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Edited by
Bernardo Bianchi, Jorge Chaloub,
Patricia Rangel and Frieder Otto Wolf

15 Psychiatric Power

Exclusion and Segregation in the Brazilian Mental Health System

Marlon Miguel[1]

1. Introduction

The history of the Brazilian psychiatric system is closely connected to the development of the country's democratic processes throughout the 20th century – the inequalities, racism, and exclusions at the foundation of the nation, along with its instabilities, advances, and retrogressions. Brazil's military dictatorship (1964–85) radicalized a system based on the principles of privatized care, isolation, and segregation of mentally ill patients, transforming psychiatric institutions into something like prisons or concentration camps. That situation would only begin to improve with the re-democratization period, in 1988, in which debates around the Brazilian Psychiatric Reform began to align with the spirit of a new, progressive Federal Constitution. The Reform movement aimed then to transform the social perception of madness and advocated for looking at the mentally ill through the lens of citizenship. It furthermore emphasized the subject's concrete experience of suffering, the current state experienced by the mentally ill, rather than their "condition" or "disorder"; "care," "social bonds," and "relationality," rather than "isolation," were the privileged concepts. These shifts drew inspiration from anti-psychiatry and institutional reform movements in Europe, as well as some exceptional Brazilian figures such as Nise da Silveira. The Reform law, first proposed in 1989, would only be implemented in the 2000s. And it has been under attack ever since the 2016 coup, directly reflecting the de-democratization that this event unleashed. Brazil has witnessed a strong return of forced hospitalization, the use of violent treatment and the dismantling of public mental health structures.

This chapter seeks to provide a historical analysis of Brazilian psychiatry. My purpose here will be to emphasize the inherent connection between (un)democratic processes and social understandings of the figure of the "mad." The structuration of the system of psychiatric care indeed would seem to be inseparable from human rights concerns and the need to consider all individuals as worthy of care. Without a doubt, social acceptance of the "mad" is intrinsically related to concerns for democracy, and de-democratization, for its part, begins by targeting "deviant" figures.

Beyond expressing a determinate social understanding of madness, I claim that mental health models directly condense the actual forms of an (un)democratic regime. Indeed, undemocratic regimes tend to create enemies and transform them into pathological beings, casting them as disrupting the natural order. The image of the enemy is thus constructed through a medical vocabulary as a pathological intrusion, to be combatted through treatment. In present-day Brazil – after the 2016 coup and in the midst of an authoritarian climate inaugurated with the 2018 election of Jair Bolsonaro – intensified discourses of pathological abnormality and the renewal of exclusionary mental health policies go hand in hand, expressing a radical shift towards the de-democratization of Brazilian society.

2. Early Brazilian Psychiatry: A Project of Isolation, Racial and Social Exclusion

The history of Brazilian psychiatry is marked by the coexistence of, on the one hand, early progressive and even vanguard clinical practices, and on the other, a heavily exclusionary, violent, and carceral psychiatric system. Already in the 1920s, Sigmund Freud's work was the subject of intense debate in Brazil and, in 1927, the Brazilian Psychoanalysis Society was founded. The use of art as a therapeutic tool also appears during this period, and, in 1929, Osório César would publish his seminal book *A expressão artística nos alienados: contribuição para o estudo dos símbolos na arte* (*The Artistic Expression of the Alienated: A Contribution to the Study of the Symbols in Art*) – a publication contemporary with Hans Prinzhorn's *Bildnerei der Geisteskranken* (1922), Walter Morgenthaler's *Ein Geisteskranker als Künstler (Adolf Wölfli)* (1921), and Jean Vinchon's *L'art et la folie* (1924). Where most doctors only recognized a disorder, non-sense, and absurdity, by observing the work of the mentally ill it became possible to envision a new way of examining delusions, behaviors, and pathologies. The artwork of the "mad" thus became a central influence in Brazilian modernism and along with César, the artist Flavio de Carvalho organized in 1933 the exhibition *Mês das Crianças e dos Loucos* (*Month of the Children and Mad*) at the Modern Artists Club in São Paulo. This was the first in a series of exhibitions where the work of mentally ill patients migrated from psychiatric institutions to the world of arts. Furthermore, with these works, Carvalho shifted the very understanding of art, claiming: "the only art is abnormal art" (De Carvalho 1936 with Cabañas 2018, 42).

While these elements reflected the emergence of a new, radical, relational, and progressive understanding of madness, most 20th-century Brazilian psychiatric institutions continued operating along the lines of the *grand renfermement* model described by Foucault (1972).[2] As Foucault has shown, a radical division emerged in the 17th-century between normal and mad people, wherein the latter are to be isolated and receive treatment. A psychiatric discourse such as Philippe Pinel's was certainly progressive for the time period, focused as it was on "liberty" and on "unchaining" the mad. However, their liberation,

based on "adequate" treatment, was conditioned by disciplinary practices. In addition, Pinel proposed a correlation between "mental alienation" and the unhealthy social milieu in which the subject lived. In that sense, his argument called for the subject's isolation from these causes. As consequence, this discourse promoted (1) isolation and (2) the identification of mental disorders with certain social milieus.

