Making no sense: Biography, Mental Illness and Sociology.

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Abstract

Whenever we make a comment, we use a socially created distinction. It does so the informant and does the sociologist. When we interview someone, we use social distinctions, it doesn't matter which sociological method we are using; but we use as well a social distinction when we write our research report. We have to make evident those distinctions that as sociologists we use in order to make reflexive our discipline. Only if we include reflexivity in our theoretical approach, not just in our methodological notes, we will drive sociology to the necessary revolution to account for the global society we are in our days living in. This communication supports this thesis in two linked ways: first, defending a reflexive theoretical framework; and secondly, applying it in an investigation using a biographical methodology.

We argue that Niklas Luhmann sociology (1997, *Social Systems*) and G. Spencer-Brown logic (1979, *Logic of Sense*) allow us to construct a proposal of a theoretical reflexive sociology. Once drafted this theoretical approach, we illustrate how we have applied it showing the results of our investigation on mental illness in Galicia, Spain. Between 1992 and 2008, we collected biographies of three groups of people related to mental illness in Galicia: patients with a psychiatric diagnosis; relatives of patients; and, workers in health services both public and private. In these interviews, we have found distinctions used to observe mental illnesses. These distinctions are used to generate social expectations and a medical ideology. The biographies collected show that these distinctions and expectations work because each of these three groups uses them with *different* meanings and in *contradictory* ways. Distinctions make sense because each group gives them a different connotation. Therefore, a thoughtful sociological observation cannot be prescriptive or normative but has to bring an element of self-reflection to social *complexity*.

Emilio makes no sense, he has entered a delirious state; he raves. Emilio can barely communicate with their peers or supervisors within the sheltered home he shares with other mentally ill persons. In a routine visit, supervisors were alarmed by his condition and refer him to the village medical center. After checking his state there, Emilio enters an ambulance for emergency to be admitted latter to a psychiatric hospital in a nearby town.

Emilio is 50 years old; he has had a diagnosis of Paranoid Schizophrenia for the last 20 years. His psychiatric medical record is long, full of pills and a long nonsense pilgrimage through many different medical and psychological specialists. As a drug addict, Emilio has gone through various detoxification programs. He was a migrant in Switzerland; where he married, divorced and had a daughter that he hasn't seen during the last ten years. Ten years ago after becoming impossible to keep living with his parents, he started to reside in a village near his mother's house. Emilio shares there an apartment that belongs to an Association of Relatives of Mentally Ill: *Pérgola*[2]. This NGO has a rehabilitation center where Emilio

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[2] Fake name given to protect anonymity. Names of persons are also fake: names of patients start with an "E" or a "P", professionals of mental health with an "M", and relatives with an "F".

spends every morning in a workshop and eats in its cantina with forty other users. After lunch, he spends afternoons and evenings on his supervised home run by this association.

Most members of *Pérgola* use Melon as their psychiatrist in the mental health unit of the public health system in the village. Emilio changed his doctor years ago after a misunderstanding regarding side effects of his medication. Emilio's current psychiatrist is now Mariano, in Santiago de Compostela, a town about 30 kilometers away. Mariano is a local psychiatrist well know as an advocate of a Galician ethno-psychiatry; being theoretically an enemy of all biological psychiatry. A few months ago, Mariano prescribed Emilio strong painkillers for Emilio's constant back pain. Emilio has lately abused these analgesics. These drugs appear to have caused his delirium by interfering with his medication for schizophrenia. After his admission in a Psychiatric Hospital, Emilio remained in a catatonic state for a few days. Giving his state, doctors started treatment with electroshock. A few days later, normalcy started again: he was then admitted for observation in a psychiatric wing of a public closed Psychiatric hospital in Santiago. After four weeks Emilio was discharged, getting back to his normal life on his supervised home.

Emilio's story is a clear example of a normal misunderstanding. For his parents and all psychiatric workers helping him, Emilio is a schizophrenic. From his point of view, he takes his medication, accepts his condition and keeps living. For himself, he is just timid and most people don't understand how much pain he has to suffer. He cannot tolerate pain and that is the reason because he said he ingested so many analgesic pills. Family and psychiatric workers relate this incident with his drug addiction without saying anything to him. They get a patronizing look at him, "understanding" without pronouncing any word. His psychiatrist prescribed those strong analgesics even after knowing his long clinical record on drugs; and after reducing all his other psychic pills. He defends on his psychiatric articles a cultural understanding of mental illnesses, far away from a biological psychiatry. But within his practice, Mariano supervises a Mental Health unit that prescribes as many psychiatric pills as any other Mental Health unit in Galicia. *Pérgola*'s supervisors had seen Emilio during many days, both at his home and at the workshop where he spends every morning working. His peers at the association and his friends at his apartment had seen daily during the last months. And no one detected any thing. We could state that his delirium has been a side product of a *complex* system of misunderstandings; he makes no sense, and he raves in a social system full of no sense. If no sense means not being understood or not being able to understand; Emilio's case is a quite common example of a no sense making, socially constructed and, I will defend, perfectly *normal*.

Words such as delirium or psychiatry, or schizophrenia, or specially electroshock; all these expressions communicate a complex set of meanings that cloud, no doubt, our observation. The thesis defended in this paper is that each person involved in Emilio's case means different things when using these expressions.

