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"Reginaldo Came Home": Psychoanalysis' Contributions to the Anti-Asylum Struggle

"Reginaldo voltou pra casa": Colaborações da psicanálise à luta antimanicomial

"Reginaldo Volvió a Casa": Colaboraciones del Psicoanálisis a la Lucha Antimanicomial

"Reginaldo est rentré chez lui": Contributions de la psychanalyse à la lutte pour la désinstitutionnalisation

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Abstract

This work results from clinical care provided to a patient admitted to a public hospital for patients with cardiac disorders located in Rio de Janeiro City. The patient in question had a serious heart condition requiring hospitalization after an episode of acute myocardial infarction (AMI). In addition to this condition, Reginaldo was diagnosed with schizophrenia without follow-up from the mental health network. We will address the patient's attempts to insert himself into this network despite the tireless resistance offered, both by his closest family member (mother) and by professionals at the hospital, who insisted that admission to a long-term care facility would be the only viable option. The methodology will include bibliographical studies, contributing to the elaboration of clinical questions raised by the case presented. One of the authors was involved in the institution where the patient was hospitalized, working directly on the case. On the other hand, the other authors collaborated by supervising the care and theoretical deepening of the clinical discussions developed in the article. Our objective is to demonstrate how psychoanalytic interventions could contribute to the conduct of your treatment. An attempt was made to enable the activation of the mental health network, aiming to support his desire to return home and not to a mental institution, which would mean a setback concerning the advances achieved since the last Brazilian Psychiatric Reform.

Keywords: *Psychoanalysis, mental health, general hospital, schizophrenia, anti-asylum movement.*

Resumo

O presente trabalho resulta do atendimento clínico a um paciente, internado em um hospital público, voltado para pacientes com alterações cardíacas, localizado na cidade do Rio de Janeiro. O paciente em questão apresentava uma grave cardiopatia, sendo necessária internação após episódio de infarto agudo do miocárdio (IAM). Além desse quadro, Reginaldo apresentava diagnóstico de

esquizofrenia, sem acompanhamento da rede de saúde mental. Abordaremos as tentativas de inserção do paciente nessa rede, mesmo com as incansáveis resistências oferecidas, tanto por seu familiar mais próximo (mãe) quanto por profissionais do próprio hospital, que insistiam que a internação em uma instituição de longa permanência seria a única opção viável. A metodologia utilizada conta com estudos bibliográficos, contribuindo com a elaboração das questões clínicas suscitadas pelo caso apresentado. Uma das autoras esteve inserida na instituição onde o paciente se encontrava internado, atuando diretamente no caso. Por outro lado, as demais autoras colaboraram com o trabalho de supervisão dos atendimentos e aprofundamento teórico das discussões clínicas desenvolvidas no artigo. Nosso objetivo é demonstrar de que forma as intervenções psicanalíticas puderam contribuir para a condução de seu tratamento. Tentou-se viabilizar o acionamento da rede de saúde mental, no intuito de sustentar o seu desejo de retornar para casa, e não para um dispositivo manicomial, o que significaria um retrocesso em relação aos avanços alcançados desde a última Reforma Psiquiátrica Brasileira.

***Palavras-chave**: Psicanálise, saúde mental, hospital geral, esquizofrenia, movimento antimanicomial.*

Resumen

El presente trabajo resulta del atendimiento clínico de un paciente, ingresado en un hospital público, dirigido a pacientes con alteraciones cardíacas, localizado en la ciudad de Rio de Janeiro. El paciente en cuestión presentaba una grave cardiopatía, siendo necesario ingreso después de un episodio de infarto agudo de miocardio (IAM). Además de este cuadro, Reginaldo presentaba diagnóstico de esquizofrenia, sin acompañamiento de la red de salud mental. Enfocaremos los intentos de inserción del paciente en esta red, mismo con las incansables resistencias ofrecidas, tanto por su familiar más cercana (madre) cuanto por profesionales del propio hospital, que insistían que la internación en una institución de larga permanencia sería la única opción viable. La metodología utilizada contará con estudios bibliográficos, contribuyendo con la creación de las cuestiones clínicas planteadas por el caso presentado. Una de las autoras estuvo inserida en la institución dónde el paciente se encontraba ingresado, actuando directamente en el caso. Por otro lado, las demás autoras colaboraron con el trabajo de supervisión de los atendimientos y profundización teórico de las discusiones clínicas desarrolladas en el artículo. Nuestro objetivo es demostrar de qué forma las intervenciones psicoanalíticas pudieron contribuir en la conducción de su tratamiento. Se intentó viabilizar el accionamiento de la red de salud mental, con la intención de sostener su deseo de regresar a casa, y no para un dispositivo manicomial, que significaría un retroceso con relación a los avances alcanzados desde la última Reforma Psiquiátrica brasileña.

***Palabras clave**: Psicoanálisis; salud mental; hospital general; esquizofrenia; movimiento antimanicomial.*

Resumé

La présente étude résulte de la prise en charge clinique d'un patient hospitalisé dans un établissement public spécialisé dans les troubles cardiaques, situé à Rio de Janeiro. Le patient en question souffrait d'une grave maladie cardiaque, nécessitant une hospitalisation après un épisode d'infarctus aigu du myocarde (IAM). En plus de cette condition, Reginaldo avait reçu un diagnostic de schizophrénie, sans bénéficier d'un suivi par le réseau de santé mentale. Nous aborderons les tentatives d'intégration du patient dans ce réseau, malgré la résistance persistante rencontrée de la part de son principal proche (la mère) et des professionnels de l'hôpital, qui ont insisté sur le fait que l'hospitalisation dans un établissement de longue durée serait la seule option viable. La méthodologie utilisée comprendra des études bibliographiques, lesquelles contribueront à l'élaboration des questions cliniques soulevées par le cas présenté. L'une des auteures faisait partie de l'établissement où le patient était hospitalisé et agissait directement dans le cas. D'autre part, les autres auteures ont contribué à la supervision des soins et à l'approfondissement théorique des discussions cliniques développés dans l'article. Notre objectif est de démontrer comment les interventions psychanalytiques peuvent contribuer à la prise en charge de son traitement. Une tentative de mobilisation du réseau de santé mentale a été entreprise afin de soutenir son désir de rentrer chez lui, plutôt que d'être orienté vers un dispositif d'asile, ce qui aurait constitué un recul par rapport aux avancées réalisées depuis la dernière réforme psychiatrique brésilienne.

