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The dynamic of intersected social categories in social interactions in a Brazilian psychosocial care center

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Abstract

The Brazilian Psychiatric Reform advocates non-asylum treatment for individuals diagnosed with severe or persistent mental disorders, which is conducted mainly by Psychosocial Care Centers. This study aims to understand the role of intersected social categories in social interactions among social actors in those institutions. This qualitative ethnographic research uses the technique of participant observation. For the theoretical framework, intersectionality theory was chosen, in combination with the concept of intersectional stigma to reflect on intersectional discrimination. Erving Goffman´s works are also used to evaluate how social categories are socially situated. In addition to power relations between staff members and patients, the study examined the intersection of social categories, including how the social actors involved tend to notice their oppressions, but not their privileges, that is, the oppressions of others. The researcher argues therefore that, within that institution, the intersected social categories influence the dynamic of social interactions and generate an even more unjust experience for the patients in the institution in question.

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Introduction

Brazil, like many other countries, underwent a psychiatric reform in response to an anti-asylum movement. The Brazilian psychiatric reform advocates non-asylum treatment for individuals diagnosed with severe or persistent mental disorders, which is conducted mainly by Psychosocial Care Centres. This service replaces hospitalization in psychiatric hospitals. Its official objective is to create a therapeutic project for each patient.[1,2]

This article, which is based on a qualitative ethnographic methodology,[3] focuses on the social interactions between social actors (staff and patients) in a Brazilian psychosocial care center, using participant observation.[4] The conceptual framework is based mainly on intersectionality theory[5,6] and the concept of intersectional stigma.[7,8] The aim of this research is to understand the role of intersected social categories in social interactions in that institution.

Literature review

International research concerning mental health and intersectionality indicates the existence of intersectional stigma, that is, when multiple stigmatized identities converge.[7] Thus, inter-

sectional invisibility, tends to intensify unfair treatment.[8] Even if rarely used in health studies, intersectionality theory has sometimes been employed in public health interventions to analyze their effects and to support the design of such interventions. In research, some social categories (such as ethnicity, gender, and social class) are more present while others (such as sexuality and physical disability) are less present.[9]

Recent Brazilian studies on mental health in general and specifically on the Psychosocial Care Centers show little analysis of the patients' experience in general and, specifically, of how differences in social categories influence their experience. For example, race is not often considered in analysis even though racial inequalities persist in society.[10] However, some studies have focused on the analysis of different social categories, such as race and gender. They emphasize how patients' experiences are affected by these social categories and highlight the importance of decolonial thinking to promote social transformation. In this sense, the defense of psychosocial treatments that add to people's suffering through psychosocial practices could be considered an act of violence in terms of social inequalities.[11] Furthermore, analysis of intersected social categories in the health field demonstrates the importance of diagnosis as a social marker of difference. In fact, the social construction of normality concerning mental health and, consequently, the choice of psychosocial treatments is based on the diagnosis of patients. In this sense, the categorization resulting from the diagnosis further complicates their experience, especially when this experience is viewed from a biomedical standpoint without considering the impact of social dimensions.[12]

Psychosocial Care Centers have been mainly studied with respect to the psychosocial treatments made available (medication, group therapy, and other activities),[13,14] but some studies have also focused on the participation of patients in terms of their autonomy[15] and in relation to the anti-asylum discourse produced.[16]

However, even though research on mental health institutions has advanced on several fronts, numerous questions remain unanswered. Many aspects of the practical functioning of these spaces and the possible effects of this new institutional framework still need to be researched in greater detail, especially with regard to the role of intersected social categories in social interactions.

