

PSYCHOLOGY, HEALTH AND TERRITORY: PRIMARY HEALTH CARE EXPERIENCES

Roberto Henrique Amorim de Medeiros^{1 2}, Orcid: <http://orcid.org/0000-0001-8224-9755>

ABSTRACT. Mental health is a critical node for the management of Primary Health Care, convened daily to welcome the individual and collective psychological distress and counting on minimum teams. Shortly before the VIII National Health Conference, which would establish foundations for a new Brazilian health system, a community health service was structured on the periphery of Porto Alegre-RS anticipatory to the Family Health Strategy, in which some teams already counted on psychologists at that time. This article seeks to reflect on the psychologist's current place in the primary care level, based on more than two decades of experience work in psychology as part of the health care facilities of that service. Finally, it discusses the potential of the psychology's insertion at the primary level when considering the complexity of a practice that involves attention, management, training and participation in the process of working in multi-professional teams.

Keywords: Health psychology; community psychology; Unified National Health System.

PSICOLOGIA, SAÚDE E TERRITÓRIO: EXPERIÊNCIAS NA ATENÇÃO BÁSICA

RESUMO. A saúde mental é um nó-crítico para a gestão da Atenção Básica, convocada diariamente a acolher o sofrimento psíquico individual e coletivo contando com equipes mínimas. Pouco antes da VIII Conferência Nacional de Saúde, que estabelecerá bases para um novo sistema brasileiro de saúde, estruturava-se na periferia da cidade de Porto Alegre-RS um serviço de saúde comunitária antecipatório à Estratégia Saúde da Família, em que algumas equipes já contavam com psicólogos. Este artigo procura refletir acerca do atual lugar do psicólogo no nível primário de atenção, discutindo a experiência de mais de duas décadas de trabalho da psicologia como integrante de unidades de saúde daquele Serviço. Finalmente, discute o potencial da inserção da psicologia no nível primário ao considerar a complexidade de uma prática que envolve atenção, gestão, formação e participação, no processo de trabalho em equipe multiprofissional.

Palavras-chave: Psicologia da saúde; psicologia comunitária; Sistema Único de Saúde.

¹ Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre-RS, Brazil.

² Email: robertoamorim80@hotmail.com



PSICOLOGÍA, SALUD Y TERRITORIO: EXPERIENCIAS DE ATENCIÓN BÁSICA EN SALUD

RESUMEN. La salud mental es un crítico-nodo para la gestión de la atención primaria de salud, convocado al día para recibir a la angustia psicológica individual y colectiva y contando con equipos mínimos. Justo antes de la Conferencia Nacional de Salud VIII, que establecería bases de un nuevo sistema de salud brasileño, un servicio de salud comunitario fue estructurado en las afueras de Porto Alegre-RS de anticipación a la Estrategia Salud de la Familia, en el que algunos equipos ya contaban con psicólogos. En este artículo se pretende reflexionar acerca del lugar del psicólogo en el ámbito de la atención primaria, basado en la experiencia de más de dos décadas de trabajo de la psicología como parte de los centros de salud de ese Servicio. Por último, se analiza el potencial de la inserción de la psicología en el nivel primario a considerar la complejidad de una práctica que implica la atención, gestión, formación y participación en el proceso de trabajar en equipos multiprofesionales.

Palabras clave: Psicología de la salud; psicología comunitaria; Sistema Único de Salud.

Introduction

Psychology is not fully registered in the health field, either as a science or as a profession. The historical process that differentiated it from philosophy and the delimitation of its knowledge objects by the scientific paradigm made it plural. The complementarity of training to take care of the professional field becomes familiar to the psychologist. Recent Residency programs and some Specializations usually accommodate demands for preparation for work when the psychologist's practices should be in the health sector.

Psychology started to integrate health teams only in the last decades of the last century. It had to rely on the training that was at its disposal: academic graduation and, eventually, training at psychoanalytic institutes. Like psychiatry, which at some point in its history has appropriated elements from psychoanalysis to enrich its practice, psychology has also adapted it as psychoanalytically oriented therapy. In both cases, the effective use revealed that the transposition of psychoanalysis praxis to serve to the therapy logic produced wrong results (Figueiredo, 2004).

