Medicalization, mental health and biopower: an integrative review

Medicalização, saúde mental e biopolítica: uma revisão integrativa

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ABSTRACT

This study had the purpose to investigate the phenomenon of medicalization in adults in the mental health field in a Brazilian context, problematizing the use of medications as the main tool to handle psychic suffering, with Foucault's concept of biopower and contributions of Amarante to the mental health field. The chosen method was the integrative literature review of published scientific articles, in Capes Portal of Journals and scientific electronic library SciELO and PePSIC, between 2011-2021. The collected data was managed by content analysis as a method. The medicalization and its main pillars were pointed as a limited logic of the subjects and political-economic current system maintainers; as well as the correlation between the indiscriminate use of medications and suffering individualization, reducing the wealth of care. Therefore, contributes to a desmedicalization process and anti-asylum conditions

Keywords: Psychosocial care. Psychotropic drugs. Psychopathology.

RESUMO

Este estudo objetivou investigar o fenômeno da medicalização em adultos no campo da saúde mental no contexto brasileiro, problematizando o uso de medicamentos como principal ferramenta terapêutica para lidar com o sofrimento psíquico, dispondo do entendimento de biopoder por meio de Foucault e das contribuições de Amarante para o campo da saúde mental. Adotou-se como método a revisão integrativa de literatura a partir de artigos científicos publicados no Portal de Periódicos da Capes e nas bibliotecas eletrônicas científicas SciELO e PePSIC entre 2011 e 2021. Os dados coletados foram tratados por meio da técnica de análise temática de conteúdo. Apontou-se a medicalização como lógica que limita as subjetividades e atua na manutenção do sistema político-econômico vigente. Além disso, identificou-se a correlação entre o uso indiscriminado de medicações e a individualização do sofrimento, reduzindo o cuidado à saúde. Portanto, contribuiu-se para condições desmedicalizantes e antimanicomiais.

Palavras-chave: Atenção psicossocial. Psicofármacos. Psicopatologia.

INTRODUCTION

Seeking a cure for diseases is something common to human beings. Historically, medical practice was the first to claim jurisdiction over disease and any aspect related to it, acquiring authority over what would be considered healthy or pathological. Medicine won the right to say how to relate to the world, how to sleep, eat, work, desire, among other actions, impacting the process of construction of subjectivity. Therefore, the aim is, in general, to stop a malaise that is present in the body in a certain period, and medications are a possible means for the treatment and/or relief of this malady[1].

However, the indiscriminate use of medication and self-medication practices can be understood as a quest to eliminate any kind of discomfort and suffering inherent to human life[1]. With this, it is important to emphasize the effort and attempt of health professionals to defend their rational use and to discourage self-medication practices, since many psychotropic drugs have great potential to promote psychic and physical dependence, one of the main issues to be addressed by subjects with experiences of intense psychic suffering[2].

To propose a mental health therapy that includes the use of medication, an assessment that depends on the differential diagnosis is necessary. The uniqueness and social, historical, and family contexts must be taken into account - in addition to their organic condition and the exclusion of pathologies of a physiological nature through laboratory and imaging tests - in order to avoid confusing organic conditions with mental disorders primary, due to possible similar symptoms. Possible side effects, cost in the family budget and ways of administering the drug[2] are the main criteria to be adopted for starting a drug treatment.

Historically, the field of mental health is marked by hospitalization practices as the main intervention, which contributed to the exclusion of subjects, weakening social and family ties, resulting from an asylum logic of control[3]. In an attempt to break with this functioning, the process of deinstitutionalization took place, which aims to reorganize the structures that prevailed over mental disorders, beyond hospitalizations and the hospital environment, but also the deconstruction of a whole set of segregating and pathologizing knowledge and practices[4]. Thus, through Law no. 10.2016, sanctioned in 2001, the intention of progressively extinguishing asylums and implementing substitutive services, among them, the Psychosocial Care Centers (CAPS) I, II and III, and CAPSi – children, CAPSad – alcohol and other drugs, whose objectives are aimed at contributing to the development of user autonomy[5].

In this context, the struggle of the Brazilian anti-asylum movement, with anti-psychiatry as a contributor, emerges as a critic and challenges the notion of mental health/illness. It argues that mental illness does not come from the subject but constituted by his experience with the social context[4]. Thus, it is up to questioning the diagnostic systems, since the classifications of the so-called mental disorders constitute one of the pillars that support the medicalization[1].

Nowadays, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases and Related Health Problems (ICD) are used worldwide, the latter produced by the American Psychiatric Association (APA). Both materials previously categorize the concepts of "normal" and "pathological" and work from them to develop treatments based on pragmatic criteria[6].

The criteria and classifications of diagnostic systems change historically and are related to political, institutional, and moral contexts, causing categories to be excluded or included. The DSM is currently on its fifth update, and the ICD is on its eleventh version. With each edition, a progressive increase in diagnostic categories can be seen, as in the 2013 edition of the DSM, in which there was an increase of

approximately 12% of diagnostic categories in relation to the previous one[1]. Therefore, it questions whether the diagnosed subjects who need therapeutic intervention are receiving the proper support and treatment and whether the others who do not need this intervention are exempt from undue medical actions that can produce harmful effects to health[6].

