


Subjectivity modes in psychiatric speech: implications and impact of psychiatric diagnosis on the subject of identity construction


Modos de subjetivação e discurso psiquiátrico: implicação e repercussão do diagnóstico psiquiátrico na construção de identidade do sujeito

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Abstract

This article aims at presenting the results of a study that approached the impact of the psychiatric diagnosis on the modes of subjectivity. It also proposed to demonstrate the relation of the diagnosis and the medicalization process with the repercussion on the individuals' social relationships. Thus, an exploratory qualitative research was conducted, using data from medical records and semi-directed interviews with ten users of a Basic Health Unit with Family Health Strategy in a city of the state of Rio Grande do Sul, Brazil. The main findings were expressed in three axes: subjectivity by the disease, in which the subjects recognize themselves and reproduce a behavior consistent with the imposed diagnosis; medicalization as self-control, which discusses their dependence on medication; and interpersonal relationships after diagnosis, alluding to the change in behavior that the closest people have towards the subject under treatment.

Keywords: Psychiatric Diagnosis; Subjectivity; Medicalization; Identity.

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Resumo

O objetivo do artigo é apresentar os resultados da pesquisa que versou sobre o impacto do diagnóstico psiquiátrico nos modos de subjetivação do sujeito. Também se propõe a demonstrar a relação do diagnóstico com o processo de medicalização e a repercussão sobre as relações sociais dos indivíduos. Desse modo, foi realizada uma pesquisa qualitativa exploratória que se baseou nos dados dos prontuários, bem como em entrevistas semidirigidas realizadas com dez usuários de uma unidade básica de saúde com Estratégia Saúde da Família de uma cidade do interior do Rio Grande do Sul. Os principais achados se expressaram em três eixos: subjetivação pela doença, que traz a ideia de que os sujeitos se reconhecem e reproduzem um comportamento coerente ao diagnóstico imposto; medicalização como controle de si mesmo, que discute a dependência dos sujeitos à medicação; e relações interpessoais após o diagnóstico, que alude à mudança de comportamento que as pessoas mais próximas têm com o indivíduo “doente”.

Palavras-chave: Diagnóstico Psiquiátrico; Subjetividade; Medicalização; Identidade.

Introduction

Throughout the 21st century, medical Science has been pathologizing something intrinsic to the singularity of subjects. A feeling caused by a stressful circumstance became the target for numerous psychiatric diagnoses inside doctors' offices. The hegemonic biomedical model focuses on the illness instead of the individual and, although useful for the medical system, it dismisses the value of the patients' subjective experiences (Remen, 1993).

In addition to the biomedicine discussion, we witness the increase of medicalization as treatment of choice for medical-psychiatric interventions. According to Gonçalves and Ferreira (2008), the intense and unwise prescription of drugs has the purpose of managing most of the psychic problems and creating a conflict-free subject, as a standard of normality. Thus, a dependence on drugs emerges, given that diagnosed subjects believe to be incapable of facing daily life without having their emotions “under control.” In addition, medicalization presents other consequences, such as the chemical and physical dependence caused by long-term use.

Contrary to the referred model, we mention the Psychiatric Reform as a relevant Brazilian political and social movement in the 1970s, which questioned the basic principles of psychiatry and of the hospital-centric model, raising discussion about the rights of psychiatric patients. However, although Reform claims demanded a change in mental health approaches, we still see circumstances in which the psychiatric diagnosis determines the individuals' ways of live and subjectivity (Brasil, 2005; Silva; Brandalise, 2008).

Thus, this work addresses the influence of the psychiatric diagnosis and its medicalization in the construction of subjectivation and social relations, in addition to its effects. The research, qualitative and exploratory, used two procedures for data collection: the first, documentary, based on medical records; and the second, semi-structured interviews, both conducted with users of a Family Health Strategy (FHS) unit located in a city from the Rio Grande do Sul state, in Brazil.

We studied a theoretical framework concerning biopower and its relation to the biomedical model. Our goal is to reflect on biopower while a dispositive for controlling life, in a sense that, after receiving the diagnosis and the prescription, patients' self-comprehension changes. Lastly, we present the results, a discussion about the interviews, and the final considerations.

