

**Living, coping and managing a severe mental disorder diagnosis in Galicia, Spain**

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### **Abstract**

Forty-four biographies have been collected coming from three groups linked with mental disorders: (1) patients *living* a MD diagnosis (twenty-two biographic interviews, twenty-eight biographic profiles, two focus groups with fifteen patients and data from two-hundred-and-twenty-three individuals); (2) persons *coping* with a family close relative with a MD diagnosis (twelve interviews, one focus group with seven relatives and data from two-hundred-and-twenty-three families); (3) Galician mental health professionals *managing* persons with a MD diagnosis (eleven interviews; three mental health units and one association of relatives and patents participation observation with biographical profiles of twenty-three workers; three focus groups with eight psychologists, eight psychiatrists and thirteen mental health caregivers). The article describes the three interconnected *biographical careers* of these groups in Galicia (Spain) using a Luhmann's complex social systems theoretical framework.

**Key words:** Medical sociology, mental disorders, schizophrenia, bipolar disorder, Galicia, Spain, Luhmann, biographic method, social complexity

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### **1. Introduction.**

Medical sociology describes social realities assuming just nominally their complexities without being fully complex or "theoretically systemic in their usage of these ideas" (Castellani, Rajaram, Buckwalter, Ball and Hafferty 2012: 33) . In this sense, within the sub-field of medical sociology of mental disorders social, physiological and psychological complexity is named but not fully addressed. Cockerham (2014) describes a paradigm shift in medical sociology (2014 :1032) based on coming back to structurally focused approaches with middle range theories (2014: 1034-1038) . Cockerham declares classic sociological theories zombie's theories following Ritzer and Yagatich (2012) . In this sense, classical approaches "inspire" current empirical research but are not really "effectively" in empirical usage (Cockerham 2014) . General classic theory is declared half death, zombie. He argues, that classic theories such as functionalism or structuralism have not enough impact on the main flow communicational streams (high impact journals) of medical sociology, as Cockerham had declared about postmodern theory previously (2007) . Cockerham focuses his contribution on "US medical sociology" ignoring any approach analyzing health issues within a social systems complexity approach.

This article describes data on *how the complexity related to mental disorders is socially organized in communication*. Biographical data of three groups in Galicia

(Spanish northwest region) has been collected: first, a group integrated for those *living* the experience of a severe mental disorder diagnosis during the last ten years; a second group composed by close relatives *coping* with a family member with a severe mental disorder diagnosis; and, a third group integrated by those who *manage* mental disorders: psychiatrists, psychologists, social workers, mental health nurses, etc..

## **2. Theoretical perspective: medical sociology of mental disorders, social complexity and biographical careers.**

“Our task as researchers is to produce not only knowledge but also help others understand the limits of the knowledge we have produced” (Díaz de Rada 2003)

Social systems observe humans as biographies: "In order to exist in the social world with a comfortable sense of being a good, socially proper, an individual needs to have a coherent acceptable and constantly revised life story" (Linde 1993: 3) . As Denzin points out: “The lived experiences of interacting individuals are the proper subject matter of sociology” (1989 25) , because the sense “of life is given in the text that describes the life” (1989 33) . When a later named mental disorder enters someone’s life, no-sense blooms everywhere. Social systems intervene then to construct sense (Pintos de Cea Naharro 1995 11-15) . A biography contains the story of narrated life experiences of a person as Karp describes with depression (1996, 2001, 2006) . But far from being simply assigned based on authenticity, the *biographical genre is itself a form of social constructed observation and communication*. Biography is one of the ways in which a

social system observes a human being (Bruner 1987) . Human beings have learned to repeat models to give an account of their life to others. These models have a biographical meaning because we accept the meaning they assume. The sociological relevant question related to biography is not if it is or not an accurate or authentic report, not even if it could be a cruel history from the margins. The sociological question is *how meaning is constructed within a biography and communicate with success*. The opportunity to observe both how meaning is constructed and its evolution is offered to researchers in biographies.

A social system is complex when it cannot describe its own complexity given that each of its elements does not directly connect with all its other components (Torres Cubeiro 2008: 46) . Any description of a complex system, a biography, is in consequences a simplification of its complexity. According to Luhmann's theory (1996) , societies emerged in evolution to organize increasing complex social elements (see: Moeller 2006, Torres Cubeiro 2008) . Societies emerged then to *build plausible descriptions of that complexity*. Luhmann constructs his sociology with two premises. First, Luhmann establishes that human beings are not part of societies (Izuzquiza 1990) . Therefore, Luhmann focuses on *sociology as the study of communication*. Sociology with no reflexivity has "the tendency to treat the human subject as the ontological basis for social reality" (Castellani, Rajaram, Buckwalter, Ball and Hafferty 2012: 36) . Then, biographical accounts communicate about human beings within a social system.

