Papers on Social Representations
Volume 27, Issue 1, pages 4.1-4.21 (2018)
Peer Reviewed Online Journal
ISSN 1021-5573
© 2018 The Authors
[http://psr.iscte-iul.pt/index.php/PSR/index]

Social Representations, Knowledge and Practices of Deinstitutionalizing Insanity. Argentina, Brazil and France

NOEMI GRACIELA MUREKIAN[a1], VICENTE DE PAULA FALEIROS[b], EMMANUELLE JOUET[c]

[a] Universidad Nacional de Quilmes. Universidad Nacional de Córdoba (Argentina)

[b] *Emeritus* Professor at Universidade de Brasília (Brazil).

[c] Research Laboratory, EPS Maison Blanche; Education, Ethics and Health, Université François Rabelais, Tours (France).

ABSTRACT

This paper proposes a dialogue among specialists from Argentina, Brazil and France, in order to address the different ways of generating knowledge regarding the deinstitutionalization of the mental health care system. Each author's theme specificity responds to the temporariness of local reforms as a fight for a social representation of the insanity as suffering, different of the biomedical mental sickness. From that point on, the knowledge interplay materializes into

[1] Correspondence concerning this article should be addressed to Noemi Murekian. E-mail: noemimurekian@uolsinectis.com.ar

heterogeneous modalities in light of the psychosocial representation paradigm**:** (a) implications of research on the transformation of the mental health field: experiences and representations in Argentina; (b) social representation of insanity and the deinstitutionalization practices in Brazil; (c) recognition of the 'patients' expertise: changes in the social representation of insanity, in France.

Keywords: *Mental health; social representations; insanity; knowledge and practices.*

The Mental Health field faces major ethical and political challenges (WHO, 2013). New laws define people with mental illness as citizen and establish a legal framework, the subjective and social impacts of which require new psychosocial intervention methods and ways of understanding. In the framework, it occurs opposition between the biomedical representation and the minority active[2] for the deinstitutionalization.

Based on the epistemology of daily life, Denise Jodelet has updated what such challenges entail by highlighting questions that need to be posed, especially those that bring knowledge comparison into play: "The study of social representations (…) should benefit from the contribution of questions currently being posed concerning the diversity of knowledge and the emergence of a new category: experiential knowledge" (Jodelet, 2015, p. 59).

Equalization of the epistemic value between scientific thought and common-sense thought, expert knowledge and practical knowledge, successfully envisaged by Serge Moscovici (1961, 1976), has accompanied the changes that have taken place in Mental

[2] Although important in the general understanding of the phenomena mentioned here, the theory of active minorities is not deepened here. We refer to Moscovici who, in 1979, wrote the book *Psychology of Active Minorities* (PUF) where he places conflict as a form of social influence, questioning the ideology of consensus and conformity. For Moscovici, innovation processes must be considered as processes of social influence, in which generally *"a minority or an individual tries to introduce or create new ideas, new modes of thought or behavior"* (Moscovici, 1986: 76). An active minority is characterized by certain styles of behavior: *effort* (investment of time and commitment), *autonomy* (independence from the dominant power of the majorities), *consistency* (regularity in the exhibition and defense of values and ideals as well as practices that they substantiate them), *equity* (egalitarian social position in front of the majorities), *firmness* (adoption of consistent and inflexible positions against those against which one struggles). Through these, minorities aspire to achieve social recognition of their innovative project by pointing out conflicts to be resolved, and aiming at the ultimate goal of the social conversion of majorities (Murekian, 2017: 238).

Health. In this sense, out of an explicit social commitment, Moscovici helped create an epistemology of neglected and ignored knowledge. In the words of Jodelet (2015), "(…) this knowledge is very often unspoken, hidden and unconscious and must be the subject of research based on manifestations provided by subjects that express themselves, invoking social representations" (p. 71). In the context of the new ethical concerns regarding care and therapeutic education (Jouet & Flora, 2010), "experiential knowledge" transforms the "patient" into a "specialist" that can share their knowledge with other actors that are a part of their world and their particular life context (Jodelet, 2015, p. 75).

As few studies focus on the pertinence of Social Representations framework to conceive links that underlie the understanding of institutional evolutions in the field on mental health, this paper thus proposes a dialogue among specialists from Argentina, Brazil and France, in order to address the different ways of generating knowledge regarding the deinstitutionalization of the mental health care system as a anti-asylum fight. Furthermore, through local examples is showed the fact that these are not only content of institutional discourses and nature of objectives which are changing, but also, that this evolution could stem from social representations changes.

MENTAL HEALTH AND SOCIAL REPRESENTATIONS

The foundational origin of the theory of Social Representations and its most transcendent developments (Moscovici, 1961, 1976; Jodelet, 1989) were associated with the Mental Health field.

