with reference households. The family plays in all cases, positively or negatively, as seen every one, a role essential. Or openly accepts and works, or for reasons not always clear to the user, involves a certain break. The three cases are not exceptional, most periods in their lives tell where the family did not understand what was happening, so they lived on their own for a while. In none of the interviewed family breakdown is permanent or total.

After the long history of income, many treatments and therapies they reach a certain stability in their behavior or their lives. Someone referred to them or told of Pergola, in most cases after an income or local USM. Mostly a family goes with them in the first visits to learn. In many cases one season to attend workshops or living in supervised flats to quit after the association and the services it offers. Many users today have come and gone Pergola Association several times. Pergola To join must be stable, a psychiatrist and medication, and must be drug free (some receiving methadone in Pergola). They must pay a monthly fee that varies depending on the capabilities of each user and the services that he uses. Everyone is in a workshop (sewing, leather, framed, paper ...), but most narrates a tour of the various workshops to find the right one. Also attend workshops on education and psychology, have a dining room and 12 of them live

on all three floors of the association protected in the village. To perform all these activities are gathered in several vans each morning and leave them at home each evening. Most users have handled their non-contributory pension (about 440 euros per month) through the association, which also manages and administers the medication and reviews with psychiatrists and doctors of each.

In spite of all hospital admissions, the long histories of different medications and tests with various experts in MS, none of the interviewees were defined as mentally ill or schizophrenic. They speak of their "illness" but did not add the nickname mental. His identity is as sick, not mentally ill. Therefore do not accept the diagnosis of MS, although the medication, participation in partnership with nuances ("it work," says the majority) and they are capable of repeating the patterns defining learned about his "disease." Each has a different explanation of what has happened to be who they are: a blow to the head, a bad experience (sexual, family, etc.), Poor medical treatment, etc. No user of Pergola of respondents closely define its status as EM or madness. Each has a name for your "problem." None spoke in the privacy of a "failure" biochemical or genetic brain. Pergola Each user has a different causal explanation for his state. But when talking about what they have learned in Pergola, all seem to repeat the same "lesson" MS is an imbalance in the brain that medication restored. All the comparison over and over with diabetes. In this same sense of lessons learned all agree on terminology, examples and vocabulary to describe what the Schizophrenia. Thus all report having learned what their "disease" only once became part of daily life Pergola.

They agree to use a varied vocabulary to describe his shyness, his taciturn states. These states are not blamed in principle to the disease but who identify themselves as belonging to their personalities, their character. And even after years of having a stable diagnosis, rarely attributed, in dialogue, in Schizophrenia and Bipolar Disease. Make a clear distinction between the near moods of depression, those close to violence and attacks or crises. Violence, stress or ants that are unable to control their situation worse and usually end up visiting a doctor.

The major difficulty of getting an MS is to identify the distinction from which to observe. While facing the public identify the symptoms of MS, communicating its experience in understandable semantics, they do so in privacy. Here the vocabulary to explain their condition is personal and idiosyncratic. Each one moves away from the features of schizophrenia to explain his state from some other acceptable meaning but without the social costs of MS. The distinction between sick sane is used in a flexible manner. This ambivalence is the key to understanding the distinctions from the officially diagnosed with MS are communicated. We now a quick tour of the other distinctions observed in the experiences narrated in first person in the first profile of our first group.

Although the difference between delusion and reality, the EMG is often placed on the side of delirium. But I call their imaginary life. They know that is not real, but its persistence despite the medications, are required to talk about it, not always from him. Elijah talks to God while Eladia a distinction in his speech asking if I want to hear your imaginary or real life. The border separating the two, and fluctuations are the key.

In the biographical narratives built on interviews make a clear difference between the first attack or the onset of his illness. All freely admit, if it were the case, drug use, the

majority among the users of Pergola. They describe a series of crises after another, income and proof of this or that medication and unpleasant side effects. In this process few see their doctor in their stories, their own initiative. They take their families. The pilgrimage by different specialists inevitably ends in a psychiatrist at the public social security.

Those diagnosed with Bipolar Illness idealize their periods of mania. They feel themselves as they describe their periods of depression sadness. The living energy euphoria identify it with the best of times, turned into an ideal state models. The abandonment of medication match the output of a depressive phase and the beginning of a rise in mood. If you are well, leaving the well why do they need the medication?

In all cases the routine, the presence of relatives or friends with the same problems are the mirrors that look. Without them the course of MS would not be atajarían leading to periodic crises. The experience of many years of course of MS along with the presence of others around them communicate their mood or state, are the key. Each user is dimly aware of this reality, and not separated from his family, other Arbor users. Which of course does not prevent failures in the system because the revenue and relapses occur.