Luhmann's second premise leaves out any ontological concerns applying for the logic of Spencer-Brown to sociology (1979). From the perspective of Spencer-Brown's logic an observation of a complex system - a simplification - is self-constructed on a non-ontological basis because societies are to build over communications. In this sense, from a sociological point of view there is not an ontological entity called mental disorder; *there are social communications about mental disorders*. Therefore, medical sociology of mental disorders (MD's) study communication related to MD's.

MD's affect bodies, psychology and social relations. This complexity must be simplified to be reported to a doctor, to a friend or to a family member. Social systems make sense of this complexity increase the probability of communication simplifications with likelihood of making sense. A term as schizophrenia refers to a complex situation, but the term itself simplifies a complex issue to communicate. A simplification is then a communicative semantics option constructed within a social system. Schizophrenia could be a physiological entity between the walls of a lab; but neither the biochemical nor the psychological components, nor the social elements provide a complete picture of it. By choosing the term schizophrenia, one *ego*, a system in Luhmann's terminology (1996), chooses a socially created meaning. From a sociological perspective, the term schizophrenia simplifies complexity and selects a meaningful element within communication. Societies provide contexts of higher plausibility in order to maintain successful communication within complex situations. Education, mass media throughout

repetition increase the chances of understanding and maintaining successful communication. Luhmann (1996) defines *semantics cultural pools* as the set of meanings and expectations where a given *ego* and its *alter*, two systems in interactive communication, can select terms with higher communicative possibilities of success. *A mental disorder then designates what in a given society its socially designed specialists denominate as such.* Mental disorders communicate in the complex semantic pool in which society facilitates social interactions. Medical sociology of mental disorder describes the sociological pool constructed to make sense of such no-sense (Cockerham 1996, Tausig, Michello and Subedi 1999) .

### **3. Methodology.**

Data has been recollected using three successive strategies (Torres Cubeiro 2009, 2012) . First, contact with *Creba* was established in 2006, an association of relatives and patients with a severe mental disorder diagnosis in Noia, a Galician coastal village<sup>1</sup>. During the last eight years a observation participation strategy as volunteer has allowed to establish rapport with relatives, users and workers. Second, during two years (2007-2009) forty-five biographical interviews have been taped. Each interview lasted from two to four encounters of at least one hour duration each. Most of the interviews were conducted with members of *Creba*. Third, six focus groups were conducted in a Galician General Hospital and data from three Mental Health Units was collected. Three groups have been differentiated according to the way each collective related to severe mental disorders. The

published biographical narratives of severe MD's have also been considered (Torres Cubeiro 2012: appendix) .

The first group is integrated by those how *live* MD's in their own lives: people with a diagnosis of a MD (PMD's). Twenty-two PMD's with a diagnosis of a severe mental disorder have been directly interviewed: seventeen suffering schizophrenia, four bipolar disorders and one depression (five recognized a drug issue), seven females and eleven males; eighteen uses of *Creba*, four non members. Another twenty-eight biographies of *Creba's* users were recollected while working as a volunteer (Torres Cubeiro 2012: 380-390) . Two-hundred-and-twenty-three other *Creba* users' biographical information have been collected from their administrative files<sup>2</sup>. In 2004 (Pintos de Cea Naharro, Rey and Marticorena 2004, Pintos de Cea Naharro, Rey Pousada and Marticorena 2004) , two focus groups of seven and eight speakers respectively with either a schizophrenia or bipolar disorder were conduced and taped (2012: 359-383) .

The second group differentiated is shaped by close relatives *coping* with a spouse, a father, or a son suffering a severe mental disorder diagnosis (FMD's). Twelve interviews were taped: ten women and two males; three with a bipolar diagnosis in their families, the rest schizophrenia (three also recognize a drug issue); seven were relatives of users of *Creba*, five not. Biographical data of 223 family units was also collected from *Creba's* archive. A group discussion with seven family relatives was taped, transcribed to text and analyzed (Torres Cubeiro 2012: 335-339) .



A third group integrates health workers who *manage* in their day by day people with a severe mental disorder diagnosis. Eleven interviews were taped: four females and seven males; nine psychiatrists, one psychologist and one mental health nurse. Three mental health units and *Creba* were observed during at least a week each and biographical data from their workers was collected in field notebooks: data from another twenty-three mental health workers was obtained. Three focus groups were conducted with mental health workers: one with eight psychiatrists, another with eight psychologists and a third group with thirteen mental health caregivers (Torres Cubeiro 2012: 340-354) .