Doctors speak about a biological entity when pronouncing Schizophrenia, but their patients use that word mainly only with them. Patients never use that evil word referring to their experience. And even in this misunderstanding situation involving schizophrenia and delirium the fact is that communication actually works. Doctors and patients communicate using different meanings for the exact same words. Parents and mentally ill persons interchange those expressions without sharing the same significations. Our investigation pretends to give some social context to this no sense interchange of an ongoing working communication. Doing so, it would allow us to understand situations as the one Emilio lived as pain self medication under medical supervision but that drove him to delirium and catatonia. With our research we would give context to a situation in which users of mental health services, roommates, relatives, *Pérgola* workers, psychiatrists and physicians use the "same" verbal words with quite different meanings and, nevertheless they understand each other. The society works precisely in that "incommunicado". As sociologists we have to start our research over this initial premise; if not we would not offer a picture at akk of our social reality. If not, we would be just honestly signing an ethical compromise to solve social problems.

In the investigation on which Emilio's case fits, I have collected the biographies of forty-four persons directly related to Mental Illness (MI) in Galicia[3]. I've divided them into three groups regarding the type of relationship they maintain with this illness. Firstly, the group of those who suffer on themselves a MI: the patients like Emilio. They all have a diagnosis of a MI during at least the last ten years. Most of interviewees are somehow related to *Pérgola*: I collected nineteen whole interviews with at least two taped face to face dialogues; but I also have basic data of all the 270 users of this association since its creation (1992). A second group is constituted by those with a family link to someone with a MI diagnosis. In this group, I include all the non professional care givers (no paid) of any member of the first group. I have collected nine taped interviews on this group. They live a MI on their privacy family intimacy. Our third group is made up of Mental Health professionals in three Mental Health Units and several Hospitals throughout Galicia (ten taped interviews and six reconstructed biographies based on their public testimonies both published and collected during research field work). This latter group lives the responsibility of caring for the mentally ill in their working atmospheres. With all these collected biographies and adding a comprehensive review of the literature, I have reconstructed three biographical *profiles*. Each profile defines the line followed by a MI patient, a family member or a mental health worker in Galicia. Doing so we

[3] This article is base on an still ongoing research started in 1995 as a PhD thesis on sociology defended on June 2009 (Torres 2009, USC). To collect my data I keep participating since 2005 as a volunteer on *Pergola* giving a weekly workshop about philosophy, English, and movie making. I have also followed as an observer the work of two Mental Health Units in Santiago and visited most of the Mental Health facilities that exist in Galicia. Throughout those processes I have contacted those that I have later interviewed and collected their biographies.

would be able to reconstruct the social processes in which the experience of living is Mental Illness is constructed. We would “understand” the no sense on which social interchange works.

Mental illness complexity: biological, social or psychological?

I use the concept of Mental Illness (MI) as defined in our society by its social specialists in its detection, identification, care and treatment: physicians specialized in psychiatry. Before the advent of medical science and psychiatry, healers in every region and culture attended, detected and treated similar ailments. With the emergence of psychiatry in the nineteenth century in western societies, these local medicines did not disappear. Most sociologists, sometimes without conscious intention, seem to defend that modern societies implied the extinction of those “old” normally religious cures. In Galicia, the possessed still have their places of healing rituals and treatments with herbs and spells, exorcisms, and of course their customers.

In the nineteenth century the German physician Emil Kraepelin[4] classified mental illnesses basing his taxonomy on external symptoms assuming that doing so we would later be able to detect the underlying physical causes. This raised a biological psychiatry where MI “has” a physiological cause within the body, still in our days to be defined precisely. In the late nineteenth century the Viennese physician S. Freud associated mental ailments with childhood traumas, suggesting a cure through speaking in what he called psychoanalysis. Along with the birth of psychology as a science, mental illnesses were defined here on psychological components. During the twentieth century several drugs were discovered to calm most severe symptoms of MI or just to help stabilize mood swings. Psychotropic drugs were added then to the biological definition of MI. Drugs added a chemical mechanism not yet fully understood but that it "works", even with side effects. Already in the sixties and seventies a new conception of MI started to appear. In this case it had a social component, calling for closing psychiatric asylums and demanding the creation of "community networks" to face MI; giving bird to a “social” or community psychiatry (anti-psychiatry). In his *History of Psychiatry,* Shorter names these three revolutions giving bird to three “branches” within psychiatry: biological, psychological and social psychiatry.

We have then these complexity defining elements of MI in our society (we should add local medicines): first, a MI is seen as a biological and chemical entity according to biological psychiatry. Drug therapies are the best allies of this perspective. Second, we have a galaxy of psychological ideas and therapies helping to understand MI and constructing ways to live with them. Finally, we have those ideas that build social links around those touched with a MI. When a MI is lived as a personal experience these three perspectives are present. When Emilio speaks with his doctor about his diagnosis of Schizophrenia a myriad of those complex meanings is working on their communication, or if you prefer their lack of communication.

[4] Shorter (1997) speaks of these three revolutions I refer to in a moment.

Life before MI.

Every Mentally Ill had a life before his/her diagnosis. They generally have confused and idealized memories of how life was like before MI showed up. They rarely distinguish between their own personalities and their illnesses. In most cases the presence of an MI was detected after or during their adolescence; normally, at that edge they had an increasing number of problems and conflicts. Most of my interviewed have memories of a strong critical crisis that ended with a first admission, and most of them point out that crisis already in their adult lives. So, they drew a clear line dividing happy childhood, or a normal young adulthood from an increasing number of problems since then. Many recounted the use of alcohol and illegal drugs (heroin, cocaine, hashish etc.). A large majority identify this abuse as the cause of their current situation. In the case of Emilio, he lived a happy childhood in his hometown. His parents were emigrants outside Spain and, like his brothers he grow up first with his grandparents and later during his adolescence he attended as an inmate a strict boarding religious male school (we were then at the end of the seventies with final year of Franco's dictatorship). Later, Emilio finished at the university the training to become a primary school teacher. It was during the end of the sixties and the beginning of the seventies when he started using illegal drugs and problems started.