Thus, this multiplication of diagnoses can be understood as a development of the game of forces between the materiality of the active process of medicalization, through the appropriation of psychic suffering, and the unique and free experience of different ways of being and living. The medicalization of life as a phenomenon, within the scope of psychopathology, refers to "the transformation of deviant behaviors into illnesses or mental disorders, generally implying the action of medical control and power over the conditions transformed into medical entities"[6]. In this sense, questions are asked about the possible fabrication of diseases and the role of the pharmaceutical industries in this scenario, since medical intervention, when trying to know and collect data about the disease, can end up producing it[7].

Therefore, this study is based on concerns in the face of a scenario in which the field of mental health has been appropriated by the logic of medicalization based on the classification of ways of existing that are more or less close to operational normality[6]. This classification system is constituted by a mosaic of capture, analysis, and readjustment of ways of being and living considered infamous, by a normalizing and biopolitical power. Biopolitics, as a political action of legislating on the biological body of the population[7] which, immersed in fields of visibility, become targets of a capillary network of surveillance technologies and state control, such as, in the area of health, quantification, description, comparison, interception and prediction in terms of birth rate, death, fertility and mortality, among others. In biopolitics, people lose "the right over their own body, the right to live, to be sick, to heal and die as they wish"[7]. In this way, biopolitical surveillance is the moderator of the complex, constant and tense game between individual freedom and collective security.

With this, the present study is justified by allowing the examination of the lines of forces acting in the medicalization of life as a way of tensioning and dismantling the biopolitical system that, through practices and knowledge, tends to manage lives considered abnormal, rehabilitating them, bringing them to life as the norm, healthy living[7]. Therefore, the objective was to understand and investigate the phenomenon of medicalization in adults in the field of mental health, in the Brazilian socio-historical context, questioning the use of medication as the main therapeutic tool to deal with psychic suffering. In this sense, scientific articles published in the Journal Portal of the Coordination for the Improvement of Higher Education Personnel (Capes) and in the electronic libraries SciELO and PePSIC between the years 2011 and 2021 were analyzed.

METHODOLOGY

This research was based on the integrative literature review (LR) method, which covers current knowledge on a given topic and leads to a synthesis of knowledge in order to contribute to future practical research and point out gaps on the topic in question[8]. In addition, the data were examined through thematic content analysis[9].
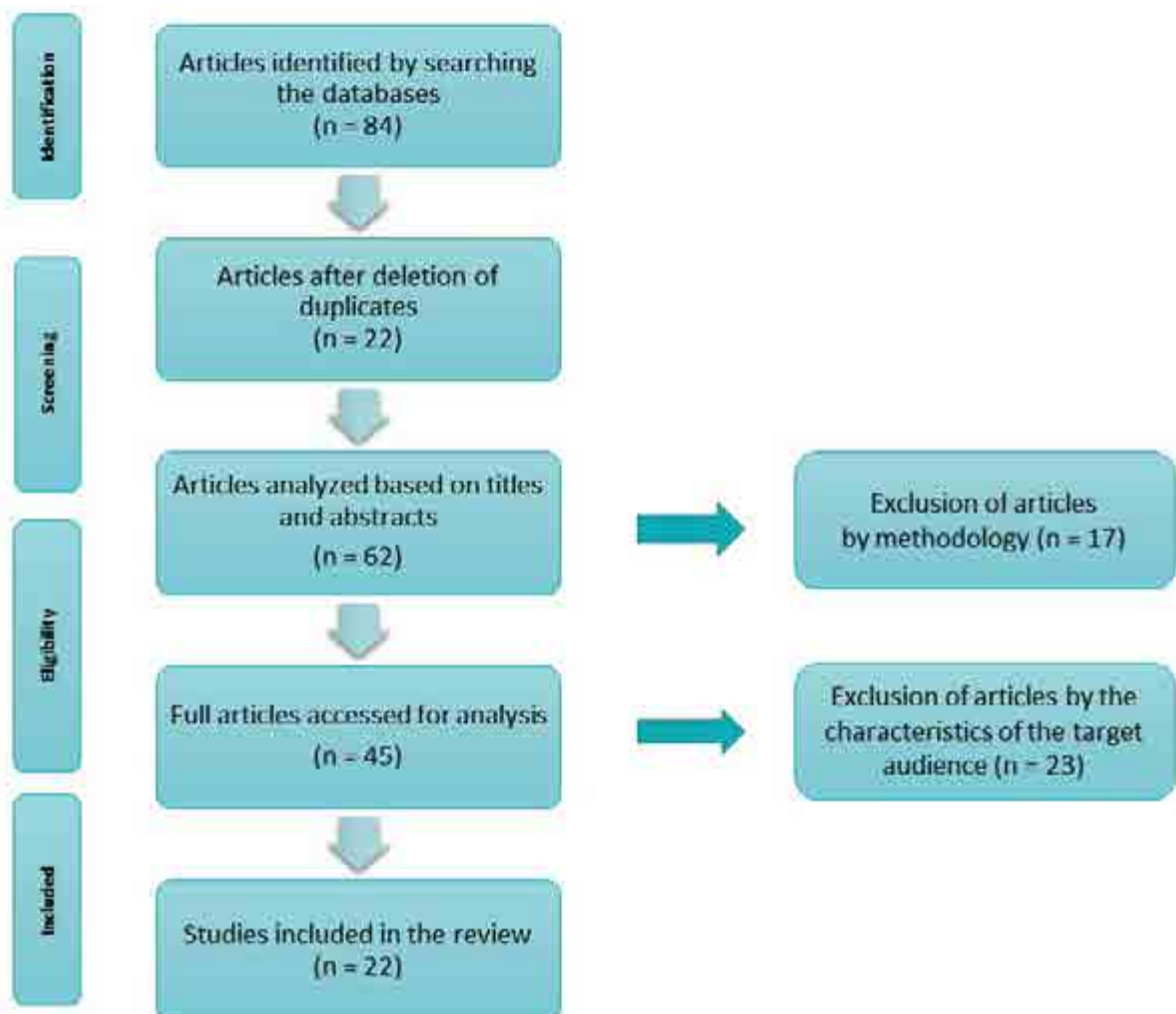
DATA COLLECTION PROCEDURE

