Biolegitimacy, rights and social policies:

New biopolitical regimes in mental healthcare in Brazil

Sônia Weidner Maluf
Federal University of Santa Catarina (UFSC)

Abstract

This paper discuss biolegitimacy as an instrument and device for the production of rights, recognition and access to services and care from the state, as a means to demand and conquer rights and as an expression of a new biopolitical regime. Biolegitimacy is articulated with a broader context of political shift, with an emphasis on the processes of pathologization, medicalization or biologization of social experiences, particularly concerning the production of public policies and actions of the state in the field of rights and citizenship. Despite the breadth of the issues that can be addressed through this concept in its formulation by Didier Fassin, the focus of this article is mental health policies in Brazil in the context of Brazil's Psychiatric Reform program, particularly those policies aimed at women. If on one hand the Psychiatric Reform is based on the principles of the human rights of the ill and of psychiatric patients, and on the democratization and universalization of access to healthcare, on the other hand, in various aspects these same policies reproduce the device of biolegitimacy. The focus is the notion of the "life-cycle" of women, a principle widely used in the documents and guidelines mainly in those specifically aimed at women's health.
Keywords: Biopolitics, Biolegitimacy, Mental Healthcare, Gender, Public Policies, Subject

Resumo

Este artigo procura trazer uma reflexão sobre um aspecto cada vez mais presente nas políticas sociais contemporâneas: a biolegitimidade como um dispositivo de produção de direitos, de reconhecimento e de acesso a serviços

e atendimento por parte do Estado, e também como meio de reivindicação e de conquista de direitos. Biolegitimidade se articula com um contexto mais amplo de deslocamento do político, com ênfase nos processos de patologização, medicalização ou biologização das experiências sociais, sobretudo no que diz respeito à produção de políticas públicas e às ações do Estado no campo dos direitos e da cidadania. Apesar da amplitude das questões que podem ser abordadas através desse conceito, a partir de sua formulação por Didier Fassin, o foco deste artigo são as políticas de saúde mental no Brasil no contexto da Reforma Psiquiátrica brasileira, particularmente aquelas dirigidas às mulheres. Se por um lado a Reforma Psiquiátrica tem como princípios de base os direitos humanos dos doentes e dos pacientes psiquiátricos, assim como a democratização e a universalização do acesso à saúde, por outro, em diversos de seus aspectos essas mesmas políticas reproduzem o dispositivo da biolegitimidade. O foco é a noção de ciclo de vida das mulheres, um princípio largamente utilizado nos documentos e diretrizes principalmente naqueles especificamente voltados à saúde da mulher.

Palavras-Chave: Biopolítica, Biolegitimidade, Saúde Mental, Gênero, Políticas Públicas, Sujeito

Biolegitimacy, rights and social policies:

New biopolitical regimes in mental healthcare in Brazil

Sônia Weidner Maluf

This paper reflects on an aspect increasingly present in contemporary social policies: biolegitimacy as an instrument for the production of rights, recognition and access to services and care from the state, and as a means to demand and conquer rights. Despite the breadth of the issues that can be addressed through this concept, the focus of this article is mental health policies in Brazil in the context of Brazil's Psychiatric Reform program, particularly those policies aimed at women. If on one hand the Psychiatric Reform is based on the principles of the human rights of the ill and of psychiatric patients, and on the democratization and universalization of access to healthcare, on the other hand, in various aspects these same policies reproduce the device of biolegitimacy. In this article I will discuss two of these dimensions: the way that certain subjects are considered and described in government documents as more vulnerable to problems of a psycho-social order, and the place that medications occupy in the policies for democratization and universalization of health care. This shift in demands and social and economic rights to what we can generically denominate the "right to life," visible in the processes of medicalization and psychiatrization of suffering and of social demands, establish parameters for the legitimation of these demands that largely dilute their political meanings. It also involves a two-way process of political movement, not restricted to the realm of the state and its actions, but present in the scientific statements, in technological production and in the platforms of social movements, as well as in the individual and collective agencyings involved in the struggle for rights, justice and recognition.

Biolegitimacy and biopolitics

In his formulation of the concept of biolegitimacy Didier Fassin begins from the recognition that the right to life has gained priority on the human rights agenda in relation to social and economic rights. Fassin locates and problematizes the moral potential of this "right to life" (which is expressed in article 3 of the Universal Declaration of Human Rights of 1948), in contrast to a growing "moral debility" of social and economic rights (included in article 22 of the Declaration), as a historic and contemporary contingency. That is, there was an inversion of priorities in the contemporary moral and political field, in which the right to life would become more important than social and economic rights, and would impose itself in detriment to the others. He calls this difference between the two perspectives "the conflict of two ethical communities that have an unequal legitimacy" (Fassin 2010: 193).

There are numerous examples of this shift or inversion of priorities in the political field, and the author addresses some ethnographic cases, including the significant increase in the concession of asylum for therapeutic treatement and decline of political asylum (Fassin 2005). Another case discussed by Fassin concerns controversy in AIDS prevention and treatment policies in Africa, in which the medical community and that of specialists, defenders of the right to life of HIV positive patients and of the urgency for treatment, question government policies and the administrators of healthcare policies, which focus on issues such as management of the healthcare system and equitable distribution of the right to healthcare, or that is, issues related to social and economic rights (Fassin 2010).

The central issue for the author is that "human life has become the most legitimate value upon which the contemporary world bases human rights thinking" (Fassin 2010: 201).

If on one hand the centrality of life in modern politics had already been described by Foucault in his formulation of the concept of biopolitics, Fassin and other authors, such as Giorgio Agamben, have discussed how, since the second half of the 20th century, this dimension has become the basis for considering policy.

I consider the concept of biolegitimacy particularly useful for considering some aspects of social policies in Brazil, how the state relates to social demands and how social demands incorporate these new forms of legitimation. I can mention some examples related to studies that I have

coordinated or supervised. These include the broadening of the fields of the pathological and of medicalization in the context of mental health policies and of psychiatric reform in Brazil (which I will explore in greater detail in this article). Another is the recognition by the state of the demands of certain social subjects through their self-recognition as individuals who have a type of disability (for example rights related to the so-called "gender identities" of transgender subjects). To have their right to intersex surgery recognized, these transgender subjects must be diagnosed as afflicted with gender-identity disorder). Finally there is the adoption of medicamentous control of children and youth as part of children and youth policy, in schools, shelters and institutions for minors.[1]

But this instrument extends beyond the state, reaching the movements and groups that work to defend rights, as is the case of the struggle for the rights of transgender people and the centrality given to biomedical or medicamentous intervention, whether through hormones or sex-change operations. Another example is the movements and individual or collective pressure from patients for the "right to healthcare," expressed in the demand for free access to high technology medication or to the most advanced treatments existing.[2]

In general, biolegitimacy as an device for production of rights and access to public policies is articulated in a broader context of political shift, which some authors have analyzed from different perspectives, with an emphasis on the processes of pathologization, medicalization or biologization of social experiences, particularly concerning the production of public policies and actions of the state in the field of rights and citizenship.[3] One of the effects

---

[1]   About the diagnosis and medicalization of children in the mental health field see Brito; 2014 and Souza, 2013 and the work underway by Fernando Moura, about the diagnosis of ADHD in public schools and Maria Fernanda Salvadori Pereira about diagnosis of depression in children.

[2]   See, about this issue, Ferraz, 2009 and Ferraz and Vieira, 2009. A recent case involving a Brazilian prisoner in Indonesia, accused of drug trafficking is also emblematic of biolegitimacy as a mode of justice. For a few days the Brazilian media reported that the only possibility for him to escape the death penalty would be a diagnosis of schizophrenia from an Indonesian psychiatrist, which would impede execution under the country's law. (Published on the site G1of Globo, on 12/2/2015 - http://g1.globo.com/mundo/noticia/2015/02/laudo-de-medico-indonesio-pede-internacao-de-imediata-de-brasileiro.html, accessed on 03/3/2015.

