



DISEASE EXPERIENCE AND STOCK OF KNOWLEDGE IN COPING WITH PSYCHIATRIC DIAGNOSIS¹

Experiencia en enfermedad y acervo de conocimiento en diagnóstico psiquiátrico

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Experiência de Doença e Estoque de Conhecimento no Enfrentamento do Diagnóstico Psiquiátrico

Abstract: With the accumulation of experiences gained from the world of everyday life, at all times, a stock of knowledge becomes available to each person, allowing him/her to operate on the world. All lived experiences are added to the stock of knowledge, which makes it exist as a continuous flow that changes according to the current experience. If we act referenced by a stock of knowledge in all experiences, we do so in the experience of falling ill: when one finds oneself in a situation of suffering, it is to this stock that one resorts to understanding, signifying and taking care of one's illness. In this phenomenological investigation, we researched people diagnosed with mental disorders as how they coped with the disease. Twenty in-depth interviews were conducted with people of both sexes, aged 19 to 59 years and with different psychiatric diagnoses, who were in attendance at a Psychosocial Care Center in the metropolitan region of Curitiba, State of Paraná, Brazil. When mobilizing their previous experiences and stock of knowledge, we identified that the following strategies and protective factors were used in coping with the disease: self-observation, isolation, art, emotional bonds, organization/routine and leisure.

Keywords: Mental Disorder; Experience; Coping; Psychopathology; Phenomenological sociology.

Resumen: Con la acumulación de experiencias obtenidas del mundo de la vida cotidiana, en todo momento, está disponible para cada persona un acervo de conocimiento que les permite operar en el mundo. Todas las experiencias vividas se agregan al acervo de conocimiento, lo que hace que exista como un flujo continuo que cambia de acuerdo con la experiencia actual. Si actuamos referenciados por un acervo de conocimiento en todas las experiencias, también lo hacemos en la experiencia de la enfermedad: cuando alguien se encuentra en una situación de sufrimiento, es a este acervo que recurre para comprender, significar y cuidar de su enfermedad. En esta exploración fenomenológica, investigamos cómo ciertas personas, con un diagnóstico de trastorno mental, se enfrentaron a la enfermedad. Se realizaron veinte entrevistas en profundidad con personas de ambos sexos, de 19 a 59 años y con diferentes diagnósticos psiquiátricos, que estaban siendo atendidas en un Centro de Atención Psicosocial en la región metropolitana de Curitiba - Brasil. Al dar cuenta de sus experiencias previas y su acervo de conocimiento, identificamos que fueron utilizadas las siguientes estrategias y factores de protección para hacer frente a la enfermedad: auto observación, aislamiento, arte, lazos afectivos, organización / rutina y tiempo libre.

Palabras clave: Trastorno Mental; Experiencia; Afrontamiento; Psicopatología; Sociología fenomenológica.

Resumo: Com a acumulação de experiências adquiridas junto ao mundo da vida cotidiana, a todo o momento, fica à disposição de cada pessoa um estoque de conhecimento que permite que ela opere sobre o mundo. Todas as experiências vividas são acrescidas ao estoque de conhecimento, o que faz com que este exista enquanto um fluxo contínuo que se transforma de acordo com a experiência atual. Se agimos referenciados por um estoque de conhecimento em todas as experiências, assim também o fazemos na experiência de adoecimento: quando a pessoa se descobre em uma situação de sofrimento é a este estoque que ela recorre para compreender, significar e cuidar da sua enfermidade. Nesta investigação fenomenológica, pesquisamos junto a pessoas com diagnóstico de transtorno mental como elas enfrentavam à doença. Foram realizadas 20 entrevistas em profundidade, com pessoas de ambos os sexos, com idades entre 19 e 59 anos e diferentes diagnósticos psiquiátricos, que estavam em atendimento em um Centro de Atenção Psicossocial na região metropolitana de Curitiba. Ao mobilizarem suas experiências prévias e estoque de conhecimento, identificamos que as seguintes estratégias e fatores de proteção foram usados no enfrentamento da doença: auto-observação, isolamento, arte, laços afetivos, organização/rotina e lazer.