The first psychiatric institutions created in Brazil in the 19th century adhered to this isolationist logic while targeting particular parts of the population.[3] Moreover, in the Brazilian context, it clearly integrated racist discourses.

The Pedro II Hospital was the first asylum created in Brazil, in Rio de Janeiro in 1853, followed by many others, such as the São Pedro Hospital, in Porto Alegre (1884) and the Juquery Colonial Hospital, in the suburbs of São Paulo (1898). These institutions mainly received lower-class Brazilians. Following behind "schizophrenia" and "alcoholism," the third most common cause of hospitalization was "unknown" (IBGE 2006, 235). Furthermore, most of the patients that entered an asylum would never leave. For example, under the direction of Franco da Rocha (1898–1920), around 60% of the patients that entered the Juquery Hospital would also die within the institution. Even more striking is that this numbers would go up to between 70.9% and 90% among black people (Machin and Mota 2019, 2). Patients were often sent to asylums by the police, for seemingly random reasons or simply based on "social disorder."

The early history of Brazilian psychiatry was also marked by a eugenics project (Costa 2007; Reis 1994) based on the concept of "race" and the classification of disorders according to ethnicity. This project was represented by prominent medical figures in São Paulo, like Renato Kehl (creator of the São Paulo Eugenics Society), José Paranhos Fontenelle, Pedro Monteleone, Otávio Gonzaga, and Da Rocha himself, or the Brazilian League for Mental Hygiene, created in 1923 in Rio de Janeiro. The discourse around the "mental disturbances of black people" was commonplace, as was the attempt to pseudo-diagnose "Brazilian racial reality" (Roxo 1904; Juliano Moreira with Reis 1994, 132). Very often, these discourses contained categories of mental disorder associated with "race" and the "degeneration" of the human species. Some psychiatrists, such as Raimundo Nina Rodrigues, defended immigration control in order to progressively limit miscegenation, "whitening" the Brazilian population and with it reducing mental pathologies (Reis 1994; Oda 2003).

Eugenicist ideologies, sanitation concerns, and mental hygiene discourses weighed heavily during this period in Brazilian society, which in turn was characterized by radical transformations: the abolition of slavery (1888), the early years of the Republic (1889), industrialization, significant immigration, and rural exodus – São Paulo, for example, doubled its population in the final decade of the 19th century. Eugenics and psychiatry were fused in an attempt to reorganize urban centers, with particular concern for "pathologies of the poor" – delinquency, alcoholism, prostitution, along with tuberculosis

and syphilis – and the repeated correlation between madness and (racial and psychic) degeneration. Lower-class populations being mostly black or miscegenated, these ideologies associated the project of racial cleansing with maintenance of social order and crime reduction. Medical discourse functioned during the period as a means for "social disqualification of black people" (Birman 1989). The aforementioned eugenicist Kehl, who later moved to Rio, was an active member of the League for Mental Hygiene in the 1920s and 1930s, an organization where other important figures participated, such as Juliano Moreira (Pedro II Hospital's director), Miguel Couto (president of the National Academy of Medicine), Carlos Chagas (director of Oswaldo Cruz Institute), Edgar Roquette-Pinto (director of the National Museum), and Monteiro Lobato (writer and cultural figure).

The League for Mental Hygiene remained very active in the 1930s, during the Vargas Era, which saw several reforms after the 1933 Constituent Assembly. The League formed a powerful lobby advocating for the identification of health with eugenics, and sought to turn terms such as "eugenetics," "eufrenia," "eugenics," "dysgenics" into common parlance (Stepan 2004, 376). Their project consisted in an attempt to "extend the methods of mental hygiene to the entire Brazilian population" (Costa 2007, 60). Furthermore, their members would occupy important administrative positions in Ministries of Education and Public Health, and the Ministry of Work. In 1934, the Assistance for Psychopaths and for Mental Prophylaxis was created. This marked a moment in which psychiatry acquired, for the first time, a prominent status among other areas of public health.

The 1930s also saw the emergence of the Integralists, a kind of local fascist movement led by the political and literary figure Plínio Salgado. Characterized by strong anti-communist sentiments, the movement disseminated a discourse in which communists were identified with pathologies or infectious agents (Motta 2000, 79–80).[4] This discourse would return, even stronger, decades later during the pre-1964 coup era.

The *Estado Novo* (1937–46) would emphasize the practice of preventive medicine, education, and individual care, while at the same time suppressing more openly racist and eugenicist discourse.[5] It also confronted the Integralist movement. Furthermore, after 1941, the Brazilian state centralized all public sanitary administration and created the National Service of Mental Disorders (SNDM). The Brazilian Health Code proposed in 1945 also explicitly condemned terms such as *asilo* and *hospício* (asylum and hospice), proposing to replace them with "hospital." Under Juscelino Kubitscheck's government, the SNDM would later expand psychiatric services across the country in an effort to prevent dislocation, with patients having to travel to urban and economic centers, as well as reducing hospital over-population. Finally, this period saw an important expansion of medical posts providing outpatient care for the prevention of mental disorders.