[3]   In addition to the processes of biolegitimation and of biolegitimacy analyzed by Didier Fassin (2005 and 2010), this political shift has been analyzed from different perspectives, some of which at times are discordant with each other: the psychiatrization of conflicts and of the experience of violence (Fassin and Rechman, 2011), the "biologization of poverty" (Teresa Gowan, 2012 and other authors), the medicalization of the homeless (idem), and even in broader approaches to contemporary policy, above all through the recent readings of the biopolitics of Foucault in authors such as Agamben (2002) and Roberto Esposito (2006), among others. Paul Rabinow and Nicolas Rose have sought to understand the transformation in biopower through the new biotechnologies, pointing to what would be the "individualization of biopolitical strategies." (Rose & Rabinow

of this shift is the extension of the domains of the pathological to the field of social policies and recognition, through which the legitimacy of the needs and demands of groups, populations, communities or social subjects passes through the filter of recognition of a disturbance, dysfunction, disease or of some type of biological specificity or difference. In this process, biolegitimacy and the "right to life" become the determining factors for the recognition of the demands for rights that sustain these social policies. This dynamics has diverse and complex consequences, even in relation to the analytical tools, including the question of how much this process would represent a new biopolitical regime.

In his reflection about the concept of biolegitimacy and the imperative of the right to life in contemporary policies, Didier Fassin considers that life itself was an aspect not developed by Michel Foucault in his discussion about biopolítics.[4] Life and the politics of life are one of the focuses of the contemporary revival of Foucault and of authors such as Georges Canguillem, Walter Benjamin and Hannah Arendt, through concepts such as "life itself ", "mere life", "good life", "life in it self ", "bare life", *bios* and *zoe*, "precarious life" (Canguillem 1966; Fassin 2006; Rose 2013; Agamben 2002; Benjamin 2012; Arendt 1961; Esposito 2006; Butler 2006). My question in this article does not exactly involve a discussion about life, but about the concrete effects of these new biopolitical regimes and the forms of subjectivation engendered by contemporary biopolitics. My argument is that biolegitimacy as a tool that informs government practices, public policies and even social demands, can be considered as an effect of these new biopolitics.

Since his first statements about the concept, made at a lecture in Brazil about "The Birth of Social Medicine" in 1974 (later published in *Microfísica do*

2006: 38) Nicolas Rose conducts a criticism of what he calls the "pessimism" of critical sociology, considers the concepts of medicalization and biologization outdated and insufficient to explain certain contemporary phenomenon and takes another perspective (Rose 2007 and 2013). Rose is quite optimistic in relation to new biomedical technologies and also in relation to new psychopharmaceuticals as modes for establishing a "biological citizenship," in dialog with Paul Rabinow's concept of biosociability. He understands that we are now experiencing a new "somatic ethic" and the possibility for a "politics of life itself" (Rose 2013: 67). Despite considering his reservations pertinent, I think that in some moments the author adheres a bit easily and acritically to a perspective dictated by the biotechnologies and I have the impression that what he defines as politics of life itself is a perspective that winds up weakening his dimensions. In this sense I consider the concept of biolegitimacy more suitable to consider these new forms of citizenship and access to rights, reviving the critical and political dimensions presupposed by this concept.

4   "Ni la anatomo-politica, que concierne a la disciplina del cuerpo, ni la biopolitica, que despliega la regulación de las poblaciones, abordan de manera central la cuestión de la vida" (Fassin 2010: 200). See also Fassin 2006.

poder) and in *The Will to Knowledge*, of 1976, Foucault developed the concept of biopolitics through his courses and published works, not only in a cumulative manner but also by transforming the concept and expanding it far beyond the field of social medicine, to reach the politics of population and finally to neoliberalism.

Foucault describes the emergence of biopower in contrast with sovereign power, exercised with a basis on the right to life and death of the sovereign over his subjects.[5] This transition is described, not based on changes in political theory but on changes "at the level of the mechanisms, techniques, and technologies of power" (Foucault 2005: 288). In his book about the birth of the prison, *Discipline and Punish*, he emphasizes the emergence of a dimension of biopower, disciplinary power, or anatomo-politics, aimed at bodies and individuals. The other dimension of biopower would be developed in his later work, mainly in the tryptych formed by three of his courses at the Collège de France, *Security, Territory and population*, *Society Must be Defended* and *The Birth of Biopolitics*, about the concept of biopolitics as politics aimed at the population and of population as a political problem.

A proviso is important in relation to these two modes of biopower: for Foucault, one does not substitute the other, they are juxtaposed, articulated with each other:

> We thus have two series: a series body-organism-discipline-institutions; and the series population-processes biological-mechanisms regulators-state. An organic institutional set: the organo-discipline of the institution (…) and on the other hand, a biological and state set: the bio-regulation by the state (Foucault 1999:298.)[6]

One example is the issue of sexuality, which would be at the crossroads of the body and the population, and would depend both on discipline and on regulation. (Foucault 2005: 300-301). Another example of this articulation, according to Foucault, is medicine, "a knowledge-power that incides simultaneously on the body and on the population, on organisms and biological

---

5   One of his syntheses of this transition practically becomes a formula to distinguish the sovereign power of biopower: "The right to sovereignty is, therefore, that of the right to kill or to let live. And thus, this new right is that which is established: the right to make live and to let die." (Foucault 1999: 287).

6   Foucault also discusses another juxtaposition, that between forms of biopower and sovereign power, from the right to death – mainly when he speaks of racism of the state and of Nazism.

processes, and which, therefore, has disciplinary and regulatory effects (idem: 302). It is not by chance that medicine and medical policies, and those of hygiene, wind up earning a detailed description in Foucault's works. It is at the heart of biopolitics, at the same time as which it constitutes one of the biopolitics (Farhi Neto 2010). Thus, questions such as public hygiene and the medicalization of the population, births and deaths, problems of reproduction, everything that refers to life, to the body, the population, from the organic to the biological, such as aging, to diseases and anomalies, that which removes individuals from the production line, but also the problems of the relationship of humans with their means of existence, from the swamps and the epidemics related to them (in the nineteenth century) to the problems of city, all this is the object of biopolitics. A form of government of bodies, individuals and populations.

In the 1979 course, The *Birth of Biopolitics*, in which he explored the various liberalisms and in particular neoliberalism, Foucault developed another dimension of biopolitics, which is of interest to my discussion about biolegitimacy, which is the formation of human capital as an expression of a regime of subjectivation based on the form of the enterprise, of the subject as an entrepreneur of him or herself. The production of subjectivities thus becomes the central aspect of neoliberalism.

I will dialog with two readings from this course and discuss its importance for the formulation of one of the dimensions of the concept of biopolitics as a dynamics of globalized capitalist politics, or, in the interpretation of Leon Farhi Neto, who wrote about Foucault's biopolitics (in the plural), of neoliberalism as a biopolitics, or as the very form of contemporary biopolitics. Farhi Neto classifies five variations of Foucault's biopolitics: the biopolitics of medicine, war, sexuality, the security pact and finally, biopolitics in relation to economic rationality.

For Fahri Neto, who attempts to conduct a conservative or restricted reading of the concept of biopolitics, the approach to liberalism and neoliberalism undertaken by Foucault in *The Birth of BioPolitics* refers to a contemporary mode of governmentality through the economy, in which the population is governed indirectly, with the strong presence of economic forces, the market and the privatization of social policy. Biopolitics would be pertinent here to describe the neoliberal techniques of government (Farhi Neto 2010).

