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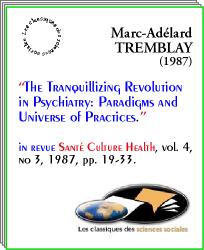
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Introduction

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This article is a critical look at the evolution of psychiatric services in Quebec since the establishment of the provincial health insurance regime. I was a research advisor to the Castonguay-Nepveu Commission (CNC) whose mandate was to determine the course of this important health reform ; therefore, my observations are self‑critical, as well as critical of the Commission as a whole. Having participated in the process, I am able to examine it from a historical point of view which is not only based on today's perspective. My approach here is that of the anthropology of health (Tremblay 1982a) and is systemic (De Vries 1980, Tremblay 1982b, 1982c, and 1983).

1. Overall Framework

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My critical analysis is based on two complementary theoretical models : that of the history of science, of ideas and institutions and that of innovation in the broad field of social intervention (Paul 1955 and Goodenough 1963).

The first of these conceptual schemes allows me to examine the historical, ideological and socio-political context of the emergence and the evolution of the new model of psychiatric services. The second focusses upon a particular reform whose main objective was to modernize the Quebec socio‑sanitary system in the light of new knowledge of organizational principles adapted to the post‑industrial society and of current practices in the health systems of some Western nations.

Inspired by recent biomedical discoveries and by foreign organizational models and socio-sanitary-programs, Commission members were becoming true "agents of change". The two analytical frameworks mentioned above allow us to understand both the governmental, institutional, professional and clinical facets of reality and the main operational [20] parameters (reorganizational principles, socio‑political and legislative frameworks, policies and programs) of the rationalization of the Quebec health system.

a. The working hypothesis

The following is the working hypothesis which will guide me throughout my observations and analyses. As it was formulated by the Castonguay-Nepveu Commission (CNC hereafter), the reform of psychiatric services can be seen as a partial response to a bourgeois ideology regarding "illhealth" in general, and "mental disorder" in particular, and as an attempt to secularize and socialize health services. The overall *reorganization of* the Quebec health system can also be seen as a way in which those who conceived and promoted it sought to assure their own security in that system. In other words, a manifestation of aspirations of an upwardly mobile social class (Boudreau 1984) which was attempting to appropriate new powers and to spread its areas of influence.

Conversely, the CNC poorly assessed the needs and expectations of those which were to become the main users of the incoming socio-sanitary measures. They neglected to take into account that area of social representations which can be observed in perceptions, conceptions and collective attitudes, especially in the sub‑system of psychiatry and mental health. It is noteworthy that popular knowledge, and the symbolism of body spirit in a time-space configuration are invariably reflected in a particular discourse which represents as many ways of perceiving and understanding social reality. Popular science, of course, is of great complexity since it depends as much on cognitive systems as it does on affective systems, which makes it difficult to decodify.

It is possible to Bee ‑the innovation in psychiatric services as containing an element of security for those conceived and promoted it inasmuch as it provided them with satisfactory circumstantial responses to the chronic states of crisis which then prevailed in psychiatric hospitals as well as in affiliated health institutions : these responses dealt with deinstitutionalization, the establishment of therapies in a clinical 'setting, therapeutic relations adapted to the pathological conditions of patients, and the promotion of psychiatric units in general hospitals. On the other hand, Commission members remained insensitive to the nature and scope of the needs and expectations which were likely to arise with the *diffusion of* the new therapies of both official and alternative medicines (Larouche 1985).

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b. The three poles of analysis

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My analysis is articulated upon three complementary and interdependent analytic axes. The first deals with the major principles of the reorganization of Quebec's health system related to psychiatric care ; within this framework, I shall discuss two fundamental notions : that of "mental illness" and that of "psychiatric services". The second axis centers upon the transformation of state, institutional, professional and clinical practices in the psychiatric sector ; I shall illustrate how these practices stem from general policies and strategies for action inspired by a health management model which gives a high priority to rationality, internal consistency, productivity and administrative efficiency (Bibeau 1986 : 28). In addition, I shall document how this model of technical rationality has imposed upon health managers a type of reductionist vision leading not only to an administrative blind alley, but also to a clinical impasse. The third avenue I shall explore refers to the social representations of psychiatric institutions and psychiatrists, of mental illness and of the clients of psychiatric services [[2]](#footnote-2). The fact that these popular perceptions and conceptions have been completely overlooked, is another reason that the primary objectives of the innovation have become lost in bureaucratic conventions.

