

# The complexity of non-sense making: a proposal of complex medical sociology of mental disorders.

## La complejidad de construir el sin-sentido: una propuesta para una sociología médica compleja de las dolencias mentales

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**Resumen:** El artículo describe la complejidad de las biografías de los conectados con el diagnóstico de una dolencia mental severa en Galicia, España. 147 biografías han sido recogidas y analizadas en tres grupos de personas diferentes. Un primer grupo son aquellas personas que viven el diagnóstico en primera persona: se han recogido 65 entrevistas y datos biográficos de otras 300 personas. El segundo grupo lo constituyen quienes comparten la vida con una personas con un diagnóstico de una dolencia mental grave: se recogieron 19 entrevistas y datos biográficos de otras 300 familias. El tercer grupo está conformado por los profesionales de la salud mental encargados de gestionar médica y burocráticamente a aquellos con un diagnóstico. Se recogieron 63 biografías de este tercer grupo. Usando datos de estas biografías se reconstruyen los perfiles biográficos publicados previamente (Torres Cubeiro 2009b) proponiendo al mismo tiempo una sociología médica de las dolencias mentales usando la propuesta teórica de Niklas Luhmann.

**Palabras clave:** Sociología médicas de las dolencias mentales; método biográfico; complejidad social; Galicia; España.

**Abstract:** The article describes social complexity of the biographical accounts of those connected with a mental disorder diagnosis in Galicia, a Northwest Spanish Autonomous Community. 147 biographies associated with Mental Disorders diagnosis (MD) have been collected and gathered in three groups differently linked to these conditions. Our first group has lived with a diagnosis of MD for at least 10 years (65 interviews and data from 300 people). Our second cluster of people shares their lives with those with a MD diagnosis mainly with a family relative bound (19 interviews and data from 300 families). Our third group, gathers Galician mental health medical professionals from three mental health units and other mental health facilities which medically and administratively manage people with a MD diagnosis and their relatives (63 biographies). Using data from these biographies, we have constructed three interconnected biographical profiles early published (Torres Cubeiro 2009b) using a social systems theory approach based in Niklas Luhmann sociology.

**Keywords:** Medical sociology; mental disorders, Luhmann; biographic method; social complexity, Galicia; Spain.

## 1. INTRODUCTION

“The pain and misery that losing one’s mind entails for its victim, for their loves ones and for society at large is something no one who encounters this subject can or should ignore, not minimize” (Scull, 2015, p. 11)

Mental disorders affect a complexity of issues that relate to the body, its genetics and neuro chemistry; Mental disorders (MD) affect also the personal psychologies of those involved; and MD affects social relations as well, to name a few elements of that complexity. The technical job of society is to make sense of this complexity not yet scientifically completely understood (Scull 2015, epilogue); increasing in doing so the chances of a communication with sense while the “real” knowledge is not yet available (Moeller, 2005). This complexity is scarcely addressed in the literature of medical sociology of MD. The sociology of N. Luhmann faces directly this density.

Schizophrenia could be a physiological entity between the walls of a lab; but neither the biochemical nor the psychological components, nor the social elements provide a complete picture of such condition. By choosing the term schizophrenia, one person’s chooses a socially created idea. Societies provide context in order to maintain successful communication within these complex situations. Society functions when contradictory senses co-exist.; social systems function harmonizing such contradictions with simplifications. A simplification is then a communicative semantic option of a social system. An idea that has been shared so many times as to be accepted by speaking humans. Schizophrenia simplifies complexity because the shared meaning under that term has been selected as a meaningful element of communication plenty of times before. Education, mass media and repetition increase the chances of understanding and maintaining successful communication. Luhmann refers as semantic cultural pools to this set of meanings and expectations that the social systems has made meaningful in socialization, in our example, the term schizophrenia (Luhmann, 1996). In consequence, from a sociological point of view, there is not an ontological entity called mental disorder; there are only communications about mental disorders. Luhmann's sociology describes how the whole social construction produces and maintains sense of social systems “without” human beings. According to Luhmann’s social systems theory, society is complex because each inside social element can’t relate to all the other components of the social whole. A society needs shared meaning with simplifications of such complexity within the process of socialization. Therefore, Luhmann focuses on sociology as the study of communication. This social construction of shared meaning defines the technical function of society (Luhmann, 2007). Society creates the communicative context in which human beings can interconnect. Doing so, society increases the chances of human beings success (Torres Cubeiro, 2013). Society increases chances simplifying such complexity and allowing meaningful

encounters. A term such as schizophrenia refers to that complexity, but the used term schizophrenia itself simplifies such complexity, to reduce complexity.

In this line of argumentation, this article assumes that the sense given to Mental Disorder is built in a complex social process (Wolf, 1982). This sense or meaning is then socially communicated using the expression Mental Disorder in a way that disassembles / simplifies such complexity. Therefore, concepts as MD, Schizophrenia or Bipolar disease designate “packages” of relationships and expectations socially constructed. Only by understanding these names as clusters of relationships socially built; and then, placing them back into their complex totality we can hope to avoid misleading interpretations or patronizing intentions. The work of Sociology as science is to describe how that simplification of complexity was built, and how it is communicated without human beings realizing of the social process that gives sense to such simplification.

From this point of view, a biographical account is a social construction, biography is one of the ways in which a social system helps to make sense of a human being life. In a biographical account there are rules of what should and not be mentioned, rules learned in society. Once a biographical account is shared, the personal understanding of what is a mental disorder communicates in the complex semantic pool in which society facilitates social interactions. A MD such as schizophrenia names then what makes sense to the person speaking thanks to the social system that helped to create that meaning. Our socially designed specialists (psychiatrists and psychologists) detect mental disorders, identify them, organizing how to take care of and treat them. In consequence, medical sociology of mental disorder job is to describe how the sociological pool has been constructed to make sense of such no-sense (Cockerham, 2006, 2010; Pescosolido, Wright & Sullivan, 1995; Tausig, Michello & Subedi, 2004)

When a mental disorder enters someone’s life, no-sense blooms everywhere. It takes time and effort to build up sense out of the experiences with a mental disorder (MD). The biographic accounts of these experiences are then shared with others in social encounters. These accounts constituted the ground in which social understanding of MD is built because, as Denzin points out, “the lived experiences of interacting individuals are the proper subject matter of sociology” (Denzin, 1989, p. 25). Then, the sense “of life is given in the text that describes the life” (1989, p. 33). Thus, from a sociological point of view the biographical genre is itself a form of social constructed observation and communication (Bruner, 1987). Human beings have learned thought the process of socialization to repeat biographical models, and in such repetition, give sense to an account of their life to others. In consequence, biographical and autobiographical accounts offer researchers the opportunity to observe both the construction of meaning and its evolution (Atkinson, 1998). The sociological relevant question related to biography is not, if it is (or not) an accurate or authentic report, not even if it could be a cruel history from the margins. The sociological question is how meaning is constructed in social

encounters to give sense to a biography and then repeat it to be communicated once and again.