Palavras-chave: Transtorno Mental; Experiência; Enfrentamento; Psicopatologia; Sociologia Fenomenológica.

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Introduction

How does a person diagnosed with a mental disorder deal with the disease in everyday life? This is the focus of this study, starting from the observation that there is a lot of literature in the area about biomedical care for psychiatric illnesses. We tried to approach the strategies for coping with patients and their resources as a way of looking at the object of study from another perspective, given that every phenomenon is a complex of appearances (Kelkel & Schéerer, 1954). To this end, an empirical research was carried out with users of a Psychosocial Care Center (CAPS) in the metropolitan region of Curitiba, State of Paraná, Brazil.

Considering the phenomenological framework, based on Alfred Schutz, the concepts of disease experience and stock of knowledge were used to understand how people with mental disorders find in their own life the ways to face their diagnosis and the presence of illness in everyday life, activating knowledge and strategies that have worked previously and that are therefore full of meanings; different, often, from the therapeutic proposals brought by health professionals and that are unknown to patients. However, it is not a question of hierarchizing the forms of care, but only of rethinking biomedicine as a unique and hegemonic way of care.

The article begins by presenting the concept of stock of knowledge and how it can be triggered when a person becomes ill, and then presents the empirical research, the method and the participants. The collected content pointed to the following coping strategies and protective factors: self-observation, isolation, art, emotional bonds, organization/routine and leisure, and leads to the question of how the stock of knowledge could be mobilized by health professionals as part of the therapeutic process of people diagnosed with mental disorder.

Experience and stock of knowledge in an illness situation

When starting this discussion, it is necessary to use the concept of experience. For Husserl, “every existing object is the object of a universe of experiences” (1929/1992, p. 24), then the act of experiencing is a constant in the life of any person.

The basic starting point for all phenomenological considerations is the current or immediately vivid essential experience, that is, the flow of subjective and spontaneous experience in which the individual lives and in which, as a flow, he/she carries spontaneous bonds, traces of memory, etc., from other previous experiences. The experience becomes a subjectively significant experience only through an act of reflection in which a current experience, in retrospect, is consciously apprehended and cognitively constituted (Schutz, 1970/2012, p. 345).

Schutz (1970/2012) highlights the subjective aspect of the experience, where all human conduct appears in a significant subjective context. For phenomenology, subjectivity has the meaning of intersubjectivity: a subjectivity that is constructed in the world and in contact with other subjectivities, in a triple structure: subjectivity-intersubjectivity-world (Zahavi, 2015). In this sense, it is opposed to the idea of a subjectivity confined within the individual, constituted and accessible only to the individual himself.

In the above excerpt, the author also identifies in the act of reflection the moment when the meaning is attributed to the experience. In this context, reflection can be understood as the modification of an original impression of a phenomenon. These changes occur in view of the “evocation of equivalent moments, of previous experiences, capable of interfering, completing or evaluating, the present situation” (Castro, 2012, p. 56).

One of the experiences we can have in the world is precisely the experience of falling ill, that moment when we feel that something is not going well. Then, we signify this situation as an illness and then we look for adequate care. In this sense, “the disease is integrated into the human experience and becomes the object of human action as a significantly constructed reality” (Souza, 1999, p. 89).

To understand the disease experience, we need to understand the process of becoming ill as a biographically determined situation. Schutz (1970/2012) uses this expression to refer to a situation that is linked to a personal and unique history, while the sedimentation is related to all the previous experiences of the individual. The notion of situation then involves the place someone occupies and the roles he/she plays in society, as well as his/her intellectual, political, religious and ethical positions (Capalbo, 1979).

Schutz (1970/2012) points out that each person lives in a world of everyday life - the world at his/her fingertips - which is formed by his/her own experiences, but also by the experiences of those close



to him/her, be they family, friends, neighbors, teachers and also by his/her predecessors, the people who inhabited the world even before he/she was born. Experiencing this world that is particular to him/her, at all times, the human being is in a biographically determined situation, which concerns his/her history and trajectory, and the experience cannot be thought apart from these references.