The image that define their membership is mostly Pérgola the workers. They come to the warehouse to work in different workshops. Identify themselves to the villagers: "I am at Pergola, without adding anything else.

When asked about the benefits of belonging to Pergola, almost all answer something. Here indicate that they understand, they want, listen and receive affection. The distinction is clear inclusive. Outside the association does not know who they are, inside, they are someone. Even outside the public eye, despite the generally negative stereotype hides, belonging to Pergola serves to justify their status, their weirdness of strangers. La Pergola MS communicates and lives. With it gives identity, and being a normal feature exclusive MS becomes the linchpin of the inclusion, at least within the association itself and the local area.

II. INTIMACY WITH THE MADNESS: NO SENSE FAMILY

Respondents in this second group agree a common feeling of helplessness and uncertainty. Throughout the entire life process of living with MS in family privacy (from early indications, the first visits to specialists, the first psychiatrist, the first crises and hospital admissions, relapses, changes in therapy) to Throughout this career staff, there is something constant fear and lack of understanding. The uncertainty lives with them since the EM appeared in their lives.

Families face the first signs of MS as a challenge. Behavior inexplicable bursts into their lives. After several crisis reasonable explanations are abandoned one after another: the persistent unexplained behavior destroys the obvious reasons. Neither drugs nor a psychological ordeal after personal problems or stress, can be maintained and as an explanation. Here is a first clear distinction from that seen in MS. There is a before and after the time when there are no easy explanations can be sustained. Respondents generally describe a single crisis that becomes a breaking point. Uncertainty, fear, panic sometimes are always there, but after this point, "things started to make sense," they say. Everything else will be re-interpreted in the future from this new perspective. The

search for a justification and begin treatment as soon as it concludes that it is a MS. No more excuses: something is wrong. A first explanation is often the Somatization: physical systems must account for such strange behavior. Through trial and error began a method of eliminating possible causes. A common strategy is the use of social network looking for reasons and justifications treatments. Doctors and specialists are used to add evidence to that comes the realization: the problem persists and have not yet understood. Neither private medicine, not all economic efforts stabilize or calm the crisis. There are periods when the symptoms are not alarming or almost disappear. In retrospect remember how they thought the problem had disappeared. But after a while, the symptoms returned. The problems were then increased until the situation became untenable and somehow they have to step up and accept a first hospital admission under the supervision of mental health expert.

Interviewees recalled how difficult it was to accept the MS after the first psychiatrist, mainly because they lived a contradictory situation. On the one hand, the family faced the embarrassment of seeing a psychiatrist, but instead it offers an explanation "socially" accepted and acceptable. If they continue with psychiatry, then he must assume as chronic psychiatry recognizes that no cure for MS. In contrast offered pills to make it easier to live with psychotic symptoms. Later, they recognize that there are black spots that do not receive much help from doctors, but at this point the psychiatrist and MS are a relief. Somehow all respondents end up using the resources of public psychiatry. The cost of all other options makes this the best solution to the problem persists.

A major workhorse, permanent in many cases, the Family is to find a psychiatrist who understands your loved one and themselves. First, the family must now understand the complex world of mental health care. Respondents described situations in which various problems faced within the health system: there were no beds available during a crisis, were denied a prescription when it was necessary bureaucratic nightmares for a pension, etc. The diagnosis of severe mental illness simplifies things but it comes with new problems and contradictions. Diagnosis provides a valuable solution. The EM gives meaning, explanations, and can speak openly. A label of MS can communicate with each other and communicate to others in a way understandable problems until now incomprehensible. The privacy of the family is now going abroad. Even better, it has eliminated the blame because MS causes away from the family environment. Now there is something "objective" can be shared with neighbors. The peace comes because the fault lies in brain chemistry: or education, or poverty, or trauma, or a bad childhood is now possible cause. The trauma of a bad father, husband or wife may also be ruled out. Now the family understands and can openly imply. can live without blaming themselves or blaming their decisions. But this relief has some "side effects": the medicine "side effects" on the one hand, and chronicity on the other.

We note here that all the interviewees are relatives of a mentally ill person with a stable diagnosis. The main feature is therefore persistence. Thus, this distinction between before and after an initial crisis continues. They now know with certainty: MS is going to stay. Stabilizing medications, treatments and the relative peace is confirmed. But it opens up other uncertainties. The mothers, husbands, wives, fathers, brothers, are all concerned about the future of your loved one: what social system they provide care in case they disappear? This concern is heightened when an elderly mother is the main provider care for mentally ill as an adult. Pergola users perceive this problem. Your

guess is as pergola itself is expected to supply them with necessary care. With the diagnosis of MS found relief, explanations and choice (or not) to communicate, Pergola but gives them hope of continuity even in his absence.