Emilio had worked as a seasonal fruit picker in Europe occasionally but, after finishing at the University he decided to make that his normal source of income. At that point in his life, he started to use drugs as a heroin until becoming an addict. After several years by living and traveling in various countries around the world, has settled in Switzerland where alternating grape harvesting with other farming strawberry in France. He lived with another addict with who ended having a daughter and married. With the arrival of their daughter, Emilio and his partner started a detox program supported by his Swiss father-in-law who also gave him a job as an executive in the family firm. Emilio's wife made a successful drug detoxification, but Emilio only managed to stay clean of drugs for a season. After entries and exits for years in detox programs, he ended at an emergency room almost death in an asylum in Thailand. His mother had to travel there and to pick him up because his wife had gave up any hope at that point. She asked him divorce and the custody of their daughter. Emilio returned then to Spain being 39 years old. He lived at his parents' with a diagnosis of paranoid schizophrenia, an addiction of many years of evolution and a long list of admissions, different psychotic pills and quite a long list of doctors, medical advisers and psychiatrist.

Landing on a MI.

Patients interviewed report many different types of specialists before attending a first psychiatrist. Casuistry is quite diverse in each case, but generally someone's advice carries them to that healer or that other specialist in the capital of the community or region. If drugs become a central issue in their lives, then they describe how they try different detox programs; initially private programs but after burning resources,

they attend those offered by the public administrations. Again, they acknowledge about those detox programs following the advice of this or that relative or friend.

Once attending a psychiatrist is common to give a first visit to a private paid practice. It is worth noting here that none of those interviewed has kept this first psychiatric specialist. Every interviewed I have spoken with has gone through more than three psychiatrists. Most *Pérgola* users today visit Melon public health practice. But no one has had Melon as his or her first or only psychiatrist. All users of *Pérgola* have gone through a long list of psychiatrists and specialists of various kinds: acupuncturists, "*curandeiros*", herbal specialists, "*albeites*", psychologists, psychoanalysts, psychiatrists and all schools offered on various medical open markets.

At some point during this pilgrimage, they have met a psychiatrist with they felt comfortable or with who they felt understood. Once this happened, they stayed with him for a while and they obtained a formal diagnosis of a serious mental disease. And associated to this illness label, they also conquered a prescription for psychotropic pills. This first encounter often coincides with a major psychotic crisis and a first admission on a psychiatric hospital. It's quite frequent that interviewed describe how their relatives could not take it any more at that time. It dominates a first private expensive practice or psychiatric sanatorium. But this expensive medical services didn't last when psychotic crisis start to happen often. Cases at this point vary greatly depending on their employment status, both of their relatives and of the patients themselves. After this first contact with psychiatry, the list is long in length, attending various psychiatric hospitals available in Galicia. Each person has a different list of admissions at those facilities, depending on the presence or absence of free beds; their income or diverse factors. None of the interviewed without exception, speaks of less than ten revenues over the years. In many cases, during the interview it is difficult to establish a clear chronology of all the admissions and practices visited.

After receiving a diagnosis of a serious MI, interviewed narrate a long pilgrimage to find the exact doses of anti psychotic pills and their side effects. They tell stories of trial and error in a complex interaction with their crises, their family incomes and their varied situations. Everyone remembers periods in which they have "feel better" or even felt cured. Then, they stopped taking their medications. The reasoning is similar in all cases. "If I am right now, why should I keep taking these pills?"[5]. Then, they tell how they had later come back to their pills. The carrier to obtain a right doses and survival of side effects never ends. Only a few remember exactly the names and quantities of the pills they are currently taking. Members of *Pérgola* have a supervisor of their medication. Those living with a relative have them to supervise their pills. Many receive an injection for acute symptoms every other week, making easier to forget about it. But they have also six to ten pills to complete their treatments; mainly those other pills are to help avoiding unpleasant

[5] Karp (2006) relates similar circumstances with MI patients in the US.

side effects. As a consequence, medical doses prescribed by doctors are pragmatically altered by those who supervise them. They increase or decrease doses according to the evolution of each one mental illness.

In at least three interviewed cases, they ended with a family breakdown coinciding with the acquisition of their psychiatric diagnosis. The interviewed recognize the strong role played by their close relatives. They give them love and understanding. These three cases agree in that *Pérgola* members are now giving them what they cannot obtain any more out of their families. But these breakdowns are not exceptional because most of the interviewed openly speak of periods in which their parents or close relatives were not able to understand them. In most cases those circumstances were just temporal. But in general, most of them fixed up those communication crises within their families and got back to a normal interaction with them.

Landing on *Pérgola* and "learning".