With the accumulation of experiences acquired in the world of everyday life, a stock of knowledge is available to each person that allows him/her to operate on the world. Schutz (1970/2012) understands that this stock of knowledge works as an interpretive scheme of past and present experiences and, also, of those to come. All new experiences are added to the stock of knowledge, which makes it exist as a continuous flow that changes according to the current experience. In view of this, any interpretation of the world of life "is based on a stock of previous experiences about it, our own experiences and those transmitted to us by our parents and teachers who, in the form of 'knowledge by hand', operate as a reference scheme" (Schutz, 1970/2012, p. 84). This formed picture, in spite of the inconsistencies that it may present, is sufficiently articulated to be used to solve most of the practical problems that a person faces in his/her daily life.

When a person finds him/herself in a situation of illness, it is to this stock that he/she resorts to understand and signify his/her illness. This process begins when the person recognizes him/herself in suffering and starts looking for some type of care to relieve his/her pain among the possibilities he/she knows: doctors, psychologists, folk healers, pastors, priests, faith healers, medicines, prayers, teas, magic rituals and a plurality of other options, or combinations of them, that are mobilized as a treatment for what ails him/her. In this way, the stock of knowledge has a dual function, it is activated both to signify the current situation and also to choose the best line of action:

This is a knowledge of reliable recipes to interpret the social world and to control things and people in order to achieve the best result in each situation with the minimum of effort, avoiding undesirable consequences. The recipe works [...] as a precept for actions and, therefore, serves as an expression scheme: anyone who wants to achieve a certain result has to proceed as indicated by the recipe provided for this proposal (Schutz, 1944/2010, p. 121).

However, on some occasions, the person's stock of knowledge may not be sufficient to resolve the disease, and the disease becomes a problem-situation, as it breaks the assumptions and recipes of everyday life. The natural attitude¹ is put in check, which reveals the insufficiency of available knowledge and, therefore, mobilizes people to seek new reliable recipes to explain and deal with the situation and thus be able to reintegrate that experience into the unquestioned zone of the world of everyday life (Alves, Rabelo, Souza, 1999; Alves, 2006).

When the disease becomes a problem-situation, it will necessarily imply disorder, since the routine ways of dealing with the world and with others become impractical and ineffective to deal with the situation. This is because there is no coherent whole in relation to the content that forms the stock of knowledge, it is marked by contradictions and vast zones of imprecision, which leads to different courses of action, vacillations, doubts, inputs and outputs in different modalities of treatment, changes in arrangements in daily life and the establishment of new social networks (Alves, 2015; Rabelo, Alves & Souza, 1999; Rabelo, 1999).

In this scenario, the patient (and the social group) needs to reorganize, find a new norm for its functioning (Canguilhem, 1943/2009). To find this order, it is necessary to mobilize actors, institutions, strategies, arrangements and choices among those that are available in a given social context (Alves, 2015). Thus, this article aimed to identify which coping strategies are used by people with mental disorders in their daily lives, especially those supported by their stock of knowledge, as these speak of the unique experience of each individual and the meanings he/she attributes to the world.

Method

The present study has a qualitative character that, for Minayo (2008), responds very particular questions for working with the universe of actions, meanings, motives, aspirations, beliefs, values, attitudes, at a level of reality which is not visible, needs to be exposed and interpreted, first, by the researcher. When the researcher asks him/herself about the meaning of the social world, according to Schutz (1970/2012), he/she no longer accepts the social world in a naive way and neither accepts the idealizations about him/her as something ready and that cannot be questioned. The researcher then adopts an understanding attitude towards the world and begins to seek the meaning that phenomena and experience have for people.

With the focus of study on experience, within the various qualitative methodologies that could help

¹ Husserl (1907/1986) understands the natural attitude as the automatic reaction to lived experiences, in which we take the things we experience as if they were known, for that, universal knowledge is transferred to singular cases, generalities are deduced and we operate on the basis of judgment. The natural attitude is opposed to the philosophical attitude in which the knowledge that until then was something obvious, now has the character of a mystery, since it starts to reflect on the relationship between knowledge and object. In daily life, people tend to operate by the natural attitude and not by the philosophical one.



to think about the object of study, phenomenological sociology was chosen because it has a privileged character in the study of phenomena and their meanings. Holanda (2014) points out that phenomenology makes its path towards a descriptive and comprehensive methodology, which leads to a privileged model for analyzing reality precisely because it does not abandon the empirical ground of this reality.