Most respondents defined MS as a chemical imbalance in the brain. Although, do not seem to understand exactly what this means if they see, and so repeated, how medications work. Even with terrible side effects, the pills prove the actual existence of MS in their loved ones. With MS have gained a glimmer of hope. Respondents are a great comfort to be able to talk with other relatives in Pergola. The ability to communicate the intimate experience with MS does not cure the sick, but it creates social ties. Pergola is your bet, and seems to be working, repeated in interviews. When asked about the benefits of belonging to Pergola, almost all respondents said something similar. Family members feel understood here, because every time I speak not have to re-explain all his experience from the beginning. Go there, listen, talk and feel understood, give and receive affection. Outside the association does not know who they are, inside, they are someone. Membership Pergola justify their status, but also its oddities with strangers. La Pergola MS communicates and lives: but also offers hope. It gives them identity, and becomes the hinge of its inclusion, at least within the association itself. As we have seen, this NGO makes mentally ill relatives to acquire meaning, a meaning different from that obtained by propis sick as we saw earlier.

III. Managing Nonsense: MENTAL HEALTH PROFESSIONAL.

Our third group consists of the biographies of the management of MS, with special attention to their psychiatrists. All interviewees share a pragmatic attitude: they use anything to make it work, whether or not inconsistent with the image that everyone has MS, the overall mental health or psychiatry in particular. Added to this is a clear eclecticism Although each interviewee can choose one of the possible existing schools in psychiatry as preferred. Professionals trained in the Franco era have a more phenomenological psychiatry (MS would be a very human definciencia for this subgroup), the middle-aged blend of psychoanalysis as an ideal model of community psychiatry and health care system (MS would eminently social thing that society has a responsibility to serve). Finally the youngest closer to a medical model, trying to catch up to other clinical specialties (in this case MS is a biological imbalance or without individual or social responsibilities, but with care and psychological consequences). All, however, share a tone of irony and skepticism in justifying its eclecticism and a clear clinical orientation and pragmatic.

There are certain concepts in different psychiatric settings psychiatrists using all respondents, regardless of their predominant orientation. The duality psychosis / neurosis originated in psychoanalysis is one of them, the concept of community psychiatry as an ideal of social assistance is another, and the opposition between psychiatry and psychology, psychological tests compared to therapy and medication are other examples. All access to medication use, although they share an initial reluctance to prescribe it.

The years of training in their specialty justify the predominant orientation for each specialty, while feeding a network of contacts with doctors that address the needs of your clinic: refer a patient, make an inquiry or to get a bed for an entry . The common complaint about his formative years is too much theory and little reality of learning. All

relate the change to having to treat real patients, once they are faced with this complaint fits perfectly with the combination of pragmatism and skepticism that defined a moment ago.

Once started the practice beyond the formative years, all recognize one or several cases that have become paradigmatic, or that somehow made them learn. One patient, a history of violence or of an error used to define the identity of each. In this case we learned to make, for example, the distance to the patient. Must have empathy with the EMG, but can not carry absorberte. It plays with the imagination of community psychiatry, psychiatry and ethno psychiatry or even more organismic psychotherapy. Each manager or psychiatrist dominant, but they are not closed to use the other to communicate in interviews with me or how they view their practice in consultations with their patients. The paradigmatic case marked them also defines what exactly the imagery of the EM and psychiatry that predominates in each. Or it shows the contradictions of his own theory, justifying its identity as a psychiatrist or a bilogicista psychoanalytic trend. In his professional identity as this case clearly marked a difference.

The interviewees of this group, the criticism of the system is common, but hope in a better organization of health care or new discoveries is attached to it. The hopes for the future is consistent with the predominant perspectives in each, but they all build their communication expectations in terms of them. Thus, a community-oriented psychiatrist but with a nationalist vision criticizes the lack of understanding of psychiatry's official "Galician peasants." It is very critical eg psychiatry theoretically more biologist but has no problem in prescribing many drugs as his peers openly organicist. In both cases the justification is pragmatic and clinical application with which the patient presents.

There is no criticism of the fact of private psychiatric practice. Their existence is not even mentioned nor taken into account, nor is criticism. All psychiatrists interviewed, except one, maintained a private practice, sometimes working more hours in her than in his position in public health. Speaks about it is not any kind of criticism. Maybe not to mention the fact it is a way to assume its existence as part of their role and identity as a doctor or psychiatrist ..

Yes criticize private partnerships. Usually done by assuming that cheap labor that should be under the administration or by the fact simply be private. In this way the community network are necessary but always ideally organized from público.Los sector managers and organized in Galicia EM observation, from a purely medical approach and a care orientation. In the continuum between the extremes of the distinction arise positions number where a clinical pragmatic and eclectic theoretical position are the norm. All integrated into an image of a responsible job in the "good doctor."

