Depressão, suicídio e sociedade.[1]

Depression, suicide and society.

Modesto Leite Rolim Neto[2], Vera Maria da Rocha[3]

1. Article from the Doctoral Postgraduate Program in Health Sciences, Federal University of Rio Grande do Norte - UFRN, Natal, Brazil.
2. Doctoral Postgraduate Program in Health Sciences, Federal University of Rio Grande do Norte – UFRN, Brazil.
3. Doctor, Department of Physiotherapy and Postgraduate Program in Health Sciences, Federal University of Rio Grande do Norte – UFRN – Brazil

Abstract

Clinical observations indicate that suffering and psychic pain, by means of the repertory of languages established by depression, are associated to subjective experiences of commitment to well-being and the social recognition of this experience. The objective of this qualitative study is to understand how people interpret the meanings associated with depression and probable consequences of suicidal tendencies. 150 people, including adolescents and adults of both sexes, were investigated. Narrative interview and listening were the instruments adopted to understand the problem. Besides the patients, statements from family members and the medical team were analyzed. The target population consisted of all individuals in states of depression, with suicidal manifestations, or with a history of attempted suicide. After classifying the data, an analysis was performed to bring all types of information to the final report.

Key-words: Depression. Suicide. Society.

Resumo

Observações clínicas indicam que o lugar do sofrimento e da dor psíquica através do repertório de linguagens estabelecidas pela depressão estão associadas aos espaços das experiências subjetivas de comprometimento ao bem estar e reconhecimento social dessa experiência. Este estudo teve como objetivo compreender como as pessoas interpretam os significados associados à depressão e prováveis conseqüências de desejos suicidas. Foram pesquisados 150 sujeitos, incluindo adolescentes e adultos de ambos os sexos. A entrevista narrativa e a escuta foram os instrumentos adotados para a compreensão da problemática. Trata-se de uma pesquisa qualitativa. Além dos pacientes, foram analisados depoimentos de familiares e da equipe médica. O público-alvo foi constituído por todas as pessoas relacionadas a estados de depressão, idéias suicidas ou histórico de tentativa de suicídio. Depois da classificação dos dados, houve um trabalho de análise em vista da redação de um relatório final, trazendo todo tipo de informação.

Descritores: Depressão. Suicídio. Sociedade.

Introduction

We undergo in many stages of our daily life, experiences where we search for the meaning of words. In this context, we confront personal and collective difficulties, dualities, and expectations in the different situations in which words allow for dialogues on examining conflicts, chance, complaints and descriptions which guide individuals in their pain and psychic suffering.Alert to messages which seek to transmit and explain the harshness of secret areas, regions of non-listening, spaces of need, recurrences and narratives, we have been tracing during the course of our anxieties, reflections on the spaces of listening, for a determinate field of application: depression. What to say about pain which cannot be said? Pain of nothingness, simply of the emptiness of being, indescribable, incommensurable, and because of this, call the word in vain? [(1)]

In this sense, words enter the field of listening lacking forms of recognition in that which bears the possible and the necessary, familiarity and its absence, repetition and contempt when pain and psychic suffering transform themselves into disease. A person is defined as being ill if there is agreement between his own perceptions of commitment to well-being and the perceptions of people around him. Becoming ill is a social process, which involves other individuals besides the patient[(2)].

The objective is not to force truths, meanings which these words may hold, but, faced with circumstances which arise, to reveal fragilities and anxieties, the movements of its elaboration, upon the emergence of voices, in the articulation of the gaps with the

experienced. It is the gaps which confer ‘truth’ to the story, the narrative which would open space for another/Another, for a sensitive listening[3].

This discussion is interesting when we think about the concept of order and disorder, as well as the relation between both, on repositioning the personal and cultural meanings in the context of the language of suffering itself, which makes its presence in the bridge between the subjective experiences of commitment to well-being and the social recognition of these experiences[2].

The term depression may signify a symptom, which is but a part of innumerable emotional disorders, without being exclusive of any one of them, may signify a syndrome, represented by many and varied psychic and somatic symptoms or, may signify an disease, characterized by marked affective alterations[4].

Our interest was in defining it as the place for responding to bad experiences, in the dialogical interaction with its interpretations, effects and solutions in people’s lives. The process, however, of defining someone as ill contains words on self comprehension, as in the perceptions of others, that which is represented by suffering or in the interaction of both. Perhaps it is possible, at this moment, to recognize the role of listening as an appeal to what exists and seeks to communicate, normally implying a series of subjective experiences.