Phenomenology is an effort, an attempt to clarify reality. It is an opening to experience, to the experience of the world. It is the search for the phenomenon, for what appears on its own, for what appears, which reveals itself. Phenomenology is going to the very things, discovering them as they present themselves to my senses, as I perceive them, in a continuous relationship. But it is a “go in search” combined with my own concrete subjectivity. It is a look and see, not just a statement about something. It is participation, involvement (Holanda, 2014, p.47).

To “go in search” of the coping strategies of people who were diagnosed with a mental disorder, an in-depth and non-directive interview was chosen. The choice for the interview is in line with the thought of Schutz (1970/2012), in which human phenomena can only be understood in the context of human motives, human means and ends, human planning, human actions. Thus, it is up to the researcher to question the individual subjects about the phenomena in which they are involved.

The research was conducted at a Psychosocial Care Center in the metropolitan region of Curitiba, State of Paraná, Brazil, a specialized service in mental health of the Unified Health System, where people with mental disorders are treated. In total, 20 people with a psychiatric diagnosis were interviewed², 14 women and 6 men, aged between 19 and 59 years. The interviews lasted between 15 and 76 minutes, and were recorded on audio to be later transcribed and analyzed. All ethical principles were obeyed during the investigation, which is a part of the author’s doctoral thesis, and the research project was approved by the Ethics Committee of the Federal University of Paraná (CAAE: 67177417.1.0000.0102; Opinion Number: 2.044.014).

Coping with mental disorder

As previously presented, people act in the world referenced by the stock of knowledge, an interpretive framework that gives order to everyday life. This stock gathers our previous experiences, as well as the knowledge that was transmitted to us by our parents, family, teachers and other people with whom we come in contact, providing instructions to act in the face of the situations that arise (Schutz, 1970/2012).

The disease is one of those events, and through the interviewees’ report, it was observed that there is often nothing in the stock of knowledge that the person already has to help them deal with the illness, and it is necessary to start a journey in search for new knowledge, especially biomedical knowledge. But when the initial disorganization brought about by the diagnosis passes, the person conceives the chronicity of the mental disorder. So, the possibility of living with this situation for a long time and the perception that biomedicine did not bring the quick cure that he/she hoped for, can make the person turn to his/her old world recipes, in order to find a way to face the problem, aiming at what has worked previously.

In our research, we recognize several of these unique formulas, which we will call coping strategies and protective factors that will be detailed in sequence: self-observation, isolation, art, emotional bonds, organization/routine and leisure.

Self-observation

People with mental disorders do not spend all their time in crisis or outbreak, on the contrary, if they are receiving therapeutic follow-up, these moments can be very rare. The crisis is an important concept for mental health and concerns a serious clinical condition that causes intense suffering for the person and the family. Lobosque (2015) summarizes some behaviors and emotions that may be present in a crisis situation in mental health: loss of self-control; lack of criticism regarding his/her psychic condition; high degrees of delusional-hallucinatory activity, disorganized thinking and behavior; excessive mood elevation or depression; severe and persistent suicidal ideation and occurrence of significant episodes of self- or hetero-aggressiveness.

The crisis is a hovering threat, because when it occurs it brings disruptions and negative consequences for the patient and those around him/her, in addition to demanding many resources in its management. There is then a constant effort to try to prevent the crisis from occurring, so that the interviewees put all their actions under examination, in order to try to identify the first signs of an outbreak coming.

“I can already police myself. When I perceive that the crisis is coming and the corner of my mouth starts to shake

² We did not prioritize any psychiatric diagnosis when conducting the interview and the interviewees were chosen for convenience to include the largest possible number of experiences, observing the differences in age, gender, social class and length of treatment at the CAPS.



like that, you know? It starts to give me that trembling, that palpitation, I already know that I need the medication to be able to control myself and that way I have led my life” (Betânia³, 36 years old, chemist).

