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ARTICLES

Paradigms, Perceptions and Practices in Mental Health: A Case Study Based on Bakhtin / *Paradigmas, percepções e práticas em saúde mental: um estudo de caso à luz de Bakhtin*

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ABSTRACT
This paper proposes to think about the vicissitudes of care in the public psychosocial care network and about the fundamentals of an ethical-dialogical perspective of work with grounds in the Bakhtinian contributions. The reflection is interwoven in the analysis of the impasses and possibilities for the praxis in one Centro de Atenção Psicossocial – [Psychosocial Care Center – PCC] in the metropolitan area of the State of Rio de Janeiro, Brazil. The study is the result of a Master's Degree research, linked to the Public Health Postgraduate Program of the Sergio Arouca National Public Health School of the Oswaldo Cruz Foundation. Semi-structured interviews and participant observation were carried out with professionals during the institutional routine. From the analyses performed under the perspective of Social Constructionism and using the resource of analysis of discursive practices and meaning production, we verified the presence of contradicting positions expressed in perceptions that are both aligned and conflicting with dialogical ethics assumptions.
KEYWORDS: Mental health; Psychic suffering; Dialogism; Care; Ethics

RESUMO
Este artigo propõe pensar sobre as vicissitudes do cuidado na rede pública de atenção psicossocial e sobre a fundamentação de uma perspectiva ético-dialógica de trabalho a partir de contribuições bakhtinianas. A reflexão se entretece na análise de impasses e possibilidades para a práxis em um Centro de Atenção Psicossocial (CAPS) da Região Metropolitana I do Estado do Rio de Janeiro. O estudo é resultado da pesquisa de mestrado vinculada ao Programa de Pós-graduação em Saúde Pública da Escola Nacional de Saúde Pública Sergio Arouca da Fundação Oswaldo Cruz. Foram realizadas entrevistas semiestruturadas com os profissionais e observação participante no cotidiano da instituição. A partir das análises realizadas sob o prisma do Construcionismo Social e do recurso de análise de práticas discursivas e produção de sentidos, verificamos a presença de posicionamentos contraditórios expressos em percepções que se mostraram ao mesmo tempo consonantes e conflitantes com pressupostos ético-dialógicos.
PALAVRAS-CHAVE: Saúde mental; Sofrimento psíquico; Dialogismo; Cuidado; Ética

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Outlooks as Producers of Knowledge and Practices

The production of a discursive fabric is noted when analyzing the way a subject in mental suffering is perceived in the social environment through space-time, culminating in the emergence of the madness stigma and the social exclusion of those classified in this category (FOUCAULT, 2006).[1] In this sense, madness reveals itself as a position that is socially created through discourses, that is, a reality that is socially elaborated through the sharing of a specific perception, of a discourse that concerns such perception (PORTER, 1987;[2] GOFFMAN, 1963;[3] 1982).[4] Therefore, from this perspective, discourses would not be only a set of signs, but, "[...] practices that systematically form the objects of which they speak" (FOUCAULT, 2002, p.49),[5] that take place in the relationship and may be seized in the observance of their historical and cultural essences (VOLOŠINOV, 1973).[6]

The historical models of comprehension and treatment of madness corroborate the introductory paragraph. Among them, there is one example that remained in operation for over two centuries, producing concrete practices that guide silencing and stigmatizing relationships with individuals in mental suffering. This is the psychiatric paradigm – a standard of attention to psychic suffering forged by the classical psychiatry at the end of the 18th century and still hegemonic in the Brazilian context.

Traditionally, the psychiatric paradigm consists of a hospital-centered organization where hospitalization is indispensable and compulsory, in which the psychiatric knowledge is a treatment-exclusive asset. Overcome by this logic, madness was the target of inefficient therapy that led to the isolation of patients in conditions marked by reified relationships, disrespect to humanity, and violence. In such

[1] FOUCAULT, M. *History of Madness*. Translated by Jonathan Murphy and Jean Khalfa. London/New York: Routledge, 2006.
[2] PORTER, R. *A Social History of Madness: The World Through the Eyes of the Insane.* London: Weidenfeld e Nicholson, 1987.
[3] GOFFMAN, E. *Stigma*: Notes on the Management of Spoiled Identity. New Jersey: Prentice-Hall, 1963.
[4] GOFFMAN, E. *Interaction Ritual* - Essays on Face-to-Face Behavior. New York: Pantheon Books,1982.
[5] FOUCAULT, M. *Archaeology of Knowledge*. Translated by A.M. Sheridan Smith.2.ed. New York: Routledge, 2002.
[6] VOLOŠINOV, V. N. *Marxism and the Philosophy of Language*. Translated by Ladislav Matejka and I. R. Titunik. Cambridge, MA: Harvard University Press, 1986.

circumstances, the typical outcome was the aggravation of general health conditions or death (AMARANTE, 2011).

The 1980s mark a time of change that was demanded with the purpose of reformulating mental health assistance. After that time period, the traditional psychiatric model began to be actively questioned, and the asylums were rejected as places for treatment, as the perception that such places reinforce stigma, segregation, and the silencing of its relationship with subjective difference is made clear (AMARANTE, 2009). Thus, the process of Psychiatric Reform started[7] with broad social participation and articulated with militant struggles, such as the Movimento da Luta Antimanicomial – MLAM [Anti-Asylum Movement] and those regarding the achievement of health as a constitutional right and in favor of the country's re-democratization. The new proposals for mental health assistance gave rise to a model of psychosocial basis that orients current practices by the logic of health-promoting care that transforms the social perception of psychic suffering. In this attempt, many directives were issued[8] at that time and have gradually been implemented up until today.

The synthetic historical incursion mentioned above aimed to establish and introduce the discussion regarding what we identify as the birthplace of a current deadlock: the coexistence of two different assistance standards governed by opposing logics; two diverging ways of understanding health infirmity care process. This means there is a clash of paradigms in the field of mental health, between the paradigm of the asylum model (inclined to the traditional psychiatry) and the paradigm of the psychosocial model (new modality of care that emerged from the Psychiatric Reformation process). We will discuss the characteristics involving both models, regarding the standoffs that unfolded from their coexistence in the care field and the possibilities of

[7] Amarante (2009) defines the Psychiatric Reformation as a historical process of critical and practical formulation that had the purpose of questioning knowledge and the psychiatric institutions, and elaborating proposals to transform the classic hegemonic model (the traditional psychiatric model, or asylum model) of mental health care.