After taping and transcribing interviews and group discussions, the texts have been analyzed to detect similarities and differences (Kitzinger 1994, Flick 2014) . Later a narrative of each group career on *living, coping and managing* severe mental disorders has been constructed (career in the sense of moral career used by Goffman 1968: 125 ). An account of the career that each group has described in our interviews is offered<sup>3</sup>.

#### **4. *Living a mental disorder diagnosis in Galicia*<sup>4</sup>.**

Patients who first face a diagnosis of a mental disorder (PMD's) have had a life before diagnosis (Torres Cubeiro 2012: 301-316) . PMD's portray confused but idealized memories of what life was like before being diagnosed. In most cases, the presence of a MD is clearly remembered in their adolescence during an increase of conflicts (2012: 306) . Most PMD's remember the first serious crisis ending with their entrance into adulthood. Most of them found a dividing line between memories of happy childhood and

a somehow young adulthood with an increasing number of problems. Many of the interviewees reported at this time how they abused alcohol and illegal drugs (heroin, cocaine or hashish). Most link that drug usage as the cause of their current state.

During these first moments, interviewees narrate a race trying with different types of therapists before going to a psychiatrist: a second phase to acquire their diagnoses (Torres Cubeiro 2012: 306) . The advice of someone carries them to a healer, to a specialist practice set in the county's capital, or to the doctor's of a next door neighbor nephew. If the illegal drugs become a central issue, the detoxification programs are essential then in their narratives. The first psychiatrist they visit is generally a paid private practitioner (2012: 306) . It is worth noting here that none of the respondents have stayed with this first psychiatrist. PMD's have gone through more than three psychiatrists till the one they visit today (2012: 308) . Most users of *Creba* today are treated with a psychiatrist in the local public Mental Health Unit, but none have had him as their first visited psychiatrist. All users have gone through a long list of specialists of various kinds: acupuncturists, *curandeiros*, herbalists, therapists, psychoanalysts and psychiatrists (2012: 310) . At some point during this pilgrimage a psychiatrist "understood" him or her. This psychiatrist gives a first diagnosis of a MD and prescribes some medications. This first psychiatric labeling usually coincides with another major crisis where closer relatives do not take any more easy explanations or excuses facing weird behavior. If the crisis is strong enough, they end up being admitted to a psychiatric sanatorium. Most first

admissions are in private expensive institutions (2012: 311) . After this first attempt PMD's report more than five admissions in Psychiatric hospitals mainly in public free institutions. None of the interviewees remember the exact number or order of the urgent admissions over the years.

Upon receiving this first MD diagnosis PMD's report a long pilgrimage first to find an accurate diagnostic label with a sympathetic psychiatrist and to find out the exact dose of anti psychotic pills and its side effects (see also Karp 1996, 2006 ). They relate stories of trial and error while their crises keep re-appearing. The casuistic varies deepening on income and family situations, but all interviewees have periods when they give up their prescribed meds while feeling sane. The reasoning is similar: "If I feel right, what do I need these pills for?" (Torres Cubeiro 2012: 312) Then, a circle that repeats once and again starts: feeling right, not taking meds, a new crisis, and an urgent hospital admission after burning up relative's patience. Most PMD's do not remember exactly names and quantities of the pills they are currently taking. Most receive now meds in *Creba* or their relatives administrate them. Many receive an injection for the acute symptoms, and they also take six to seven pills to complete the treatment and avoid unpleasant side effects. Doses are prescribed by their physicians, but relatives or those who supervised them can change or advise them to change the doses at the onset of a predicted crisis.

A family crisis generally occurs coinciding with a first MD diagnosis and medication (Torres Cubeiro 2012: 309) . It mainly goes with a crisis within their reference

households. In the lives of PMD closer relatives and family play an essential role, positively or negatively valued but essential. At this point in their carriers with a MD, even family relatives which openly accept their MD diagnosis would accept that this label involves a certain breaking point. In three cases that break was final, involving a lasting rupture. These three cases are not exceptional because quite a few PMD's report periods in their lives when relatives did not understand them (2012: 310) . Then, they lived on their own for a while. In none of my interviews the family breakdowns were permanent.