DISCUSSION-CONCLUSION: COMPLEXITY SIMPLIFIED.

In the literature on MS in Galicia there has been, to our knowledge, a sociological perspective. Marcial Gondar Galician Anthropologist 16 together with the psychiatrist and anthropologist Emilio Gonzalez 17 have published a series of works in which they denounce, among other things, the little importance is given to the concept of culture in helping the mentally ill in Galicia . have a lawyer and to remedy the lack ethnopsychiatry. From a medical and psychiatric approach have been published,

associated in some way to the chair of psychiatry at USC, two types of studies related to psychiatry in Galicia. On the one hand, a number of studies of the history of psychiatry Galician until the eighties and nineties did not exist in the literature (highlighting the work of D. Simon Lord 18). On the other hand, without a systematic continuity after his death and the extinction of the chair of psychiatry at USC, a series of epidemiological studies with a dye made sociological under late Professor Antonio Rodriguez Lopez 19. There are of course a number of studies of psychiatric eminently guidance published in several magazines both Galician (SISO-Saúde of the Galician Association of Psychiatry, 20), Spanish (AEN 21 among others). They are also isolated case studies on some aspect directly or indirectly related to psychiatry.

In conclusion we can say that has not made a systematic study of psychiatry and MS in Galicia from a sociological point of view. And certainly not from a perspective that takes social complexity of contemporary social system. This research is an attempt to begin to resolve this problem.

The aim of this paper was to present a description of some of the elements involved in the social complexity of MS in Galicia. In particular the evolution of consciousness and meaning attributed to the MS over time in the biographies of three distinct groups: those with a diagnosis of MS, family members of these, and finally those involved as professionals in managing MS. We have outlined the biographical profiles of the three groups. The three share elements but the most important are the differences between them. Thus, the meaning of mental illness for a patient is not the same as for a family member for a mental health professional. The theoretical approach adopted sought to show these differences, understanding that the social system works precisely in this disagreement, not consensus.

REFERENCES

Narrow Saura, T. "The concept of hysteria in some physicians in Galicia." In Seventy-five year history of psychiatry (1924-1999). III Jornadas nacioinales history of psychiatry, edited by T. Narrow Saura, Antonio Rodriguez Lopez and David Simon Lord, 245-260. Ourense: Spanish Association of Neuropsychiatry and Galician Association of Psychiatry, 2001.

Narrow Saura, T., Antonio Rodriguez Lopez and David Simon Lord, eds. Seventy-five year history of psychiatry (1924-1999). III National Conference on the history of psychiatry. Ourense: Spanish Association of Neuropsychiatry and Galician Association of Psychiatry, 2001.

Basaglia, Franco. "The anti-psychiatry." The old mole 45 (1980).

Berrios, Germain. The History of Mental Symptoms. Psicopathology Descriptiuve Since the 19th century. Cambridge: Cambridge UP, 1995.

Berrios, Germain. "Recent Advances in the history of psychiatry." In Origins and foundations of psychiatry in Spain., Edited by Victor Aparicio Basauri, 13-20. Madrid: Book of the Year, 1997.

Berrios, Germain. "Recent advances in the history of psychiatry." In Origins and foundations of psychiatry in Spain., Edited by Victor Aparicio Basauri, 13-20. Madrid: ELA, 1997.

Berrios, Germain. History of symptoms of mental disorders. Descriptive psychopathology since the nineteenth century. Translated by Laura de los Ángeles Rodríguez Díaz. Mexico: FCE, 2008.

Berrios, German and Tom R. Dening. "Introduction to" The significance of symptom complexes in psychiatry. " In Symptoms of Madness, edited by Alfred Hoche, Emil Krapelin and Oswald Bumke. Madrid: Fundación Archives of Neurobiology; Editorial Triacastella, 1999.

Berrios, German and R. Porter, eds. The history of clinical psychiatry. London: Athlone, 1995.

Cabaleiro Goas, Manuel. "A Galician folk medicine psychiatry na: etiopatoxénia." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 123-40. Santiago: Laiovento, 1992.

Cockerham, William C. Sociology of Mental Disorder. New Jersey: Prentice-Hall, 1996.

Cockerham, William C. "Labeling theory and mental disorder: a synthesis of psychiatric and social perspectives." In Studies in symbolic interaction, edited by Norman K. Denzin, 257-280, 1979.

Cockerham, William C. "Becoming mentally ill: a symbolic interactionist model." In Studies in symbolic interaction, edited by Norman K. Denzin, 339-350. New Jersey: JAI Press, 1990.