Psychology is called to work in multidisciplinary teams for mental health actions at the primary level, in the mid-1980s (Jimenez, 2011; Camargo-Borges & Cardoso, 2005). As everyday activities, the psychodiagnostic, the analytical psychotherapy for adults, the guidance and the counseling for groups (Tanaka & Ribeiro, 2009). Difficulties in resignification of traditional clinical settings for the living territory, cultural distances - between professional and users - and conceptual - between psychological practice and the Unified National Health System (known in Brazil as Sistema Único de Saúde – SUS) values. In addition to the incipient teamwork, it established some of the factors that resulted in the low resolution of mental health actions at the primary level (Jimenez, 2011).

These facts, added to the issue of low financing and other options for the care model, contributed to the fact that the psychologist did not integrate the Family Health Strategy (Known in Brazil as Estratégia da Saúde da Família – ESF) team in its first project, still as a

program (Brasil, 1994), despite the high demand for mental health situations. Only in 2008, with the creation of the Support Center for Family Health (Known in Brazil as Núcleo de Apoio à Saúde da Família – NASF)) that the psychology professional will once again be considered as a possible member of a multidisciplinary team of Primary Health Care (Known in Brazil as Atenção Primária em Saúde –APS) (Portaria nº 154, 2008).

This article aims to contribute to a reflection on aspects of the psychologist's practices at the primary level of health care. Therefore, it seeks to problematize experiences of health psychology through the expressiveness of some scenes of the psychologist's work as a member of a multidisciplinary team in a community health service in Porto Alegre-RS. Their practices are guided by the principles of SUS and the guidelines of APS. Such analysis material comes from the daily observations and experiences with the colleagues' practices, especially those of the author himself, carried out for ten consecutive years from 2003 to 2013. So, it will discuss how it can operate the insertion of psychology in APS considering the complexity of its work articulated among attention, management, training and participation in the work process.

Psychology at the primary health care

At the same time that the Health Reform instituted its proposals through the VIII National Health Conference and, later, by the Federal Constitution of 1988, which would result in the establishment of the new Brazilian health system (SUS), social movements in Porto Alegre (capital of Rio Grande do Sul –RS) peripheral neighborhoods won the right to use the service of health units close to their homes. Community doctors, nurses and, little by little, other professionals began to meet the most common health demands, without that population having to use the emergency services of the general hospital as the only alternative. Thirty years later, about 110,000 inhabitants, a population equivalent to medium-sized municipalities in RS, have basic health units, Psychosocial Care Center (known in Brazil as Centro de Atenção Psicossocial – CAPS), Street Office and support services in epidemiology, health education and matrix support, as components of a well-structured community health service.

The teams' formation was carried out according to the needs of the territories and jointly negotiated by the population and the professionals involved. The conquest of the communities evolved into the establishment of more complete multi-professional teams. In the 90s early years, three units also had psychologists, besides doctors, nurses, dentists, social workers and technical professionals in nursing and dentistry.

The choice of principles as organizers of that community health service played an essential role in the definition of multi-professional teamwork processes. Based on the realities of each territory - taken in its figurative sense, which includes the consideration of ways of life, uses of spaces and the relationships established among people - each team was defining its way of operating guided by the principles of the first contact, longitudinality, integrality and care coordination.

When rethinking academic canons that supported its reasoning and practice to integrate with that new situation, psychology recognized the complexity of what it means to provide comprehensive health care in the territory: it is not limited to the health care of users, but it also implies acting in the management, training and social control records (Ceccim & Feuerwerker, 2004).

Although it is not a practice prohibited to APS, organizing the work only on scheduling appointments constitutes a double mistake. The first is located at the management level, as

the scheduling possibilities exhaust quickly or consultations tend to be underutilized, either due to absenteeism or due to a poorly addressed need. The second mistake is conceptual, since outpatient care based on complaint-approach does not affect health indicators, does not work with the promotion or with the continuous vigilant care over the health of families and individuals, as expected from primary care.

By mid-2000, all twelve teams came to have psychologists. In the process of continuing education in service, the psychologists were introduced to a way of working that required an effort to adapt their knowledge and the development of other practices more integrated to the APS logic in the territories.

As a procedure to fulfill the objectives of this work, after a brief questioning about the possible meanings that health and mental health can assume in the context of an institution structured by medical knowledge, some practices developed by psychology in the referred community health service will be presented in scenes format to highlight the effects of the construction of the psychologist's place in the APS context and to allow some conclusions about it.

The practice scenarios

The APS established its bases through a historical process that officially dates from the Alma-Ata world meeting on primary health care in 1978, due to the needs of developed countries to provide sustainability to their health systems, mainly due to the disruption of capitalism in the 70s.