As Psychologists, we have been selecting, through clinical observations, the difficulties that people face on manifesting their pain and psychic suffering, when emptiness, loss

or need offer words on encountering mediation between personal experience and the meaning that these offered to their own selves. It is from this experience that will arise the particular interest for the language of suffering and its repercussions in becoming ill. Fundamental in this process, was perceiving that falling ill involves subjective experiences of physical and/or emotional changesand to what degree this provokes order and disorder in the conduct of individuals when mobilizing words to express helplessness. To support the emergency of the strange is to live an experience of deterritorialization with another, and of resistance created by the forces which act in this field, in this intersubjective relationship, we seek another territory, another option in life[(3)].

Thus, we attempt to comprehend the existing relation between being depressive and the level of comtempt contained in the individuals' narratives, on recognizing their subjectivities, as well as the suffering encountered in the treatment of underpriviledged patients at Primary Health Care Clinics. The narratives represent cultural documents which emerge in moments of unexpected rupture in the flow of daily life[(5)].

The results of this study are revealing linear forms of translating the personal and cultural meanings concealed in the treatment of the depressive, that is, on decodifying the words of commitment with the real nature of the suffering and its dimensions, characterizing as “passive” the pain and suffering which reside in that which wants to be translated.

In studies developed in the mental health area at Auta Alves Ferreira Health Clinic (founded in 1971, associated with SUS (Brazilian Public Health System), with Clinical, Psychological and Odontological services), in the city of Aparecida, in the hinterland of the state of Paraiba, we encountered a population of adolescents and adults from both sexes, derived from the rural and urban zone, whose principal economic activities were handcrafts (hammocks, quilts, cushions, embroideries) and subsistence agriculture (corn, beans, and rice) as well as a small production of cotton, having a per capita income averaging $35.00 per month.

In an attempt to better understand the experience of meeting these individuals, treatments for depression were discussed during their visits to the Health Clinic. In this case, it can be concluded that the narrative would be exercising basic forms of organizing the experience with that of depression, allowing for the search of meaning in that which affects and mobilizes feelings. The subjects of this relation arrive invested with a series of experiences, bearing marks which were acquired over their lifetime. It is these marks which may resurface at this meeting, and this is only possible there, whether with another as a support for these marks, or of 'another' capable of mobilizing these marks. All are bearers-proponents of an enigma. Of a 'voice'[3].

At this same time, we received an invitation to act in the Clinical Psychology area at the Santa Cruz Municipal Hospital, (with 30 beds, functioning with an ambulatory, minor surgeries and a psychological treatment service), located in the Paraiba hinterland. With patients from the rural and urban zones, we verified that the Health Secretary is concerned with establishing standard forms of becoming ill, known as "disease of the

nerves", considering the factors involved in depression. We concentrated our activity in the aforementioned Hospital, in the dimension of listening to the real meaning of the symptoms associated with the idea of "nerves". We noticed that the concept of nerves is associated to the forms of explaining pain and psychic suffering, in 46% of the subjects examined, in a population of 150 individuals. "Nerves", however, puts the question of distance and approximation of the communication forms established in depression in the exposition of the narratives, assuming, however, a unique manner of explaining traumatic experiences, associated to the symptoms.

It was from this experience that arose the interest for another clinical manifestation such as suicide, obliging us to better reflect on this question and the interchange with depression. Doctors frequently objectify the disorder and separate it from the life of the patient, in whom the disorder is imbedded. They concentrate on the pathology. Possibly not perceiving the real significance of the problem[6].

It is in this professional and academic direction that depression and suicide acquire the stature of a more elaborate research to reveal the listening, the familiar and the tragic. It is worthwhile, at this point, to mention that the demands observed in the voices which needed interpretation by means of the authentication of the disease, come to assume the character denominated as world configuration[7], as defining personality as a form of organizing individual subjectivity[8].

Thus, listening comes to constitute a decoder of what is obscure, confused and silent, to bring out the "sub" meaning from the conscience (that which is experienced, postulated,

intentionalized as concealed[9]. That is, connected to the spaces of pain and suffering from which the individual seeks to communicate through the psychic.