Frederic Gros also seeks to go beyond the readings that see in this course

of Foucault, despite its title, an absence or even an abandonment of biopolitics. He seeks to establish a continuous line between Foucault's previous reflections on the two forms of biopower: the anatomical politics of bodies and individuals (represented above all in his analysis of prison) and the biopolitics of populations. Gros proposes a new definition of biopolitics:

> ... biopolitics is a set of requests through which the individual, in the plane of his vital potential, is submitted to certain directions in order to intensify the production of wealth and the power of the dominant classes." (Gros 2013:38)

Disciplinary power, for example, would be a form of chronopolitics needed by capitalism: "to transform the time of life into useful and productive time" (Gros 2013:35). In the second major form of biopower, according to Gros, the governmentality of the population takes place through the public policies conducted by the state (2013:35). Now it is the "biological dispositions" of the human species that are the object of state action (idem: ibidem). The "biopolitical operation" would consist of depoliticizing the subject, who is presented as an economic subject in different modes: as a consumer subject, as human capital and as an entrepreneur of oneself, and finally in what would be a fourth step of capitalism not explored by Foucault - because it is more recent - that of financial capitalism. In this step, the subject, similar to capital itself, would be a set of flows more than a stable identity. It is in this dimension that Gros needs to improve his definition of biopower (and of biopolitics):

> Biopolitics would thus be a strategy that seeks to transform certain vital tendencies or fundamental biological traits of individuals or of the human species, with the goal of serving to reinforce the economic-political forces. In fact, we find for each form of capitalism this scheme of transformation. (idem: 41)

And later, "Financial capitalism invites us to establish ourselves as a pure point of exchange of flows of images, of information of goods, etc. [...] a vectoralization of vital trends considering the increase of economic-political forces" (idem).

Gros also mentions Foucault's refusal to counter this process of domination, exploitation and captivation with "basic human rights," based on a "metaphysical logic, whether enrooted in an eternal nature, or guaranteed

by a divine transcendence" (p. 41). To think, as does Foucault, that power is a relationship, is to also think that "to be caught in a biopolitical process gives us rights, including the right to not accept everything or to refuse this or that." This is the "right of the governed," the "resistance biopolitics," "affirming the will to exist in another manner." (p. 42). In Gros' reading, it is liberalism itself that provides this opportunity for resistance, not an economic or political liberalism but something that he calls critical liberalism, that which "feeds the biopolitical resistances." (idem). I will not discuss here the author's questioning of Foucault's more or less critical characterization of liberalism. I am interested in focusing on the discussion made by Foucault of human capital and how contemporary biopolitics, which go far beyond the state (in the Birth of Biopolitics Foucault describes a retraction of the state, in which the *laissez faire* of classic liberalism becomes a "do not let the state do," in neoliberalism (idem: 339)), would approximate the human subject to forms of capital, whether as an entrepreneur of the self, or as space or point of flows.

In his discussion of neoliberalism Foucault shifts in a certain form the biopolitical process of the state and of the public policies to the market and economic relations. At the same time, we can consider that public policies themselves and government techniques wind up incorporating these new dispositions of capital. The focus of this new configuration of contemporary capitalism is the production of subjects and subjectivities. These three dimensions: shifts of biopolitical processes to the market and the economy, incorporation by the state of the new dispositions of capital, even in its social policies, and the production of new subjectivities, are present in the context and in the field of mental health.

The ambivalences of the state in mental health and women's healthcare: the cycle of life and the medicalization of women

The questions raised above about the new contemporary biopolitical dynamics, which include indirect forms of governmentality and its shift to the market and to economic relations, have implications for an approach to public policies and the state itself. If on one hand we have public policies particular to the welfare state, which seek to integrate historic demands and agendas of the social movements, and which define procedures and modes

of operation of the state, on the other there are dimensions that run through these policies that are related to scientific and technological productions, and to interests and pressures from economic sectors (for example the pharmaceutical industry) and with values and moralities that circulate in these various spheres.

A first movement in this reflection is the analysis of the practices and actions of the state and its constitutive ambivalence in relation to social subjects, between care and control, dependence and autonomy, the processes of institutionalization and deinstitutionalization, and of the subjection and subjectivation of people who use services and are the target of public policies produced by and in the context of state actions.

An anthropology of the state, or more specifically of public policies, begins from the questioning of its existence as an organic entity, a substantive given being,[7] seeking to understand it as practices, actions and discourses that involve a heterogeneous and contradictory set of actors or social agents, with different moral and subjective dispositions.[8] Beyond laws, texts and documents, the state is also what is produced in the plane of what its agents do, who instead of being only executors of public policies are also those who, in their daily practices, also make public policy.

The ethnographic approach can offer an interesting perspective for an understanding of contemporary political and subjective processes by using a line that articulates the realization of public policies, the concrete action of the state, on one hand, and the experiences and agencying of the target subjects and users of these policies on the other.

This dynamic is quite visible if we take as an example mental health polices in Brazil and the expansion of psychiatrization of basic healthcare policies. The Brazilian psychiatric reform project[9] calls for the progressive substitution of psychiatric hospitals for a pyscho-social network of services, including reception and care for patients and users. Based on a broad "deinstitutionalization" program for patients, it sought to break with the asylum model, above all through the Ministry of Health's Return Home Program,

7 This questioning was already found in Radcliffe-Brown (1940); and more recently in Abrams (1988); Trouillot (2001), and others.

8 Abellès (1992), Worsley (1994), Abrams (1988), Bevilácqua and Leirner (2000), Trouillot (2001) and Lima (2002), among others.

9 Lei 10.216, de 16 de abril de 2001.

which calls for the social reintegration of interned psychiatric patients. These government programs also propose the creation of a broad and disseminated public network of in- and outpatient care, both at basic health clinics, and in the creation of other spaces such as the Psycho-social Care Centers (CAPS), which are more specialized spaces aimed at cases considered by professionals to be of so-called "greater/higher complexity" or for some specific disturbances, such as alcohol or drug addiction (the CAPS-ad), or for specific publics, such as the CAPSi, for children and adolescents, among other measures such as therapeutic residential services. But as various authors have highlighted, the reform process is heterogeneous, unequal and contradictory, while it simultaneously falls short – yet at times goes beyond - that which is established in official documents.[10] In addition to the measures established in the Psychiatric Reform, the mental health field includes instruments such as private clinics, at times informal shelters for the mentally ill and elderly, therapeutic communities and assistance centers linked to religions, associations of users of mental health facilities, various groups of alternative or dissident practices (such as schizo-analysis projects) and other forms of patient care, and which must coexist with the permanence of various psychiatric hospitals (which continue to exist despite the Law).

In addition, the more general context of implementation of these policies raises a series of factors that are determinant in the application of national policies, such as the growth and expansion of the domains of action of biomedicine and of its various measures, including new diagnostic procedures and the priority given to pharmaceuticals in the therapeutic processes (but not only this, consider for example the return to the use of electroshock therapy in recent years in Brazil). A broad range of experiences, which include suffering and affliction, the constitution of the Person and the production and reproduction of life, the guarantee of rights and the exercise of citizenship, shift to the field of health and biomedicine. Questions such as the medicalization of subjectivity, the pathologization of suffering, the therapeutization of individual choices and the biolegitimacy of the demands

---

10   Or even rhizomatic, according to the discussion of Fonseca et alii (2007). About Psychiatric Reform, Brazilian Psychiatric Reform and the process of deinstitutionalization of mental health see Amarante, Paulo (1994, 1996 and 2000); Desviat, Manuel (1999); Fonseca, Tânia Galli; Engelman, Selda & Perrone, Claucia Maria (2007) and the recent thesis of Ana Paula Müller de Andrade (2012) among others. For a reflection about psychiatry and psychiatric hospitals in Brazil see Machado et. al. (1978), Costa (1989), Venâncio (2011) ; Venâncio and Cassilia (2005 and 2011), Cardoso (1999 and 2002), Teixeira (1990), among others.

of specific sectors are treated by the most recent anthropological literature as signs of an expansion of the domains of action of biomedicine and of the extension of the field of the pathological to within what traditionally would be domains of the "normal."