[8] The main directives are highlighted here: i) Gradual extinction of asylums; ii) Organization of an open care network, which would consist of different non asylum-like institutions of care; iii) Deinstitutionalization of patients who were chronically hospitalized in asylums and the articulation of their return to a life in society; iv) Composition of multi-disciplinary work teams; v) Use of different therapeutic resources, the least invasive possible; vi) Offer of multiple activity formats and alliances in the territory to ensure larger social insertion of patients under treatment; and vii) Human and respectful treatment that is guided to promote patient's re-socialization (BRASIL, 2001).

potentializing the psychosocial model based on the contributions made by Mikhail Bakhtin. We will reflect upon these concerns throughout this case study.

1 The Asylum Paradigm

The term *paradigm* is commonly used to set a model, rule, or standard to be followed. At first, the realities are interpreted from a paradigm that serves as a guide for choice making, points of view, sense production, knowledge, and practices in general. One paradigm may be understood as a model that allows the formation of perceptions through comparison (CAPURRO, 2003). Therefore, as history has it, Psychiatry has achieved recognition as the first medical specialty to develop new knowledge concerning madness and a model of treatment that establishes the psychic understanding through comparisons to the biological. In other words, the psychiatric paradigm guides the perception of madness according to the logic and the values of medical science. Thus, the work, as one type of medical work, is based on the application of the knowledge that is acquired through training and learning, and the professional work is based on a technique that was previously acquired for observing, researching, identifying, and diagnosing illnesses (PERRUSI, 1995, p.112).

Such approach clearly appears in the first study on psychiatric science: the Medico-Philosophical Treatise on Mental Alienation (2008 [1800]).[9] In this bi-centennial book, the French doctor Phillipe Pinel proposed a methodology based on the hospitalization of subjects in exclusive asylums for meticulous study, cataloguing, and description of madness manifestations (the symptoms). It is enlightening to observe that Dr. Pinel was a member of a group called "the Ideologues," who were committed to finding scientific foundations for the phenomena he studied and that had its origin in the Natural History model (AMARANTE, 2008, p.39). In this rationale, illnesses are something natural, formed by symptoms, which require explanation and classification in order to be distinguished from other types of conditions (MACHADO, 2006, p.65). Hence, based on the Natural History paradigm, madness was reified as a mental illness.

[9] PINEL, P. *Medico-Philosophical Treatise on Mental Alienation*. Translated by Gordon Hickish, David Healy, Louis C. Charland. 2.ed. West Sussex, UK: Wiley-Blackwell, 2008 [1800].

In the psychiatric norm, mental illness consists of a set of symptoms that are not only understood as signs of infirmity, but also represent them. It is a clinical model that circumscribes illness (represented by a set of symptoms) as an object of study and intervention. To illustrate this, Franco and Franca Basaglia use a rather opportune aphorism: they state Psychiatry puts the subject between brackets and occupy themselves with the illness (AMARANTE, 2003, p.57). The act of "putting subjects between brackets" harms the delivery of a comprehensive care service, and this is because there are other life dimensions between brackets involved in mental suffering, leading to a partial attention delivery, with strictly technical-biological focus.

Let us take the psychiatric interview as an example to illustrate this statement. We could define it as "[...] a communicative event in which the patient 'describes' symptoms and the doctor analyzes them and prescribes the best treatment" (PEREIRA, 2010, p.685).[10] In this definition, we see that the main objective is the diagnosis, which is carried out in a research process that involves the individual's discourse to compare captured elements to symptoms catalogued according to the mental illness class framework. In this case, we may say that the listening is selective, as all that is heard from the reports is only what allows nosographic classification (NOVAES, 2005, p.03). The contradiction in the procedure of "selective listening" tends to reproduce itself beyond the resource of psychiatric interview, in the standards of multi-professional team assistance.

The comprehension of madness as an organic disorder is a reality produced by the traditional psychiatric paradigm, whose activity have led to the naturalization of perceptions of mental suffering that resisted resignification for over two centuries.[11] Therefore, the history of mental Medicine exposes the construction of modes of relation with the madness mediated by signs of negativity: the symptoms. Amarante (2008) summarizes it: "The behavior of people towards the mad will be the same the psychiatrist produces and adopts" (AMARANTE, 2008, p.82).[12]

[10] In Portuguese: "[...] um evento comunicativo em que o paciente 'descreve' sintomas e o médico os analisa e prescreve o melhor tratamento."

[11] The discourse of the alienist discipline has incorporated stigmatizing labels to classify the mad person; signs such as abnormality, dangerousness, degeneration, social inadequacy, strangeness, unreasoning, moral deviation, amongst other negativities that have been historically accepted in society, have been renewed by a scientific reading that has represented them as mental illness symptoms.

[12] In Portuguese: "A conduta das pessoas para com o louco passa a ser aquela mesma que a psiquiatria produz e adota."

The analysis of the fundamentals of psychiatric paradigm is essential to understand the persistence of a great impasse that lies in mental health care today: the prioritizing of drug therapy. We may see this issue as a consequence of understanding the psychic suffering expression as symptoms of a pathology, which must be suppressed with psychotropic drugs. This derives from the social perception of drugs as a solution for mental suffering.

This logic has been fomenting the phenomenon of medicalization, a term that refers to the process through which the biomedical knowledge appropriates itself of problems that are external to its disciplinary field and interprets them as illness and medically treats them. In this sense, to medicalize[13] refers to the literal translation of "to make medical" (CONRAD, 2007, p.161).[14] Freitas and Amarante (2015) clarify that the phenomenon of medicalization denotes different meanings, whose common points refer to the action of "[...] turning undesired or disturbing experiences into health objects, allowing the transposition of what is originally of social, moral, or political order for the domains of medical and medical-related practices" (FREITAS; AMARANTE, 2015, p.14).[15] The medicalization of psychic suffering has become a problem of greater severity since the intervention of neuroleptic drugs in the 1950s. The novelty gave rise to alliances between the pharmaceutical industry and the Psychiatry, leading to the rise of this specialty's credibility and to promotion of the belief in the scientific progress of "mental illnesses" treatment, regarded as incurable until then. From then on, the idea that the cure for mental suffering was possible through drug therapy was reinforced (FREITAS; AMARANTE, 2015, p.18).