The understanding built over the years about APS is not unique. It can be understood both as a set of basic health medical practices and as the organizer of a health system (Muldoon, Hogg, & Levitt, 2006). Thus, the practices in an APS is not standardized at all. The care first level in the Brazilian health system is based on the principles, guidelines and values of APS. However, it takes the name of Basic Care (Known in Brazil as *Atenção Básica - AB*) to mark a difference promoted by the collective health discourse built during the Health Reform process.

The presence of collective health, problematizing biological paradigms with the social determinants of health and disease phenomena (Ceccim, 2007), did not definitively alter the programmatic organization of the teamwork, the clinic, the health prevention and surveillance, which often still are built on medical rationality.

The health psychologist practices in that community health service needed to reinvent itself from the effects of medical discourse - biological and mechanistic paradigms about the body and health and the APS discourse –the first contact, longitudinality, integrality and care coordination.

Nevertheless, the specific health needs of the territories and the involved multiprofessionality contributed to the establishment of renewed relationships and work practices. What initially appeared as demands to the psychologist, such as emotional issues arising in medical consultations, learning disorders referred by schools and conflicts between teammates in the work process, started to be taken not only as therapy objects. The naturalization of demands such as psychological ones was also made relative, a movement that made teams reaffirm the intervention potential of other professionals.

The two significant scenes of the health psychologist's practice, presented below, can be considered as the result of constructions and reinventions of a work that stretched along three decades. A tributary presence of the psychology professional on the front lines of

health territories, in the SUS context, permeated by the principles of APS, as well as the two major reforms, namely, the Health and the Psychiatric.

Training and work scenes

Two common demands need to be addressed by the psychologist so that his way of proceeding does not repeat practices that are not very effective in health. One of them comes from the hegemonic medical discourse that usually legislates about how and with whom the psychologist should intervene. Working on adherence to medical treatments or doing therapy with a multi-complaints patient, who never gets better, are examples. The other, resulting from the first, is the social construction of the demand for mental health and what the psychologist's performance is: one that solves cognitive problems or behavioral maladjustments that are not from organic order, through some suggestion technique or therapeutic dynamics. Is it necessary to ask how psychology can provide better answers and collaborate in the process of comprehensive health care?

It is common for APS professionals to feel overwhelmed by the work fronts to which they have to correspond. However, as they constitute a kind of desalination from the paradigmatic recipes of compartmentalized work, they can perceive that operating jointly through the four discourses of the health field is essential for the care integrality and enhancing of their practices. The clarification on the APS principles and the intimacy with the territory and its territorialities also play a decisive role in the understanding of the APS specificities, by workers, and for the relevance of their caregiving acts.

First scene, the first act

Among so many challenges arising from the peculiar way in which problems arise when working with the living territory, one of the first concerns that led the author to produce acts as a new psychologist of an old team was the problem of long lines at each start of shift and the return of many users to their homes without getting what they were looking for. The community's perception was that there was a lack of doctors. It was 2004, and the reception policy had not yet been established in the units of that community health service. However, there was already an awareness of the problem of access, which, it is known, was not restricted to medical consultation. To the new psychologist, listening to that population about their experience in accessing the unit seemed essential, which concerns the observance of the first APS principle: be the health system open door, that is, the first contact.

In a meeting of the unit's managing collegiate, the psychologist proposed an intervention based on listening to the community. The unit would open half an hour before regular hours on each shift and invite anyone in line to come in, have a coffee and talk about the experience of waiting for his service. Talking about waiting had the double effect of learning about the experience of that person who waits at the door of the health unit, besides listening to a dimension of desire implied in the possible sense to the act of someone who expects something.

For two weeks, all the team's professionals, as well as medical residents and psychology trainees, participated in pairs in two-shift meetings with the users, which allowed us to raise a series of impressions about the team, the unit work and get some ideas for improving access. The next step was to give the feedback about the compilation of problems and proposals to the team so that it could carry out a reformulation of its work process, inventing new ways of receiving users and redirecting ways of serving the population.

The complete description of this device, which integrated elements of management, attention and participation, is in Medeiros, lung and Comunello (2007). In this article, it is worth rescuing one of the effects of this attempt to diagnose problems related to access to primary care. It is the relativization of the idea that the whole line represented a natural demand for medical assistance. It was discovered, outside the office, that not every request was addressed to the doctor, but that it was the custom of the population to schedule the appointment as a means to reach its main objective. This discovery, confronted with the common perception that an unclear or displaced complaint on the medical field by the patient would represent a lack of demand, seems to be a sufficient condition for the need to establish a listening that would allow the user's complaint to be transformed into the construction of demand for care. Essential act, where the lines are long, and the agendas are short.