Biopower

The biopower concept, proposed by Foucault (1994, p. 145), alludes to the construction of a model of centralization and domination of life, called "somatocracy" by the author. Foucault (1976) argued that we live under a regime in which the state intervention also comprises body and health cares. Thus, medical intervention subjects life to the state attention. The following quote states it:

From the 18th century onward, medicine never quit addressing what is unrelated, that is, what fails to connect to the different aspects of ill and the illnesses; attributing the medicalization of medicine, of society, and of the population to four processes connected to the expansion of the medical knowledge. These are the emergence of the medical-political authority, the instauration of the state medicine and of the medical police; the expansion of the medicine domains beyond the ill and the illness; the medicalization of hospital and, lastly, the constitution of mechanisms for medical management, data record, collection, and comparison of statistics etc. (Foucault, 1976, p. 50)

In first instance, medicine would have emerged in Germany, articulated to a state knowledge in questions configuring statistics about natural resources, the functioning of the state political machine, making the population health an object of concern and evaluation. Johann Peter Frank introduces the medical police who, between 1779 and 1790, published five volumes that would turn into the first public health treat, whose propositions embraced a project while

"organization of a state medical knowledge, of normalization of the medical profession [...] and integration of doctors into a state medical organization" (Foucault, 1977, p. 214).

With the emergence of urban medicine, the urban structured changed, turning the big cities into production centers, favoring the growth of the poor and blue-collar population. A homogenous and coherent regulation mechanism turned then mandatory. The leper exclusion and the pest quarantine systems emerge from this second process, in which the medicine political power divided the city into sector and subsectors, surveilling and controlling everything and everyone (Martins; Peixoto Junior, 2009).

The third step, which characterized the expansion of the medical knowledge, was the construction of the general hospital (Foucault, 1977). In early century years, it worked concomitantly as an institution of exclusion and assistance. In there, the mentally ill, ill, prostitutes, and all sorts of outsiders mingled, subjected to the therapeutic curative tools. This is the fourth movement in the expansion of medical knowledge that, articulated to other movements, especially statistics, constituted mechanisms for recording and comparing data about health, illness, and the quality of life of population.

Biopower, according to Foucault (1994), is a strategy for regulating/governing a population, organizing and controlling life. A care regulating not only the individuals' bodies and what they produce, but birth, mortality, and longevity of populations instead (Cardoso, 2005). The biopower became part of a technology with two vertices, which led modern state to: (1) assume the administration of bodies - anatomo-politics -; and (2) the administration of life and populations - biopolitics. In this context, biopower expresses itself as a technology of power enabling control over entire populations, mainly over the protection of life, regulation of the body, and over the creation of other technologies while political concerns (Foucault, 1978).

This power comes from a thought that uses means of correcting and transforming individuals, determining ways of life and behaviors

while, within society, introduces a distinction between normal and pathologic. This power eventually imposes a system of normalization of existence, work, and feeling (Foucault, 1978). Thus, by analyzing the effects of attributing a diagnosis to a person, we observe the agency of biopower ruling subjectivity and its ways of acting.

Next, we will approach the biomedical model, a tool for ruling life and bodies - the biopower. Medicine is, among other attributions, a tool for social and individual regulation.

Biomedical model

Biomedicine is seen as a knowledge of the biological dimension of human beings. According to Moraes (2012), in the 19th century, medicine starts producing a discourse about the relation health/illness, establishing new cause and effect relations, leading to the objectification of analysis and objectification of patients. It conceives the body as a machine, since it presents a fragmented view of the individual, evidencing only part of it, rather than the whole. Because it is a scientific knowledge, the subjects accept the diagnosis and make it a part of their identity, behaving accordingly to the assigned classification. This shows the valorization of specialization applied to the body, in addition to the dismissal of the value of subjective experiences and biographies of patients.

Dantas (2009) argues that the biomedical stand restrains both the comprehension about health and illness as components of the same process, and the sensitivity of perceiving the positive resources of the patients that could help in their recovery. Thus, for the most part, the decision-making process of diagnosis targets only the denomination of a pathology matching presented symptoms. Since the biomedical model grounds the formation of many health professionals, their perceptions may turn exclusively towards aspects recognized as inadequate in the patient behavior.

Opposing the biomedical model, we may argue that the absence of illnesses alone does not constitute health. The relation between health and

illness goes further than the internal boundaries within the organism, involving also social, environmental aspects, and individual biological characteristics. The Psychiatric Reform proposes a different stand for mental health, which we will discuss next.