Thus, some aspects of the contemporary constitution of the field of "mental health" in Brazil accompany the Psychiatric Reform process.[11] In the first place, in the shift from an exclusively psychiatric and asylum focused model of care to an outpatient model, not only does psychiatry come to be exercised in the spaces of public healthcare, but issues related to "mental health" care and to medicamentous therapies in this field come to be largely exercised by other medical specialties. Secondly, and this is also not a phenomenon specific to Brazil, since the late 1970s, there has been a process of remedicalization or biologization of psychiatry and mental health,[12] consolidated above all with the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) of the American Psychiatric Association.[13] Thirdly, the growth in the use of psychopharmaceuticals and psychotropics of all kinds in Brazil, mainly anti-depressants, particularly among women, and not only traditional consumers in the middle and upper classes, but now increasingly among lower income, rural and indigenous women.[14]

In a certain way, these different aspects are forms of growing biomedical rationalization not only of subjective life, from the perspective of the subject, but also of the rationalization of the social policies and ways of acting of the state.

---

11   According to Maluf (2010). One of the issues that I have discussed in these works is the problematization of the concept of "mental health" and its analytical and descriptive limits.

12   To speak of remedicalization of psychiatry does not mean that the psychiatries exercised previously were outside the medical field or did not have a bio-physical-organic orientation. The concept of medicalization used is related to a dual trend: on one hand, the reduction of the phenomenon of suffering and affliction to imbalances and disturbances of an organic or physical-chemical nature, on the other, an extension of the scope of medical action and intervention.

13   This process is deepened in DSM-IV and in the recent DSM-V, with a growing hyperspecialization of diagnosis and treatment.

14   This is expansion is recognized in the documents of the Ministry of Health, such as the Relatório de Gestão 2007-2010, *Saúde Mental no SUS As novas fronteiras da Reforma Psiquiátrica* [Administrative Report, 2007-2010, Mental Health in the Single Healthcare System The new frontiers of Psychiatric Reform], which recognizes the increased consumption of benzodiazepines, anorexics, amphetamines and antidepressants among women, and as a result of a meeting held in 2008 with technicians, professionals and researchers in the field, in a partnership between the Ministry of Health and the Special Secretariat of Policies for Women, the recognition of a "growing trend of public healthcare and mental health services to emphasize medicalizing responses, in response to diffuse complaints of psychic suffering of women" (Brasil 2011: 76)

If on one hand these mental health policies and the very meanings of Psychiatric Reform in Brazil are those of universalization and democratization of access to healthcare, as well as the respect for the human rights of patients and users of the healthcare system, on the other we can perceive biopolitical and control measures in the resulting policies and practices.

I will more specifically address one of the dimensions of this process, which is the way that gender issues appear in some public documents about mental health and women's health and the discourses and practices specifically aimed at women and at what would be, according to these discourses, the specificity of their greater vulnerability to disturbances and problems of a psychosocial order. The focus is the notion of the "life-cycle" of women, a principle widely used in the documents and guidelines mainly in those specifically aimed at women's health, even when not explicitly. The "life-cycle" of women is understood here as the various phases related to their reproductive career: menarche, pregnancy and childbirth, post-partum and menopause. My investigation is not exhaustive and the examples raised from the public documents do not represent the force of this concept and its disseminated use beyond these documents, by professionals in the field, academics and researchers and even by social groups and movements. The broad use of this concept in the psychiatric literature aimed at women shows its scientific validation and the strength as a truth that it acquires when expressed in healthcare policies.[15] By the social modes and territories in which it circulates, life-cycle winds up constituting a discourse, which is produced and distributed in various spaces based on different actors, constituting in this circulation a regime of truth about women's suffering, demands and rights.

It is important to emphasize that I do not consider that all mental health policies in relation to women are reduced to the notion of life-cycle. As I will describe below, the concept of life-cycle informs the ways that women appear in a number of these documents, along with other insertions, more closely linked to social, political or economic dimensions.

---

15   In a quick search on the site of the American Psychiatry Association (APA) and on sites of U.S mental health care centers, I found various ways that the life-cycle of women appears as the central element for defining probabilities, diagnoses and treatment. In the APA publications about women and mental health, I found various references to greater vulnerability of women to psychiatric disturbances and to the importance of the moment in a woman's life-cycle as the cause or context of psychiatric disturbances. Some books specifically address each phase of the life-cycle, with an emphasis on menopause and post-partum.

In the case of mental health policies, the concept of biological phases of life and of "higher risk groups" appears in the National Mental Health Guidelines of 1977, presented at Brazil's VI National Healthcare Conference, defining, among other things, the need for primary prevention actions "aimed at high-risk groups: pregnant women, mothers, adolescents and the elderly, to reduce, in this population [...] the rise of alterations and the promotion [*sic*] of satisfactory levels of mental health" (*apud* Cardoso 1999:36). In this formulation, life-cycle appears both in relation to the phases of women's reproductive career (pregnant woman, mother) and in relation to the age determination of risk (adolescents, the elderly). This logic reappears in other later documents, even if formulated in other ways.

In the first three National Mental Health Care Conferences (1987, 1992, 2001), women appear little. In the case of the I and II conferences, they are not mentioned and in the report of the III Conference they are mentioned alongside children, adolescents, the elderly, indigenous, the street population, the third age and "alcohol and drugs" (*sic*), still using the age or risk group logic (BRASIL, 2001). It is at the IV Conference, in 2010, that a significant change in this perspective appears, the need for a specific policy aimed at women is more explicit, together with the need for a gender policy.[16] It is interesting that, in the report of this last conference, women move from being presented as a vulnerable group, particularly among certain age ranges (children and the elderly) to being presented as a specific identity (gender and race/ethnicity). In addition, the post-partum situation is defined with a basis on the father-mother-child triad, no longer only from that of women in post-partum.[17] Here the influence is perceived from feminist debates and from other social movements, like the movement for racial equality, in a context where the Brazilian state is highly porous to these movements, many of whose leaders have entered the government.

Nevertheless, the same degree of politicity is not found in other documents, mainly in those that seek to detail the general policies, or establish

---

16   "634.To implement healthcare strategies, from the focus of gender, for the mental health of women to: 1) improve the information about women with psychic suffering in SUS; 2) qualify the attention to women's mental health; 3) include the focus of gender and race (Brasil 2010:108-109)

17   "567. Establish, in maternity and infant hospitals, specialized teams or support nuclei in mental health to accompany the triad fathermother-baby (*sic*) during the gestation period, childbirth and the post-partum period" (idem: 97)

programs or action protocols. In the same way, this perspective is little reflected in the realm of the practices of the technicians, professionals and public employees who work at the point of the public policy, or that is in direct relation with users of the healthcare system.