Corsi, G., E. Esposito, and C. Baraldi, Eds., 1996 (1995): Glossary on the social theory of Niklas Luhmann. Anthropos Universidad Iberoamericana, 191 pp.

Denzin, Norman K. Interpretative biography. Vol 17, Qualitative Research Methods. London: Sage, 1989.

Denzin, Norman K. "Stanley and Clifford: Undoing an interactionist text." Current Sociology 43, no. 2 / 3 (1995): 115-123.

Denzin, Norman K., ed. Studies in symbolic interaction. Greenwich, CT: JAI Press, 1979.

Denzin, Norman K. Interpretative interactionism. California: Sage, 1989.

Denzin, Norman K. The alcoholic self. California: Sage, 1987.

Denzin, Norman K. "Emotions as Lived Experience." Symbolic Interaction 8 (1984): 223-240.

Denzin, Norman K. "On Understanding Emotion." In Research Agenda in the Sociology of Emotions, edited by Theodore D. Kemper. Albany: New York Press, 1990.

Denzin, Norman K. Childhood socialization. San Francisco: Josey-Bass, 1977.

Denzin, Norman K. On Understanding Emotion. San Francisco: Jossey-Bass, 1984.

Denzin, Norman K. and Y. Lincoln, eds. Handbook of qualitative research. London: Sage, 1995.

Díaz de Rada, Angel. Ethnography and anthropological research techniques. Madrid: UNED, 2003.

Fuentenebro, F., Rafael Huertas García-Alejo and C. Valiente, eds. History of psychiatry in Europe. Trends and Issues. Madrid: Freni, 2003.

Garcia Alvarez, Victor Pedreira MX and Crespo. "The history of public psychiatric care in the province of Pontevedra: Creating a psychiatric ward in Provincial Hospital (I)." In Seventy-five year history of psychiatry (1924-1999). III Jornadas nacioinales history of psychiatry, edited by T. Angosto Saura, Antonio Rodriguez Lopez and David Simon Lord, 261-268. Ourense: Spanish Association of Neuropsychiatry and Galician Association of Psychiatry, 2001.

Garcia Alvarez, Victor Pedreira MX and Crespo. "The hospital's psychiatric ward Provincial de Pontevedra (II)." In Seventy-five year history of psychiatry (1924-1999). III Jornadas nacioinales history of psychiatry, edited by T. Narrow Saura, Antonio Rodriguez Lopez and David Simon Lord, 269-276. Ourense: Spanish Association of Neuropsychiatry and Galician Association of Psychiatry, 2001.

Portosany Gondar, Marcial. Mulleres mortar. Cara da muller anthropology are running in Galicia. Vigo: Xerais, 1990.

Portosany Gondar, Marcial. A morte. Sada: O Castro, 1987.

Portosany Gondar, Marcial. Crítica Galega da reason. Among or-nós mesmo e nós, outros. Vigo: A Nosa Terra, 1993.

Portosany Gondar, Marcial. Romeiro do Allén. Antropoloxía da Morte in Galicia. Vigo: Xerais, 1989.

Portosany Gondar, Marcial, ed. Anorexia: diet, beauty, crenzas. Santiago: Museo Pobo Galego, 1995.

Portosany Gondar, Marcial. "Wise and doctors: medicine or conflict official / folk medicine na Galicia non urban." In AA.VV. 1989, 1989.

Portosany Gondar, Marcial. "Therapeutic relationship and conflict of interest na saúde mental. Estratexias of xestión." In AA. VV. 1997, 323-332, 1997.

Portosany Gondar, Marcial. "O exotic as cultural please. As symposium keys do." In Anorexia: diet, beauty, crenzas, edited by Marcial Gondar Portosany. Santiago: Museo do Pobo Galego, 1995.

Portosany Gondar, Marcial. "Wise and Doutorado." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 239-254. Santiago: Laiovente, 1992.

Portosany Gondar, Marcial. "A doenza as a form of culture." In spirits. Ethnopsychiatry Ensaios of Galician, edited by and E. Marcial Gondar Portosany González Fernández, 15-40. Santiago: Laiovento, 1992.

Portosany Gondar, Marcial. "Neoliberalism e saúde mental. Loucura da Political Economy." A Lock de Ouro 61 (2005): 13-29.

Portosany Gondar, Marcial Fernandez and Emilio Gonzalez, eds. Espirito. Ethnopsychiatry Ensaios of Galician. Santiago: Laiovento, 1992.

Portosany Gondar, Marcial Fernandez and Emilio Gonzalez, eds. Possessed: Galician ethnopsychiatry tests. Santiago: Laiovento, 2003.

Portosany Gondar, Marcial, Esperanza Guisan, Joaquín Rodríguez, Javier San Martín and Juan Vazquez, eds. Anthropology and Rationality. Santiago: Salvora, 1980.

