

Experience Report

Restriction scenarios and forms of (r) existence in the field of mental health: an experience report

Cenários de restrição e formas de (r) existência no campo da saúde mental: um relato de experiência

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ABSTRACT | This article aims to explore the limits and possibilities of performance of a public mental health service that has an assistant profile different from that established by Psychosocial Care Network regulations, and that was going through an intense political scenario of precariousness and scrapping of the health network at the time of the research — triggering the uprising of the Mental Health Workers Forum in the municipality, which forms an important element in the research. It is based on the construction and narrative of the scenario, on the relationships established between the actors that composed it, both in the service in question, and in its relationship with other devices, the management, and the workers' forum, so that they can express the existing and necessary psychosocial articulation, besides interpreting/telling about the service and the work done there, establishing bridges between the individual/singular, the group, and the institutional. A methodological bet was made based on psychoanalytical psychosociology. The main results are four emerging elements of analysis: group and intersubjective processes; alliance, and recognition; crisis, and suffering in institutions; creativity; and wholeness. Destructive forces have taken place with the mass replacement of workers, the choke of the network due to lack of inputs/resources in general, and by the difficulty on the part of workers to create a new place for themselves. It has been found that despite the scenario, the uniqueness of the service allowed the production of caregiving practices whose maintenance relevance in the network should have a better evaluation.

KEYWORDS: Innovation. Narrative. Mental Health. Psychoanalysis - Institutions. Resistance.

RESUMO | Este artigo tem como objetivo explorar os limites e possibilidades de atuação de um serviço ambulatorial público de saúde mental que possui um modelo assistencial e características organizacionais não previstos no desenho preconizado pela Rede de Atenção Psicossocial (RAPS) e que atravessava à época da pesquisa um (in)tenso cenário político, simultaneamente produto e produtor de um processo de precarização e sucateamento da rede de saúde municipal. Este fator foi disparador do levante à época, promovido pelo Fórum de Trabalhadores de Saúde Mental. Tem-se como base a construção e narrativa do cenário e das relações estabelecidas entre os atores que o compunham, tanto neste serviço, quanto na relação deste com outros dispositivos, a gestão e o fórum de trabalhadores, para conseguir expressar a articulação psicossocial existente e necessária. Além de traduzir/contar sobre o serviço e o trabalho realizado, estabelecendo pontes entre o individual/singular, o coletivo e o institucional. Realizou-se uma aposta metodológica com base na psicossociologia de base psicanalítica. Os principais resultados são quatro elementos emergentes de análise: processos grupais e intersubjetivos; vínculo e reconhecimento; crise e sofrimentos nas instituições; e criatividade. Forças destrutivas se manifestaram de forma contundente com a substituição em massa dos trabalhadores, a asfixia da rede pela falta de insumos / recursos gerais e pela dificuldade de parte dos trabalhadores criarem um lugar novo para si. Constatou-se que apesar do cenário, a singularidade do serviço permitiu a produção de práticas cuidadoras cuja pertinência de manutenção na rede deve ser melhor avaliada.

PALAVRAS-CHAVE: Inovação. Narrativa. Psicanálise - Instituições. Resistência. Saúde Mental.

Introduction

This article aims to explore the performance limits and possibilities of a public outpatient mental health clinic whose care model and organizational features differ from the design recommended by the Psychosocial Care Network (RAPS). In 2015, the clinic was going through a (in)tense political scenario, which was both the result and the cause of a process of destabilization and deterioration of the municipal healthcare network. That condition triggered an uprising at the time, promoted by the Mental Health Workers' Forum.

This situation and its specific features make us think about the conditioning factors of mental health in Brazil, referring to both an innovative experience and the structural issues of the system, which underpins our research.

The research methodology is based on building a narrative of the first author's professional experience at the clinic. The memories and thoughts she developed later as a researcher about care practices and group dynamics in 2015, when she worked as a psychologist at the clinic, are used as elements of analysis. A selection of memories was reconstructed by means of a careful and sensitive process of remembrance by considering the distance required by scientific investigation and associated with her involvement in the clinic. Research questions and academic guidance also supported this process of recollection /construction of the narrative and helped her select relevant factors and how to approach them.

This process resulted in four emergent elements of analysis: group and intersubjective processes; bond and recognition; crisis and suffering in institutions; creativity. To a large extent, these elements dialogue with what the debate brought about by the Brazilian Psychiatric Reform, with the way care is understood in the field of psychosocial care, and with the references of psychosociology, the underlying theory of this research.

As our research goal is influenced by a point of view that takes into account transference relations and unconscious issues, the method we chose was to establish a dialogue with the qualitative clinical analysis (Turato, 2003) to support us in selecting the material, the way of conducting its analysis

and discussing it. The autobiographical nature of this research required us to adopt the Narratives approach (Ricoeur, 1997; Onocko & Furtado, 2008) to formulate the empirical material. Analysis-based psychosociology (Kaës, 1982; Giust-Desprairie, 2001) helped clarify the necessary points of the questions that arose regarding the psychosocial association in the scenario of the practices described.

To fully understand the present research, one needs to take into account the starting point that underpins it theoretically, which is based on significant researchers (Turato, 2003; Emerich, 2017) from the field of health care who state that a researcher is neither neutral nor outside the researched object and who emphasize the production of knowledge based on experience. Another basic factor of this debate considers the Brazilian Psychiatric Reform as an ongoing process, rather than as a punctual and temporary movement, as it requires creating new ways of being on a daily basis to face psychologically distressed people and thus introducing innovative care practices in Mental Health Care, such as actions of deinstitutionalization and social inclusion.

The term "innovative" is used by some authors in general health care and especially in mental health care (Cecílio, 2012; Amarante, 2015) to name practices open to the singularity of human illness and suffering that allow professionals to deal in a creative way with the intense and peculiar suffering experienced by users of health clinics. To this debate, we would like to add a factor that requires openness to creativity and innovation: the context of restriction and setback caused by regulations, structure, funding, politics or a partial combination of these factors, such as in the present case, which shows how essential creative processes are for the possibilities of resistance.

To deal with the singularities of each service and with the reality of the care model suggested by the Reform, a care network centered on territory was built, acknowledged as a space for work and construction, for interlocution and interaction of services and people, for a dialogue between academic and popular knowledge (Brasil, 2011). Amarante (2015) reminds us that Franco Basaglia, who greatly influenced our Reform, conceives territory as a place where real and symbolic exchanges take place, a space that shows how forms of solidarity and fraternity are developed, as well as rejection and discrimination, depending on the social culture in force at that time and place.

The concept of territory is basic for the debate suggested in this article. We think of territory as a space, a process, a relationship and a composition. Operating by the logic of the territory implies thinking of it as a scenario of encounters, as a place and time of the processes of subjectification and autonomy. It also means considering it as a source of production of actions and provocations of care acts that are interconnected in the form of a network. It is, therefore, a matter of deconstructing / inventing a possible space of subjectification. For each proposal of psychosocial practices, there is a unique territory that is marked by a multitude of existential territories (Yasui & Amarante, 2018).