My epistemological position leads me to question the implicit and explicit postulates of the socialization of health services and the medicalization of social services at a time when the Welfare State was being implemented in Quebec by the artisans of the "Quiet Revolution". Many questions come to mind, for instance : has the bureaucratization of institutional resources and specific objectives of health institutions, especially those which define responsibilities, status and inter‑institutional relations, been at the root of the breakdown of the original concept of the health network ? Has it not, to some extent, set the implementation strategies recommended by the CNC in a direction contrary to the goals sought ? Have the compartmentalization of the health professions and the influence of corporate ideology engendered, at the very heart of the therapeutic process, an increased fragmentation of clinical interventions, and insurmountable difficulties for the project of resocialization and reintegration ? One cannot remain indifferent to the fact that the incidence and the prevalence of psychiatric patients requiring prolonged and diversified care have increased dramatically in the last twenty years.

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There is also a deep dissatisfaction towards institutional medicine : the popularity of alternative medicine is not mere coincidence. The psychiatric sector has been under scrutiny for more than a quarter of a century. Today, much more so than in the past, a large number of ex‑psychiatric patients speak out and denounce, in dramatic testimonies, their condition of internment. What lies behind these feelings of dissatisfaction ? Is there anything that can be done to allow the active participation of citizens in order to redress the situation ? I believe that the‑initiative must come from the base rather than from the top down as in the past.

2. Principles of reorganization  
of the health system

The principles of the psychiatric innovation of the sixties stem from two fundamental notions which permeate the overall system and model its various expressions : the concepts of "mental illness" and "psychiatric service".

a. The concept of "mental illness"

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The content of the "mental illness" concept is rooted in a negative social representation which is profoundly damaging to those who have gone through the dramatic experience of a psychiatric disorder, ranging from mental deficiency to psychoneurosis and deep neurosis. Even so, apart from a few researchers who proposed the positive concept of "mental health" (Jahoda 1950), the notion which is used to designate these types of disequilibrium is that of "mental illness". And, with the exception of a few specialists, few people are able to clearly distinguish the various types of psychiatric disorders or establish their degree of seriousness with any reliability (Bédard, Lazure and Roberto, 1962). The word "dumb" is ordinarily used to designate the "mentally deficient" whereas "insane" labels those who have stayed for long periods of time in psychiatric hospitals and are incapable of being autonomous. In popular terminology, the concept of "mental illness" ‑or "craziness" means a disorder of the mind, an inability to hold a coherent conversation according to current linguistic codes, an interference of emotions, an incapacity to control exacerbated feelings, and difficulties regarding social integration. This manifold deficiency, associated with impairment and the production of handicaps, is perceived as being structural since it is the result of an unbalanced heredity, an deregulated physiology and a disoriented psyche.

These popular conceptions which existed at the time of the Commission, are not substantially different from those of the traditional biomedical paradigm which, through its hegemonic position, provides us with a thorough explanation of psychiatric disturbances and accounts for all anomalies [23] classified within the psychiatric domain. Although the biomedical scheme identifies a few subsidiary components relating to the social environment, and, in a more tangential way, to life experiences, it is in essence an organic model. Knowingly or not, the CNC members inherited this model. Accordingly, "mental illness" is just another illness and it must be dealt with as such. The expression, "an illness like other illnesses" is rather ambiguous. Without negating, in an absolute way, the specificity of the psychiatric disorder, Commission members concluded that "mental illness" could be treated with biomedical prophylactic techniques (electroconvulsive therapies, neurosurgery and chemotherapy). Taking note of the unending failures of health professionals in dealing with problems of a psychiatric nature, convinced that reclusion was an outmoded technique, and impressed by the undeniable success of the advanced scientific medicine of the sixties, Commission members believed that identical breakthroughs could happen in psychiatric care, if structural reforms were put in place and if particular incentives (scholarships, for instance) were used to speed up the evolution of that medical specialty and the acquiring of greater competence among its practitioners. The arrival of neuroleptics and antidepressants on the pharmaceutical market revolutionized, for a brief period of time, the treatment of psychological disorders, reducing acute neurotic patterns as well as some other behavioral disorders. Stemming from that therapeutic context, it was not illogical to deduce that, with treatment at general‑ hospitals, "mental illness" would eventually be considered as an ordinary disease.