PMD's reach certain behavioral stability in their lives after a history of hospital admissions, different treatments and therapies. They point then how they arrive at *Creba*. This marks a third phase in their biographies (Torres Cubeiro 2012: 310-13) . PMD's describe how someone refers them to *Creba*, in most cases after a hospital admission or at the local mental health unit. They then take a first visit to *Creba*'s building. Almost all of them describe how they have this first visit accompanied by a family relative. In many cases, they report attending *Creba* only for a few months. In some cases, *Creba*'s users have come in and out of the association several times (2012: 311) . To join *Creba*, PMD's must meet certain requirements: first, they have to be stable, with a psychiatrist and their prescribed medication; this implies that they must be drug-free (some receive methadone in *Creba*). Furthermore, PMD's ought to pay a monthly fee that varies depending on the incomes of each user and the services provided. Every *Creba*'s user attends a daily workshop (sewing, leather, framing, paper...). In most cases, they narrate

their tour though the various workshops finding the "right one." PMD's also attend workshops on reeducation and psychology. They also have a dining room and twelve of them live in three supervised apartments. Vans gather them daily to perform all these activities. Most users have obtained their noncontributory pension (around 440 Euros per month) through *Creba*.

PMD's do not define or see themselves as mentally ill in spite of all hospital admissions, histories with different meds, etc. They speak of their "illness" but do not add the adjective "mental." Their identity is as sick, not as mentally ill (Torres Cubeiro 2012: 311) . In consequence PMD's do not accept the diagnosis of a MD, although they do accept and take their medication. In contract, they acknowledge their participation in *Creba* but many add immediately that they come to *Creba* to work: "this is just a job." All *Creba* users repeat a similar description of what is a MD, as if they have learnt the lesson with a primary teacher but each PMD offers a different idiosyncratic explanation of what has happened to him: one describes a blow to his head, some others some bad experience (sexual harassment, breaks with love partners, family crisis, etc.); others relate their current states to a poor medical treatment, and others with substance abuse. *They all coincide in that none of them define their status as with a MD label such as schizophrenia, bipolar disorder, etc.* Each PMD has a name for his "problem." None of them speak of a biochemical brain "failure" or a biochemical or genetic heritage. Each PMD's use these terms in a general sense, with the tone of a primary school student.

Then, speaking about MD's they repeat the same "learned lesson": "a MD is an imbalance in the brain that medication restored." All PMD's compare his MD over and over with diabetes (2012: 312) . In this same sense of lessons learned, they all agree on the terminology, the examples and the vocabulary they use it to describe what schizophrenia is. When further explanations are required, interviewees report how they have learned what their "disease" is only once they start to attend *Creba*.

PMD's agree to describe their "states." These "states" are not blamed in principle on the disease but on their personalities or characters. They rarely attribute this feeling to Schizophrenia or Bipolar Disease; even after years of having a stable diagnosis. They are able to describe clearly positive and negative symptoms of schizophrenia, but again in their dialogue they scarcely use these characteristic applied to themselves. PMD's make a clear distinction between their depressive moods and those close to violence, attacks or crises. If they speak about violence, stress or violent tingle, they refer those to acts and feeling against themselves: they describe then how in some periods of crisis they were unable to control their situation and usually end up visiting a doctor or entering a psychiatric hospital. Interviewees describe how being *Creba* users have helped them to prevent that type of behavior and reduce their hospital admissions.

As we have been describing, *the major difficulty for PMD's is to identify the distinction from which to observe themselves and to communicate to others*. While having a private dialogue, they use personal and idiosyncratic vocabulary. In personal context, a

detailed and flourished terminology is dominant. Here, they move away from the features of schizophrenia to explain their state from a socially acceptable meaning but without the social costs of a mental disorder label. The distinction between sick and sane is used here flexibly. When they have to fill in official forms, PMD's handle perfectly a public identity flourished with MD symptoms; they communicate a public official version of themselves. *This ambivalence* is the key to understand their social lives (Torres Cubeiro 2012: 313) . Although some PMD's differentiate between delusion and reality, they often place themselves on the side of delirium. Some of them call this their "imaginary life." They know that is not real, but its persistence even though medication requires them to take it in account. For example, Pedro talks every day with God while Patricia starts our interview asking me if I want to hear about her imaginary life or her real one (2012: 301-304) . They describe their inner voices as real, but the border separating the two and its fluctuations is the key.

Summarizing, PMD's point out some common turning points in their lives. First, they agree to make a difference after the first "attack" or the onset of their ailment. They all freely admit, if it was the case, drug abuse. They describe a series of crisis, hospital admissions, meds' trials and unpleasant side effects. In this process a few of them have come to see a doctor in the first place on their own will. They report being taken by their relatives or families, and this is a first turning point that makes a difference in their biographical accounts towards a psychiatrist at the public social security service. Those

diagnosed with Bipolar Illness idealize their periods of mania (Torres Cubeiro 2012: 313) . They feel only really themselves during “high” times. The description really contracts with their accounts of depression, sad or “down” periods. They identify life with that living energy of euphoria of their best times. Bipolar patients turn those times as their ideal state models. The abandonment of medication matches them the output of a depressive phase and the beginning of a rise in mood. This draws a clear distinction to observe themselves in social dialogue with others.