This article describes the semantic pools socially shared on MDs focusing in interviews that were conducted in Galicia, a Spanish North-west region. The data has been presented in a former publication of a PhD dissertation (Torres Cubeiro, 2009b), a fully ethnographic account could be there consulted. In this article, after a methodological description of how data has been collected, a short summary of the administrative complexity that a person with a MD diagnosis and its relatives have to deal with in Galicia during the last forty years is first presented. Then, we focus on a short outline of the biographical accounts of the people interviewed: those with a MD diagnosis themselves, those with a family link to a person with a diagnosis, and finally those who work in Mental Health Units in Galicia and then manage medically the people with a MD diagnosis and their family relatives. The reader should keep in mind that the rich fully ethnographic account has been already published elsewhere and is therefore available (Torres Cubeiro, 2009b). The article ends with a discussion of the interconnections of these four described complexity that should guide further research in this field.

## 2. METHODOLOGY: DATA COLLECTION

Data has been recollected using three successive strategies as part first of a PhD investigation (Torres Cubeiro, 2009b); and later as background data for a documentary film titled *ConEtiqueta* produced by the author of this article (Villanueva, 2013). A first approach was a contact established with the association *A Creba* in 2006. *A Creba* is an association of relatives and patients with a severe mental disorder diagnosis in Noia, a Galician coastal village. Since then an observation participation strategy as volunteer has allowed the author to establish permanent contact with relatives, users and workers of this NGO.

A second strategy for obtaining data has been interviewing forty-four people and tape their biographical account between 2007 and 2008. Each interview took place in two to four encounters of at least one hour duration each. Interviews were conducted with members of *A Creba* and other similar associations and Mental Health Galician facilities. A final approach involved six focus groups (families, patients and professionals of Mental Health) conducted in a Galician General Hospital and data from three Mental Health Units was collected as well (Pintos, Marticorena y Rey, 2004; Pintos, Rey, y Marticorena, 2004). Finally, secondary bibliography of first persons accounts published has also been taken in consideration (for further details see Torres Cubeiro, 2012, appendix).

This article presented as short outline of the biographical accounts with this data collected and already published in Spanish (Torres Cubeiro, 2012). The data has been ordered in three groups. The first group is integrated by those how live MD's in their own lives: people with a diagnosis of a MD (PMD's). Twenty-two

PMD's with a diagnosis of a severe mental disorder have been directly interviewed: seventeen suffering schizophrenia, four bipolar disorders and one depression (five recognized a drug issue); seven females and eleven males; eighteen uses of *A Creba*, four were nonmembers of *A Creba*. Another twenty-eight biographies of *A Creba*'s users were informally recollected while working as a volunteer (Torres Cubeiro, 2012, p. 380-390). 300 other *A Creba* users' biographical information have been collected from administrative files of *A Creba*. In 2004, two focus groups of seven and eight speakers respectively with either a schizophrenia or bipolar disorder were conducted and taped (Pintos, Rey y Marticorena, 2004; Pintos, Rey y Marticorena, 2004, p. 359-383).

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

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

After taping and transcribing interviews and group discussions, the texts have been analyzed to detect similarities and differences (Kitzinger, 1994; Flick, 2014). Later a narrative of each group career on living, coping and managing severe mental disorders has been constructed (career in the sense of moral career used by Goffman, 1968, p. 125). An account of the career that each group has described in our interviews is offered here, starting with a quick background of the bureaucratic and administrative complexities in which this takes place.

### **3. GALICIA (SPAIN): ADMINISTRATIVE COMPLEXITY.**

In 2000, Manuel was appointed chair of Psychiatry in one of the main Hospitals in Galicia. His hospital covers a population of over 500.000 inhabitants. When interviewed, Manuel described how his first main task included unifying ten different administrations paying psychiatrists under his control. A single Mental Health hospital obtains its founding's from 10 different bureaucratic organizations.

This complexity plays for sure a role in understanding how anyone could face a MD diagnosis in Galicia. Let's see.

Galicia is one of the 17 Autonomous Communities in the administrative organization of Spain. Each Autonomy has a public founded Health system, in which Mental Health Care include the benefits provided since the creation of the Galician Health System (SERGAS) in 1989. But this starts with charities from the 19th century. Early during the 19th century, in Galicia free public charities were organized inside local municipalities. Since January 1885 until 1959, there has been only one insane asylum in Santiago, Galicia, called Conxo (Torres Cubeiro, 2010). Conxo was founded by the local Bishopric who quickly signed agreements with those local councils to attend poor "insane". During Franco's dictatorship (1936-1975) the Social Security Health System emerged to unify a "free" universal medical insurance to all paying workers, but while general health problems were successfully covered, the coverage for MD had to wait.

A health act was passed in 1986 with the Socialist Party in power, but it was not executed until the 21st century. Coinciding with the economic development of the 60's and 70's, four other state psychiatric hospitals opened in Galicia and several private "sanatoriums" were founded. A chair of psychiatry was created inside the faculty of medicine in Santiago's University. This chair had a specialized practice within a psychiatry unit inside the university hospital, and a child psychiatry team started to work during the late 80's. Later, twelve mental health units at different public ambulatories were created in rural health centers and non-urban hospitals throughout Galicia. To add complexity to the picture, different administrations also opened facilities in Galicia: a mental health clinic in a military hospital; several psychiatric public practices inside Hospitals for fishermen (Torres Cubeiro 2009b); several units for drug addicts with psychiatric professionals ruled by city councils but European founded in our current days, joined by a system of private psychiatric consultations and private sanatoriums in almost every Galician town and village.

