adeMM
Usuaris de Salut Mental
de Catalunya

THE RELATION BETWEEN USERS AND PROFESSIONALS IN THE SCOPE OF THE MENTAL HEALTH

The OPINION of the USERS

Association of users of Mental Health of Catalonia (ADEMM)
Equipment of project ADEMM, Empowerment and Concienciacion of the users: Spreading of its opinions.
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0. Prologue

The association **"ADEMM, Association of users of Mental Health of Catalonia"** already takes to 15 years working for the defense of the rights and duties of the group of affected people. From year 1992, the ADEMM task has been consolidated progressively and has allowed to construct a space of participation and collaboration between the affected people and the institutions and associations related to the mental health.

Between the main initiatives of ADEMM we found the comanagement of Social Club ADEMM-JOIA, the creation of Groups of mutual help (GAM) for its members, the participation in European projects like the projects SÓCRATES and EMILIA, or the direct participation in the Advisory Council of the Plan Director of Mental Health and Adiccions (PDSMA).

One of the lines of performance that it wants to develop ADEMM to continue working for the defense of the rights and duties of the group of affected people is the one of the promotion of activities search in the scope of the mental health.

From ADEMM, the denominated project "Concienciacion and Empowerment arises from the users; Spreading of its opinions", that is born of the experience acquired with the participation in the Sócrates Project, Grundvigt II, of the European Union, in which the organization JEWEL offers to participate us, and that has taken to us to travel to several countries of Europe and to as much contact with different organizations, professional as of users, being acquired new knowledge and experiences.

This project, has been subsidized by the Department of Health of the Majority of Catalonia, among other objectives, we try to initiate a line search that base and visibilice the sociosanitaris necessities of the group of affected people. In day of today, the Literature specialized in the scope of Mental Health is enough very that incorporates in its analyses and proposals the voice of such usuary of rigorous way.

The study that we presented/displayed is one of the results of the mentioned project, and has the intention to improve the relations between the users of mental health and the professionals of this scope, being analyzed how they are these relations and as routes of approach and dialogue can be fomented.

This study follows, in fact, the lines and the strategies that consider from the PDSMA of the Majority of Catalonia. The Plan Director raises, among others, the following objectives:

- To analyze the necessities of health and sanitary services of the groups of population affected by mental diseases and addictions.
- To design performance plans to foment the search and teaching in the scope of the mental health.

Initially, this search tries to show the opinion and valuations of the usuary people of these services so that they consider and get up their points of view at the time of structuring and developing the rear area net of Mental Health to Catalonia.
Nevertheless, this single one is a first passage of one long-haul. The members of ADEMM we know that to complete this study it will be necessary to incorporate the voice, in the first place, of other affected people who are not members of ADEMM and, secondly, of such professional of the network of Mental Health. As well as we cannot consider as it completes a policy or study that does not incorporate the affected people, we cannot either do it without the participation of the professionals.

Really, one is to foment a joint work between users and professionals facing the improvement of the conditions of the services of Mental Health. Let us think that this joint work is a key element definitively to break the present prejudices and stereotypes in this relation. In order to finalize, we would want to thank for the accomplishment of this search to the team of Spora Sinergias, tie consultant search and psycho-social evaluation in the Park search of the UAB. Also, we want to specially appreciate the collaboration of all the people who have participated in this study and they have made it possible.

Albert Ferrer
President

1. Introduction

This report shows an analysis of the relations that establish the usuary people of the services of mental health with the professionals who work. This analysis tries to give answer to a key question formulated to users of the services: ***As you would outside like that the relation with the professionals of mental health?*** For this reason, the report tries to gather, by means of the stories of the people interviewed, those events and those associate demands that expose in relation to the different situations - interaction context which they are possible to be lived in the services of mental health.

Objectives:

- To describe what the users and users of ADEMM think on their relation with the professionals of mental health.
- To detect the demands of the users with respect to the services of mental health of Catalonia.

The population of this report is constituted mainly by members of the association **ADEMM, Association of users of Mental Health**. By methodologic questions one remembered that the members of this association that have participated in the interviews were developing to no position nor responsibility to the association. This way we wanted to catch the heterogeneity of speeches and opinions that there are within the group, isolating the interviews of which are questions of organization and management of the association.

Although this report does not try to be representative of all the group of users, yes we try to show some of the elements that contribute to the meaning creation shared by good part of the members of the group.
The structure of this report consists of different oriented chapters to develop different thematic tie with its objectives. The three first chapters have a more descriptive character, creating an optimal frame to be able to extract those situations and those demands that take place. The last chapter - practical Considerations and directions try to generate a reflection on the contents of the previous ones. One is not an exclusively analytical reflection, on the contrary, this one incorporates followed of considerations and directions, following the stories of the people interviewed, to be able to promote assigned initiatives to transform certain aspects of the analyzed reality.
This search has been developed by means of a qualitative methodology. Concretely, we have worked with the stories of the participants of four focal groups (a type of group interview). It is necessary to clarify that two of these focal groups counted on the presence and participation of professionals of mental health of different scopes. The other two focal groups were made up exclusively of members of ADEMM.

Therefore, the analysis leaves from:

- 2 made focal groups with members of ADEMM.
- 2 mixed focal groups, made up by professionals of mental health and usuary people of the services.

In methodologic terms, we have chosen by which in the studies of ethnographic type is known like dense description. We spoke of a description that simultaneously are constituted by the story of the people interviewed and by the interpretation that their investigators and investigators do. The task of the dense description is to extract structures of meaning that often seem irregular, nonexplicit or unconnected, but that, throughout the analysis, investigator/a must be able to connect.

It is necessary to make mention that the qualitative methodology must like objective make an exhaustive analysis of the stories expressed on the part of the people interviewed. The qualitative methodology does not have like analysis criterion the representativeness of its data, nor the analysis of percentage in the expressed opinions, but that it tries to detect and to analyze a set of speeches on followed of subjects and a way that have these to tie and to generate forms of thought and social perception.

Let us create advisable to expose that this report works with a relational perspective, that is to say, that centers its constitution and its analysis in the relation that settles down between user and professional. The relation of both considers like the configurator element of the necessities and the demands that we will be developing during the report. We have not done because an analysis centered in some of the present figures in the relation. For this reason, we think that it would be interesting to complete the results of this report with the future incorporation, within the analysis, of the stories of the implied professionals.

2. Irruption and management of the disease. First contact with the services of Mental Health.

In this first point we will describe the process that the person at the moment lives at which it appears the disease, and as she adapts to this situation. Also we will be centered in the effects that the disease can have on the person and her surroundings, and will analyze the diverse perspective that the person can assume to face certain situations.

2.1 The irruption of the disease

The explanations that give the people us interviewed on their experiences at the moment at which it appears the disease arise when it is asked to them on his first contact with the agents of mental health. We have observed that the appearance of this situation can be lived on several ways and can be confronted with different attitudes.

Of entrance we detected that the appearance of the first symptoms of the disease supposes a change in the **daily life of the person.** In most of the cases, the person it detects east change when it finds that something does not work so as is habitual, and as it is exemplified in the following commentary:

> "I went to the psychologist and there I began with ideas. First of all to think very fast, very fast, a very strange thing, later already I began to have like persecutory ideas and things of these. The psychologist derived to me to urgencies of the Clinical Hospital." (2: 82)

The person who undergoes these first symptoms can recognize to it him and to clearly be conscious, but also the case in that can be given the person lives them without being conscious, that does not perceive that something is happening. In these cases, the change is detected single on the part of other people, who notice that there is something is changing. Since the person is not conscious of these symptoms, she does not make them explicit, and she can be that the sanitary attention occurs of involuntary way.

> " thirty-and-so many years ago I had one problem in the company and the one that loaded it I was . It came to look for my brother to me and it took to me... we were in a house and it came a gentleman with white dressing gown and it said to me if it would make nothing me go to test, and these tests were fifteen days in the hospital of Sant Boi. And there was no test." (2:78)

We considered interesting to indicate, on the one hand - and as it illustrates the previous commentary, as the professional of mental health is represented by a significant symbol, the "white dressing gown", and on the other hand, as this first contact takes place through an enter a psychiatric hospital.

Habitually, the person is entered when the symptoms appear in form of crisis, and is at this moment that the first contact with the services of mental health settles down. We understand like **moment of crisis** "when you are bad, that you have a crisis, that you are that you do not hold and they must try to you to lessen the crisis", that is to say, when the person requires of a specialized attention because she cannot face the situation by her self. This situation is agravated when it is the first crisis, moment at which appears following of symptoms that are not known for the person, that does not understand and, therefore, does not know like confronting a new and intense situation.