Second act

The office that the psychologist shared with his social service colleague was, at that time, right next to the unit's reception desk. It was inevitable to hear how each receptionist dialogued with users to guide them in what they sought. One of them only forwarded orders. The other asked the reasons.

What perhaps seemed inappropriate to users due to the supposed embarrassment in revealing the reasons for their visit, was, in fact, a powerful way of operating for the better forwarding of the order itself, which manifested itself only as a wish, "I want to see a doctor". The receptionist's unusual question - why? - called the user to try to put into words something of his desire and part of his suffering. The wisdom about the scheduling limits and the fact that other professionals than the doctor solve many cases allowed that young receptionist to forward individual requests without wasting time or spending resources.

A device that could work on the complaint to build care demands seemed relevant to the psychologist's work in that unit. Experiences taught that opening the agenda and meeting the demand was also a double mistake, that is, such conduct would account for the volume of referrals to psychology and that the demand for care had already been built at the time of the complaint, which are different things.

After the study on reception experiences in mental health, the author established the reception group as a device for access to psychology: a collective space where those who expressed a request to listen to the psychologist would be welcomed to start the process of building demand for care. Unusual space that had caused strangeness even for team members, who imagined how delicate the exposure of a supposedly vulnerable subject in a group evaluation could be or, perhaps, that therapy should be something private. The overvaluation of his symptom is characteristic of the neurotic structure and the mistake of the team and some users are justified, as they believe that all professional health practice is similar to the medical consultation model. The purpose of the reception group and the technique of initial interviews differed from a psychological assessment. It was about welcoming and building demand for care with a view to the therapeutic project. The clarity about this difference and the potential to transform common complaints into demands addressed to the service or the psychologist, a fundamental step at the beginning of any treatment, brought some significant changes. Unnecessary appointments were avoided, time reservations in the psychologist's schedule were better used with the reduction of absenteeism and waiting times for the first appointment were reduced.

The creation of an open psychology agenda, in which users themselves reserved their schedules and filled out a form with their data and reasons for the consultation - in a first effort to enunciate their suffering - was one of the first products of the receiving device. Gradually, this same agenda started to be used by the team itself. The logic of constituting a space to welcome requests addressed to psychology, therefore, was extended to the discussion of cases of referrals to psychology, supervision or even to carry out joint consultations with other colleagues, revealing clinical potential and clinical management.

Final considerations

The experience of psychology, as presented in this article, is not intended to be paradigmatic. Considering that psychology does not fully enroll in the health field gives it degrees of freedom to deal with fundamental conditions: the problematization of ideological lines that support its practices and the potential to cast a different glance at the health and illness phenomena in the territory, as well as about institutional processes. The interest of this article is in the reflection about problems and possible ways to situate potent places of the psychologist when faced with the discourses of the health area.

Public policies that order the health care network have not fostered an increase in the presence of psychology at its primary level. The Brazilian psychologist, today, is expected to be a member of teams from CAPS (psychosocial care center), NASF (family health support center), Street Offices or other secondary-level equipment from psychosocial care networks (RAPS). Although mental health is one of the critical nodes of APS, the psychologist is at least one step away from this scenario. If the psychiatric reform process was responsible for creating substitute services to address severe and persistent disorders and drug abuse, the ESF (Family Health Strategy) is responsible for the least serious - but most of the time prevalent, especially depression, learning disorders and social relationship,

According to the policies for APS, it is assumed that the psychologist's functions closest to the territories are institutional support and matrix support in the NASF registry. As mentioned at the beginning of the article, the explanation for the unsatisfactory result of the initial insertion of psychology in APS fell mainly on the confusions of adapting the psychoanalytic clinic to serve therapeutic purposes, evidently co-opted by the medical model of treatment, as well as the impossibility of having arisen at that time a psychoanalysis in tune with the peculiarities of the attended territories and community (Jimenez, 2011). In the 1990s, the theoretical support base of the first psychologists who composed the teams of that community health service was psychoanalytic. Psychologists, who arrived in the second half of the 2000s, supported their practices in social psychology and public health assumptions. However, traces of psychoanalysis continued to serve the listening acts in the office.

It is essential to point out that the author's work as a psychologist in the context of health was structured on his psychoanalytical training. This aspect is important to establish the first proposition: there is no select theoretical line for the success of health care nor psychological practices more appropriate than others. Apparently, it is the willingness to let the reality of the territories and the different knowledge question their rationalities, which enhances a practice in psychology.