At the beginning of the 21st century, the Galician Autonomous Community administration passed legislation to unify these complex nets of Mental Health facilities starting public social security health services (SERGAS). This unification coincides in time with what was called the psychiatric reformation: closure of psychiatric old hospitals psychiatry and the defense of the so-called community psychiatry. Exactly during that process, more than 20 mentally ill relative associations were founded. These private founded organizations covered a demand of health care for those chronically ill. A *Creba*, where part of our data has been collected, is one of these organizations. These partnerships created a network of private care funded by state grants and European funding: rehabilitation centers, supervised apartments and businesses to provide employment for the sick.

This complex network generates the cultural semantic pool where the sense of MD is built. From 19th century charity organizations to 21st century SERGAS,

the systems integrated inside the medical system have fueled the semantics in which mental health workers operate, in which relatives of patients cope with their family crises, and in which patients have been living their MD biographies. Let's know describe concisely their biographical lines dealing with MD

#### **4. PATIENTS: LIVING IN FIRST-PERSON WITH NO-SENSE**

We will use the acronym PMD to refer to those Persons interviewed who had a diagnosis of severe MD for the last 10 years. All those who conquered a diagnosis of a MD had indeed a life before such experience arose. PMD portray confused but idealized memories of what life was like before being diagnosed (see full transcription details in Torres Cubeiro, 2009b, chapter 10). They seldom draw a clear distinction between their personalities and their MD. In most cases the presence of MD is clearly remembered as being detected during their adolescence coinciding with an increase in the number of problems and conflicts. Most PMD remember the first serious crisis ending with their entrance into adulthood. Utmost found a dividing line between memories of a happy childhood and a somehow young adulthood with an increasing number of problems. Many of the interviewees reported at this time how they used alcohol and other illegal drugs (heroin, cocaine or hashish). A large majority associate those drugs as the cause of their current state.

Once established a first permanent contact with MD, all interviewees narrate a race with different types of therapists before going to a psychiatrist. The advice of someone carries them to a healer, to a specialist practice set in the county's capital, or to the doctor's practice of a next door neighbor nephew. If the illegal drugs become a central issue, the detoxification programs are essential then in their narratives. The first psychiatrist they visit is generally a paid private practitioner. It is worth noting here that none of the respondents have stayed with this first psychiatrist. All PMD have gone through more than three psychiatrists till the one they keep today. Most users of *A Creba* nowadays are treated with Melon, a local psychiatrist part of the SERGAS mental health unit; but none have had Melon as their first visited psychiatrist. All *A Creba* users have gone through a long list of specialists of various kinds: acupuncturists, local healers or curandeiros, herbalists, therapists, psychoanalysts and psychiatrists.

At some point during this pilgrimage a psychiatrist "understood" him or her. This psychiatrist gives a first diagnosis of a MD and prescribes some meds. This first psychiatric labeling usually coincides with another major crisis where closer relatives do not take any more easy explanations or excuses facing weird behaviors (see next section for details). If the crisis is strong enough, they end up being admitted to a psychiatric sanatorium. Most first reported admissions are in private expensive institutions. PMD report more than five internments in Psychiatric

hospitals, after this first one, mainly in public state institutions. Almost none of the interviewees remember the exact number of the urgent admissions over the years.

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

A family crisis generally occurs coinciding with a first MD diagnosis and medication. It mainly goes with a strong crisis within their reference households. In the lives of PMD closer relatives and family play an essential role, positively or negatively but essential (FMD: we will refer by FMD to family close relatives of a PMD). At this point in their carriers with MD, even FMD which openly accept their MD diagnosis would accept that this MD label involves a certain breaking point. In three cases that breaking point was stronger than in all the other, involving a full rupture with the family. These three cases are not exceptional because almost every PMD reports periods in their lives when FMD did not understand them, or in which PMD break temporally with the FMD. Then, they lived on their own for a while. But in none of my interviews, the family breakdowns were permanent (I contacted them throughout *A Creba*. This implies certain personal stability and a call for help from FMD; maybe there are cases in which this was not the case and the breaking with the family became permanent).

PMD reach certain behavioral stability in their lives after a history of hospital admissions, different treatments and therapies. They point then how they arrive to *A Creba*. In general, PMD describe how someone told them about *A Creba*, in most cases after a hospital admission or at the local mental health unit. They then take a first visit to *A Creba*'s building. Almost all of them describe how they have this first visit accompanied by a FMD. In many cases, they report attending *A Creba* only for a few months. In some cases, *A Creba*'s users have come in and out of the association several times. To join *A Creba* PMD must meet certain requirements: first, they have to be stable, meaning that they have a psychiatrist and they have taken their prescribed medication for some period of time; this implies that they must be drug free (some receive methadone in *A Creba*). Secondly, PMD ought to



pay a monthly fee that varies depending on the capabilities of each user and the services provided. Every *A Creba*'s user attends a daily workshop (sewing, leather, framing, paper...) In most cases, they narrate their tour through the various workshops finding the right one. PMD also attend workshops on re-education and psychology. They also have a dining room and 12 of them live in the three supervised apartments. Vans gather them daily to perform all these activities. Most users have received their non-contributory pension (around 440 Euros per month) through *A Creba*. Those I have interviewed are now in *A Creba*, so we lack testimonies of those who left *A Creba*.

PMD do not define or see themselves as mentally ill in spite of all hospital admissions, histories with different meds etc. They speak of their "illness" but do not add the adjective "mental". Their identity is as sick, not as mentally ill. Consequentially, PMD do not accept the diagnosis of MD, although they do accept their medication. In contrast, they acknowledge their participation in *A Creba* but many add immediately that they come to *A Creba* to work: this is a job. All *A Creba* users repeat a similar description of what is a MD, as if they learnt the lesson with a primary teacher. Each PMD has a different idiosyncratic explanation of what has happened to him: one describes a blow to the head, others some kind of bad experience (sexual, breaks with partners, family crisis, etc.); others relate their current states with a poor medical treatment, and others with substance abuse. But, they all coincide in that none of them define their status as MD or madness. Each PMD has a name for his "problem". None of them speak of a biochemical brain "failure" or a biochemical or genetic heritage. When a PMD uses these terms he speak in general, with the tone of a primary school student. Then, speaking in general about MD, they repeat the same "lesson": MD is an imbalance in the brain that medication restored. All PMD compare MD over and over with diabetes. In this same sense of lessons learned, they all agree on the terminology, the examples and the vocabulary used to describe what Schizophrenia is. Thus, when asked, PMD report how they have learned what their "disease" was only once they started to attend *A Creba*.