Before this situation of disorientation, we observed that the person needs a process adaptation to assume the disease. We have detected **different attitudes** that can take the person at this moment. In the first place we observed that, sometimes, the person does not know very well like fitting these events, so that decides **not to express nor to share** what experiments. In these cases the person can decide not to communicate the experience of the disease, nor so at least to her family.

> "I... was fifteen years already I noticed something... that did not work in me and I was myself single to the doctor, I did not say to anything to my mother , and this doctor cured to me with the psychologist who I have all the life, of mental health." (2: 62)

On the other hand, in other cases this situation of change is not perceived by he himself individual like mental disease. It appears a second type here of reaction in which the person takes one more a more negative attitude to the respect and **rejects the diagnosis** that to him the doctors grant.

> " they have said to me that I am a mental patient, but nevertheless I do not create it; I talk about in the sense that, because to the seventeen years I heard a voice for the first time and then they said to me that he was a mocking spirit, and who I had a series of paranormal faculties and hidden sciences, that could develop if it wanted... and get to be medium; and then I did not want that because she gave to much fear that subject me... and I said that no, and then now I am because a paranoide schizophrenic, according to the professionals." (1: 55)

Simultaneously, at the moment at which appear the first symptoms of the disease, the person crosses to the centers of medical attention without differentiating the type from center, although mainly speech of psychiatric hospitals.It is at this moment when the person makes the first contact with the enemy with the services of mental health. It is necessary to indicate, nevertheless, that in front of the disorientation situation in which is the person when it is the first crisis, this one does not know to where crossing since it does not know the different options from which arranges. Then, the situation is lived with a strong sensation of **neglect.**

> "I was found in the IMPU and I did not know that it existed neither the IMPU nor the Caps nor nothing. They took to me there and there everything began. (...) Hay a great disinformation at level of the population, sure you arrive at an age and you do not know what is a psychiatric one, and do not know anything, and you see yourself there put and you undergo much, you do not know where you are." (1: 213)

In order to culminate this critical situation we observed that, once the person has put itself in contact with one of these professional centers, this one continues ignoring the procedure that is followed and its operation. Thus, to anguish that derives directly from experience of symptoms that suffers person - and if in addition it is the first time that appears, is added the fact that this one does not know what happens to him, does not know what must do nor where can go. Also, when definitively it has found the place in which he does receive the attendance that corresponds to him, knows either what is what whatever is made there, what it will happen to him, of time will be, and follows without knowing what is what it happens to him nor so that.

It is necessary to indicate that, at this moment from disagreement, is key the way as the events follow one another. That is to say, the first contact with the services of mental health has an important weight at the time of determining the perception that the person can have of these services. Therefore, we can be found whereupon some negative experiences with the services of mental health can help to formulate an also negative speech, not only of the disease, but of its consequences associated, as it is the unavoidable entrance.

> "I was in a rented room seeing "Dancing with wolves" in the television and called to the door and was two young men of square and three of an ambulance. They took to me, they cleared the sport shoes, they put mouth to me in the stretcher down, they tied to me, and they took me the psychiatric one." (1: 215)

Yet, not always the negative experiences correspond with an intrusión of the privacy of the person, but that, sometimes, simple disorientation already is aversiva. This situation of ambiguity and disagreement can be perceived, by itself, like a negative experience. The different people interviewed agree when denouncing a lack of information over which she is happening to them at the moment for running into for the first time with the different agents from mental health.

It is necessary to indicate that, in these first moments, the type of center in which this situation takes place is of great importance, since the necessity of this information and the form in that it occurs are different in each context. Nevertheless, in spite of the context, the diverse analyzed opinions put on the table that the fact to give to basic indications respect the symptoms that the person - like on the center thus undergoes in which remarkably is aid to include/understand the situation and, therefore, to adopt one more a more able attitude to confront it.

2.2. **Psycho-social effects of the diagnosis**

After the appearance of the first symptoms, once the first crisis has been back, the person is with the diagnosis that him been have granted by the doctors, and with that must assume a new condition that sometimes tolerates a style of different life. In this period of adaptation, the person must confront several situations that can be to him problematic due to certain limitations that come to him externally imposed.

These adversities influence, at the same time, in the construction of the identity that the person develops according to are the diverse situations. Which can be these situations and how they can affect the person they are the points that we expose next.

2.2.1 **The diagnosis: the face and the cross**

From the first contact with the services of mental health it is, generally, a diagnosis, which responds in the first place to a necessary system of cataloguing for the medical services.

> "The doctor needs to put this label by when you go to another place, so that a doctor in another place knows that you are a diabetic, a hypertense one, or a bipolar one." (3: 135)

The diagnosis, nevertheless, not only has effects actually medical to locate a treatment, but that the same diagnosed person is included inside a cataloguing to which it did not belong until the moment. If the crisis or the appearance of the disease already supposed one first stage of disorientation, we were now before one second phase in which the person must adapt to a new element that defines it. This phase can be very and very distressed.

> "There is a part of you who... that sinks, sinks when they diagnose a mental disease to you" (1: 768)

Often, the person does not completely know the meaning of this diagnosis, what means and as it corresponds with which she experiments; what implies and how it will affect his daily life. We must consider, in addition, that what must be a new element of definition and understanding of the situation comes from an external figure to the next surroundings and than it is defined as expert in the matter of Mental Health. Also, the diagnosis can be changing based on the center and of the professional who is in charge of the case as well as of the future development of the events. This compendium of factors forms a situation of lack of understanding that it has like effect, again, that the person feels lost, without referring nor examples to which to cling.

> "Whenever I have entered psychiatric me they have put a diagnosis different. In the end I no longer know what I have." (1: 233)

The medical system of cataloguing becomes, this way, in a **social label.** Not only it has effects on the diagnosed person, but that also affects the surroundings of this person. We will see next as the diagnosis takes a different sense in "the nonexpert" society, and is used to justify all a series of decisions, behaviors and attitudes before the diagnosed person.

2.2.2. **The social effects: the labels**

Independently of the problems that the same disease can cause to him, the person is with following of obstacles that often they prevent him to follow the life rate wished, to carry out certain daily activities or to establish according to which social relations. As it comments one of the people interviewed, "when you already have the put label… according to which things you do not let them do." Many of these restrictions are justified by the **meaning that takes the diagnosis in the social surroundings** from the person.

> "From which they diagnose to you the disease… you are not part of the society, you are a part that does not count, to more if you do not have means economic, you cannot work, because… you remain a little like in no-man's land." (3: 18)

One is not only the difficulty that can suppose the fact to confront certain precise obstacles, but that the individual is very limited in all a series of scopes that surpass the own constrictions of the same disease. The person, then, is questioned and limited by the society so that this one is the one that considers what can or it cannot do.

> "I now am hoping that they make a medical checkup me to see if they renew the driver's license to me. Solely because I said that he took antipsicotics." (1: 65)

In this story we observed that the medication has a key paper in the limitations of the person, but this concrete aspect we analyzed it more ahead in chapter 2 of this report.

We considered the effects specially excellent that the diagnosis at the time of locating the person **like able has or it does not stop to work.** By a band, the work supposes in good part economic autonomy for the person. This economic autonomy is translated in a freedom at the time of deciding in that investing to time and money. On the other hand, the lack of work tolerates a lack of autonomy that forces the person to be tied very socioeconomically another person. This lack of economic autonomy is translated of general way in a lack of personal autonomy.

The person, in this case, can have the sensation that is relegated under the dominion of the other or the other people.

> "No, always depend of the father… because give the sensation of that be a child small, of that not have… and often not be the disease, but be the fact of not have resource." (2: 751)

She turns out key to understand that this relation of dependency appears like an added problem, beyond the difficulties that can cause the disease in itself.

> " because they are living in precarious all the life! There are pairs that they have to live on the parents, of whom welcome them, because they do not have access to a house, do not have nor to go to a cinema… There are people who are the condemned to live with her parents and the day that lack the parents, to the teller! And that yes that a disease" (3: 61)

On the other hand, it is necessary to approach the work like means of inclusion in the community. In our society the work provides an important network of interpersonal relations; the fact of being able to work bucket the consideration of a person like valid and activates within the community. The negation of the capacity to work, on the other hand, is "as if the society already directly did not remove the potential from that person like individual", prevents the possible development of an ample network of social relations, essential for the coexistence in community. In some cases, we even can say that it tolerates a desvinculacion of the society until the point that can end up becoming a species of negation of the possibilities of social relation of the individual.