In the specific case of healthcare policies aimed at women, the near totality of these policies (expressed, for example in the Women's Integral Health Care Program – PAISM, prepared in 1984, and which was reproduced in later programs) is occupied with the issues of reproductive health and prevention.[18] This situation did not change substantially for nearly twenty years. In the PAISM of 2004, a section about gender and mental health was introduced, recognizing the need to consider cultural, social and economic factors of gender inequality in the mental health care policies (Brasil 2004). The I National Conference of Policies for Women, held in the same year, briefly suggested that mental health policy "contemplate actions of prevention, treatment and social inclusion, with a gender perspective and with the preparation of healthcare professionals to address women's social, ethnic, cultural and biological specificities" (Brasil 2004b). The II National Plan of Policies for Women, approved at the II Conference, called for, among the priorities in relation to the item "Women's health, sexual rights and reproductive rights," the implementation of a model for mental healthcare for women, from a gender perspective, considering ethnic-racial specificities" (Brasil 2007, P. 15). And among the goals for the period: "To implement five pilot-experiences, one per region, of a model for mental healthcare for women from a gender perspective" (Idem, p.16). In the same item about health in the document, the emphasis is on "reproductive rights" and the notion of the "vital cycle" of women, defined by various phases of their biological cycle, as "climateric" women, "youth and adolescents" (idem).

Post-partum depression has also appeared in a more detailed manner in the concerns of the Ministry of Health. It is mentioned in various documents produced by the Ministry. The Technical Manual about pre-natal and post-partum periods, of 2006, dedicates an entire item to "Emotional Aspects of Pregnancy and post-partum," suggesting that they include "psychological

---

18   Finding reinforced in the Report for 1998-2002: strategic, programmatic and financial aspects. Brasília: Ministério da Saúde, 2003, prepared by Correa, S. O.; Piola, S. F. (*apud* Brasil 2004: 19).

processes that permeate the pregnancy-post-partum period, notably, in the case of pregnant adolescents who, because of the psycho-social specificities of the development phase, experience an emotional overload brought on by pregnancy." (Brasil 2006, p.35).

That is, even with the incorporation of the debates from the feminist field about gender inequalities and their socio-economic reflections, the concept of "life-cycle" as a succession of phases in the biological life of women, linked mainly to their reproductive cycle, continues to be central in the definition of the specificities of women in the preparation of healthcare and mental health policies and in the recognition of their rights.

In addition to official mental health policy documents, in the local dimension of the application of the public policies, the specificities of each context reveal a quite heterogeneous situation in relation to the healthcare practices, which range from distribution of psychotropic medication to the implantation of other forms of treatment or support, such as therapeutic groups, groups of the elderly, groups of women in treatment for depression and other disturbances, ranging to classes for stretching and gymnastics, acupuncture, homeopathy, phytotherapy, art therapy and others. But, even recognizing that the practices are not homogeneous, the weight that the distribution of medications such as benzodiazepines and anti-depressants has today in public healthcare cannot be denied (not only in the CAPS, which are specialized in mental or psycho-social health, but also and particularly in the basic health clinics). We have many examples of field research conducted in previous research phases, related both to patients and to professionals who serve in these units, in addition to data related to the distribution and consumption of these medications, which reveal the fact that the overwhelming majority of consumers of these medications in the public healthcare system are women.[19] These data indicate that although there is still not an explicit and consolidated policy of gender and mental health in the official programs, it is perceived that in the application of the healthcare policy, in the daily activity of the healthcare clinics and of the Psychosocial Care Centers, a policy of difference is present and evidence of a discourse of gender difference sustained in a physicalist and biologicalized vision of this difference.

---

19   See report cited above (Brasil 2011) and, in the case of the field research conducted, the article by Diehl, Mazzini & Becker, 2010 and various other chapters of Maluf and Tornquist, 2010.

If the official documents and texts incorporate a gender discourse that emphasizes socio-economic issues, reducing the strength of the life-cycle rhetoric, it is pertinent to question to what point this advance in the discourse is reflected in the effective mental health policies for women. To what point do the procedures at the front line of these policies, where professionals are in direct contact with users of the healthcare services (of the basic healthcare at CAPS) reflect this rhetoric? Another dimension enters here, in terms of the establishment of the diagnosis and the therapeutics used: the diagnosis is essentially based on biological cycles and the treatment continues to be overwhelmingly medicamentous.

In a previous study (Maluf 2010), based on government documents and together with healthcare agents and professionals, we raised some issues for a discussion about mental health policies, particularly concerning basic and public healthcare, which I reproduce here: 1) the need to conduct a critical review of some institutional practices that wind up reinforcing gender inequality; 2) the finding of a reality of hypermedicalization and pharmaceuticalization of population segments, with an emphasis on women, with the use of psychopharmaceuticals; 3) the confusion between democratization and universalization of access to healthcare and the widespread distribution of medications, which would imply rethinking basic care in mental health in relation to the need for a therapeutic (and psychotherapeutic) policy which is less based on a medicamentous model; 4) the need for a mental health policy that offers other treatments in addition to pharmaceuticalization, such as systematic therapeutic accompaniment, among others; 5) the need to reconsider the models of care, health, disease, suffering and cure in the official women's health and mental health policies; 6) the break with a model of women's health based on the biologicalist vision of the "life cycle" and on phases of the reproductive life of women as determinants of greater or lesser "vulnerability" of women to mental health problems (Maluf 2010: 35-36). To these aspects, I would also add a seventh, which is the recognition of other forms of knowledge and dealing with the affliction and suffering that go beyond the biomedical or psychological paradigm.

The analysis of public policies, not only in terms of what they call for but also in relation to their concretization by agents and professionals who act in the name of the state, gives visibility to dimensions that otherwise would not

be perceived, and allows a critical reflection on these policies, and an evaluation of their meanings, effectiveness and effects.

Social experiences, practices and agencyings[20]

It is precisely based on the different discourses and social experiences that the physicalist and rationalizing models of the experience of affliction - in this case represented by the notion of life-cycle - are confronted in a more evident form. By social experiences I am designating the dimension of experience and production of knowledge and discourses by those men and women who are precisely the "target public" of the public policies and of the action of healthcare professionals and agents. This perspective is not in any way a reification of the dichotomy between "fact" and "value," represented in anthropological studies of healthcare with a phenomenological approach to the experience of individual subjects, on one hand, and of the social representations of disease, the body and the person, on the other. Our theoretical and reflexive understanding about issues such as disease, affliction and suffering and of the strategies of action and meaning given by the different social actors are based on the idea that experience and its social meanings are two complementary dimensions in an anthropological approach to healthcare.

The study conducted with women residents of peripheral neighborhoods of Florianópolis, contrary to the hegemonic discourse both in government policies and in the platforms of social movements, indicate other issues related to social experiences seen as "disturbing," which are usually articulated to their daily experiences and to their social, cultural and economic context and not to a perception of phases in their "life cycle" as we discussed above. What issues are these? In general they are issues related to their daily life, to their dual or triple work shifts - since many of them, if not most, work outside of the home, in informal jobs or as house maids; to moral abuse at work (many of them report that they have been diagnosed with panic syndrome triggered each time they get to their work place); to violence in their neighborhood, with situations of death of children and husbands, violent

---

20   Part of this item reproduces some paragraphs from the chapter published in the book, *Gênero, saúde e aflição: abordagens antropológicas*, in which the initial results of the study were published (Maluf 2010 and Maluf & Tornquist 2010)

incursions by the police in their neighborhoods and the presence of conflicts and abuses related to drug dealing. In the case of the neighborhood of the study conducted by the team of Carmen Susana Tornquist, Ana Paula Muller de Andrade and Marina Monteiro, an issue emerged in relation to how, in the narratives of the women in the neighborhood, the situation of suffering they experienced at the time was countered to a moment, to a time of struggle and of leadership, reviving the process of occupation of the neighborhood by families, most of them led by women and in which they had a fundamental role. (Tornquist, Andrade & Monteiro, 2010) Two dimensions are found in these narratives and in these other statements that emerge from the discourse of these women, the experience and the knowledge. The experience, as described quite briefly above, concerns other issues that are not related to their life cycles, their reproductive trajectories; the forms of knowledge are triggered to understand this experience, to inform them, impregnate them with meaning. Certainly, in the composition of these experiences and this knowledge, the physicalist rhetoric of the life-cycle is present, through the diagnoses that many of them or their children, mothers-in-law and mothers, receive, through the consumption of psychopharmaceuticals, etc.. Nevertheless, this is not the dominant rhetoric, or in other words, life-cycle does not explain and express the totality of their experience. Their suffering and afflictions do not find easy translation in medicamentous diagnoses and treatments.