The LR method began with the elaboration of the guiding question formulated from the PICOT strategy (P – population/patient; I – intervention; C – comparison/control; O – outcome/results; and T – time)[8]. In this study, it is described as follows: how adults in psychological distress (P - interest group) are affected by the phenomenon of medicalization in everyday life, in the context

of mental health (I - intervention studied), based on research published in the Portal de Capes journals and in the SciELO and PePSIC electronic libraries (O – search results) between 2011 and 2021 (T – time restriction)? There was no purpose of comparison, so item C was not specified.

For the survey of articles, the search in the mentioned portal and scientific electronic libraries considered the descriptors "medicalization" and "mental health", crossing them using the Boolean operator "AND". The inclusion criteria for the selection of articles were: adult audience; mental health; published between 2011 and 2021; type of field research; and experiences in the Brazilian context, regardless of the published language. The following were excluded: articles with an audience under 18 years old and over 60 years old; no full text; duplicates in databases and languages; theses and dissertations; and that were based on changes in the development cycle, such as pregnancy, pathologies and organic lesions.

Based on the 84 articles located (of which 19 in Capes, 7 in PePSIC and 58 in SciELO), a selective reading of the titles, abstracts and keywords was first carried out, considering the inclusion and exclusion criteria (the process is detailed in Figure 1. Then, 22 articles were selected to carry out a complete and analytical reading, extracting data on subjects, objectives, methodology and results. Subsequently, a critical analysis and discussion of the results were made and, by Finally, this LR was elaborated.

Figure 1. Flowchart with article selection procedures
Source: Prepared by the authors

DATA ANALYSIS PROCEDURE

In addition to the LR, the collected data were investigated based on thematic content analysis, which "consists of discovering the nuclei of meaning that make up a communication, whose presence or frequency means something to the analytical object targeted"[9]. It started with the pre-analysis, choosing the documents that would be the object of this task, resuming the hypothesis and the initial objectives of the study; then, registration units (keyword or significant phrase) and context, clippings, categorization form and general concepts were determined. From this work, categories were found, which are explained in the "Discussion" section of this article.

The themes that cross the problem of the present study are compiled in Table 1, showing the main subjects addressed in each article, which were compiled by thematic proximity, resulting in the following axes of analysis: 1) medication, medication use and medicalization; 2) biomedical and psychosocial models as forms of mental health treatment; 3) medicalization, biopolitics and mental asylum; and 4) production and management of mental health care: achievements and challenges. These axes were interpreted and interrelated with the theoretical framework.

Table 1. List of the authors' main contributions to the subject of this study

Author (year)	Main subject(s)
Affonso et al. (2015)	Health of health workers
Aguilar et al. (2014)	PTS, bonding, and medication use
Barbosa et al. (2018)	User-professional relationship in CAPS
Bezerra et al. (2014)	APS and FHS
Bezerra et al. (2016)	CAPS, professionals, users and family members
Caminha et al. (2021)	Professional-user relationship in PHC
Campos et al. (2019)	CAPS and APS
Cavalcante et al. (2017)	Psychopharmaceuticals, CAPS II and users

(Conclusão)

Author (year)	Main subject(s)
Cescon et al. (2018)	Suicide
Constantinidis et al. (2018)	Therapeutic activities, CAPS, and mental asylum
Duarte et al. (2020)	CAPSad and CT
Félix-Silva et al. (2021)	Cartography, subjectivation and art
Ferrazza et al. (2013)	Prescription of psychotropic drugs
Filardi et al. (2021)	Psychopharmaceuticals, every-day problems and biopolitics
Filardi et al. (2021)	Psychopharmaceuticals, non-pharmacological approaches, biopower and social class
Lima e Guimarães (2019)	Continuing care and territory
Lima et al. (2020)	Autonomous Medication Management (GAM) and training experience
Meirelles e Kantorski (2021)	Biomedical model and Psychosocial Care
Oliveira e Martins (2020)	Madness and stigmatization
Onocko-Campos et al. (2013)	GAM and practices in mental health
Santos et al. (2020)	GAM, mental health practices and public policies and management
Sousa et al. (2018)	Social representations, madness, and mental health

Source: prepared by the authors

RESULTS

Initially, the search in the databases resulted in 84 articles. When the inclusion and exclusion criteria were applied, 22 works were identified and analyzed. It was evident that the year 2021 had the most publications on the subject (five articles), followed by 2020 and 2018, with four publications each. The magazine *Saúde Debate* led the number of works (four), followed by a tie between the magazines Ciência & *Saúde Coletiva*, *Trabalho Educação e Saúde* and *Saúde Sociedade* (two publications each).