Another characteristic of such a conception of "mental illness" comes from the curative tradition of medical pathology, which requires the setting up of services attributed to current and anticipated needs, be they latent or expressed. Commission members rightly perceived that when compared with the U.S. and some other Western countries, Quebec was backward with regard to psychiatric policies, programs and practices. Policies established following the Report of the Bédard Commission had produced, some positive results. It was now urgent to close the gap. Let us note in passing that this catching‑up affected mainly Quebec francophones since little attention was paid to native populations and minority groups, both of which required specific policies lacking ethnocentric biases. The norms which prevailed then to define "normality" were those of the majority group and this has delayed the setting‑up of adequate psychiatric services in ethnic environments (Tremblay 1985). Today the psychiatric community has developed some sensitivity towards the particular needs of ethnic communities and yet, it is still difficult for their members to obtain psychiatric services of a quality that compares with that available to the majority.

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b. Psychiatric services

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A second reorganizing principle of the Quebec health system is rooted in the notion of "psychiatric service", which has five different expressions : (a) the general hospital, the privileged locus or the treatment of those who experience emotional disturbances of a psychiatric nature ; (b) the professionals ensuring the quality of services and seeing to it that the professional ethical code is respectful of individual and collective rights ; (c) the curative biomedical model ; (d) a type of technocratic planning, centered on rationality ; and (e) the psychiatric hospital.

Even though the CNC members attempted to attenuate the curative character of the allopathic model in stressing the importance of prevention, it is undeniable that the structuring of services in the realm of health in general, and mental health in particular, is hospital-centered. The hospital as a therapeutic institution is thus confirmed in its traditional function and in its precedence over all other health centers committed to the curing of ill people. This is a structural principle that entails functional consequences. It does not only reaffirm the verticality of the health care system and the ordering of health professionals in a hierarchy, but it also confirms the hierarchy of the professions themselves within the health team, where power is mainly held by medical doctors.

Psychiatrists remain at the very heart of clinical practices in the field of mental health, which gives them the monopoly of decision‑making in all aspects of the therapeutic process. They are the guardians of the acceptable norms of behavior ; they label the patient's illness with questionable assurance ; they determine therapeutic strategies and types of clinical in‑house interventions on the ill, as well as the kind of services to be given during the post‑hospitalization period ; they also sign the release form.

The psychiatric innovation examined here is based upon a technocratic type of planning, where services to be developed are conceived in conjunction with required resources rather than being tied to the health problems and pathological conditions of patients. Without being fully explicit, this kind of planning relies on permanent economic growth. An equation is established between the uncontrolled increase of costs and the diversity of services over a period of time and their widening accessibility. Twotypes of abuse can result from this. First, there is the classifying of "mental patients" in two categories, "the curables" and "the incurables", and the development of a clinical strategy. Through the latter, the clinician treats the patient as if all therapeutic itineraries were identical and as if the [25] awareness of one's conditions and growth processes followed essentially the same paths. With regard to the curable and incurable dichotomy, its creates serious problems not only because of misjudgments in the labeling process but also because of the "incurables" ’s dependence on their respective institutions. As for those who receive the authorization to reintegrate within their community of origin, they must prolong their professional dependence for an undetermined period of time and their drug dependence for the rest of their life.