> "You are the different one. With that expels to you from places, do not let to you enter, when they see that you are a little altered… " Uy, this one is crazy! We are going to leave it…" and they happen of you, all people." (1: 61)

In this same line, we were whereupon sometimes the interpersonal relations also are restricted. An example could be **the pair relations.** It is related, in some cases, that when a person suffers a mental disease she recommends to him on the part of the services of mental health that does not initiate or maintains an intimate relation with another one.

> "Normally if you are going to expose a psychiatrist to him that you have a pair relation or you want to live in pair, I do not know how it will be now, but I when I began, years ago, it said to me "no, no, the pair does not have to be, the pair will break… the pair not…" that is, everything against [the ill pairs between]." (1: 758)

If the surroundings understand a person like nonable, nonuseful, nonapt for certain requirements of the social life, that conditions its margin of action directly. The **social perception** that has the surroundings to the person who suffers the disease and of his capacities and abilities they are fundamental elements for his daily life

> "To put the label or… and say it… that you are there like a furniture, which you are but that or they consider you like a patient, no longer like a person." (3: 89)

Often, the society perceives the diagnosed person of negative and homogeneizada way. This negative perception is nourished, partly, of the way in which the mass media expose the problematic one in the scope of mental health. In many occasions, the news that appear to means relate the mental disease to criminal conducts or a total losses of the control on a same one. This effect of mass media is agravated, in addition, by the lack of general information that it has the population on mental health.

The mass media, then, have a paper and a very important power in the construction of imaginary groups.

> " Normally the information that arrives from mental health is always bad, under me to seem. The information that we are customary to receive is, we say in inverted commas…, dramatic, that on the other hand, in mass media nor nowhere soon explains you that that to the equal one is the 0.001 of I do not know that." (4: 76)

The mass media contribute to distort the information showing those events that will cause more sense of expectancy in the public but which, in fact, they are perhaps little frequent.

> "To the films, or the series of television, what leaves mental health? The psycopath and the Syndrome of Down." (4: 136)

We observed, then, that the mass media have great influence at the time of creating myths and to transmit information. The upheaval is associated of indiscriminate way to loaded concrete profiles of negative connotations.

This distorted expression has a direct influence on the relations that the person with her surroundings settles down. According to the people interviewed, a "normal relation" with which been it has diagnosed would happen "to treat it like individual, not to see it like a discapacity." It is necessary to emphasize that this difficulty to hour to establish relations represents one of the greater problems whereupon are the people diagnosed with a mental upheaval. The discrimination or lack of

understanding is still more significant when it comes from those people who coexist with the affected person, those that represent the next surroundings: **the family.**

> "That implies a little plus the family with us, who sometimes… have a little to us like which is mad lost…" (2: 715)

The fact is very important for the person to feel in conditions of equality with the rest of people of its surroundings. We spoke of relations of equality like opposition to a relation of subordination or marginalization. If the next surroundings do not maintain with this person an equality relation, of symmetry in the relations, the situation it happens to be very difficult to manage.

> "One would be due to end with the paternalism and the under protection. There are some families… I have seen people here who have erased of the association because… well, by paranoias that the family has that sure "is their children" and who… in short, I believe that more confidence in the patients would be due to give more freedom and to have." (2: 805)

Finally, we observed a last effect that can have the estereotyped labels on the person. If we understand that a person can be defined by several labels - like for example by the physical aspect, the nationality, political tendencies or aesthetic tastes the label of "patient" controls here over the others. In the case of those people diagnosed with a mental upheaval, this label predominates by on of the others, without giving the opportunity to the person to define itself otherwise.

> "There is another very peculiar thing with mental health, and that to the people of mental health as only has that no longer it happens to him nothing else…" (4: 315)

And for the same reason, all those circumstances that could alter the vital cycle of any person do not have the same impact on the mental patient, since this it lives under a circumstance altered on by life.

> "It had an entrance… but either, or, or, a psicotic decomposition…, was… because not to be able with a situation that was, that in addition was… that affected very many and the poor man then to him… in the end… because it watches, it went away down, it went away down…" (4: 318)

We can determine, in last term, that the problems with which it is possible to be found a person diagnosed with a mental upheaval go beyond the symptoms that the same disease can cause.

> "After all, a mental patient who is? A person who socially does not find her hollow, or cannot participate that roll... Then they are neither social diseases, nor diseases" (4: 265)

Often, the effects of the diagnosis remarkably influence the person and her surroundings, being able to affect of significant way the identity of this person and being constituted themselves as one of the main obstacles whereupon is in its daily life.

2.2.3. The identity through diagnosis. Effects and labels.

The diagnosis responds in the first place to a pragmatic and functional question of the medical services. The problem lies in the interpretation that becomes, in the meaning that this label adopts in according to which it is the context. And, coverall, in as the person even assumes this label at the first moment for appearing in public.

> "P1: What I say? The name?
> E: If.
> P1: I do not know, that I am ill mental... and from the twenty-three or twenty-four years, more or less...
> E: And the name? It pardons, eh" (2: 87)

This small dialogue corresponds upon presentment of the people in one of the made interviews, and illustrates of significant way this assumption of the label, until the point of which the person appears to itself like mental patient before indicating her name. We observed, then, that in some cases **the identity** becomes so fragile and permeable that it absorbs the diagnosis like synonymous of one same one. In some occasions, when this diagnosis is susceptible of change the person suffers, because its identity is in game. In many of the stories, which defines the person in first term is this label, which are located by on of everything.

On the other hand, also we observed that many of the people interviewed relate to the label the main negative social consequences that suffer, starting off of the same distorted perception that expresses the community. In order to avoid them, these people react denying the diagnosis, or hiding it to the rest, by fear to the reaction of the others.

> "But as you say "I am bipolar, or I am schizophrenic, uy, uy, you already are." you that no longer can say it." (3: 99)

One third situation, compatible with the two previous ones, takes place when the person responds of passive way in front of all these circumstances. That is to say, when the person takes control of the limitations socially attributed, and one complies in this situation.

> "Sometimes also the users put often pretexts to their situation, in which the pretext is "according to agrees to me, my disease does not allow me to do that"." (3: 13)

In these cases, the attributed limitations are autoadapted so that the assumption of certain responsibilities is avoided adducing to the disease. Finally, we also emphasized the position that takes the person when it accepts neither the diagnosis nor the disease.

> "Evidently perfect I am not, have my low stops and, my tips, slopes and ascents, like any other person, that is… I really do not consider a patient" (1: 55)

In this story the disease like synonymous is understood of discapacity. When the declared person does not consider itself ill is because she does not feel discapacity, since it can take a "normal life". What it is rejected, then, is this negative sense of dissability that takes the label from patient.
Finally, we will mention the **taken care** of concept of since it is a term that implicitly is tied to the disease concept that appears in some of the stories. In the first place we observed that some people give by all means that the fact to be cured tolerates a total absence of the symptoms of the disease. In this case the person understands the care "like the suppression of symptoms".

Secondly, it appears an idea very different from the care meaning, which describes east concept like an integration of the individual in its surroundings. So and as she comments one of the people interviewed, is "one better readjustment the community". We considered the sense that takes this perception from the taken care of concept of in relation to the patient definition, since specially excellent it illustrates the one that is also understood by disease like a subjective feeling and not like a verdict solely doctor.

> "Sure is very subjective, you can be very ill and if you… , if there is a good adaptation to this discapacity you cannot feel ill, and is people who are not so ill perhaps as this person and feels very ill, it is very subjective…, the line that separates the one that you can, at subjective level, to say that you are more ill or less ill, is very is transparent, is very fine and in addition not only it depends on the health state." (3: 207)

As we see in this story, the fact that a same one is also considered ill or non ill comes determined by the subjective perception that the person has of herself. From this affirmation another one is derived, and is that the terms taken care of disease and absolute nor are not opposed. One is not two completely antagonistic concepts and incompatible but that they settle down like the ends of a same line in which the

person locates itself, oscillating constantly between these two poles. This idea is represented in the following commentary:

> "The health or the disease I believe that a continuous one is everything where they are occurred to regressions and progressions, more worsened more or less, but than at heart it is a solid line continuous line of trenches." (3: 197).

What it seems more interesting to us of the reflection that to us the diverse people do interviewed she is that she is tied directly what is understood by well-taken care of with the perception that is had of the disease in subjectivity terms.

2.3The paper of the information

We have observed that the information on the disease is key in several situations. In the first place, the people interviewed demand attention and information of special way at the moment of the **irruption of the disease**, moment at which the person is disoriented because she does not know what happens to its environs nor what is what must do.

