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Ethical dimension of mental health care within the public health network

ABSTRACT

OBJECTIVE: To analyze the meanings of caring for people who seek assistance in mental health, from the perspective of psychologists engaged in their daily activities within public health services.

METHODOLOGICAL PROCEDURES: An exploratory qualitative study was conducted in the city of Fortaleza, Northeastern Brazil, in 2006. The sample was composed of eight female informants, all of which were psychologists working in the state public health network. Data was obtained by means of non-directive interviews which were taped and transcribed. Categories were obtained from the discourses based on a hermeneutical approach by means of which an interpretive network was constructed.

ANALYSIS OF RESULTS: The interpretative network indicated that psychologists recognize their insertion in the field of public health as distinct from the professional field in which they obtained their training and, consequently, as a challenge. The predominant conceptions of care were circumscribed to the technical dimension, although other dimensions, closer to ethical concerns and to those related to respect for the "other" were also identified.

CONCLUSIONS: In the daily routine of assistance within the public health network, care is perceived as a technical attitude. It involves control and nullification of alterity, being more closely aligned to the traditional models of biomedicine and clinical psychology. However, other practices were observed that overcome this attitude. These emerging practices assume a new configuration, oriented towards affection, dialogue between professionals and those seeking assistance and an ethical commitment forged within a political and socio-cultural perspective.

DESCRIPTORS: Psychologists. Ethics, Professional. Mental Health Services, ethics. Qualitative Research.

INTRODUCTION

When facing the challenge of entering the field of public/collective health, psychologists come in touch with a complex domain, given its historicity, polyphony and multiple contours. These aspects express themselves in the model of assistance, marked by political issues – a sphere within which the definition of health itself has been passing through constant transformations. Health can no longer be conceived of in an isolated or static manner, given the acknowledgement of its close ties to the social context, both with respect to symbolic and material dimensions of each individual's life.

Such an expansion of the concept of health derives from intense social mobilization, and unfolds into discussions by distinct professional categories that

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Recebido: 13/9/2007
Revisado: 3/3/2008
Aprovado: 26/3/2008

shape the sector, conducted in conferences and other events. In these events, the foundations of current health policies and assistential models were also reconfigured, particularly the paradigms based on the concept of health as the absence of disease.^{16,18}

In Brazil, there were many repercussions with respect to this process, the apex being the proposal of a typically national movement for social change – the sanitary reform movement. Characterized by its demand for a critical revision of the field's systems and services, the sanitary reform movement also made demands for increased State participation.

The expansion of the health concept, discussions on integral health care, and transformations in the organization of systems and services within the sector propelled the creation of new areas of activities and the incorporation of other professional specialties. According to Resolution n^o. 218/97^a the *Conselho Nacional de Saúde* (National Health Council) is an organ of the Brazilian Ministry of Health which acts as a forum for popular participation in the health system. The Council recognizes officially diverse categories of health professionals with college degrees – among which are psychologists – that are called upon to contribute towards the process of change, including amongst others, dimensions that are not present in the dominant model.

However, within the field of health, including the sphere of non-psychiatric institutions – site of the present investigation – the predominance of biomedical attention is still significant, as well as the “verticalization of assistance”¹⁷ and the privilege of technique, in detriment to relations.^{5,10,11} Furthermore, the rules and routines that characterize institutional reality often operate as obstacles to the expression of singularity and the presence of the other, in this case, individuals who attend health services.

Emphasis on health technology reduces the encounter among subjects in the institutions to an obsession with respect to the object of intervention: the diseased organ or pathology. This aspect leads authors such as Ayres to characterize assistance as a “desubjectifying objectivation”.³

Accomplishments attained by biomedicine, such as: the expansion of its diagnostic power, the ever greater precocity of therapeutic intervention, the increased efficacy of treatments and of certain dimensions of patient's quality of life, are acknowledged. However, patient's rights should not be disregarded. People attending health services are, in general, deprived of their condition as subjects and considered “patients” - and thus wait passively for an intervention, seeing

themselves recognized as a diagnostic “label” or as a number in a file, portraying the “depersonalization” characterized by Goffman.¹³