Theoretical framework

Intersectionality theory takes into consideration the intersection of social categories (e.g., race, gender, and social class, etc.), which can lead to intersected oppressions and intersected privileges. In fact, this theory analyzes how intersecting power relations can influence social relations.[5-6] Social categories, which are socially constructed, are understood to be interdependent by intersectionality theory and they shape each other in several possible combinations, as in a crossroad, resulting in intersecting oppressions and privileges.[5] Thus, intersectionality allows the analysis of how social categories position people differently in the world.[5-6] However, it should be noted that individuals respond to oppressions in different ways, including by resistance.[17]

The term "intersectionality" was coined by Kimberlé Crenshaw, a scholar who identified herself as a black feminist. This theory was born from the need to understand the specific oppressions experienced by black women, that is, the specificity of the unequal reality experienced by black women, a reality different from that of black men and of white women. It involves oppression at the intersection of more than one social category (race and gender).[5] Although nowadays intersectionality theory is used to understand people's reality according to differ-

ent combinations of intersections of social categories, the importance of race in this analysis should be noted considering the whitewashing of this theory in some recent research.[18]

The following characteristics of intersectionality theory should be taken in consideration: 1) it aims to examine oppression at the individual (microsocial) and structural (macrosocial) levels; 2) in addition to being a theory, it is also focused on praxis and the advancement of social justice; 3) it understands identities as being multiple, interdependent and mutually constitutive, that is, one type of oppression is neither hierarchical nor simply added to another; 4) it can be defined in different ways and is always evolving; 5) it offers a critical analysis of the connection between multiple social identities and power structures.[5,6,19] Thus, the identity of an individual needs to be considered in an intersectional way on three different levels: the individual (linked to social interactions), the community (linked to institutions) and public policies (linked to social structures).[20]

The role of social categories, according to Erving Goffman's theoretical perspective on social interactions, must also be taken into consideration. According to Goffman, social categories (e.g., gender, social class, etc.) are socially situated[21] and expectations exist, in terms of ceremonial rules (conduct, dress, attitude), as part of deference and demeanor in the interaction rituals.[22] In order to respond to expectations associated with social roles, markers of belonging to specific categories can be employed, that is, the display of social categories (e.g., gender or social class, etc.). In fact, responding to social expectations in interactions is necessary to build trust among individuals, that is, the alignment of the presentation of the self of an individual and the expectations of society. In this sense, the hyper-ritualization of social categories can be used to reinforce an expectation. For example, a psychiatrist should behave and look like a psychiatrist (e.g., clothing, etc.) in order to be recognized in the intended social role by society.[23]

The presentation of the self also relates to the existence of stigma (which can be known or visible or can be unknown or non-visible), which needs to be managed in social interactions. In the case of unknown or non-visible stigma (e.g. sexuality), the information in social interactions must be managed and, in the case of known or visible stigma (e.g. gender), the tension in social interactions must also be managed.[24] Specifically, the concept of intersectional stigma highlights the convergence of multiple stigmatized identities relating to an individual or a group to understand its effects. Considering that the different types of stigma are interdependent, the intersection of stigmas can generate inequalities also in an intersected manner.[7] In fact, when considering multi-stigmatized individuals or groups, intersectional invisibility needs to be examined because cases of multiple stigmas have different effects than those in which only one type of stigma is involved.[8] However, stigmatized individuals and groups can resist and implement strategies to react to the experience of (intersectional) stigma.[7]

Material and methods

This qualitative research used an ethnographic methodology[3] and, more specifically, the technique of participant observation to collect data.[4] A field notebook was used throughout the research to record the data collected.[25] Consistent with the technique chosen, the analysis of the data focused specifically on the definition of the situation by the social actors involved in social interactions within the institution.[26]

Ethnography is a type of qualitative research which involves immersion in a given community to understand its members' social interactions. The goal is to provide descriptions with sufficient

information to enable those outside the community to fully understand the reality being studied.[27] The technique of participant observation consists of following as closely and systematically as possible the daily context of the social situation studied. It involves following the daily activities of the group in question without relying on previously standardized parameters, as is expected in the context of ethnographic research.[3] The observer must pay particular attention to issues considered by the group or institution studied as being conflicts or problems.[28] In fact, it is important to observe the norms of decorum, that is, the way that the social actors behave when they are on "stage", when they are aware that other people are watching them, even if they are not involved in conversation with other people.[26] As for my posture in the research field during the observations of the social interactions, I tried to be discreet regarding verbal and non-verbal language (e.g., to talk using a low tone of voice, to smile and observe without starting a conversation, but when openings arose, to listen more than talk etc.).