PMD agree in using a varied vocabulary to describe their shyness, their taciturn states. These states are not blamed in principle on the disease but on their personalities or characters. They rarely attribute these feelings to Schizophrenia or Bipolar Disease; even after years of having a stable diagnosis. They are able to describe clearly positive and negative symptoms of schizophrenia, but again in their dialogue scarcely use these characteristics applied to themselves. PMD make a clear distinction between their depressive moods and those close to violence, attacks or crises. If they speak about violence, stress or violent tingle, they refer those to acts and feelings against themselves: in general, they describe then how in some periods of crisis they were unable to control their situation and usually end up visiting a doctor or entering a psychiatric hospital. PMD describe how being *A Creba* users

have helped them to prevent those type of behavior and reduce their hospital admissions.

As we have been describing, the major difficulty for PMD is to identify the distinction from which to observe themselves and to communicate to others. While having a private dialogue, they utilize personal and idiosyncratic vocabulary. In a personal chat, a detailed and flourished terminology is dominant. Here, they move away from the features of schizophrenia to explain their state from an acceptable meaning but without the social costs of a MD label. The distinction between sick and sane is used here in a flexible manner. But when they have to fill in official formularies or applications, PMD handle perfectly a public identity flourished with MD symptoms; they communicate a public official version of themselves. This ambivalence is the key to understanding their social lives.

Although PMD differentiate between delusion and reality, they often place themselves on the side of delirium. Some of them call this their “imaginary life”. They know that is not real, but its persistence despite the medications requires them to take it in account. For example, Pedro talks everyday with God while Patricia starts our interview asking me if I want to hear about her imaginary life or her real one. They describe their inner voices as real, but the border separating the two and its fluctuations is the key.

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

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

PMD need mirrors to observe themselves: a routine life, the constant presence of relatives and having friends around with the same problems are the mirrors in which they look at themselves. PMD describe these “mirrors” as another turning point: without them the course of their conditions would not be so good, they would stay. They then admit that without those “mirrors”, they could not stop behaviors that could take them to another hospital admission, a new crisis and consequently a deterioration of their states. The key is clear then: the experience of many years living the course of their MD but also the presence of others around

them. Both things draw a clear difference for them. Each user is barely aware of this reality, and if they don't prevent new failures, it really helps.

Another distinction is related to the way they define themselves when facing other that can identify *A Creba*. As we have pointed, PMD describe themselves as "workers" doing a job. When they identify themselves facing mate- villagers, they state: "I am at *A Creba*", without adding anything else. *A Creba* is well known within the village, mainly for their cheap works of framing paintings, making basketry and making weddings gifts.

PMD, belonging to *A Creba*, respond in a quite similar fashion: they feel understood. They sense that they are loved and listened, but almost all pointed how they receive as users of *A Creba* quite more affection. The distinction is clearly inclusive. Outside the association, they are no one, no one knows them and they have to repeat what happens to them; but once they are member of *A Creba* everyone knows them, no explanations are needed and no more repetitions are necessary. But belonging to *A Creba* has also a bad side; it includes some kind of prejudices. To prevent these collateral effects, they use the pointed above "worker" role. In conclusion, belonging to *A Creba* serves PMD to justify their status, their weirdness to strangers. Within *A Creba* PMD communicate and live, obtaining a public identity, becoming also a linchpin of inclusion, at least within the association itself and the local area.

## 5. SHARING A MD DIAGNOSIS: FAMILY NO SENSE.

FMD (family relatives of those with a MD diagnosis for at least the last 10 years) respondents in this second group share a constant feeling of helplessness and uncertainty (Torres Cubeiro, 2009b, chapter 8). Throughout the processes of living with a PMD in their family privacy, they express constant fear and lack of understanding. With the first signs, throughout the first visits to specialists and the first psychiatrist; towards the first crises and hospital admissions; and finally coming to relapses, changes in therapy, and more crises; all throughout this vital career uncertainty shows up continuously inside their biographical narratives.

FMD face the first signs of a MD as a challenge. Some inexplicable behavior bursts into their lives. The common sense explanations fall down one after another while new crises come again: no personal crisis or bad period can explain any more what keeps happening. After several crises these reasonable explanations are abandoned: the persistent unexplained behavior destroys these obvious reasons. Neither drugs, nor a psychological ordeal after personal problems, nor stress can be maintained as an explanation. FMD remember this first naïve approaches to what they know now as MD. Here, we have a first clear distinction from which FMD observe MD. There is a before and an after the time when there were no more easy explanations left. Interviewers generally describe a single crisis that becomes a breaking point. The uncertainty, the fear and the panic has been always there but

after that turning point: “things started to make sense”. Everything after would be re-interpreted from this new perspective.

Before a MD diagnosis landed in their lives, FMD needed justification. No more excuses: something is wrong and now they have a name for it: Mental Illness. But they add a complementary explanation: somatization is quite frequent. The inexplicable intervention of a body system must account for such strange behavior. A trial and error method is used and wrong possible causes are progressively eliminated. FMD use extensively their social network searching and analyzing reasons and justifications of MD treatments. Doctors and specialists are used to add evidence during this search for meaning. At some point they arrive to a conclusion: the problem persists and they have not yet understood what is really happening. Not private medicine or all economic efforts calmed their beloved crises. There have already been several periods during which acute symptoms almost disappeared. In retrospective, FMD remember how they thought at that point that their inexplicable beloved problems had disappeared. But they have also verified that after a relieved period, symptoms inevitability returned. And they have also sadly confirmed that after those periods of reliving, problems increased a bit each time. The situation became untenable and somehow FMD had to step up and accept a hospital admission under the supervision of mental health expert.

FMP interviewees lived a contradictory situation at this point. They recall how difficult it was to accept a MD diagnosis after a first psychiatrist admission mainly because they felt embarrassment. On the one hand, the FMD face the embarrassment of seeing a psychiatrist, but the psychiatrist offers an explanation “socially” accepted; something that it could be sad but that everyone would understand. Given the fact that my interviewees have relatives with a MD diagnosis for more than ten years, they have continued their live close to psychiatry. Their next step takes them to assume that MD is a chronic ailment because there is not a magic cure. In contrast, Psychiatry offers pills to make it easier to live with their relatives’ psychotic symptoms. The first contact with psychiatry occurs to them, and FMD find clear relief. Later after a few years with the MD diagnosis, they recognize that there were dark spots. They claim that they do not receive much help from doctors, or that the information given was not complete or not enough.