> "Then I think that the person who welcomes to you, in that, would have to be... to have to char it of information with them, but you are fought, you do not know where you are... you are that... you do not know it. It is necessary information, people does not know what is a psychiatric one." (1: 213)

But so that this information I really arrived at the affected person, that is to say, so that it can be included/understood without difficulty, it must be significant. And with that we mean that the technical information and theoretical on the disease is not useful for the person who is undergoing it, since hardly she will see reflected what being, nor will diminish her possible fears and preoccupations.

> "To me I would like to have more information because sure I do not know what is paranoide schizophrenia, that is, and it assumes that I know what I have, but still do not know what is." (1: 215)

In the same way that this information is essential so that the person can accept the disease and coexist with her, also it is necessary to introduce the surroundings next to the new context. Often the person who is with this situation - that already is not quite complicated in case single must explain it to the family, which often includes/understands it either. The family is without resources, without knowing what to do nor like helping to the affected relative, "the family which happens is that it does not include/understand what it happens to you, thinks that... they think that you have story, that are trivialities...". Before facts that are not known and

misunderstood, the question can finish becoming taboo. The facts can be ignored and even denied, which becomes a problematic one added for the affected person.

> "I believe that my mother has still not assumed whom… my disease, and are many years." (3: 89)

If before this situation of disorientation effective and significant information to the person and her then surroundings is provided it does more possible to give a sense to the situation. Before a correct explanation, the circumstances no longer are perceived negatively, the person does not feel so lost when she understands what she is living, and also diminish the prejudices that can have the surroundings to this person, since this surroundings respond with understanding.

> "Who puts the label, that always is in a medical unit, they would have to be the first to expline, to the patient, to the family, this label what is, what implies, what will happen, what can happen or what it cannot happen… And then, instead of being Mrs. Maria "ay, that my son is schizophrenic, that I do not know that…" then no, it will say "no, my son so, and I do not know that and I do not know whatever" and will explain the neighbour and does not pass anything, and will make the function social…" (3: 181)

Secondly, we detected that the same information also is necessary at **global level**, facing the community in general, so that the social prejudices and the described erroneous perceptions diminish on mental health.

> "I think that… that there is much prejudice or in the society, the tendency is to put the label, that one often same or put himself. Then I believe that there would be… would make more lack more information to put the things in its site." (4: 22)

It is, nevertheless, which during of the made interviews a debate around this question has been generated, of that we have gathered different opinions. Of entrance it seems that everybody agrees at the time of denouncing a **lack of knowledge** on which is mental health, to general level.

> "We always spoke on the information, but… to me it seems to me that ignorance is very many more powerful. Because ignorance, automatically, it generates fear, rejection,… and all the adjectives… that are happened to us." (4: 41)

Even so, the contradictions appear when it is assumed that to have information it implies knowledge. Of entrance it seems clear that the information dissemination is necessary to fight against ignorance. But the information can be transmitted of

many ways, and is here where they appear different points of view, of which we have extracted three speeches.

On the one hand, some of the people interviewed insist on which the information does not generate knowledge directly: "you can have information of such thing but you have an ignorance of that". It is more, according to in which contexts and how this information spreads, the effects even can be detrimental. Under this point of view, the knowledge appears like vulnerable, susceptible, based on as I arrived and which is the origin of the information.

On the other hand, it appears one second opinion tied to the influence of the mass media, denouncing **a lack of referring social** that collaborate to change this defocused image that is had of the people affected by a mental disease.

> "I believe that they make lack referring social that fights against this estigma, which they see that there is a part of the healthier mental health…" (4: 108)

Although these sources of intelligence have a great one to be able at the time of generating knowledge, it seems to be that they are not elements sufficient to reduce the discrimination that undergoes the person.

> "That the knowledge does not have anything to do with the discrimination or the awareness. You can know from A to Z a song and nonknowledge that sings it, you know" (4: 163)

A third speech proposes to obtain a more personal knowledge, through the experience, so that I was more significant for the person.

> "Perhaps what helps more is to have an **emotional experience**, that often… that is a little like the example of the tobacco, that much people smoke and who do not know that the nicotine and… etcetera is detrimental? As everybody knows, because often, until there is no a certain experience emotional, more emotional, or more existential, of a fact, sometimes it is difficult, by much information that you read, the power somehow to catch something of this fact, and something that can do reframe." (4: 104)

It is very interesting to see the effects that can have a positive experience of this type, "surely can be much more rich at level of taking of conscience with a social reality "x" that not to read twenty books on that social reality". The difference lies in the active paper that takes the person in the experiencial experience, like contrast to one more an attitude more passive than it has the individual when it is to receive information without a direct implication.

> "After all the one that ends up prioritizing is plus the authentic thing, which one has been able to integrate within its way to be that not reading much… much… much bibliography on a subject."
> (4: 165)

When the information is integrated in experience form, the person settles down a bond that will serve to him as referring. It is more, to be able to know thoroughly and personally something, is necessary this experience.

> "People, until she has not made contact with enemy with affecting of mental health does not know what is the mental health." (3: 212)

In spite of the importance of the experience, the contact is not always positive. To know a person who suffers a mental disease directly does not imply to include/understand the disease.

> "The fact that the mental disease is hardly visible…, you break a leg and everybody understands it, however, you are of loss by depression to the work and has from which she will say "uy, this one… today" to that will say "this has story, this…" because it is not a thing that is understood." (4: 305)

We observed, in last term, that as much the people who suffer a mental disease like those professionals who work within the scope of the mental health denounce a lack of information and knowledge on different scale, that it is as much necessary for that suffers the disease like for its surroundings.

3 The relations with the services of mental health

In this section we will happen to treat the relation that settles down between the usuary people of services of mental health and the professionals of these services. In order to be able to locate these relations and the different events that take place we will expose this chapter according to the different contexts from interaction of this relation.

Thus, we try to explain these relations enrolled in a context, elements that take a vital importance at the time of determining the sense and the meaning that these take. Evidently, it is not the same the one that is come off the relation when it is different services. In this chapter we will comment two contexts with which the people interviewed have made contact with enemy: the psychiatric consultations and the income.

3.1. The consultations: a relation of three.

In this point we will focus our attention on the stories that speak to us of the relation that the users maintain with the psychiatrists. Concretely, we will expose the interactions that take place in the visits and the consultations that the people to

these professionals make. Thus, mainly, we will take care of the stories that speak of the experience of the visits, gathering the aspects mentioned in the interviews.

The first that becomes patent is the more structural circumstances of type of this relation in the context of the consultations. That is to say, as they comment to us, the users are used to visiting and the regularly continued psychiatrist. Normally they have a frequency of visits established to carry out the pursuit corresponding to the person. "A consultation that I go every three months thus or, because the time is not either much". And as also it happens to the doctors of the social security, the duration of these visits is short, of about fifteen minutes at the most.

> "No, to us he gives a psychiatrist us but, which I say to you, the psychiatrist has consultation and has an average of three hundred patients by doctor, that is who go to top" (1: 185)

Even so, it is necessary to indicate that the frequency of the visits can undergo changes according to the medical necessities that they derive themselves from the state of the people. "because I, when I was of crisis, they did a visit every fifteen days to me, soon… they extended it up to two months of… of time." And he is that, as we see, it is not the same the attention that occurs at moments of crisis that at moments at which the person is stabilized.

Also, this professional figure is the one that makes the diagnosis of the person affected by a mental disease. This way, also is the one in charge to give to a medication adapted to the diagnosis, considering the reaction that this one causes on the person. We must consider that the treatment of a mental disease not always is the adapted one for different people. In this sense, during the different visits in that the relation between user and psychiatrist takes place, this last one takes to the control and the management of the state of the people by means of the types of medicines and the dose. For this reason, one occurs by all means that the visits to the psychiatrist have a certain character of obligatory nature.

> "It is like unemployment that goes away every month, because I am going to fulfill because my parents want that I go. Evidently, I know that also aid, then… with which desire? Then if you find a person more or less reasonable, as it is the case, you go" (2 willingly: 165)

Thus, with the passage of time, the usuary people relate that a bond of confidence with the psychiatrist can be constructed. This fact supposes a greater fluidity at the time of explaining since same one has been one during the period of time between visit and visits. In terms practical, also experiences can to cross to previous, because the relation enjoys a history that serves to its two members like referring, in communication terms. The knowledge that has the psychiatrist of the person includes last experiences that can help to understand what happens in the present.

In the same way, this bond of confidence can give to the usuary person a greater facility to express what it is feeling.