Another turning point is related to the way they define themselves when facing others. PMD's describe themselves as “workers” doing a job. When they identify themselves facing mate-villagers, they state: “I am at *Creba*” (Torres Cubeiro 2012: 313) , without adding anything else. *Creba* is well known within the village, mainly for their cheap works of framing paintings, manufacturing basketry and producing weddings gifts. PMD's, belonging to *Creba*, respond in a quite similar fashion: they feel understood. They sense that they are loved and listened. The distinction is inclusive. Outside the association, they are no one, no one knows them and they have to repeat what happens to them; but once they are members of *Creba* everyone knows them, no explanations are needed and no more repetitions are necessary. But belonging to *Creba* has a bad side as well; it includes some kind of prejudices. To prevent these collateral effects, they use the “worker” role. In conclusion, belonging to *Creba* serves PMD's to justify their status, their weirdness to strangers. Within *Creba* PMD's communicate and live, obtaining a



public identity, becoming also a linchpin of inclusion, at least within the association itself and the local area (2012: 314) .

### **5. Coping with a close relative with a mental diagnosis in Galicia.**

FMD's (Family relatives of a person with a MD diagnosis) respondents in this second group share a constant feeling of helplessness and uncertainty (Torres Cubeiro 2012: 273-284) . Throughout the processes of living with a PMD in their privacy, FMD's express constant fear and lack of understanding. FMD's go through this process with similar trajectories: the first signs of a MD drive them throughout the first visits to "specialists" and finally the first psychiatrist. Then, after a first crisis and hospital admissions, after some relapses, changes in therapy, and more crises their *vital careers of uncertainty* obtain a stable diagnosis. Four phases could be differentiated: a first phase of refusal and search of information (2012: 274-75) ; a second period of treating different medical experts until conquering a stable diagnosis (2012: 276-280) ; a third phase in which FMD's acquire final acceptance of the MD diagnosis going through a change in their identities (2012: 281) ; A final phase comes when they must face an uncertain future of their close relatives (2012: 281) .

FMD's face the first signs of a MD as a *challenge*. Some inexplicable behavior bursts into their lives. One after another commonsense explanation fall down while new crises repeat: no personal crisis or bad period can explain any more what keeps happening (Torres Cubeiro 2012: 274-75) . After several crises these reasonable explanations are

abandoned: the persistent unexplained behavior destroys these obvious reasons. No explanation can longer be maintained neither drugs, nor a psychological ordeal after personal problems, nor stress. FMD's remember these first naïve approaches to what they now know as a MD. Here, we have a first clear distinction from which FMD's observe their MD's. There is a before and an after the time when there were no more easy explanations left. Interviewers generally describe a single crisis that becomes a breaking point. The uncertainty, the fear and the panic have always been there but after that turning point: "Things started to make sense" (2012: 274-75) . Everything after would be re-interpreted from this new perspective.

Before a MD diagnosis lands on their lives, FMD's need justification. No more excuses: something is wrong and now they have a name for it: a mental illness. But they add a complementary explanation: alluding *somatization* is quite frequent (Torres Cubeiro 2012: 274-75) . The inexplicable intervention of a body system must account for such strange behavior. Trial-and-error-method is used and wrong possible causes are progressively eliminated. FMD's extensively use their social network searching and analyzing reasons and justifications of MD treatments. Doctors and specialists are used to add evidence during this search for meaning. At some point they arrive at a conclusion: the problem persists and they have not yet understood what is really happening. Not private medicine or all economic efforts calmed their beloved crises. There have already been several periods while acute symptoms almost disappeared. In retrospective, FMD's

remember how they thought at that point that their inexplicable problems had disappeared. They have also verified that after a relived period, symptoms return. They have also sadly confirmed that after those periods of reliving, problems increased a bit each time. The situation becomes untenable and somehow FMD's has to accept a hospital admission under the supervision of mental health experts.

Interviewees lived a contradictory situation at this point. They recall how difficult it was to accept a MD diagnosis after a first psychiatrist admission mainly because they felt embarrassment. On the one hand, FMD's face the embarrassment of seeing a psychiatrist, but the psychiatrist explains within “socially” acceptable standards; something that it could be sad but that everyone would understand as well. Interviewees have relatives with a MD diagnosis for more than ten years, and they have continued their lives close to psychiatry; in consequence, their next step takes them to assume that a MD is a chronic ailment because there is not a magic cure. Psychiatry offers pills to make it easier to live with their relatives’ psychotic symptoms. A first contact with psychiatry gives FMD's clear relief. Later after a few years with a MD diagnosis, they recognize that there were dark spots. They claim that they do not receive much help from doctors, or that the information given was not complete or not enough (Torres Cubeiro 2012: 274-75) .