While this broad trend saw a marked shift towards prevention in the mental health field, that same perspective was undeniably hygienic and racist at its

foundation. And that same view would continue to structure Brazilian psychiatric policy for years to come.

3. Nise da Silveira: An Exception to the Psychiatric Order

While early Brazilian psychiatry was generally a dismal affair, one important figure represented an exception: Dr. Nise da Silveira. Born in Maceió in 1905, she began work as a psychiatrist in the early 1930s in Rio de Janeiro at the Praia Vermelha Psychiatric Hospital, in the National Department of Mental Health (Dinsam) and in the Brazilian Feminist Union (UFB). A fellow traveler of the Communist Party and member of the UFB, she was persecuted by the Vargas regime, held in prison for 17 months and spent several years living underground. She was eventually accepted back into the public health system, in 1944, and began work at the Pedro II Hospital. Although a reader of Freud, her work is based rather on that of Carl Gustav Jung – with whom she corresponded – as well as the work of Antonin Artaud and Spinoza – whose work she read with particular devotion during her time in prison.

In 1946, in collaboration with the artist Almir Mavignier, Silveira opened a painting studio at the Pedro II Hospital. There, they organized exhibitions and encouraged figures of the art world to visit – among those invited were Belgian critic Léon Degand and Brazilian critic Mário Pedrosa, as well as the painters Ivan Serpa and Abraham Palatnik. The collaboration with Pedrosa would prove essential to the studio and later, to the foundation in 1952 of the Museum of Images of the Unconscious. The museum, housed within the hospital, contained the work of Silveira's patients, which she considered crucial instruments for further scientific study of psychosis. Silveira emphasized the creation of a favorable working environment for artistic endeavors and organized permanent exhibitions. The exhibition space was not however conceived for teaching art, but rather as encouraging the patients' artistic production.

Silveira managed, against great adversities, to develop her work over the course of several decades. She struggled constantly with the so-called "modern" psychiatric methods (insulin shock therapy, Cardiazol-induced convulsions, psychosurgery, and lobotomy) that were common practice during the period. Not only that, her patients' exhibitions too served to call attention to the violent practices and precarious conditions of psychiatry. Here too Pedrosa played a vital role. His conception of modern art was crucial for the critique he would develop of rationality, as well as the methods of modern psychiatric institutions. Underlying Pedrosa's critical project was an interesting tension: he insisted on the autonomy of form, paying close attention to the work of art, while simultaneously critiquing bourgeois rationale justifying the exclusion of the mentally ill. The "mad" are here neither outside modern art nor a model of transgression, but as Pedrosa puts it, echoing Goethe's *Denn was innen, das ist außen*: "They [patients] see everything simultaneously from inside and from outside" (Pedrosa 1979).

Silveira's "rebellious psychiatry," as she herself described her method in her unfinished autobiography (Mello 2014), is not just the integration of madness

into humanistic practices, but, based on her Spinozian monistic "unity of things" (Da Silveira 1995 with Mello 2014, 85), it is also a critical inquiry into the separation of nature and culture, and the hierarchical categorization of things – and with them, humans. Her psychiatric method consisted in investigating a possible reconfiguration of living things according to their singular and plastic forms. For her, "creative activity" mobilizes "several aspects of the psyche," and in particular, its "ordering auto-healing forces" (ibid., 27). Furthermore, she recognizes the necessity, when treating mental disorders, of reconnecting patients with a social environment, incorporating the suffering body into a certain community. Hence, we might call her a kind of "ecological doctor" (Pordeus 2018).

Silveira's practice and thought anticipated by several decades many of the principles that would later appear in the Brazilian Psychiatric Reform, as well as resonate with the global institutional reform and anti-psychiatry movements.[6] Already in 1956, she created the *Casa das Palmeiras* to host former patients of psychiatric institutions. She advocated for the importance of the *externato*, or outpatient halfway house, crucial for the deinstitutionalization of patients. This dimension will prove central to the Reform project, as we shall soon see.

In 1961, Silveira sent a letter to then-President Jânio Quadros proposing a national reform work program. Her aim there was to completely rethink the existing psychiatric structure, focusing on the isolationist practices of hospitals:

> The hospital is reinforcing the pathology, because it does not help at all in re-establishing connections between the patient and their *milieu*, from which they are being separated because of the pathology. . . . The Hospital becomes an extremely efficient apparatus for the chronification [*cronificação*] of disease.
>
> (Da Silveira 1961 with Mello 2014, 29)

While Quadros expressed interest in Silveira's proposal, he renounced it some days later and no further progress was ever made. Her project would be completely forgotten, existing for decades as an exceptional, alternative project.

4. Barbacena and the Military Dictatorship Years

The structure of Brazilian psychiatric institutions would remain stable from the end of the Vargas Era up to the 1964 military coup. In 1941, Brazil had 62 psychiatry hospitals, of which 39 were private and 23 public – though public hospitals were responsible for 80.7% of hospital beds. In 1961, the number of total hospitals approached 135, with 81 hospitals in the private sphere and the remaining 54, public, accounting for 71.1% of hospital beds. The years following the military coup would see the radical redistribution of private and public hospitals: by 1981, the private hospitals would represent 70.9% of hospital beds (Paulin; Turato 2004, 245).