> "To see, that you obtain it after long time to be in contact with the enemy with your psychiatrist. The fact to be in contact with the enemy and to have a confidence, that you say
> "sight, if I take myself that passes such to me, so, so…" sure, S.A. yours you go each… every three months, that does not spend after year and tip, two years." (1: 382)

This fact allows to establish another type of dialogue with the psychiatrist, so that its experience I did not tolerate the application of unquestionable norms but that I meant more soon an element than it can help to harmonize the medication to the own necessities of the person. "When you already have a confidence with him and you can comment the one of the medication "eh, that that goes to me bad, that goes to me better, I do not know what"." And it is that to guess right the medication he is not something simple: it is necessary that I became stabilized the disease, to make disappear the effects, and is necessary that the person has a good reaction, diminishing the indirect effect that are derived from the medication.

Thus, it is no wonder we observed stories that, of entrance, they see an important problem in the change of the psychiatrist in charge to make the pursuit of the medication and the diagnosis. This change supposes "to begin of zero", to have to return to construct the confidence relation and to return to explain the own experiences.

> "When or I have the point found with the psychiatrist me changes it, because it goes away to another place, or they transfer it or… they change it. And sure these four years that you have yourself been working, you, a relation for to say "eh, that… control me that, that me you must control because…" the four years or five years to the excrement." (1: 538)

What or it was possible to be given by all means in the relation with the professional, like the daily habits, the relation with the family or determined problematic with the medication, they will have to return to be specified like referring elements of the relation. We spoke, concretely, of those aspects that go beyond the clinical history that will be transmitted between the professionals, of that knowledge and dynamic that has been consolidated in the interaction between the two people.

Another change that pronounces as problematic is the one that affects the diagnosis. "First schizophrenic, later bipolar, and later I do not know what. They have said to me of everything, bipolar, schizophrenic, that is… they have said to me of everything." Since we have already seen, the diagnosis plays a very important

role on the identity of the person. This one appears like an explanatory element, in medical terms, of which it happens to him to one same one and, therefore, the **change of diagnosis** also will tolerate, in a certain sense, a change for the own identity.

With the change of diagnosis, something of one same one that imagined scientifically like objective - the one that affects the person is modified without this has to have detected nothing new or different in its day from day. This difference between which it is diagnosed and what it is experienced will tolerate an important degree of disagreement in the person, since what served to explain itself a part of one same one has changed without the own vital experience of the disease has changed.

In addition, if the diagnosis is the tool that has the psychiatrist to orient the farmacologic treatment, the change also can suppose a modification of the medication. This fact that will mean to make a work again to harmonize the medicine and the person. And it is that the medication and its management are one of the points that are related like more controverted in the relation that unfolds between the professional and the user. Let us see it next.

3.1.1. **The medication: the third element of the relation.**

One of the points more conflicting than is related in the relation between users and psychiatrists are the medicine administration and its effects on the person. On the one hand, he relates himself that the medication has a very important paper in disappearance of the symptoms of the mental disease. The medication helps to create a frame of stability in relation to the crises.

> ""Then it would not be necessary that you took nothing" and I was one season without taking nothing and fell". (2: 82)

As in the case of the diabetic people, the medication happens to be something that comprises of the routine of the people to maintain a certain balance in the organism. However, unlike the insulin, the medication in mental health does not present/display a predefined exact dose.

In the first place, it is necessary to make a work to be adapting the dose to the effects that the medicine causes on the person, as much on the effects wished as on the indirect effect. Secondly, it is necessary a period of test to see which is the adaptation of the person before the different doses from the medicine. Thirdly, it is necessary to even consider the individual and contextual reactions in front of the change of the own medication, since there is no an only type of medicine at the time of dealing with a concrete type disease. In summary, it is very important to guess right **the type of medicine and the dose** adapted for the person.

> "And you say "good… no" so that you are… that you guesses right it and that they guess right the dose to you, because you are in the medication have its indirect effect. And to me as I say to you, that it was cured to me with enough facility and immediately I react. To the indirect effect also I am very sensible, and also it step very badly, and until… the indirect effect have not known them to control, also I have passed it… I have sacrificed myself because I have seen that it cleared the deliriums to me, but on the other hand are moments that you would let take the medication by the indirect effect." (2: 268)

And, it is in this point - in the search to find the balance between the stabilization of the crises and the indirect effect that the person lives in which she relates the greater moment of controversy between the psychiatrist and the user. By a band, it is related that the psychiatrist prioritizes **the stabilization** and the disappearance of the deliriums: "They know very clearly what is the medication and everything what makes, and, if they find that it is either, the rest then or is or." On the other hand, the user emphasizes the importance of being able to continue taking a normal life, that I implied to be able to continue developing its daily responsibilities without **the indirect effect** of the medication incapacitate it. "And thank heavens that has made me case. But… he cost then vomits, to find me bad and to be that he could not make life normal, neither going to buy, nor preparing the food to me." Finally, which is inevitable is that this subject I ended up myself speaking in the visits, looking for a form to conciliate the experience of the person and the medical requirements of stability.

However, the people interviewed understand as problematic the way **as consider and communicate** certain subjects, as well as some of the attitudes that the psychiatrist in relation to the demands of the people affected versus the medication takes. The indirect effect, which they are something that is related like a strongly uncomfortable element, to incapacitate and annoying, not always are sufficient reason for changes in the medical treatment for the psychiatrist. "And it says to you that you are due to hold with the indirect effect; "And they are these refusals to change to the dose or the type of medicine those that take the sense from less valuation of the own perceptions or the personal experiences in relation to the medicine. This feeling becomes specially excellent when feedback that receives the person does not contemplate its own experience.

> "Then, listen to me… listen what I am requesting to you, or the contraindications of medicines, read before giving them to me, that I am saying to you that it gives these indirect effect me. "No, no, you must continue taking because the indirect effect are not important". No, yes that is important…" (1: 149)

The negation of the importance of the indirect effect or the arguments based on the medical authority causes a great malaise and a deep sensation of impotence in the people interviewed. This sensation is multiplied in the cases in that already a time has occurred to see if the organism adapted to the medication and the malaise continues declaring. In case that it occupies to us, to medicate itself it must imply an incapacity at personal or social level unavoidably?

> "That is, that they listen to you and they give time you, no? That is, time... I talk about in the sense that... you it give to a time taking the medication them, since they also give time you to that you perhaps do not need as much medication." (1: 464)

Although we do not try to generalize, seems that the lack with the forms of communication and the deal with the patient it seems to be a very present deficit in this relation that is pronounced clearly in the interviews. In addition, in many occasions this communicative deficit is used to being associated to the mental disease.

> "Since at his moment they listened to, as they would listen a patient who had a liver problem, a one problem to us pneumonía, a problem of a normal thing. Not because he is a mental patient listens to less to him." (1: 458)

That is to say, that the fact to be suffering a mental disease is argued like the cause of the cause that does not become case to the demands that are done the psychiatrist to him. The people interviewed understand the sense of infravaluation who we previously commented like a prejudice towards the person by the fact to suffer a mental disease. In this case, the users interviewed seem not to consider that these same communicative problems can happen in any relation between the sanitary professionals and the thickness of their patients, whatever their affection.

To finalize, we will comment an aspect that is related so much to the controversy between the stabilization and the indirect effect like with the communicative problems that we finished mentioning: **the automedicacion.** The people interviewed relate practices of autodose of medicines, taking care of the own state in relation to the indirect effect. Before continuing, it is necessary to clarify that these practices single we have detected them once already for a long time the person has been following a treatment medical. Thus, to reduce certain types of effects, the people interviewed comment meticulously to have diminished the dose prescribed by the psychiatrist. Thus, although we ahead were a practice that can tolerate high risks, also relates itself in many occasions that this fact tolerates a diminution of the indirect effect. In spite of it, this one is a practice that causes an important fear, since the person always exposes itself to a crisis and, therefore, to a possible entrance, a situation detested by the people interviewed.

3.1.2. The medication like epicenter of the relation

Until now, all the stories that explain a demand to us of attention were trims in the controversy to fit the dose of medicines. Nevertheless, we have observed that this demand of attention goes beyond the referring subjects to the medication. The people interviewed unfold following of commentaries, in the sense of deficits, oriented to the same **dynamics of the visits**.

> "because if you explain the problems, that there is an understanding between both, that a barrier are not, but that to mine you cannot speak to him openly…" (1: 109)

And it is that the people interviewed raise that exists a deficit of attention in relation to the problems that constitute the day to day of the people. It express the sensation that the preoccupations or the restlessness with what the person arrives at the visit do not receive the treatment that would be desired: "Yes, it seems that they are wanted to forget you, it gives that sensation." As in the case of medicines, the answers of the psychiatrist take a sense from infravaluation. Also, in other occasions a greater implication of the psychiatrist is demanded, before who we were stories that expose "that after twenty years that to me I treat I feel much coldness in the relation, of us, when I speak to him". Although we have spoken of the construction of a confidence relation, in many occasions calls to each other a certain affective implication, that is to say, a greater proximity in the treatment and with which the person proves to communicate.