It has then been showed that social representation of insanity is a social construct. Jodelet (2005), in her research on Ainay-le-Château in the beginning of the 1970s, confirms that insanity is represented either as a brain disease or nerve disease, the latter implying more danger, and therefore, more of a repressed response to behaviors. Corollary, Foucault (1995) proposed that people considered insane were carriers of unreason. The paradox of social representation of insanity is that its logic, its reason, is not having reason. Thus, it is considered a derangement or negation of reason, the domain of impulses, of nonsense, of the devil. Unlike the negative vision (Abbagnano, 2015) insanity was also considered a divine gift, valued as a prophecy. For Erasmus of Rotterdam "the chief element of happiness is this:

to want to be what you are" (1508, p. 18). He ends his text by mentioning the joy of experiencing the ecstasy of delirium, criticizing the dominant society of wealth and power, valuing the simple life. Insanity is socially represented in a historical way, contextualized, diversified, as a break with society and its normality. It means, paradoxically, on the one hand, living one's singularity suffering discrimination or, on the other hand, being bound to the productive life suffering from rejecting oneself in order to appear normal. A person that does not find a reason to exist in society suffers psychologically and is discriminated for not having a reason to be "normal".

From this genesis, important research programs were prompted that excelled first in Europe and then in Latin America, some of which comprehensively evaluated the impacts of psychiatric reform processes in social representations of insanity. However, interest in these was overshadowed, in part, by the stagnation and burnout that such experiences involved, even when certain laws and political decisions endorsed them.

After a plateau period, the inclusion/exclusion debate (Paugam, 1996; Jodelet, 1996) and the negative effects of stigmatization in psychiatry and mental health (Giordana et al., 2010) were updated, and a renewed wave of critical thinking inspired studies aimed at identifying and analyzing the effective changes in the subjective and social life of individuals suffering from mental illness. Indeed, the isolation of people that burden hospices, clinics and residential facilities has been the dominant form of exclusion. The practice of inclusion supposes a theoretical-critical paradigm of mental health that considers mental illness as a singularity of life, a way of living in the world. In this way, mental health means practicing social exchanges as a basis for coexistence among people, considered insane or not, in the recognition of the singularity/otherness/citizenship relationship, with shared living mechanisms in day-to-day life

The aim of critical studies was to determine, in light of current legislation, to what extent the ethical goal of inclusion, very much promoted by international health and human rights organizations was being met. In fact, the joint effort to move forward in line with the goals agreed upon by the WHO and Member States (2013-2020 Action Plan, WHO, 2013) exposed the issues of implementing and rooting the social integration paradigm, including: (a) countries should systematically replace long-term stays at psychiatric hospitals with community-based care; (b) hospitalization should be short-term at general hospitals; (c)

outpatient treatment and primary health care should be provided at mental health centers, day centers; (d) support should be provided to individuals with mental disorders who live at home with their families (WHO, 2014, p. 19). The hospitalization and the asylum is replaced by substitutive services in the community or by the state and the society.

In the context of the risks of equating inclusion to social disciplining (Foucault, 2002) and ignoring inequality as a typical response in fragmented societies (Dubet, 2015), a critical interpretation is required, in particular, regarding objective and symbolic resistance with respect to the ideals of citizenship, autonomy and freedom. In search of answers to address this, social research prioritized the daily experiences of direct protagonists: "users", family members, associations and active members of the community, their hardships, grievances and demands.

Without a doubt, we have a generous theory, that of social representation allows for a more comprehensive study of the interaction of knowledge in the social construct of reforms; an ethical goal of horizontalization that it shares with the community-based approach to mental health (Jodelet, 2015; Murekian, 2017).This is what is going to be explored, now, through examples widespread over three countries.

HORIZONS OF DIALOGUE

Implications of Research on the Transformation of the Mental Health Field: Experiences and Representations in Argentina.

Argentina has not escaped the realities reflected in the 2013-2020 Action Plan, which is why certain local contexts that currently exhibit achievements and difficulties are evaluated with special attention[3]. Moreover, with the enactment of National Mental Health Law 26.657 (2010) and its regulation (2013), the Review Body of Law 26.657 supervises the conditions of bringing about reform. In particular, the medical guild has resisted by qualifying as an intrusion into its professional work, the supervision by the interdisciplinary teams arranged by the law. For their part, the human rights organizations denounce the obstruction of certain

[3] Approximately 25,000 people are hospitalized in Argentina's psychiatric institutions (CELS, 2008).

sectors to the application of the law. However, transformation programs currently face powerful political, social and economic tensions.

Therefore, it is worth highlighting here: (a) how the social representation has favored understanding identity construction of reform processes; (b) how the actions of certain minorities made up of mental health workers were able to sustain change projects despite adverse psychosocial, political and economic conditions; (c) how the need to include in the professional debate the voices of users and family members, their subjective experiences, and the experiential knowledge that allowed them to endure an institutional system removed from any presumption of rights or obligations came about.

To illustrate and summarize, we will present two reform cases: (a) the *"desmanicomialización"*[4] of the Rio Negro Province and (b) the *"replacement of asylum logic"*[5] in the Santa Fe Province.[6]

The case of the Rio Negro's psychiatric reform

In the Rio Negro Province, the self-named *"desmanicomialización"* process was studied as a new social representation phenomenon (Murekian, 2006, 2013, 2017; Cohen and Natella, 2013), i.e., as a result of controversial representations that arose in the context of an unfair system of institutional abandonment of people suffering from mental illness. Reform actors coined a neologism as they believed that the Italian concept of "deinstitutionalization" contrasted with the historical moment of institutionalization of recovered democracy in Argentina[7].