The affiliated universities that published the most articles on the subject were those in the southeast and northeast of Brazil. In the Southeast Region, the state of São Paulo led, with seven publications, followed by Minas Gerais (two). In the Northeast Region, the state of Ceará appeared with four publications, followed by Pernambuco (two). The Southern Region appears through the states of Paraná, Santa Catarina and Rio Grande do Sul (one publication each), and the Central-West Region is represented by Mato Grosso do Sul (one publication).

Regarding training at the undergraduate level of the authors, most belong to the area of Psychology, followed by Nursing and Medicine, Pharmacy and Occupational Therapy; Physiotherapy was the one that least appeared, with only one publication. It was also noted the interest of people from the area of Philosophy and Social Sciences on the subject. Among all the professionals identified, the expressive majority corresponds to the female gender: of the 22 articles analyzed, 13 were written only by women, and 9 by women and men; even among these, 5 have the majority of women authors, and 4 show the same number of women and men.

DISCUSSION

AXIS 1: MEDICATION, USE OF MEDICINES AND MEDICATION

Historically, the practice of mental health is related to the medical figure, seen as an authority that sometimes does not have its actions questioned, specifically regarding the prescription of drugs, especially psychotropic drugs[10-14]. With this centralization, other care is put in the background, which contributes to the devaluation of other therapies in dealing with suffering[11,15].

Brazil is among the ten largest consumers of the pharmaceutical market, constituting an oligopoly with a high participation rate of transnational companies in the country. Unlike the practices of developed nations that focus on the harm that self-medication can have on health and encourage the rational use of medicines, expansion of access is still held back nationally when it comes to medicine policies[16]. In this sense, there is a centralization of the medical figure in the daily life of health services[17], as indicated by non-medical workers as a barrier to the exchange of knowledge about medicines, whose consequences include, for example, the lack of autonomy of users[13]. It is worth mentioning that this autonomy must be exercised in the face of information, that is, the use or not of the medication needs to be a choice made based on clarifications about its possible benefits and risks. However, it is noticed that, many times, there is an imposition of the use of medications, which disregards any possibility of the autonomy of this subject[16].

The medicalization of everyday life as a social phenomenon is understood as a reading of the indiscriminate and excessive use of medication. Such use also stems from the fact that the most available therapy in the services are psychotropic drugs in order to deal with and alleviate the psychological suffering that is part of the human condition[18]. Thus, there is a search, through this use, for the dampening of emotions arising from existential aspects[17].

In this sense, it is understood that the indiscriminate and excessive use of psychotropic drugs is "at the same time, a consequence and legitimation of the medicalization of life that has its origin in biopower", that is, the exercise of power imbuing the management of ways of living[18]. With the emergence of biopolitics, articulated by biopower, the management of life gains prominence, being guided by the liberal logic, of a productive and rational subjectivity on which medicalization is based. In this way, health starts to be understood as knowing and being able to experience and deal in a supposedly satisfactory way with the sufferings of living, producing bodies with the possibility of numb affectation

and weakened in the face of conflicts. This converges with the perception of Family Health workers who, when asked in an interview about managing the use of psychotropic drugs and/or non-pharmacological therapies as ways of assisting in the care of patients seeking help to deal with everyday difficulties, reported little appreciation and difficult acceptance of non-pharmacological practices by users[18].

This issue is similar to the difficulty of having discussions about medications, both by users and among professionals themselves[10,19], since non-physicians do not seem to take ownership of the topic as much. This collaborates with the centralization of decisions in the medical figure and the devaluation of the user's autonomy over the health-disease process itself[18]. Furthermore, the high rate of referrals (80%) of the population assisted at a Mental Health Outpatient Clinic in the state of São Paulo to psychiatric consultations[14] is identified. Practically everyone referred to psychiatry had psychotropic drugs prescribed, which corroborates a care practice based on the traditional medical model. In addition, the use of psychotropic drugs, even before seeking the service, was also considered commonplace.

Thus, there is an ambivalent relationship on the part of users when it comes to the use of medication, as there is both recognition of the improvement of symptoms and the positive effects that the use of medication can bring and perceptions of the negative consequences of this use, such as possible dependence and side effects[2]. Therefore, when it comes to the indiscriminate use of medicines, the relationship between this use and the health market is recognized, which involves different interests and social actors, such as doctors, patients, the pharmaceutical industry and regulatory agencies[20].

It is understood, therefore, that there is a recurrent normalizing movement that converges to the objective of diagnosing and treating with medication[14,16]. There are life governing practices that promote forms of care that operate based

on a rationalist paradigm that seeks to connect diagnosis, prognosis, health promotion and disease prevention[15], processes that would supposedly lead to healing understood as the expansion of life from bodies healthy[7]. Thus, it is questioned whether the symptom really is a malaise that should be diagnosed and treated, preferably with medication, since there is difficulty, even on the part of the health services team itself, in distinguishing everyday suffering from pathological processes[21].

AXIS 2: BIOMEDICAL AND PSYCHOSOCIAL MODELS AS TREATMENT FOR MENTAL HEALTH

Most of the articles analyzed brought the Brazilian psychiatric reform as a legal and socio-historical framework with regard to mental health treatment, deinstitutionalization and deconstruction of kidnapping institutions (such as asylums), creation and strengthening of other therapeutic practices and another look at the person in psychological distress[17,22]. However, remnants of the asylum logic can be seen in actions in the field of mental health even today, which demonstrates how there is a long way to go towards the effectiveness of Psychosocial Care (PC)[3,5,10,13,15,17,19,23].