FMD's describe as a major workhorse the search to find a psychiatrist who understands their PMD's, and especially their family situation. In most cases, this is a non ending search. First, FMD's must somehow grasp the complexity related to the social

defined institutions taking care of the mentally ill. They describe how they faced various problems with the system of health care. One issue that they frequently name is when they arrive at a psychiatric hospital and no beds were available during a major crisis. Another common topic described is when they were denied a meds prescription; or the bureaucratic nightmares for obtaining a pension. The list is quite long (Torres Cubeiro 2012: 280) .

The diagnosis of any severe MD simplifies things but it comes with new problems and contradictions (Torres Cubeiro 2012: 279) . Any MD diagnosis provides a valuable solution: it gives meaning, explanations, and allows them to speak openly. A label of a MD can now be communicated and some resources are now open to them. Even if they do not exactly know what a MD is, they use the label to communicate to others, and somehow be understood. The privacy of the family is now broken, but blame has been eliminated because a MD was found and sets away blame from the family. Now, there is something “objective” that can be shared with neighbors, doctors and civil workers. Something close to peace or normality comes because the fault now is lying on brain chemistry: nor education, nor poverty, nor trauma, nor bad childhood. These blaming causes are ruled out. The trauma of a bad father, husband or wife may also be ruled out. Now, the family understands and can openly speak out. They can live without blaming themselves or without blaming their decisions. But this relief comes with “side effects”: pills “side effects” on the one hand, and a chronic condition on the other (2012: 280) .

We must remember that all the interviewees are relatives of a mentally ill person with a MD stable diagnosis. Thus, this distinction between before and after an initial crisis continues marking their entire lives. They now know with certainty: the MD is going to stay. Stabilizing medications, treatments and the relative peace confirm this: his/her relative is mentally ill, and there is no way out. It comes with other uncertainties. Mothers, husbands, wives, fathers, brothers; they are all concerned about the future of their appreciated relatives: which social system is going to provide care in case they pass away? (Torres Cubeiro 2012: 280) . This concern is more acute when an elderly mother is the main care provider of an adult mentally ill. Family relatives of people with a mental disorder using *Creba* perceive this problem. *Creba* is their bet to supply care. If with the diagnosis of a MD, FMD's found relief, explanations and chances, *Creba* is giving them hopes of continuity and future.

FMD's describe how they arrive at *Creba* referred by a doctor or a neighbor (Torres Cubeiro 2012: 280) . They land in this organization after a psychiatric hospital admission. Almost all respondents agree that *Creba* was and is a relief for the day by day life. Most narrate a long career of psychiatrists, therapists and different types of professional care before a stable day by day arrived. Of course, they tried private psychiatric resources but all respondents ended up using the resources of public psychiatry. The cost of all other options makes this the best solution when the problem persists. FMD's find extremely helpful workshops with other FMD's. During these meetings, they started to realize that

their situations were not unique. They shared an experiential vocabulary. They all agree that was a real reliving (Karp 2001) .

Most respondents repeat the definitions of a MD as a chemical imbalance in the brain. Although FMD's do not seem to understand exactly what this means, they agree with this and they repeat how psychiatric medications work. Even with terrible side effects, these pills prove the existence of a MD in their relatives' bodies. The MD has given them a glimmer of hope (Torres Cubeiro 2012: 282) . Respondents are a great comfort to be able to talk with other relatives in *Creba*. *The ability to communicate their intimate experience with a MD does not cure the sick, but it creates social ties. Creba* is their bet, and it seems to be working. When asked about the benefits of belonging to *Creba*, almost all respondents said something similar: they feel understood here, because of every time they speak, they point out, they do not have to re-explain all their experiences from the beginning. They go to *Creba* to listen, to talk and to feel understood; to give and to receive affection. Outside the association no one knows who they are; inside, they are someone. Membership within *Creba* justifies their status, but it also points out their oddities to strangers. *Creba* communicates their relation with a MD in their lives, but also offers them some hope; It gives them identity, and becomes the hinge of their inclusion, at least within the limits of the association itself (Torres Cubeiro 2012: 281-284) .