Contrasting one discursive and symbolic universe to the other (that of the public policies and that of the social experiences) two models or two perspectives of understanding of affliction are revealed, one that is physicalist (or, as I wrote in another moment, *physio-logical*) which emphasizes a biological conception of gender difference and of the processes of suffering and illness, and a conception or model that can be called *socio-logical* of their disturbance, centered on their different daily experiences and of these women's life histories and narratives. In a certain way, we have here what Fassin calls a conflict of two ethical communities, as I previously described, and as in the examples mentioned by him, ethical communities with unequal legitimacies.

What I am calling a *socio-logic* of the narrative of the women studied is the dimension that encompasses social and historic dimensions of their experience. As I presented, they relate their feelings of affliction to the context

of their daily life in the neighborhood, economic problems, a double work shift, participation in neighborhood movements etc.. This is a *socio-logic* that does not fail to incorporate or encompass the physicalist dimension of the biomedical discourses and practices (accepting the diagnoses, conducting the "treatments" taking the medications), but which resignifies them based on the women's daily experiences and shared values and eventually incorporating them or combining them to physical-moral concepts of suffering and disease.[21] In summary: what I call here a socio-logic to speak about their afflictions, expands the perception and discourses about disease and suffering beyond the concepts of body, health and disease, incorporating the social and political dimensions of the lived experience. An understanding based on the circumstantiality and on the historicity of the experience, beyond and outside of the biomedical ontologization of the person.

It is important, however, to note that I am not adhering to a sociological reduction by identifying the social condition as a cause of their afflictions. By a *socio-logic* model or perspective I am exclusively referring to knowledges mentioned in the womens' statements and narratives and to the recognition of these knowledges as legitimate, and at times in contrast to the biomedical scientific knowledge. This recognition is not made by the state, and public healthcare policies. It is not only the experience of these women that is not recognized by public policies, but their epistemologies, that is their modes of knowledge, perception of experience and of the world.

One question that also permeates my argument is that of the status of science and of the so-called technological advances, mainly in the case of the example discussed here, that of mental health. In a previous article (Maluf 2011), I discussed the place given to medications, above all the anti-psychotics, as a possibility for deinstitutionalization of the patients interned in psychiatric hospitals. This is an argument that permeates a wide variety of segments involved in the mental health field: promoters and public administrators of de-institutionalization, public health professionals and agents, users, the pharmaceutical industry, researchers from various academic fields, associations of users and movements for the universalization of healthcare

---

21   It is also possible to see how much the rationalizing logic of the relationship between cause and effect found in the use of medication, for example, is present and disseminated by other practices, such as the search for spiritual relief or cure, often frustrated by the impossibility of immediate resolution or instantaneous relief from suffering, pain or affliction (which a medication can offer, at least temporarily).

access. By these arguments, we are in a moment of biological citizenship (Rose, 2013), established by bio-pharmaceutical-medical technologies.

Evidently, anthropologists and social scientists in general have supported the universalization of access to knowledge and to benefits brought by science and technology. Nevertheless, in the equation between universalization of access to these benefits (including biomedical diagnostic technologies, treatment, surgery and medicamentous practices) and the question of the meaning of these technologies and of this knowledge, it is necessary to admit that it is not possible to only critically address the issue of "sociological privilege" (Santos, 2004) (with proposals for access, democratization, universalization) without approching the "epistemological privilege" (Idem) (the historic and contingent sense of scientific production, offering the recognition and legitimacy of other forms of knowledge and other epistemologies, etc.). One of the contributions that anthropological study can offer is to give visibility to and allow the emergence of experiences and knowledge that are invisible and not considered both in the conformation of scientific knowledge and in the development of national social policies but also on the global plane.[22]

Modes of sujbectivation, biopower, and other politics of life

The concept of life-cycle produces a statement that unfolds in three aspects. According to this notion and by the way that it is used in different discourses and care practices in the mental healthcare field: 1) generic complaints of the women reflect on psychic or mental suffering as a phenomenon of an organic and biological order; 2) the "female" specificity of this suffering would be directly and unavoidably linked to the women's biological cycle (that is to their reproductive cycle, given that these different steps traced in their life cycle are the phases that constitute their reproductive career) – reproducing the modern movement of reduction of the other (women, as is done with blacks) to an essentialized biological body; 3) it is

---

22   This is not to neglect this other field of the human sciences (anthropology in particular) which develops around the investigation of science and of laboratories, not only around their social consequences, but also from the perspective of revealing their technical dimensions and methodological and cosmological aspects. To bring science to the field of social, symbolic, political and cultural investigation is the complementary counterpart of having emerge and giving visibility and recognition to knowledge and forms of knowledge denied in their specific rationalities.

this biologicalized dimension of suffering and affliction that legitimates a public "mental health" policy, configuring a form of "biolegitimation" and finally 4) it is through the biomedical technologies, and mainly through the use of psycho-pharmaceuticals that the public policy and the access to the right takes place.

As discussed in the beginning of this article, the gradual transformation of life into a problem of power mark the threshold that Foucault called "biological modernity," with health gradually becoming a question of governmentality, or, for Agamben (2004), of the state (while, for the later, Nazism is the biopolitical state par excellence – where so-called "biological life" is politicized). Biopolitics is not only and not exactly a politics of life, but the placement of the governmentality of life at the center of politics. For Foucault, social medicine (and the politics of health, as well as medical knowledges and practices themselves) is one of the forms of the instruments of biopolitics, or government of life, considering biopolitics as the mode of constitution of subjectivity, as a regime of subjectivation. He writes in "The Birth of Social Medicine":

> For capitalist society, it was the biological, the somatic, the corporal, that mattered more than anything else. The body is a biopolitical reality. Medicine is a biopolitcal strategy. (Foucault, 1979a [1974]:80)

In this text, central for the formulation of the concept of biopolitcs, Foucault, reconstitutes the three steps of formation of social medicine: "state medicine, urban medicine and labor-force medicine."(80). He identifies Germany as the place where state medicine arose in the early eighteenth century, developing a focused medical practice. According to Foucault, it is in "the improvement of the level of the population's health," and developing "effective programs for improving the population's healthcare," that they were denominated as state medical policy or "medical policing." (since 1764, but enacted at the end of the eighteenth century and during the nineteenth century). According to Agamben (2004), it is when the distinction between *politics* (the struggle against enemies and preservation of the state and the nation) and of *police* (procedures for the improvement of the health and welfare of the population) evanesce, that, the "*police* now becomes *politics*, and the care of life coincides with the fight against the enemy" (idem:154). (It

was also at this moment that biopolitics became a "tanatopolítica" (idem), a politics of death. For Foucault, it is in France and England that developed, in the late eighteenth century and early nineteenth century respectively, what he calls the "second" and third "directions" of social medicine; the French no longer based on the state, as in Germany, but on urbanization and on urban policies, and the English, as "medicine of the poor." We are speaking here of the birth of social medicine and of the policies of governmentality and of the state related to the population's health, to which today we can join to the contemporary expression "public healthcare policies."