As stated by Yasui and Amarante (2018:187), acting according to the logic of the territory "is to think of it as a field of interactions and relationships, a reproduction of hegemonic and pasteurized ways of living, but also as a place of resistance that focuses on what differs". Therefore, it is a process of emancipation aimed at freeing local knowledge that arises from local needs, local realities.

Over the past twelve years, the first author has worked in different health care clinics in the states of Pará, Rio de Janeiro, and Bahia, experiencing different and singular realities. Observation and experience helped her understand that the Report of the IV Conference (2011) is right in stating that mental health work is special and requires that standards and regulations, as well as professionals and management, be open to new practices that try to address the scope and singularity of care practice and seek to find specific ways of meeting the demands of that intersectoral clinical area.

Regarding regulations, we understand that they are general and do not meet the entire range of peculiarities and specificities. What has been calling our attention, however, is how those regulations sometimes hamper the introduction/maintenance of care practices, such as those addressed in this article.

Thus, we believe it is essential to get to know and discuss the practices proper to every territory. We feel that this approach may help us get closer to a

care model according to which the singularities and specificities of (difficult) mental health care are increasingly guided by bonding, defined as unique and sensitive practices that may be (re)constructed anytime, adjusting and dialoguing with the other areas whenever necessary.

A fundamental starting point of this debate concerns our position as researchers and pro-Reform activists. We strongly oppose any setback in the Anti-Asylum Fight. The present research questions the possibilities of change in the area of mental health care services and models. However, we neither question advances achieved nor suggest reintroducing models of asylum care practices – an increasing trend that started in 2016 with the so-called New Mental Health Policy, called by many authors as the Psychiatric Counter Reform (Nunes, Lima Júnior, Portugal, & Torrenté, 2019). Also, one needs to consider what a huge challenge it has been to meet minimally RAPS regulations.

The recent proposals approved and backed by the Ministry of Health's coordination of Mental Health, Alcohol and Other Drugs (EC 95/2016; New Mental Health Policy/2017; Resolutions 32/2017, 36/2018; Ordinances 3588/2017, 2434/2018, 3659/2019; Interministerial Ordinance 2/2017; CONAD Resolution 1/2018; SENAD accreditation notice 1st/2018; Technical Note 11/2019; Decree 9761/2019) heavily attack the anti-asylum movement. Among other measures, they freeze investments, break with the asylum destructuring logic, include therapeutic communities and put back psychiatric hospitals on the list of RAPS components, as well as dismantle the logic of damage reduction, which is fundamental for the work in this area given the intense and complex logic of eminently intersectoral, integral practices that take into account every subject's singularities / possibilities / choices in a given context and territory.

This article expands the discussion beyond the RAPS and includes any other and all contexts of restriction, be they political, normative, structural, or of any other kinds that threaten the possibility of creativity and invention based on care ethics that is democratic and against asylums. This text is an invitation to debate, to invent, and create new paths.

Practices in context

About the Network in question

This topic describes the political and structural scenario of the network at the time the first author worked at the clinic (whose name will not be disclosed to preserve its anonymity and the privacy of its team) and took part in the workers' movement via the Mental Health Workers Forum.

Workers are generally hired in an insufficient number to meet the demands of both the territory and the clinic. They work on a RPA-basis, i.e. they provide freelance services and issue "Self-employment income receipts" (RPA). Workers had no employment relationship with either the clinic or the municipality and therefore no labor rights (vacation, transportation voucher, 13th salary, etc.), as they were considered outsourced service providers. Despite the issues this kind of work causes for a health care clinic, it is not illegal, were it not for the fact that this model allows workers to remain at the clinic for three months at the most. However, that was not respected at this clinic, as many of them had been working there for ten times longer than that.

Wages were quite below those paid in the market. A neighboring municipality, for example, would pay higher education professionals a base salary twice the amount on average for the same number of working hours. The physical structures of the services, in general, were quite degraded due to low investment in the mental health network. The clinic itself, the object of this research, showed numerous and serious issues. One might say, it was a small sample of the problems that were also found in other clinics: rooms were smaller than required to perform activities and accommodate the secretary's office and the archive correctly, leaks and infiltrations (part of the ceiling of one of the rooms collapsed), poor lighting, ventilation, phone lines and Internet access, and few resources and materials for activities.

This situation caused permanent high personnel turnover and was deplored by everyone passing at the clinic. Unfortunately, because of the dynamics and daily flow of patients, it eventually was put up with as such.

There were reports of a similar situation in the past, but we will now focus on an event that characterizes this moment at the Network: the lack of supply of fundamental and basic remedies aimed at services and registered patients, as well as long and recurring delays in the payment of wages and sometimes even their suspension. The public transportation card of Home Visitors (another special feature of this clinic), whose work is fundamental in the territory, was suspended for a long period of time, hampering important actions or requiring them to take long walks on foot, which would take twice as long and be extremely tiresome.

As stated before, it was not an entirely new scenario, but many other issues that added to that situation ended up great dissatisfaction among workers. This feeling, inflated by the situation of absurd precariousness to which patients were submitted, interrupted mental health services twice and resulted in protests with marches, talks with representatives of the Mental Health Coordination and the City Hall, and meetings with health care clinic users. This process may have been influenced by a collective commotion of workers, the fact that they shared their specific situations via social networks and the media, and the revival of the Workers' Forum space, which joined the users and family movement, among other factors.

In this dramatic context of precariousness, we formulate the hypothesis that the Workers' Forum functioned as a device that favored solidarity (although fragile) between workers and users in processing and managing the crisis. To convey the Forum's potential as a device and its possible impacts on service practices, a brief description of this movement follows below.

Workers met every fortnight on the night shift in a room provided by a university. A high number of representatives from the most diverse clinics took part, all of whom were eager to share their specific situations. The high number of participants was a recent occurrence, which strengthened the movement. Actions in the streets and at clinics were planned, tasks were distributed, such as keeping the minutes, controlling talking time and sharing activities planned during the meetings. Workers were engaged to such an extent that despite internal differences, some important actions were taken.

It was an intense and not always peaceful period, given the permanent tension between management, coordinators and workers. Threats of dismissal, pressure not to suspend or reduce care services and several other conflicting situations were experienced on a daily basis by those close to the Forum, a device that, at that moment, was configured as a movement to stop the deterioration of the Network.

One of the projects suggested transforming this space into a training center, in the long run, creating workgroups to deepen our knowledge of bureaucratic procedures, rights, financing/funding, etc., but there was not enough time to put it into practice. A few months after this little whirlwind began to gain strength, the City Hall announced a Competitive Selection Process for all vacancies of all mental health clinics of the municipality. Although this measure aimed at ensuring some rights, it actually shattered the entire network.