“Nowadays I feel a bad feeling, you know? and when I feel this bad feeling, I feel like staying at home, I feel like not going out for anything, I feel like not socializing, not getting close to friends, but I do the opposite. When I have this bad feeling, I say ‘I’m going out’. Or when I’m on the street and this feeling comes, I say ‘I will continue, I will continue here, I will not leave’ and I think this is an effort that I am making to try to improve” (Kevin, 26 years old, production assistant).

“I’ve had an improvement over the past few years. I really learned to know myself after I started doing all the treatments. We end up getting to know better and end up knowing how to act when getting into a crisis, right?” (Marcos, 41 years old, radiology assistant).

By recognizing the first signs of the crisis, such as the corner of her mouth trembling for Betânia or a bad feeling for Kevin, it is possible to develop an action plan for that situation, to take control in the face of the crisis, at least in some way, since the outbreak represents the disorder. Marcos did not detail his way of dealing with the crisis, but Betânia takes psychiatric medication and Kevin tackles the situation.

Another situation in which self-observation is used is in the use of psychotropic drugs, since from the psychiatric diagnosis, medication becomes highly valued among patients and health professionals, and the routine of the person with mental disorder starts to revolve around the handling of pills, capsules, injections and drops (Muhl, 2019). Thus, the interaction of the medicine with the organism is placed under scrutiny, where an assessment is made to decide whether or not to maintain that medication or dose by the own patient:

“The first antipsychotic I took I had something a little bad like that because I started to see a lot of black balls and then that anxiety started, shapes and started to give me some strange things then I ‘mom can’t take this medicine’, then we changed [...]” (Helena, 20 years old, student).

“The risperidone that I took ... that I went and told him [psychiatrist] that I thought it was not doing me well, but then he looked over and said he was going to change and changed” (Lorena, 39, vigilant).

Self-observation in relation to medication can be an important tool to be used by psychiatrists when adjusting medication, because when performing this detailed examination of side effects, the patient gives the professional access to a set of physical and subjective information that the professional would not have on his/her own, since they depend on the patient’s reflexivity and the intersubjective relationship between them. If these reports are heard, they can lead to more efficient therapeutic approaches, considering the uniqueness of people. However, Foucault (1954/2007) has already warned us about how the speech of people with mental disorders, even the reports about themselves, can be dismissed, after all, they are “mad”.

Among the mental disorder coping strategies discussed here, self-observation seems to be constantly applied by the interviewees, as a search to better understand the situation experienced, being fundamental in the pre-crisis moment, as it allows a line of action to be drawn so that the crisis does not start or be mild. In this sense, adding the pre-crisis function and the identification of the therapeutic and side effects of psychiatric medication, this seems to be the strategy most frequently used to face the presence of madness in everyday life.

Isolation

When self-observation works and the person perceives the crisis coming, another form of coping that he/she can use is to seek isolation, to reduce the damage that can be caused by the event:

“Today I can control myself. When I see that I am leaving the limit, I already know the medicine I have to take or if I have to lock myself up ... because I am afraid of exploding near my daughters, near my husband. Because sometimes when there are strong crises in me, I go inside the room, close everything, hit the pillow, punch the bed, but I’m not close to them” (Betânia, 36 years old, chemist).

“I usually isolate myself, I get angry, but I isolate myself and keep myself there... I stay, stay, stay until I explode” (Marcos, 41 years old, radiology assistant).

Isolation seems to have the main function of preventing those close from being affected by the crisis. As the interviewees cannot predict how they will act during the episode, if they will become aggressive, breaking things and uttering offenses, as has happened in their past experiences and are characteristic of crises (Lobosque, 2015), they prefer to walk away and face the crisis alone, sometimes placing physical

³ Os nomes são fictícios para proteger a identidade dos informantes da pesquisa.



barriers between themselves and the world, as when Betânia locks herself in her room.

Thus, if self-observation is used to identify the crisis coming, isolation is a strategy for coping with the crisis. The crisis is a critical moment, of disturbance, discontinuity and suffering (Martins, 2017), being a possibility in people's lives, but for those who have a mental disorder it is recurrent, so the interviewees sought to create their own method to deal with it.