Although it is widely known that psychotropic drugs do not promote cure, they are attractive for their silencing effect, a normalizer of conducts and behaviors that generate social disturbance. The action of these drugs concerning the inhibition of emotions, thoughts, sensations, and motor skills leads the subject to difficulties regarding speaking and sharing his/her story and significations of life in dialogue. When the French

[13] It is important to emphasize the difference between medicating and medicalizing. In the act of medicating, the medical treatment focuses on an illness and, therefore, it is appropriate. In contrast, in the act of medicalizing, the medical treatment focuses on what is not an illness, and is inappropriate, in this case.
[14] In Portuguese: "tornar médico."
[15] In Portuguese: "[...] transformar experiências indesejáveis ou perturbadoras em objetos da saúde, permitindo a transposição do que originalmente é da ordem do social, moral ou político para os domínios da ordem médica e práticas afins."

psychiatrists Jean Delay and Pierre Deniker released the neuroleptic drugs in 1952, they boasted that the mad people would have their voice back (ROUDINESCO, 2001, p.11).[16] In reality, the result was quite the opposite of what was promised.

2 The Psychosocial Paradigm

The current model of mental health care is the result of efforts and militant struggles to break with the asylum logic. The National Policy on Mental Health portrays the engagement towards the consolidation of a new paradigm concerning the care of people in mental suffering. In this sense, work on implementing an open, community-based Rede de Atenção Psicossocial – RAPS [Psychosocial Care Network] is being carried out, as well as the creation of multidisciplinary teams that must guide their practice towards fighting the stigma of madness, recognizing health's social determinants, cooperating towards the individuals' recovery of dignity and their insertion in society. RAPS is part of Brazil's Sistema Único de Saúde – SUS [Unified Health System] and consists of different assistive facilities[17] that serve as asylum substitutes (BRASIL, 2011).

In the psychosocial care model, the institution of an intersectoral network is sought to better meet the needs of people under treatment, with attention to psychosocial and human rights demands. It also seeks to aggregate territorial resources to the treatment through interlocution and alliances in the educational, community, work, and family scopes, among other possibilities. This is important for the promotion of care aligned with the principle of integrality and is a strategic way to fight the old paradigm that silences, isolates, and discredits madness.

Somehow, the new paradigm of care shows great, innovative and transformative power, as its directives are applied to promote standpoints that oppose those observed in the model it intends to replace. However, in contrast to technical-assistive standards, the medicalization problem prevails – a silencing practice that denounces the difficulty of

[16] ROUDINESCO, E. *Why Psychoanalysis?* Translated by Rachel Bowlby. New York: Columbia University Press, 2001.

[17] Among the assistive services that compose RAPS are: Centros de Atenção Psicossocial – CAPS [Psychosocial Care Centers], Núcleos de Atenção Psicossocial – NAPS [Psychosocial Care Nucleus], Serviço Residencial Terapêutico – SRT [Residential Therapeutic Service], Centros de Convivência e Cultura – CECO [Culture and Social Centers], comprehensive care beds in general hospitals and in CAPS III, social cooperatives and companies, and Unidades de Acolhimento – UA [Host Units].

establishing a relationship with the subject in mental suffering. Paradoxically, the person under psychic pain does not find space for dialogue in the place that exists to serve the purpose of caring and working with this person's speech. Psychotropic drugs, or other ways of "silencing," are administered in situations in which it would be possible and desirable to opt for dialogic therapies.

This situation calls for an analytical approach to what concerns the negatives to dialogues: problems in the relational dimension in the process of assistance. Addressing relational aspects is crucial for the discussion regarding care production barriers to go beyond consideration of structural, organizational, and biological quesitons, where the analyses usually stop.

Indeed, several studies have been demonstrating that the main dilemmas and conflicts in the field of psychosocial care derive from the relational dimension. In this sense, the investigation of some contexts points out, as the main setback, that the perception of professionals is aligned with the asylum logic, conforming practices that are incompatible with the new assistance standards (KODA, 2002; SILVEIRA; VIEIRA, 2005; GUEDES *et al.*, 2010; NUNES *et al.*, 2016). In view of the aforementioned discussion, we must reflect upon the way dialogic processes may contribute to overcoming the challenge of transforming perceptions and practices in the mental health care field when regarding relationships.

3 Bakhtinian Contributions towards Dialogical Ethics

What is the importance of dialogical processes for the production of assistance in psychosocial care? To reflect upon this issue, we need to put the word 'dialogue' in the center of our analysis - for although it is semantically rich, its application is usually empty and allegorical. However, it is essential to emphasize that "[…] a word that is imposed is, many times, a whole world of revealed relationships; [...]. When a word loses its power, an idea loses its life" (NOVAES, 2009, p.13).[18] Thus, it is beneficial to rescue the word

[18] In Portuguese: "[...] uma palavra que se impõe é, muitas vezes, todo um mundo de relações que ela revela; [...]. Quando uma palavra perde o vigor, é uma ideia que perde a vida."

"dialogue," highlight its meaning, its epistemological value and its contribution to the consideration of issues related to mental health care.

The term 'dialogue' has its origin in the Greek word *diálogos*, which consists of the overlapping of two particles: the preposition *dia*, which means "by means of" and the noun *logos*, usually translated as "word." Dialogue, then, is the semantic equivalent to "by means of word." From the etymological perspective, the word is the condition for dialogue and, in this logic, we may understand dialogue as an experience that links subjects and creates possibilities for meaning sharing through words (BRAIT; MAGALHÃES, 2014). Novaes (2009) understands dialogue as a provider of bridges of understanding for the joint construction of meanings. Therefore, dialogue would not be only a discourse genre; it would have ethical value in any human activity. For Novaes (2009), the rising difficulty in dialoguing constitutes a "contemporary tragedy" that is present in the different manifestations of intolerance towards differences.