The institution researched treats exclusively adults and is located in the city of São Paulo in Brazil. It currently receives about 300 patients, approximately 50 during the daytime, because the frequency of presence of each individual varies according to the indication of treatment for each case. The unit studied is staffed by about 50 professionals of various specialties (e.g., psychiatrist, nurses, occupational therapists, etc.), with around 15 technicians per shift. In addition, patients may be present in the institution at night and on weekends when the staff deems it necessary. There-fore, the greatest number of patients is concentrated during the daytime from Monday to Fri-day and, consequently, also the number of staff members present during this period is larger. Finally, it should be noted that the researcher spent around 6 hours per week for two years in the institution (from 2014 to 2016).

In terms of research ethics, the study was approved by the Ministry of Health of the government of Brazil. To guarantee the anonymity of participants, only the first letter of their first name is presented when sharing excerpts of the field notebook in the section on the results of the research. Furthermore, since it is an ethnographic study, the researcher did not apply a sociodemographic questionnaire to learn about individuals' self-identification, but their different attributes became evident through self-identification and the categorizations established during social interactions in the institution (e.g., the use of certain personal pronouns indicating gender identification).

Moreover, as indicated in the process of collection and analysis of research data based on an interpretative-critical perspective, the position of the researcher was taken into account. It is important to bear in mind that researchers have their own ideologies and make interpretations when carrying out research.[29] Thus, to conduct an exercise in self-reflexivity, researchers must identify the impact of their privileges and oppressions on the construction of their research. This exercise includes an examination of all stages of the research (from research design to dissemination of the results).[17,30] When conducting research, it is essential to think and act ethically about the following subjects: Who can study whom, and how? Who profits from the research? Are the results of the research considered valid?[29] Thus, as an exercise of self-reflexivity, it is relevant to note that I am a Brazilian woman who comes from a low socio-economic and educational background. In addition, I have never worked in or received treatment at a Psychosocial Care Center, but a member of my family received treatment for a period at a Psychosocial Care Center.

Concerning the analysis of the observations, the definition of the situation was taken into consideration, that is, the analysis of the understanding of social interactions by participating

social actors. According to Goffman,[26] social actors have a facade, that is, expressive equipment used intentionally or unintentionally during their performance (e.g., social position, gender, etc.) and this facade aims to define the situation for observers of the performance. In general, social actors who are part of a social situation seek to define that situation in order to know how to act and react. This definition tends to be provided by society and is not created by social actors, although they can negotiate certain aspects. Social actors in each other's presence look for signals that offer information about the other individual and, at the same time, seek to manage the signals they give, consciously or unconsciously, regarding their performance (impression management).[26] Thus, the definition of the situation is an analysis of how participants try to understand what is happening during social interactions and how they adapt their behaviors, based on the signals sent and received by those present.[26]

Results

In terms of the results of this research, it should first be emphasized that the categorization (and consequently self-identification) resulting from the mental health diagnosis was the main category present in all the social interactions observed. This makes sense considering that the analysis was performed in a psychosocial care center. It should also be noted that the patients observed in this institution refer to this categorization (and consequently self-identification) by different terms, such as: "crazy", "mentally ill", "sick", among others. However, they also resignify these terms, that is, they assign new meanings to terms considered as being socially pejorative. For example, they would sometimes refer to songs that talk about mental health (and mental illness), directly or indirectly, and then refer to the terms mentioned, notably "crazy". In these songs, being "crazy" is presented as a positive trait, for example, as being open-minded. In fact, they emphasize how there had to be something "wrong" with those who were not "crazy". Thus, they use art to process their feelings and their categorization and self-identification in relation to the subject.

In the interpretation of the data, apart from the mental health diagnosis, four social categories (gender, age, social class, and sexuality) were considered in an intersectional way. However, some social categories seemed more prominent than others in specific situations. In addition, it needs to be emphasized that race was not a major element during the social interactions observed, probably because both staff members and patients seemed to share a racial background of mixed ethnicity. The researcher also noticed, through inductive analysis, two relevant themes connected to these social categories: the existence of power relations (between staff members and patients) and the fact that social actors seemed to be aware of their oppressions, but not of their privileges, nor of the oppressions of others. Therefore, the presentation of the data is divided in three topics: 1) power relations between staff members and patients; 2) intersection of the social categories of gender, age, sexuality, and social class; 3) unawareness of the oppressions of others.