Elements of these three moments and directions of the rise of social medicine are present in healthcare policies today, they are: 1) the regulation and legitimation of the action of professionals and agents and of medical and biomedical knowledge itself by the state (and we can consider a set of contemporary discussions that refer to this aspect); 2) the need to produce information and knowledge about the population that is the target of these policies (above all with quantitative, statistical and epidemiological studies of health – and this dimension includes mental health); and 3) the adoption of healthcare programs, for providing public services at different levels and complexities and intervention of the state in the health of the population through systematic actions (the healthcare policies, the therapeutic programs, etc.) or specific ones (such as vaccination campaigns, fighting epidemics, and others).

A fourth aspect refers to new biopolitical regimes discussed in the first part of this article and the moral power of the "right to life" in detriment for example of socio-economic rights. At the same time, it is these socio-economic conditions of neoliberal capitalism that define the dynamics of these new biopolitics and the way that the moral economy of the right to life can be realized. The very notion of technological innovation with which the psycho-pharmaceuticals are presented, even as the great "actors" of the possibility of the Psychiatric Reform (Maluf 2011), are linked to these new biopolitical measures. Foucault discusses the question of technical innovation and progress not based on its intrinsic development and its forms of productivity, but as a form of renovation that the neo-liberal economists call "human capital," which is materialized in the extension, to the subject, of the enterprise-form and of the idea of the enterprise-subject as a new regime of subjectivation. Beyond public healthcare policies, the individualization of the biopolitical

strategies in the field of mental health, which are focused on the production of increasingly specific individual diagnoses (the logic of the DSM) and forms of medicamentous treatment aimed at the subject, appear to respond to this new regime of subjectivation and the construction of a certain type of subject and subjectivity.

I describe this dynamic based on the concept of biolegitimacy, formulated by Didier Fassin as that which defines the crucial contemporary question, no longer the power *over* life (biopolitics), but the power *of* life as such. For Fassin, biolegitimacy refers to a "shift of legitimacies in the politics of life": the shift from a political life to a biological life (of *bios* to *zoé*).[23]

In the case of healthcare policies, these shifts between *bios* and *zoé*, from the political to the "biological," at the same time that they can appear more evident (after all, questions of health are more easily understood as related to biological life or life itself) are more difficult to understand as objects of a critical reflection, The quasi natural relationship between healthcare policy and the maintenance, care and prolonging of the body and physical life (of each citizen) appears unquestionable. The two fields of healthcare policy in which the reflections presented here are located, however, open spaces for a critical reflection - perhaps because of the quality of their objects; mental health on one hand, and women's health on the other.

Specifically related to mental health, public policies today are, as described above, focused on the realization of the Psychiatric Reform Project, which is focused on the so-called "deinstitutionalization" of mental health services, and of the people interned in psychiatric hospitals with their gradual termination. To do so, it discusses the forms of constituting a "network of psycho-social care" which cares for the universe in question: from care for the "deinstitutionalized" subject to the user of the public system who has a form of suffering or affliction that is "treatable" (an increasingly broader concept) with bio-psycho-medical knowledge, mainly

---

23   The difference between the Greek terms for "life" found in Aristóteles, is revived and developed by Giorgio Agamben (2004), who, inspired by Hannah Arendt, defines this difference as follows: for the Greeks, there were two terms to express the notion of life: "*zoé*, which expressed the simple fact of living common to all living things (animals, men or gods) and *bios*, which indicates the form or way of life specific to an individual or a group," or "qualified life." It is certainly necessary to be careful with the reification of this dichotomy. Butler criticizes a certain naturalist illusion in the formulation of the idea of bare life (p.2). For Butler bare life as such does not exist, to the degree to which life has already entered the political field in an irreversible manner (Butler: 69). It appears to me that the essential question is the way that a new hegemony of the idea of "life itself" (*zoé*) appears to define the dynamics of various contemporary political processes.

with psychopharmaceuticals. Nevertheless, there is a generalized recognition of the difficulty of implementing in practice what is called for in the foundations of the Psychiatric Reform. In various situations, the operational logic of the various spaces of public services created to effectuate these psychosocial networks (particularly the Psychosocial Care Centers – CAPS, but also the basic care network of public health, the substitute services and others) maintain an institutonalizing, medicalizing and eventually asylum-oriented logic.[24] That is, it is not only the dynamics of care in the post Psychiatric Reform period that reproduces in some situations the logic of the psychiatric hospital and of psychiatric hegemony itself, focused today on physicalist and medicalizing concepts of psychological suffering, as this same logic now extends to a much broader population, formed above all and mostly by women who consult the basic healthcare centers and clinics seeking (bio) legitimacy for their ailments. In this framework and context, would another "politics of life" by the part of the state be possible, in its mental healthcare policy? How can the state construct "social networks" for taking in these subjects beyond their medicalization and insertion in a regime of normalization? This appears to be one of the challenges facing Brazilian Psychiatric Reform today, concerning the realization of a certain set of ideals present in its fundamental principles (the definition of which obviously involved disputes and conflicts among the different social, political, ideological and corporate forces that participated in the development of this policy).

In relation to the politics of "women's health," which range from reproductive rights in their broad sense, passing through prevention of various types of afflictions, to breast and uterine cancer more specifically and reaching women's "mental health" policies, the physicalist reduction of women to a biological body is returned to, which in turn is reduced to its reproductive cycle, its "life cycle," to which I referred. In this case healthcare policies function as a "technology of gender" (Lauretis 1987), which refers to specific modes with which biopolitics and the technologies of the subject are shaped in the reproduction of gender differences and hierarchies. Considering the social dimension of the lived experience reported by the women with whom the study was conducted, how would it be possible to have this dimension be

---

24   See the doctoral study by Ana Paula Müller de Andrade, Interdisciplinar em Ciências Humanas/UFSC [Interdisciplinary Human Sciences program](Andrade 2012).

incorporated to healthcare policy? Would it be possible to think of a women's healthcare policy that sought not the reproduction of difference but its deconstruction? How can another configuration of the biological and of the political be conceived today in women's healthcare policy – which shifts from the "living" to the "lived", from the life-cycle to the "course of life," from the biological to the biographical? How is it possible to construct forms of legitimation of another public policy, in a context in which, as I raised, it is precisely the biologized dimension of suffering and affliction that legitimate a public policy in "women's health" or in "mental health."

But beyond this, it is necessary to discuss how the very procedures and methods used to elaborate and enact these policies wind up hiding, making invisible and preventing these other epistemologies, modes of understanding and even styles of thinking (Rose 2013:26) from being heard.

Anthropological research and qualitative and ethnographic research have demonstrated that other politics of life are being exercised by real subjects in their daily lives and experiences. It should be asked how much the recognition of these politics, knowledge and practices can contribute to rethinking the dynamics of the operation of the institutions and instruments of the state in the field of public policies, recognition and rights.

Bibliographic references

ABÈLÉS, Marc. 1992. État. In : Bonte, Pierre & Izard, Michel (dir.). *Dictionaire de l'Ethnologie et de l'Anthropologie*. Paris: PUF, pp. 239-242.

ABRAMS, Philip. 1988. Notes on the difficulty of studying the state. *Journal of Historical Sociology* I(I): 58-89.

AGAMBEN, Giorgio. 2010. *Homo sacer:o poder soberano e a vida nua I*. Belo Horizonte: Editora UFMG.

AGUIAR, Adriano Amaral de. 2004. *A psiquiatria no divã: entre as ciências da vida e a medicalização da existência*. Rio de Janeiro, Relume Dumará.

AMARANTE, Paulo (org.). 1994. *Psiquiatria social e Reforma Psiquiátrica*, Rio de Janeiro: Ed. Fiocruz.