Mikhail Bakhtin stands among the most influential theorists on dialogue. According to him, the essence of life is inevitably dialogic; for this reason, one of the main themes of his investigation was human interaction mediated by speech. The Russian philosopher characterizes dialogue as a basic and necessary means of communication, a genre of primary discourse that is produced in the immediate relationship between subjects (BAKHTIN, 1986a).[19] He affirms that "[...] dialogue can also be understood in a broader sense, meaning not only direct, face-to-face, vocalized verbal communication between persons, but also verbal communication of any type whatsoever" (VOLOŠINOV, 1973, p.95).[20] He also explains the term as a way of reacting to other people's word with another word (MACHADO, 2014).

Bakhtin has invigorated the word 'dialogue' by proposing the concept that is based on this very word, i.e., dialogism. Although it apparently seems a case of synonymy, as one's first reading would suggest, dialogism refers to inter-relational events as the foundation of human existence. The concept alludes to openness to relationship, expressed in the effort to understand meaning from others, bearing in mind that

[19] BAKHTIN, M. The Problem of Speech Genres. *In*: BAKHTIN, M. *Speech Genres and Other Late Essays*. Edited by Caryl Emerson and Michael Holquist; translated by Vern W. McGee. Austin, TX: University of Texas Press, 1986a. pp.60-102.
[20] For reference, se footnote 6.

"Understanding is always dialogic to some degree" (BAKHTIN, 1986b, p.111).[21] Therefore, the dialogic relationship is presented as a singular relationship mode that is grounded in meaning, which occurs from the exchange of utterances between the discourse subjects.

According to Brait and Melo (2014), the notion of utterance is in the center of the Bakhtinian studies and allows us to reflect on historical, cultural, and social dimensions of language. Speech is articulated through utterances, which is the smallest unit of discourse; the expression of human thoughts and feelings and their translation into words happens through utterances. So, "After all, language enters life through concrete utterances (which manifest language) and life enters language through concrete utterances as well" (BAKHTIN, 1986a, p.265).[22]

In sum, an utterance is a particular expression that is supported by a triune structure: theme, language style, and compositional construction,[23] which is connected to a certain domain of human activity and language use. According to Bakhtin, each domain has a repertoire of specific utterances - or discourse genres. Bakhtin does not make any distinction between oral and written genres, but categorizes them as primary[24] and secondary discourse genres[25] and points out that genres have characteristics that are inherently social, dialogic, and ideological (BAKHTIN, 1986a).[26]

Thus, situations of communication are processed through utterances, real discourse units, which may be spoken or written and are part of a discourse genre (BAKHTIN, 1986a).[27] Discourse genres are acquired in a similar way the mother tongue is developed – that is, through concrete utterances transmitted in daily communication,

[21] BAKHTIN, M. The Problem of the Text in Linguistics, Philology, and the Human Sciences: An Experiment in Philosophical Analysis. *In*: BAKHTIN, M. *Speech Genres & Other Late Essays*. Translated by Vern W. McGee. Austin, TX: University of Texas Press, 1986b. pp.103-131.
[22] For reference, see footnote 19.
[23] For more information regarding the elements that compose the utterances, see Brait & Melo (2014).
[24] The primary discourse genres are dialogues that are marked for their simplicity, immediatism, and informality. One example would be daily routine conversations.
[25] The secondary discourse genres are more complex types of communication. They are similar to primary genres, but more elaborated, more institutionalized, stable. Moreover, they usually come in the written form (as in novels, dramas, scientific research, theater plays, etc.) As examples of discourse genres, we find the artistic genre, the scientific, the daily dialogue, the official, the literary, the technical, the rhetorical, the socio-political, the advertising genres, among others (MARCHEZAN, 2014; BAKHTIN, 1986a [For reference, see footnote 19]).
[26] For reference, see footnote 19.
[27] For reference, see footnote 19.

and not in dictionaries or grammars. According to Machado (2014), human communicative experiences unfold from the act of creative appropriation of the word of the other.

In contrast to a sentence (language unit that is governed by grammar rules and expresses finished thoughts), each utterance consists of a link that is part of a chain of utterances. From this understanding, we may say that in situations of interaction, reciprocity is expected from all the involved. The other participants are expected to take an active part by agreeing, disagreeing, presenting complements, challenging, or responding in some other way. This takes us to the principle of *alternation*, which sets the boundaries of utterances. This means that, in communication, discourse subjects must take turns in the use of word: "The speaker ends his utterance in order to relinquish the floor to the other or to make room for the other's active responsive understanding" (BAKHTIN, 1986a, p.71).[28]

For Bakhtin, responsive understanding means conceiving of subjects not as simple message senders and receivers (speakers and listeners), but quite the opposite: "Any understanding of live speech, alive utterance, is inherently responsive [...]. Any understanding is imbued with response and necessarily elicits it in one form or another: the listener becomes the speaker" (BAKHTIN, 1986a, p.68).[29]

At this point, we emphasize that the outcome of the identity process owes to the experience of otherness. For this reason, "the subject identity is processed through language, in the relationship with otherness" (MACHADO, 2014, p.123).[30] It is logical to think that relational experiences may contribute both to the construction and the destruction of identities. Based on that and considering the Bakhtinian perspective that the foundation of human existence is the dialogic relationship, that is, that the individual is a dialogical being, we may conclude that being deprived from this experience leads to suffering. This being the case, we need to question the possibility that the dialogical exchange is subtracted from some subjects, especially in contexts in which the production of care is proposed. We ask this question because, historically, the subject regarded as

[28] For reference, see footnote 19.
[29] For reference, see footnote 19.
[30] In Portuguese: "A identidade do sujeito se processa por meio da linguagem, na relação com a alteridade."

mad is silenced[31] in the relationships that are established with him, including therapeutic relationships.

The Bakhtinian dialogical philosophy brings us elements to discuss these impasses more sensitively, as it broadly approaches the vicissitudes of the inter-human relationship and the importance of the development of responsive/understanding positions. Words, in essence, want to be heard; they wish and attempt to be understood, and detest irresponsiveness (BAKHTIN, 1986a).[32] In this vein, if we consider that the ethical posture is always relative to the other, and if consider individuals were made for dialogue, the notion of responsive understanding will be elevated to an ethical posture that is indispensable in all relationships, including care assistance relationships.