In all clinics, the staff was suddenly changed and despite attempts made by users to keep working with their attending professionals, that request was denied by the management. In addition to this disaster, which demotivated and dismantled the movement, many job vacancies took months to fill, strongly disrupting assistance and treatments. Crisis might be the best word to describe this process and we will develop a theory-based discussion on that concept below.

About the network's outpatient care clinics

The mental health network of the municipality runs five mental health outpatient clinics that point to a way of offering care differently from the traditional medical office model and value instead multi/interdisciplinary work and group therapy activities, although they still offer individual clinical care when required. Units are regional and cover as much of the municipality as possible, provide assistance to a diverse population, and work in spaces that are shared with other health professionals in polyclinics that offer various medical specialties.

Technically, the clinic's primary function is to receive less serious cases, but cases of different complexities and vulnerabilities are also monitored, such as patients who were discharged from psychiatric hospitals or long-stay patients who are sometimes in

crisis, people suffering from alcohol and substance use disorder, children, adolescents, adults and elderly people suffering from mental problems who were referred by one of the various devices of the Network, such as primary care clinics, polyclinics, specialty clinics, inpatient services, etc. or through spontaneous demand.

Outpatient clinics are run by a multidisciplinary team - psychiatrists, psychologists, nurses, occupational therapists, home visitors, and interns whose main activities include: the first interview to refer patients to the required care network, provide assistance to individuals, groups, family members and organize workshops for family members and users (meals excluded), offer assistance to patients in acute crisis who look for a specific service or professional they have relied on before. In such cases, the team tries to provide direct assistance to avoid the inconvenience of an overnight stay caused by the emergency, mechanical restraint, or a transfer to a psychiatric hospital.

In these outpatient clinics, Home Visitors make visits, monitor tour groups, perform daily activities and a series of follow-ups of users who were allocated to that kind of activity. Professionals from different shifts take part in team meetings and in weekly collective supervision meetings, which allows them to exchange information to proceed with individual therapeutic projects.

Despite their problematic condition, outpatient clinics value communication with Primary Care, schools, Psychosocial Care Centers (CAPS), Hospitals, families, management, and other institutions that provide their users with care services. That contact does not always take place the way the team wishes, but it has been a strong feature of this Network. As this outpatient clinic format has not been designed by the RAPS, there are consequences: lack of funds to keep up clinical work, lack of staff, precarious structures, etc.

This scenario could easily be confused with that of a more complex clinic, such as CAPS, which could suggest that outpatient clinics provide care in inconsistent ways with the guidelines and should therefore be redesigned to optimize budget and prioritize the strengthening of the network. At the time, the Mental Health Coordination discussed a possible transformation of these services with the team.

Two main transformation options were discussed: reducing complexity by transforming clinics into primary care outpatient clinics as provided for in the RAPS or making adjustments so that they would meet CAPS I standards. No agreement was ever reached. The connection between users and clinics was one of the basic reasons to avoid taking action.

The outpatient clinic in question

Over time, the team and its management positions changed and we will only be able to describe its organization at the time of our arrival at the clinic. The team consisted of eighteen professionals, six of whom were psychologists (two of them worked in assistance and in Coordination and Technical Coordination positions), one occupational therapist, four psychiatrists, one nurse, two home visitors, two interns, one supervisor, and one secretary. Of these, only one was a public servant and all the others were outsourced.

There were four consultation rooms, one for group activities and meetings of professionals. Employees had their meals in a small pantry equipped with a microwave oven and a sink. The clinic has no private bathroom and the office contains a computer, medical records, appointment books of professionals, all sorts of required documents and files, the clinic's telephone set, which often was out of order or would not allow us to make direct calls, so that we had to call the operator first.

A reduced staff had to meet a wide range of different demands made by a large number of users. Only short breaks or none at all were taken for a short rest, for meals or to update medical records.

At the time, the outpatient clinic coordinator, who was cherished by everyone, was dismissed. The entire staff felt that the decision was careless, abrupt and uncompromising, which made workers arrange for a meeting with the mental health coordination and write a collective letter to the City that stated their position. This event led the first author and one of her colleagues to join the Workers' Forum.

Over time, after repeated invitations, some other professionals began to attend Forum meetings or

to bring up the discussion of the network's macro situation at the clinic's supervisions and meetings. They eventually accepted occasional help from workers' representatives (via the Forum) to jointly elaborate statements for the network given the chaotic situation.

One issue was the (non) participation of physicians in supervisions and meetings. During the time frame of this research, only one of the four doctors was present for a short time. She happened to be the only non-psychiatrist. Given the poor hiring policy and the huge amount of work of that clinic, there were virtually no specialists and general practitioners had to be hired instead. As a result, the team shared some main points from supervisions with their absent colleagues, a careful attempt to make them participate in the group's initiatives.

Over time, spaces for dialogue with users about the scenario were expanded, both individually during consultations and on the occasion of collective activities. Acts, protests and hearings with the management included clinic representatives (professionals and users) and one may say that in a certain way, political activities became part of the psychosocial work routine.

This research does not take into account previous evaluations of the clinic and assesses, in the light of the references and memories of this period, the care practices offered by the clinic in the network. However, one question persists: is psychosocial work performed at the clinic based on ethics? Are patients listened to, welcomed, and correctly followed up according to the propositions of the Psychiatric Reform?

From experience to psychosocial analysis of mental health practices

This is the most challenging part of this article, since it links theory to experience. As already mentioned, four emergent elements of analysis were singled out and didactically divided into subtopics for a more organized discussion, but one should remember that all of them are interconnected and dialogue directly with each other.

Group and Intersubjective Processes

This topic provides an understanding of group and intersubjective processes of a collective/organization/institution and analyses what shape these processes take in our case and the following discussions. We discuss psychic processes involved based on an idea by Freud (1923) that individual psychology is social psychology insofar as it understands that the other is always either a model, support, or adversary. We rely on the contributions of analysis-based psychosociology in a broader field in which the social character of individuals reveals the functioning of the group, place and culture in which they are inserted.

According to Guist-Desprairies (2001:243) when we unveil the way social actors feel, live, appropriate or transform organizations based on exploring representations, beliefs, values and effects on behavior, that “makes collaboration possible, in organizations, between the people involved and those in charge.” If a form of interdependence is found in people's behavior, it is at this point that the structures “of the organization and the company culture give a social dimension to the rearrangement of the intersubjective space”.

Let us start with how groups are designed, how they are formed and some of the resulting consequences to better understand the bases and what is expected from these interdependencies. According to Enriquez (1994), every group establishment is chaired by a common project. Subjects start to put it into practice based on common values.

These common values, associated with collective representations of what a group, organization or society is and what it would like to be, make up the group, organizational or social imaginary. They are intellectually thought and affectively felt, and contain a certain idealization of ourselves. Therefore, a group is made up of people who are, in a way, spokesmen and guardians of something that is larger than they are and legitimizes their action and their life, participants follow a mission, fight for a cause (a shared ideal “I”) and its functions based on idealization, illusion and belief.