In the sphere of public health services, in as yet a timid manner, psychologists enter the “paraprofessional” hierarchy, built around the figure of the physician. They encounter difficulties in attaining autonomy with respect to their own competencies, and, consequently, they find it hard to clarify their specific contribution to other professionals within the health sector. These facts approximate them to the characterization of the paramedical professional as it is conceptualized in the sociological literature concerning professionalization.⁹ However, in daily experience within health services, this model of work organization has come into question, despite the high technical level it has achieved, for it has shown itself to be incapable of accounting for the complexity inherent to the health-sickness process.^{5,9}

Within this reality, it is necessary to launch new foundations so that distinct professional categories do not lose their reflexive capacity⁷ and their ethical commitment,^{10,11} as well as the specificity of their *praxis* in the construction of the ideals of the *Sistema Único de Saúde* (SUS - Brazilian Health System), which include humanization and integral health care.¹⁹

Professional performance, within this context, requires therefore a revision of the way one places oneself at another person's service: placing traditional assumptions in check; being open-minded with respect to ethics, which implies in a new attitude towards the individual who comes to the service seeking assistance; and assuming one's role as a critical actor in the development and “creation” of practices that are more likely to bring about a warm reception and to produce care.

Currently, people are increasingly indifferent towards others. This kind of “allergy to the other” is distant from the philosopher Lévinas',^{14,15} propositions of “radical ethics”, a central reference in the present study. This is not merely distant from what Lévinas proposes but, instead in clear opposition to what is encountered in the substance of his work, in which the place of the other occupies a fundamental role. Although it is not possible to review Lévinas' contributions in this paper, we believe it is suitable to retrieve some of his ideas, still not present in analysis within the domain of Public Health. This will be undertaken throughout the hermeneutic exercise developed further on and based upon informant's discursive material from this study.

The objective of the present study was to analyze the meanings of care, from the perspective of psychologists working within the public health care services, attending people who seek mental health care assistance.

^a Ministério da Saúde. Resolução n^o 218, March 6th, 1997. Regulates the health professions. Diário Oficial da União. May 5th, 1997; Seção I:8932-33 [Accessed on Mar/15/2006]. Available from: <http://conselho.saude.gov.br/docs/Resolucoes/Reso218.doc>

METHODOLOGICAL PROCEDURES

Eight psychologists working at public health care services within Ceara's state health care network participated in this study. The public sphere was chosen because it allocates a specific segment of these professionals, since the service network reveals a singular reality within the scope of the production of care in mental health. According to information obtained from the Department of Health of the State of Ceara, eight health services located within the capital of Fortaleza had psychologists on their staff.

One professional from each of these services was designated as key-informant for subjective accumulation in the face of the phenomenon being investigated. The study population was composed exclusively of women, which indicates some interfaces with gender as an analytical category, a discussion not approached in the article.

Selection criteria for the eight key-informants were the following: being a member of the institution's permanent staff; having been working at the service for a longer period of time (in case there was more than one psychologist); not working professionally in the field of human resources within the service; and not being in the health sector in consequence of a functional deviation. The latter is a common practice within the context analyzed, in which public servants with psychology degrees and working in the technical-administrative level often solicit permission to transfer to health care units.

Non-directive interviews were conducted in order to apprehend and construct the data. The contents of these interviews were taped, with the permission of the informants, who were guaranteed anonymity and secrecy. According to the interviewees' preference, the majority of the interviews were conducted in a room within the psychology service of the health services where they worked.

Once the interviews were transcribed, singular themes were categorized, making it possible to identify themes, dimensions and sub dimensions. These, in turn, made it possible to build an interpretative network, in an interrelated manner and according to a hermeneutic approach.

Conceptions concerning ethics of care were unfolded into three dimensions: care as a technique, care as an ethical open-mindedness; and care as a health policy.