The opening for reception and respect of the significance of the other only occurs in a dialogical relationship, although such significances are challenging to be grasped. Only in dialogical relationships, efforts towards comprehension and collective production of new meanings are made. Through word, the subject unveils his subjective existence, the affection that is provoked by the vicissitudes of living, and his/her ways of dealing with social ill-being. For this reason, only the listening of utterances[33] may promote the opportunity for the construction of a care pathway that produces health. In Bakhtin, we have found arguments to think of an "ethical-dialogical" mental health care, that is, a way to assist in which dialogue is set forth as the ethical foundation of the therapeutic bond, a type of care in which understanding listening, appreciation of the subject's presence and the welcoming look towards the difference of the one who suffers from psychic pain are primordial guidelines.

There is an exemplary ethical-dialogical experience called Open-Dialogue – an approach that began almost four decades ago in the Finnish Western Lapland, officially used in Finland's public mental health system (SEIKKULA; ARNKIL, 2006).[34] Freitas and Amarante (2015) report that the region of Finland was going through severe setbacks

[31] The example is in the election of drugs as the resource preferential in the treatment of mental suffering, a practice that occurs inside a model of care that is intended to be dialogical, but unfolds as a monological process, as it abdicates from opening speech possibilities and from recognizing it as a relevant element in the process of care - in general, as a result from the rush to judge what in utterances is understood as a psychotic symptom.

[32] For reference, see footnote 19.

[33] In many mental suffering experiences, the utterances may be disorganized or confused, as it is difficult for the subject to put his/her traumatic and painful mental experience into words.

[34] SEIKKULA, J.; ARNKIL, T. E. *Dialogical Meetings in Social Networks*. New York: Routledge, 2006.

in the economy and health areas, presenting unsatisfactory results in the treatment of schizophrenia (which was hospital-centered and medicalized), and showing the worst indexes when compared to other European countries. In the 1980s, for example, the incidence was 35 schizophrenic people per 100,000 inhabitants (SEIKKULA *et al*., 2003). Today, the region shows the best western figures. The number of annual cases of schizophrenia decreased from 35 to 2 per 100,000 inhabitants from 1985 to 2005 – this average remains until today, and puts the country in evidence for its excellent results and, for this reason, the Open Dialogue approach has been widely researched and applied in other countries.

The Open Dialogue approach has two fundamental attributes: (i) it is an integrated treatment system, community-based, in which involving family and the subject's social network is essential from the first contact to request assistance; (ii) it is a "Dialogic Practice," a distinctive form of therapeutic conversation within the "treatment meeting" (which is the main therapeutic context) (OLSON *et al*., 2014). In short, it is a way of organizing the practice in which the selective and minimal administration of psychotropic drugs is performed for the shortest time possible and only under imperative need (when psychosocial actions no longer respond). The dialogue is the treatment guideline, and the dialogical communication involving the network of professionals, the subject under treatment, his/her family and social network is the central point of this approach, which also has the Bakhtinian dialogic ideas as foundation.

4 The Research: Place and Design

The research was carried out in a Type II Psychosocial Care Center (PCC-II)[35] in the metropolitan area of the State of Rio de Janeiro, Brazil. The place of research was chosen for being representative of realities that face extreme adversities to their operation as well as for being in a city that is close to areas where large asylums have had their headquarters. We are talking about a historical-cultural context that was formed shadowed by large asylum institutions. Therefore, the selection of the research place comes from the interest in observing the dilemmas related to the development of mental

[35] CAPS implemented in cities with population between 70,000 and 200,000 inhabitants (BRASIL, 2004).

health care in this sort of conjunctures. The city[36] in which the PCC is located was evaluated with the worst Municipal Human Development Index (MHDI) out of the 12 cities that are part of the same metropolitan region, and features as one the worst HDIs in the country. The local Health Care Network (HCN) suffers the impact of the current conjuncture. In this sense, the process of public-health dismantling (recurrent in the State), the increase in the search for health services (due to the progressive aggravation of territorial problems), the cut of financial resources (consequence of repeated corrupt city administrations) have all come down to alarming precariousness.

All demands identified in the HCN as "mental health" are directed to the PCC-II unit that hosted our research. It has existed since 2001, when it was founded in a temporary venue. Little by little, the permanent venue was built: a small two-story building. Despite the continuous lack of investment, up until 2014, it remained active and in service with a psychosocial work approach. Moreover, efforts were directed towards solving severe territorial problems, such as assisting attending to and adolescents in severe and persisting mental suffering, as well as to other people in mental suffering that resulted from alcohol and drug abuse. Therefore, despite their routine difficulties as a Type II PCC unit, the service embraced the challenge of additionally operating as a Centro de Atenção Psicossocial Infanto-Juvenil – CAPSi [Children and Youth Psychosocial Care Center][37] and a Centro de Atenção Psicossocial para tratamento de usuários de álcool e outras drogas – CAPSad [Psychosocial Care Center for treatment of users of alcohol and other drugs].[38]

With the city government crisis and the change in administration, 2015 started with mass lay-offs that led to the reduction of the unit's working teams in about half and a radical financial divestment. From then, the unit's precariousness increased, and most

[36] This is a small municipality, plagued by severe social issues, such as unemployment and underemployment, precarious transportation, low sanitation, paving and water supply coverage. In addition to these problems, there are serious setbacks in Education and the Public Security crisis in view of the ruling of militias in the city, which has unfolded in the form of illicit drug abuse growth. Such social and health inequities are revealed immediately, albeit through a cursory examination, and affect the health of the people living in this territory.

[37] CAPS that attends to children and adolescents that are severely and psychically affected (as in psychosis, autism, or other severe neuroses), implemented in cities with population above 200,000 inhabitants (BRASIL, 2004).