Indeed, the psychiatric model implemented during the Brazilian dictatorship (1964–85) was based on the principle of private care. The state itself invested in the private system, providing the working classes with access to these services through social security policies, subcontracting those same services within public hospitals. The public system was thus neglected, reaffirming, once again, the idea of the public psychiatric hospital as a place of isolation, segregation, and "chronification" of patients treated in these institutions – a zone of "social abandonment" (Biehl 2005). At the same time, and because of the catastrophic state of public services, the discourse emphasizing the "efficiency" of the smaller, private services began to gain ground.

The privatization of the psychiatric sector was accompanied by a huge increase in hospitalizations. Between 1965 and 1968, the hospital population swelled by 20% – although the same number jumped to 60% in private institutions (*idem*). Private hospital beds funded by the state increased from 14,000 in 1965 to 30,000 in 1970, reaching 98,000 in 1982; the number of psychiatric spaces lacking in proper hospital beds (*leito-chão*, translated euphemistically as "ground-beds") climbed to 1045% in the private hospitals (*idem*; Resende 1987). These numbers are significant insofar as they also reveal the dominant perspective structuring psychiatric discourse: hospitalization. The dominant psychiatric ideology during this period held that the proper place for the mad was away from the public eye and enclosed in the asylum. Lacking in other clinical services to assist, host, and treat patients with mental disorders, the only remaining option was to send them to hospitals. And, furthermore, hospitalization in this discourse implied long-term hospitalization. As all these transformations were taking place, the psychiatric system became a very lucrative business for private hospitals receiving money from the state – but lacking in government oversight – for the patients they received. The period in question thus became known as the boom of "madness industry" (Mello 1977; Cerqueira 1984; Amarante 2011).

Statistical figures from the period also reflect the absence of state control. In the 1970s, it was calculated that more than 7,000 hospitalized psychiatric patients lacked a bed, that hospitalization periods on average lasted seven months, and that the mortality rate at psychiatric facilities was 6.5 times higher than in other hospitals for chronic diseases (Paulin; Turato 2004, 250). All the while, given the military dictatorship, any type of dissenting voice against the state of asylums was often paid with firings, persecution, and expulsion from public service.[7]

Higher rates of hospitalization during the dictatorship were linked in turn with the shift towards the so-called preventive orientation of prior decades, a policy that, as we have seen, was premised on a racist model. Not unlike the model implemented by the United States in the 1960s, psychiatry aiming at preventing social instability targeted certain population profiles. In the USA, these were segregated minorities: black and poor people, hippies and the drug dependent. This phenomenon reflected a very problematic "conceptual slippage," wherein "social deviation, a by-product of the individual's political and

economic maladjustment" was correlated with "the behaviour of the mentally ill" (Birman; Costa 1994, 64). The psychiatry in service of the state and as "manager of risks" (Castel 2011) becomes a dangerous tool and the influence of this ideology is very present in the Brazilian context.

The 1960s also witnessed the updating of the communist-as-enemy discourse. This same discourse was accompanied by the revival of a discourse concerning the pathological and infectious infiltration of foreign agents, representing a disruption of a supposedly natural, organic order. These elements, together, lent weight to a discourse in which the figure of the "mad" was stigmatized, while expanding on the notion of madness and deviation and emphasizing the need for exclusion and isolation.

Perhaps no other institution better represents the dramatic situation of the Brazilian psychiatric system as the Colonial Hospital of Barbacena, in Minas Gerais. Upon his visit to Barbacena in 1979, Franco Basaglia compared the hospital to a "concentration camp" (Arbex 2013, 207), and indeed, it was a perfect example of a "total institution" (Goffmann 1961). The hospice was founded in 1903, along with the creation of the country's first psychiatric hospitals, and was designed according to the "colony" model – isolated from the urban centers, the asylum would be a place where patients were meant to work as part of their treatment, according to the motto *Labor/Praxis Omnia Vincit* (Work Conquers All). The colony had initially been projected to host 200 patients. During its first three decades, almost 50% of the hospital's funding came from the commercialization of products harvested there (beans, corn, potatoes, etc.), as well as from the patients' labor force, employed for a variety of activities, such as road maintenance. The colony started to become famous around 1930 and got quickly over-populated. Around this period, it would already have about 5,000 patients. José Consenso Filho, Minas Gerais State National Department of Neuropsychiatry's director at that moment, decided to replace the usual hospital beds by "ground-beds" made of grass, something that would be later, in 1959, adopted by other asylums of the state.

The situation would progressively worsen in the following decades, with increasingly more people sent to the colony. The asylum became a fitting symbol for the use of psychiatry as tool for power, beyond its supposed treatment of mental illness. It is calculated that 70% of the patients hospitalized did not even have a proper mental disorder diagnosis (Arbex 2013). Patients were sent there for a variety of unrelated reasons: epilepsy, alcoholism, homosexuality, prostitution, social disorder, or to unburden influential members of society. Many pregnant women were also "hospitalized" during that period: the victims of rape – by their bosses, lovers, etc. – or the daughters of influential landowners who had engaged in premarital sex. At least 30 babies were born inside the asylum and were taken from their mothers.