[4] From here onwards: Rio Negro's psychiatric reform. This reform not only sought to close the spaces of confinement, but also the change of the asylum mentality.

[5] In its original expression: *sustitución de lógicas manicomiales.*

[6] These two cases have been researched by teams established at public universities (Universidad de Buenos Aires, U. Nacional del Comahue) and backed by academic organizations (CONICET, SECyT).

[7] This neologism transcended its socio-genetic context to be used in other reform cases in Argentina. From the perspective of social representations theory, the word in question sums up the dynamic of it's symbolism: it suggests a new meaning by prefixing " de " (eradicating the confinement and medicalization of madness) from an already existing popular term (the asylum / *manicomio* in spanish). This term in its etymology comes from the noun "mania" and in turn from the Greek "κομειν" (komein) that means to take care of.

Toward the middle of the 1980s, a group of mental health workers, became true activists for the rights of *persons with mental suffering*[8], and for promoting new rules of coexistence with insanity in the public space (Murekian, 2017).

In its infancy, the group self-identified with filmic image, such as *Brancaleone Armada*[9], but once the notion of "social representation" was assimilated, practical appropriation thereof was just one of the actions taken in pursuit of transformation (Cohen and Natella, 2013; Schiappa Pietra et al., 2016). Aware of the need for cultural change, they began a symbolic fight that has been upheld thus far avoiding obstacles and resistance, with countless efforts of self-affirmation and reproduction (Markova, 2006).

In a nutshell, the Rio Negro's psychiatric reform promoted a conceptual shift by means of a new social-legal designation of "insane" as a "person with mental suffering", simultaneously with an institutional shift, with the closure of the provincial neuropsychiatric institution, the enactment of Law 2440 and mental health community-based assistance. In fact, the process of *desmanicomalización* poses an epistemological and political confrontation with the biomedical model. This reform tensed the values, knowledge and practices of traditional psychiatry from a double dynamic: centrifugal (going to the community) and centripetal (working within the institutions of health, education, justice and politics). The disclosure of his nomination, as well as the discursive and strategic appropriations of his principles by different actors of the public sphere, justified his study as a new object of social representation.

The diachronic study of representations of mental health in general population (Viedma, 1992-2000) (Murekian, 2006) revealed that next to an invariant *figurative nucleus* (Moscovici, 1976) (balance / imbalance, problem, fear) the representations around the insanity showed gradual changes, by deconstructing negative visions and favoring more dynamic or mixed visions.

The qualitative evaluation of the impact of the psychiatric reform practices on users in Rio Negro led Paulín Devallis (2015) to sustain that those who possessed greater knowledge and information regarding reform appeared to be more sensitive to political events with respect to Law 2440. Awareness of access to rights was a key piece of information with

[8]According to Law 2440 which considers persons with mental illness as a suffering instead of carriers of a stigmatizing illness.
[9] Refers to the film (1966) by Italian director Mario Monicelli.

respect to changing confinement practices: from there the threat of a potential breakdown in the continuity of policies would provoke a constant fear in users. The specialist also tested how three phenomena coexisted in the experiential representation of users and family members: the asylum model, the logic of the hospital program and minority presence of community mental health characteristics. This coexistence, from the social representation focus, is explained socio-genetically and allows unavoidable contradictions to be understood within change processes; arduous, slow processes that are very often very wearisome for those who undertake them.

The case of *replacement of asylum logic*

Research on deinstitutionalization devices within the framework of psychiatric reform in the Province of Santa Fe (Faraone and Valero, 2013) illustrates how local historical and cultural conditions involve their own identity, nominative and socio-political processes. The author's intention was to reformulate certain notions (*de-psychiatraisation, anti-psychiatry, "desmanicomialización"*) of the Psychiatric Colony better known as Oliveros Colony[10], and whith that explain the emergence of a new concept. The search for a new designation was in fact due to the need to gain distance from the utopian connotations of the Rio Negro's psychiatric reform. In an interview, the Colony Director eloquently said: *For us, we needed to find words that would give a name to our attempt at transformation and which was not the notion of desmanicomialización* (p. 62). These words were: replacement of asylum logic, an expression that, according to the authors, not only seems to have referred to a change of name, but also of identity and practices. Faraone and Valero characterized it as a *political clinic* or *expanded clinic* (pp. 23, 63-66). In this sense, the need for distinction allows not only for recognition of the particular socio-genesis of local processes, but also that which requires representation and influence to be rooted and socially objectified. The study particularly focused on analyzing the replacement program in institutional kidnapping spaces in order to eradicate repressive practices, observing the actors involved based on a macro and micro-political approach.

Corollary: The reform of Río Negro embodied in a neologism based on common sense, and the substitution of objectified logics in an expression closer to the technical language, are

[10] Usual name by its location. "Dr. Abelardo Irigoyen Freire Psychiatric Colony" is his official name.

examples of processes whose temporality has been interpreted from the perspective of social representations. Both illustrate the dynamics of constituted and constituent thought (Jodelet, 1989a: 37) around insanity and, in this sense, highlight the future of research as a fundamental resource for the development of mental health system transformation processes.