FMD describe as a major workhorse the search to find a psychiatrist who understands their loved PMD, and specially their family situation. In most cases, this is a non-ending search. But first, FMD must somehow grasp the complexity related with the social defined institutions taking care of the mentally Ill. As we have earlier described, the mental health care systems in Galicia is quite complex. They describe how they faced various problems with the system of health care. One issue that they frequently name is when they arrive at a psychiatric hospital and no beds were available during a major crisis. Another common topic described is when they were denied a meds prescription; or, the bureaucratic nightmares for obtaining a pension..

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

We must remember at this point that all the interviewees are relatives of a mentally ill person with a MD stable diagnosis. Their main feature is therefore persistence. Thus, this distinction between before and after an initial crisis continues marking their entire lives. They now know with certainty: MD is going to stay. Stabilizing medications, treatments and the relative peace confirm this: their beloved relatives are mentally ill, and there is no way out. But it comes with other uncertainties. Mothers, husbands, wives, fathers, brothers, they all are concerned about the future of their appreciated relatives: which social system is going to provide care in case they disappear? Who is going to take care of their beloved? This concern is more acute when an elderly mother is the main care provider of an adult mentally ill. *A Creba* FMD users perceive this problem. *A Creba* is their bet to supply that care. If with the diagnosis of MD, FMD found relief, explanations and choices (or not) to communicate, *A Creba* gives them hope of continuity and future.

FMD describe how they arrive to *A Creba* referred by a doctor or a neighbor. In general, they landed in this organization after a psychiatric hospital admission. Almost all respondents agree that *A Creba* was and is a reliving the day by day life with their ill family members. Most FMD narrate a long career of psychiatrists, therapists and different types of professional care before a somehow stable day by day arrived. Of course, they tried private psychiatric resources but all respondents ended up using the resources of public psychiatry. The cost of all other options makes the public health system, the best solution when the problem persists. But most of the mothers I have interviewed point out something especially helpful that they found when attending *A Creba*: its workshop meetings for mothers, fathers and relatives of PMD *A Creba*'s users. During these meetings, they started to realize that their situations were not unique. They shared an experiential vocabulary of what has been going through their lives. And they all agree that was a real reliving.

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

## 6. MEDICAL PROFESSIONAL MANAGING NO-SENSE..

Our third group is constituted by the biographies of those who manage officially Mental Illness: workers of the mental health sectors with a special attention to psychiatrists (in short: MHW). As general common attitude, all MHW share a pragmatic attitude: they use anything that works (for further detail see Torres Cubeiro, 2009b, chapter 9). Maybe it doesn't fit with the dominant professional theory, but they all recognize a pragmatic attitude: if it is helpful for their patients but goes against their main theories, they use it. Side by side with their pragmatic approach, a clear eclecticism is also part of their common tools box. Although each MHW interviewee describe an idiosyncratic preference for one of the multiple schools in psychiatry or psychology, they pragmatically practice a mixture of all those schools. Among the MHW interviewees three outline profiles could be differentiated depending of their age and the historical period in which medical school was attended.

(1) Professionals trained during Franco's dictatorship have a more phenomenological psychiatric approach: MD is seen as a very human deficiency that they help to overcome (Duro 2010). (2) Those MHW in their middle-age share a tendency to value psychoanalysis as an ideal model for community psychiatry and health care systems: MD is seen as an eminent social problem, a society that MHW have a responsibility to serve. (3) Finally, the youngest MHW share a more bio-medical model, trying to catch up psychiatry to other clinical specialties: in this

case, MD is a biological imbalance without individual or social responsibilities, but with care and psychological consequences. All professionals share an ironic tone when speaking about the others points of view that they acknowledge as existing. In consequence, MHW practice an ironic and cynical skepticism; justifying their eclecticism with a pragmatic clinical orientation.

Regardless of their predominant orientations, MHW share certain concepts when they communicate between them. One of these concepts is the duality psychosis / neurosis. These two words originated within Freud's psychoanalysis but are broadly use in our days referring in general to "hard" MD in the case of psychosis and to somehow "softer" MD when using neurosis. Another conceptual framework used by all MHW is that of community psychiatry. This is seen as an ideal of social assistance. Other concepts born in one of the psychiatric schools but used now by all workers are: the opposition between psychiatry and psychology, psychological tests rule as the attributed job of psychologists and meds for psychiatrists. All MHW accept the use of psychotropic medication to treat MD, although they all share an initial reluctance to prescribe it.

Each MHW describe his years of training in his specialty to justify his predominant orientation in psychiatry. During those years they describe how they constructed a network of contacts with other doctors. Those networks include specialists of all types, so that when they need a bed for a patient or a second opinion, they easily know who to contact with. The common complaint about their formative years is that they included too much theory and too little real clinical training. They point out as a real school the day by day contact with patients. They relate how big the change was of having to treat real patients after so many years of faculty theories. These complains fit perfectly with the combination of pragmatism and skepticism defined above.

Once MHW started their practices, they recognized one or two cases that had become paradigmatic, or that somehow made them learn something in an especially hard manner. One death patient, a patient's history of violence or a memory of a fatal error defines usually the self-pointed identity. Most interviewees learned with a case how to draw distance with patients: empathy with the Mentally Ill, and they clearly draw a line here. One must remain objective and not be influenced by a strong identification with the Mentally Ill. Most MHW use community psychiatry as an ideal, almost as a social imaginary, used to describe how psychiatry should be working (Pintos, 1995).

In general, if their main orientation is biological, community psychiatry plays that role. But if their orientation is less organic, then biomedicine is used as an ideal future solution to come. So, we have that each manages the picture of how care should be provided with the help of all psychiatric schools at hand. Given that MD is still in our days not completely understood by the existing schools, these mixtures of justifications and imaginaries serve them to obtain identity as MHW at the same time that they communicate with all the other workers. The main identity of the

professional is orientated to a psychoanalytic perspective. Within any mental health unit, any given MHW would inevitably face that the other workers would be coming from the Other schools. In their professional identities, those paradigmatic cases are used to interpret their identities while they communicate them to all the co-workers within the unit. These identities clearly marked a difference for them.