González Fernández, Emilio. A psychiatry in Galicia. A Galician and Conxo psychiatry. Madrid: Do Rueiro, 1977.

González Fernández, Emilio, ed. Saude Culture and mental. Aproximacións antropolóxicas a psychiatric clinic in Galicia. 190 vols. Santiago: Xunta de Galicia, 1994.

González Fernández, Emilio. "Folk Medicine: racionalidade hysterical e das das Crises Respostas as thyself." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 157-170. Santiago: Laiovento, 1992.

González Fernández, Emilio. "A pilgrimage two symptoms." In AA. VV. 1997, 307-322, 1997.

González Fernández, Emilio. "Folk Medicine: racionalidade das e da resposta hysterical crisis ore Mesmer." In AA.VV. 1984, 1984.

González Fernández, Emilio. "Transcultural Psychiatry. A achegamento pragmatic." In spirits. Ethnopsychiatry Ensaios of Galician, edited by and E. Marcial Gondar Portosany González Fernández, 41-66. Santiago: Laiovento, 1992.

González Fernández, Emilio. "Cultural Psychogeriatrics: the clinical interview as a cultural intervention." Public Psychiatry 11, no. 1 (1999): 27-35.

González Fernández, Emilio. "Units of cultural broker saúde mental: da xestión alterative to rural municipality galego nun crazy." Universidade Santiago de Compostela, 1999.

González Fernández, Emilio. "Psychiatry and Religion." Encrucillada (1977): 321-330.

González Fernández, Emilio. "The" mad room "and" insane department "of the great Hospital of Santiago (Virtual Spaces)." In Seventy-five year history of psychiatry (1924-1999). III Jornadas nacioinales history of psychiatry, edited by T. Narrow Saura, Antonio Rodriguez Lopez and David Simon Lord, 193-206. Ourense: Spanish Association of Neuropsychiatry and Galician Association of Psychiatry, 2001.

González Fernández, Emilio and Josep M. Comelles, eds. Transcultural psychiatry. Madrid: Spanish Association of Neuropsychiatry, 2000.

González Fernández, Emilio Garcia and Xosé. As institucions da madness in Galicia. By running in a nova psychiatry. Santiago: Minerva, 1978.

González Fernández, Emilio, Alfredo Mazaira Xosé Castro and David Simon Lord. "O please psychoactive drug as cultural. Transcultural psychiatry approach Efeitos you galicians placebo in patients." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 171-181. Santiago: Laiovento, 1992.

González Fernández, Emilio and David Simon Lord. "Thinking two doctors antropolóxico Galego (Historical Record)." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 91-120. Santiago: Laiovento, 1992.

González Fernández, Emilio and David Simon Lord. "Anthropological Thought Galician physicians. Point history." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 91-122. Santiago: Laiovento, 1992.

González Fernández, Emilio and David Simon Lord. "A vision of psychiatric care in the twentieth century Galician: Manuel Cabaleiro Goas." Magazine Spanish Association of Neuropsychiatry, no. 62 (1997): 305-309.

González Fernández, Emilio and David Simon Lord. "Stories of the Insane Asylum Vilapedre-Sarria-Lugo: Ricardo Núñez Rodríguez, an atypical protopsiquiatra of the Twentieth Century Galicia." In The Management of Madness: knowledge, practices and scenarios, edited by AA. VV., 121. Cuenca: U. Castilla la Mancha, 2001.

González Fernández, Emilio and David Simon Lord. "A Galician history of psychiatry in the twentieth century." Archives of Psychiatry 64, no. 2 (2001): 101-136.

González Fernández, Emilio and David Simon Lord. "Materials for a history of psychiatry in Galicia: the twentieth century." PsiquiRed (2002).

Hoche, Alfred, Emil Krapelin and Oswald. Bumke, eds. The symptoms of insanity. Madrid: Fundación Archives of Neurobiology; Editorial Triacastella, 1999.

Huertas García-Alejo, Rafael, ed. Orfila, knowledge and medical power. Madrid: CSIC, 1988.

Huertas García-Alejo, Rafael. The laboratories of the standard. Medicine and social regulation in the liberal state. Madrid: CSIC octahedron, 2008.

Huertas, R. "History of Psychiatry: Why? Why?" Freni 1, no. 1 (2001): 9.

Huertas, Rafael. "Professional and rhetorical strategies of legitimization of mental medicine nineteenth-century Spanish." Journal of Contemporary Psychiatry 2, no. 2 (2002): 92-106.

Karp, David A. "The Dialectics of depression." Symbolic Interaction and Cultural Studies 17 (1994): 341-366.