Said this, one becomes necessary to take care of which are **the expectations**, in the context of the visits, that the people interviewed deposit in the relation with the psychiatrist. To know what is what it is expected of the consultation will allow us to understand so that the relation can take this sense from infravaluation or lack of implication. In this sense, we have found two forms to understand as it must be this relation. On the one hand:

> "I believe there that you go to… finding something positive, and leaving to the knapsack and all the negative energy that you take, there to leave to everything full dead you and go of better things, of good things, to relate in your life, the advice whom the doctor gives you so or, no? Full go of things good and for leaving all the sign there that you bring bad." (2: 159)

If these are the expectations, it is easy to include/understand that in those occasions in which the psychiatrist I did not develop this function I specified a deficit in the relation accompanied by a infravaluation sense. In addition, this sensation more intense will at the most be marked is in favor of the professional distance. However, which we are due to ask in this point is: they are the visits or the consultations the suitable place to maintain this type of relation?

In order to respond to this question we will put the attention in two aspects. In the first place, it is necessary to have well-taken care of in which it is the context in which this relation occurs. We remembered that the visits tend brief and to be very spaced in the time: "Then that does not have anything of normal, ten minutes every three months, that is to enter to say "hello" and to say "good bye", you do not have time don't mention it more." This fact makes difficult the accomplishment of a work of more therapeutic look, where active listening can have a privileged place.

Secondly, we must remember that the task of the psychiatrist is oriented towards the control of the medical treatment. For that reason, it is no wonder all dialogue or conversation that occurs in the space of the consultation tends to be translated with referring aspects to the medication. That is to say, from the stories of the people interviewed we see as the conversation and listening are the tool that has the psychiatrist to determine if the farmacological treatment is working.

> "It is not possible to be spoken to him thus because it changes the medication to you, to me it has happened to me (…) me it cleared it, it gave Disperdan me, it wanted to me to put an injection and I say "but I am very well, but she does not pass anything to me", and then good, me they have returned to Cipresa ten milligrams now, one at night and it´s already is, no"(1:113)

Thus, we see a great interpretative distance between the expectations of the person and the direction that the psychiatrist gives the visits, fact that power still more the possible comunicative difficulties that they can emerge from the relation between both. This interpretative distance, in addition, can have consequences that fall more on the farmacological treatment that not on the attention and the listening that the person requests.

On the other hand, when the expectations are centered more in subjects related to the medication and its management, we found that the visits take another sense.

> "Well, yes, the expectations… if they will raise the medication to me, if me they will lower it… Also the preoccupation, no? of if me they raise it, by all the indirect effect…" (2: 169)

The person no longer hopes to find a space dedicated to the attention of its problematic or personal restlessness. In this case, the interpretation versus the sense of the session more or less is shared, allowing a greater coincidence between both members of the relation of which it is possible to be hoped and to be obtained in the visits. This fact avoids a greater communicative complexity and facilitates a greater mutual understanding.

> "Well, I think that either it is not due to speak much, no? I… my psychiatrist gives instructions to me and already it is, and then it is well. (…)

> But with the psychiatrist this yes, because we are due to see often and is good relation, and he it indicates to me, but… in short, I do not need either that me of moral, you understand to me? With four words already… it is to me well that it is short the session." (2: 129)

This fact, nevertheless, does not suppose that it is continued demanding a space in which the person can work her problematic personal. That is to say, independently of the expectations that deposit in the consultations or visits to the psychiatrist, the people interviewed demand another type of the strictly medical relation different from or farmacological one.

> "But I need, in addition to support psychiatric only for medication, I need support psychological because I have very… I have low autoesteem, I have many fear, I am facing me world labor, that I have several psychologists who are helping me, but is not the same to have a psychologist for the work that to have a psychologist for your personal things." (3: 225)

A place where the conversation and listening are a tool of **therapeutic work** oriented to improve the quality of life of the person. The necessity is related to be able to make therapy for, finally, giving to an intimate place to the own thoughts and sensations.

> "Man, in the therapy… if you can speak of to you, like you are saying, and with confidence, you can express things that are happening to you, or who are past to you, and that with certain people you cannot do it, with intimate friends, yes then for me she would be a psychiatrist or a psychologist would be something more than an intimate friend, that is, much more because evidently she assumes that she has a series of knowledge to give or medication or to guide in a therapy" (1: 131)

As the people relate to us interviewed, this demand is not something new, "I take to ten years soliciting a psychologist ". The demand of a therapeutic space imagines in the figure of the psychologist, like the professional in charge to offer this space of privacy. Thus, or because the possibilities that the network of mental health offers or by the economic possibilities of the person, the fact is that is not habitual that the people affected by a mental disease have access to other therapeutic services.

Really, since already there are saying, the medication happens to be an important element for the stabilization of the crises. In spite of it, the farmacological treatment would not finish giving answer to the necessities that the people relate interviewed.

3.2. The psychiatric income, the entrance to the fifth world?

Another context very commented to the interviews is the one that makes reference to the spaces in which the people are entered when they undergo a crisis. In generic we spoke of the psychiatric institutions, although normally the stories talk about hospitals, or within the unit of psychiatry or in a psychiatric hospital properly.

The crisis entrance in a while is seen practically like the entrance to another world. The experience of an entrance is something that does not forget and, in addition, is used to being associate to the experience of a crisis. It is why the great majority of commentaries on this first experience - on which an entrance represents for the person have a negative tone.

> "I, the hospital, encounter that… that if only strictly necessary to enter, because, sometimes, salts worse of since you have entered. And soon everything what you… absorb there, fictitious, that is, like a film who happen to you and who soon… soon not the reality, that is, you see everything it distorted" (2: 211)

In addition, the entrance not always is made of voluntary way, fact that by himself locates the action in a conflict plane. **The own will** can be put in fortieth due to the effects of the crisis.

> "Man, if you voluntarily return to enter is that you need it, surely. Now, involuntarily, unless you are delirious… that also can happen… I was being delirious, and they did not enter to me, and when they entered to I was not being delirious, I was absolutely conscious, and it was involuntary. That… I do not know, is a thing that I cannot understand it." (2: 227)

When the own decisions no longer are had in consideration - as it is used to happening in the case of the infants the person feels disoriented. The development of the personal events is incursion to the decisions of another person. The own relation with the reality, suddenly, is half-full by the glance of the other.

Then, in principle, it is related that the **objective of the entrance** would consist when doing to leave the person the state of crisis. For that reason it is understood that there is to have a psychiatric and farmacological treatment oriented to stabilize the person until this already it can give back to his habitual context. However, this is not the impression that the people take of the experience of the entrance.

> "I for that reason, must say that you when you go to a general hospital, in principle you have the impression that you go for to cure, and that you go better for the one than they cure to you, no? and also I must say and this impression… that is, is not… you do not go there for to cure, good… unless

> with woods because they have to you to cure, but it does not give the sensation of hospital in this sense, that you are improving." (2: 201)

It is explained that the atmosphere of these institutions is not very pleasant for the person. Sometimes it is described, in fact, like "very terrible, very depressing." As much it is so, at the time of explaining the entrance experience many people cannot differentiate if the state and the experiences of malaise that suffered were fruit of the same crisis either of the dynamic characteristics and of the institution," because or the atmosphere generates the more disease of which there is really, people is put fatal, single to put a foot there, is put fatal…" On the one hand, the structure of the institution, their architecture and internal organization, is explained as if a prison it was, "that is, everything closed, everything under control, all this and… watched, and controlled everything and… of a way that you feel that you say "Mother mine! But where I am? Where am put I? "". This fact causes disagreement, since, if what is expected of this place is a work for the recovery, like is that it is looked more like a prison than to a health resort (Thermal)?

On the other hand, the relations that settle down within these institutions very are marked by the social isolation. The person can receive few visits and, everything and to be constantly watched and in company of another one, is single.

> "The person that you have close more does a hug to you. I, when my sister entered to me, in… that is, in the psychiatric one, which I was needing is that somebody put in the bed with me and embraced me, simply that." (1: 560)

In addition, the people interviewed mention that the great majority of their acts is constantly under a glance that tends to attribute to the delirium or the effects of the disease any type of commentary or demand.

In order to finalize, the uncertainty is a phenomenon that surrounds the income in these institutions. We must consider that as much with regards to the crises as the characteristics of the institution, the entrance supposes a singular situation of disorientation and ignorance. In these institutions, as if a same delirium one was, "you know when you enter but you do not know when salts, that is that…".