The overvaluation of drug therapy may indicate a difficulty in associating mental health treatment with other forms of care, such as the subject's relationship with the territory, access to leisure and cultural devices, quality housing and food, among others. Thus, the medicalizing logic constitutes a palliative method in the face of adversities in the complex field of mental health, composed of cultural, socioeconomic and subjective aspects[20].

The drug treatment considered essential by the medical discourse is configured as a "disciplinary strategy of physical and psychological containment of the person in mental distress"[24]. Thus, it is understood that drug dependence can contain confrontations in

the face of social suffering, which also promote psychiatric illnesses[10]. Thus, CAPS teams, by adopting medication as a central aspect of care, can contribute to weakening therapeutic power[2]. In a survey on the formative experience in conjunction with the International Observatory of Autonomous Management Practices (GAM) in order to develop emancipatory strategies in mental health, an overvaluation of drug prescription in CAPSad practices was highlighted, being prescribed (according to the interviewed users) for practically all[21]. With this, it is clear that there is also a lack of other therapeutic treatments, which impairs the practice of PC.

It is also emphasized the importance of collective spaces in the daily work that allow sharing of doubts, learning and knowledge[25], paying attention to horizontality as a fundamental process in the production of care in mental health[17]. Furthermore, despite the acknowledgment, including by users, of the effects that the medication can offer, as well as its help, it is necessary to understand that it can increase risks, especially for those who are homeless[21]. Added to these are other groups in a situation of vulnerability in which they are disguised as government tactics of care and protection regarding behaviors that enhance normalized ways of living[7]. Despite the fact that the service is sometimes understood as a "medicine dispenser"[20] due to rigid practices in the biomedical model, which deprives it of its essential principles — it encompasses promoting the social reintegration of users through access to work, leisure and strengthening of ties with the support network Users of CAPS — is the fact that this is a differentiated care service compared to other experiences they had in Therapeutic Communities (TC) and Psychiatric Hospitals (PH), generating equivalence between the violence of these environments and the experienced in the streets[21].

CAPSad users who had experiences in TC perceive the experience in these institutions as negative, mainly due to the excess of rules that they consider too rigid[5], in addition to the presence of religious discourse in mandatory practices in the treatment, such as prayers, sharing the same faith practiced in the institution and abstinence in relation to the use of psychoactive substances. The latter is a practice contrary to the harm reduction policy, which plays an important role, including in redefining the use of substances, by proposing their use in a non-harmful and/or less harmful way, making other institutional activities and affective networks available to the user.

However, resistance from the community to contribute to the realization of these shared and expanded practices is perceived, and there is a kind of hidden negotiation between family and community about spaces in which the user may or may not be accepted[24]. This limits the subject's involvement in life-enhancing actions, that is, participation in community life, neglects autonomy and can promote even more suffering, fostering stigmatization and muzzling care in freedom, moving away from the guiding practice of AP[15]. Thus, in order to discuss the biomedical model and implement PC, one must deconstruct the ideal of passivity in which the subject in psychological distress is still placed - as if he should submit to the care of the other, in this case the health professional (mostly the medical figure), who supposedly has knowledge about him and his illness —, and proposes the transition to an active subject, protagonist and manager of his own care[23], converging with the Foucauldian understanding of authoritarian medicalization[7].

Research on autonomy analyzed mental health practices in CAPS in three Brazilian cities and noted that users had an ambiguous feeling about the service, relating it simultaneously as a place of reception and care, and guardianship[13]. Thus, a fine line was shown between what is done as care and what becomes a management of this subject's life. In addition, there is a threat of being transferred to a supposedly more derogatory place if the user refuses the imposed drug treatment, a manifestation of the biomedical hierarchical relationship.

Therefore, it was found that when CAPS users have more knowledge about medications than is supposed, a hierarchical care attitude can be triggered that tends to protect them by service workers[13]. This conception, however much it perceives the subject as such, still reduces him to his suffering, leaving his potential and autonomy in the background, aspects that are so necessary when it comes to PC that aims to create links between subject and community.

AXIS 3: MEDICALIZATION AND BIOPOLITIC STRATEGIES

The expansion of therapeutic and anti-asylum practices is understood as an opportunity to occupy community, existential and everyday spaces, as well as to transform and create new articulations based on criticism of the practices and discourses that produce and are produced by parameters of normality and reductionism[15]. Thus, there needs to be a social reconfiguration of how the subject in psychic suffering is perceived, since, when defending resocialization, it is essential that the community operates in a way that allows this process to occur in a genuine way[23]. The dismantling of mental asylums that reproduce the asylum logic in everyday life is defended here in order to release this cloistering logic and rid societies of concrete asylums[26].

In this sense, it was noticed that the search for a so-called normality is recurrent[11,24,26]. In order to deal with the everyday complexities of life, users using psychotropic drugs are driven by the medical discourse to reach supposed normality, in addition to demonstrating "fear of emotions, reactions, imbalance, of 'going crazy'"[11]. Such elucidation showed the asylum logic still engendering social representations of the figure of the person in psychological distress as someone who needs to be protected from the disease and, ultimately, also from themselves, through treatment. Protecting and treating operate along the same path, that of control to govern life, individually, and to maintain social order, collectively[7].