(Re)construction of the interpretative text was sought, based, on one hand, on the theoretical references concerning the issue of health traversed by Lévinas' ethics; and, on the other, the informants' narratives concerning their daily experiences at the public services and perceptions attributed to care. Both were unified in a

comprehensive, interpretive exercise, yielding a web of ever incomplete meanings, in consonance with the hermeneutic circle.¹²

As regards the hermeneutic proposal, the posture is descriptive and comprehensive of lived experience. Having this in mind, an attempt was made to understand the meanings of the phenomenon investigated through Gadamer's philosophical hermeneutics.¹² Comprehension, for Gadamer,¹² implies in the production of a different, and therefore, original, meaning. The true meaning of a text does not exhaust itself in that which the informant says, nor in a specific point. Rather, this is an infinite process since "new sources of comprehension emerge constantly, that reveal heretofore unsuspected relations of significance".¹²

In this sense, not only does the "manifest, but equally, what is not said and is interdicted, should be understood in contrast with the context of speech (the social setting) and with intrasubjective levels that, ultimately, confer limits with regard to what may or may not be said, independently even of the desire of the person who speaks".^{1,6}

Gadamer's work is adopted herein as the hermeneutic foundation. However, analytical categories were not found in his work that could help derive meanings for the narratives. Other contributions were thus incorporated, particularly Lévinas' writings, especially those books referred to at the end of this article. Propositions regarding the "ethics of alterity" present in these works allowed us to select this analytical category as a central concept. Other authors who have been systematically discussing the issue of care in the sphere of collective health were also aggregated within an interpretative vein inspired by interdisciplinarity.

ANALYSIS OF RESULTS

Conceptions of the ethics of care

The dimension "Care as technique" refers to practices more committed to the traditional model of biomedicine and to clinical psychology. Within this perspective, the individual who seeks assistance secludes himself from his self-administrative capacity, playing the role of being dependent upon – in the literal sense of the word – the specialized help of professionals; these, in turn, insist on playing "deaf" to the individual who seeks care and guide their practice by the subject-object model of relationships. The best characterization of this case is the relation object-object,^{11,15} in which the psychologist, being detached from him/herself, does not assume a critical and reflexive posture⁷ with respect to his/her way of being at the other's service within the institution: *"Caring for the other is specialized (...)I'm going to use techniques to take care of that patient, that is the*

pre-evaluation, it's all the techniques I'm utilizing, (...) I am not taking care of him because I think he is marvelous and I feel sorry for him." (Informant 5).

Such care as revealed by the informant is in consonance with the meaning of care disseminated by common sense, according to which it is a "set of procedures technically geared towards the success of a treatment"³. In this informant's experience, care was considered the correct application of diagnostic procedures, according to the steps instituted by the health service, considering those who seek assistance as "a well-known object"¹⁵, besides subjugating them to the technicist intervention still so present in the services within the state network under consideration.

Care as minimizing the other's pain is another aspect of this dimension: *"Sometimes the patient will not become cured, perhaps he/she will not be able to emerge from that situation, but we can provide him with a certain amount of comfort, in terms of diminishing his anxiety..."* (Informant 8). The risk lies in transforming the other, once again, in an object of intervention and of interest to the psychologist or to the team, shifting him/her from the sphere of singularity and relationship to the sphere of labeling, as Andrade & Morato² and Freire¹⁰ have alerted.

In compensation, a sub dimension recurrent in the statements refers to the need felt by informants for taking better care of themselves, which would enable them to find the means of resisting the frustration of dealing with other's suffering without being able to help them or doing less than is expected of them: *"Of course it isn't easy. We have to have a great deal of resistance to frustration, because the degree of success is minimal."* (Informant 7).

Although it is present, "caring for oneself" seems more "interested in the other"¹⁵ and, consequently, "in his/her suffering, as an object of technicist intervention by the psychologist"^{7,10}.

Imagining oneself individually satisfied with the service being rendered to the person seeking health assistance seems, however, to occur amongst those who intend to exempt themselves from any sense of guilt and, consequently, as Lévinas^{14,15} already demanded, from any responsibility *vis-a-vis* the other. Insisting on an attitude of caring for oneself at the same time represents a practice of not caring for the person seeking assistance: *"I write my report. If he is going to be operated, even if I am saying that, at the moment he is not [fit] (...) My report has been registered. I'm not guilty of anything. It's already there in the file: that, at the moment, he should wait a little longer."* (Informant 5).