4. The paper of the group

Once described in detail the process that the person lives, from the same appearance of the disease to the relation whom it establishes with his surroundings and the different agents from mental health, it is important to emphasize the different observed references to the equal role that the group of in all this process plays.

The fact to belong to a group or to be associate to a group has important effects, of entrance, for the person who comprises and, also, facing the society in which the group works. It is necessary to indicate that the people interviewed in this search are tie to a same group, the Association of Users of Mental health (ADEMM).

Of entrance we can say that the group is a very excellent element to **share experiences**, emotions and thoughts.

> "That you reunite to a series of individuals that to each other have a disease, different, and joint parties experiences, and that… then sometimes because it makes you see that there is people who are worse than you, there is people who are better than you…" (1: 201)

The person who has the option to **express and to share** what she is living with other people who experience similar situations has the possibility of noticing that what happens to him and the anguish is not a unique and particular sensation. The fact to put in common following of doubts and restlessness helps the person "to feel supported in the others and to see that what happens to you not only happens to you, it give account you from which to the others also it happens to them, you feel supported." The group helps, then, to that the person, in the experience of its so strange, different or lost disease.

For the same reason, because the rest of people of the group possibly is in similar circumstances, which probably expresses the person will be accepted by the rest with naturalness and understanding. The fact to put in common these sensations also allows the person **to reflect** over which it is happening to him, beyond its own experience, since it can take like reference the experiences from several people.

In these circumstances, the person can observe, at the same time, if their restlessness are shared of common way or although they are interpreted or lived on way different by the rest from companions. We could say that in the group context a way is opened to be able to take distance from a personal circumstance. And this distance allows to look objectively at the experiences within a context or a determined situation, and therefore to establish new forms of management on which it is being lived.

Parallelly, the group experience allows to reduce or to eliminate the sensation of prejudice and estigma that falls to many of the people affected by a problem of mental health. In a group of equal, the differences that can exist they are perceived as a threat, but that is including in a collective feeling of property.

> "In a group in which because yes that is an empathy, because it is not necessary that all are schizophrenic or all bipolar ones, not… but, at least, around the same problem. At least you remove from above the discrimination of "uy, I will not say that I am so because but they will watch to me bad. "" (3: 249)

The possibility of sharing, of being able to express itself freely and with complicity, to be listened without no type of discrimination, and to see that the people with whom are spoken pass by similar situations, can have a very positive effect on the person. We can say, then, that the feeling of property to a group has an **integrating effect** of the person in its surroundings or community.

> "In us it has had like a species of regeneration like individuals." (3: 249)

Since we have seen, to be member of a group allows the person to compare itself with the rest of individuals, like active people within a community, and thus to give a place to the own singularity like member of one group. "Of some form it helps you not to be marginalized, and to say "good, you are a patient of mental health but first of all you are a human being"." When is perceived that what feels and suffers is not so different from the rest, the same person feels neither so single nor so excluded.

If the fact to be member of a group or group facilitates east effect of social inclusion of the person, a second effect is the **active paper** that can take this person within the group. So that the group works and obtains the objectives that set out need the active participation the individuals that form it. We took like example from group the Association from Users from Mental health (ADEMM).

> "As in ADEMM all we are usuary, because one assumes that each one in its level because we will be able to contribute our sand granite so that is all that listened to, and in the end be able it to be changing... or modifying themselves, so that all we are better." (1: 618)

Nevertheless, the function of the associations goes beyond the promotion of the inclusion and the participation of the individuals that comprise. The group, in addition, promotes the integration and the action of the group in the community, no longer like isolated individuals but like movement within the society. And this fact is important for two reasons: first it is that the ideas and the necessities of the people acquire a different power when is a group that shows them. **A speech coming from one group** much more has done and social impact that not if it comes from a single person. Therefore, the associative route allows the people to visibilice and to denounce those problematic or incidences that affect all the group.

> "E: That can make ADEMM so that you are things improve? Like association...
> P4: Since they find out the doctors of all you are opinions that we have, that is stopped between the doctors, between the professionals, who know it, they, because if they do not know to it and only we know it we... do not do anything."(2:506)

The second reason we found it in the form by which these necessities become visible. We spoke, then, of **collective actions**. It is important to locate this power that acquires the group like effect transgressor, since it allows to take part and to modify a social reality through these collective actions. At the same time, way allows to relate of direct to other agents social, so that is not a single person the one that fights against a situation, but that is a group.

> "To appear in infirmary schools, to appear in conferences, char them and all this, it stops of some form, or for example the study this that stays doing now, to protest or so that... that is a complaint, and not of one or two, as it happens to us separately, but of group, which we are requiring then that..."(1:618)

On the other hand, the group groups the speeches of the people who integrate the group in a single voice that represents them in the social reality. The group, then, also makes the **function of referring**. As it comments one of the people interviewed, "it is well that there is a voice that represents to us, no" In this case, the association is a referring one for the people who comprise and happens to be a space where to look for resources, to raise doubts or to make proposals. And he is also a referring one facing the society, since it is the tool by that spread these doubts, ideas and proposals facing a population that it does not have so that to be found out the necessities of this group.

> "I think that ADEMM must exist, becouse yes, becouse is like a species of union, that we are join a trade union, the patients, and must exist, and nobody considers if psychiatry must exist, that is a question that does not become. It must exist, so that? Because everybody has its union, and then must exist." (2: 574)

We can conclude, then, which the fact to be member of a group not only has effects on the person, but that also has important social effects. In the first place, aid to the person to locate itself in a disorientation context, like could be the moment at which it appears the disease, a situation of crisis, or the taking of contact with the different agents from mental health, so and as we have described in the previous chapters.

Parallelly, the group also satisfies the necessity with understanding and acceptance that has the person, and makes possible a space in which this one can be expressed freely. And secondly, it introduces the voice of an own colectivity in a social reality, facilitating that the community know the referring necessities to mental health that, of entrance, they can be other people's and strangers. One is a denunciation to the society on those aspects that do not work and that are detrimental for the group through a collective practice that is able to change this reality indeed because is protagonist.

5.Practical considerations and directions.

In this last chapter we contributed to a set of reflections and main oriented proposals to give answer problematic and to the necessities that we have detected throughout the search. The contributions that we will develop next come off the analysis of the stories of the people interviewed.

We must understand that these contributions take sense in the singular contexts that we have developed throughout the report. Even so, the case that can be given some of the proposals has a cross-sectional sense to these contexts, that is to say, that its battle area or development extends the concrete context in which it occurs to the relation between the users and the services of mental health.

5.1. Necessity of a significant information.

Due to the expressed constant demand in the made interviews, the first point to that we want to give special emphasis is to the paper that plays the information for the person who suffers a mental disease. This paper that has the information it we have located in relation to three circumstances.

In first, we make reference to the moment at which the first contact with the professionals of mental health because of the appearance of the mental disease settles down. In second, we will speak of the persistent importance of this information facing the diverse necessities that can have the person throughout its coexistence with the mental disease. And in third, we showed the necessity that also has the family and around the person to receive this information.

5.1.1. The knowledge as it prescribes.

Resuming the circumstances that surround the appearance by the symptoms, described previously, we are wanted to center at the moment at that the person goes to the services of mental health, or of voluntary or involuntary way. Since we have already seen, this moment is specially delicate. The people interviewed have denounced repeatedly a lack of information. The necessity exists to receive this information of precise and customized way, of such form that I adjusted to the necessities at the moment that it makes contact with enemy with the services of mental health. We stated, thus, that the aid and the support that can be received at this moment is transcendental for the person.

In this sense, then, it is necessary **that the welcome and the information that is offered in the irruption of the mental disease are significant for the person who lives this situation.** So that the information is significant, the person must understand this information and, in addition, this one must be to him useful. So that the information is comprehensible must be transmitted in a language clear and easy to understand. And so that it can be useful and beneficial for the person,

it must to him the situation is due to explain at great length by which it is happening to diminish his anguish, and to also transmit what is what can happen and which options at that time it has certain. **The information will be clearly more significant for the person if this comes from one equal one**, that is to say, of whom it can act like referring for the person.

Since also we have commented previously, **the experiencial or emotional information is next and more excellent for the people who not one more a information more technical or expressed in terms exclusively doctors.** Thus, the experiencial information would have to go accompanied of a medical explanation that makes reference to the symptoms, the effects of the disease, possible attempts of solution or treatment, to as the different alternatives would be carried out, etc.

Let us create, then, that would be interesting the creation of an equipment of immediate attention, at this moment of crisis and necessity of information, that it conjugated the medical information with a type of information of experiencial look. This equipment could be formed by a professional and to the hour by a user of mental health, which had passed by a similar situation. That would allow that the person received a professional attention next to the attention of a person, who being lived similar experiences, can recognize necessities that escape of the technical knowledge, more centering in medical aspects.