In medicalization, the subject is subjected to the biomedical discourse and norms, rules and parameters of a normalized life and a healthy body; they are discourses and knowledge of power that operate on these individuals as biopolitical strategies[7]. The subject limited to psychopharmacological therapies loses autonomy and freedom[14], subjected to discipline, becomes subject to the control of the other, weakened in his power of resistance in the face of suffering, inevitable to human existence[11], which is related to the ideal of madness and out of control. These aspects were identified through reports from penitentiary agents and technicians from a Hospital for Custody and Psychiatric Treatment (HCTP); therefore, in their perception, patient prisoners were understood as those who could "freak out" at any moment[3].

When analyzing the speeches of students and professionals in the health area about the social representation that they have of the subject in intense psychic suffering, it is verified how the representation of the crazy person is linked to the idea of someone "different", deviant, outside normality; to this is added the perception of the subject "as a threat and affected by an organic disease, located in the brain"[23]. In this sense, one perceives the challenge of dealing with the remnants of the asylum logic, fed by the circulating discourses that value the symbolic, political and economic dimension that crosses madness[26].

More vulnerable populations, such as indigenous people, do not escape this logic, as they are recurrently perceived as being controlled, unbalanced and/or sick. In this way, by pathologizing them, instead of enhancing the difference and the singular meanings that the subject can attribute to the different forms of existence, an effort is made with the objective of framing and controlling him – again an investment in the docility of the subject's body understood as outside the norm[26].

This logic also permeates the DSM and ICD, which operate through the meticulous look

at madness and the subject in psychic suffering, understood as the one who needs to be guided by normalizing paths that keep him away from the danger of mental insanity that, subject to predetermined diagnoses and treatments, can be modulated and adjusted in a dignified way of being and living. Thus, such classification manuals end up neglecting the socio-political-economic context in which the subject is inserted[26].

In this direction, attention was paid to the reality of the work contexts of health professionals, who sometimes use bureaucratization as a strategic solution in the face of work overload. In addition, nuances of the authoritarian perspective of some professionals about the users were perceived, which is reflected in the daily life of the service, such as in the measurement of the professional's time, evaluating that this is more important than the user's time waiting for the service. This attitude feeds back the naturalized convention that the user must wait for the professional (the opposite should never happen), strengthening, once again, the idea of disciplining the body in an exercise of power[17].

In this sense, it was noted that some workers resisted other ways of dealing with users and the difficulty of establishing horizontal dynamics in an institutional context crystallized in a hierarchy. Therefore, it is necessary to collectivize the fight for the extinction of the asylum logic, because, in an individualized way, one runs the risk of becoming ill with the system that intends to change[19]. Furthermore, the limits of an individualized struggle are recognized through the report of a penitentiary officer at HCTP who, repeatedly, had to be removed from work due to depression. This professional said "being a thinking subject in an environment that is foreign to him and hostile to his work [because] it is like drying ice", which represents the minority of service workers who make an effort to build another relationship with users[3].

Therefore, it is understood as imperative the collective and shared deconstruction of the asylum, concrete and mental logic in order to promote more effective access to health services, not stigmatizing the insane and insanity, and favoring adherence to the user's treatment, guiding acting on the principles of PC[2,16,21,27].

AXIS 4: MENTAL HEALTH CARE PRODUCTION AND MANAGEMENT

Health care must be comprehensive and decentralized, powerful in terms of deconstructing a logic of preponderance of medication and assistance, recognizing the limits of the field itself[5]. The process of attention and care in mental health is something gradual and dynamic, carried out through coping strategies, planning for the future and subject-service co-responsibility, while considering the specificities of life, support networks and desires of each one[11].

It should be noted that, for this care to be constructed by health professionals based on the pillars of psychiatric reform and the anti-asylum struggle[19], it is urgent to vacate "the place of someone who can do anything: to be able to heal, to know more about the other than he himself, power to understand madness, to have ready answers; and to allow oneself to experience the place of being together in the outbreak, in the production of meaning, in the walk, in the party, in pain"[26].

However, even in the face of the existence of public mental health policies, the lack of mentions and guidelines about concrete actions was revealed to be something recurrent[13,15,21,22,28]. As one of the challenges posed for the implementation of anti-asylum care, guided by psychosocial logic, the fragility and limits of a medicalizing and excluding biomedical training of health professionals were identified, therefore insufficient to deal with the complexity of the reality of care that demands reflections criticisms and creations of other possible health care practices[20,22,28].

Soon, it was noticed the insufficiency of the academic training of professionals to work with

people in intense psychic suffering[20]. As much as there are qualification actions, these are still short-lived, and professionals rarely practice what they have just learned. Thus, continuous supervision with more experienced specialist professionals and a continuous support service for the workers are recommended. In addition, the relevance of permanent evaluation processes with an emphasis on the role of users is highlighted, presenting the effects of the psychiatric reform process[5].

However, the precariousness of the service and the overload of mental health workers make it difficult for these actions to be carried out satisfactorily[12]. What is perceived in daily practice are specific actions that are not co-responsible, hindering a therapeutic project and an effectively anti-asylum joint struggle[16], a reflection of the formation of medicalizing preponderance that produces care based on specialization and fragmentation[27]. As one of the effects of this fragmentation, we mention the reports of professionals who, sometimes, end up dealing more with crises, and not with continuous and daily care, as it should be. Thus, when necessary, they have to "run to assemble the network"[13], which constitutes a problem, since, according to the principles of psychosocial care, it should exist permanently.