Another informant, who was more restricted to the instituted norm, demonstrated indifference to the other's appeal for care. This fact characterizes the predominance

of the "individual-universalist character"³ of health assistance, also present in Gadamer's argumentation,¹¹ regarding the persistence of this more technical configuration among health professionals.

However, reports as the one transcribed below, reveal another attitude with respect to the person seeking assistance and a concern with taking care of oneself by means of a specific process or of external support, with the intention of giving greater attention and being more available for an encounter with the other: *"For me... pain permeates this activity; our psychic suffering. I must care for myself, because of the kind of work that I do, so that it won't bring me pain that is, let's say paralyzing, but suffering is a part of my activity, every single day."* (Informant 1).

In this excerpt, the informant reveals a necessary availability towards the other's suffering, by assuming, in the presence of the person who seeks her service, a "posture of non-exemption"¹⁰. Furthermore, her position attempts to acknowledge the need to break off from the "objectifying rendering" of assistance, that has already been so criticized by Gadamer.¹¹ This posture leads us towards a shift to a second dimension: "Care as an ethical opening up towards the other".

Care as an ethical opening up towards the other

One aspect that emerged immediately, within this dimension, was the opening up towards the other, recognized and respected as a singular person, with his life history and values, his fears and sufferings, as the informant explicates: *"I see that the person who seeks our assistance has a great need to be heard and welcomed. I believe that in my professional capacity, I try to do this a lot. [...] I note that the attitude of being receptive, of being open, in and of itself, promotes relief from symptoms."* (Informant 3).

Within this angle, the professional attempts to keep a distance from the formulation of rules, from the diagnostic frame and from following predetermined routines, revealing an open attitude towards an encounter with alterity. This openness leads to a rupture with the "allergy" towards the other, typical of current relationships and which has already been denounced by the philosopher Lévinas:^{14,15} *"I do not like this posture of maintaining a distance from the patient. So my posture is really to come closer, to welcome and listen to that person, become really involved in his/her story"* (Informant 1).

This sensibility during the encounter with the person seeking assistance was also experienced by other informants that tried to develop a differentiated attitude, giving priority to the gaze and the intersubjective relationship, without leaving the technical aspects aside: *"This is how I see it: care for people as a whole, not*

only according to the symptoms they manifest, their disease” (Informant 4). Likewise, it is naïve to assume the techno-scientific language and to presume it is the only one capable of dealing with the complexity of the actions and care in the field: “*Doctor, when you have a patient with cancer, send him/her to me, but give me advice as to how I should act...*” (Informant 2).

Caring for the other as an ethical dimension is a demand that must be experienced by those who care and implies “not exercising knowledge or power over the other”,¹⁰ that may transform him/her in the order of the identical,¹⁵ “domesticate him/her” or adapt him/her, according to institutional precepts and expectations.

Taking Levinas^{14,15} discussion of ethics as a starting point, receptivity begins the moment the psychologist becomes available for an encounter and for dialogue. In order to assume to be an ethical subject, it is not possible to abstain from one’s obligation towards the other. And in order to maintain it magnificently in its singularity and its knowledge, desires and history, it is necessary not to become restricted to technique: “*This issue of reception, of listening, is in large part a result of this, we can give these people, who come with so many stories of suffering, a continent*” (Informant 1).

It is the “auscultation” of the other’s discourse and desire, from which the psychologist, or any other professional from the health care team, “cannot retrieve the word”,¹⁵ but may offer him/her a genuine, respectful encounter, that has as its fundamental mark an intersubjective dialogue. This dialogue must also be delimited by the asymmetry,¹⁵ that represents a rupture with the persistent symmetry of traditional relationships with the other, based on technique and in authority¹⁰ over him.

Understanding the sick person, without compartmentalizing him/her in aspects – be these biological, psychological or social – implies in seeing him/her from the perspective of integrality,¹⁹ by means of which one or another of these aspects may predominate and demand greater attention, without restricting the gaze to only one of them, or annulling the web that entwines them: “*In the hospital, in the majority of the hospital routine people only take care of the disease, right? And so it isn’t just the disease we should take care of, we must see the patient as a whole, as a human being, as a life story.*” (Informant 4).