People were often sent to Barbacena by trains – the so-called *trem dos loucos* (train of the mad) – that would leave crowded and return empty. Most of the individuals were sent there to die or to remain enclosed forever. With one psychiatrist for every 400 patients, over-populated spaces, frightful conditions,

food and clothing shortages, it is believed that over time more than 60,000 people died inside the colony. As part of that same "madness industry," 1,823 corpses were sold between 1969 and 1980 to 17 medicine faculties, most of them to the Federal University of Minas Gerais (Arbex 2018, 76).

In 1961, when Nise da Silveira sent her reform work program to then-President Jânio Quadros, photographer Luiz Alfredo, and journalist José Franco published an important article in the *O Cruzeiro* newspaper documenting the asylum's situation. Quadros reacted immediately by proposing to improve the institution's condition, but after his resignation, there was no follow-up. No other journalist would enter the institution again until 1979, and the entire affair remained completely blocked during the military dictatorship's "years of lead." New documentation would only be produced in 1979, with a series of articles by Hiram Firmino for the *Estado de Minas* newspaper, and with the documentary *Em nome da razão* (*In the Name of Reason*) by Helvécio Ratton. These documents, Basaglia's public pronouncements, and the movement for the Reform would finally start to exert real public pressure on the treatment of Barbacena.

While Barbacena represents an extreme case, it also remains very representative of how most Brazilian psychiatric institutions functioned. No doubt, the histories of other asylums around the country remain to be told, in particular those histories from the military dictatorship years.

5. The Movement for Brazilian Psychiatric Reform

By the end of the 1970s, the situation of Brazilian psychiatric institution had become unsustainable. In that same context, a new generation of critical and engaged psychiatrists and psychoanalysts started to organize themselves. In 1978, echoing a broad impulse for more social movement participation, the MTSM (Mental Health Workers Movement) was formed in Rio de Janeiro. In the same year, the First Brazilian Congress of Psychoanalysis, Groups and Institutions took place, with the participation of figures such as Franco Basaglia, Felix Guattari, Robert Castel, Erving Goffmann, and Thomaz Szasz. The debates around the SUS (Unified Health System) also started to mature.

The movement for psychiatric reform was driven by a systematic critique of the exclusionary and isolationist practices on which the asylum-form was based. It took as its target the very core understanding of madness and the way in which the entire system was structured on a *hospital-centric* model. The same movement took part in larger debates, beyond clinical issues, and was framed broadly in terms of citizenship and human rights.

The Brazilian Reform drew on the ideals of the anti-psychiatry movement – in particular the Italian – as well as from French institutional reforms. These movements, however, were very different one from another. The Italian movement fought for the total dismantlement of asylums – typified by the experiences of Franco Basaglia in Gorizia (1961–68) and Trieste (from 1971), and culminating in the Italian Mental Health Act of 1978 (the famous Law 180).

The French movement, in turn, claimed the necessity of a radical transformation of the hospital structure, although without abolishing its function – represented by the *psychotérapie institutionnelle*, the experiences taking place in Saint-Alban Hospital during the Second World War and at La Borde Clinic (from 1953). What both movements had in common was the concern about rethinking mental disorders in terms of their intrinsic social and relational dimension, the critique of the absolutely vertical doctor-patient relationship, and the importance of rethinking care in more horizontal and collective terms.

Basaglia's proposal was certainly radical: the need to dismantle the traditional psychiatric structure, that is, to close the pavilions and psychiatric infirmaries in order to replace them with a series of more efficient and humanized services, spaces, strategies, *dispositives*. The alternative proposed by the psychiatrist was the creation of local *Centri di Salute Mental* (CSM) that would be territorially based. According to this perspective, the CSM would at the same time treat the mentally ill and work to advance the social comprehension of madness, adapting society to serve as a welcoming host for the mad. According to Basaglia, the traditional therapeutic institution gave too much power to the psychiatrist, and in reality only served so that people could be reconciled with the violence they suffer. In other words, "psychiatric science" was a tool in the service of dominant powers, reflecting what society at-large decided to make of the mentally ill person (Basaglia 1965, 107). In this perspective, there is no mental disorder "in itself": it always appears inside a certain structure of relationality that gives it meaning. Furthermore, there are certainly better and worse structures for providing care, structures in which the disorder expresses itself. In that sense, the crucial issue where mental disorders are concerned, claims Basaglia, is to determine what type of relationship is established with the patient and thus with the disorder (ibid., 109). By assuming this position, Basaglia did not deduce that the pathology does not exist,[8] but, rather, he sought to question the presupposition according to which the mental disorder must be isolated in order to be treated. On the contrary, by isolating the mental disorder, one in fact transforms it into a fictive object devoid of any relation to the broader, complex existence of subjects and social bodies in which it develops. And, by doing so, one only renders chronic the pathology. In that sense, Basaglia considered it a crucial task to shift the perspective "from mental disorders to the existence-suffering" of the subject as Franco Rotelli, Basaglia's successor, puts it (Rotelli; Amarante 1992, 53). It was important for the Italian psychiatrist, following Edmund Husserl's gesture, to operate a sort of phenomenological reduction, suspending the idea of disorder in order to work with the subject's concrete experience, revealing the singular, suffering subject hidden behind the nosological framework of the "pathology."