This way, **it is necessary that the attention at moments of crisis I compensated the present structure that offers the network of mental health with a welcome that has like main objective the well-being of the surroundings and the person, offering knowledge, advice and support to face the situation in which it is**.

5.1.2. The management of a new reality.

It is necessary to indicate, however, that the information that we spoke continues being very important to surpass the diverse necessities of the person once has surpassed the irruption of the disease. The experience of the mental disease is something that continues requiring the attention singular necessities in what the paper of the knowledge has an excellent paper. One is not a knowledge any: this it must allow that the person can continue being independent and can continue developing her project of life. **The same person must have an active paper in the management of the disease that also carrying out of other social agents.**

In this point, **is recommendable that himself equipment that is offered welcome to the person at the first moment continues orienting it later, during the course of the experience of the disease**. Thus, offering the same type of attention and oriented knowledge to confront those specific necessities that they are excellent at that time for the person. We talked about to situations like a

change of diagnosis, a medication change or a new crisis, for example; situations that can suppose an important problem for the person.

5.1.3. The familiar context.

It is necessary to add that this information is as much necessary for the person who suffers the mental disease like for her relatives or their next surroundings. Since we have seen previously, the family plays an important role in the way that has the person to accept and to manage the disease. In the stories of the people interviewed, it often appears that the family does not know as to react to this situation and often it provides neither the preparation nor the understanding that the affected person wishes. **Therefore, also an informative and referential work for the family, oriented is made necessary to locate it ahead a new reality and to offer guidelines to him of performance in front of the experience of the mental disease.** Then, the family will have the possibility of developing an active paper and of collaboration with the affected person. And it is that, we can say that this work versus the mental disease can have two effects in the familiar context. Of entrance, **the informative work will help to stump the prejudices that can exist on the person who suffers a mental disease.** And secondly, **the referential work will offer a space in which the people can verbalize and give sense to the new familiar reality.** A fact that will help to diminish the fault feeling that can arise as much in relation to the important changes that are living, on the part of the person as on the part of the family.

5.2. The sense of the medication.

One of the basic demands that appear in the report is the necessity to conciliate the benefits that contributes the medication and the indirect effect that are derived from this.

Taking care of the descriptions of the experiences of the indirect effect of the medication we can say that these play a fundamental role so that the person can self-manage her day to day. If the daily necessities of the people at the time of carrying out a treatment of the mental disease do not consider, this it can as much happen to be incapable as such symptoms that are wanted to eliminate. That is to say, if due to the indirect effect of the farmacological treatment a person sees difficulty in the development of her own capacities, **then the psycho-social effects of the medication happen to be a symptom more of the mental disease.**

On the contrary, if the farmacological treatment considers the weight of the indirect effect in the development of the capacities and daily responsibilities of the person, then the psycho-social effects of the medication ahead pass to be a empowerment route a disease mental.

5.3. The meaning of the care.

The controversy towards the benefits of the medication and the indirect effect takes to us, inevitably, to the necessity to take care of which is the taken care of conception of that maintains each one of the options that determine the sense of the medication. Evidently, the type of medical treatment that becomes and the management of the medicines that I tolerated will derive from the concept of well-taken care of that is had.

Thus, we found that a speech exists that understands the care like the disappearance of a disease, whereas their symptoms and their effects disappear. In this sense, the medical checkup completely is oriented to the search of a biochemical stability of the disease. **The disease stays defined as something continuous, like a disfuncion that is to disappear or to restitute itself to be able to speak of care.**

Nevertheless, also we found a speech that understands the care like which biochemist goes strictly beyond that. Everything and to contemplate the importance of the disappearance of the symptoms also includes a social dimension. That is to say, the care also incorporates the possibility of being able to continue developing an active and independent life within the community. In these terms, the disease is not something that affects the totality of the person and, therefore, of the direction of the treatment. In this sense, **to cure itself allows to develop the own life, although this in a process of treatment of the mental disease.**

To separate the medical treatment of the social context, since we have seen in the first speech on the care, implies to avoid the indirect effect that has got the same treatment on the person and her to day.

5.4. The negotiation of the treatment.

In order to be able to conciliate the medical requirements with the personal necessities it becomes necessary that all treatment incorporates a minimum of directives shared between the affected person and to the professionals. In the scope of the mental health, it becomes essential that the indirect effect are contemplated at the same level that the suppression of the symptoms of the upheaval. This fact is due to the incapable power and to the malaise that cause many of the indirect effect of drugs prescribed for the treatment of the mental upheavals.

Then, by being able to conciliate the medical necessities and the personal necessities it will be necessary that the treatment I was based on the expert knowledge of the doctor and with the expert knowledge of the user.

5.5. The communication in the negotiation.

The relation between the professional and the person affected by a mental upheaval contains following of dynamic comunicatives that make difficult, in some occasions, the well-being of the relation. In this point we will develop a set of oriented communicative advice to each one of the members of the relation in order to introduce a qualitative improvement in its interactions. An improvement that, in first term, can facilitate the negotiation which we mentioned in the previous point.
Concretely, we have detected communicative elements that they make difficult this relation. Before continuing, it is necessary to mention that these elements talk about to the relation and not the people who participate. That is to say, these practices are exclusive neither of the professional nor of the user.
Not to deny the experience of the other. Any affirmation which I tolerated not to contemplate the experience of the implied other in the relation will tend to the confrontation. All negotiation must offer a place to the experience of the other to be able to have it like referring communicative. For example, to deny the usuary knowledge of the respect the effects of medicines is to leave without no place the own experience of the person. As it is possible to be decided yes by a same one the own experience is not been worth?

Not to locate the communicative problems in the people. The comunicatives difficulties that appear in the relation do not have to be attributed to the qualities of one of the members. The relation is something that goes beyond the two people who constitute it. The communication problems accustom to being something due to which they contribute each one of the implied members. For example, to associate a communicative difficulty to the own suffering of a mental upheaval implies to avoid what there is of one same one in the words of the other. It is let consider the affirmation of the other like something valid. And what is worse, the objective of the interaction, the conciliation of the treatment with the personal life is lost of Vista, to be centered in mutual accusations.

5.6. The necessities more there of the medication.

Although the majority treatment that receives the affected people is exclusively farmacological, also we have detected the demand of a treatment of therapeutic look. One is that the person can have a space to be able to work, no longer the psycho-social effects of the disease, but effects to suffer a disease in our context. One is to be able to work those aspects of the experience of the disease that affect the own identity. Also, one is to be able to work those aspects of the society that affect one same one in relation to the upheaval. It is necessary to qualify spaces in which the people affected by a mental upheaval can, in case that therefore they want it, of making a work of individual therapy.

In this sense, ADEMM has generated practices group, like the Groups of Mutual help (GAM), in what the activity that is carried out can be therapeutic for its

members. And, therefore, it can fill this emptiness that at the moment declares the people interviewed.

On the contrary, we have detected that many of the people interviewed give a therapeutic sense to the psychiatric consultations. This fact supposes a frustration source, due to the little frequency and duration of the consultations and to medical cautious constant that dominates any conversation that of within these. In this line, the same psychiatrist of the consultations, in case that therefore he wanted it, either does not arrange of the resources to be able to offer this type of more therapeutic consultation. **The consultations oriented to the pursuit of the treatment do not have the objective nor the resources of a therapy consultation.**

5.7. The group like via of empowerment.

Gathering the experience to belong to association ADEMM, we want to indicate the series of advantages that the fact supposes for the person to belong to a colectivity, as well as the contributions that the group allows in terms of change of articles of incorporation.

In the first place, first that there is to mention it is that the enrolled members to ADEMM emphasize and the communion that the fact supports to them to be associate. Within the group they can make, on the one hand, a more personal work oriented to share experiences that serve them like referring vital and like knowledge source. On the other hand, they can make a work oriented to the social transformation. **The fight against stigma and the improvements of the conditions that surround this group amplify and find a place in the society thanks to the collective action**.

Secondly, **the possibility of implying itself of active form in dynamic the collective ones happens to be an empowerment route**. We spoke of one personal empowerment, whereas the person can reflect on her quality of life and can act on as she wants that this is expressed. At the same time, we spoke of a empowerment social, whereas the person enters a dynamics of citizen action, participating in the political life of the context how it starts off.
Thirdly, the group can happen to be a referring model for the group of affected people. The knowledge that comes from the dynamic ones of the group and the personal experiences of its members can pass to be a tool and a strongpoint for those people who are living similar situations.

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