It also seems clear that psychologist work has experienced various areas in the health field. This characteristic may indicate that devices and actions built through the circulation

and reciprocal assignment of management, training, participation, in addition to attention, have more significant potential to design innovations and solutions to health collective work (Ceccim & Feuerwerker, 2004). When this is possible, as it implies articulation among the varied spheres of health practices, the complexity of the work does not become a heavy burden, but a condition of its creative potential.

Affecting oneself by the territorialities and enriching the practice through the other perspectives present in the team help the psychology practice in an APS. It was in this way that the understanding of the work purposes in APS was fundamental for the psychologist to learn his specificity and place in the team. The APS principles, guidelines and values, when guiding practices of all professional categories present in the teams of that community health service, act as an element that enables interdisciplinary dialogue, as long as everyone was invited to speak at least the same language, although with different dialects. The field and knowledge and practices nuclei (Campos, 2000) start to operate dialogically and collaboratively.

According to Medeiros (2008), the principles of APS can even serve as mediators for discussions of clinical cases in a multidisciplinary team, which can materialize truly transdisciplinary practices in health work. Permanent education, which would be solidified as a guideline for professional training (Brasil, 2009), was already present in this experience that is analyzed: training in a transformative and productive service of innovations in the work process (Ceccim, 2005).

Another expressive illustration of the creative potential of non-dissociation among management, clinic, training and participation, appears in the fundamental elements of the psychology reception group's proposal and its products, such as the open agenda and the discussions of referrals or joint consultations with other professionals categories. Such a device promoted direct effects not only in the psychologist's time management but in the interdisciplinary meeting processes with a view to mental health care, in addition to training activities based on discussions, supervision or collaborative care.

The participatory aspect of that listening space was present due to the privilege of speech and the user's experience concerning the technical knowledge of psychology. After the work of initial interviews, the therapeutic guidelines were not limited to referrals for individual therapy. The decision on what to do was based on clinical listening, joint construction with the user and eventually with the professional who referred him, even from institutions such as school or social assistance network equipment. The construction of demand and therapeutic guidance allowed the user to choose either to remain in that group or to participate in other health promotion and education activities in or outside the unit. The restoration of the support network, leisure, consultations with other professionals or guidance to obtain social benefits also made possible referrals among so many possible ones. The demand denaturalization as psychological based on psychoanalytic listening, in this case, expanded the potential of comprehensive care by not summarizing actions in the psychology context.

The history of the practices and how the group of twelve psychology professionals got to know each other and built common elements of action in APS, despite maintaining conceptual differences, seems to reinforce that the potential of psychology's performance increases when it does not remain rigid in its theoretical bases and allows the sharing of health actions. The recognition of the historical process and the achievements of the health reform movement that modified the access to health and increased the quality of life indicators in Brazil, especially in the peripheral communities of large urban centers, commits the psychologist from the health network to take a stand ethically concerning his place along

with the APS teams or in specific mental health practices. This critical position added to the clarity about the objectives and specificities of work in APS and to the singularities of the territory understood as a process of relationships and production of ways of life, includes the psychologist as a health promoter, which exceeds the technical and specialist mental health approach.

Psychology professionals at the community health service, as mentioned earlier, have supported the integrated work with the team in the health territories for more than three decades and, it seems, they show the effectiveness of their presence at this level of care. The circulation among the four spheres of the health sector, as many directly played the role of residents and trainees' preceptory and supervision, as well as unit managers. More than representing an overflow of functions, revealed the potential of the psychology professional for work on the frontline of APS. At a certain point in the past decade, due to the accumulation of practices and knowledge, more than half of the component teams were coordinated by psychologists, revealing other types of competences in the exercise of a natural function to the doctor or nurse.

The quality of the relationship that the psychologist can establish with the rest of the team, territory and users, seems to facilitate the approximation of perspectives on health and establish work partnerships. This quality works better when he participates in the daily work of a team than only in sporadic situations of support or matrix support, as attested by recent experiences (Leite, Andrade, & Bosi, 2013). The scheduling of joint consultations, discussion of referrals to psychology or establishment of Unique Therapeutic Projects from the reception group are examples of practices similar to matrix support (Cunha & Campos, 2011), organized in the teamwork process itself. The NASF team does the same work currently. However, the relationship among professionals who work together daily and know their territory and the organizational culture of the Unit's work is insurmountable. Facts that relativize the policy decisions of the psychologist's strategic location in the network concerning the primary level of care.