Idealization implies strengthening the ideal self and the ideal of the self - Freudian concepts - giving consistency to the group. On the other hand, illusion belongs to the symbolic order, its function is to eliminate doubt, it provides a solution to conflicts and

it is somehow sacred in the sense of unassailable. Belief comes very close to illusion, it eliminates the question of truth (Enriquez, 1994). The author states that these three elements are inevitably present in the establishment of a group. However, they may become more flexible over time and alternate between each other instead of taking place in a massive way.

According to Enriquez (1994), only a minority group will fight for a specific cause, since the majority has already successfully established its cause and merely seeks to preserve and consolidate it. Therefore, workers need to feel that they belong to this collective to wish for more than just protesting against the current object/order, but also to transcend it by creating new ways of being in the world.

This is what Enriquez (1994:65) calls “the destruction of institutions”, which requires a certain amount of violence, it is not a courteous or harmonious process. It implies a certain feeling of intolerance and intransigence. He states that the institution is an “element of social regulation which aims at repetition, the identical, the reproduction of social relations.

As group narcissism emerges, hatred against the outside world results in fraternal love among members, making the libidinal flow circulate so those selfish feelings are transformed into altruistic ones. Enriquez (1994:66) says that not every group will need to kill the father of the horde (an allegory that represents the first figures of power taken as a reference in the constitution of a collective). However, it is essential that the entire group creates an “irreversible event, mediated by an act of violence that replaces the instituted violence, which the new brothers find unbearable, the founding violence of a new world.” The construction of a group bond, however, does not exempt us from suffering the consequences of this process, which are described below.

According to Kaës (as mentioned in Trachtenberg et al., 2011), group organizers do not appear after the bond is created, but at the very moment of its creation, promoting and sustaining its existence. Besides, they are an unconscious formation, develop unique intrapsychic formations, and show that certain psychic contents are structured in/by the group, i.e. group bonds perform an organizing function. We highlight here that group processes are subject to their own psychic functioning called “transpsychic”, which is fundamental for the structure and features of group bonds.

These processes and results are established by the group bond itself and are impersonal, as they are not individualized, although they are an important part of the formation and transformation of the individual psyche (Trachtenberg et al., 2011). Kaës (1991) calls this process "transpsychic intermediate formations", which is what supports the necessary relationship between the individual subject and the group and they emerge by means of narcissistic contracts and denegative pacts.

The narcissistic contract, like every intermediary formation, is "biface", in the words of Kaës (1991), i.e. it belongs to both the subject and the group. When the subject is inserted in an intersubjective setting, what keeps him attached to the contract is precisely the pleasure he gets as he is recognized as unique by the group, as having a distinctive place, i.e. this subject is not only a repetition of the group's ideal, but his narcissistic identity and uniqueness is somehow acknowledged as well.

Enriquez (1994) points out that the issues inherent to every group are related to the conflict between desire and identification. It is a question between the recognition of desire and the desire for recognition, which allows a journey towards either mass or differentiation.

Mass is related to the desire to be recognized. It imposes equality on members and identification is its first guiding principle. It has five main consequences: lack of innovation; autonomization of individuals or the group itself, obedience and submission being strong components; fear and paranoia of fragmentation and destruction of the group are exacerbated, so that decisions are taken based on affects; the imminent risk of disappointment, since the relentless effort to build the group's ideal self makes subjects believe that they are satisfying their own ideal self; exclusion of those who do not follow such imposed standards.

On the other hand, differentiation accepts differences and varieties of desire to a greater extent. Participants of this kind of group believe that "fine discussions, vigorous negotiations and contradictory arguments" (Enriquez, 1994:69) are required to obtain more pertinent and effective projects. This attracts more people and tolerance is therefore greater. The risk lies in maximizing contradictions and cause disruption or dissent, thus wasting time with debates and neglecting the group's purpose (Enriquez, 1994).

Therefore, both absolute individualization and total massification would dissolve the group and conflicts are thus an inherent part of it. To tackle the paranoia that affects the entire group, although at different degrees of intensity, psychologists and psychoanalysts recommend an in-depth analysis and regulation of the group, conducted by either an internal or an external analyst to restrict the "constant temptation" of paranoia (Enriquez, 1994: 72) and avoid making it the only path to be followed.

However, Enriquez (1994) states that groups need to look for collective spaces to understand the processes that take place and to avoid the illusion that one day they will achieve full knowledge, i.e., eliminate blindness, because that blindness is, to some extent, the reason why a group exists, as it allows people to bond. In summary, ambivalence, contradiction, and some degree of opacity are constitutive elements of any group.

A first conclusion is required at this stage using the theoretical bases presented above to analyze the processes surveyed at the clinic. Although the clinic was supervised by a psychoanalyst with extensive clinical experience, the dialogue failed in significant ways and professionals were not able to fully address either the elements of analysis or the actual work processes, which could have allowed them to process possible feelings of breakdown and the suffering of the team caused by all the issues and uncertainties of the macro and micro scenarios.

High clinic staff turnover also resulted in frequent changes of the coordination positions, which points to a fragile group bond. Nevertheless, some actions and responses to the network were performed collectively and we may therefore conclude that a group bond actually existed, as well as some smaller groups within the group.

Thus, the movement of certain professionals in comparison with others gets clearer due to this research. Those who had been working at the clinic for a longer period of time seemed rather inclined to follow a mass movement, which might be due to the symbolic references and ingrained values that date from the foundation of the clinic, but recent workers did not. This caused a wealth of internal conflicts and may explain why the new workers were more receptive to the discourse of the Forum.

From what has already been discussed based on Enriquez (1994) and Guist-Desprairies (2001) about the group as a project developer, we may say that the older workers shared a kind of collective project regarding their work, practice and mission at the clinic, even if this project had never been formalized in writing. They found it rather difficult to give up these old references, also because the new workers were actually unable to create or consolidate a new project. This fact also helps us think about processes of resistance to change, because if the group identity is weak, people will not be able to take strong standpoints, such as those required for the establishment of a group.

Those factions and the wide range of issues mentioned above created a tense scenario that was difficult to manage, which also directly affected creating and preserving bonds at the clinic. The next element of analysis discusses that aspect.

Bond and Recognition

This emergent element of analysis came up repeatedly in this research and reported experiences: the visible power found in the constitution of bonds as a support for the provision of care.

Figueiredo (2007) speaks about care based on two positions: implication and reservation. These are two interconnected and necessary positions for the provision of care. Regarding implication, the subject who temporarily occupies a caregiver position opens up to the subject who receives care (as he also needs to allow himself to be receptive to care), an opening that requires an act of recognition, i.e., to witness the other's singularity and uniqueness and, if possible, reflect/mirror it so that the subject may recognize himself by this movement. It is essential here that the caretaker preserves himself from the other, knows our limits, accepts that he doesn't know beforehand what the other wants or needs, but rather accesses that which is unique and shares it with his patient so that he may find his way by himself.