After a long history of admissions, treatments and therapies; those mentally ills reach certain stability in their behavior and lives. Someone referred to or told them about *Pérgola*, in most cases after an admission in a local mental health facility. Most interviewed describe how a relative went with them to pay a first visit to *Pérgola's* building. In many cases, they stay in *Pérgola* facilities just one season, leaving it for various reasons: too expensive dues, too much work at the workshops, feeling just well enough to try on their own, etc. Many currents users of *Pérgola* have come in and gone out of the association more than once. To join *Pérgola*, they must be stable with a psychiatrist and with their medication. They must be also drug-free (some are receiving methadone in *Pérgola*). They must pay a monthly fee that varies depending of their incomes; but that fee is calculated based on which services they use (coach pick up service, lunch cantina, workshops, sheltered homes, psychological advices and therapies, etc.).

Every user of *Pérgola* attends a first morning period workshop: sewing, leather, framing, paper workshops among others. After a break, a second period starts each morning: cooking, psychological, educational, gym, English workshops. Most users narrate how they had to tour and change among the various workshops offered to find the right one, or sometimes to help finishing a received order. *Pérgola* raises some income for users taking orders on their craft workshops within the village. They have a coach service that pick them up and leave them after having lunch at the association cantina. Most users live at their own homes but twelve of them share three sheltered homes. The majority of *Pérgola* users have obtained a non-contributory pension (about 440 Euros per month) through the association; *Pérgola* also manages and administers medication reviews with the psychiatrists of each user.

No interviewed refers to himself or herself as a mentally ill. In spite of all asylums admissions, long records of different medications, long list of tests with various specialists of MI, in spite of all these historical fact none of the interviewed defined himself or herself as mentally ill, schizophrenic, or bipolar. They speak of their "illness", but they have never added during interviews the "nickname" of mental. His

identity is as sick, not as mentally ill. Therefore, they do not accept the diagnosis of a severe MI, although they do take their medications, they do participate in the partnership but not without adding: "it a job, it is just work" the majority says. They are of course capable of repeating patterns learned about how to define their "mental illness" in case they need to do so. But each one has a different explanation of what truly happened to them: a personal crisis, a hit on his back head, a bad experience (sexual, personal...), or an evil medical treatment. None a single interviewed use *Pérgola* and define their status as MI or madness. Each one has a name for his/her "problem". None speaks of a biochemical "failure" or a genetic inheritance. Each user has a different causal explanation for his state. But when talking about what they have learned in *Pérgola*, all of them seem to repeat the same "lesson": MI is an unbalance in the brain that medication restores. They all bring up over and over a comparison with diabetes. In this same sense of learned lesson, all interviewed agree on the terminology, the examples and the vocabulary used to describe what Schizophrenia is. Thus, everyone reports having learned what his "illness" was only once they became part of the daily life of *Pérgola*. They also agree pointing out that within the association they feel that they are understood and loved. After conquering a normal routine life among other users of *Pérgola*, the presence of these Mentally Ills become a mirror in which they observe themselves and in which they are observed. Any sign of a crisis or a change of mood is rapidly detected. Interviewed are awake of the importance of this to their current welfare. Within *Pérgola* they feel understood without words and they recognize the importance of this while speaking of the prevention of new hospital admissions.

They agree to use a wide and varied vocabulary to describe his shyness, his taciturn states. These states are not linked primarily to their diseases as any psychiatric manual could point out[6]. Everyone defines those personality traits as part of their identities and their characters. And even after years of having a stable diagnosis, they rarely attributed those traits to their schizophrenia. They draw a clear distinction between the depression moods and those acts close to violence. Those violence crises usually end up with an admission and some kind of physical deterioration.

The major difficulty of living with a diagnosis for my interviewed is to draw a distinction from which to observe themselves and then to communicate their state to others[7]. Even if in public then identify themselves with the learned symptoms of MI, they do not use those expressions when chatting in privacy. Vocabulary now explains their conditions in a personal and idiosyncratic terminology. Any semantic proximity to the consequences of the social stigma associated to MI is avoided in these private atmospheres. The distinction between sick and sane is used flexibly, almost deleting their boundaries. Although the label

[6] Hans-Albert 2008, or Torrey 1988, Torrey-Knable 2002.

[7] Spencer-Brown (1979): drawing distinctions allows us to observe and communicate. Luhmann's sociology is based on his revolutionary epistemology.

of schizophrenia is well-known to all my interviewed, repeating its learned meaning, they don't use it to define themselves. Fear, shame or preventions against rejection are the explanations implied.

Mental illness in medical science.

Different administrations overlap in Galicia throughout its history. They have given coverage, treatment and care for "Mental Illnesses"[8]. During the nineteenth century free public assistance through Charity was organized within municipalities. Paid private medical services also started to appear mainly in urban areas along the Galician dispersed geography[9]. In January 1885, a psychiatric madhouse asylum was opened in Santiago de Compostela: *Conxo* Madhouse. During the next 60 years *Conxo* would be the only psychiatric public hospital in Galicia. It was founded by a monk religious order under the supervision of the local bishopric. The local catholic authority quickly signed agreements with municipalities. With these contracts, the Galician mentally ill would have a place to stay and be treated paid by City Councils Charity or family private contributions[10]. Only in 1959 a new psychiatric public hospital in Ourense (Toén) will be opened.