[38] CAPS that attends to people who make harmful use of alcohol and other drugs, implemented in cities with population between 70,000 and 200,000 inhabitants (BRASIL, 2004).

activities were suspended. The unit's infrastructural conditions are terrible and profoundly impacted due to their high level of degradation.[39]

This research was designed as a case study, and the investigation strategy consisted of semi-structured interviews and participant observation during the institutional routine – a fertile option for researches that take human perceptions as their object of study. Therefore, if we seek to understand perceptions, we must consider they are the result of a combination of multiple and complex processes (cultural, social, unconscious, economical, technical, etc.). Also, we need to get close to the research participant, to his/her text (or discourse) and context (the scope within which the discourse is produced) (BAKHTIN, 1986a).[40]

The research participants are employees of the PCC. All team members accepted to be interviewed. Fourteen professionals were interviewed: nine with higher education level and five with high school or technical studies level. All signed the Free and Informed Consent (FIC). In the presented analysis, we used fictitious names to safeguard the research participants' anonymity.

5 Theoretical and Methodological Assumptions

Reality is the result of a human process of co-creation that occurs with continuous effort made towards world comprehension. We continuously seek to give substance to things that surround us, to facts, experiences, feelings. The attribution of meaning is an activity that is fundamentally human, and meaning itself has a responsive nature; that is, it is conditioned to give responses. When providing answer to a question or attributing meaning to something is not possible, this something will remain external to dialogue (BAKHTIN, 1986a).[41] Another feature concerning meaning is its infinite potential. It does not exist, neither *per se*, nor isolated, but only for another meaning. Therefore, what

[39] To mention a few: painting extremely worn due to time and weather, wall infiltration problems and mold and mud (reason for the prominent bad smell in the venue); bushes growing freely along sidewalks; broken window glasses; badly illuminated environment, hot and saturated air; lack of cleaning; and some isolated compartments due to use condition (insalubrity).
[40] For reference, see footnote 19.
[41] For reference, see footnote 19.

is at cause is the exchange, as "an idea becomes a real idea in the process of its exchange, that is, in the process of uttering production for the other" (BAKHTIN, 2016, p.149).[42]

Attributing meaning is to produce knowledge – an activity we perform all the time (SPINK, 2010, p.34), and this allows us to solve our daily problems and practical everyday issues. Our perceptions are elaborated from the articulation of countless intersubjective elements (values, ideologies, traditions, norms, wishes, culture, fantasies, beliefs) that intertwine in a singular fashion through meaning production.

Regarding the connection between meaning production and care processes, two inseparable health work particularities are highlighted. First, the work in the health field is inherently relational, and it occurs with, between, for, and about the subjects. It is about a practice which intense psychic work is demanded, as diverse intersubjective elements reconcile and collide and vary in type and intensity to everyone involved. Second, it is a work that is fundamentally communicative, which gives it high complexity, as communication involves language, socio-cultural context, apart from professional training and field of action specificities. Discourse is born in this communicative exchange, extended as a result of social interactions; a sort of social language,[43] always directed to the other. It varies according to the context, the social group, and the relationship that is established with this (SPINK, 2013, p.03).

According to Bakhtin, "Discourse is language in action" (BAKHTIN, 2016, p.117).[44] Such understanding leads us to the concept of discourse practice, defined as "[...] language in action, that is, the ways through which people produce meaning and set themselves in everyday social relationships" (SPINK, 2013, p.05).[45] Pink and Gimenes (1994) described discourse practices as a means of psychological and social reality production via discourse. This concept is also expressed in the following affirmation: "[...] the practices that are developed in the health care services, whether conscious or not, are directly related to certain conceptions of health-illness-care in force"

[42] In Portuguese: "uma ideia se torna ideia real no processo de intercâmbio de ideias, isto é, no processo de produção do enunciado para o outro."
[43] The social language is a Bakhtinian concept that refers to language styles, or functional styles, that is, a genre that is peculiar to a specific professional field or communication moment - the equivalent to the *Speech Genres* described by Spink (2010).
[44] In Portuguese: "Discurso é a língua *in actu*."
[45] In Portuguese: "[...] linguagem em ação, ou seja, as maneiras a partir das quais as pessoas produzem sentidos e se posicionam em relações sociais cotidianas."

(BATISTELLA, 2007, p.01).[46] Besides, Koda (2002) observes that the work of mental health care institutions produces a knowledge that subsides everyday know-how.

Discourses are transformed into practice: discursive practices that, in a simplified way, may be understood as a product of the articulation that involves what we think, say, and do. Hence, discourse is the knowledge that is produced for practice and, at the same time, it is the practice that creates knowledge (FOUCAULT, 2002, pp.182-183).[47] With this in mind, the perceptions are understood as knowledge producers that conform reinforcing or modifying practices of concrete social realities.

This is the main idea that is defended by Social Constructivism: reality is a dialogued and shared construction, an enterprise that is only viable with and through social practices (SPINK, 2010, p.09). By this logic, reality is an instance created by social subjects in the context of the cultural tradition that prevails in a particular group, within which it exists, but may vary or may not exist outside it. Meanings are elaborated within relationships governed by rules, habits, values and norms that are recognized and shared in a particular community. Thus, the construction of reality is conceived of as the implementation of community agreements that endorse the recognized truths (GERGEN; GERGEN, 2004).[48] From this perspective, truth is produced by the social group. This is an enlightening way of perceiving, which leads to the rejection of universal truths and the valorization of reflections supported by plural ways of conveying meaning and evaluation, specially favoring dialogue in the processes of signification.

6 Case Analysis

Through interviews and participant observation, we examined how PCC professionals position themselves in relation to the individuals under treatment, their health condition, and the care given to them in the service. We directed the focus of our analysis to the meanings produced in the narratives, attitudes, gestures and everything that allowed us to glimpse the modes of meaning of events, concepts, relationships, and

[46] In Portuguese: "[...] as práticas desenvolvidas nos serviços de atenção à saúde, conscientes ou não, estão relacionadas diretamente com as determinadas concepções de saúde-doença-cuidado vigentes."
[47] For reference, see footnote 5.
[48] GERGEN, K. J.; GERGEN, M. *Social Construction*: Entering The Dialogue. Chagrin Falls, Ohio: Taos Institute Publications, 2004.

experiences in daily work. In this sense, the analysis of discursive practices sought to perceive the distancing and approximation to an ethical-dialogical direction in care, considering the interviewees' interpretative repertoires, addressing the interlocutors in the utterances and the polysemic occurrences. Based on the information made available through a field diary, the practice of listening to the interviews, and the Association Map of Ideas [49] produced from them, we proceeded to the analysis, organizing it into three categories that we called 'listening arguments,' as we see in the table below.