Care actions that take place in excess and mismanagement of caregiver functions result in the undeniable ravages of pure implication. Acknowledging our limits as caregivers prevents our care from being tyrannical and allows it to be shared with others who might be in the same position. (Figueiredo, 2007)

The issue of recognition came up in the previous item as one of the factors that directly influences the subjects' position in a group, i.e., it is influenced by the construction /maintenance of a bond. We understand that what Figueiredo (2007) points to is the need to recognize the desire so that care becomes possible – both by the professional with himself, as well as by his ability to forget himself to recognize the other's desire and give it space.

The issue of recognition is also an important factor for our reflection on the possibility of coping with suffering at work and the construction of group identity. One of the ways pointed out by Dejours (1999) to transform suffering into pleasure at work is related to the issue of recognition by peers and superiors of dedicated and inventive work. It is related to both recognizing the desire of the other who is a member of this group, as well as being recognized as part of this group and as someone whose contribution is important, i.e., recognition of one's uniqueness.

In the scenario analyzed by this research, the caregiver's function /position alternates between users and professionals and these among themselves. Users were able to listen to the team's limits and positions, while professionals had to interrupt their evaluations to listen to them. New ways of relating were coming up, although the conditions of the clinic and social network did not always allow that or make it easy.

In view of all these care premises, we may say that the Forum also may be interpreted as having a care function aimed at workers and users, as it expresses a certain way of functioning of that collective, occupying what Figueiredo (2007) calls a space for testimony, recognition (of both its value and its suffering) and in a certain way, giving subjects a "stronger" image of themselves back or one that has been made potent and that somehow also supported their clinical practices.

We feel that the Forum strengthened the bonds of the mental health network of the municipality. The exchanges that took place there provided a greater internal knowledge of the network, helped in the strategic mobilization of the claims, in exchanging experiences regarding cases, recommendations of paths that had to be followed in the network and training based on the exchange of experiences.

We may say that the function performed by the Forum reduced the psychological suffering of workers as it helped them recognize this territory, the territory of their partners and possible paths, and as it allowed them to be recognized by them. This plays a fundamental role according to Emerich and Onocko (2019), who state how common it is to look for refuge and protection in the face of the unknown. Such defenses result in bureaucratization or the use of stereotypes. This space is therefore essential to perform more individualized work that takes into account peculiarities, rather than just applying hard rules to the daily routine of the clinic.

Therefore, in this scenario, the bond is not restricted to the care / therapeutic relationships of a team / professional with users, but results of all these other interferences found in that territory and at that moment. However, we raised the question of whether the Forum actually managed to dialogue and establish a connection with the clinic. We found that these spaces dialogued very little with each other and will try to find out why.

One of the main reasons was the lack of consensus among clinic professionals (and with the network) in the debate about changing the complexity of the clinic, which was partly because this change would change its public, since RAPS regulations allocate less serious cases to outpatient clinics and patients suffering from severe and persistent mental disorders and substance abuse to CAPS. (Brasil, 2011) As the clinic treats patients suffering from less serious to more complex disorders, the main concern was that referring patients to other clinics would disrupt their bonds.

That situation points to a fact that transcends any rule (since building a bond cannot be prescribed) and therefore allows us to reflect on what may actually be essential when we think about the organization of a network and the provision of mental health care services and practices. What would be the most appropriate path in such a situation: “follow the rules”, break bonds and cope with unpredictable (and possibly both positive and negative) consequences? Or, preserve our one-of-a-kind mental health care clinic in a given territory, even if that requires to remain “off-design”?

That raises another question: does “following the rules” ultimately mean to abandon the group's founding project (Enriquez, 1994) - a project that aims to preserve the clinic as a mental health unit - in favor of a project designed by RAPS, but not backed by the group? In such a case, would the function of the bond in general - between users and professionals, as well as between professionals and the institution - be jeopardized, given the fact that it is the project that bonds the group?

Was the call for preserving the clinic rather related to fears or fantasies about change, as we saw in Kaës (1991), rather than to the relationship issue highlighted by workers? These questions remain open, since we are unable to answer them at the moment.

The outpatient clinic was going through a difficult time, both internally and externally, and that may have been one of the reasons for its difficulty to connect with the Forum, which radically encouraged workers to adopt a new professional attitude. Workers were such a fragile team that mobilizing such a fragmented group was unconceivable.

Despite this fact, we believe that at certain times the team attempted to build and/or strengthen bonds among workers and between them and their work, such as when it tried to mobilize its members politically (even if they participated in various ways), which implied an arduous process of debates and supervision to help participants listen to each other, expose their thoughts, exchange ideas and disagreements, think together so as to respond as a 'team'. In other words, this process resulted in a libidinal / affective investment in the fight for better working conditions.

At certain times, that increased unity or solidarity between some of the workers, gave them a certain feeling of recognition for their work, as the debate very clearly exposed the attacks and the deterioration of the network that directly affected them. They had to rethink their work conditions and mainly take into account that the clinic could be dismantled and closed. Their relationship with users and the territory was also influenced by this process, since mapping the actual conditions of the network upset the workers and boosted their intention to preserve their work at any cost.

Despite these movements, this project was not actually formulated. The group, trapped in those possible (false) dilemmas, hardened their position and decided not to change the clinic's care project, as they were not able to adopt a new vision or perspective that would allow them to formulate a new care project. They decided to maintain their activities and any changes to care services were dismissed.

In the face of the news that workers were going to be replaced in great numbers, these meager ties got even weaker. After a long thought process, the first author decided to resign as teamwork was jeopardized and her work perspective was becoming increasingly bureaucratic and therefore meaningless.

Crisis and Suffering in Institutions

Such a scenario makes it difficult to distinguish between the crisis of the subject and the institutional crisis (not only regarding the network, but also the clinic). We focus on the crisis of the clinic, which also dialogues to some extent with the crisis of the RAPS, but preserves its specificities since, as a group, it presents its own psychic constitution. However, how would we define crisis?

Kaës (1991) addresses the crisis of the subject, although he refers to the crisis of the psychosocial association and the intersubjective question in his discussions. We will try to apply one of his dialogues to the macro-scenario of the clinic. He also performs an analysis of suffering and psychopathology in institutions (Kaës, 1991), a point to which we will give special attention to achieve the goal of this topic.

The author rejects the idea of crisis as a genuinely personal event, but rather treats it as an expanded concept by considering areas that are not only at the level of the subject and the singular, but include group, cultural and subjective aspects that contribute to disorganization. In the same way, we understand that the clinic also had its history and its relations (internal ones and with the network), that it was governed by a specific culture and one may therefore only evaluate its crisis by associating it to the series of events that took place at the time.