MHW commonly throw frequent criticisms out to the health system where they work. Their reasoning is that doing so, they try to improve the organization of health care. There is not always a clearly pronounced hope: a new cure could be discovered any time. These hopes for the future are consistent with the predominant perspectives in each practitioner, but MHW all built their communication expectations in terms of their own school. In consequence, a community-oriented psychiatrist but with a Galician nationalist vision criticizes during our interview the lack of understanding of psychiatry's official "Galician peasants". He shows easily a strong critical view against those orientated by a biological psychiatry. This psychiatrist also points out the main problems of psychiatric drugs: they don't face the main socio-cultural problem underling each patient case. But he has no shame in recognizing that he prescribes as many meds as any other psychiatrist in Galicia. A biologist psychiatrist does not need an explanation to justify the use of a pills therapy, but he would prescribe it to their patients. In both cases, the justification is pragmatic and clinically they both apply anything that works.

Most of my interviewees worked for the public health system of the Autonomous Galician Community. Most of them also have a private practice. Coherently, there is no criticism of the fact of these private psychiatric practices. Their existence is not even mentioned during the interviews, nor taken into account. Only when asked directly they mentioned it. But they mention then the necessity to protect the privacy of their patients. All psychiatrists interviewed, except one, maintained a private practice, sometimes working more hours in that than in their public health position. It seems that what isn't mentioned is a fact taken for granted as part of their role and identity as a doctor-psychiatrist.

On the other hand, most MHW criticize private organization such as *A Creba*, but not their private practices. They usually do so assuming that work done in these organizations is cheap labor that should be assumed by the State and its health administration. MHW idealize community networks as the solution to complement medical services, but when they speak about organizations such as *A Creba* they assume that they should be state founded (assuming a suspicion of the psychiatric private sector).

In conclusion, MHW interviewees organize their observations from a purely medical approach and a care given orientation. They organize their visions within a continuum between the extremes of a clinical pragmatic practice, and an eclectic theoretical position integrated under an image of the responsible job of the "good white coat doctor".



## 7. DISCUSSION: SOCIAL COMPLEXITY, THE SOCIAL MEANING OF NO SENSE MAKING.

Cockerham (2014), one of the more quoted scholars in the field of medical sociology of mental disorders, describes a paradigm shift in medical sociology (Cockerham, 2014, p. 1032). This scholar declares the classical sociological theories as zombie's theories, following Ritzer (Ritzer y Yagatich, 2012). In this sense, classical approaches "inspire" current empirical research but they are not really "effectively" in empirical usage (Cockerham, 2014). Classical theories as functionalism or structuralism are declared zombies because they have no impact on the main flow communicational streams, meaning high impact journals, of medical sociology; as Cockerham himself declared postmodern theory in an earlier article (Cockerham, 2007).

Leaving aside that Cockerham focusses only on "US medical sociology, he ignores any approach that analysing health issues within a social systems complexity theoretical approach. A gap common in medical sociology. Medical sociology describes social reality assuming nominally its complexity without fully complex or "theoretically systemic in their usage of these ideas" (Castellani et al., 2015). In this sense, within the sub field of medical sociology of mental disorders, the field addressed by Cockerham himself (2016), complexity implies psychological, somatic / physiological and social issues. The literature on this mental disorders complexity is frequently named but not fully addressed as we will shortly discuss.

Literature specialized in biographical and autobiographical accounts of MD centers on four main topics: first, we find literature recollecting first-person accounts of patients living with a MD diagnosis (LeCroy y Holschuh, 2012; Landis y Mettler, 1964; Karp y Sisson, 2010; Peterson, 1982; Landis y Mettler, 1964). Second, bibliography focused on biographical accounts of relatives/friends sharing their lives with those who live directly a MD diagnosis (Jiménez y López, 2003; Sones, 2011; Riley, 1982, 1984; Simon, 1997; Lachenmeyer, 2001; Spiro & Wagner, 2006; Earley, 2006; Lamb, 1998; Lyden, 2015; Berger & Berger, 1992; Berger y Vuckovic, 1994; Neugeboren, 2003, 2001; Karp, 2016; Brown & Roberts, 2010; Rebecca Woolis 1992; 2010; Nathiel 2007). Third, publications describing first-person biographical accounts of professionals of medicine - physicians, nurses, social workers, etc. - managing those with a MD diagnoses and their relatives (Castilla del Pino 2004, 1987, 1977, 1997; González Duro 1987, 1978, 1992, 1974, 1975b, 1975a; González Fernández 1992; 1992); including bibliography of medical professional themselves with a MD diagnosis (Kay Redfield Jamison 1990, 2004, 2011, 2014; Rippere & Williams, 1987). Finally, literature covering descriptions of how is life within MD different types of mental health institutions (Goffman 1972; Estroff 1985; Covan y Kahn 1994; D. E. Jodelet 1989; 1990; Payne y Sacks 2009; 1988; Cáceres Lescarboursa 1991; Lera 1972). A

few publications conceptualize differently the biographical approach we have outlined here out of the former groups. An example of this other conceptualization is the article by Leamy (2011) which systematically reviews how personal recovery from MD is conceptualized within a biographical framework.

Prior literature focus on those groups without addressing its social interconnected complexity. There is not literature focused on the social complexity of the interactions that these different biographical perspectives have in social day by day life. From a sociology of complexity perspective, this gap needs to be attended. Cockerham (2006) offers a compressive approach to complexity on the topic in his manual on mental disorders offering a map of such complexity. In a different later publication, he speaks of social complexity applied to MDs without fully addressing such complexity (Cockerham, 2007). Among others academics specialized in this field, Pescosolido has approached such complexity but only from the point of view of the stigma associated to MD diagnosis (Pescosolido & Martin, 2015; Harkness, Kroska & Pescosolido, 2016; Pescosolido & Olafsdottir, 2013). And the Australian professor A. Jorm has also touched this complexity regarding mental health literacy (Jorm et al. 1997; Reavley, Morgan & Jorm, 2017). These two late long research endeavors by Pescosolido and Jorm, they both approach social complexity of MD not frontally but sideways in its link with stigma and mental health literacy respectively. Only the German sociologist Niklas Luhmann built his theory to describe social complexity directly (Corsi, Esposito & Baraldi 1996; Moeller 2005, 2013) and we adopt this approach to address the social complexity of biographical accounts of MD (Torres Cubeiro 2009a, 2009b, 2012, 2013, 2016).