Social Security was created by Franco's dictatorship (1936-1975) giving birth to free medical insurance for all workers during the sixties. The coverage of mental illnesses will have to wait for long. The Health Act (1986) recognized mental health coverage on paper during democracy with the Socialist Party. Meanwhile, four free public psychiatric hospitals were opened during the sixties and seventies at the same time that several "sanatorium" private facilities. The Chair of Psychiatry at the Medical University School of Santiago had also a Psychiatry Unit in its University Hospital in Santiago; and this Chair also ran a team that specialized in child psychiatry. At the same time, twelve mental health units were opened in different clinics, health centers, ambulatories or hospitals throughout all Galician geography. We must combine them with mental health services launched in two military hospitals, various services in "Hospital do Mar" attending fishermen and quite a few drug dependence care units ran by psychiatrists working at each municipality with European founds. Since the seventies until the late twentieth century this complex network increases its size adding many private psychiatric practices, and their private psychiatric sanatoriums in the seven major towns in Galicia. This complex private network and public net flourished within the context of this "uncertainty" legal coverage we have mentioned above.

During the first five years of the twenty-first century, the administration of the Galician Autonomous Community[11] passed a few laws unifying Mental Health services. It slowly began assembling all these clinics, hospitals and units under the rubric of "*Servicio Galego de Saúde*" or *SERGAS*. Two inteconected

[8] Torres 2009.

[9] Galicia covers almost 30000 km^2 with 95 inhabitants per km^2 but with more than 4500 population nucleus with less than 1000 inhabitants.

[10] Opening two systems of psychiatric care: one based on charity with floor hay mattresses and one based on family paid private bedrooms with wood mattress (both within the same Conxo's building legitimized by religious ideology). Torres 2009.

[11] Spanish 1978 Constitution recognizes 17 Autonomous Communities with their own political parliaments and progressively their own Health services. This complex sanitarian network is in 2009 still under development.

events take place a bit before that unifying laws. First, the official "closing" of public asylums as deposit of those with a severe mental illness finished by the end of the twentieth century. An old vindication of Anti-psychiatry was to close up Madhouses as Conxo. The political compromise was to create a social network to cover the needs of those traditionally attending there. Second, families of those suffering a MI started to associate to vindicate the creation of those social networks. Associations like *Pérgola* started to show up during the nineties. Twenty-five associations cover now that area in which the law has still a hole: the chronicity of these diseases. These partnerships created a network of private care facilities funded by grants and European subventions: rehabilitation centers, supervised apartments, businesses to give jobs to the MI, etc.

There is a constant along this institutional tour we have covered: its complexity. If you suffer a MI, where do you have to go to obtain some help? In Galicia a MI person has legally the right to ask for health coverage for his/her disease. But since the Charity religious facilities towards the current sheltered home facilities in an association of relatives the path is complex if not impossible. There is universal coverage on legal papers, but social reality is complex, adding a level of complexity to the biological and psychological entity of any MI. This situation makes no sense, and it can only be defined as indefiniteness. That undefined complex situation is where professional and patients must socially interchange and communicate.

Professionals of MI no-sense.

Mental health professionals are trained and exercised their jobs in this midst of Charity, Private and Public facilities we have described above. The choice of a profession related to health is generally vocational: nurses, social workers, psychiatrists and caregivers agreed on this point. But, choosing to work and specialize on mental health makes a different among the professionals. While psychiatrists reported a conscious election of this specialty, all the other workers reported to have chosen mental health either by a job chance that appeared or just by causality. Psychiatrists interviewed consciously chose psychiatry, knowing it was the "poor Cinderella girl" within medicine.

Professionals clearly tended to a biological perspective on psychiatry. As patients, they reported explanations comparing MI with diabetes or some similar chronic ailments: MI is a biochemical unbalance of the brain somehow solved by psychotropic pills. But when asked farther, all professionals interviewed recognize a day by day eclectic clinical practice. Against this clear biological focus but without interfering with it, everyone accepted a pragmatic and eclectic practice. This clear contradiction is openly but without conflict related to those believes based on the biology of the brain. So, interviewed recognize to use all types of therapies: psychological tests, psychoanalytic interviews, cultural approaches, herbs or anything that could help their "clients". This pragmatic stance is an acknowledgment of being ready to use anything that works, whether or not contradictory to the imagery that each has of a MI or of psychiatry. This defines

their *eclecticism*. But there is a difference among the interviewed professionals. Those trained during Franco's era define their practice as phenomenological psychiatry[12], while those being around fifty years old see themselves as closer to psychoanalysis with an ideal community network; finally, the youngest ones clearly distinct their psychiatry as biological. But all professionals shared a *skeptical and ironic* tone when justifying its eclecticism and, every single interviewed shared a common clinical *pragmatism*.

Their long years of training justify their views on their specialty. Those years also serve to feed a network of contacts with other medical specialties; network that they address whenever they need during their daily practice: to refer a patient, to make an inquiry or to obtain a bed for urgent admission.

The common complaint referred when speaking of these long training school years is the gap between theories and actual clinical patients. This gap also helps to justify their eclecticism and pragmatism. Once they face real patients this complaint fits perfectly with the combination of pragmatism and cynicism that defines clearly their conception of mental health: clear expressions of this pragmatic eclecticism are the so-called inter-disciplinary teams integrating the Units of Mental health. The current public mental health units have within their staff members, persons with various theoretical backgrounds: organic psychiatrists, ethno-psychiatrists; psychiatrist or psychologist of different schools: Lacan psychoanalysis, systemic psychology, behavioral sciences specialist, etc.; social workers, pedagogues, psychologists and caregivers all working together in partnerships.