According to Basaglia's critique, the only possible position is to *negate* the institution, the asylum's mode of operation and push for *extra-hospital* forms of care. In the first instance, his thinking centers on a "therapeutic community":[9] organization of discussion groups, "operative groups" co-involving the patients in their own treatment, along with doctors, caretakers, and relatives.

The "therapeutic function" should be exercised by all of these actors. What is at stake in Basaglia's critique is hospitals' hierarchy – a critique that advocates for "horizontality" and the "democratization" of the therapeutic relations. However merely dismantling the hospital and multiplying extra-hospital services, or use of the term "therapeutic community," does not itself solve the problem, and these practices have their ambiguities (Basaglia 1985, 112; Rotelli; Amarante 1992; Birman; Costa 1994). What is crucial is the permanent deconstruction of asylum logics – which in turn means the permanent reinvention of care situations.[10] And this permanent movement does not come without an unending questioning of social reality and positions of power.

The other crucial figure behind the Brazilian Reform is Catalan psychiatrist François Tosquelles, who fled Franco's regime during the Spanish Civil War and began practicing a very innovative type of work at the Saint-Alban Hospital, in Lozère, southern France. This experience preceded the later *psychothérapie institutionnelle* of Jean Oury and Félix Guattari, implemented at the La Borde Clinic. Tosquelles attempted to disrupt the traditional patient-doctor/caretaker relationship by introducing (1) the idea of a "therapeutic collective"/"therapeutic club" and (2) breaching the dichotomy between "inside/outside" that characterizes asylum spaces. His main aim was to "integrate madness at the *cite*," at the same time seeking to create strategies so that the mad "succeeds in his madness" (François Tosquelles with Recherches 1975, 87) when provided with favorable conditions and are not "suppressed" (*réfoulés*) by society.

For Tosquelles, the psychiatric institution must break with its conventional closed-circuit, so that the mental disorder can be properly treated. In order to achieve that, it is crucial to reconnect the mentally ill patient with their social milieu and continue working after their hospitalization has concluded. Tosquelles and Lucien Bonnafé called this "geo-psychiatry," a practice in which the patient is reinserted into society. According to Bonnafé, Saint-Alban's real innovation was geo-psychiatry – a practice rarely emphasized by historians and commentators who, according to Bonnafé, instead insist on intra-hospital work. Geo-psychiatry involved work outside the hospital that would enable the patient to "disalienate" and help their "reinsertion into a human geography" (ibid., 89).

While La Borde remained a psychiatric hospital, that institution's orientation was defined by an openness towards the outside, with several activities taking place within the clinic also being open to the public, and those outside available to patients. La Borde also applied the notion of "institutional analysis" as a decisive tool for disrupting the static forms of traditional psychiatric organization, placing particular emphasis on *transversality* rather than power relationships. Institutional analysis consisted of a permanent questioning of the hospital's functioning, enabling it to be open to the constant transformation of relations between those working and living in the institution. Thus, in 1957, for example, it was decided that everyone working at La Borde would earn the same salary regardless of their position. *Transversality* and the search for

horizontality were also the specific objectives of "clubs" where patients would play active roles leading activities and workshops (Recherches 1976). Hence, while the French and the Italian contexts certainly shared similarities, Basaglia had aimed at dismantling the psychiatric institution, whereas Jean Oury saw "anti-psychiatry" as "the true psychiatry" and the "institutional utopia" capable of "saving psychiatry" (Oury 1996, 70).

Guattari paid several visits to Brazil beginning in 1979, and he took a sharp interest in the foundation of the Workers' Party. Basaglia travelled to Brazil in 1975, and again in 1978 and 1979. The closure of the Psychiatric Hospital in Tristes in 1976 and the approval of Law 180 in Italy gave special impetus to the Brazilian movements.

More than "humanizing the asylum" – which in a sense was already Pinel's motto – the Brazilian Reform aimed at a new social understanding of the figure of the mad and, in keeping with the Italian movement, sought to close the asylums. The reform intended to reframe the understanding of what was meant by "mental health": "to debiologize pathology and sociologize suffering" (Biehl 2005, 135); to shift the perspective from disorder towards the state of suffering and the subject's concrete existence. Furthermore, it was argued that the notions of care and treatment needed to move beyond the fields of medicine and psychology. In that sense, the progressive replacement of the asylum by other *dispositives* was envisioned as helping the patient to recreate social ties. Indeed, one of the foundational concepts behind the Reform was "territory" or "subjective territory": a network of social references that anchor the subject in the world and that are essential to the cure (Delgado 1997). The Reform thus emerged as the exact opposite of the private, exclusionary, and isolationist model adopted by the military dictatorship. Against isolation and the hospital space, it proposed a notion of social, public, and territorial care that would nourish the patient's social ties.