The de-stigmatization of the psychiatric hospital is another expression of the "psychiatric services" envisaged by the CNC. The establishment of psychiatric services in general hospitals and the formal recognition of outpatient clinics were seen as ways to increase accessibility, to render mental health services more commonplace, and to put on the same footing organic diseases, psychosomatic illnesses, and neurophysiological, and psychiatric disorders. The rationale behind such extensive psychiatric care was the assumed vulnerability of all members of Quebec society to existential problems at various stages of their lives.

3. Practices

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In moving into the realm of practices, the analytical scheme became more complex due to the variety of interdependent issues at stake. As a consequence, if I were to deal with them as separate items, I would run the risk of greatly reducing the scope of my analysis. Therefore, I propose a reading which cuts across these various strata to encompass issues which relate to government, health establishments and affiliated institutions, professional bodies, and users. Three major tendencies both hide and reveal the internal contradictions and the multidirectional forces of the psychiatric subsystem : (a) the excessive autonomy of the constitutive units ; (b) the administrative and clinical impasse of institutional psychiatry ; and (c) groups opposing institutional psychiatry, and volunteer organizations proning the individual's control of his own health, parallel to the official health system.

a. The excessive autonomy of constitutive units

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The first tendency, which affects the others, is that each of the constitutive units of the health system and the psychiatric sub‑system acts as if it were completely independent of all the other units. The atomization of the network creates problems in exchanges between establishments, the Department of Social' Affairs, and other institutional partners. It causes interference in the respective [26] functions of each of the network units and delays feedback. The administrative autonomy of health establishments is undoubtedly a stumbling‑block in the coordination of collective undertakings. Its appears to be linked to the dissatisfaction arising from the management of shared physical and human resources.

The acute conflicts observed recently between the government and civil servants in the Department of Social Affairs, whose mandate includes psychiatric services, are but a pale reflection of this active dissociation between the constituting units of the health system. The drastic financial cuts imposed upon health institutions and the consequent reactions of managers, unions and employees, are additional manifestations of profound divergences in goals and means. Public quarrels between health institutions concerning their respective mandate within a given region, and the competition which exists between them regarding the allocation of operating funds, reveals both inequality and uneasiness. One could make the same diagnosis about interpersonal relationships in clinical settings, about relationships between corporations and unions, about different health programs having the same target populations and, finally, about the therapeutical relationship itself.

b. The Administrative and clinical impasse  
of institutional psychiatry

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The autonomy deadlock leads to a second level of analysis : the administrative and clinical impasse of institutional psychiatry. At first sight, this critical assessment may appear exaggerated, especially if one takes it exaggerated literally and applies it to all categories of the mentally ill. This judgment should be viewed within the overall socio-political context and in the light of the evolution of psychiatric services in the last two decades. We have seen a greater sensitivity to individual and collective rights, better definitions of mental health and well‑tested mental health policies which take into account environmental and socio-cultural factors in the aetiology, therapies, readaptation and prevention of psychiatric disorders. There have been experiments aiming at finding new therapies, and accredited voluntary organizations that defend the interests of those who are ill-fitted for current psychiatric programs, But in spite of generalized accessibility and free services, these achievements do not seem to occur in the dominant form of psychiatric care, that is, institutional psychiatry. This can only be explained by the existence of many converging conditions which make the functioning of the system so awkward that it creates a [27] routinization of therapeutic actions, inertia, and professional morosity.

In the past, psychiatric intervention began and ended during an acute phase of the patient's illness. Today, the progress of the therapeutic action is more visible on the surface than in depth. That seems to be the result of the fact that psychiatrists have been successful in neutralizing acute crises. The less visible zone of troublesome behavior remains vague. Therapies are still predominantly inspired by a binary model and are almost always circumstantial rather than part of a long‑term therapeutic scheme. Therefore, it comes as no surprise that the social reintegration of patients, whenever it is initiated, depends almost entirely upon support by professionals and other human resources in the patient's environment.