***Mots-clés :** Psychanalyse, santé mentale, hôpital général, schizophrénie, mouvement de désinstitutionnalisation.*

Based on the experience report of one of the authors of this article, as a psychologist in a hospital located in the State of Rio de Janeiro and belonging to the public network of the Unified Health System (SUS), it was possible to carry out this work.

The article was written based on the observation of a patient with schizophrenia, hospitalized due to heart problems. Through the theoretical development carried out by the authors, contributions are presented regarding the difficulties

in sustaining the precepts of the Psychiatric Reform, even after more than two decades of its initial milestone, with the enactment of Law No. 10,216 (2001).

The hospital in question receives patients coming from several emergency care units after having suffered episodes of acute myocardial infarction. We consider this information important, since, generally, the patients who arrive have already undergone catheterization in cardiac hospitals. Catheterization is a procedure that allows the identification of the coronary arteries that caused the infarction. Depending on the degree of impairment, patients can undergo two types of interventional procedures: angioplasty and revascularization surgery. The first is simpler and consists of the implantation of a metal mesh (*stent)*, which dilates the clogged artery. However, when there is multiple impairment of the arteries, it is necessary to perform revascularization, also known as "bypass". In this case, "grafts that function as bridges that bypass the lesions and return normal blood flow to the heart" are placed (SeuCardio, 2024).

However, the case we will discuss does not fit into the situations described above. After all, our patient, who we will call Reginaldo here, and who was 54 years old, despite having suffered a heart attack, was advised to undergo conservative treatment, that is, not to perform an invasive or surgical procedure. This recommendation was based on a series of conditions suffered by Reginaldo, which would make surgery very risky. Due to the severity of his case, the risks of an invasive procedure would be greater than not performing it: he had a serious injury to the sacral region, impaired motor skills that prevented him from walking, and the presence of type II diabetes mellitus. In addition, Reginaldo had been a smoker for many years before being admitted to hospital, which made his condition even more delicate.

Furthermore: Reginaldo was financially dependent on his mother and had always lived with her. His first psychotic episode occurred when he was still young, and he was then diagnosed with schizophrenia. Since then, Reginaldo had been confined to a room in that house, only getting up to eat and go to the bathroom, and spending most of his time lying in bed. This caused serious injury to the sacral region, which reached grade IV, reaching the patient's bone. Because of his time in that room, he also developed significant motor weaknesses and muscular atrophy in his extremely slender legs.

The case will be described below, but we can already say that the greatest complexity in its management was not directly due to the configuration of the patient's psychological condition. The greatest difficulties encountered came from the strong resistance found within the multidisciplinary team itself, in the face of our attempt to reinsert the patient into his daily life after his discharge, since his mother, whom we will call Vanda, an elderly woman over 80 years old, demanded that her son be permanently hospitalized, with the justification that she was already too old to take care of him.

By presenting this case, we intend to demonstrate the possibility of including patients with mental health issues in the public health care network, even in institutions that are not directly linked to providing care in this field. Although psychotic individuals also present organic pathologies, the reaction of health professionals often seems to contradict this obviousness. This is because these professionals, including hospital psychologists, find it impossible to establish any kind of care relationship with psychotic patients, or do not consider that caring for them is an activity related to their work (Pereira, 2023, p. 18). This leads Pereira (2023, p. 85) to note the "absence of a place for psychosis in the repertoire of health professionals, which is due to its absence in the logic of contemporary health".

With this work, we aim to warn health professionals about the necessary precautions to avoid regressing in the advances achieved since the last Brazilian Psychiatric Reform [1]. It is necessary to avoid repeating the asylum model that, as Couto and Alberti (2008) pointed out, "has always been the driving force behind public mental health policies in Brazil, until it was challenged in the 1970s". Based on the complexity of the case, we demonstrate the great work involved from the moment we assume the need to resist the pull that many institutions show towards old asylum models. Our objective is to demonstrate how psychoanalytic interventions can contribute to the management of Reginaldo's case, enabling the activation of the mental health network to support his desire to return home and not to an asylum.

The Field of Mental Health Today

In his doctoral thesis, Bastos (2019) warned of a serious situation that had been occurring in the State of Rio de Janeiro, related to the lack of investment in public health services, especially in the field of mental health. Despite the state's economic crisis, there was another issue involved in this lack of investment, related to the fact that the field of mental health – as it had been developing since the last Brazilian Psychiatric Reform (Couto & Alberti, 2008) – was not being prioritized by public policies.