Most interviewed recognize a case that have become especially significant. One single patient, a history of violence or of a committed mistake defines the identity of each professional interviewed. They learned with this case how to keep distance with patients and their social networks. They learned the boundaries of empathy. This case becomes paradigmatic and marks them during their formative years, but it also defines what exactly the imagery of MI they have. It points them the importance of biological psychiatry, or the importance of social communities, or psychoanalytical therapies. Each interviewed has a different combination of those, being one more important than the others. They play with those cases building imaginary perfect community psychiatry, or ethno psychiatry, or a perfect organic biological approach or psychotherapy. In each professional predominates one main school related to those paradigmatic cases, but all schools are ready to be used if they need them to.

The role of professional psychiatric specialists has changed over the years in Galicia. In the early twentieth century, they were employees working for charities; later, they slowly entered the ranks of the Social Security systems first, and *SERGAS* later. All those changes haven't moved their private practices. One constant in their biographies is that almost all interviewed have a private practice at the same time they

[12] González Duro (2008) describes links between Franco's paternalist ideology and some psychiatrists. Some of them with a "well-known international carrier"

work for the State. Almost everyone maintains a private practice, sometimes working more hours in it than in his/her public position. None verbalized any kind of criticism; being clearly understood that both practices were part of the social role as a mental health professional. It is worthy to point that those not working for associations as *Pérgola* they did have criticism to this type or associations based on the assumption that they are "cheap labor" that should be covered by the administration; arguing that community networks are necessary but always ideally organized by the public sector.

Managers of the Mental Health in Galicia organize their observations about their jobs between a purely medical care and a pure managing orientation. In a continuum between these extremes arise what we have called their pragmatic clinical practice combined with an eclectic theoretical perspective. All these must be integrated into an image of a job where complex responsibility pictures the social imaginary[13] of what a "good doctor or mental health professional" must be.

Biological psychiatry *versus* Galician ethno-psychiatry: Mariano.

Mariano is Emilio's psychiatrist; he is a good example of the professionals of mental health that we have been describing[14]. Emilio ended his degree during Franco's times. He defined himself in the sixties and seventies against the official line of psychiatric care: first being a follower of an anti-psychiatry or of a community psychiatry perspective; later he evolved towards an ethno-anthropological psychiatric approach[15]. Since he ended his degree in Santiago, he has kept two practices: one at a public mental health unit working for the state, and a second practice on a private client basis (both practices in Santiago de Compostela).

For six months I followed the work at his unit in Santiago and in two rural communities where they go once a week. A cordial atmosphere prevails while new cases are discussed each Monday. The unit counts with a diverse background team: a Lacan psychologist, a nurse, a social worked with a degree in sociology, another two psychiatrists with a biological orientation and two janitors. In consequence, the unit has an eclectic orientation. Besides that, there is a clear tendency to interpret each case within the specific cultural context of Galicia. Mariano has published extensively on the need that mental health workers must use local knowledge and local "language" to understand what patients are saying. Only with that local knowledge could, Mariano argues, patients' symptoms be understood. Mariano is critical of biological psychiatry and pharmacology. Surprisingly, the main remedies prescribed are pharmacological therapies. In this unit we have confirmed that they prescribe as many psychotropic drugs as in any other Galician mental health unit observed for this investigation.

[13] Pintos 1995, 2004.

[14] I have observed Emilio's Mental Health Unit during six months in 1992-3. I attended his practice with patients and taped most of the encounters between professional workers of the unit.

[15] He has published many articles and books. I don't quote them to protect anonymity.

Emilio wanted to change his psychiatrist in his village because he didn't want to decrease his medications. He complained at that point that he was not able to have sex with his girlfriend. Emilio's schizophrenia medication interfered with what he thought was a normal sex life. He migrated from Melon to Mariano as his psychiatrist. Mariano decreased his doses and has been his doctor since then. A year before his last hospital admission, Emilio asked Mariano a recipe for his persistent back pain. When he entered the hospital a year later, *Pérgola* supervisor found a lot of pain and Viagra pills inside the backpack he carried. Given his history of drug dependency, his suicide attempts, his detoxification processes this prescription seems to make no sense.

Intimate MI: families' no sense.

If what patients live is everything but a MI; if for mental health professionals is a biological problem but they face it with pragmatic eclecticism; then, how it is like the experience for relatives of a person with a MI diagnosis? My interviewed strongly agree on a common sensation of helplessness and uncertainty with which they live the whole process. From the first signs and clues of something that is not working with their love ones; from the first visits to various specialists; towards the first psychiatrist and the many crises and hospital admissions, relapses, changes with therapies; all along this race, there is something that stays constant: fear and lack of understanding. Both together are described as no sense uncertainty that lives with them since MI appeared on their lives.

Families face the first sign of something unclear with their relatives as a challenge. A strange and inexplicable behavior breaks in their lives. Reasonable explanations are given up one after a few crises: with the persistence of the inexplicable behavior neither drugs, nor a psychological bad experience after a personal problem, nor the stress can be maintained as the explanation. Here we have a first clear distinction from which the MI of the relative is observed; one that was learned and is learned painfully. There is a before and an after this point where no more easy explanations can stand any more. Interviewed describe a crisis that became a breaking point. Uncertainty, fear, sometimes panic would be always there, but after that breaking point "things started to make sense", they say. Everything else would be reinterpreted in the future from this break point.