This gap has been attending here in this article. We have presented the elements of Galician MD complexity. We have outlined three groups biographical profiles: first, those with a diagnosis of MD during at least the last 10 years; second; secondly, we approach the complexity of the biographical accounts of relatives of those with a diagnosis of a MD; and finally, those involved as professionals in managing MD. They share elements, but they also have quite different views. The meaning of MD used by patients is not the same than that utilized by his family member or his mental health professionals. Our theoretical approach has shown these differences because it understands that the social system works precisely in this disagreement. But this complexity deserves more consideration, being more investigation in deed needed.

Far from building social order out of consensus, societies make no sense possible simplifying complexity. That is precisely the social systems job: keep nonsense under control. But as sociologists our job is to describe that complexity, understanding the processes in which meaning is constructed.

**REFERENCES.**

- Atkinson, R. (1998). *The life story interview* (Vol. 44). London: Sage.
- Berger, D., & Berger, L. (1992). *We Heard the Angels of Madness: One Family's Struggle with Manic Depression*. New York: Harper Trade.
- Berger, L., & Vuckovic, A. (1994). *Under Observation: Life Inside a Psychiatric Hospital*. New York: Tickor and Fields.
- Brown, M. J., & Roberts, D. P. (2010). *Growing Up with a Schizophrenic Mother*. McFarland, Incorporated, Publishers.
- Bruner, J. (1987). Life as narrative. *Social Research*, 54(1), 114-32.
- Cáceres Lescarboua, Á. (1991). *Los habitantes del pozo (vida y muerte en una cárcel manicomio)*. Alicante: Aguaclara.
- Castellani, B., Rajaram, R., Buckwalter, J. G., Ball, M., & Hafferty, F. W. (2015). *Place and health as complex systems: A case study and empirical test*. Springer.
- Castilla del Pino, C. (1977). La psiquiatría española (1939-1975). En A. VV (Ed.), *La cultura bajo el franquismo* (pp. 79-102). Barcelona: Bolsillo.
- Castilla del Pino, C. (1987). *Cuarenta años de psiquiatría*. Madrid: Alianza.
- Castilla del Pino, C. (1997). *Pretérito imperfecto*. Barcelona: Tusquets.
- Castilla del Pino, C. (2004). *Casa del Olivo. Autobiografía (1949-2003)*. Barcelona: Tusquets.
- Cockerham, W. C. (2006). *Medical sociology*. New Jersey: Prentice-Hall.
- Cockerham, W. C. (2007). A note on the fate of postmodern theory and its failure to meet the basic requirements for success in medical sociology. *Social Theory & Health*, 5(4), 285-296.
- Cockerham, W. (2010). *The new Blackwell companion to medical sociology*. John Wiley & Sons.
- Cockerham, W. C. (2014). The sociology of health in the United States: recent theoretical contributions. *Ciencia & saude coletiva*, 19(4), 1031-1039.

- Cockerham, W. C. (2016). *Sociology of mental disorder*. Taylor & Francis.
- Comelles, J. M. (1988). *La razón y la sinrazón. Asistencia psiquiátrica y desarrollo del estado en la España contemporánea*. Barcelona: PPU.
- Corsi, G., Esposito, E., & Baraldi, C. (1996). *Glosario sobre la teoría social de Niklas Luhmann*. Barcelona: Anthropos Universidad Iberoamericana.
- Covan, F. L., & Kahn, C. (1994). *Crazy all the time. On the psych ward of Bellevue Hospital*. Toronto: Randomhouse.
- Denzin, N. K. (1989). *Interpretative biography* (Vol. 17). London: Sage.
- Duro, E. G. (2010). *Los psiquiatras de Franco: Los rojos no estaban locos*. Grupo Planeta.
- Earley, P. (2006). *Crazy. A Father's Search through America's Mental Health Madness*. New York: Putnan.
- Estroff, S. E. (1985). *Making it Crazy. An ethnography of Psychiatric clients in an American community*. London: California U.P.
- Goffman, E. (1972). *Internados. Ensayos sobre la situación social de los enfermos mentales*. Buenos Aires: Amorrortu.
- González Duro, E. (1974). *Informe sobre la asistencia psiquiátrica española*. Madrid: Cuadernos para el diálogo.
- González Duro, E. (1975a). Asistencia psiquiátrica madrileña a finales del siglo XIX. *Medicina e Historia*, 51, 1-15.
- González Duro, E. (1975b). Evolución de la psiquiatría en España. *Doctor*, Febrero.
- González Duro, E. (1978). *Psiquiatría y sociedad autoritaria : España 1939-1975*. Madrid: Akal.
- González Duro, E. (1987). *Treinta años de psiquiatría en España: 1956-1986*. Madrid: Libertarias.
- González Duro, E. (1992). *Memoria de un manicomio*. Madrid: Prodhufi.

- González Fernández, E. (1992). Psiquiatría transcultural. Un acercamiento pragmático. En M. Gondar Portosany & E. González Fernández (Eds.), *Espirados. Ensaíos de Etnopsiquiatría galega* (pp. 41-66). Santiago: Laiovento.
- González Fernández, E., & Simón Lorda, D. (1992). Pensamiento antropológico dos médicos galegos (Apunte histórico). En M. Gondar Portosany & E. González Fernández (Eds.), *Espirados. Ensaíos de Etnopsiquiatría galega* (pp. 91-120). Santiago: Laiovento.
- Harkness, S. K., Kroska, A., & Pescosolido, B. A. (2016). The Self-Stigma of Psychiatric Patients: Implications for Identities, Emotions, and the Life Course. En *50 Years After Deinstitutionalization: Mental Illness in Contemporary Communities* (pp. 207-233). Emerald Group Publishing Limited.
- Jiménez, Á. L., & López, A. (2003). *Trastorno afectivo bipolar: La enfermedad de las emociones*. Editorial Edaf, S.L.
- Jodelet, D. E. (1989). *Les représentations sociales*. París: PUF.
- Jodelet, D. (1990). *Madness and Social Representations*. London: Harvester.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., & Pollitt, P. (1997). «Mental health literacy»: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*, 166(4), 182-186.
- Karp, David A. (2016). *Speaking of sadness: Depression, disconnection, and the meanings of illness*. Oxford University Press.
- Karp, D. A., & Sisson, G. E. (2010). *Voices from the Inside: Readings on the Experiences of Mental Illness*. Oxford University Press.
- Lachenmeyer, N. (2001). *The Outsider: A Journey Into My Father's Struggle With Madness*. Crown/Archetype.
- Lamb, W. (1998). *I Know This Much Is True*. HarperCollins.
- Landis, C., & Mettler, F. A. (1964). *Varieties of psychopathological experience*. Holt, Rinehart and Winston.