What Bastos highlighted is that, with regard to the field of alcohol and other drugs – a field related to mental health –, instead of advancing in relation to harm reduction (precisely the proposal conceived and born in 2003 (Ministry of Health, 2003) by the health and psychiatric reforms consolidated in law: Law No. 8,080 of 1990 and Law No. 10,2016 of 2001), we have witnessed a setback in this field. Since 2010, there has been an intensification of the war on drugs, fueled by religious

[1] The psychiatric reform project was presented in 1989 by then congressman Paulo Delgado (MG). After 12 years, the text was approved and sanctioned as Law No. 10,216 (2001), becoming known as the Psychiatric Reform Law, Anti-Asylum Law and Paulo Delgado Law.

morality (Bastos & Alberti, 2021), which has been promoting a disinvestment in harm reduction and, consequently, in the public health equipment that supports this guideline. This is happening in favor of private equipment that has increasingly been financed with public money. Therefore, the Brazilian Government has increased funding for Drug Users' Communities Therapies Centers These private entities provide shelter for people with disorders resulting from the use of psychoactive substances, according to several reports (Federal Council of Psychology, 2011, 2018; Regional Council of Psychology of São Paulo, 2016; Institute of Applied Economic Research, 2017), most of the time guided by a religious discourse, with highly controversial practices, including mistreatment of inmates.

The discursive repositioning in favor of prohibition in drug use, according to Alarcon et al. (2012), was the result of the modification of Law 11.343 of 2006, which introduced harm reduction into the legal field, softening "the expanded logic of harm reduction as the antipode of prohibition" (Law 11.343, 2006, p. 80). This fact allowed a rapprochement between the fields of justice and health, "introducing the possibility of, in 2010, launching the Integrated Plan to Combat Crack and other Drugs (...), which gave rise to the Crack, It Is Possible to Win! Plan and to the discussion on the financing of therapeutic communities centers" (Bastos & Alberti, 2018, p. 220).

If this was already observed at the time of Bastos' research in the mid-2010s, we can see that, currently, there is an even greater increase in the allocation of funds to private companies that provide inpatient treatment for drug addicts. According to a survey carried out and published as a report by the newspaper Folha de São Paulo (Barbon, 2023), the transfer of funds to private companies supposedly in the health sector rose from R$153.7 million to R$300 million in 2020. In addition, the Folha de São Paulo report also found that "74% of therapeutic communities that receive federal funding are religious in origin". Correspondingly, CAPSad (Psychosocial Care Centers – alcohol and other drugs) have been gradually losing ground to Therapeutic Communities, which present "a proposal totally contrary to that of CAPS, because instead of social inclusion, it favors the isolation of the subject, through hospitalization" (Beteille, 2019, p. 44).

According to Bastos and Alberti (2018), therapeutic communities have asylum-like models and characteristics of total institutions, which can already be inferred from the way they understand drug use: "as both a moral and a disease issue, adding the spiritual factor, with abstinence as a paradigm and isolation (hospitalization) as treatment" (Bastos & Alberti, 2018, p. 221).

Bastos (2019) found that, despite significant investments in the field of mental health after the Reform, the number of existing mental health clinical devices was still very discrepant compared to the enormous demand in the sector. However, the large reduction in the allocation of resources for assistance in the field of mental health led to an even greater difficulty in serving the population. This deliberate reduction in public investment would be intended to justify the proliferation of entities such as Therapeutic Communities for drug users, as suggested in the thesis (Bastos, 2019, p. 136):

> (...) Could it be that our leaders were just waiting for mental health to fail to perform miracles to make people believe, in a perverse discourse, that: "Look! Mental Health Harm Reduction Policies are not efficient! So, let religious communities perform the miracle of transforming drugs into faith!"

In 2022, two government actions pointed to a trend towards a return to the asylum policy in line with the ideas that the Reform so strongly opposed. One of them was the publication of Ordinance GM/MS No. 596 (Ministry of Health, 2022), which revoked the so-called Deinstitutionalization Program and abolished funding for the social reintegration of people with mental health problems and problems resulting from the use of alcohol and other drugs, who had been admitted to psychiatric hospitals for more than a year. This action led to a return to old asylum models, such as the contracted hospitals that began to be financed by the State, starting in the 1960s (Couto & Alberti, 2008) – such as Casa de Saúde Dr. Eiras, in Paracambi (RJ), with more than three thousand inpatients.

Another recent government action, carried out by the Ministry of Citizenship, was the launch of Public Call Notice 3/2022, aimed at financing private psychiatric hospital projects. As indicated on the Ministry of Citizenship website, the Notice will select "Civil Society Organizations (CSOs) that provide care as a psychiatric hospital, in the modalities of inpatient care, day hospital, outpatient clinic and/or emergency care" (Ministry of Development and Social Assistance, Family and Fight against Hunger, 2022) . On the same government website, there is a statement by the national secretary for Care and Drug Prevention, Quirino Cordeiro, according to which the alleged lack of care for patients with mental disorders and drug addiction would be a consequence of "old ideological policies". Although the secretary did not specify which policy he was referring to, it is possible to infer, based on the government's direction, that these were policies aimed at deinstitutionalizing and replacing the old mental hospitals with devices such as the Psychosocial Care Center (CAPS) and Therapeutic Residences, based on the goal of treating "drug addicts" [2]and including them in society through harm reduction policies – instead of excluding them in institutions of a total nature (Goffman, 1974). This model, then, is

[2] The expression is in quotation marks because it has a controversial nomenclature. In psychiatry manuals, the nomenclature currently used is Substance Use Disorder (SUD). In psychosocial care, we speak of drug users, since, as Alarcon et al. (2012) point out: not all use is harmful.

reproduced, through public investment, in Therapeutic Communities, which are maintained at the expense of an ideology and economic motivation, as discussed by Bastos and Alberti (2021).

We then ask: was the fierce setback that has occurred in the field of alcohol and other drugs since the renewal of the war on drugs, in truth, also the beginning of a return to the confinement of madness? Could it be that the ideal of a world without drugs, related to the prohibitionist approach – in which every deviation must be punished – was just a prelude to returning to intolerance of madness, that is, to the segregation of those who, from the outset, are already deviants from the norm?