Power relations between staff members and patients

During the social interactions observed in the institution, staff members did not often seem to take patients seriously. For example: "B asked her psychiatrist: 'Help me, my head is empty. Is there a medicine for an empty head?' He replied: 'No, it's just that you think a lot, your head is resting'. She then left without saying anything." (Field notebook notes) Thus, this example shows how a patient asked for assistance, did not get the expected help, and left in silence. It should be noted that B is a female patient from a low social economic background and that

her doctor is a male psychiatrist from a higher socioeconomic background. Thus, through an intersectional lens, one can perceive the stereotype of the male doctor suggesting that women "think a lot" and how he disregarded her experience, which can often happen to mental health patients as well as to patients from low socioeconomic backgrounds. Moreover, some patients seemed to get excessively attached to staff members in their social relationship: "During the meeting, B told A [a staff member] that she loves her, and A responded by telling her to pay attention to the meeting." (Field notebook notes) Once again, the response from the staff member was probably not what the patient expected, though it was understandable considering the patient-staff relationship.

Patients also seemed to be considered untrustworthy in the opinion of staff members. For example, a patient shares the distrust she encountered when she asked some staff members for adhesive tape to help me (the researcher) hang papers on a mural in the institution: "After a while she came back with the tape but complaining. She said they questioned her several times before giving her the tape." (Field notebook notes) It is noticeable then how a simple item such as a roll of adhesive tape is cause for suspicion.

Finally, the posture of staff members seemed to influence their social interactions with patients because of existing power relations. Apart from the examples already mentioned which clearly show a boundary between patients and staff members in terms of hierarchical power, the attention of the researcher was attracted to the posture of staff members when talking to patients during meetings in the institution: "The body posture (erect), the tone of voice (firm, loud), and the choice of words (vocabulary indicating higher education) seem to influence social interactions. In fact, after receiving suggestions from the staff, patients changed their minds and agreed with them." (Field notebook notes) In this case, it is noticeable how, through "suggestions", the staff members managed to steer the meeting in the direction that they believed it should go, since patients followed their "suggestions".

Intersection of the social categories of gender, age, sexuality, and social class

The social categories observed (gender, age, sexuality, and social class) intersected, but some of them occupy more space than others during certain social interactions. In terms of gender, a noticeable difference in treatment and behavior occurred between male and female patients. In fact, the behavior of male patients tended to be judged as violent. For example: "F described his previous stay in an 'asylum'. He said that when he got angry, he threw a tray of food at the wall and, because of that, he was put in a straitjacket." (Field notebook notes) In contrast, female patients were expected to control themselves and tended not to be considered as violent by staff members. For example: "She [a staff member] said that R 'screams and swears', but is not physically violent, she said she 'softens when people get close'." (Field notebook notes) In this case, it is important to emphasize the use of the verb "soften" to refer to this patient's behavior. This example shows how stereotypes of gender are reproduced (e.g. men are violent, and women are "soft"), but also how gender intersects with the social category of mental health disability since these gender stereotypes influence how staff members treat the patients.

Gender also seemed to play a role in romantic or sexual advances between patients and from patients directed to staff members, that is, some patients seemed to desire to become closer to some staff members that they found attractive. One example of the dynamics between patients is a young woman (the issue of age often seemed to mix with the issue of gender)

who frequently received invitations (or even advances) from male peers (including some who were much older than her). For example: "He asked B if he could kiss her (he looked much older than her), she said no and told him to leave." (Field notebook notes) Continuing the same interaction, he looked at me (the researcher) and said: "she is beautiful and intelligent, but look at her clothes, they are all dirty, she always wears the same clothes." (Field notebook notes) In the case of this excerpt, the reference to her clothes stands out and can be connected to the issue of social class, in addition to social expectations about how women should dress. Moreover, since this interaction happened inside a psychosocial institution (the individuals in question are patients who receive daily treatment in the institution), B has to repeatedly manage this situation. This example shows how the social categories of gender, age, social class, and mental health disability intersect. The patient in question needs to manage all of them at the same time.