Care as health policy

This dimension reveals the urgent need to (re)construct the ways of thinking and practicing the issue of health. Humanization of assistance represents a current proposal experienced daily by informants in the state services as a means of reconstructing the field of mental health, as the following excerpt corroborates: “*At the moment*

in which I’m capable of responding to his needs, I am humanizing my assistance, I am individualizing, I am giving him what only Mr. Jose needs at that moment.” (Informant 8).

Furthermore, humanization must address, in a critical, reflexive manner, the issue of dominant forms of knowledge in the field of health, reviewing the systems of truth that are in play in daily life within the services.⁴ Humanization should be conceived, therefore, as “an ethical political practice”,⁸ because it implies in being at the other’s service and the health professional’s action or discourse has repercussions on him/her. Furthermore, it should be conceived in this manner because it is directed towards the ways of relating to and constructing peoples lives.

A constant critical reflection is required on the part of the psychologist regarding both his/her way of being at the other’s service and governmental policies. As is well known, the revision of health practices, needs to pass through “actions centered on ethics, on dialogue and on the negotiation of the senses and of the direction of the production of care in health”.⁸ Fundamentally, the professional informants in this study already experience this need, although in different degrees. They attempt to assume a greater commitment to the issue of care in a critical reflexive manner. Care is thus resignified, based on an ethical attitude towards the other and is recognized as a condition for exercising professional activity in mental health within the state health network.

CONCLUSIONS

The field of health demands a differentiated manner of being at the service of those seeking assistance. It is not suitable to deny the current medical model, or the technical achievements it has made possible. However, this should not impede professionals involved in assistance, whatever their *locus* of activity, from insisting on building new spaces and new models founded on dialogue, which can reverse the supremacy of technique, in detriment to intersubjectivity.

Caring for other’s health in a public service – whether it is a general non-psychiatric hospital, a health care center or another type of service – requires a critical-reflexive posture from the professional and a differentiated attitude towards the other. This attitude is more committed to the social, cultural and political reality of professional practice, with partaking of actions and responsibilities; and it is less focused on the diagnostic label, on minimizing the other’s pain, on mere adjustments and, above all, on the other as an object of technician intervention. This attitude represents a rupture with traditional practice that maintains the professional “stranded on an island”, with the crystallized role of an expert, with an “allergic” posture – according to the terms with which this expression was herein defined.

In the daily activities within the health services investigated, two significant groups of practices were perceived among psychologists. The first and preponderant is characterized by occupation with and interest regarding the other as an object of technical intervention, in which the professional – as an expert – insists upon the identification, the crystallization of knowledge-power and the annulment of alterity.

The second set of experiences, on the other hand, reveals attention “with regard to” the subject who is no longer a simple passive receptor but rather another interlocutor. This attitude makes it possible for the psychologist to go to the encounter of something that eludes the previous group: to call into question his/her role as an expert and create practices which are closer to a respect for the demands of those seeking the service and to a receptive attitude towards his/her singularity. This openness and affectation that are required in an encounter with the other imply in an understanding of care as an ethical attitude, as opposed to care as a technique. It also places an ethical demand upon the psychologist: he/she must not exercise any kind of power or domination over the other that annuls his alterity, or transforms him/her in a means towards any end,

for the other should “be an end in and of him/herself”. Furthermore, this posture requires that the psychologist act as a mediator and responds to the necessities of the other, whose complexity cannot be reduced to a number in a file or a diseased organ. There is, therefore, a demand for a dialectical overcoming, without denying the implied dimensions. It becomes necessary, consequently, for the psychologist to assume himself as an ethical political subject.

Care as an ethical attitude, however, does not fit in a theoretical formulation, typical of rational thought. It implies in a personal availability, in which each professional allows him/herself to be affected by a non-theoretical path of non-exemption: a path of the senses, of the affects and of opening up towards the other, that requires being open towards new dialogues and continuous reflection.

This posture, although it has revealed itself to still be incipient, can already be noted in the daily experience of the professionals interviewed. The latter have tried to assume the key role of authors and actresses of the task of weaving an intricate web of revision of the (mental) health practices within the services of the public network.

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