Understanding how individuals interpret depression and suicide and how they respond to them, constitutes the objective of our investigation. In this context, the study interprets the voices used by people in organizing this experience, principally that which confers them meaning. Such an interest was articulated about the words which the subjects employed in their visits to the Auta Alves Ferreira Health Clinic in the city of Aparecida, and Santa Cruz Municipal Hospital, in the city of Santa Cruz, both located in the hinterland of the state of Paraiba, about the components of their suffering and psychic pain. Such an encounter was linked to investigations. It was an invitation for reflection, curiosity, search; not to certainty, but to multiple voices, to polyphony[10].

METHODS

We assembled, by means of a cartography of symptoms associated with depression, the experience of the voices that interpret. This idea can be much more understood if we refer to the notion of cartography in the sense of providing a theoretical and political reading – concepts, absences, practices and effect, new meanings, an interesting model for interpretation[11].

In addition, we reconstructed the events linked to depression and to suicide, from the perspective of the patient[12]. The narratives, however, were the focus of attention of the study, marking and searching for channels of communication established between the

individuals' pain and psychic suffering, revealing their experiences when expressing individual and social existence. We follow, therefore, six steps for its analysis[12].

1º) Detailed transcription of verbal expressions from the subjects of the study;
2º) Division of the text into indexed and non-indexed subject matter. The indexed statements have a concrete reference to "who did what, when, where and why", whereas the non-indexed statements go beyond the experiences and express values, judgements and all manner of a generalized "knowledge of life";
3º) Use of indexed subject matter from the text, in order to analyze the order of each individual's experiences, which Schutze calls "trajectories";
4º) Investigation of the non-indexed dimensions of the text, such as "knowledge analysis";
5º) Understanding of the grouping and comparison among individual trajectories;
6º)Comparison of cases and individual trajectories, within the context, and determination of similarities. This process allows for the identification of collective trajectories.

Universe and Sample

The study universe included 324 individuals 10 years of age or greater, who sought treatment in the referred study areas for the following disorders: depression, suicidal tendencies or attempted suicides. Initially the following were performed: data gathering on the subjects during medical and psychological appointments, related to principal complaints linked to pain and psychic suffering; the selection of subjects was elaborated from registered cases of depression and from a history of attempted suicides, in the

medical records of the previously-mentioned Primary Health Care locations. With this information, we began mapping our sample considering:

- Number of visits to the Primary Health Care Service, when the complaint was the non-improvement of previously reported symptoms;
- Prolonged psychotropic drug treatment, with repercussions in the present;
- History of two or more recurrences in the same year
- History of suicidal tendencies
- History of attempted suicide
- Prolonged psychological treatment

We constituted from this mapping, 03 inclusion criteria for the sample, taking into account the following indicators:

· Being depressive

· Having suicidal tendencies

· Having a history of attempted suicide

150 individuals who satisfied the inclusion criteria, were selected, including adolescents and adults from both sexes, distributed as follows: **(Table 1 and Table 2)**

Table 1 - Mapping of subjects. Study area: Auta Alves Ferreira Health Clinic – Aparecida/PB

SEX	MALE		FEMALE	
	34		41	
PROVENANCE	URBAN ZONE		RURAL ZONE	
	37		38	
OCCUPATION	EMPLOYED		NOT EMPLOYED	
	35		40	
MARITAL STATE	SINGLE	MARRIED	WIDOWED	
	32	40	03	
AGE GROUP	10 to 19 years	20 to 39 years	40 to 59 years	>> 60 years
	09	45	14	07

Table 2 - Mapping of subjects. Study area: Santa Cruz Municipal Hospital – Santa Cruz/PB

SEX	MALE		FEMALE	
	31		44	
PROVENANCE	URBAN ZONE		RURAL ZONE	
	37		38	
OCCUPATION	EMPLOYED		NOT EMPLOYED	
	30		45	
MARITAL STATE	SINGLE	MARRIED	WIDOWED	
	24	49	02	
AGE GROUP	10 to 19 years	20 to 39 years	40 to 59 years	>> 60 years
	07	48	14	06

At a subsequent moment, we recovered the words themselves and their meanings in that which is learned, experienced and shared in the dynamics of health services, pertaining to psychic disease. Interviews were conducted with a medical and psychological team.as well as with family members, in order to better understand the formation of events in the flow of pain and psychic suffering.