## **6. Managing to work in mental health care in Galicia.**

Our third group is integrated by the biographies of those who manage officially Mental Disorders (Torres Cubeiro 2012: 287-289) : mental health workers (MHW's). Three periods could be differentiated in their biographical narratives: first, the initial years of medical school formation that takes them to the "real clinical practice." Then, a second period in which they meet a case that somehow helps them to become "real doctors." Finally, a third phase drives MHW's to work within interdisciplinary teams where they must face other MWHs coming from different educational backgrounds than theirs owns.

Each MHW describes his years of training in his psychiatric specialty to justify his predominant idiosyncratic orientation in psychiatry. During those years they describe how they constructed a network of contacts with other doctors (Torres Cubeiro 2012: 288) . These networks include specialists of all types, so that when they need a bed for a patient or a second opinion on a diagnosis they easily know whom to contact. The common complaint about their formative years is that they included too much theory and not enough real clinical training. They point out as the real school the day by day contact with patients. They relate how big the change was of having to treat real patients after so many years of faculty theories. Complaints fit perfectly with a *combination of pragmatism and skepticism* with which they describe their practices.

A first phase in their biographies ended when they face clinical practice after obtained their professional grade (Torres Cubeiro 2012: 290-297) . Once each MHW starts their

practices, he recognizes one or two cases that had become paradigmatic, or that somehow makes them learn something in a hard manner. One death patient, a history of violence or a recall of a fatal error usually defines their self-pointed identity. Most interviewees learn with this clinical case how to draw distance with patients: showing empathy with the Mentally Ill, but clearly drawing a line. One must remain objective, they reason, and not be influenced by a strong identification with the Mentally Ill. Most MHW's use community psychiatry as an ideal, almost as a social imaginary used to describe how psychiatry should be working (Pintos de Cea Naharro 1995) . If their main orientation is biological, community psychiatry plays that role. If their orientation is less organic, then biomedicine is used as an ideal future solution to come. Each MHW manages the picture of how care should be provided with the help of the different psychiatric schools at hand. Given that MD's are still in our days not completely understood, these mixtures of justifications and social imaginaries serve them to obtain identity as MHW's.

All MHW's share a *pragmatic attitude*: they use anything that works. Maybe it does not fit with the dominant professional theory, but they all recognize a pragmatic attitude: if it is helpful for their patients but goes against their main theories, they use it (Torres Cubeiro 2012: appendix) . Side by side with their pragmatic approach, a clear *eclecticism* is in usage as well. Although each interviewee prefers one of the multiple schools in psychiatry or psychology, they pragmatically practice a mixture of all those schools.



Taking this in consideration we can differentiate three profiles presented by MHW's depending of their initial education.

(1) Professionals trained during Franco's dictatorship have a more *phenomenological* psychiatric approach (Laín Entralgo 1987) : a MD is seen as a human deficiency that they help as doctors to overcome (González Duro 2008) . (2) Those MHW's in their middle-age share a tendency to value *psychoanalysis* as an ideal model for community psychiatry and health care systems: a MD is seen as a social problem, a society that MHW's have a responsibility to serve (Torres Cubeiro 2011) . (3) Finally, the youngest MHW's share a more *biomedical model*, trying to drive psychiatry closer to other clinical specialties (Tyrer and Steinberg 2005) . In this case, a MD is a biological imbalance without individual or social responsibilities, but with care and psychological consequences. All professionals share an *ironic* tone when speaking about the other's points of view that they acknowledge as existing. MHW's practice an ironic cynical skepticism justifying their eclecticism with a pragmatics clinical orientation.

Regardless of their predominant orientations, MHW's share certain terms when they communicate among them. A first word is the duality psychosis / neurosis (Torres Cubeiro 2012: 288) . These two words originated within Freud's psychoanalysis but are broadly in usage; they refer to a "hard" MD in the case of psychosis; and, to a "softer" MD when using neurosis. Another conceptual term used by MHW's is that of community psychiatry. This is seen as an ideal of social assistance. MHW's also use an opposition

between psychiatry and psychology: psychological tests rule the attributed job of psychologists and meds the day by day of psychiatrists. Additionally, all MHW's communicate an initial reluctance to prescribe med even if they all use them.

Most interviewers work for the public health system of the Autonomous Galician Community (Torres Cubeiro 2012: 348-50) . Most also have a private practice. All psychiatrists interviewed, except one, maintained a private practice, sometimes working more hours in that than in their public health position. It seems that what is not mentioned is a fact taken for granted as part of their identity as a doctor-psychiatrist. Coherently, there is no criticism of the fact of these private psychiatric practices. Their existence is not even mentioned during the interviews, nor taken into account. Only when asked directly they mentioned it. They then and only then mention the necessity to protect the privacy from their patients.