Table 1: Scheme for Analysis Organization

Listening arguments		*Themes*
1	Two moments of the PCC	a) Before: a work that followed a psychosocial model; b) After: precariousness, abandonment, and loss of significance.
2	Stances toward difference	a) The meanings about the subject in mental suffering and his/her health condition.
3	Meanings about mental health care	a) About the PCC: the prescribed, the possible, and the necessary; b) About the I-Other relationship - "*listen, observe, talk, and treat.*"

Source: The author (2018)

We realize the narratives of professionals are actively crossed by contextual aspects. One fact stands out in this regard: an indicative time division of two distinct phases of the care center, referring to before and after the change in political municipal management in the early 2015. Perceptions were quite sensitive to this time division in a way that explanations were supported in this argument for most of the addressed topics. Based on this fact, the first listening argument was the "Two moments of the PCC."

The period from 2001 to the end of 2014 was widely contemplated in the speeches of professionals who worked for the institution. It was reported as a time of intense activity, ideal and pleasant work, despite the difficulties arising from the progressive divestment in health policies. What they say about this time period is nostalgic, and

[49] The Association Map of Ideas is an interview analysis resource, whose purpose is to organize the analyses and thus assist the activity of interpretation. The map is based on interview content organization according to general categories (themes), which are fine-tuned with the objectives of the study. For more information on this resource, see Spink (1994).

service practices were seen as activities that were in tune with the guidelines of the Psychiatric Reform. In this sense, the interviewees understood that purpose of the unit – as described in Brasil (2004) – was fulfilled in this phase identified as the "before" phase.

It is important to note that the PCC was inaugurated in 2001, the year Federal Law 10,216 was promulgated. It became the state policy in mental health care, marking a moment of change in the logic of care. Probably, for this reason, the atmosphere of the early years of the care center was surrounded by anti-asylum principles and by the effort to incorporate the parameters of the Psychiatric Reform. The main characteristics referred to as marks of the "before" period by the professionals are the power of multidisciplinary work, the spaces for knowledge exchange, the joint effort to promote the difficult work in the health care network, and the support for inventive actions.

In face of the administrative change in the municipal management, in 2015 a new phase began for PCC. It is identified here as the "after" phase. The experiences of this phase, which includes the present moment, are reported with the words "lack of motivation," "abandonment," "discouragement," "apathy," "precariousness," "lack of resources," "lack of network," "devaluation," "reduced staff," "downtime," and "stagnation," to highlight the most frequent qualifiers. This is a moment perceived by professionals as the beginning of the process of mortification of the PCC and its workers.

From then on, the abandonment of the new municipal management, the consequences of the radical de-financing and, mainly, the dismissals of active people from the team, who were inspiring despite the daily adverse reality, appear in their speech as a reason for the feeling of hopelessness and impotence they all shared. As a result, the unit reduced its activities to the offering psychiatric appointments, a few psychological appointments, intense medication prescription and distribution (the latter being the real reason for users to attend the service). Some professionals pointed that, in this configuration, it became an outpatient unit.

There was only one positive aspect of daily work that was pointed out by the interviewees: the team members themselves. This perception was unanimous in the reports to indicate the technical preparation and human qualities of peers through expressions such as "they roll up their sleeves"; "show willingness"; "are always ready"; "are available"; "do a wonderful job"; "take it seriously"; "are active"; "work with love"; "show sensitivity"; "are skilled."

As explored in the theoretical discussion, we are based on the idea that perceptions are built from a complex process of intersubjective nature and are revealed in discourse practices. For this reason, by observing the living work, the real everyday work in its context and the inter-relational dynamics, it is possible to grasp the meanings produced concerning the subject in mental suffering and their difference. Thus, we have analyzed the second listening argument ("Stances toward difference"), seeking to learn meanings and identifying in them elements that approach or move away from the dialogical ethics.

Some modes of understanding the subject in mental suffering relied on the signifier "need." The subject is perceived as someone that needs affection (a fact related to stigma), needs material possessions (a vision that may be linked to the reality of extreme poverty that is predominant in the city), and needs to be heard (a fect that alludes to the importance of the listening directive).

Suffering and anguish are two recurrent signifiers in the narratives to explain the health condition of the subjects in mental suffering, which does not focus on categories or causes, as in the psychiatric perception. In this case, meaning does not focus on what differentiates humanity, but on what is common in them. After all, suffering and distress are possible to occur to everyone. In this vein, mental suffering has to do with the vicissitudes of living, with the malaise produced by social life. In the reports, the subject does not appear as a mentally ill patient; in contrast, most interpretive views are more in line with the psychosocial perspective.

Regarding the analysis of the last listening argument, "Meanings about mental health care," the professionals shared their understanding of the old and the new patterns of care services, of what should be prioritized or fought against in the treatment. With this in mind, we sought to observe the discursive practices and apprehend the perceptions that guide the modes of caring and the relationships with the subjects treated in the micro-context we studied.

When speaking about the unit's work, the respondents discussed the prescribed work. They mentioned that which is standardized for asylum substitutes in general. Within this repertoire, they highlighted the interdisciplinary work as a priority, as well as the offering of multiple therapeutic activities, networking, listening and, especially,

reception. Thus, marked by a polysemy, reception[50] appeared in the narratives as a priority of PCC, understood in its power to provide dialogue, proximity, and to collaborate with subjects' resocialization. When asked to talk about what had been possible to concretely be done in daily activities out of the prescribed assignments, most professionals stressed that they could only offer reception, as we can see in the excerpt below.