RESULTS

The perspective of individuals about their symptoms generally reveals keywords , used to explain what the subject feels, interpret the origin and importance of suffering, as well as the effects on his behavior, functioning as conceptual remnants. In these remnants, the symptoms represent specific forms for elaborating feelings about the vicissitudes resulting from pain and/or psychic suffering, placing them in a pattern which is recognizable in the language of depression. These help to provoke and legitimize the narrative, as well as the emotional response, in trying to explain the cultural, psychic and biological context into which they are inserted. **(Table 3)**

Table 3 - Cartography of Depression. Dimensions (most frequent symptoms)

BIOLOGICAL	(...) fatigue, (...) dizziness, (...) stomachache, (...) headache, (...) pressure in the head, (...) out of breath, (...) weakness, (...) lack of patience, (...) shaking, (...) insomnia, (...) tiredness, (...) palpitations, (...) despondency.
PSYCHIC	(...) pessimism, (...) agitation, (...) poor memory, (...) distress, (...) desire to die, (...) feeling of guilt, (...) restlessness, (...) fear, (...) sadness.
CULTURAL	(...) self-depreciation, (...) lack of financial perspective, (...) few employment options, (...) nothing to do, (...) disinterest in spouse, (...) lack of leisure, (...) constant quarrels, (...) alcoholism.

Concerning this question, the words are inserted at the center of the reflections, as conductors of feeling, which implies perceiving them in their course through listening, in the reference involved between the person, in the exchange of conversations and reactions established in diagnostic evaluations, as well as in the treatment determined for the individual. Words are only the gestures, sounds, behavior or body posture which participate as consensual elements, in the flow of consensual coordination of behavior which constitutes language. Words are, however, forms of consensual coordination of behavior[7].

In this perspective, depression and suicide share a set of responses which denounce and contribute in creating a context, an ecology of ideas which energize themes, inquiries and metaphors[9, 13-15].

We are led, however, to a reactivation of relationally thinking[16], the network or configuration of objective relations between positions which releases the depressive process in that which guides the narrative of the symptom. We are accentuating the things instituted, their materiality, their forms of self-organization where resistance and perverse effects, neutralization and obstruction, autonomy and creativity are generated[17].

Our focus was on defining how these themes, inquiries and metaphors guide the narratives. This aspect seems very interesting to us, especially if we consider the cartography for conception of disease, in the context that it produces an intertextuality between concurrent concepts and discourses, to show that knowledge and action are

interrelated[11], in the spaces which are defined as suffering or in the reactions to psychic pain. **(Table 4)**

Table 4 - Cartography Of Depression. Dimensions (Conception Of The Disease)

BIOLOGICAL	(...) head exploding, (...) no nerves, (...) constant nervousness, (...) buzzing in the ears all day, (...) lack of courage.
PSYCHIC	(...) sad thing, (...) long time to get well, (...) it is of no use, (...) constant fatigue, (...) crying, (...) suffer in silence, (...) much suffering, (...) ache in the soul, (...) strange thing, (...) dying inside.
CULTURAL	(...) the old blue prescription (all psychotropic prescriptions are blue), (...) never get better, (...) wandering around after medicine, (...) it is the same medication, (...) living aimlessly, (...) hardship, (...) people not understanding what is the matter with you.

The conception of depression as an disease brings with it fragments of daily life. These likely constitute “maps” characteristic of transformations identified over the course of suffering or of the reactions to psychic pain, influencing the manner in which they express their complaints.They become useful representations , at the same time as they seek to form the images necessary for them to accurately describe/guide their vulnerabilities.

Thus, the area of suffering and psychic pain was interpreted from a repertory of languages established by order and disorder, as a structure based on their meanings. If reality is not natural and self-evident, more structured, it can also be destroyed, investigated, questioned[10].

Following this direction, translating the words, while manifestation of areas unique for each person, that which surrounds order/disorder, has characterized “baggage-words”[18], contextualized, faced with areas of pain and suffering, into its dualities and

oppositions, description and compartments of psychic life, frequently concealed in private places.

This implies a *tematha* when promoting themes which contain impulses and existencial options, linked to the search for knowledge[19], on rethinking the presence/absence of interlocutors, when depression and suicide cause a crossing of instabilities and fragmentations in the development of words and their meanings.