If the orientation of harm reduction policies is ideological – and we can say that there is no policy that is not ideological –, the policy currently supported is no less ideological, with the intensification of the exclusion of patients from plural coexistence with society. This exclusion is terrible not only for each of them, but also for society itself, which finds itself led to a "growing intolerance towards madness" (Beteille, 2019, p. 17) and is restricted from coexistence with the "crazy person", whose social role is of great importance, because it undermines any possibility of a single discourse.

This preamble is necessary to introduce the issues involved in monitoring the discharge of a schizophrenic patient from hospital. Through this case, we intend to demonstrate that, despite all the setbacks, it is still possible to count on mental health services. This fact highlights the incongruity in the speech of the National Secretary for Drug Prevention and Care, Quirino Cordeiro, and the error in the current tendency to seek to solve problems related to mental health through incarceration. Despite the demand from the patient's mother and part of the hospital staff for institutionalization, we managed to include him in the mental health network, demonstrating that the need for long-term psychiatric hospitals in the treatment network is questionable. Let us therefore move on to the case.

Case Description

Reginaldo arrived at the hospital where we work coming from an Emergency Care Unit (UPA) after suffering an acute myocardial infarction (AMI). During the first few days of his hospitalization, he suffered another heart attack, which resulted in a drop in his level of consciousness and respiratory failure, requiring him to be transferred to the Intensive Care Unit (ICU). According to the doctors who treated him, Reginaldo very nearly needed to be intubated.

During the first treatments he received in the ICU, when he was very weak, Reginaldo seemed very sad. He said that during his youth he had had a very happy life, with friends and an active social life. Although the patient, now over 50 years old, made it clear that his stories about his youth seemed very current. At one point, he talked about the music of bands he liked to listen to, with special emphasis on a progressive rock band from the 1970s called *Kansas*. When asked if he would like to listen to one of the band's songs, he said yes, because it would make him "remember a really good time" (*sic)*. He then chose to listen to the song *Play the Game Tonight,* which translates to "Play the game tonight". In fact, when listening to the song, Reginaldo seemed very happy, which helped him bond more with us.

As Reginaldo's recovery from respiratory failure progressed, and through conversations with his mother and sister, we began to learn more about his life story. While still in school, Reginaldo played for a soccer club in Rio de Janeiro. His soccer career, however, was interrupted by a psychotic episode when he was 20 years old. His sister's account revealed that this episode had been triggered after Reginaldo had been officially signed by the club. In the patient's words, he had given up soccer due to the high level of physical exhaustion that the sport imposed on him. After this decision, and even after the first episode, which culminated in psychiatric hospitalization, Reginaldo reported that he began working as a real estate agent for some time, until he suffered a new episode, this time more aggressive, at the age of 24.

Reginaldo narrates the episodes of his life and illness with incredible precision regarding dates. In his narrative, however, he does not seem to be referring to his own history, such is the emotional distance he displays. At no time did we receive any information about the delusional content of his crises. He would only say that he "started to act strange" or that he "wasn't well" and that he "became very nervous", but he did not reveal anything about the psychological manifestations of his illness. From the time we were able to follow Reginaldo during his hospitalization due to his heart problem, we corroborated the accuracy of this diagnosis, based on the theory of psychoanalytic clinic in conjunction with classical psychiatry.

The second crisis occurred four years after the first and was treated at home by a psychiatrist. His father died of heart problems like Reginaldo's shortly after this second episode. Since then, the patient reports that he has been living in seclusion at home, without ever working or keeping in touch with friends. The decision not to work was ratified by his mother who, according to him, "didn't think I would be able to have a job" (*sic)*.

Reginaldo spent the last three decades of his life locked in his room, listening to music on a radio station that had belonged to his father. It is worth mentioning that his father, before becoming a civil servant, had worked as a radio announcer. Reginaldo would only get up to defecate and urinate in a container that he kept near his bed. This behavior led

[2] A expressão encontra-se entre aspas por apresentar uma nomenclatura controversa. Nos manuais de psiquiatria, atualmente, a nomenclatura utilizada é Transtorno por Uso de Substâncias (TUS). Na atenção psicossocial falamos usuários de drogas, já que, como Alarcon et al. (2012) chama à atenção: nem todo uso é danoso.

his mother and sister to consider admitting him to a psychiatric clinic, sometime before his first heart attack, as they noticed a worsening of his negative symptoms, such as isolation and increasing refusal to perform daily activities.

Reginaldo proves to be a Subject

Reginaldo's confinement certainly played an important role in his dementia process, as did the exclusively drug-based orientation of his psychiatric treatment. When he arrived at the hospital after the heart attack, some of these medications were withdrawn due to the decrease in his levels of consciousness, which compromised his clinical condition, with the presence of lethargy and drowsiness. This factor contributed to Reginaldo's gradually becoming more lucid and, consequently, also more demanding. Furthermore, it is worth considering that his departure from the home environment allowed him to have contact with other people, in addition to his mother and sister, which, in a certain way, broke with the process of " autistic satisfaction of desires", to which Bleuler (1950) already referred when he conceptualized schizophrenia in the field of psychiatry, in 1911.

After making progress in his recovery from the second heart attack that had taken him to the ICU, Reginaldo began to insistently ask to speak to his mother so that she would take him to the house where she lived with her – and which had been built by his Portuguese great-grandfather when he arrived in Brazil. The fact that his mother was elderly and had health problems prevented her from making daily visits to the hospital, although she had always visited him, at least once a week. To ensure that they could maintain communication, our team made phone calls or video calls, allowing contact between them – and, sometimes, also with his sister who, although she lives in São Paulo, visits her mother regularly. During these calls, Reginaldo asked his mother to "find a way" to get him out of the hospital (*sic)*. At these times, his mother tried to reassure him, saying that he still needed medical care. Even after the possibility of cardiac surgery had been ruled out – due to the complexity of the case – it was not yet time to talk about hospital discharge, due to the pressure ulcer that had reached grade IV, requiring hospital treatment. As mentioned at the beginning of this article, the fact that he remained in this position, both at home and in the hospital, combined with the low intake of nutrients and the presence of diabetes mellitus, made treatment difficult, sometimes causing the condition to worsen.