On the other hand, most MHW's criticize private organization such as *Creba*. They usually assume that work done in these organizations is cheap labor that should be assumed by the State and its health administration. MHW's idealize community networks as the solution to complement medical services, but when they speak about organizations such as *Creba* they assume that they should be publically founded (assuming a suspicion of the psychiatric private sector). In conclusion, MHW's organize their observations from a *purely medical approach and a care orientation day by day practice*. But they organize their visions within a continuum between the extremes of a *clinical pragmatic practice*

*and an eclectic theoretical position integrated under an image of the responsible job of the “good white coat doctor”.*

Given that within any mental health unit, a MHW would face other workers coming from the other schools; in their professional identities, those paradigmatic cases are used to interpret their identities while they communicate them to all the co-workers within the unit. These identities clearly marked a difference for them (Torres Cubeiro 2012: 295) .

MHW's commonly throw frequent criticisms to the health system in which where they work. Their reasoning is that doing so, they try to improve the organization of health care. There is always a clearly pronounced hope: a new cure could be discovered any time. These hopes for the future are consistent with the predominant perspectives in each practitioner, but MHW's all built their communication expectations for their own school. In consequence, a community oriented psychiatrist but with a Galician nationalist vision criticizes during our interview the lack of understanding of psychiatry's official “Galician peasants.” He shows easily a strong critical view against those oriented by a biological psychiatry. This psychiatrist also points out the main problems of psychiatric drugs: they do not face the main sociocultural problem underling each patient case. But he has no shame in recognizing that he prescribes as many meds as any other psychiatrist in Galicia. A biologist psychiatrist does not need an explanation to justify the use of a pills' therapy, but he complains on how poor help patients receive besides med themselves. The

justification is pragmatic and clinically in both cases and they both apply anything that works (see: Torres Cubeiro 2011 ).

## **8. Conclusion: Mental disorders complexity in Galicia.**

A investigation on genetic traits of schizophrenia published in *Nature* (Schizophrenia Working Group of the Psychiatric Genomics Consortium 2014) states in its introduction: "Therapeutic stasis is in large part a consequence of the fact that the pathophysiology of schizophrenia is unknown." (2014: 29) . Genetic complexity in 108 genetic loci is pointed in schizophrenia, opening new traits of needed basic medical research to guide knowledge within that unknown area. Given this biological complexity of MD's, society offers plausible simplifications in order to provide its members with strategies to solve difficult situations.

As we have just described, people *living* a MD diagnosis, their close *coping* relatives and those who *manage* their medical issues apparently use similar terms to communicate their experiences in Galicia. Their biographic careers take them throughout different phases in order to construct sense. They utilize those terms referring to mental disorders with different meanings depending on at least two circumstances. First, meanings are differing depending which group is considered. Sense rest furthermore on which developing phase each person is going through. In any case, they refer to quite "different things." Each person presumes that the others refer to the exact same meaning they assume, but as we have seen this is not the case. What gives a term like mental illness or

schizophrenia *its social significance* is precisely that it refers to quite different meanings depending on which group the person belongs. As Radley points in his title *Making sense of illness* (Radley 1994) , we could refer to this *social phenomenon* as “no sense making”: the psychiatrist names schizophrenia with his patient; but, they both psychiatrist and patients understand that expression in quite different senses. It occurs so because *it is the social system within which they communicate* that allows that “no sense making.” The constructed social system gives credibility to the idea of this complex “no sense.”

Elements of Galician mental disorders' complexity have been described. Three groups biographical careers have been outlined coming from data recollection: first, those with a diagnosis of a MD during at least the last 10 years; second, coping relatives of those with a diagnosis of a MD; and finally, those involved as professionals in managing MD's. They share elements, but they also have quite *different* views developed through their biographical careers. As we have shown, the meaning of a MD diagnosis used by patients is not the same than that use by his family member or his mental health professionals. Our theoretical approach has shown these differences understanding that the social system works precisely in this disagreement. *Far from building the social order out of consensus, societies make no sense possible.* That is precisely the social systems job: keep no-sense under control.

## NOTES

<sup>1</sup> A documentary film (*ConEtiqueta*) on mental health issues was produced on *A Creba*( [www.acreba.org](http://www.acreba.org)).

<sup>2</sup> The association keeps records of more than two-hundred-and-twenty-three users. There are seventy users in their two buildings (Torres Cubeiro 2012) attending their activities in 2014.

<sup>3</sup> See: Torres Cubeiro 2012: chap. 5 .

<sup>4</sup> Published biographical accounts of PMD's, FMD's and MHWs see (Torres Cubeiro 2012: 333-82)

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