The search for a justification and treatment begins now. There are no more excuses because something is terribly wrong. The first explanation is often somatization: some physical broken systems must account of the strange behavior. A trial and error method monitors explanations covering the outgoing succession of crises and problems. A normal strategy is to run out the whole social network in the search for reasons. Doctors and specialists of various types come to add evidence to a terrible realization: the problem remains and they still do not understand why that strange behavior keeps occurring. Neither private medicine, not all economic efforts will level or calm crises. There are periods of relief, where crises or symptoms are not

alarming or they remember how they believed that they had disappeared. But after a while they have kept returning once and again. Problems are then increased until the situation becomes untenable and they have to just give up and accept a first hospital admission under a mental health expert supervision. Interviewed relatives recall how difficult was that time accepting their loved one as Mentally Ill after this first encounter with a psychiatrist. But here there is a contradictory situation: on one hand, relatives must face the shame of visiting a psychiatrist, but on the other hand that specialist offers them a socially somehow accepted explanation of that strange behavior. If they keep with psychiatry, then they must also assume a future persistence of the disorder because psychiatry recognizes not cure for MI. Psychiatry offers them pills to make easier living with psychotic symptoms. Later, they acknowledge that even with psychiatry there are some black spots without coverage. Somehow all interviewed ended using resources of the public psychiatry. The cost of all other options makes this one the best solution giving the persistence of the problem. But it is far for offering a whole coverage for all side problems of having someone with a MI life.

The pilgrimage to find a psychiatrist who understands is the family's major workhorse. First, they must somehow grasp a mental map of the wild system and how it operates. Interviewed describe with full details situations in which they have found once and again problems with the system: no bed available when her relative was maniac, negation of a prescription when urgently needed, nightmares of paper bureaucratic work to obtain a pension, etc. A diagnosis of a severe mental illness greatly simplifies things. But, it comes with new problems and contradictions. Diagnosis provides a valuable solution; a MI gives meaning, explanations and allows talking openly. A MI label enables to communicate their family intimate problem with a concept that others can understand. Even better, it removes guilt because it takes MI out of inside family rooms. Now, there is something "objective" that you can share with your neighbors. Now they have something to blame: guilty MI. If everything is caused by a disorder of the brain and not to poor education or childhood trauma, the tranquility offered by diagnosis is maximum. The trauma was not caused by an evil or malicious husband, wife, father or sibling. Now, they understand and can be openly understood. They can live without blaming themselves or being blamed. But, this relieve comes with some "side effects": medication and its collateral effects on one hand, and chronicity and no final cure on the other.

We must not forget at this point that interviewed respondents are relatives of a mentally patient with a stable diagnosis for at least ten years. The core characteristic is the persistence of the illness throughout the whole process. Communication is not the same since the advent of the first crisis, and although the diagnosis was obtained, that does not entail the disappearance of the disorder. The previous distinction between before and after the first crisis is maintained because, we now know with certainty: the disease is going to stay with us. Medication, treatments and the relative stabilization confirm this out and open other uncertainties. Mothers, husbands, wives, fathers, siblings; they are all worried about a social system that

would provide care in case they were not there. This worry becomes especially acute when an old mother is the main care provider of a becoming mature Mentally Ill son or daughter. Relatives of *Pérgola* users perceive problems when they will be no longer alive. Their bet is *Pérgola*, as a social system that they hope would provide care to their loved ones.

Serious mental illness diagnosis does not solve the disaster to family members, because they have to worry for their relatives now and in the future. So, most of the interviewed define MI disease as brain chemistry unbalance. Although, they do not exactly understand they see how medications have improved their lives. Even despite the terrible side effects, pills probe somehow that MI is a physical entity. Their Mentally Ill relatives have conquered a glimpse of hope with them. They must live with this contradiction. Those interviewed found huge relive speaking with other family members in *Pérgola*. Communicating the complexity of their intimate relationship with serious mental illness doesn't cure their relatives, but it creates social links that give them some hope for the future. Pérgola is their bet, and it seems most of the time to be working.

A good example is Emilio´s mother, one of the founders of *Pérgola*. After collecting his son in Thailand, Feli toke him to their family home. But a few months later she had to recognize being overwhelmed. Feli describes how difficult was dialing with a drug addict that didn't want anything else but the next dose. After a long admission inside a psychiatric wing in Santiago, Feli met a neighbor with a similar situation with her son. They shared a bus coming and getting back to visit their sons at the Hospital. Feli knew then of the existence of *Pérgola*. She phoned then first and before Emilio was discharged, Feli had arranged an ambulance to take him there. Her initial plan was to move closer to the village where *Pérgola* has its facilities, but Emilio started to live alone within a sheltered home of the association. Feli has other sons living close to her house. They needed her to baby sit their grandsons, so this solution was perfect for everyone.

When asked about the benefits of belonging to *Pérgola*, almost all interviewed answered something similar. Relatives feel here understood; when they explain something they don't have to start again from the beginning. They go there and they are heard and they also receive affection. The integrative distinction they draw is clear. Outside the association none knows who they are; inside, they are someone. Belonging to *Pérgola* serves them to justify their status, their oddities to strangers. Serious mental illness in *Pérgola* communicates and lives: it offers them some hope. It gives them identity, and being normally an exclusionary element serious mental illness becomes the hinge of their inclusion, at least within the association itself and at the local village level.

Theoretical notes: Luhmann.

Mentally Ill's biographies show us various components involved: biological, genetic, chemical, psychological, emotional and social elements (to name just a few). Therefore, we can say without doubt that mental illness is complex. Neither the biochemical, nor the psychological components, nor socio components could offer us a closer complete picture of what is involved in living a mental illness. But whenever we speak with one of the victims, some doctors, or some relatives they all seem to have a clear idea of what exactly happens and how to fix it. Even when describing the evolution of their biographies, even the reconstruction of how they came to those certainties up, we seem to intuit (feel) that they talk about complete different experiences. And yet, they appear to understand each other when they use the expression "mental illness".