One month after heart surgery was ruled out, Reginaldo was still unable to walk, and his ulcer was still in stage IV. After noticing the delay in his recovery and considering that his stay in a hospital could lead to infection with resistant bacteria, the medical team raised the possibility of discharge if it were possible to treat the ulcer at home. They considered that the risk of remaining in the hospital, given the severity of his heart disease, was even greater. When informed about the possibility of discharge, Reginaldo's mother became increasingly resistant to receiving him, saying that she did not have the financial means to pay for her son's treatment. Dona Vanda began to insist more and more vehemently that her son be sent to a long-term hospital, reiterating that she would not stop visiting him there.

In addition to claiming that she did not have the financial means to care for her son, Mrs. Vanda said that she would not like to see her son die, as had happened to her husband, Reginaldo's father, due to the same heart disease. She also spoke about her mobility difficulties, resulting from a series of pains that affected her joints. It is worth noting that every time the issue of her son's discharge was discussed, she claimed that these pains had increased.

When, in discussions with the social service team, we drew attention to Vanda's resistance to having her son back home, arguing that the reasons for this were not limited to those she had mentioned, a deep reaction was generated. Vanda felt offended by the assumption that she did not want her son back home, interpreting it as a moral judgment about her limitations, which, in her view, would demonstrate a lack of sensitivity on our part regarding her real difficulties.

Unlike the psychology team, the social service team did not closely monitor Reginaldo, so their perceptions of the patient came from his mother's accounts. Very concerned with resolving the problems brought up by this woman, many of the social workers did not consider that Reginaldo also had rights over the house where he lived and that his desire was to return there. There was a focus on listening to Vanda, beyond her immediate demands for hospitalization. Just like Reginaldo, seen only as a schizophrenic, Vanda was only considered based on the imaginary aspects involved in the fact that she was elderly.

We sought, through psychoanalytic listening, to consider the effects of the cut in the signifying chain, the only means, according to Lacan (1960/1998, p. 815), that allows:

> (...) verify the structure of the subject as discontinuity in reality. If linguistics promotes the signifier, by seeing in it the determinant of meaning, analysis reveals the truth of this relationship, by making the holes in meaning the determinants of its discourse.

We tried to point out that Vanda, when requesting her son's hospitalization, was perhaps seeking shelter for herself, which was demonstrated as the case unfolded. However, the more we tried to consider the error in Vanda's speech, the more we were taken as people insensitive to her situation. In the meantime, Reginaldo's account is curious: "My mother doesn't want to take me. If you think she's a poor old lady, you're very mistaken" (*sic)*.

In the end, we could not avoid a great division from forming, so that the hospital became a kind of court: on one side, there were those who "defended" Vanda and her right not to be with her son; on the other, we were identified as staunch defenders of Reginaldo and, therefore, opposed to his mother. Vanda, in turn, claimed that we were "putting this idea in his head that he should go home" (*sic)*, excluding the possibility of Reginaldo's choice. At one point, his sister even claimed that the State was responsible for her brother's treatment, since she would take care of "whoever is alive" (*sic)*, his mother. Both she and his mother assumed that he would not survive his hospitalization. However, in addition to surviving, he showed a desire to live!

Not recognizing Reginaldo's ability to desire and express his desires was undoubtedly also a consequence of the many years he had lived as an autistic person at home. Previously, other issues had been raised to nullify this ability: after so many years living in his room at the expense of his mother and sister, keeping Reginaldo hospitalized would actually be a relief. This became clear to us when his sister, in a difficult conversation with us, said that the hospital should increase his medication, since his wanting to go home was an obvious consequence of his having a breakdown. It is worth noting that Reginaldo used his stay in the hospital – both in the Intensive Care Unit and in the ward – not only to treat his heart condition, but also for his mental health, a situation unknown to the members of the team, as well as to his sister and mother. This approach was made possible by the hospital care, which included an integrated team of psychologists committed to valuing the expression and subjective needs of patients.

At first, Reginaldo simply insisted that his mother take him home, stating his dissatisfaction with being in the hospital. Gradually, the patient shared his story and interests, especially musical ones, so that, as already mentioned, we began to include his favorite music during his treatment. After these first sessions, which allowed Reginaldo to express himself as a subject, the patient began to show great joy when he saw us around.

When he was transferred to the ward, Reginaldo, very agitated, told us about a dream that involved legal proceedings and the commission of a "crime" that he himself did not know about. "What crime did I commit to feel so guilty?!" (*sic)*. When we asked him the question again, he said that he had always felt very guilty about having "mental problems". He then said that his mother needed to take him out of there and that she should find a caregiver right away. At that moment, we said that his mother would not do that, because she was very resistant to taking him in, which caused Reginaldo to become dissatisfied and angry with the team, who said that we should not say that. In the following consultations, however, the patient was able to formulate a strategy to be discharged: "I will be my own caregiver" (*sic)*. That was when he showed clear improvement, being able to even stand up and walk, which he had not been able to do since before being admitted. The fact that he remained standing coincided with the improvement of the sacral lesion, which rapidly evolved to grade II.

Reginaldo's incredible recovery surprised even the doctors. Although his heart problems, involving the blockage of his coronary arteries, remained, the patient's determination to recover quickly had positive effects on his overall condition. Even with Reginaldo's incredible recovery, Mrs. Vanda continued to refuse to take him home, putting up all sorts of obstacles to receiving him. The situation became increasingly complicated, involving a growing number of hospital professionals: everyone had an opinion on the case, from the assistants to the director.