An important turning point for the movement was the Second Congress of the MTSM, held in 1987. The movement at that time began to perceive the necessity of opening its ranks beyond the almost exclusive participation of mental health professionals, and include patients and families. It was in this period as well that the movement adopted its clearest slogan: *Por uma sociedade sem manicômios* (For a society without asylums). The creation of groups and associations followed, spreading across the country: SOS Saúde Mental (São Paulo), Cabeça Feita (Rio de Janeiro State), Loucos por Você (Minas Gerais State), Loucos por Cidadania (Pernambuco State), Lokomotiva (Rio Grande do Norte State), Qorpo Santo (Rio Grande do Sul State), among others (Amarante 2011, 79).

Another landmark event contributing to the Reform took place in Santos (São Paulo State), in 1989, at the Casa da Saúde Anchieta. Also known as the "House of Horrors," this psychiatric institution was a space typical of the "madness industry": an over-populated and derelict private institution – funded by the state – that employed abusive disciplinary methods such as electroshock as means of punishment, leading to the death of patients. Telma de Souza, city counsellor and later mayor for the Workers' Party – also a party

co-founder – led an occupation of the institution, protesting against the Casa's conditions and eventually achieving the institution's closure. The occupation was also a way of demonstrating that the ideals of patient deinstitutionalization and the private sector's interest in maintaining the patients hospitalized were fundamentally incompatible interests. The new therapeutic spaces to be created along with reform would thus be exclusively public.

These movements played an instrumental role in drafting the chapter on health included in the 1988 Constitution, as well as the legal institution of the SUS through Law 8.080 (19/09/1990) and the subsequent "social control law" (Law 8.142), which transformed local communities into central sites of healthcare administration. Likewise, thanks to reform movement, communities became central actors in debates around mental health policy and the administration of psychosocial institutions. It was also through this law that the term "patient" was replaced by *usuário* (user, customer) or by "*citizen* burdened by mental suffering," emphasizing their agency and role as social actor.

In 1989, the Workers' Party deputy for Minas Gerais, Paulo Delgado – brother of activist psychiatrist Pedro Delgado – presented law proposal 3657/89, the Psychiatric Reform bill. Its main points were: (1) put a halt to the construction of new psychiatric hospitals; (2) redirect state resources to the creation of non-traditional psychiatric care structures; (3) make it obligatory that forced hospitalizations be reported to the corresponding legal authority, so that hospitalization could be legally approved (or denied). Two other important elements are added to the project in 1992: (1) the notion of *atenção integral* (integrated assistance), against "specialized assistance," which would pave the way to diversified forms of care; and (2) the notion of "citizenship" as fundamental where mentally ill patients' rights are concerned. The project began implementation during the 1990s with the creation, in particular, of Psychosocial Community Centers (CAPS).[11] However, the "mental health law" (Law 10.216) would only be approved, after many years of discussion and in a watered-down version, in April 2001. That law would also emphasize the assistance model, as well as the protection and rights of people suffering from mental disorders, but it did not adopt one of the movement's central demands: the progressive dismantlement of asylums. Finally, Law 10.708 (07/31/2003), legislating for the program *De volta para casa* (Back home), emphasized, again, deinstitutionalization, establishing assistance for long-term hospitalized patients. Albeit slowly, and still struggling with the remnants of a derelict system, the public mental health system has grown considerably throughout the 2000s, in keeping with the new progressive agenda set during that time period.

6. De-democratization and the Dismantlement of the Mental Health System

The 1987 *Bauru Letter*, a landmark for the Reform, equates "democratic society" with "a society without asylums." The Reform movement was far from fulfilling all its promises. However, for the first time, structural questions

concerning mental disorders were finally being addressed and efficiently managed. The World Health Organization, for example, recognizes the importance and improvement of the Brazilian mental health system after the implementations of the Reform, and calls for the program's expansion (WHO 2007).

Despite these recognitions, in 2016 Michel Temer implemented Constitutional Amendment Number 95, and later in 2017, through a series of policies, his administration began to dismantle the Reform's achievements not only by cutting funding to healthcare (which did in fact take place), but also by fundamentally targeting its main principles: reducing territorial mental health structures, resuming the hospitalization strategy and investing in psychiatric hospital beds, and so on. Between that project, initiated by Temer, and the current agenda led by Jair Bolsonaro, there has been remarkable continuity.[12] In three years (2016–19), their shared agenda (1) modified the National Program of Primary Care (PNAB) dispensing with communitarian health worker assistance for families; (2) expanded funding for psychiatric hospitals and increased the price of daily hospitalization; (3) reduced the registration of new CAPS; (4) reasserted the role of psychiatric hospitals as the main institution responsible for care; (5) re-established day-hospitals structures; (6) re-established specialized and non-local outpatient services.