We call attention to the *thematas* used in understanding the complaints which contribute to depression at the moment that words seek to explain the impulse points of the meanings, giving them directions over the disease. **(Table 5)**

Table 5 - Cartography Of Depression. Dimensions (Principal Complaints/*Temathas*)

BIOLOGICAL	(...) dizziness, (...) tremors, (...) cold sweat, (...) body fatigue, (...) imbalance, (...) frog in the throat, (...) buzzing in the head, (...) shortness of breath, (...) weakness, (...) headache, (...) tingling in the body, (...) accelerated heartbeat, (...) nausea, (...) sleeplessness
PSYCHIC	(...) distress, (...), emptiness, (...) loneliness, (...) abandonment, (...) desire to die, (...) negative thinking, (...) nerves, (...) nervousness, (...) weak concentration, (...) discouragement, (...) irritation, (...) sadness, (...) anxiety, (...) agitation, (...) aggressiveness, (...) lack of perspective, (...) not loved
CULTURAL	(...) husband's drinking, (...) family problems, (...) financial hardship, (...) love problems, (...) loss, (...) no employment, (...) lack of understanding, (...) death, (...) nothing to do, (...) lack of recognition

Conclusions

It is necessary to reorganize the words which enable us to think about how and why a person became depressed or attempted suicide, which enables us to think about the

language repertory derived from the culture in which this suffering occurred, expressed in a culturally specific manner[5, 20]. This repertory can be understood as a *hypomnemata* – solid memory of things read, heard or thought[21] to the re-reading of the words, within the possibilities of contact with their meaning and significance.

Individuals, principally through their complaints, employ words which include not only personal experience, but also the meaning that these acquire in relation to one another. Following this course, the metaphors of depression operated simultaneously with things read, heard and principally thought. **(Table 6)**

Table 6 - Cartography of Depression. Most Frequent Metaphors

FIRE	(...) it is like a brush fire, everything is on fire, (...) my head is boiling, (...) there are moments when my body is in turmoil, like fire destroying everything, (...) my life is on fire, (...) my dreams go up in smoke, (...) it is like a bonfire inside me.
EXPLOSION	(...) my heart almost explodes, (...) my head seems like it is going to explode, (...) I am going to explode with fatigue, (...) my life exploded, there is nothing left, (...) explosion is part of me.
DRYNESS	(...) everything dry, nothing in bloom, (...) it is pain hurting you, (...) from so much suffering I think my life has dried up, (...) depression is like the dam near my house that was drying up, (...) my mouth gets dry.
DEATH	(...) there is a voice saying, die, (...) I would like to end it all, (...) disappear, (...) put an end, (...) I grabbed a rope to die, (...) I took what I had to take, (...) death is like a leap, in an instant you are there, (...) a strange thing, saying die.
CAUSTIC SODA	(...) everything destroying, (...) your dreams, your life, your desires being devoured, corroded, (...) people become like caustic soda, (...) it is the desire to destroy like caustic soda.

The words encounter a substitute to create meaning, when faced with the discovery of experiencing the disease. The idea that they represent is of something that destroys, inside or beyond the mind, incorporating the intensity of their suffering and pain within

the vulnerabilities to which they are exposed, principally when the deleterious effects of pain and/or suffering are mediated by social conditions and unfavorable contexts.

In this course of private places, depression and suicide prevail as a sequence of referential systems while sharing pain and suffering. Individuals and their feelings enter into areas of order and disorder, violation and diversity, absence of self and of others- and learn that, cumulatitively, they challenge their own uncertainties, by which the value of the word and of listening is put up for discussion. Life, at all its levels, is inextricably interconnected by complex networks[22]. The strategy would be a scenario of action which can be modified in function of the information, happenings, and the unforseen which occur during the course of the action[10].

Depression, however, acquires diverse points of interpretation concerning the daily experience of the disease, reorganizing it into the very words of experienced reality, represented as an disease of the nerves, of fear, of the soul, of death, of the heart, of negative things. Discourse responds to a clearly-heard virtuality, or in other words, the understanding of interpretation as a realization of meaning[23].

This presupposes, however, a particular relation with the equilibrium of the interlocutors, for the other meanings which will arise through the medication process, invested by the desire for improvement.**(Table 7)**

Table 7 - Cartography OF Depression. Dimensions (Meaning Of the Medication)

BIOLOGICAL	(...) my body shakes, (...)I feel weak, (...) food has no taste , (...) I think this medication leaves an alarm clock in my heart, (...)I get dizzy.
PSYCHIC	(...) it is knowing how to hope, (...) it is having a lot of patience, (...) it is controlled, (...) it makes us dependent, (...) I cannot live without my diazepam, (...) it is getting angry, (...) it is only being able to sleep with the medication, (...) it is years taking the same medication, (...) it is only lexotam, (...) it is diazepam 5mg, (...) diazepam 10mg, (...) it is improvement.
CULTURAL	(...) it is trying to ease the suffering, (...) search for doctors, (...) decrease the pain, (...) question the treatment, (...) possibility of a cure.