Both the doctors and the hospital's technical director felt pressured to discharge the patient as soon as possible. This is because one of the criteria for a hospital's performance in the network's evaluations is the length of each patient's hospital stay: the sooner the patient is discharged, the better. Since Reginaldo was already in a condition to be discharged, given that the severity of his injury made it possible for him to receive care at home, there was great pressure from the medical team to discharge him as soon as possible.

On the other hand, the social services had completely alienated themselves from the family discourse, which is understandable, considering that this is the sector most directly focused on serving families in hospitals. This situation resulted in growing resistance from part of this team to our work. We had to act more emphatically when the director and some of the social workers found a *final solution* for the case: sending Reginaldo to a distant sanatorium that, despite being public, was not part of the SUS network, being only accredited to it.

As we were able to ascertain, and according to statements from people who work in the public health system, the institution in question is a place where patients who do not have family references and do not have the autonomy to be discharged without a care reference are sent. Thus, people with psychiatric problems and socially marginalized people are sent to this type of institution: the inhabitants of the "uniform world of madness" (Foucault, 2019), about whom Beteille (2019) discussed in her thesis. With the Psychiatric Reform, it became theoretically impossible to send a person, for psychiatric reasons, to a long-term hospitalization through the SUS network. This clinic, and many others that Bastos (2019) discussed, were solutions found so that the isolation of the insane and socially deviant could be institutionalized. Could this be a repetition of the asylum model that the affiliated clinics began to offer in Brazil in the 1960s? We intend to develop this issue at another time.

The reference above to the expression *final solution* originates from the association we make between the situation described and the isolation of a myriad of socially segregated people in Nazi concentration camps, including Jews,

homosexuals and mentally ill people. An association that is also inspired by films about psychiatric hospitals that were in force in Brazil before the last Brazilian Psychiatric Reform.

The clinical practice with schizophrenic patients is very enriching, if we can do away with segregating and prejudiced observations and, at the same time, dedicate ourselves to listening to what each schizophrenic subject has to say. In fact, this is what allowed Eugen Bleuler to identify what is at the core of schizophrenia, beyond what Emil Kraepelin (1988) had already conceptualized 12 years earlier as dementia praecox. For, while for Kraepelin the schizophrenic patient necessarily presents dementia, Bleuler rejects the term "dementia" for schizophrenia because he "does not agree with the inexorable evolution towards dementia in these cases" (Quinet, 2006, p. 64). According to the author, it is necessary to distinguish between "symptoms that derive directly from the disease process itself, and secondary symptoms that only begin to operate when the sick psyche reacts to some internal or external process" (Bleuler, 1950, p. 348). Thus, Bleuler considers that the symptomatology of dementia praecox, as described by Kraepelin (1988), would be "secondary". The primary symptoms would be related to "association disorders", which occur as if "those paths of association and inhibition, established through experience, had lost their sense and meaning". The associations, then, "seem to take new paths more easily" (Bleuler, 1950, pp. 349-350). Bleuler also tends to include the tendency to hallucinate as a primary symptom, recognizing that both hallucinations and delusions "appear in the most varied cerebral processes, in intoxications and also in the dreams of healthy individuals" (Bleuler, 1950, p. 351).

We emphasize that Reginaldo was admitted as a patient at a time when he did not present florid manifestations, that is, effective creations of delusional or hallucinatory content. He only made plans that were not consistent with his reality, such as starting medical school. Reginaldo refers to the period in which he presented an acute case of schizophrenia with a certain detachment and never went into detail about the delusional content that we assume to have existed in the past.

However, let us remember that Reginaldo was found after a long period of seclusion, during which he had been heavily medicated. The initial state in which we found him is not far from what Kraepelin (1988) had already identified as negativity. The fact that Reginaldo did not show any strangeness regarding the excess medication may indeed have derived from what Bleuler called "emotional deterioration". The author considers this state to be one of the most relevant symptoms of dementia, emphasizing that "no effort can occur when the affects are blocked or absent" (Bleuler, 1950, p. 351). Another factor that contributes to the outcome of dementia is identified by Bleuler as being associated with desires: when all desires (*Wünsche)* are autistically satisfied or when it seems impossible that they can be fulfilled. There is no reason for effort. When relations with the external world are broken, or greatly distorted, there is no impulse (*Antrieb)* that can be present (Bleuler, 1950). Reginald's hospitalization changed all that!

We hypothesize that the first outburst occurred when Reginaldo was called to take on the starting position on the soccer team, requiring a subjective response from him that would attest to his psychic integrity. Just as occurred in the classic case of President Schreber (Freud, 1911/1991), who had an outburst when he was assigned the role of a judge for other judges in his career in Law, Reginaldo also has an outburst when he is forced to take on the position of a starting player. Freud (1940/1975) emphasizes that the moment in which a psychosis is triggered coincides with the moment in which "objective reality becomes unbearably painful" so that "the drives demand an extraordinary effort" (Freud, 1940/1975, p. 203). If we listen carefully to what Reginaldo told us, this is exactly what happened to him when he felt that soccer was demanding too much of him, and that he could not cope.

But Freud had already observed that the separation from external reality does not occur "without leaving a trace". After all:

> Even in a state as far removed from the reality of the external world as that of hallucinatory confusion (amentia), one learns from patients, after their recovery, that at the time, in some corner of the soul there was a normal person hidden, who, like a detached spectator, watched the tumult of the illness pass by him (Freud, 1940/1991, p. 203).

The 30 years that followed the first episode, years of autistic seclusion in his room, constituted this constellation in which "affects are blocked or absent" and "there is no impulse (*Antrieb)* that can be present" (Bleuler, 1950, p. 378). In fact, the Reginaldo we met in the hospital, after a long period of seclusion, corroborated exactly Freud's observation cited above, when he reported his illness as a spectator. It was the fact that he had met with a mental health team in the hospital that produced the reactions that led him to be able to express, once again, what he wanted: to go home.