A mental illness affects the body, the psychology and the social relations of those who experience it. But to communicate their status to a doctor, a friend or a relative, they must simplify this complexity. This simplification is a communicative semantics option out of a social system. Schizophrenia is not a physiological entity, it not such a thing from a sociological point of view. By choosing the word or expression "being of the nerves", or "suffering schizophrenia" they have chosen a socially created semantic item. This item simplifies the complexity by choosing an element of communication that makes sense socially.

The German sociologist Niklas Luhmann (1927-1998) built a theoretical framework to describe this complexity based on two revolutionary premises. The first premise asserts the absolute independence of human beings in any social system: humans are not part of the social system, they are its surroundings[16]. Once humans are driven out of sociology, his second assumption states that sociology is the study of communication, not the investigation of social action, neither of social structures. This second premise leaves out of sociology any ontological concern, centering its study on communication. Therefore, there is no an ontological mental illness entity from the sociological point of view, there are just communications about something called MI: it could be defined in a context of demonic possession or be understood as an organic disorder. Luhmann's theory aims to describe how this complex construction can make sense. The sociological question is about how make more probable communication not assuming an ontological reality behind. Each social system works on its semantics. Each historical period builds meanings within its semantic in order to make sense and prescribe an exorcism or an anti psychotic pill.

Communication is then not the transmission claimed by the classical ontological linguistic theory of *communication*. Following Luhmann, communicating is a complex *operation* based on a triple choice

[16] We offer here a simplification of Luhmann sociological approach: his concept of system is base on its difference with the system's environment or surroundings (each concept having a technical meaning within his theory). See: Luhmann 2007, Moeller 2008, Corsi-Esposito 1996, Torres 2008.

between two *systems* in a situation of *double contingency*[17]. A given *ego* chooses first to communicate *information*[18]. With the presence of an *alter ego* makes a second selection: he chooses to attempt to communicate making sense. At this point *Alter* must select himself if to accept or not *ego's* communicative intention. Let's take an MI example to clarify this: Emilio chooses to request new drugs for his back pain. To do this Emilio selects to exaggerate his pain symptoms in order to ensure a medical prescription. His psychiatrist Mariano accepts Emilio's intention and handles a strong painkiller. Even if Mariano is normally against pills, he understands that back pain is quite acute and he forgets his bias as an ethno-psychiatrist. The meaning of a prescription is completely different for Mariano than to Emilio, but they both have been reported poorly understood. Luhmann calls semantic to this cultural pool that makes more probable communication in complex social situations. The mass media and education systems within society help to generalize this semantic.

As we have seen communication is based on selections. Social systems are built with the recursive repetition of these selected chooses to ensure that communicate encounters can meaningfully happens. Social systems become complex social systems throughout evolution by diversifying their functions to ensure communications. But each of them builds itself by simplifying complexity of its environment. Luhmann theory describes this process from first societies based on face to face communication towards our current global society with more complex media. One interesting consequence of Luhmann's approach is that old social systems do not disappear when new ones emerge; this is mainly because semantics keeps making sense even with new meaning emerge creating more complexity.

Luhmann introduces another important *reflexive* element in his sociology. Sociology is part of this constantly *evolving*[19] construction of social semantics. The science of society's mission is to provide descriptions of this complexity; but these descriptions must be different from those offered as *self descriptions* of the system itself. The difference with sociology is its scientific intention. Contrasting those descriptions of the social system offered by a barber, the sociologist finds simplifications that do understand the immense complexity of our current global social system. In Luhmann's sociology, the concept of evolution is an essential element. How can we study social systems with a method that respects that complexity and offers insights of its evolution? The biographical narratives have been selected for this research to integrate both elements: complexity and change over time. They have been in our research our fundamental reflexive methodological tool.

[17] Again these are technical concept within Luhmann's sociology.
[18] Luhmann (2007) uses the logic of the form defended by Spencer-Brown (1979) as the basis for his proposal.
[19] The concept of evolution is again technical here, being a crucial element of Luhmann's approach (2007).

Methodological Notes: biographies.

A biography is the story of all "the life experiences of a person"[20]. But far from being something simple based on authenticity, biographical genre is itself a form of social observation and communication. Biography[21] is one of the forms in which a social system observes a human being[22]: Luhmann extrapolates here literary theory[23] to sociology. Humans repeat learned models to account their lives to others. They biographically make sense precisely because we accept the sense we assume they are narrating. The sociological question is not about the authenticity of the story being told, not about the abandoned margins of the social system that could be showed on a concrete cruel story. The sociological question is how to build sense within a biography in communication with the sociologist. Biographical accounts offer us investigators the opportunity to observe both meaning construction and its evolution throughout time.

Given that all communication a simplification using biographies we can as sociologist reconstruct complexity. When a sociology offers you a simplification (like mine with this presentation), we help you to make your own reflection. Our sociological approach aims to rebuild complexity under your eyes hoping to allow you to understand the social complexity in which it evolved and emerged. If we have reached this objective, it is up to you to decide. What do you think?

[20] Denzin 1989: 136.
[21] Corsi-Esposito 1996.
[22] Psychic systems in Luhmann's terminology.
[23] Luhmann assumes a radical proposals of the theory of narrative (Lieblich, Tuval, 1998; Mattingly - Garro 2000; Linde 1993; Lupton 1994.

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