The review of the two cases attests to various ways in which research has impacted transformation processes, bringing about a true space to generate and exchange knowledge. The studies do not only reveal the history of achievements and obstacles, but rather that they are subject-matter for political and socio-healthcare reflection. Hence, the goal of safeguarding and preserving the democratic values and ethics of the paradigm shift (Marková, 2015) is yet to be accomplished by the multiple actors involved in reforms in Argentina.

Social Representation of Insanity and Deinstitutionalization Practices in Brazil

This attempts to characterize the deinstitutionalization of care for people with mental illness in Brazil, taking into account the experience of a non-governmental organization and the public policies of Psychosocial Healthcare Centers—PHCs.

The organization called *Inverso*[11], created in 2001, operates using volunteers in a space of coexistence, workshops and citizenship with people suffering from mental illness that have been institutionalized a number of times (Faleiros, E.; Campos, T.; Faleiros, V., 2017), in the perspective of deinstitutionalization, contrary to the biomedical model of treatment. It is precisely the exercise of freedom, collective communication, citizenship, expression of singularity, considering health as a series of social exchanges, reciprocal interaction, according to network and personal singularity mechanisms. Reciprocal interaction entails acknowledging the other as a citizen, someone that bears a social identity due to their inclusion in relationships of citizenship and proximity, due to their history and singular conditions, and due to their life options. Citizenship recognizes the right to have rights in general, implying their effectiveness in daily life, in the primary family network and in the secondary network of public services such as health, education, safety, transportation, and a healthy environment. It is the affirmation of inclusive citizen identity, without discrimination or exclusion. In proximity, each person has a designation, a name, an experience that

[11] The opposite of an asylum.

presupposes respect, dialogue, reciprocity, protection and self-development in their way of living and being in the world.

This reflection is shared by Franco Rotelli (2008, p. 94) when he says that mental health develops when someone can exist with others and communicate, speak about him or herself, in a process of tension between inclusion/exclusion “in order to find a common ground, a common practice, an interrelated project”. According to Kirchmayer (2012), who reintroduces the idea of recognizing the subject’s existential singularity based on Sartre, “illness is like each person’s own way, the way they respond to contradictions in their world” (Kirchmayer, 2012, p. 3). Illness has been a way of excluding, of separating, whether to avoid contagion or reestablish common life, very often also called normal. However, normality is different from common life as it involves a pattern of socially produced normativity, presupposing, in capitalism, productivity, inequality and conformity.

The *Inverso* space is comprised by the movement of people interacting, as a deinstitutionalization practice, articulating democratic coexistence with social life, citizen rights and inclusion in the city, as a *polis*, as an experience of a world open to circulation. Faleiros and Campos (2016) have highlighted five strategies of collective movement, joined together, in the praxis of *Inverso*: (a) the relationship with culture; (b) the relationship with autonomy, democracy and power; (c) the exercise of freedom and creativity; (d) the expression of feelings and suffering; (e) the construct of citizenship, the network and solidarity in a cultural and artistic context, for example in mosaic workshops or in urban intervention. Reciprocally learning the perception of the psychological crisis that causes suffering is also nurtured and invigorated. The image of oneself is also expressed through mirrors, photos, theater, collective videos, insertion in Facebook; in a context of mutual support, of narratives regarding their stories in an environment of listening. Urban intervention interprets the exercise of citizenship, with social participation out on the streets, as inhabitants of the *urbis* and *polis*, as coexistence in a political space. They cease to be dangerous, incapable, unproductive, unreasonable, by participating in the anti-asylum fight.

As a result of this practice, very few frequenters have been re-institutionalized in clinics or hospices. The families get together, they learn without stigmatization and they help one another in order to cope with the crises.

Public psychosocial healthcare services in Brazil are organized according to Law No. 10.216, dated April 6, 2001, which establishes the protection and rights of people who suffer from mental illness and a new mental healthcare model that replaces the asylum. Institutionalization is still defended by a strong group of psychiatrists and the pharmaceutical industry.

The 2001 Psychiatric Reform (in the processing stage for 12 years, since 1989), also receiving pressure from family associations, establishes rights for subjects suffering from mental illness, the State being responsible for this psychosocial healthcare, in the perspective of insertion. In December 2008, the 1st Brazilian Mental Health Congress was held, sponsored by Abrasme —*Associação Brasileira de Saúde Mental* —include the participation of academics, professionals, public organizations and civil associations. The 5th Brazilian Mental Health Congress was held in 2016, and in 2018 the 6th it will be held in Brasilia.

Various types of PHCs — Psychosocial Healthcare Centers — can be created in towns (for children and teenagers, alcoholics and drug addicts, adults with mental illness, also taking into account the complexity of care, according to the seriousness of the crises) with multidisciplinary teams. Healthcare at PHCs includes psychiatrists, psychologists, social workers, nurses, physical therapists and other professionals that work in workshops and clinical healthcare, with greater or lesser intensity.

The deinstitutionalization process, as Amarante (2015) mentions, is not the paradigm of all PHCs, viewed as deconstruction of all asylum logic, thus functioning as a therapeutic clinic or with new healthcare techniques, even with a Singular Intervention Plan.

Radical deinstitutionalization does not consider the illness or crisis to be the focus of healthcare, or only as recovery. The creation of mutual support groups (Vasconcelos, 2013) and collectives in movement has contributed to socializing people suffering from mental illness, but it is necessary that the limelight be shared between citizen participation and social network actions.