According to Kaës (1982), crisis does not only disorganize and disintegrate, it also changes, transforms, develops, hence its ambiguity. Destruction also gives rise to creativity. Crisis is always singular, unique (for each subject and at each time) and, although it takes place unexpectedly, he does not understand it as a novelty, but rather as a process that results from history and recollection.

Pereira, Sá, and Miranda (2013) discuss crisis from a psychosocial perspective based on Ferigato et al. and Kaës and state that crisis situations require urgent actions using both clinical-institutional resources and actual health system resources. Those actions need to be performed by community institutions and other service partners. The authors point out that such transit spaces between the self and the group form an intersubjective set that may provide an understanding of the crisis processes and constitute itself as a space / setting that supports critical moments of fragmentation, conflicts and tension between what is instituted and the subjects' ability to invent and create.

This also meets Miranda's (2013) point of view: creative work is not the result of spontaneous events, but rather of an effort to create work that facilitates, encourages and sustains this mode of production, which means that management plays a fundamental role. Emerich and Onocko (2019) corroborate this act of investment in creativity and state that the proposal to change the way work is organized, opening space to the unknown and to experimentation at the institutional level, also implies motivating professionals to change at a personal level.

According to Kaës (1991:30), suffering in institutions comes from three types of sources and these are mixed up in workers' complaints: "the first one is inherent to the institutional fact itself, the second one is inherent to a specific institution, to its social and to its own unconscious structure and the third one is tied to the psychic configuration of the singular subject." This leads to psychic work that develops defense mechanisms and the search for superior satisfactions; it paralyzes the psychic space of both the singular subject and the common and shared spaces of the subjects associated to their different bonds.

Suffering is not always visible and institutions have mechanisms to hide it, especially if they cause it. In other words, as a wide variety of suffering occurs during institutional life, this hiding mechanism aims at psychic non-registration of such experiences. The denial pact, for example, is related to this mechanism. It is "this suffering and this specific difficulty in recognizing it that the psychoanalyst must be aware of" (Kaës, 1991:31).

The meetings and supervisions of the outpatient team were directly influenced by the macro scenario, revealing internal conflicts regarding the clinic and working together. One of the creative solutions of that process was that a clinic worker suggested sharing the situation in a clear way with users. They hoped that the establishment of a more horizontal relationship between workers and users would create a possibility of jointly developing coping and action strategies, in addition to the fact that, given the mobilization of the network, these topics were circulating among clinics and users in a very organic way. The situation clearly affected everyone directly and could not be hidden from users, even if they did not know how to explain it.

It was difficult to reach a consensus. Part of the group considered it risky to inform users as it could unsettle them, others felt that psychotic subjects were in no condition to participate in political acts or even in assemblies, as they might not be able to cope with such a situation (an issue that highly surprised some of the professionals). It is interesting to notice how the team behaved, its limits / possibilities, concepts and biases, including in dealing with its own suffering. After much effort, the decision was taken to share the situation with users. The results were mostly positive and helped deepen care relationships.

This act by the team corroborates what is required to work in mental health, i.e., to break away from the way of looking and understanding the human experience generically called madness or psychological suffering. The object changes from being a disease to being the complexity of life (Yasui & Amarante, 2018).

In addition to this, there was a difficult relationship with the municipal management of the network, which was neither open nor available to welcome and create new work front lines. This process reinforces the need for a type of management that takes into account the subjectivity of the team and of users

to deal with the clinical-political issues, implying a change in how the accountability of the subjects is viewed. We understand that such conditions may provide possibilities to build creativity, the next element of analysis. According to Figueiredo (2007), caring is not just repairing, but also creating - producing new connections and creating new ways of being in the world.

Creativity

There is a "not-knowing" attitude that needs to reach out in all directions, i.e. an openness so that positions and paths to follow to build and offer care do not crystallize, both within the team and in the team-user relationship. This requires creativity.

Miranda (2013) states that for that openness to happen, it is essential to create zones of trust. If there is no confidence in the stability of the work environment or in the ability of partners to offer support and recognition, creative and appropriate responses to this unexpected situation are unlikely to be provided, because "in the face of the unforeseen and the impossibility of control, professionals tend to hold on more strongly to their narcissistic and identification contracts, fantasizing more intensely about the clinic's soundness, stability and omnipotence." (Miranda, 2013:105).

The understanding of that psychic functioning of the group and its extension that may lead to a crisis scenario broadens the spectrum of vision about the clinic: in that scenario and conditions of employment contracts, trust zones could virtually not be built. Coordinators held positions filled by the management, which denied the requests made by the Forum. Workers' bond was fragile as they were outsourced. Users were increasingly exhausted by the lack of medication, care, etc. Not only did the macro scenario affect everyone, but the hierarchies inside the team also prevented stability.

The zones of trust are therefore the pillars of creativity, but how do we define this term? Creativity is linked to spontaneity and coexists with the complex issues of any clinic. It is the creative dimension that gives meaning to practice, it may help foster empathy between professionals and users and endure difficulties by supporting professionals in finding pleasure and fulfillment at work (Miranda, 2013).

According to the author, the possibility of experiencing creativity depends on what Kaës (1991) calls Intermediate Formations discussed above, formations that do not concern either individual subjects or the group, but their relationship. This means that when a collective/group is attacked, the impact is felt by all components.

We have already analyzed how these formations were strongly attacked, both inside and outside the clinic. What path should one follow in such a setting?

In a micro work scenario, what matters is the positioning of professionals and the management in the construction and maintenance of intersubjective relationship devices (case discussions, clinical-institutional supervision, working groups, management committees, reference teams, meetings, health councils and others), which share one and the same feature: they may become interstitial, transit, "inside-outside" zones (Miranda, 2013).

According to Onocko and Furtado (2008), these spaces should not only increase the degree of analysis of practices, but also of the understanding of the unconscious drive states in which the work is built, so that they may be "analyzed, rather than repressed, to avoid their transformation into perverse or bureaucratic actions aimed at professionals, users and the community" (Onocko Campos & Campos, 2006:686).

Another factor highlighted by Miranda (2013) is the openness to encounter the other, otherness, which is fundamental in any change process, as it allows practical intelligence and creative action to rise. This is where the creative potential of interdisciplinary teams lies. Yasui and Amarante (2018) state that thinking about the construction of mental health care implies thinking about the time and place of care, woven as a network strategy, i.e., care takes place in a specific network and place and encourages the dialogue with the diversity by which it is constituted.

Therefore, one of the greatest challenges lies in people's readiness to collaborate in the search for points that support a dialogue between initially antagonistic positions without losing the necessary specificities (Miranda, 2013). This implies the possibility of tolerance of functioning at heterogeneous levels,

added to the acceptance of interference of different logics (Miranda, 2013).