Individuals possess their own repertories of suffering interconnected to the use of medication, which determines meanings with respect to subjective experiences of changes to the physiological and/or emotional level, as well as recognizing the very dependence to which they are exposed. The resulting pattern of this experience delimits the connection between the time and space which lead to risk and its repercussions on psychism.

It is a fundamental problem for human society, involving a practical challenge, since solutions and theories must be found, for we need to explain what occurred, how it originated and what its history is. Thus, it leads to a search for meanings, which, in order to be recognized, must be interpreted[24].

REFERENCES

1. Peres UT. Depressão e melancolia. Rio de Janeiro: Jorge Zahar Editores; 2003.
2. Helman CG. Cultura, saúde e doença. 4ª ed. Porto Alegre: Artmed; 2003.

3. Kanaan DA-B. Escuta e subjetivação: a escritura de pertencimento de Clarice Lispector. São Paulo: Casa do Psicólogo/EDUC; 2002.

4. Ballone GJ, Neto EP, Ortolani IV. Da emoção à lesão: um guia de medicina psicossomática. São Paulo: Manole; 2002.

5. Becker G. Disrupted lives. Berkeley: University of California Press; 1997.

6. Finkler K. Physicians at work, people in pain. s. L.: Westview Press; 1991.

7. Maturana H. A ontologia da realidade. Belo Horizonte: Editora da UFMG; 1997.

8. Rey FG. Sujeito e subjetividade: uma aproximação histórico-cultural. São Paulo: Pioneira Thomsom Learning; 2003.

9. Barthes R, Havas R. Escuta. In: Enciclopédia Einauide. Oral/Escrito. Argumentação. Lisboa: Imprensa Nacional; 1987. p. 139.

10. Schnitman DF, organizador. Novos paradigmas, cultura e subjetividade. Porto Alegre: Artmed; 1996.

11. Cortesão L, Stoer SR. Cartografando a transnacionalização do campo educativo: o caso português. In: Santos BS, organizador. A globalização e as ciências sociais. 2ª ed. São Paulo: Cortez; 2002. p. 382.

12. Jovchelovitch S, Bauer MW. Entrevista narrativa. In: Bauer MW, Gaskell G. Pesquisa qualitativa com texto, imagem e som: um manual prático. Petrópolis, RJ: Vozes; 2002. p. 91.

13. Guatarri F. Las tres ecologías. Valencia: Pré-textos; 1990.

14. Hayles NK. Chaos and order. Chicago/Londres: The University of Chicago Press; 1991.

15. Morin E, Bocchi G, Ceruti M. Un nouveau commencement. Paris: Editions du Seuil; 1991.

16. Bordeau P, Wacquant LJD. Réponses: pour une antropologie réflexe. Paris: Editions du Seuil; 1992.

17. Santos BS. Uma cartografia simbólica das representações sociais. Rev Crít Ciênc Soc 1988;24:139-172.

18. Morin E. Ciência com consciência. Rio de Janeiro: Bertrand Brasil; 2000.

19. Morin E. O método IV: habitat, vida, costumes, organização. Porto Alegre: Sulina; 1998.

20. Kleinman A. The illness narratives: suffering, healing & the human condition. New York: Basic Books; 1988.

21. Foucault M. O que um autor? Lisboa: Vega; 2002.

22. Capra F. As conexões ocultas: ciência para uma vida sustentável. São Paulo: Cultrix; 2002.

23. Figueiredo LCM. Escutar, recordar, dizer: encontros heideggerianos com a clínica psicanalítica. São Paulo: Escuta/Educ; 1994.

24. Barros DD. Itinerários de uma dor emissária: loucura em territórios Dogon (oeste da África) [Tese de Doutorado]. São Paulo: Universidade de São Paulo; 1998.

Andress to correspondence

Modesto Leite Rolim Neto

Rua Pe. Rolim, 299, Centro

Cajazeiras, PB, 58900-000

E-mail: modestoleiterolim@bol.com.br