Bleuler considers that the most important elements of "schizophrenic dementia" are found in the secondary phase (Bleuler, 1950, p. 378). In this article, we are highlighting this aspect, because we did not find the patient in the primary stage of schizophrenia, nor, as mentioned, in a productive phase of symptoms such as hallucinations and delusions. The patient was initially found to be excessively medicated, coming from a daily life in which his only contact with the world was through the small radio that his father, the now deceased radio announcer, had left for him. Only gradually, with the withdrawal of some psychiatric medications, was it possible to establish a therapeutic bond with the team that witnessed an awakening of desire, completely different from the initial lack of impulses.

Consequently, it was essential that we vehemently oppose the idea of sending Reginaldo to a distant sanatorium, a proposal that we did not even consider as an alternative. In contrast, we proposed sending mother and son to a CAPS. However, one of the social workers considered this possibility absurd, after all, "the network does not work, it is all fragmented" (*sic)* and would not be able to handle this case. According to another social worker: we were dealing with a "very elderly" lady, and she also had rights that protected her, "not being obliged" to stay with a man who "is probably very violent at home" (*sic)*. This violence, by the way, was never mentioned in any speech, neither by Reginaldo nor by any member of the family and was therefore an absolutely imaginary effect of the schizophrenia diagnosis for this social worker.

On the other hand, the team members who did not agree with the idea of sending Reginaldo to a distant sanatorium began to be harshly criticized, regardless of their areas of expertise. Even a social worker was questioned by her colleagues, asking why she was "taking care of Reginaldo so much?" The proposal we were able to make would serve both mother and son, without excluding either one. The plan was to refer him to a CAPS, thinking that it would be both a place for Reginaldo to receive treatment and a place for his mother to receive daily institutional support, given her difficulties due to both her age and joint pain.

Here we need to raise some points about the position of social services in relation to the resolution push, following legal models and about some points related to the real financial condition of this family, taking as reference the social interview carried out with Vanda when Reginaldo entered the hospital.

The Big Turnaround: "I don't want my son away from me"

Reginaldo's case, then, was presented based on constant polarizations between the medical and social perspectives: for the doctors, Reginaldo needed to be discharged because he ran a greater risk of contracting a hospital infection while hospitalized, in addition to the fact that an excessively long hospital stay tarnishes the institution's productivity spreadsheet, with the patient remaining in a bed for much longer than normal. In the psychology department, where there was greater concern for the patient's mental health, there was a perception of the delicate nature of the situation. Even though Vanda was elderly and had health problems, we noticed that in both her speech and that of her daughter, Reginaldo's sister, the resistance to receiving him was related to the fact that both had experienced his hospitalization with relief, after accompanying him for so many years in that home, without, at any time, having received any assistance, even minimal, from the mental health network . At no time was there a support system for them, making it impossible for them to recognize him as a person. The severity of his heart condition made him even more objectified, to the point that he was identified by his family as a dead man.

Once, when the patient was already in the ward and able to stand, a doctor asked Vanda: "Why is your son still here? What do you want to do?" Embarrassed, Vanda said, with her back to her son, to keep him from following the conversation, that she wanted to leave him in an institution so that she could visit him regularly. However, Reginaldo responded, opening his arms: "That institution you want doesn't exist, mom, take me home right now!" Vanda then said that she didn't want to have that conversation in front of her son, to which the doctor replied: "But it's about his life that we're talking about, he needs to know!" (*sic)*.

This conversation made Vanda very angry, after all, someone on the hospital's medical staff realized that Reginaldo was perfectly capable of expressing himself as a subject. However, Vanda understood that any form of expression by her son was considered aggressive behavior. Furthermore, after the doctor's speech, she reported feeling a lot of pain in her joints, making it necessary to sit down. After this episode, she began to complain about the doctor and the psychologist who were by her side. Her complaints extended to several other professionals.

Even though they realized that Vanda was hiding her real financial situation, some of the team said that she would not be able to pay for a caregiver to perform the necessary dressings on her son's sacral lesion. We tried to argue by saying that we would contact the CAPS network and the Family Health Department so that the family could be monitored, but even so, Vanda's reactions were the most pessimistic possible: negativity now seemed to have invaded her soul.

When Reginaldo's stay in the hospital became unsustainable (due to issues involving charging for beds), the management decided to send him to the sanatorium. During the meeting in which the director presented this decision to the teams, we expressed our opposition and recalled all the struggles involving deinstitutionalization since the Psychiatric Reform, including before that, in Italy, with Franco Basaglia.

In 2018, we participated in a conference [3]in Italy to commemorate the 40th anniversary of Law 180, or the Franco Basaglia Law, which established the end of psychiatric hospitals in that country. One of the rapporteurs of this law, the psychiatrist and then congressman Bruno Orsini, stated at the conference that Basaglia had a very peculiar characteristic: that of always wanting the impossible when it came to deinstitutionalization. It was this speech that we remembered at the time of that meeting when they decided to send Reginaldo to the sanatorium. We thought that, despite all the progress

[3] International Congress CIPRA: an Italian madness, held at the University of Milano-Bicocca (16 and 17 November 2018).

that Basaglia had made, in addition to all his influence on our Reform, it is still necessary to fight against very powerful asylum forces, disguised, every day, as good intentions. At that moment, we also had the impression that we were fighting for the impossible, because it seemed very likely that Reginaldo would be institutionalized.