Therefore, attention is drawn to structural precariousness and illness at work as contributors to the emergence of protection mechanisms among workers that further individualize services[12], such as bureaucratization and the use of retaliatory behavior with users[19]. Faced with the existence of care practices that still have little articulation with the territory, precarious conditions of safety at work and in the community were evidenced, in addition to the lack of time due to the overload of tasks, one of the limiting factors for extramural actions and a fundamental element to the psychosocial model[22]. Despite this, territorial practices are perceived as powerful, as they enable the production of care in the spaces of daily life of users, reinserting them and strengthening ties with the community[15,22].

It is therefore necessary to pay attention to the different contexts and realities, as well as to the intersectional issues that cross them in multiple ways. As an example, it can be seen that the majority of users of the CAPSad service are men, so it is possible to state that women suffer double stigmatization: due to the use of psychoactive substances and because they do not match the expected performance of femininity. This may be one of the explanations for the fact that they take a long time to seek treatment and/or that they abandon it early[5].

It was noted that the aspects that contribute to the use of medication are diverse and affect all social classes[18]. However, in the midst of everyday life marked by extreme poverty and/or serious situations of violence, there is a fear of going crazy and/or that reactions to suffering and issues seen as problematic are considered abnormal[11], causing a portion of the population is affected in a more specific way. Thus, it is understood that the engine of illness is also social.

Regarding the economic dimension of care management, there was a decrease in funding for community health services and territorial devices, while there was an increase in investments in HP, CT and other large equipment[19]

CONCLUSION

Therapy for patients with intense psychological distress should not only consist of medication, but should include interventional and care actions, such as psychological follow-up and guaranteeing the fulfillment of basic social rights. For the demedicalization of everyday life, it is necessary to strengthen practices that discourage the incorrect or excessive use of medications, in addition to understanding that diagnoses of mental disorders do not define or speak for a subject.

Thus, this contextualized analysis does not agree with the logic of individual responsibility, both for psychic suffering and for

mistaken identification of disorders described in diagnostic systems. This is because it imprisons subjectivities by directly and indirectly relating to the trivialized use of medications based on the discourse of the possibility of alleviating symptoms and manifestations of malaise, producing the numbness of feeling and the docility of disciplined bodies. In this way, medicalization as a logic that runs through the maintenance of the economic political system of utilitarian and obedient forms of existence implies direct and indirect consequences for society in a biopolitical configuration of mental health care.

More elements were found indicating weaknesses in the care model than advances and implementation of PC. Moreover, regarding the investment of public funds in health services, it is important to establish an alliance between the community and health professionals so that they are an active and valued part of institutional management. It is believed in the need for reflection, transformation, and creation of mental health actions for health workers, without negligence and damage to the system itself and its mode of production.

Finally, the importance of establishing a research agenda is indicated that deepens different designs and cuts on the themes addressed in the present study, as well as that advances in overcoming the limits of this text.

FINANCING SOURCE

REFERENCES

1. Amarante P, Freitas F. Medicalização em psiquiatria. 2. ed. Rio de Janeiro: Fiocruz; 2017. 146 p.

2. Cavalcante DM, Cabral BEB. Uso de medicamentos psicotrópicos e repercussões existenciais para usuários de um CAPS II. Estud Psicol. 2017;22(3):293-304. doi: http://dx.doi.org/10.22491/1678-4669.20170030

3. Félix-Silva AV, Soares GP. Processos de subjetivação em arte e saúde mental em um manicômio judiciário. Psicol Ciênc Prof. 2021;41(spe4):1-16. doi: https://doi.org/10.1590/1982-3703003212322

4. Amarante P. Saúde mental e atenção psicossocial 4. ed. Rio de Janeiro: Fiocruz; 2019. 123 p.

5. Duarte MVG, Barros GS, Cabral BEB. Uso de drogas e cuidado ofertado na Raps: o que pensa quem usa? Saúde Debate. 2020;44(127):1151-63. doi: https://doi.org/10.1590/0103-1104202012715

6. Dalgalarrondo P. Psicopatologia e semiologia dos transtornos mentais. 3. ed. Porto Alegre: Artmed; 2019. 505 p.

7. Foucault M. Nascimento da biopolítica. São Paulo: Martins Fontes; 2010. 452p.

8. Mendes KDS, Silveira RCC, Galvão CM. Uso de gerenciador de referências bibliográficas na seleção dos estudos primários em revisão integrativa. Texto & Contexto Enferm. 2019;28(e20170204):1-13. doi: https://doi.org/10.1590/1980-265X-TCE-2017-0204

9. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014. 407 p.