The inclusive network is not a summation of services distributed in the territory, but the shared structuring of responsibilities for the subject in individual and collective movement, dialectically taking into account both the primary family network and the individual person as a process of social exchanges. This presupposes a counterpoint to targeting the crisis using medication, hospitalization or institutionalization.

The deinstitutionalization process thus needs to radicalize itself in considering the complexity of mental health in the social-political-cultural-economic subject/structure relationship.

In fact, the process of deinstitutionalization or *"desmanicomialización"* is an epistemological and political challenge to the biomedical model, having as an oponent an army like the 'Armada Brancaleone' as is mentioned by Schiappa Pietra et al. (2016) when referring to Argentina. In Brazil, the anti-asylum fight has not yet consolidated the paradigm, and practice of deinstitutionalization continues to pose a fight, a movement and a horizon. The social representation of insanity is rooted, in the framework of the anti-asylum fight, in the exercise of universal citizenship with singularity; while the biomedical model is rooted in illness, treatment and dominant normality.

As exposed in Argentine and Brazil the minority activity fight for a new paradigm of mental health with the social representation of insanity against, at the same time, the social discrimination, the hospitalization and the medical domination, with a psychosocial view of a protagonist participation of the persons in the transformation of the self and the society.

Recognition and valorization of mental health users knowledge: a deep change is occurring in French care system

The deinstitutionalization of mental health care systems initiated in France as a result of sectorization[12] during the 1960s is now entering a period of renewal, concerning both the framework of economic policies for mental health and the approaches to assistance and understanding of psychic disorders.

This French historical-cultural moment can be identified by the four following four features:

- A wide range of approaches regarding care and assistance with opposing/complementary roots. The predominant psychoanalytic approaches of the last fifty years are now being contrasted with the rise of cognitive-behavioral theories and neuropsychiatry, in particular;
- A balkanization of the care offer inherited from the psychiatric sectorization policy (Giodarna, 2010);

[12] During this time, "psychiatric sectors" (in French, *secteurs psychiatriques*) were created in France in the framework of the deinstitutionalization policy. Each sector was delimited geographically to provide psychiatric care and assistance for a population of around 70,000 inhabitants.

- Economic-financial requirements imposing the regrouping of hospitals across a given territory and creating mega-structures far from professional practices and population needs[13]
- A geopolitical context that demands an intensification of the security culture in which social representations about the presumed violence of the persons concerned always hold the front pages of the media (Coldefy & Fernandes, 2017).

At the same time, the recognition of knowledge acquired through experiences of illness or life situations of psychological, physical, social and cultural vulnerability has now become a social fact. Five indicators can be mentioned today that characterize this phenomenon in the field of mental health and psychiatry within the French context (Jouet et al., 2010).

In the first place, legal foundations can be referred, with laws on which the actors may rely to act, or that give recognition to an already established reality, and the expansion of laws on health promotion and education[14] into laws that establish mandatory therapeutic education for health and care systems[15]. Besides, concerning the fight against stigma and discrimination, there is a continuum from the 1948 Human Rights Laws addressing those defending patients' rights[16] and, more recently, the major programs of the WHO[17]. Finally, it is worth mentioning the policies of inclusion of disabled people that still remain dominant[18].

Secondly, healthcare institutions and health and social workers training institutions are getting organized to provide users, professionals and other actors with qualified training programs, with the purpose of legitimating and validating the experience acquired through illness, or even developing the professionalization and recognition of new professions (peer health mediators, peer caregivers, users-trainers, users-researchers). Patient universities at all levels of the training program, easier access to universities and vocational schools are all institutions that create new possibilities for interaction between professionals and users in the field of health and medico-social assistance (for example, Paris 6, Paris 13 and Lyon 3 universities). Moreover, training programs managed by users—with and for the persons concerned—are opening their doors, such as the COFOR in Marseille (*Centre de formation*

[13] Law No. 2016-41 dated 26 January 2016.
[14] Ottawa, WHO, 1982.
[15] HPST Bill, 2009.
[16] Law No. 2002-303 dated 4 March 2002.
[17] WHO 2001, 2005.
[18] Laws 1975, 1987, 2005.

Pour et Avec les Personnes Concernées, literally meaning "training centre with and for the persons concerned"), and the actions taken by the collective *Pouvoir d'agir* ("Power to Act") in Laval.

Thirdly, new figures of patients or persons in a vulnerable situation have appeared within or on the boundaries of health institutions, whether as supporters or as opponents. Patients have organized themselves not only to acquire new rights and guarantee their exercise in representative associations, but also to occupy jobs/perform functions hitherto reserved for qualified professionals only, such as being in charge of producing and disseminating information, researchers, trainers, lawyers, teachers or caregivers.

Outside the health systems, the persons concerned have engaged in processes of constructing their own knowledge from their experience, a knowledge they no longer consider in terms of biomedical understanding, but in terms of their own subjective understanding, which has its roots in learning communities (particularly the Hearing Voices Network). Also, there have been collective actions in participatory research with the purpose of addressing research process in its entirety, for example, the action-research programs of the *Advocacy France* association, based on the *Mad Studies* and critical philosophical and social movements.