AMARANTE, Paulo. (org.). 2000. Ensaios. Subjetividade, saúde mental e sociedade. Rio de Janeiro: Ed. Fiocruz.

AMARANTE, Paulo. 1996. *O homem e a serpente. Outras histórias para a loucura e a psiquiatria*. Rio de Janeiro: Ed. Fiocruz.

BEVILÁCQUA, Ciméa & Leirner, Piero de Camargo. 2000. Notas sobre a análise antropológica de setores do Estado brasileiro. *Revista de Antropologia*, São Paulo: USP, V. 43 nº 2, 105-140.

BENJAMIN, Walter. 2012. *Critique de la violence*. Paris: Payot.

BRASIL. 2004a. Política nacional de atenção integral à saúde da mulher: princípios e diretrizes / Ministério da Saúde, Secretaria de Atenção à Saúde, Departamento de Ações Programáticas Estratégicas. – Brasília: Ministério da Saúde.

BRASIL. 2004b.Presidência da República. Secretaria Especial de Políticas para as Mulheres. Anais da Conferência - Brasília: Secretaria Especial de Políticas para as Mulheres, 164 p. (Série Documentos)

BRASIL. 2006. Ministério da Saúde. *Manual Técnico. Pré-natal e puerpério. Atenção qualificada e humanizada*. Brasília,.

BRASIL 2007. Secretaria Especial de Políticas para Mulheres. *II Plano Nacional de Políticas para Mulheres*. Brasília.

BRASIL .2011. *Saúde Mental no SUS: as novas fronteiras da Reforma Psiquiátrica. Relatório de Gestão 2007-2010*. Ministério da Saúde: Brasília.

BRITO, Mirella Alves de. 2014. *Entre cobras e lagartixas. Crianças em instituições de acolhimento se construindo sujeitos na maquinaria da proteção integral*. Tese de Doutorado em Antropologia Social, Universidade Federal de Santa Catarina, Florianópolis.

BUTLER, Judith e Spivak, Gayatri Chakravorty. 2009. *Quien le canta al Estado-Nación? Lenguaje, política pertenencia*. Buenos Aires: Paidós.

JUDITH BUTLER. 2006. Vida Precaria. El poder del duelo y la violencia, Paidós, Buenos Aires.

CANGUILHEM, Georges. 2000. *O normal e o patológico*. Rio de Janeiro: Forense Universitário.

CARDOSO, Marina. 2002. Psiquiatria e antropologia: notas sobre um debate inconcluso. Ilha. Revista de Antropologia (Florianópolis), Florianópolis, v. 4, n. 1, p. 85-113.

CARDOSO, Marina. 1999. *Médicos e clientela: da assistência psiquiátrica à comunidade*, São Carlos, FAPESP/Ed. UFSCar.

COSTA, J. S. F. 1989. *Historia da Psiquiatria No Brasil - Um corte Ideológico*. 4. ed. Rio de Janeiro: Campus,.

DESVIAT, Manuel. *A Reforma Psiquiátrica*. Rio de Janeiro, Fiocruz, 1999.

DIEHL, Eliana et alii. 2010. "A minha melhor amiga se chama fluoxetina": consumo e percepções de antidepressivos entre usuários de um centro de atenção básica à saúde. In: Sonia W. Maluf, Sônia &, Carmen Susana Tornquist. *Gênero, saúde e aflição: abordagens antropológicas*. Florianópolis: Letras Contemporâneas, pp. 331-365.

ESPOSITO, Roberto. 2006. *Bíos. Biopolítica y filosofía. Buenos* Aires : Amorrortu.

FASSIN, Didier & Wiktor Stoczkowski. Should anthropology be moral? A debate. *Anthropological Theory*. Vol 8(4): 331–332, 2008.

FASSIN, Didier. 2009. Another politics of life is possible. *Theory, Culture & Society*, Vol. 26(5): 44–60

FASSIN, Didier. 2008. Beyond good and evil? Questioning the anthropological discomfort with morals. *Anthropological Theory*. Vol 8(4): 333–344.

FASSIN, Didier. 2006. La biopolitique n'est pas une politique de la vie. *Sociologie et sociétés*, vol. 38, n° 2, pp. 35-48.

FASSIN, Didier. 2009. Les économies morales revisitées. Étude critique suivie de quelques propositions, Annales. Histoire, Sciences sociales,6 : 1237-1266.

FASSIN, Didier. 2010. El irresistible ascenso del derecho a la vida. Razón humanitaria y justicia social. *Revista de Antropología Social*, , 19, 191-204.

FONSECA, Tânia Galli; ENGELMAN, Selda & PERRONE, Claucia Maria (orgs.). 2007. *Rizomas da Reforma Psiquiátrica*, Porto Alegre, Ed. UFRGS.

FOUCAULT, Michel. 1979. *Microfísica do poder*. Rio de Janeiro: Graal.

FOUCAULT, Michel. 2005. *Em defesa da sociedade*. São Paulo: Martins Fontes.

FOUCAULT, Michel. 2008a. *Nascimento da biopolítica*. São Paulo: Martins Fontes.

FOUCAULT, Michel. 2008b. *Segurança, território e população*. São Paulo: Martins Fontes,.

GROS, Frederic. 2013. Y a-t-il un sujet biopolitique? *Noéma*, IV, 1 : 32-42.

LAURETIS, Teresa de. 1987. *Technologies of Gender. Essays on theory, film and fiction.* Bloomington: Indiana Univ press.

MACHADO, Roberto; LOUREIRO, Ângela; LUZ, Rogério; MURICY, Kátia. 1978. *Danação da norma: a medicina social e constituição da psiquiatria no Brasil*. Rio de Janeiro: Edições Graal.

MALUF, Sônia Weidner & TORNQUIST, Carmen Susana. 2010. *Gênero, saúde e aflição: abordagens antropológicas*. Florianópolis: Letras Contemporâneas.

MALUF, Sônia Weidner. 2010. Gênero, saúde e aflição: políticas públicas, ativismo e experiências sociais. In: MALUF, Sônia & TORNQUIST, Carmen Susana. *Gênero, saúde e aflição: abordagens antropológicas*. Florianópolis: Letras Contemporâneas, pp.21-67.

MALUF, Sônia Weidner. 2011. Saúde mental e medicamentos. Entre políticas públicas e experiências sociais. *IX Reunião de Antropologia do Mercosul*. Curitiba: UFPR.

SANTOS, Boaventura de Sousa (Org.). 2004. *Conhecimento prudente para uma vida decente:* "Um discurso sobre as ciências" revisitado. São Paulo: Cortez Editora.

TEIXEIRA, Mário. 1990. Hospício e poder. Fpolis: EdUFSC.

TORNQUIST, Carmen Susana; ANDRADE, Ana Paula Müller de; MONTEIRO, Marina. 2010. Velhas histórias, novas esperanças. In: MALUF, Sônia & TORNQUIST, Carmen Susana. *Gênero, saúde e aflição: abordagens antropológicas*. Florianópolis: Letras Contemporâneas, pp. 69-131.

TROUILLOT, Michel-Rolph. 2001. La antropología del Estado en la era de la globalización. Encuentros cercanos de tipo engañoso. *Current Anthropology*, Vol.42, N°1, febrero (Traducción: Alicia Comas, Cecilia Varela y Cecilia Diez**).**

WORSLEY, Peter. 1994. The nation state, colonial expansion and the contemporary world order. In: Ingold, Tim (org.). *Companions Encyclopedia of Anthropology*, Londres: Routledge, pp.1040-1066.

Sônia Weidner Maluf
Department of Anthropology, Center of Philosophy and Human Sciences, Federal University of Santa Catarina (UFSC)
soniawmaluf@gmail.com