10. Aguilar ML, Campos RTO, Dorigatti AE, Fonseca FG, Madureira RM, Nascimento JL. Projeto terapêutico singular no âmbito da saúde mental: uma experiência no curso de graduação em Medicina. Rev Bras Educ Méd. 2014;38(1):113-9. doi: https://doi.org/10.1590/S0100-55022014000100015

11. Filardi AFR, Mendonça SAM, Oliveira DR. O ser humano é assim, sofre, mas alguns dias são piores: a percepção dos pacientes

para o início do uso dos medicamentos psicotrópicos. Psicol Est. 2021;26(e46557):1-13. doi: https://doi.org/10.4025/psicolestud.v26i0.46557

12. Affonso PHB, Bernardo MH. A vivência de profissionais do acolhimento em Unidades Básicas de Saúde: uma acolhida desamparada. Trab Educ Saúde. 2015;13(1):23-43. doi: http://dx.doi.org/10.1590/1981-7746-sip00041

13. Onocko-Campos RT, Passos E, Palombini AL, Santos DVD, Stefanello S, Gonçalves LLM, et al. Gestão autônoma da medicação: uma intervenção analisadora de serviços em saúde mental. Ciênc Saúde Colet. 2013;18(10):2889-98. doi: https://doi.org/10.1590/S1413-81232013001000013

14. Ferrazza DA, Rocha LC, Luzio CA. Medicalização em um serviço público de saúde mental: um estudo sobre a prescrição de psicofármacos. Gerais. [Internet]. 2013 [citado em 24 mar. 2023];6(2):255-65. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1983-82202013000200008&lng=pt&tlng=pt

15. Constantinidis TC, Cid MFB, Santana LM, Renó SR. Concepções de profissionais de saúde mental acerca de atividades terapêuticas em CAPS. Trends Psychol. 2018;26(2):911-26. doi: https://doi.org/10.9788/TP2018.2-14Pt

16. Bezerra IC, Morais JB, Paula ML, Silva TMR, Jorge MSB. Uso de psicofármacos na atenção psicossocial: uma análise à luz da gestão do cuidado. Saúde Debate. 2016;40(110):148-61. doi: https://doi.org/10.1590/0103-1104201611011

17. Caminha ECCR, Jorge MSB, Pires RR, Carvalho RRS, Costa LSP, Lemos AL, et al. Relações de poder entre profissionais e usuários da Atenção Primária à Saúde: implicações para o cuidado em saúde mental. Saúde Debate. 2021;45(128):81-90. doi: https://doi.org/10.1590/0103-1104202112806

18. Filardi AFR, Passos ICF, Mendonça SAM, Ramalho-de-Oliveira D. Medicalização da vida nas práticas vinculadas à Estratégia Saúde da Família. Rev Latinoam Psicopatol Fundam. 2021;24(2):421-45. doi: http://dx.doi.org/10.1590/1415-4714.2021v24n2p421.10

19. Santos DVD, Federhen C, Silva TA, Santos IR, Levino CA, Onocko-Campos RT, et al. A gestão autônoma da medicação em Centros de Atenção Psicossocial de Curitiba (PR). Saúde Debate. 2020;44(esp.3):170-83. doi: https://doi.org/10.1590/0103-11042020E315

20. Bezerra IC, Jorge MSB, Gondim APS, Lima LL, Vasconcelos MGF. "Fui lá no posto e o doutor me mandou foi pra cá": processo de medicamentalização e (des)caminhos para o cuidado em saúde mental na Atenção Primária. Interface Comun Saúde Educ. 2014;18(48):61-74. doi: https://doi.org/10.1590/1807-57622013.0650

21. Lima LT, Surjus S, Pereira EM, Lauria BC, Thomé AM. Articulações GAM em Santos e a partir de Santos. Rev Polis Psique. 2020;10(2):122-42. doi: http://dx.doi.org/10.22456/2238-152X.103710

22. Campos DB, Bezerra IC, Jorge MSB. Produção do cuidado em saúde mental: práticas territoriais na rede psicossocial. Trab Educ Saúde. 2019;18(1):1-18. doi: https://doi.org/10.1590/1981-7746-sol00231

23. Sousa PF, Maciel SC, Medeiros KT. Paradigma biomédico X psicossocial: onde são ancoradas as representações sociais acerca do sofrimento psíquico? Temas Psicol. 2018;26(2):883-95. doi: https://doi.org/10.9788/TP2018.2-13Pt

24. Barbosa VFB, Caponi SN, Verdi MIM. Risco como perigo persistente e cuidado em saúde mental: sanções normalizadoras à circulação no território. Saúde Soc. 2018;27(1):175-84. doi: https://doi.org/10.1590/S0104-12902018170233

25. Cescon LF, Capazzolo AA, Lima LC. Aproximações e distanciamentos ao suicídio: analisadores de um serviço de atenção psicossocial. Saúde Soc. 2018;27(1):185-200. doi: https://doi.org/10.1590/S0104-12902018170376

26. Oliveira EA, Martins CP. Sobre práticas de medicalização e "loucura": algumas reflexões (in)disciplinadas. Rev Psicol Saúde. 2020;12(1):101-13. doi: https://doi.org/10.20435/pssa.v12i1.747

27. Lima DKRR, Guimarães J. Articulação da Rede de Atenção Psicossocial e continuidade do cuidado em território: problematizando possíveis relações. Physis: Rev Saúde Colet. 2019;29(3):1-20. doi: http://dx.doi.org/10.1590/S0103-73312019290310

28. Meirelles MCP, Kantorski LP. Ação comunicativa: um olhar sobre processos de gestão de uma Rede de Atenção Psicossocial. Ciênc Saúde Colet. 2021;26(9):4183-92. doi: https://doi.org/10.1590/1413-81232021269.16342020