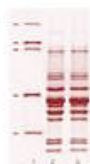
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445-452.
- LeCroy, C.W., & Holschuh, J. (2012). *First Person Accounts of Mental Illness and Recovery*. Wiley.
- Lera, Á.M. (1972). *Mi viaje alrededor de la locura*. Barcelona: Plaza y Janes.
- Luhmann, N. (1996). *Introducción a la teoría de sistemas*. Universidad Iberoamericana.
- Luhmann, N. (2007). *La sociedad de la sociedad*. Mexico: Universidad Iberoamericana - Herder.
- Lyden, J. (2015). *Daughter Of The Queen Of Sheba*. Little, Brown Book Group.
- Moeller, H.G. (2005). *Luhmann explained: from souls to systems* (Vol. 3). Open Court Publishing.
- Moeller, H.G. (2013). *The Radical Luhmann*. Columbia University Press.
- Nathiel, S. (2007). *Daughters of Madness: Growing Up and Older with a Mentally Ill Mother*. Praeger Publishers.
- Neugeboren, J. (2001). *Transforming Madness: New Lives for People Living with Mental Illness*. University of California Press.
- Neugeboren, J. (2003). *Imagining Robert: My Brother, Madness, and Survival : a Memoir*. Rutgers University Press.
- Payne, C., & Sacks, O. W. (2009). *Asylum: Inside the Closed World of State Mental Hospitals*. MIT Press.
- Pescosolido, B.A., & Martin, J. K. (2015). The stigma complex. *Annual review of sociology*, 41, 87-116.
- Pescosolido, B.A., & Olafsdottir, S. (2013). Beyond dichotomies: confronting the complexity of how and why individuals come or do not come to mental health care. *World Psychiatry*, 12(3), 269-271.

- Pescosolido, B. A., Wright, E. R., & Sullivan, W. P. (1995). Communities of care: A theoretical perspective on case management models in mental health. *Advances in medical sociology*, 6, 37-80.
- Peterson, D. (1982). *A Mad People's History of Madness*. University of Pittsburgh Press.
- Pintos, J. L. (1995). *Los imaginarios sociales: la nueva construcción de la realidad social* (Vol. 30). Editorial Sal Terrae.
- Pintos de Cea Naharro, J.L., Marticorena, J.R., & Rey, R. (2004). *El rol del paciente en salud mental. Memoria de investigación*.
- Pintos de Cea Naharro, J.L., Rey, R., & Marticorena, J.R. (2004). *Observación de las expectativas recíprocas entre los actores intervinientes en los casos de personas con trastornos mentales crónicos: implementación de un modelo cualitativo. Memoria de investigación* (SERGAS). A Coruña.
- Reavley, N. J., Morgan, A. J., & Jorm, A. F. (2017). Disclosure of mental health problems: findings from an Australian national survey. *Epidemiology and Psychiatric Sciences*, 1-11.
- Redfield Jamison, K. (1990). *Manic-Depressive Illness*. New York: Oxford U.P.
- Redfield Jamison, K. (2004). *Exuberance: The Passion for Life*. Knopf Doubleday Publishing Group.
- Redfield Jamison, K. (2011). *Night Falls Fast: Understanding Suicide*. Knopf Doubleday Publishing Group.
- Redfield Jamison, K. (2014). *An Unquiet Mind: A Memoir of Moods and Madness*. Pan Macmillan.
- Riley, J. (1982). *Only My Mouth is Smiling*. William Morrow & Co.
- Riley, J. (1984). *Crazy Quilt*. Morrow.
- Rippere, V., & Williams, R. (1987). *Wounded Healers: Mental Health Workers' Experiences of Depression*. Wiley.
- Ritzer, G., & Yagatich, W. (2012). Contemporary sociological theory. *The Wiley-Blackwell companion to sociology*, 98-118.

- Scull, A. (2015). *Madness in Civilization: A Cultural History of Insanity, from the Bible to Freud, from the Madhouse to Modern Medicine*. Princeton University Press.
- Simon, C. (1997). *Mad House: Growing Up in the Shadow of Mentally Ill Siblings*. Doubleday.
- Sones, S. (2011). *Stop Pretending: What Happened When My Big Sister Went Crazy*. HarperCollins.
- Spiro, C., & Wagner, P. S. (2006). *Divided Minds: Twin Sisters and Their Journey Through Schizophrenia*. St. Martin's Press.
- Tausig, M., Michello, J., & Subedi, S. (2004). *A sociology of mental illness*. Prentice Hall.
- Torres Cubeiro, M. (2009a). Marcando unha diferenza: scripts, imaxinarios sociais e enfermidade mental grave en Galicia. *Sociologías de los márgenes: libro homenaje a Juan Luis Pintos de Cea-Naharro, 1000-1023*.
- Torres Cubeiro, M. (2009b). *Orden social e loucura en Galicia*. Univ Santiago de Compostela.
- Torres Cubeiro, M. (2010). Cuentas del manicomio de Conxo: 1885-1924. *Historia de un préstamo hipotecario. Siso/Saúde, 50, 27-50*.
- Torres Cubeiro, M. (2012). Imaxinarios sociais de la Enfermedad mental. *RIPS, 11(2), 101-114*.
- Torres Cubeiro, M. (2013). *Niklas Luhmann*. Baía Edicións A Coruña SL.
- Torres Cubeiro, M. (2016). Alfabetización en salud mental, estigma e imaxinarios sociais. *Imagonautas. Revista interdisciplinaria sobre imaxinarios sociais, (8), 50-63*.
- Villanueva, Adriana. (2013). *ConEtiqueta*.
- Wolf, E. R. (1982). *Europe and the People without History*. Berkeley: California U.P.
- Woolis, Rebecca. (1992). *When Someone you Love Has a Mental Illness: A Handbook for Family, Friends, and Caregivers*. New York: Jeremy P. Tarcher.



Woolis, R. (2010). *Cuando Un Ser Querido Sufre Una Enfermedad Mental: Un Manual Para Familiares, Amigos y Cuidadores*. AuthorHouse.



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