Fourthly, the construction of knowledge from experiencing illness have been favored with the rise of digital and connected instruments, *i.e.* e-health, m-health, digital networks and communities (Jouet, Chappard, Troisoeufs, 2017).

Finally, a conceptual and epistemological study at work regarding the process of study and analysis unfolds and asserts itself. In this regard, it is relevant to consider epistemological references from the Education Science trends that characterize illness or other situations of vulnerability as multiple opportunities to construct knowledge, considering life with ups and downs as sources of the entire learning process taking place all through it and in all its dimensions.

In this context, there have been new approaches to support based on the evaluation of the person's recovery process, which are also being institutionalized. This evaluation approach is currently developing in France in a lively and dynamic manner through experiments, practices and conceptualization, carried out by professionals as well as users and persons concerned.

This new concept is based on cultural and social trends, such as empowerment (Bacqué & Biewener, 2013; Freire, 1974; Rappaport, 1981), social and community inclusion, user participation and citizenship, as well as on the recognition of knowledge acquired through experiencing illness.

According to Pachoud (2012), this approach has been spreading out internationally over the last thirty years following two structuring axes: on the one hand, the medical axis, based on scientific studies and clinical developments, which suggests that a person is able to recover from the effects of psychic disorder symptoms –an objective notion of *recovery*; and, on the other hand, the more personal and social axis, based on self-determination, understood as the experiential conception of *recovery* (Koenig, 2016) and which is about to be institutionalized in France.

As a conclusion, it is clear that people suffering from schizophrenia or a mental illness are able to recover, as shown and observed by scientific studies, clinicians, professionals in the health system that also see themselves obliged to work with recovered people, and political decision-makers that now show themselves as new interlocutors. Society in general also analyses new concepts, specific discourses and different cases, and, as other actors, is compelled by their voluntary breakthrough to "create a place" for them in this new social and political ecology.

To sum up, this evolution towards citizen psychiatry is remarkable qualitatively in the mental health support system as a whole, as well as at its margins and in society. Beyond the legal inscriptions and institutional objectives, these changes are being institutionalized, in a reciprocal movement with social representations of insanity.

DISCUSSION

The different viewpoints studied here all share a related ethical prospect: the critical analysis of mental health field and its representations; the recognition of users' rights to be free, unique, different and socially-integrated citizens with shared subjective projects; the recognition of minority activism and historical diversity that results in the search for consolidation and continuity of reforms in Argentina and Brazil; and the deepening of advancements achieved in France, questioning professional and experiential knowledge.

Even though each author highlighted heterogeneous aspects of the development of the reforms in his own country, there are meeting points. Argentina and Brazil with closer socio-historical profiles have been nourished by the contributions and experiences of the sector's psychiatry. And in the same way, Latin American social and community movements, their values and conceptualizations, have inspired European specialists.

In this regard, the experience gathered in this article has been to visualize a common area of research and intervention. Space where a promising path for the psychosociological discipline opens: the joint approach of the social representations and the minority influence in the transformation processes of the mental health system. In a way, Moscovici always encouraged him: (...) *the theory of representations is also a theory of social change (...). Innovation, in another way, also considers the problem of social change* (Moscovici in dialogue with Acosta Ávila, 2006: 150).

More specifically: *social change is the central process of influence in its individual and collective manifestations* (Moscovici, 1996: 126). Hence, this article has shown not only its relevance but the need to promote its development: *The objective of the theory was not to show that minorities can influence as much as majorities, but to expand the field of psychology to new phenomena, to the phenomena of innovation, of revolution, of dissidence, of heresy, and so on, which are psychosocial phenomena of the greatest practical interest* (Moscovici in dialogue with Acosta Ávila, 2006: 157).

REFERENCES

Abbagnano, N. (2015). Verbete Loucura. *Dicionário de Fiolosofia*. São Paulo: Martins Fontes.

Acosta Ávila, M. T. (2006). The Psychology of Active Minorities Revisited: Interview with Serge Moscovici. In: *Polis: Investigación y Análisis Sociopolítico y psicosocial, primer semestre, año/vol. 2, n° 001*. Universidad Autónoma Metropolitana – Iztapalapa. DF, México. Retrieved 06/05/2018 from: http://www.redalyc.org/articulo.oa?id=72620106.

Amarante, P. (2015). *Teoria e crítica em saúde mental.* São Paulo: Zagodoni.

Bacqué, M-H., Biewener, C. (2013). L'empowerment, une pratique émancipatrice. Paris : La découverte.

CELS (2008). *Vidas arrasadas. La segregación de las personas en los asilos psiquiátricos argentinos.* Buenos Aires, Siglo XXI.

Cohen, H., Natella, G. (2013). *La Desmanicomialización: Crónica de la reforma del Sistema de Salud Mental en Río Negro.* Buenos Aires: Lugar Editorial.

Coldefy, M.; Fernandes, S. (2017). « Les soins sans consentement en psychiatrie : bilan après quatre années de mise en œuvre de la loi du 5 juillet 2011 », *Questions d'économie de la santé*, Irdes n° 222.