Karp, David A. Speaking of Sadness. Depression, disconnection and the Meanings of illness. New York: Oxford UP, 1996.

Karp, David A. The Burden of Sympathy. How Families Cope with Mental Illness. Oxford: Oxford UP, 2001.

Karp, David A. "Illness Ambiguity and the Search of Meaning: A case study of a self-group for affective disorders." Journal of Contemporary Ethnography 21 (1992): 136-170.

Karp, David A. Is it me or my meds? Living with antidepressants. Cambridge: Harvard UP, 2006.

Lamas Crego, Santiago. "About dun case of" Folie à duex "e outros avatars." In spirits. Ethnopsychiatry Ensaios of Galician, edited by Marcial Gondar Portosany and Emilio González Fernández, 141-156. Santiago: Laiovento, 1992.

Luhmann, Niklas. The science of society. Translated by Javier Torres Nafarrete. Barcelona: Anthropos Universidad Iberoamericana, 1996.

Luhmann, Niklas, ed. Theory of social systems. Articles I. Edited by Javier Torres Nafarrete. Mexico: Universidad Iberoamericana, 1998.

Luhmann, Niklas, ed. Theory of social systems. Articles II. Edited by Javier Torres Nafarrete. Mexico: Iberoamericana Univesidad; Iteso, Universidad de Los Lagos, 1999.

Luhmann, Niklas. The society of society. Translated by Javier Torres Nafarrete. Mexico: Herder - Iberoamericana, 2007.

Miguel, Jesus M. of. Auto / biographies. Madrid: CSIS, 1996.

Pintos de Cea-Naharro, Juan Luis. "The new plausibidad (The observation of second order in Niklas Luhmann)." In Towards a scientific theory of society, edited by Niklas Luhmann, 126-132. Barcelona: Revista Anthropos, 1997.

Pintos de Cea-Naharro, Juan Luis, ed. The frontiers of knowledge. Madrid: Akal, 1990.

Pintos de Cea-Naharro, Juan Luis. The social imaginary. The new construction of social reality, Cuadernos Faith and Secular. Madrid: Sal Terrae, 1995.

Pintos de Cea-Naharro, Juan Luis. "Sense and possibility." In Jesus Ibañez. Theory and Practice, edited by Fernando Alvarez Uria, 153-166. Madrid: Endymion, 1997.

Pintos de Cea-Naharro, Juan Luis. "Know and respect." In Discourse, power, subject. Readings on Michel Foucault, edited by Ramon Maiz. Santiago de Compostela: Universidad Santiago de Compostela, 1987.

Pintos de Cea-Naharro, Juan Luis. "Sociocybernetics: systemic framework and conceptual framework." In Methods and techniques of qualitative social science research, edited by Juan Manuel Delgado and Juan Gutierrez, 563-580. Madrid: Síntesis, 1994.

Pintos de Cea-Naharro, Juan Luis. "Sense, contingency and chance in the reduction of complexity in modern systems theory." Communication V Spanish Congress of Sociology, Granada (1995).

Pintos de Cea-Naharro, Juan Luis. "The social imaginary of religion as a builder of the mundane reality of unrepresentable." Communication V Spanish Congress of Sociology, Granada (1995).

Pintos de Cea-Naharro, Juan Luis. "Time, direction and risk in N. Luhmann." Communication V Spanish Congress of Sociology, Granada (1995).

Pintos de Cea-Naharro, Juan Luis. "The qualitative study of the difference." Communication V Spanish Congress of Sociology, Granada (1995).

Pintos de Cea-Naharro, Juan Luis. "Marginalized and excluded. Intedisciplinar Approach." Semantics 16 (2004): 17-52.

Pintos de Cea-Naharro, Juan Luis. "Communication and construction of social reality and imaginary." UPL 10, no. 29 (2005): 80-85.

Pintos de Cea-Naharro, Juan Luís, Rosa Rey Pousada and Marticorena, Juan R. Observación de las expectativosas recíprocas entre los actores intervinientes en los casos de personas con trastornos mentales crónicos: Implementación de un modelo cualitativo. Memoria de investigación. edited by http://www.usc.es/cpoliticas/mod/book/view.php?id=780. A Coruña: Memoria de investigación: Sergas, 2004.

Pintos de Cea-Naharro, Juan-Luis. El constructivismo sociológico de N.Luhmann. Investigación concurso cátedra : Fotocopiado, 1996.

Pintos de Cea-Naharro, Juan-Luis. "Apuntes para el estudio de la modernización política en Galicia, sobre las bases de los trabajos de EMRogers y J. Habermas." In AA.VV. 1989 , 1989.