Three types of dependence represent major obstacles to the progressive emancipation of psychiatric patients and ex-patients. These are institutional dependence, professional and drug dependence and the dependence on support mechanisms, which, in some cases, reproduce the seclusion, exclusion and rejection patterns of the institutions. This triple dependence constantly increases the contingent of individuals who are under supervision at a time when financial resources for such therapeutic actions are frozen. Besides these processes of dependence which block the growth process of individuals and clog the system, there is yet another problem which has proved significant. This is the effect of the profound social and institutional changes which have taken place in Quebec (Tremblay 1986). These abrupt changes are likely to multiply risk factors, to obstruct the growth process, and hinder the attainment of an optimal degree of adaptation and the reaching of individual equilibrium. In gaining greater momentum, the incidence and prevalence of cases of psychiatric interest (Leighton 1959, 1982) are likely to increase the demand for psychiatric services. The chemical revolution is still too recent for us to be able to initiate a true process of de‑institutionalization.

c. Resistance movements   
and the dynamics of the periphery of the system

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If one looks carefully at examples of active and passive resistance to mainstream medical practice, and at the dynamics occurring at the system's periphery (Corin 1986), indices emerge regarding certain kinds of cures that should perhaps be officially endorsed.

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The criticism of psychiatry which is heard today owes as much to the anti‑psychiatry of the 1960's (Laing 1964, Moreux 1974) as it does to the spread of the California humanist psychological movement in the 1970's.

An analysis of the tenets of different resistance advocates shows some common points : they denounce medical power and overmedicalization, the pervading invasion of the pharmaceutical industry and the abuse of drug prescription, the rigidity of institutional strategies, and the lack of creative imagination in rehabilitation programs. They also demand the right of patients to a responsible feedback and a therapeutic relationship in which the integrity of the patient is upheld.

To these are to be added marginal trends which are equally significant. Diverse types of voluntary organizations and spontaneous groups mobilize ex-psychiatric patients to help themselves, to establish adequate support services, or to compensate for non‑existent ones. They also offer listening services to those who are experiencing acute stressful conditions. The strength of this parallel movement lies in the fact that the groups practice a type of prevention which, in addition to repairing the social fabric, allows for personal growth. The building up of natural networks which deliver help represents an attractive alternative for psychiatric patients, since it converts a clinical action into social intervention and transforms an indifferent institutional intervention into a natural and empathetic one.

4. General conclusion

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With the help of two paradigms, I have made a qualitative evaluation of mental health care in Quebec's medicare system from the viewpoint of the anthropology of health, and in a global perspective. Throughout this analysis, a number of questions were given provisional explanations which, in turn, referred to more fundamental questions that were not touched upon here. In illustrating my working hypothesis on the reorganizational principles of the psychiatric sub‑system and in documenting data which establish the plausible nature of the triple diagnosis regarding psychiatric practices, I have relied on a number of facts which will be recalled below.

The main option of the CNC proning the non‑specificity of psychiatry (Bibeau 1986 : 28) relied upon a concept of "mental illness" that came from a biomedical model and gave predominant importance to hereditary and neurophysiological factors in the aetiology of psychiatric disorders. That notion corresponded to the concept of a medical system which [29] had to fully integrate all its components in a highly centralized structure that would encompass institutional, professional, and clinical practices. In that manner, general medicine and specialties (psychiatry included) would be on an equal footing with regard to their institutional status. Users would benefit from such a change, since access to different health services would be greatly enhanced and the quality of services would be, in principle, improved. To these internal advantages were added the benefits resulting from the de‑stigmatization of short term psychological disorders and the regionalization of psychiatric services. Moreover, with these undeniable assets, both from management and accessibility points of view, there was also a series of policies, programs And resources conceived to better serve users.

However the CNC's vision, reconstructed ex post facto, was conceived from bits and pieces of an idealized social reality, without sufficient understanding of social systems and culture patterns. The CNC postulated a kind of stability in socio‑cultural dynamics and, in addition, thought that technical rationality had an absolute efficiency when it was implemented in a management structure with a technocratic slant. On a more positive note, they recognized the expectations and demands of an upwardly mobile social class.