A large part of the social services team, and even some members of the psychology team, had already introduced the mother to the "clinic" and convinced her that referral would be the best option. However, we still had one "trump card": no matter how much Reginaldo's mother asked to have her son institutionalized and showed signs of seeing him as an object, she would not stop loving him. In her daily calls to the hospital, during which she asked for her son to be institutionalized, she also asked about his health. Thus, no matter how much she herself claimed to have difficulty moving around, she did not stop visiting him every week and asking to speak to him on the phone at other times. Would she "agree" to send her son to a sanatorium?! It was at this point that we tried one last attempt to negotiate with the patient's mother, who until then had been adamant.

The social services had called Vanda to a meeting, where the final details for Reginaldo's transfer to the sanatorium would be presented. The meeting with Vanda would be attended by the psychologist, but the social worker only called the department after Reginaldo's transfer had already been arranged. The truth is that, on that day, we were the ones present, representing the psychology department. Upon entering the treatment room, Vanda said: "We are here to arrange how my son will be transferred to 'clinic X'". The psychologist then asked: "Do you know where you are sending your son? Do you know that this institution is over a hundred kilometers from here? That it is not part of the SUS network and that we have never been able to visit this place?"

Vanda was disconcerted by this question, saying that she did not want to be away from her son like that. At that moment, she cried a lot, saying that she needed help. That was when the psychologist finally managed to introduce her to the CAPS, saying that she would also be supported. The social worker seemed very upset at that moment, but could not oppose Vanda's position, when she said that she would accept taking her son home if the CAPS and the Family Health Department offered her support.

After talking to Vanda, the CAPS technician, who would be the reference for the case, contacted her and visited the hospital to meet Reginaldo, where he welcomed her very well.

From then on, the discharge process occurred very quickly. Vanda often said that she was in a lot of pain and that she was old, claiming that these were the reasons why she could not take care of her son. However, from the moment she confessed that she needed help, just like Reginaldo, she stopped competing with him for care. She left the "it's him or me" position that the hospital technicians themselves had led her to adopt. The social services, which are very much identified with the discourse of Law, for reasons inherent to the profession itself, had offered Vanda a listening ear that considered only her attributes as an elderly and sick person. A social worker once said that Reginaldo and Vanda were "competing" in terms of rights, since he was "disabled" and she was "very old". Basically, since Reginaldo's first outburst, both could only be heard as subjects, regardless of labels, with the work of the majority of the hospital's team of psychologists. Based on the psychologist's clinical listening, the inclusion of both subjects in a treatment was established, making it possible to move away from the inevitable "either...or" position.

Conclusion

Thus, the purpose of presenting this case is to share an experience that we consider positive, in a scenario that is so catastrophic that we are currently experiencing in the field of public policies and, notably, mental health. We wonder if all the resistance that we encountered within the team itself, disguised as pessimism regarding the health network involving CAPS and family health, could not be related to the manifestation of a push that can still be seen towards old asylum models.

Even today, Law 10,216 of 2001, proposed by Paulo Delgado, is considered an unquestionable achievement of mental health workers who, inspired by Franco Basaglia, sought "a society without asylums". However, it is worth highlighting an interesting consideration by this exponent of the anti-asylum struggle regarding the Italian law of 1978, which would inspire the Brazilian one. This is because this law determines the abolition of psychiatric hospitals in Italy, in addition to prohibiting the imposition of compulsory health treatment for those who refuse to seek assistance. Psychiatrist Bruno Orsini, then a congressman and rapporteur of this law, celebrated the 40th anniversary of Law 180/1978 at a congress he attended. Orsini also emphasized that Basaglia had not been very enthusiastic about its enactment. For someone who always sought to "do the impossible," the law (which for the then congressman was the "best possible") meant an invitation to stagnation in the contestation process, potentially causing people to stop fighting for deinstitutionalization, as they believed it was already legally guaranteed (Beteille, 2019). Law 10,216 (2001), as well as its Italian counterpart, were the "best

[3] Congresso internacional CIPRA: uma loucura italiana, realizado na Universidade de Milano-Bicocca (16 e 17 de novembro de 2018).

possible" to be done at that time. However, the fact is that, at least in Brazil, the Paulo Delgado law did not establish itself as a guarantee of deinstitutionalization, as can be seen through the uncritical movement of the hospital technicians in the attempt to institutionalize Reginaldo, opposing his inclusion in the network.

We overcame this resistance with great effort, but we cannot fail to consider that, although the management initially proposed transferring Reginaldo to a sanatorium, they did not impose any major obstacles to our proposal to try to include him in the mental health network. While it is true that there was a certain urgency in resolving the problem of an excessively prolonged hospitalization, we cannot say that there was a particular disposition for hospitalization in this attempt. The aim was to resolve the problem, and that is why the sanatorium was sought.

To justify such a drastic measure, the director insisted that it was no longer a sanatorium, but a clinic with many internal activities for patients. However, only with the argument that these activities take place within the walls of the hospital, so that Reginaldo no longer has contact with the outside world, did he switch to another possible resolution of the case. When the director realized that we had managed to resolve the case favorably, without requiring hospitalization, they recognized that our persistence, in the end, was worth it. It is also worth mentioning that this recognition was because the problem of hospitalization had been resolved. However, we cannot help but bet that some anti-asylum "seed" may have been planted.

As predicted by Franco Basaglia, the clinical management of this case required a great sense of strategy, patience and obstinacy, generating much resistance and making it possible to compare our practice to that of chess players. The institution revealed itself as a curious force field, in which each action generated a reaction in the opposite direction, just as it occurs in a game of chess. Fortunately, we managed to ensure that the "checkmate" was ultimately left to the subject.

Reginaldo and his mother are still being monitored by CAPS today. In the last contact with Vanda, after her son was discharged, she made a point of emphasizing that "the little devil is even walking on his own!"

Furthermore, on his last day in the hospital, Reginaldo was shocked to hear from the doctor that he had knocked on "death's door". We said that "fortunately the door did not open". Reginaldo, therefore, remains alive and well with the mental health network.

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