In terms of sexuality, the sexuality of some patients and staff members seemed to be questioned because it did not meet the expectation of heteronormativity. Particularly noteworthy is the case of the patient who, when his requests were denied by a psychiatrist, used to make comments that called into question the psychiatrist's sexuality, as if this were an offense. For example, this psychiatrist once said to a co-worker: "I can't take this anymore. When he is dissatisfied with my answer, he makes comments about my sexuality." (Field notebook notes). This case demonstrates how two different social categories intersect in terms of oppressions and privileges. On one hand, the psychiatrist is oppressed in terms of his perceived sexuality, but is privileged in terms of his social role as a psychiatrist and his "normal" status concerning mental health standards in society. On the other hand, the patient is oppressed in terms of the social category of mental health disability, but is privileged in terms of sexuality (heteronormativity), which he seems to use as a bargaining tool during conflicts of a hierarchical nature (doctor – patient).

Finally, in terms of social class, the Psychosocial Care Center is a public and free organization. Therefore, in general, patients seem (e.g., the way they speak, dress, and behave) to come from low or middle social classes. For example, some written testimonies shared by some patients about activities that took place in the institution showed basic errors in writing: "There are a lot of errors in their texts. It is also interesting to notice that they identified themselves even with their ID number, although identification was not mandatory." (Field notebook notes) The following example is also worth mentioning on this subject: "J was quite agitated. He passed around a petition and wanted to sign it, but just made a scribble since he doesn't know how to write. He seemed irritated (slapping the arms or legs of the people around him)." (Field notebook notes) However, some patients seemed to come from better financial conditions, but their families, according to them, did not want to "spend money on them". (Field notebook notes). This case demonstrates how social class intersects with the social category of mental health disability, since as patients they have to accept the decisions made by family members concerning where their treatment would take place and how much money would be spent on it. Moreover, in the case of J, these two social categories intersect specifically with his educational background because he demonstrated his frustration (apparently related to his inability to write) in a way that was not acceptable to society (slapping people's arms and legs).

Unawareness of other people's oppressions

Finally, it is worth noting that patients seemed capable of noticing their own oppressions (they mainly shared with the researcher the issue of mental health), but not their privileges, that is,

the oppressions of other people around them in that scenario. Thus, they did not seem capable of showing sensitivity to experiences that they did not experience themselves. For example: "a patient said that he doesn't like being called 'crazy', that there is no longer any stigma towards black people and homosexuals, so there shouldn't be any towards 'mentally ill people' either". (Field notebook notes) This excerpt shows how they bring up questions related to their shared oppression as mental health patients and to their demands for social justice (elimination of stigmatization), but fail to notice other (intersected) oppressions in society, such as racism, sexism, and homophobia.

Discussion and conclusion

The data show the presence of intersected social categories that affect the social interactions between the social actors (staff members and patients) in the Psychosocial Care Center researched. Considering that the research took place in a psychosocial care center, the categorization of mental health disability spanned all other social categories. In fact, other studies have also emphasized how mental health diagnosis is an important social marker of difference.[12]

In addition to mental health diagnosis, the data showed the importance of gender, age, social class, and sexuality in daily life in this institution. However, race was not a central element of the analysis, since it was not emphasized by the participants. This can be explained by the fact that the social actors in the case seemed to share a racial background of mixed ethnicity, thus leveling the playing field in terms of racial social relations. Other studies have also shown how some social categories can be more present than others[9] and specifically race is a social category that is not always considered when analyzing social interactions in this specific type of institution.[10]

Intersectionality theory was useful in the analysis of the data because this theory takes into consideration the intersection of social categories, that is, the intersection of oppressions and privileges. Thus, it also takes into account how power relations develop in an intersecting way.[5,6] The data also showed how the social position inside the institution affects social interactions, that is, staff members make decisions concerning patients. In fact, the focus of this type of institution on autonomy and participation does not prevent patients from finding themselves in a position of inferiority in relation to staff members, even concerning their psychosocial treatment.[15] In addition, the anti-asylum discourse produced by the Brazilian government has also shown its limitations when confronted with the reality of Psychosocial Care Centers.[16] In fact, the superiority of certain "bodies" is only possible due to the categorization of patients in terms of their mental health status and the judgment made by society concerning their so-called "abnormality" and its consequences.[31]