Art

Historically, art is seen as a therapeutic possibility for madness (Silveira, 1981). However, it is not that kind of artistic approach that we are dealing with here - an activity strategically proposed by the professionals of a mental health service, in the format of a specific exercise to fulfill therapeutic objectives -, the art used as a coping strategy was already present in life of the person and is given a new meaning to help deal with the symptoms, as we can see below:

"Everything I see and dream, I draw [...]. I think it's easier to fight monsters when you can see them [...] I started to observe everything I saw in my dreams. That sometimes we see things repeated and then I drew them, put what I saw in that monster and maybe it was not his power. So if I was in the dream, many times I could do it in dreams, it's very funny, I dream about something, then I drew, then I dreamed again, then in the other dream when I could see him, then I faced it, it was funny, it didn't show up anymore [...]" (Helena, 20 years old, student).

"In the past, I wanted to kill myself and then I drew the way I was going to kill myself. I drew some very psychedelic drawings like that, very surreal, very cool ... I like to draw today and I don't know, it's therapy for me [...]" (Kevin, 26 years old, production assistant).

"I paint doll houses. [...] Distracts me, occupy the head" (Olga, 53 years old, confectioner).

Helena always had very vivid dreams, since childhood, with monsters and other scary creatures that ended up reverberating in her daily life. She then developed a strategy to try to face the monsters during her own dream, instead of spending the day with them: drawing them. Helena started to put those figures that chased her on paper, where they were seen and analyzed, so she could discover their weaknesses and they would be less threatening when she went back to sleep.

Kevin has a very strong connection with art, especially drawings, graffiti and photography, and expresses an interest in attending a college in this area. So, being something so central in his life, he started to use it as a way to face suicidal ideations, putting his energy into producing a drawing, so as not to get to achieve the goal of killing himself. The strategy of using art as a way to "distract" symptoms is also used by Olga. The interviewee was already doing handicrafts before the mental disorder emerged in her life, but now it takes on a new meaning, as it "occupies the head" and thus avoids crises.

If self-observation is used pre-crisis and isolation is used during crisis, art is a coping strategy that can be used in both moments, as we observed when Kevin uses it at the moment of greatest aggravation and Olga uses it to ward off more intense symptoms and remain stable. In the cases treated here, art only has these beneficial effects because it was already present as a possibility in the patient's knowledge stock, it was a recipe that was already tested and that gained a new meaning in the face of the disease experience.

Emotional bonds

According to Schutz (1970/2012, p. 92), "the social world in which man is born and in which he needs to find his way is experienced by him as a narrow network of social relations". Thus, people meet, relate and end up developing emotional bonds with each other. More than a coping strategy, affective bonds are seen by respondents as a protective factor against the disease that they can always have around:

"I really like taking care of my grandson, you know, because he gave me courage, he gives me ... I know I have to get up, that I have him to take care of [...] he is like my son, so I have an incentive in my life [...] now I also have a granddaughter with 2 months, I also transfer to her the will to live [...] it gives me a will to live, the will I hadn't had more than 20 years, this desire to live, which I say: for someone I will live, I will have to live. She will need me, for her to walk, for her to grow" (Glória, 46 years old, housewife).

"I have a granddaughter who is my life, my adoration ... She is 10 years old. Today she is 10 years old, she is my passion. Today I fight, I will be honest with you, today I fight it's not for me, for me I don't care anymore, I fight for her, because she asks me to fight, so that I can be with her [...]" (Noemi, 59 years old, cook).

"And then I started to improve with medication, I could see, not only for that, but because I think that at that moment, my mother had already shown that she was willing to help me [...]" (Helena, 20 years old, student).



Respondents understand that social interactions that are permeated with affection can be beneficial to their illness situation. Helena, for example, talks about how her mother's unconditional support helped her to face her mental disorder and no longer hide her symptoms, so she can receive help from health professionals. Glória and Noemi, on the other hand, talk about how being present in their grandchildren's daily life can bring a new motivation to live.

With such importance in coping with the disease, these emotional bonds also come to be consulted in relation to therapeutic choices. Rabelo, Alves and Souza (1999) indicate that it is within the family that the main decisions are made and strategies are developed to deal with people with mental disorders and that the networks of friendship, neighborhood and kinship are effectively involved with the drama disease.