The Psychiatric Reform: a new contextualization of madness

Madness, throughout history, had several concepts. According to Vecchi (2004, p. 490), “with the notion of mental illness, madness was reduced to (and still is) to compositions, syndromes, and diagnosis based on the negative aspects of the structure, such as alienation, incomprehensibility, dangerousness, and incapacity.” The possibility of categorizing the “illness” in labels, measurements, manuals, and codes for mental disorders occurs because of a medical-scientific approach. The clinical practices conducted in the asylums and psychiatric hospitals had their basis on the idea of madness as a synonym for incapacity and unproductivity. These perceptions, however, changed across time and suffered resignifications. In this context, the Psychiatric Reform, as a political and social movement, claims the deconstruction of the guardianship and objectification relations sustained by the psychiatric knowledge, questioning the methods adopted in the care rendered to the mentally ill. The movement advocated for the social reinsertion of the mentally ill individual, a proposition opposed to the asylum model. The Reform also reviewed the therapeutic practices then employed, going beyond a mere institutional deflation (Gonçalves Neto; Senna, 2001).

The Brazilian Psychiatric Reform and the Mental Health Law sought deinstitutionalization, social inclusion, and the offer of a psychosocial care network that overcomes and replaces psychiatric hospitals. These movements center on the users, while legal subjects and subjects of desire, singular citizens leading their ways of constructing their own lives (Brasil, 2001). In face of the challenges imposed by the movement, such as the perception of the “insane” beyond the incapacity stereotype, there is the assurance of their reintegration,

in accordance to the human rights. This means an attainment on the citizenship rights of psychiatric patients, in addition to imposing changes in the functioning of treatments in Brazil (Ramminger, 2002). However, the movement could not entirely change the conceptions about madness. Even with the advent of the Reform, another form of contention emerged, such as the increasingly consumption of drugs.

Medicalization of life

New neurochemical comprehensions of the psychic phenomena and pathologies emerge daily, and the pharmaceutical industry is willing to solve them with drugs. According to Luz (1988), medicalization is the process of appropriating human life through medicine, interfering in the construction of concepts, hygiene habits, moral norms, costumes, and social behaviors through the prescription and dissemination of psychotropic drugs. The concept is not a simple definition, given it refers to complex processes in the ethical, social, cultural, and economic spheres. Thus, medicalization has as its core goal the political intervention in the social body. According to Illich (1975, p. 10),

Three reasons make medicalization of life harmful: first, technical intervention in the organism, above a certain level, removes from patients characteristics commonly associated to the word *health*; second, the required organization to sustain this intervention turns into the sanitary mask of a destructive society. Lastly, the biomedical apparatus of the industrial system, when taking charge of the individual, removes all the citizen power to politically control such system. Medicine turns into a repair shop, targeted at keeping the worn individuals functioning as a non-human product. The individual has to request the consumption of medicine to continue one's exploration.

It is unarguable that the biomarket, by stimulating the drugs development by

pharmaceutical industries, aroused the capitalist interests, turning medicalization into a common act in the medical practice. In addition, the construction of symptoms and disorders for the renovation of diagnostic methods favors the creation of new drugs (Blank; Brauner, 2009; Hacking, 2013). These aspects transform users of healthcare services into consumers of the pharmaceutical sector when they seek into drugs the solution to their "problems." Thus, medicalization and psycho-pharmacolization become equivalent and feed off each other.

The abusive use of medicines seems to be one of the traits of Western culture, in which the prevalent conviction is that, whatever the suffering is, it has to be abolished at any costs. Because of it, the medicalization of life is becoming one of the most efficient ways for alleviating the psychic suffering hitting us on a daily basis (Dantas, 2009). This process dismisses what is at stake, valuing what is effective instead, which makes the biomedical model accurate in obtaining the alleged "cure." We see the construction of a device (biopower) strongly carried out by biomedicine to shape subjectivity (Foucault, 1976).

Production of subjectivities/modes of subjectivation

For better comprehending the subjectivation modes, we start by the notion of subjectivity: "[it] is not passible of totalization or centralization in the individual" (Guattari; Rolnik, 1986, p. 31). Subjectivity implicates an incessant production of effects, shaped after the encounters we experience with the other. We do not understand the production of subjectivities as a pre-conceived concept, given its continuous social process. Based on this perspective, multiple manners are available for one to subject throughout history, in which the individual may fix, maintain, or transform one's identity (Foucault, 1977).