> A: And, tell me what has been possible to be done?
> J: Yes, the work we have been doing, which is the work of reception. [...] In the midst of the precariousness we are living in, evidently, the reception has been strong. Because receiving evidently goes beyond structures.
> A: uh-huh... And it is independent, right?
> J: Yes. Yes, it goes beyond structures, right. Receiving is personal, individual, and this has been strong in this precarious environment. (Jair – technician)

The unit works in an "open-door" regime and the receptivity to the assisted subjects is explicit. They roam the care unit's spaces freely, being welcomed with respect and humanity. In this vein, the notion of welcoming and receiving appears as a posture that calls for relationship, the available presence for communication. However, services favorable to reception are not created, nor are dialogical therapies offered, except for the rare individual psychological appointments that occur. Moreover, contradictorily, the medication appears (in the observed discourses and practices), occupying a central position in the treatment. One of the interviewees acknowledges the possibility of her posture being medicalizing, by saying the words "I am impregnated by medicalization,"[51] as a kind of self-criticism concerning her own practices.

The meanings produced to explain the relationship with the treated subject indicate sensitivity and dialogical openness. The therapeutic relationship is thought of as an effective, communicative, humanized connection that recognizes otherness and reciprocity. Thus, the narratives stressed the importance of social skills to facilitate the

[50] The welcoming and reception guideline is widely present in health publications (especially referring to a way of humanizing relationships). In mental health, it appears as a necessary conduct in the new practices, as means of creating a therapeutic bond and overcoming the stigma of exclusion. Given this fact, providing reception appears as opposed to the production of exclusion.
[51] The term *impregnation* is generally used to inform the presence of saturation symptoms due to the intense use of neuroleptic medication in subjects.

bond and the faith in the subject as a knowledge producer that leads to the construction of health solutions. The words in the interpretive repertoire are singular and, in many cases, used in a particular and creative way. Thus, the dialogical posture, referenced especially by the valorization of listening, appears differently, as we can see below in this excerpt:

> H: [...] Because when I stop listening to the one who longs to be heard, I leave him in madness. However, in what madness? In the madness of longing to be heard. It is a healthy thing. Then, it is no longer madness. Then I change its name. It is not madness: it is longing. [...] And if anyone who has to hear does not hear him/her, that person will dive into depression. And this depression is going to cause such longing that it can lead him/her to a *transtorno*.[52] [...] When we say *trans-torno* [pronunciation in parts], we mean that in the transit of the mind, there is return... I guess it may be understood like this. So, what is mental disorder? Profoundly, it is the longing for what was there before and for that which was rescued today through the intervention of those who have prepared for it. (Hugo – Nursing technician).

Hugo uses the word 'longing' instead of 'madness' to explain how, in his conception, psychic suffering happens. In his perception, madness results from the deprivation of being heard (to miss being heard). His definition brings madness into another reality, which goes from the field of difference to the field of resemblance. In addition, madness is no longer seen as a deviation and becomes part of the dimension of ordinary human experiences as it is emptied of pathological interpretation. The same occurs with the word *transtorno*. In the excerpt, Hugo made a wordplay that changed the semantic value of this term, making it different from the one applied in psychiatric discourse. He divides the word *transtorno* into two particles: "trans" and "torno." Thus, "trans" is a Greek-origin prefix that means "displacement" or "crossing"; and the particle "torno" has the same meaning as the verb "to turn" or "to return," indicating the act of returning to the beginning. Therefore, Hugo's understanding indicates that "transtorno" concerns the unfolding of an experience that tends to rescue that previous health status that precedes the settlement of mental suffering. In the passage, the words of the asylum repertoire are used, but the meanings are formed through the deconstruction of the original meanings.

[52] Hugo uses the word "transtorno," which means "disorder" in English.

In general, the perceptions of PCC workers were in tune with the Bakhtinian notion of dialogic relationship. As we have pointed out, for Bakhtin, human beings are dialogical; therefore, dialogical interaction is essential. Being deprived of communicative exchanges can lead to suffering. The way professionals understand it points to the centrality of the dialogue standpoint in the relationships that are established with the subject in mental suffering. Thus, in the field of practices and discourses, we identify many elements that are in consonance with the ethical-dialogical assumptions but also elements that are distant. This reveals conflicts and contradictions in the way of producing meaning in the studied context. Given this divergence, a question arises: what creates the obstacles in this case?

Final Considerations

In this study, we have noticed serious impasses for the implementation of the psychosocial project at the PCC and its territory. The difficulties are mainly represented by the operation of outpatient service, medicalization, and the absence of networking. Professionals recognize the unit's team as the difference, the strength of the work, and affirm that mental health performance does not depend on infrastructure, but on "human assets." They also express that they wish that the care center would get back to its operation as a PCC service again, but they do not realize that the resources to make it happen are available – considering that in their statements they have pointed themselves out as the solution, which lies in the use of their own selves. That is, even in the face of the main resource (the qualified human resources), the problem remains.

Although this picture suggests the radical operation of the manicomial logic, we see, on the other hand, countless discourse practices in line with ethical-dialogical assumptions – especially concerning the way care and relationships with the subject in psychic suffering and his condition of health are perceived. We identify indispensable values for the event of an interhuman encounter, in its dialogical quality. However, although the psychosocial logic appears in perceptions clearly and sensitively, it does not thrive. An interparadigmatic tension in local dynamics is evident.

We saw that in the period labelled as "before," the subjective dynamics pleasure-suffering at work presented relative balance and thus, despite facing serious

problems, there were stimulation and desire for the construction of inventive ways of overcoming barriers. We realize that the "after" period, symbolized by radical and unexpected losses, was experienced as a severe discomfort that impacted the team's subjectivity by inhibiting the power to act and the loss of meaning in the work. Thus, in the "after" period, the dimension of pleasure was eliminated, leaving only pure malaise and suffering, experienced as loss of vitality, interdicted to action and impotence.

We realize the exercise of meaning production, provided by the research environment, allowed for a space where issues could be verbalized, leading to symbolizations and reflections that are essential for the construction of a *savoir-faire* with the malaise of daily praxis, generating positive impacts.

In this study, we were able to grasp the importance of focusing on the relational dimension of the care process and investigating micro conjunctures to analyze the deadlocks that uniquely unfold in the real work in each context, considering the voices that are part of the situation. Therefore, we understand that the dialogical methodologies, inspired in Bakhtin's contributions, are fruitful in providing solutions to the various problems present in the field of mental health.

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