And yet little attention waspaid to the users' views of illness and health needs. That alone meant a serious gap in a public reform of this magnitude. One might retort that the Commission received briefs and met with users at public meetings. It is difficult to believe that these vast public consultations in all regions of the Province revealed the vast spectrum of social representations of mental illness, of psychiatric services and of community resources. That kind of setting is not conducive to the gathering of data which are essential for such an understanding. Furthermore, Commission members did not foresee the kinds of resistance that would accompany such a comprehensive socio-sanitary innovation. While some health professionals benefitted by integrating into the new structure, others were relegated to less important functions. So much energy was spent to establish the new health system that one was left with little time to judge the kind of consequences engendered by this major innovation. It was taken for granted that this social megaproject would naturally take its place within the vast "Society project" set in motion by the artisans of the "Quiet Revolution" which rallied the majority of Quebeckers until 1966.

Moreover, the health system had just one entrance door. It was postulated that all individuals who would enter into this "clinical niche" would maintain the "sick role" for a [30] while, and would shed it in due time to take over their usual daily functions. In order to ensure the functionality of this clinical process, the multivalency of the therapeutic scheme and the multidisciplinarity of the clinical team were developed as the ma or clinical tools to be used in therapeutical relationships. In spite of this beautiful scheme, users found it hard to shed their "sick role", and lamented the dehumanization of care.

The psychiatry/mental health sub‑system continues to be a closed system, for acute psychiatric cases. Support institutions have a tendency to reproduce, even in mild cases, the conditions of physical isolation through a psychology of dependence. ‑Institutional psychiatry (psychiatric hospitals and general hospitals) continues to be strongly influenced by genetic and neurophysiological explanations of mental illness and psychiatric disorders, which bring with them a routinization of the therapeutic process and undifferentiatied therapies. Clinical successes, built upon a progressive resocialization and on a full social reintegration of the patient, are rare. The rigidity of the system is due to users’institutional, professional, and drug dependence, as well as their dependence upon irregular support mechanisms in their social environment. A result of the latter is an increase in the demand for services and, consequently, the congestion of the health system. This tendency is shown to be more serious when we consider that new arrivals in the psychiatric sub-system now progress at a more rapid pace than was the case in the seventies.

Now more than ever, questions arise from the new entrepreneurial state, technocrats and managers, specialists and consultants, health professionals, the community and the public, which reveal the wide variety of issues at stake and the many competing strategies. At this critical point, can we find shared solutions which go beyond a psychiatry that only redresses crisis situations ? Can we fill in the gaps and move toward the building up of a true social community with preventive psychiatry ? This will require the active participation of‑all the actors in the field, to bring about real communication and a greater concerted effort among the partners. We may face the necessity of a basic change in the mentality of all concerned. This fundamental change must begin with a larger perspective, greater sensitivity to users’expectations, and a more dedicated collective responsability that goes beyond organizational, corporate and syndicate structures.

[31]

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RÉSUMÉ

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Cet article est une version abrégée de l'allocution prononcée par l'auteur, président de la CAMA/ACAM, lors du congrès tenu conjointement par la Société canadienne d'ethnologie et l'Association canadienne pour l'anthropologie médicale (ACAM). Cette version est pubiée ici pour marquer la collaboration de la CAMA/ACAM au périodique édité par le GIRAME.

L'auteur propose une analyse critique de la réforme des services psychiatriques faite au Québec en rapport avec les travaux de la Commission Castonguay-Nepveu qui, dès 1967, ont été à l'origine d'une réforme fondamentale des Services [33] québécois de santé. Il indique notamment certains effets pervers de cette réforme eh même temps que certains bénéfices qu'en tirent certaines instances professionnelles et bureaucratiques. Les principes d'analyse qu'il propose ont cependant une portée plus générale et demeurent pertinents pour l'examen du système actuel de santé au Québec.

Fin du texte

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   Version française : “La révolution tranquillisante en psychiatrie : paradigmes, univers des pratiques et représentations sociales”. Un article publié dans l'ouvrage sous la direction de GIFRIC ET COSAME, *Pour un réseau autonome en santé mentale ?* Montréal, Presses solidaires, 1987, pp. 6-18. [↑](#footnote-ref-1)
2. The section on social representations appears only in the French version. [↑](#footnote-ref-2)