When studying the modes of existence of the subjects, Foucault (1985, 1988) reclaims the "care of the self" practices from the Greek, then limited to a small parcel of the population,

which concerned a way of life consisting of free choices, in accordance to one's desire. However, to analyze modes of subjectivity, the author resorts to the studies about stoicism, which refers to a rupture, in a way, to the Greek "care of the self." Stoicism imposed an obligation to the subjectivity of individuals, causing a behavior based on moral judgement, targeted at controlling the subjects. Investigations on the matter had Foucault to theoretically analyze the disciplinary society and the biopolitical intervention on the bodies of the individuals of and the population, in addition to, concomitantly, enable comprehension about the constitution and dissemination of modes of subjectivity throughout history. Thus, every experience that concretizes a subjectivity involves historically peculiar modes of making the experience of one self. Foucault (1985, 1988) had a concern related to the exposure of the eminent and contingent determination of our current modes of subjectivity, in addition to the possibility of constructing new processes, in an aesthetics of existence.

Considering that subjectivity modes leave marks in the psychic level, they relate to the identity standards present in the relations between subjects, according to the normative rules in each period. Thus, different subjectivities constituted by desubjectivation practices consonant with current capitalism, favoring the rise of the "consumer subject." Guattari e Rolnik (1986), argue that the social forces ruling modern capitalist understood, long ago, that the production of subjectivities is as important as the material production of consumer goods. Figuring in these consumer goods are medicines and their "miraculous" effects in lives, broadly communicated through pharmaceutical marketing. Thus, the modes of subjectivity present in the daily life reflect in the medicalization process given that, for being seen as "normal," the subject has to adjust to what is socially prescribed. From this, we apprehend the effect of the diagnosis and, consequently, of the medicalization in the subjects with a mental disorder. Next, we present the empirical results of the discussion about this effect.

Results and discussion

We analyzed the diagnoses in the medical records, preceding an interview with ten users of a Primary Care Unit (PCU) with FHS in a city in the Rio Grande do Sul state. The PCU are locations rendering healthcare services to the population of a certain territory, while the FHS refers to a team of community health workers who visit households. We performed field research for one year. Participants consisted of two males and eight females, aged 20-71 years. They presented a various educational levels, ranging from incomplete primary education to completed vocational education. Medical records indicated the following diagnoses: depression, anxiety disorder in combination to bipolar disorder, schizophrenia, intellectual disability, and intellectual deficiency. The beginning of clinical history varied among participants, varying from 15 to 50 years of age. The Ethics Research Committee approved the research project. For the results, we constructed three axes of analysis.

Subjectivation through the illness

The "subjectivation through the illness" axis shows how individuals constituted themselves post the psychiatric diagnostic. Before receiving a name for their pathology, they go through a long process of medicalization, both social and individual, consolidated in receiving the diagnosis. At this point, interviewees find an identity in the mental illness and take comfort in the explanation of their symptoms. This is clear in the following responses, given when we asked them whether they agreed to the diagnosis given by the medical doctor: *I agree to the diagnosis, it made me stand on my feet again. I feel calmer, more relaxed* (F.D.); *I have always suffered from anxiety, since I was 16 years old. I had suicidal thoughts. It was something that crossed my mind, although I did not associate it to a pathology* (A.W.); *Yes, I agree. I am supposed to agree, right?* (A.G.).

These excerpts show that the subjects incorporate and accept the diagnosis. Classification

produces effects in the ways of life, emerging in connection to the social processes, and to the contexts in which these individuals are. There we see the malleability of subjectivity reconstructed through the assigned classification (Foucault, 1984). Complementing the discussion, we observe from the fragments below how some participants felt or perceived themselves after learning the diagnoses: *I am able now to control myself; I have now a motivation for not plunging into depression again. I do have a disorder, sometimes I am happy, sometimes I cry, but thank God I am calm now* (M.); *Thank God I am happy now* (L.); *I am calmer, more relaxed* (F.D.); *I am way relaxed now, you know* (A.W.).

The quotes refer to the “tragedy”¹ of the contemporary subjectivity idea, characterized in four acts. These acts start with the patients not feeling well and seeking for a professional to be heard/cared. The sequence goes on with the decoding of the complaint into some nosological category. The third act takes place when, after examining the symptoms, the patients receive a diagnosis and medication to return to their normal state, of healthiness. Unfortunately, the subjects do not realize the power game in place. The subjects no longer recognize their selves anymore, nor do they know what they want, and are eventually “enslaved by the object of desire, by the images associated to the products questioning their emotions and imagination and cannot even see the domination to which they are submitted to, or what they really are” (Coelho, 2012, p. 59).