Mental health diagnoses influence power relations between staff members and patients in the institution, but other social categories also play a part in social interactions. All social actors involved in social interactions must deal with their own intersectional oppressions and privileges. For example, a young female patient has to deal with the advances of (older) male patients or a patient uses his impression about his psychiatrist's sexuality to try and create a social situation of equality during negotiations about his psychiatric treatment. In fact, it is possible to notice an element of resistance[17] and how their identity is multiple and, therefore, the stigma experienced is also intersectional.[7,8] However, in general, their apparent difficulty in noticing other people's oppressions, only noticing their own, seemed to indicate a unawareness of their own privileges. It should also be noted how the intersected social categories are present at different levels of patients' experience in the institution. This research focused

mainly on the social interactions inside the institution, but the patients also interact with individuals outside the institution, especially with their families.[20]

To be more specific with regard to the role of social categories in social interactions,[21-22] the results demonstrate that ceremonial rules (behavior) are not always respected. In fact, in terms of deference and demeanor, how participants make strategic use of their intersected oppressions and privileges is remarkable. An example of such behavior is the patient who felt comfortable using a psychiatrist's supposed sexuality identity "against" him as a form of resistance to the actions of the psychiatrist, that is, when he was dissatisfied with decisions made concerning his treatment and his self. In fact, since expectations exist in terms of social categories (e.g., a psychiatrist needs to behave and look like a psychiatrist according to societal expectations), when they are not met, the individual's social role can be called into question.[23] However, this expectation is considered not only through display in the form of diplomas, clothing, etc., but also in terms of social categories, that is, doctors can have their role questioned if their social categories do not respond to certain expectations (e.g., not being male, not being white, not being cisgender, not being heterosexual, etc.).

More precisely, in terms of stigma and performance during social interactions, the results indicated that participants identified mental health disability, gender, age, social class, and sexuality as social categories, that is, these were known or visible stigmas that influenced how stigmatized individuals were treated and treated one another during social interactions.[24] It is important to highlight that the mental health diagnosis is an integral part of the intersection of the social categories observed, that is, mental health disability is a social category that added to the patient's experiences in terms of oppression.[5,6] Considering that the analysis concerns a mental health institution, this social category is the main element influencing social interactions in the institution.[4] It should also be noted that other stigmas may have been present in the social interactions in question but were not highlighted by the participants (e.g. race).

In addition, to further explore the analysis in terms of how intersected social categories produce the specific social interactions presented in the results, it is important to notice the possible existence of intersected oppressions or intersected privileges in individuals' experiences[5,6] and even a mix of both, which can be used strategically by the individuals to deal with agency and systemic barriers.[32] For instance, the results showed how one specific patient has to deal with being at the same time a young woman of lower social class or how an older male patient can still exert his power in that space due to how patriarchy works. Furthermore, the importance of considering the influence of psychiatric reform in Brazil[16] and the specificities of the treatment model practiced in this type of institution must also be taken into consideration.[15] To expand the analysis of the intersection between the institutional categories and hierarchies (staff and patients) and the other social categories, one can cite the example of how a patient "used" a psychiatrist supposed sexuality against him, which might only be possible because of how this institution, which is not a psychiatric hospital, not only allows but also expects patient participation. This situation can result in more conflicts in social interactions since the established hierarchy in this institution can be considered more fluid.

Lastly, recent research has shown how different social categories can play a role in the daily life of the Psychosocial Care Center for both patients and staff members.[10–12] However, this research contributes to the existing scholarship on mental health by emphasizing existing power relations, not only due to the mental health diagnosis of patients but also as a result of the intersection with other social categories. This study also contributes to the existing

scientific literature on the subject by emphasizing how patients seemed to notice only their own oppressions, but not their privileges, that is, not the oppressions of others with whom they interact daily.

In future research, it would be interesting to compare this data with those of other units of this same type of institution or of different types of institutions. Furthermore, in terms of recommendations, adequate importance should be given to decolonial thinking when considering not only different minority groups in society,[33] but also mental health institutions and practices to counter social and health inequalities in society.[11]

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