Bolsonaro's agenda however has been even more aggressive, and his model for the mental health system is outright exclusionary. In February 2019, he published "Technical Note Number 11," regarding transformations to national mental health policy, wherein he criticized the current "ideology" of the system and proposed to replace it with "scientific methods" based on the "technical knowledge" of psychiatric hospitals, biological treatment methods such as electroconvulsive therapy, and the hospitalization of children and adolescents (Brasil 2019; Delgado 2019). The effects of these policies are already being felt. A new national report for 2018 and published last December, surveying 40 psychiatric hospitals in 17 states across the country, shows dramatic human rights violations and signs of torture inside these institutions (Brasil 2019b).

Bolsonaro's discourse is also emphatic in its attempt to revive traditional medical vocabulary as a means to pathologize his enemies. He seeks to transform "the other" (leftists, communists, the LGBT+ population) into an abnormal figure and asserts the need to exclude them from visible public space. Typical of authoritarian regimes, alterity automatically becomes a figure of deviation that needs to be isolated and "treated."

Hiding behind this pseudo-techno-scientific discourse is a program that embraces a renewed exclusionary agenda very similar to what existed before the Reform. With the same claims to scientificity and efficiency used to promote private care decades ago, Bolsonaro's program represents a clear sign of de-democratization. As in so many other aspects of the government's agenda, the insistence on private care reflects not only the economic interests of a small group of powerful individuals, but also a project to eradicate any type of large, popular, democratic agency. Against social and collective control, against the idea of public and territorial care, nourishing the patient's social ties, against

all these elements that were central to the Reform, the hospital-centric model again rears its head along with the all-powerful psychiatrist – a mere puppet acting on behalf of a radically authoritarian ideology that hates difference.

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Notes

1. I thank Nicolas Allen for proofreading my text.
2. And even inside psychiatric institution employing more humane and experimental approaches, these practices were the exception. In the years 1953–55, for example, at the Juquery Hospital, where César worked, only 60 of 15,000 patients would take part in the Arts Section (Cabañas 2018, 68).
3. Foucault notes that the appearance of the psychiatric hospital in Europe and "massive hospitalizations" were also a "police affair" inspired by concerns very divergent from "healing" (Foucault 1972, 75).
4. In fact, colonial asylums in particular were conceived as places not only for the mad, but for all those branded undesirable. Rodrigues Caldas, responsible for moving the Juliano Moreira Hospital to the Jacarepaguá neighborhood, claimed in 1920 that "besides alcoholics, mad, retarded, delinquents," the Asylum was also meant for "the undesired enemies of order and the public good, possessed by the red delirium, fanatics of the bloody and dangerous anarchists and communists doctrines, of Marxism or Bolshevism" (Rodrigues Caldas with Hidalgo 2011, 25).
5. Framed by a cultural and social perspective, although also impacting policies and ideologies, the eugenicist discourse was progressively replaced by that of racial democracy, thanks to authors such as Gilberto Freyre. Freyre's celebrated formulation emphasized, on the contrary, the positive aspects of Brazilian miscegenation. Despite that, psychiatric institutions would remain a *locus* of sanctioned exclusion, reflecting the socioeconomic structure of Brazilian society.
6. For example, after visiting the Museum of Images of the Unconscious in 1974, Ronald Laing would recognize her work as essential to the study of psychosis.
7. This was the case of, among others, Paulo Amarante, who, along with two colleagues, was fired after denouncing the conditions in the asylum where they worked (Amarante 2011, 11); or Francisco Barreto, persecuted by the Regional Council of Medicine after filing a report on the Colonial Hospital of Barcena (Arbex 2018, 204).
8. Ronald Laing takes a similar stance when he claims that mental illness should not be taken as the natural object that psychiatry takes it to be, but rather an experience of the subject in their relationship with the *socius*. However, his position concerning pathology seems much more relativistic, where the division between the "normal" and the "pathological" appears to be extremely blurred (cf. Laing 1967).
9. One can revisit the term "psychosocial medicine" as it appears in the British context around mid-19th century in James L. Halliday's work.
10. The USA, for example, saw the emergence of "deinstitutionalization" practices (measures taken to help the patients when they leave the hospital) and a community-care logic, in which the creation of mental health centers, outpatient care, clinical residences, shelters, and day-hospitals ended up contributing to the *medicalization* of life and even more demands from people concerning these services.

11. The first CAPS unit opened in 1986 in São Paulo. Several units were also created in Santos after the Casa da Saúde Anchieta was shutdown. The CAPS are local, territorial, outpatient assistance structures. Their guiding inspiration was to open up the mental health sector and connect with civil society. There are five types of structures and some function 24 hours, with the capability of treating subjects during crises. Different from hospitals, they are open spaces and allow the patient to be accompanied by relatives. The CAPS are also encouraged to create different kinds of relational, clinical, and expressive activities, with the aim of reducing medication and preventing hospitalization. They are open to professionals of other areas, such as artists who can organize activities there and are invited to interact with the local territory.
12. Psychiatrist Quirino Cordeiro served as Temer's general coordinator for the Mental Health, Alcohol and Drugs Section of the Ministry of Health and is now Bolsonaro's National Secretary of Care and Drugs Prevention, in the Ministry of Citizenship. He is a clear supporter of forced hospitalization and defends that mental healthcare should be separated from drugs-addiction policies transforming drugs into a primarily "police affair".

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