Rodríguez López, Antonio. "Historia de la psiquiatría académica gallega." In Setenta y cinco años de historia de la psiquiatría (1924-1999). III Jornadas nacionales de historia de la psiquiatría , edited by T. Angosto Saura, Antonio Rodríguez López and David Simón Lorda, 183-192. Ourense: Asociación Española Neuropsiquiatría y Asociación Gallega de Psiquiatría, 2001.

Rodríguez, A. and David Simón Lorda, eds. Setenta y cinco años de historia de la psiquiatría 1924-1999 . Ourense: AEN- AGS, 2001.

Simon Lorda, David and Xosé Alfredo Mazaira Castro. "Aprendendo a ser psiquiatra e curandero." In Espiritados. Ensaios de Etnopsiquiatría galega , edited by Marcial Gondar Portosany and Emilio González Fernández, 191-200. Santiago: Laiovente, 1992.

Simón Lorda, David. "Análise antropolóxica dun hospital psiquiátrico rural." In AA. VV. 1997 , 357-366, 1997.

Simón Lorda, David. "El caso clínico de Josefa de la Torre (la espiritada de Gonzar)." In Anorexia: dieta, estética, crenzas , edited by Marcial Gondar Portosany, 23-29. Santiago: Museo do Pobo galego, 1995.

Simón Lorda, David. "Un siglo de asistencia psiquiátrica en Ourense (1875-1975).", Santiago de Compostela : Universidade de Santiago de Compostela, Servizo de Publicacións e Intercambio Científico, 2003.

Simón Lorda, David. "Los orígenes de la asistencia psiquiátrica ourensana: De la restauración a la guerra civil (1885-1936)." In La locura y sus instituciones. Actas de las II Jornadas nacionales de Historia de la psiquiatria , edited by AA. VV., 497-516. Valencia: Diputación Valencia, 1997.

Simón Lorda, David. "Asistencia sanitaria y beneficencia en la segunda república (1931-1936). Materiales para la historia una historia de la medicina ourensana II." Auriensis (Revista del Colegio de Médicos de Ourense) 6, no. 24 (2000): 26.

Simón Lorda, David. "Las celdas de dementes en el Hospital provincial: Ourense, 1896-1897 (Apuntes sobre la hospitalización psiquiátrica en la España periférica del fin del siglo XIX)." Frenia II, no. 1 (2002): 49-75.

Simón Lorda, David. "La asistencia psiquiátrica en Galicia en la segunda república (1931-1936)." In Setenta y cinco años de historia de la psiquiatría (1924-1999). III Jornadas nacioinales de historia de la psiquiatría , edited by T. Angosto Saura, Antonio Rodríguez López and David Simón Lorda, 207-244. Ourense: Asociación Española Neuropsiquiatría y Asociación Gallega de Psiquiatría, 2001.

Simón Lorda, David and Émilio Fernández González. "El manicomio del Dr. Ricardo Núñez: Historias de Lugo, Galicia, España (1885-1953)." Interpsiquis (2005).

Simón Lorda, David and Luis Ferrer i Balsebre. "Asistencia psiquiátrica en el primer franquismo: Ourense (1939-1959)." Anales de Psiquiatría 15, no. 5 (1999): 202-222.

Simón Lorda, David, Ignacio Gómez-Reino Rodriguez and F.: Cibeira Vázquez Iglesias Abellás, A. "La hospitalización psiquiátrica en Ourense: 1897, 1965 y 2001 (tres retratos clínico asistenciales)." Revista gallega de psiquiatría y neurociencias 6 (2004): 5-13.

Torres Cubeiro, Manuel. "Analítica de los discursos definidores de la locura (¿irracionalidad?). Tesina-memoria licenciatura.", Santiago de Compotela, 1991.

Torres Cubeiro, Manuel. "Mediators Towards Balance: Legitimizations Of Chinese Medicine In The Pacific Northwest Coast. Master Thesis.", Western Washington University, 1995.

Torres Cubeiro, Manuel. Luhmann . A Coruña: BAia Edicións, 2008.

Torres Cubeiro, Manuel. Orden social e loucura en Galicia. Tese douctoral . Santiago: USC, 2009.

Torres Cubeiro, Manuel. Luhmann . A Coruña: Bahía, 2008.

Torres Cubeiro, Manuel. "Marcando unha diferenza: scripts, imaxinarios sociais e enfermidade mental grave en Galicia." In Sociologia de los Márgenes. Libro de homenaje a Juan Luis Pintos de Cea-Naharro , edited by Ángel Enrique Carretero Pasín and Coca, Juan R. Huelva: Hergue, 2009.

Torres Nafarrate, Javier, ed. Luhmann: la política como sistema . Mexico: FCE, Universidad Nacional México, Universidad Iberoamericana, 2004.