Organization and routine

This coping strategy retrieves the interviewees' argument already used in relation to art: keeping busy is good for mental health:

"I have this to organize myself... how do you say? organize myself like this, to have a routine. [...] I have, like, the reading time, I usually read from 5 to 6" (Cícero, 19 years old, unemployed).

"Because then I know that my granddaughter is going to come to lunch ... I have time to put the food on the table, I have time for her to go to school, so this, for me, occupies the day [...]" (Noemi, 59 years old, cook).

"I do things at home: washing clothes, I make food [...] and these help me too, I do house chores ... I can do something [...]" (Selma, 38 years old, kitchen assistant).

Reading these reports, it is impossible not to remember the popular saying "an idle brain is a devil's workshop". It seems to be exactly this logic that the interviewees resort to when they want to "occupy the head" and "have a routine" to prevent the devil from appearing, or in this case, the madness from emerging. However, it is curious to note the gender difference, since for Cícero the routine involves a time for reading and walking, while for Noemi and Selma, domestic chores are presented as routine.

Leisure

The last coping strategy represents a search for quality of life, which is so affected by the presence of mental disorder:

"[...] I'm always going, in constant movement, I don't stay still... I don't stop at home... My mother even complains, but I don't stop at home: I go out with friends, I'm going to play basketball, I'm always with a busy mind. Just like my brother said: 'If you stand still it will be worse, because if you go out, do activities, it will be better for you' and I think this is cool" (Kevin, 26 years old, production assistant).

"When I see that these signs are coming, I try to do some activity, something that keeps me out of it, the problem I'm having there, for example, I'm going to run in the park [...]" (Marcos, 41 years old, radiology assistant).

"I like to walk; I like to travel... when they say they are going to travel I am happy! And I like going to the pizzeria too!" (Pilar, 54 years old, general services).

Here leisure appears as a replacement strategy. In place of the symptom, the interviewees put an outdoor activity, a sport, a physical activity, a walk, a trip and so the symptom no longer has dominion over the daily lives of these people. It is also possible to observe a search for a new meaning of the disease through this strategy, because if the mental disorder is often identified with sadness, crying or apathy, the interviewees seek to do the exact opposite, pursuing activities that are identified with happiness, for warding off the disease.

In this sense, the interviewees are triggering the social meanings and stigmatization associated with mental disorders (Goffman, 1963/1982). Neto and Alves (2012) speak, for example, of depression and how it is seen as laziness by common sense, as well as, it would cause the inability to carry out daily activities and to be happy. These social meanings and stigmatizations are also shared by people affected by mental disorder who are lay people on the topic, after all, receiving a psychiatric diagnosis does not make them specialists in psychopathology, so the interviewees seem to want to remove the sadness and malaise they feel, as well as the social representation that this is how they should feel.



Final Considerations

Consulting the stock of knowledge is something that is done constantly, in all aspects of life, and is not exclusive to moments of illness, even though in these situations it gains great importance for helping to select the next action to be taken and bringing the confusion caused by the disease again into the realm of things that are known. Kleinman (1978) argued about the care system and speaks of an arena popular care, which encompasses actions in the family context, home remedies, self-medication, advice and which is triggered by the patient just as he/she triggers a doctor, a faith healer or a folk healer, which leads to the reflection that providing care and encouragement to the patient is entering a very complex field.

When carrying out this study on coping strategies for mental disorders from the stock of knowledge, it was not sought to create ready-made recipes, institute models or reveal secrets on how to deal with the disease, after all, there is no step by step that works for everyone. What the research revealed was the way these people reorganize and find ways to live, even with the ferocious attack on subjectivity, carried out by mental disorder (and by some therapies too).

Thus, using the stock of knowledge can be an important tool for the treatment of mental disorders, in such a way that mental health professionals can mobilize this knowledge and encourage people with mental disorders to find creative ways to deal with the situation. This reflection also serves to rethink the practices within health services, especially those developed in therapeutic workshops, because art as a treatment works for Helena and Olga but it may not work for others or physical exercise is a choice for Kevin and Marcos but other patients do not adopt it, as these actions are not supported by the previous personal experience of the patient, and there is no sense in performing them. Thus, the question remains: if each person's stock of knowledge is a tool at hand, why not use it to enhance the care offered?

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