Thus, when contacting a medical doctor, the patients do not recognize themselves as “normal” and trust that the professional, owner of the scientific knowledge, has an answer. The medical doctor, when classifying the symptoms, exercises a disciplinary control over the patients. Patients believe not to hold the power of knowledge, in addition to being tired of feeling “uneasy.” Because of the perception they have of themselves and of their social contexts, they

accept the professional knowledge, subjecting themselves to the drug treatment, and believing that the drug will reinstate the lost “normality,” along with the hope of resolving their problems that often reveal a circumstance of hardships and suffering.

Throughout the process, the patients no longer belong to themselves and their lives are then following the rules dictated by others, just reproducing a behavior that they believe to be compatible to their diagnoses. Likewise, the patients resignify their values and themselves, according to the diagnosis and the prescribed drugs. The statements show the relation of some participants to the drug process that, sometimes, crosses several years of their lives: *I am on drugs for a long time now, since I was 16. I have bipolar disorder, depression, listen to voices and see, although I do not know the name of it, the doctor had not said it. My mother is the one who can explain you this* (M.); *I was on a drug, but then he gave me two more antidepressants. Eventually, it would not work for me anymore, but I still have to take it. I do not want it, but I have to* (A.G.); *He [the doctor] referred me and gave me these drugs, see? I was on many of these controlled substances; I was on it for a long time* (A.W.); *For a while I was on drugs for feeling better. I got better, I tell you this* (J.H.).

The excerpts above show that, using drugs, individuals naturally feel an improvement in the symptoms of their pathology. We see, in the entirety of interviews, that no critical questions, explanations concerning the use of drugs or their side effects, appear. We may infer that, by finding the doctor and receiving drug treatment, the subjects find a true knowledge, adequate to their “problem.” The next thematic axis also discusses medicalization and the control of symptoms.

Medicalization as control of oneself

This axis approaches the medication associated to cure and control of symptoms. For the participants, drugs constitute the very

1 Coelho (2012) uses the term “tragedy” to characterize the dramatization of the subjectivation of a patient with a diagnosis.

own condition for living, given that it allows for “normality” in the social environment, by preventing the onset of certain improper behaviors. Statements by some participants unveil an intrinsic connection between their mental health and the use of medication: *I cannot do anything without meds, I depend heavily on them* (F.D.); *I am afraid of feeling again the anger and sadness I felt before. Sometimes I think of not taking the meds. But I need them* (M.A.); *I am never off meds. If I do, all I can do is cry. I cry on the bus. It is embarrassing but I cannot help* (A.); *I could not control the illness without the meds. When I go to bed and cannot fall asleep, I go for the med* (F.D.).

The use of medication turns into a common practice for individuals diagnosed with a “mental illness,” being also impossible for them to adjust to the social context without drugs. One of the causes of this medicalization process has its roots in the premises of the ideal health concept, spread by the medical industry, in which any sign of abnormality demands correction. Menezes (2002) emphasizes that, in a society permeated by biopower, the biomedical model rules the care of the self, establishing ideal ways of life. Consequently, medicalization constitutes a strategy of biopolitics, turning into a dispositive for desubjectivation, since suffering is no longer an object for reflection and production of new forms of being (Ignácio; Nardi, 2007).

Thus, by noticing that feelings of sadness or anger, expected in a circumstance of loss or grief, are relieved by medication, the user adopts a life style in which the drug controls these emotions. This makes them dependent on the medication to relieve symptoms identified as excessive or even “abnormal.” The following statements express this matter: *I was off meds for a couple of days. I got worse. I had to get back taking them. Then I went to see the doctor and he told me: “Who told you to stop taking it?” I cannot stop taking them; I need to continuously take it* (M.A.); *Doctor said I could not stop taking these meds, I know one of them was risperidone, I no longer remember the other* (L.); *Had I not been [on meds], lady, I would not be around anymore. All sorts*

of things cross my mind: jumping off a bridge, wandering the streets on my own (M.); *I do not ever go off meds. If I do, I start it all over again. I almost go crazy, pacing around, and all I can do is cry* (A.).