In this sense, the supervision mechanism needs to hold a strategic position that allows narration, acceptance, problematization and processing of experiences to take place in the search for meaning. As a protected space, it does not deny the different relationships found in the group (related to professional training, theoretical conceptions, etc.), as it understands that there is a particularity, something subjective and personal in empirical knowledge. Supervision values experience, not just the event (which never repeats in the same way when seen from the perspective of two different people), which means that there is a dialectic relationship between subjects and collectives that such a device may support without homogenizing them (Emerich & Onocko, 2019).

Emerich and Onocko (2019:06) point out that based on such a device, "the singular is built, but not individually, rather through sharing that gathers what is different and make the unprecedented emerge in the collective". Thus, the supervisor's role would be to support the group's experiments, a kind of management that lies between maternity and castration.

An important point is the fact that the outpatient clinics of this network (including the one analyzed in this article) are also strongly influenced by work that dialogues with psychoanalysis in both clinical and institutional supervision, as well as in clinical activities performed by professionals. This is supported by the concepts of unconscious transference, the search for the no-place of supposed knowledge, among other issues.

It is noteworthy that neither the practices, nor the professional categories of this clinic differ from those of other clinics (except for the presence of Home Assistants, a special network feature). However, what is different is the wide range of cases monitored and actions performed, which mobilizes the team to expand its instruments, a process we evaluated as a factor that helped to introduce actions to ease the positions of its members, although the resistance to change persisted in other areas.

In view of the precarious situation that affected everyone, the clinic entrance door was closed. Only emergencies were admitted and registrations booked. Therefore, the last point we would like to highlight is the violent and fatal process that takes place in institutions and which oppose, from a psychoanalytic perspective, the forces of connection and creation. From what experience shows us, it seems that these destructive forces act very strongly in two ways. On the one hand, workers are violently and massively replaced and the network is asphyxiated due to a lack of general inputs and resources. On the other hand, clinic workers resist change, despite their participation in the Forum.

The Forum's poor achievements include the transfer of funds and material to both clinics and professionals (salaries). However, the network found out at the time that the CAPS and the Psychiatric Hospital came always first, even if the quantities they received would not cover their actual needs. Given the blatant disinvestment policy aimed at this type of clinic, it could not be expected to survive for long. Deprivation on the one hand and resistance to change on the other is the most effective formula for destroying any possibility of creativity.

Final considerations

Based on the content formulated, discussed and dialogued with the support of both theory and practice, a discussion has taken place whose main points of analysis are found in this article. Thus, our final considerations only highlight a few items that are fundamental for new care practices in the field of mental health, as well as a brief reflection on how (and if) the current scenario, the political and regulatory issues influenced this question.

To explore the performance limits and possibilities of a public outpatient mental health clinic whose care model and organizational features differ from the design recommended by the Psychosocial Care Network (RAPS), the narrative was used as the main methodological tool. This allowed us to give life to the design of a network and to translate individual experiences through remembrance. This narrative, like all research methods, has its limits and we

acknowledge that the description and analysis of group / collective and political-institutional processes of the clinic, as well as the complexity of the scenario and network, are the result of our memories. Hard work was required to organize these experiences in a non-crystallized way and open to dialogue.

Analysis-based psychosociology supported this analysis, as it understands that the most comprehensive and complex assessment of a clinic and its work has to take into account the relationships that the subjects establish among themselves and with the institutions they work at (Guist-Desprairies, 2001). Some of its main theoretical contributions to this analysis were the question of meaning and subject, one of the highlights of this intervention understood as both social and clinical practice.

The notion that health services are an eminently intersubjective space, in addition to the material, normative and political one (Sá, Carreteiro & Fernandes, 2008) allowed us to highlight a collective device, understood not only as a space for self-reflective exchanges, but also as a common intersubjective space in which unconscious processes, transpsychic group operators and psychic elaboration by group members were taking place. This makes it a space for psychosocial activity, for transit between the self and the group capable of offering some support and creating instances of analysis for the teams.

Main research findings include a discussion based on four emerging elements of analysis: group and intersubjective processes; bond and recognition; crisis and suffering in institutions; creativity.

One point that may not be overlooked is to what extent the current scenario of restricting and dismantling mental health services goes against a recently built network of a potent and new cause - the anti-asylum struggle - that tries to change social paradigms of mental illness. It suggests that the short time required to build this change movement was enough to provoke the management's discomfort and resistance against the expansion and qualification of this plural work.

The maintenance of our research object, a public mental health clinic that does not meet the RAPS standards, needs to be carefully analyzed, especially

as long as the network does not present a broader and more solid structure found in other types of institutions, such as CAPS I, II and III, therapeutic homes, psychiatric beds at general hospitals, shelter units, social centers etc. It is essential to build such a structure so that we may reevaluate the functioning of the clinic, which is part of the network and provides special care services and significant support to the city's health care system. The workers' Forum was also deemed important, albeit transitory, to help build solidarity among workers and cope with that context of huge restrictions and setbacks.

At a personal level, we were surprised by the high degree of cautiousness required to criticize the clinic we aimed to defend. Given the current dismantling process of mental health services in Brazil, conducting the discussion of this research required writing in a way that made clear that the issues and criticisms raised are part of a search for solutions, as we aim to defend a health system in which we strongly believe. According to Mattos (2009:47), this is a "difficult task for our culture, as we are used to criticizing opponents more than allies or ourselves".

We agree with Emerich and Onocko (2019) who believe that the transformations must take place for SUS and through SUS, using health care institutions and actual demands and challenges as a fertile ground for learning and experimenting with practices. We wish to conclude with a note by these authors who state that to learn to deal with new care models, new paths must be followed. May the present article help create another bridge for debate, discussion, and collective construction.

Author contributions

Araújo JB participated in the conception, recollection and registration of the scenario analyzed by the research, as well as in the theoretical construction, interpretation of results and writing of the scientific article. Sá MC guided and supervised both the construction of the data and their interpretation in dialogue with the theory that underpins this research and wrote the scientific article.

Competing interests

No financial, legal or political conflicts involving third parties (government, companies and private foundations, etc.) have been declared regarding any aspect of the submitted article (including, but not limited to grants and funding, participation in advisory councils, study design, preparation of manuscripts, statistical analyses, etc.).