Dubet, F. (2015). *Solidaridad. ¿Por qué preferimos la desigualdad? (aunque digamos lo contrario).* Buenos Aires: Siglo XXI Editores (first ed. in french, Paris: Seuil, 2014).

Faleiros V. De Paula; Campos, T. Petra Da Motta (2016). A crítica da loucura e a práxis poética da necessidade existencial: estudo de caso da ONG Inverso. In: *Serviço Social em Revista,* Londrina, V. 18, N.2, P.111 - 131, Jan./Jun. 2016. DOI: 10.5433/1679-4842.2016v18n2p111.

Faleiros, E. T.S; Campos, T. Petra Da Motta; Faleiros, V. De Paula (Orgs). (2017). *Portas abertas à loucura*. Curitiba: Appris.

Faraone, S., & Valero, A. S. (coord.) (2013). *Dilemas en salud mental. Sustitución de las lógicas manicomiales*, Buenos Aires, Ediciones Madres de Plaza de Mayo.

Foucault, M. (1995). *História da loucura.* São Paulo: Perspectiva.

Foucault, M. (2002). *Vigilar y castigar. Nacimiento de la prisión.* Buenos Aires: Fondo de Cultura Económica.

Freire, P. (1974). *Pédagogie des opprimés*. Paris : Editions Maspero.

Giordana, J-Y. (in collaboration) (2010). *La stigmatisation en psychiatrie et en santé mentale*. France : Masson.

HPST Bill, 2009. LOI n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires. Retrieved 31/07/2017 from https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000020879475&categorieLien=id.

Jodelet, D. (1989). *Folies et représentations sociales*. Paris: PUF.

Jodelet, D. (1996). Représentations sociales de la maladie mentale et insertion des malades mentaux. In : Paugam, S., *L'exclusion. L'état des savoirs*. Paris: La Découverte.

Jodelet, D. (2015). O encontro dos saberes. In: Correia Jesuíno, J.; Mendes R. P., F.; Lopes, M. J. (orgs.): *As representações sociais nas sociedades em mudança.* Petrópolis, Brasil: Editora Vozes: 59-79.

Jodelet, D. (2015). Considérations sur le traitement de la stigmatisation en santé mentale. In : Kalampalikis, N., *Représentations sociales et mondes de vie*, Paris : EAC, 209-221.

Jouet, E., Chappard, P., Troisoeufs, A. (2017). « Addictions et apprentissages informels en ligne. Le cas du site *Psychoactif.org* ». In Las Vergnas O (dir). *Le e-learning informel ? Des apprentissages diffus, noyés dans la participation en ligne*. Paris: EAC, 127-143

Jouet, E. & Flora, L. (2010). Usagers-experts : la part du savoir des malades dans le système de santé. *Revue Pratiques de Formation, n. esp.* [Cited by Jodelet (2015 : 74)].

Jouet, E.; Flora, L.; Las Vergnas, O. (2010). Construction et reconnaissance des savoirs expérientiels des malades », Note de synthèse, Revue PFA, 58-59.

Kirchmayer, R. (2012). Critique du corps "fou". L'héritage de Sartre dans la psychiatrie de Franco Basaglia. In: *Les temps modernes.* Paris, 2012, Vol. 67, n. 668.

Koenig, M. (2016). Le rétablissement en psychiatrie, Un parcours de reconnaissance. Paris: PUF.

Law No. 2016-41 dated 26 January 201. Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé. Retrieved 31/07/2017 from https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000031912641&categorieLien=id.

Law No. 2002-303 dated 4 March 2002. Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé. Retrieved 31/07/2017 from https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000227015.

Marková, I. (2006). *Dialogicidade e Representações Sociais. As dinâmicas da mente. Petrópolis*, RJ. Editora Vozes. (First ed.: Marková, I., 2003. *Dialogicality and Social Representations*. Cambridge: Cambridge University Press).

Marková, I. (2015). Ética na teoria das representações sociais. In: Correia Jesuíno, J.; Mendes R. P., F.; Lopes, M. J. (orgs.): *As representações sociais nas sociedades em mudança* (pp. 80-102). Petrópolis, Brasil: Ed. Vozes.

Martin, A. (2016). L'aveu par l'écriture de soi ou la tentative de résolution d'une injonction paradoxale de l'institution psychiatrique. In : TRANSverse Journal. 05/jun/2017: http://www.transversejournal.org/articles-16/laveu-par-lecriture-de-soi-ou-

la-tentative-de-resolution-dune-injonction-paradoxale-de-linstitution-psychiatrique-agathe-martin/

Ministry of Health of the Argentine Nation (2010). National Mental Health Law No. 26.657. Sanctioned: 11/25/2010. Promulgated: 12/02/2010. Regulatory decree: 03/06/2013.

Ministry of Health of the Rio Negro Province (1991). Law No. 2440 of Sanitary and Social Promotion of people with mental suffering. Sanctioned: 11/11/1991. Promulgated by Decree No. 1.466. Official Bulletin No. 909.

Ministry of Health of the Buenos Aires Province (2015). Census of Interned Persons. Report on the results of the Census conducted at the Hospital A. Korn on the population housed in long-stay rooms. Melchor Romero, Province of Buenos Aires, Argentina.

Moscovici, S. (1979). *Psychologie des minorités actives*. Paris : PUF.