Health psychology presents some ethical, technical dilemmas and practical difficulties in the conduct of comprehensive care by professionals who experience it. On the one hand, the social construction of what a psychologist is and the expectation of the health sector regarding his practice, leading him to respond to all demands with the prior knowledge of an untouched theoretical affiliation. On the other hand, the belief that predetermined technical procedures can be applied regardless of the uniqueness of the territory, especially in cases where the emphasis of the complaint is situated in the field of mental health. Following the example of some proposals by Spink (2003), it is finally stated that the best work situation in health psychology can occur when he is integrated with the other knowledge circulating in the teams, sometimes modulating certain traditional and hegemonic practices in the sector, sometimes enhancing the promotion and comprehensiveness of health care in defense of life. The practical contribution of psychology in the health care network is invaluable when it manages to escape from the hegemonic discourse that also captures it and, thus, deconstruct practices that promote medicalization, either in health care or in the ways of life in society.

References

- Brasil. (1994). *Programa de Saúde da Família (PSF)*. Brasília, DF.
- Brasil. Ministério da Saúde. (2009). *Política nacional de educação permanente em saúde*. Brasília, DF.
- Camargo-Borges C., & Cardoso C. L. (2005). A psicologia e a estratégia de saúde da família: compondo saberes e fazeres. *Psicologia e Sociedade*, 17(2), 26-32.
- Campos, G. W. S. (2000). Saúde pública e saúde coletiva: campo e núcleo de saberes e práticas. *Ciência e Saúde Coletiva*, 5(2), 219-230.
- Ceccim, R. B. (2005). Educação permanente em saúde: desafio ambicioso e necessário. *Interface: Comunicação, Saúde, Educação*, 9(16), 161-197.
- Ceccim, R. B. (2007). Invenção da saúde coletiva e do controle social em saúde no Brasil: nova educação na saúde e novos contornos e potencialidades à cidadania. *Revista de Estudos Universitários*, 33(1), 29-48.
- Ceccim, R. B., Feuerwerker, L. C. M. (2004). O quadrilátero da formação para a área da saúde: ensino, gestão, atenção e controle social. *Physis: Revista de Saúde Coletiva*, 14(1), 41- 65.
- Cunha, G. T., & Campos G. W. S. (2011). Apoio matricial e atenção primária em saúde. *Saúde e Sociedade*, 20(4), 961-970.
- Figueiredo, A.C. (2004). *Vastas confusões e atendimentos imperfeitos: a clínica psicanalítica no ambulatório público*. Rio de Janeiro, RJ: Relume-Dumará.
- Jimenez, L. (2011). Psicologia na atenção básica à saúde: demanda, território e integralidade. *Psicologia e Sociedade*, 23(n. spe.), 129-139.
- Leite, D. C., Andrade, A. B., & Bosi, M. L. M. (2013) A inserção da psicologia nos núcleos de apoio à saúde da família. *Physis: Revista de Saúde Coletiva*, 23(4), 1167-1187.
- Medeiros, R .H. A., lung, A. M. B., & Comunello, L. N. (2007). A espera: projeto e ação de acolhimento a partir da escuta da população. *PSICO*, 38(1), 17-24.
- Medeiros R. H. A. (2008). O procedimento do colecionador como fundamento da condição de transdisciplinaridade. *Barbarói*, 29(1), 9-23.
- Muldoon, L. K., Hogg, W. E., & Levitt, M. (2006). Primary care (PC) and primary health care (PHC). What is the difference? *Canadian Journal of Public Health Revue Canadienne de Sante Publique*, 97(5), 409-411.
- Portaria GM/MS nº 154, de 24 de janeiro de 2008. (2008). Cria os Núcleos de Apoio à Saúde da Família. Brasília, DF.
- Spink, M. J. (2003). Os psicólogos na saúde: reflexões sobre os contextos da prática profissional. In *Psicologia social e saúde: práticas, saberes e sentidos* (p. 77-159). Petrópolis, RJ: Vozes.

Tanaka, O. U., & Ribeiro, E. L. (2009). Ações de saúde mental na atenção básica: caminho para ampliação da integralidade da atenção. *Ciência e Saúde Coletiva*, 14(2), 477-486.

Received: Jul. 16, 2018
Approved: Jun. 24, 2020

Roberto Henrique Amorim de Medeiros: Assistant Professor of the graduation course in Collective Health and Postgraduate Studies in Psychoanalysis at UFGRS.