References

- Amarante, P. (2015). *Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil* [Crazy for life: the trajectory of psychiatric reform in Brazil] (2nd ed.). Fiocruz.
- Campos, R.O., & Campos, G.W.S. (2006). Co-construção de autonomia: o sujeito em questão [Co-construction of autonomy: the subject in question]. In GWS Campos, MCS Minayo, M Akerman, M Drumond Júnior, YM Carvalho (Eds.). *Tratado de Saúde Coletiva* [Collective Health Treaty]. Fiocruz.
- Campos, R.T.O., & Furtado, J. P. (2008). Narrativas: utilização na pesquisa qualitativa em saúde [Narratives: use in qualitative health-related research]. *Revista Saúde Pública*, 42(6), 1090-1096. <http://dx.doi.org/10.1590/S0034-89102008005000052>
- Cecílio, L.C.O. (2012). Escolhas para inovarmos na produção do cuidado, das práticas e do conhecimento: como não fazermos "mais do mesmo" [Innovating when producing health care, practices, and knowledge: how to avoid doing "ever the same"?]. *Saúde Soc*, 21(2), 280-289. <https://doi.org/10.1590/S0104-12902012000200003>

- Czeresnia, D. (2009). O conceito de saúde e a diferença entre prevenção e promoção [The concept of health and the difference between prevention and promotion]. In D Czeresnia, CM Freitas (Eds.), *Promoção da saúde: conceitos, reflexões, tendências* (2nd ed., pp. 43-57). Fiocruz. <https://doi.org/10.7476/9788575413531>
- Dejours, C. (1999). *Conferências brasileiras: identidade, reconhecimento e transgressão no trabalho* [Brazilian conferences: identity, recognition and transgression at work]. Fundap.
- Emerich, B. F. (2017). *Desinstitucionalização em saúde mental: processo de formação profissional e de produção de conhecimento a partir da experiência* [Deinstitutionalization in mental health: process of professional training and knowledge production from experience] [Doctoral dissertation, Universidade Estadual de Campinas]. http://repositorio.unicamp.br/bitstream/REPOSIP/330698/1/Emerich_BrunoFerrari_D.pdf
- Emerich, B., & Onocko-Campos, R. (2019). Formação para o trabalho em Saúde Mental: reflexões a partir das concepções de Sujeito, Coletivo e Instituição [Mental Health professional education: reflections based on the conceptions of Subject, Collective and Institution]. *Interface - Comunicação, Saúde, Educação*, 23, e170521. <https://dx.doi.org/10.1590/interface.170521>
- Enriquez, E. (1994). *A Organização em Análise* [The Organization under Analysis]. Vozes. (Original work published 1992)
- Figueiredo, L.C. (2007). A metapsicologia do cuidado [The methapsychology of caretaking]. *Psyche*, 11(21), 13-30. http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1415-11382007000200002&lng=pt&nrm=iso
- Freud, S. (1996). O Ego e o Id [The Ego and the Id.]. In *Edição Standard Brasileira das Obras Completas de Sigmund Freud* (Vol. XIV). Imago. (Original work published 1923)
- Guist-Desprairies, F. (2001). Acesso à subjetividade, uma necessidade social [Access to subjectivity, a social need]. In J.N.G. Araújo, & T.C. Carretero (Eds.), *Cenários Sociais e abordagem clínica* (pp. 231-244). Escuta.
- Kaës, R. (1982). *Crisis, ruptura y superación: análisis transicional en psicoanálisis individual y grupal* [Crisis, rupture and overcoming: transitional analysis in individual and group psychoanalysis]. Cinco. (Original work published 1979)
- Kaës, R. (1991). Realidade psíquica e sofrimento nas instituições [Psychic reality and suffering in institutions]. In R. Kaës, E. Bleger, E. Enriques, F. Fornari, P. Fustier, R. Roussillon, & J.P. Vidal (Eds.), *A instituição e as instituições: estudos psicanalíticos*. Casa do Psicólogo. <https://doi.org/10.1590/S0034-75901993000500009>
- Mattos, R. (2009). Os Sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos [The meanings of integrality: some reflections on values that deserve to be defended]. In R Pinheiro, RA Mattos (Eds.), *Os sentidos da integralidade na atenção e no cuidado à Saúde* (8th ed.). Abrasco. <https://doi.org/10.1590/S0103-73312002000100014>
- Ministério da Saúde. Conselho Nacional de Saúde (2011). *Relatório Final da IV Conferência Nacional de Saúde Mental* [Final Report of the IV National Conference on Mental Health]. Conselho Nacional de Saúde/Ministério da Saúde. http://conselho.saude.gov.br/biblioteca/Relatorios/relatorio_final_IV_cnsmi_cns.pdf
- Miranda, L. (2013). Criatividade e trabalho em saúde mental: contribuições da teoria winnicottiana [Creativity and work in mental health: contributions from the Winnicottian theory]. In C.S. Azevedo, & M.C. Sá (Eds.), *Subjetividade, gestão e cuidado e saúde: abordagens da psicossociologia*. Fiocruz.
- Nunes, M. O., Lima Júnior, J. M., Portugal, C. M., & Torrenté, M. (2019). Reforma e contrarreforma psiquiátrica: análise de uma crise sociopolítica e sanitária a nível nacional e regional [Psychiatric reform and counter-reform: analysis of a socio-political and health crisis at national and regional level]. *Ciência & Saúde Coletiva*, 24(12), 4489-4498. <https://doi.org/10.1590/1413-812320182412.25252019>
- Pereira, M. P., Sá, M. C., & Miranda, L. (2013). Adolescência, crise e atenção psicossocial: perspectivas a partir da obra de René Kaës [Adolescence, crisis and psychosocial care: perspectives from the work of René Kaës]. *Saúde em Debate*, 37(99), 664-671. <https://doi.org/10.1590/S0103-11042013000400014>

- Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS) [Institutes the Psychosocial Care Network for people with suffering or mental disorder and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the Unified Health System (SUS)]. http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html
- Ricoeur, P. (1997). *Tempo e narrativa* (Tomo I) [Time and Narrative (Vol.1)]. Papirus. (Original work published 1983)
- Sá, M. C., Carreiro, T. C., & Fernandes, M. I. A (2008). Limites do cuidado: representações e processos inconscientes sobre a população na porta de entrada de um hospital de emergência [Limits of care: representations and unconscious processes about the population at the entrance of an emergency hospital]. *Caderno Saúde Pública*, 24(6), 1334-1343. <http://dx.doi.org/10.1590/S0102-311X2008000600014>
- Trachtenberg, A. R., Piva, A.B.S., Haeberle, D., Pereira, D. Z., Soares, G. F., Avritchir, R. A., & Mello, V. H. P. (2011). Por que René Kaes?. *Psicanálise*, 13(1), 257-270. <http://sbpdepa.org.br/site/wp-content/uploads/2017/03/Port-que-Ren%C3%A9-Ka%C3%ABs.pdf>
- Turato, E. (2003). *Tratado da metodologia da pesquisa clínico-qualitativa, Construção teórico-epistemológica, discussão comparada e aplicação das áreas da saúde e humanas* [Treatise on the methodology of clinical-qualitative research, Theoretical-epistemological construction, comparative discussion and application of health and human áreas] (2nd. ed.). Vozes.
- Yasui, S. Luzio, C.A., & Amarante, P. (2018). Atenção psicossocial e atenção básica: a vida como ela é no território [Psychosocial care and primary care: life as territory in the field]. *Revista Polis e Psique*, 8(1), 173-190. <https://doi.org/10.22456/2238-152X.80426>