Moscovici, S. (1976). *La psychanalyse, son image et son public*. Paris: PUF. (First ed. 1961).

Moscovici, S. (1996). *Psicología de las minorías activas*. Madrid: Morata. (First ed., 1979. Paris: PUF.

Murekian, N. G. (2006). "Mental health and social representations: structures, processes and contexts. Of the *demomanicomialización* and its representational impacts in adult population and in groups of experts. City of Viedma and City of Buenos Aires". Doctoral Thesis, University of Buenos Aires, Faculty of Psychology.

Murekian, N. G. (2013), “The *desmanicomialización* as an object of study". In: Cohen, H. & G. Natella (2013), *La desmanicomialización: Crónica de la Reforma del Sistema de Salud Mental en Río Negro,* chapter 6: “Monitoreo, evaluación, investigación” (pp. 359-390). Buenos Aires, Lugar Editorial.

Murekian, N. G. (2017). "Mental health and social representations: commitment, negotiation, transformation". In: Chardon, M. C., Murekian, N. G., Scaglia, H. (Coords.) *Investigaciones en representaciones sociales en la Argentina: problemas teóricos y producción empírica.* Chapter 10 (pp. 223-259). Province of Buenos Aires, Ed. Universidad Nacional de Quilmes.

Pachoud, B. (2012). « Se rétablir de troubles psychiatriques : un changement de regard sur le devenir des personnes », *L'Information Psychiatrique*, n°88, 2012, 257-60.

Paulin Devallis, M. (2015). Las prácticas en el proceso de desmanicomialización. La perspectiva de usuarios, familiares y trabajadores de SMC (Part II: pp. 111-208). In:

Paulin Devallis, M., Baffo, C., Onocko Campos, R. *Perspectivas de la Desmanicomialización.* Neuquén: Kuruf editors.

Rappaport, J. (1981). In praise of paradox: a social policy of empowerment over prevention. *American Journal of Community psychology,* vol. 9. p. 15.

Rotelli, F. (2008). Che cos'è la salute mentale. In: Rotelli, F. *Per la normalitá.* Vol. 2. Trieste: Microtesti Collana.

Rotterdan, E. de (1508). *Elogio de la Locura*. Available on: http://www.bahiamasotta.com.ar/textos/2c6.pdf.

Schiappa Pietra, J.; Franco, P. A.; Schachter Broide, A. L.; Baffo, C. G.; Cortez, F.; Gutierrez, A.; Lausada, D.; Mancardo, A.; Paulin Devallis, M.; Irigoyen Testa, R. H.; De Caso, S.; Calderero, M. R.; Sanz, M. J. (2016) *La Brancaleone. Teoría y prácticas Desmanicomializadoras*. Río Negro: Kuruf Eds.

Vasconcelos, E. M. (Coord.) (2013). *Cartilha [de] ajuda e suporte mútuos em saúde mental: para participantes de grupos.* Rio de Janeiro: Escola do Serviço Social da UFRJ; Brasília: Ministério da Saúde, Fundo Nacional de Saúde. Available on: http://www.saude.campinas.sp.gov.br/programas/integrativa/curso_PICS/encontro_2016_09_01/Cartilha_ajuda_e_suporte_mutuos_em_saude_mental.pdf

WHO (2013). *Mental Health Action Plan 2013-2020.* Geneva, Switzerland: Department of Mental Health and Substance Abuse.

WHO (1982), The Ottawa Charter for Health Promotion. Retrieved 31/07/2017 from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/.

WHO (2001), Mental ealth: New Understanding, New Hope Report. Retrieved 31/07/2017 from http://www.who.int/whr/2001/en/whr01_en.pdf?ua=1

WHO (2005), Mental Health ! facing the challenges, building solutions. Retrieved 31/07/2017 from http://www.euro.who.int/_data/assets/pdf_file/0008/96452/E87301.pdf

NOEMÍ GRACIELA MUREKIAN has a Doctorate from Universidad de Buenos Aires, School of Psychology and University degree in Sociology from Universidad del Salvador. She is a Professor for the Master's in Psychosocial Intervention and Research (MIIPS), School of Psychology (Universidad Nacional de Córdoba) and a consultant for the project

"Care-Related Issues. Socio-Cultural Metamorphoses and Subjectivity Production in Contemporary Social Spaces" (Universidad Nacional de Quilmes).
EMAIL: noemimurekian@uolsinectis.com.ar

VICENTE DE PAULA FALEIROS is social worker and PhD in sociology at the Montréal University, with post-doctoral studies at the EHESS in France. He has been professor in Brazil, Chile and Canada (Québec) in the domains of social policy, social work, social psychology and gerontology. He is *Emeritus* Professor of the University of Brasília. Alter 2003 he teaches at the Brasilia Catholic University with investigations on social representations and violence. EMAIL: vicentefaleiros@terra.com.br

EMMANUELLE JOUET, PhD in Educational Science, is a researcher at the Maison Blanche Research Laboratory (Paris) where she has been working on destigmatising mental health, mental health promotion, developing new training methods involving people living with mental health illnesses as both trainers and trainees, and evaluating continuous learning training programs for mental health professionals.
EMAIL: Emmanuelle.JOUET@ch-maison-blanche.fr