As seen, the purpose of a psychiatric treatment turns into the drug prescription through the clinical diagnosis. Then, by taking the medication and trying to resolve a problem, patients expect the medication to achieve what they could not/had no knowledge to do. In this sense, a dependence sets in. It is both psychologic, since the patients no longer recognize themselves without the medication, and physical, because, as soon as the patients stop using it, the inconvenient symptoms return. Moreover, we notice a life control exercised by the medicalization process, which includes the medical professional and the use of the psychotropic itself (Ignácio; Nardi, 2007). This discipline of bodies in an individual manner (through the medicalization) restrains the possibilities of subject autonomy and, in addition, the possibility of resorting to other treatment strategies beyond drug prescription. The individuals cease to be the leading actors in their histories and move on to being supporting actors, observing the action of medication over themselves.

Consequently, the individuals find themselves surrounded by a net of powers, in which the medical class constructs the concepts of health, illness, normal, and abnormal, establishing standards. In this perspective, the subjects who do not see themselves fitting the established standards seek, through the “magic pills,” an adjustment that turns them into something/someone accepted by society.

Post-diagnosis interpersonal relations

In this axis, we approach how others see the subjects, in interpersonal relationships (family, neighbors, and acquaintances) post the psychiatric diagnosis. We consider that social relations construct the comprehension of the subjects about themselves and about the subjectivation processes, produced through

the regimes of truth and models in each time (Guareschi; Hüning, 2005). Thus, although the Psychiatric Reform proposed a new perspective of mental illness, people in their daily lives still have the idea that madness means abnormality. The connotation of mental illness, to this day, is full of stigmas and biases. These aspects are present in the statements of some interviewees, when questioned about the attitude of the family and close persons who learned about their diagnoses:

I pretend to know nothing about this illness of mine so that I won't complicate their lives. For them not to be concerned, not to go to work thinking of me, I like leaving them relaxed, I go through my thing and keep quiet. Things have changed with the neighbors. Before, it was more relaxed, and now, I mind my business, they mind theirs. There are insincere people who think I am faking it and then started to treat me differently. (F.D.)

When I explained her that names would not be disclosed, she said: "You may disclose it, everyone calls me crazy already". (M.)

As usual, you know!!! Acting up, "that lady is crazy". "Crippled, it is ridiculous", but I do not mind. (L.)

From these accounts given by interviewees, we see that their relationships change according to treatment they receive, after the diagnosis. This causes the subjects, who present a distinct behavior, to become a target for criticism and rejection. According to Coelho (2012), society has codes of ethics and conduct, which, through education and socialization, permeate the minds of individuals and regulate them. The life of the individual changes in social terms, because people cease to have a relationship to a human being and start to interact with a diagnosis. The research by Silva and Brandalise (2008) shows it, through a negative change in the interpersonal relationships of the psychiatric patient. The study shows bias, and discredits circumstances, and a reduction in the attributes of patients in face of the diagnosis.

Some users, however, report positive changes in the treatment they receive after the diagnosis. Some of them even mention a greater care from those closest to them: *My family supports me* (F.); *My family understood me a little more, they are supportive. Neighbors treat me like they did before, the usual* (M.); *All is good in my family. They help me and the so* (R.); *They started to treat me more carefully* (A.W.). These accounts show that, when the people in the relationship network understand the situation of the patients, they start to offer them support and solidarity. This circumstance may indicate that family and friends also take comfort in the biomedical explanation of presented symptoms. However, these people may reduce the patients' attributes to their diagnoses, and to the need of medication, depriving them from possibilities of autonomy outside this context.

Final remarks

Resulting from the deinstitutionalization process caused by the Psychiatric Reform, we see that mental health is under new forms of control, through the practice of a psychiatry still based on biomedicine, in parallel with an increasingly medicalization process. The accounts from interviewees indicate the production of new modes of subjectivation after receiving the psychiatric diagnosis. This happens so the subjects diagnosed with any disorder are "adequate" to the norms and standards established through the influence of medical culture.

Based on our data, we conclude that psychiatric diagnosis is turning into a device for categorizing human suffering. This interferes in the modes with which the subjects produce themselves and relate to others, in addition to being a form of control and standardization of individuals, through the medicalization of life. This causes the subjects to be dependent on the biomedical knowledge and on the drugs, to forsake autonomy for ruling their own lives. We hope that these reflections stimulate new studies producing the denaturalization of the psychiatric diagnostic culture and the stimulus to the use of medications.

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Authors' contribution

Both authors conceived, outlined the project, and conducted the research project, publicly assuming responsibility for the manuscript. Reuter collected data and wrote the article. Freitas critically reviewed and finalized the manuscript, and approved the version for publication.

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