

IDEOLOGY AND MENTAL HEALTH: ANALYSIS OF THE DISCOURSE OF WORKERS IN THE PSYCHOSOCIAL AREA¹

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ABSTRACT: This study proposes to analyze the discourse of workers in a Psychosocial Care Center regarding the operation of the ideologies which express the dimension of social practices incorporated at this service. This was a qualitative research, and the *corpus* was originated by transcription of semi-structured interviews, applied to 17 out of the 25 workers of a substitute service in a city in southern Brazil. The theoretical-methodological analysis of the operation of ideologies by John Thompson was used. The discourse analysis of the workers' practice shows a plurality of ideological manifestations, so that they reserve the changing practices with innovative and creative features such as the maintenance of obsolete models, hindering or even preventing these changes. In conclusion, these issues should be worked continuously in everyday services, being a major challenge to the consolidation of the psychiatric reform in Brazil.

DESCRIPTORS: Mental health. Psychiatric nursing. Health care reform.

IDEOLOGIA E SAÚDE MENTAL: ANÁLISE DO DISCURSO DO TRABALHADOR NO CAMPO PSICOSSOCIAL

RESUMO: Este estudo reside na análise do discurso dos trabalhadores de um Centro de Atenção Psicossocial sobre os modos de operação da ideologia que manifestem a dimensão das práticas sociais constituídas no serviço. Pesquisa de natureza qualitativa, cujo *corpus* foi originado da transcrição de entrevistas semiestruturadas, aplicadas a 17 dos 25 trabalhadores de um serviço substitutivo de uma cidade da Região Sul do Brasil. Utilizamos o referencial teórico-metodológico da análise dos modos de operação da ideologia de John Thompson. A análise de discurso sobre a prática do trabalhador evidenciou uma pluralidade de manifestações ideológicas, que se reservam tanto à mudança das práticas, com características inovadoras e criativas, como à manutenção de modelos obsoletos, que dificultam ou até mesmo impedem essas mudanças. Concluímos que essas questões devem ser trabalhadas continuamente no dia a dia dos serviços, sendo um importante desafio para a consolidação da reforma psiquiátrica no Brasil.

DESCRIPTORIOS: Saúde mental. Enfermagem psiquiátrica. Reforma dos serviços de saúde.

IDEOLOGÍA Y SALUD MENTAL: ANÁLISIS DE DISCURSO DEL TRABAJADOR EN EL CAMPO PSICOSOCIAL

RESUMEN: Este estudio pretende analizar el discurso de trabajadores de un Centro de Atención Psicossocial sobre los modos de operación de la ideología que manifiestan la dimensión de las prácticas sociales en ese servicio. Investigación cualitativa, en la que el *corpus* fue originado de la transcripción de entrevistas semiestruturadas, aplicadas a 17 de los 25 trabajadores de un servicio sustitutivo de una ciudad de la Región Sur de Brasil. Utilizamos el referencial teórico-metodológico de análisis de los modos de operación de la ideología de John Thompson. Identificamos una pluralidad de manifestaciones ideológicas, preocupadas tanto con el cambio de las prácticas, de características innovadoras y creativas, como con la manutención de modelos obsoletos, que dificultan o perjudican los cambios. Concluimos que son cuestiones que deben de ser trabajadas continuamente en los servicios, siendo un importante desafío para la consolidación de la reforma psiquiátrica en Brasil.

DESCRIPTORIOS: Salud mental. Enfermería psiquiátrica. Reforma de la atención de salud.

INTRODUCTION

Psychiatric reform has enabled the construction of new discourses in the mental health area, giving new meaning to old attitudes of knowledge, rooted in traditional psychiatric models. Currently, the permanence of the Psychosocial Care Centers (CAPS, as per its acronym in Portuguese) are discussed as substitutes to asylum services, besides the strengthening of network actions, in connection with wisdom that could increase knowledge about madness and about the life of a mad person in society. Madness is discussed as being a limiting consequence of the individual, as well as a life experience that can make this same human being become renowned for his/her irreverence. Treatment and care are also discussed, with both of them being complementary and interdependent concepts and practices.

Psychiatric reform is indeed a movement, but also a process; a long path through which we transit and question ourselves. The transformations that accompany it could be felt in the context of public health because they reflect the changes in the thinking and feeling of society as a whole. In particular, these changes were built with the mental health professionals, who were also pressured to seek human rights as a target and the liberty of the mad and from the madness as the beginning, the middle and the end, as, for centuries, they had been left inside isolating and aseptic walls away from the eyes of the world. In this sense, the reform requires that this difference is seen as part of us, and, therefore, we should seek all possible strategies to promote health and citizenship in any and every social space.¹

In the Brazilian context, mental health policy, anchored in the assumptions of the psychiatric reform, has invested heavily in the creation of substitutes to the traditional care service model. From legal provisions, such as law no. 10.216/2001,² which redirects mental health care in the country, and GM/MS ordinance no. 336/2002,³ establishing CAPSs, the need to expand the network of services that can replace the shackles of traditional psychiatric treatment, centered in the asylum, is acknowledged.

Currently, there are already more than 1,600 CAPSs throughout the Brazilian territory,⁴ besides the various initiatives to strengthen the network of psychosocial care. Street Offices, Specialized Outpatient Units, Sheltered Homes, Holiday Homes, hospital referral services for alcohol and

drugs stand out, among others. As analyzed, these initiatives have been contributing to the rethinking of scenarios where the practice takes place, as well as the speeches coming from people who are part of the everyday life of these services.

Nevertheless, the rupture with traditional services does not necessarily prove the existence of new postures and attitudes faced with the individual in psychological distress. This is because the ideology that permeates the discourse of the worker may still be linked to exclusionary ideas of care in the psychiatric field. That is to say that services can be creative and innovative, producing transformations in the context of practice, but they may still be trapped in care technologies that underlie segregation, oppression and blaming others. Some studies have already pointed out this reality.⁵⁻⁷

In this sense, it is believed that the discourse on workers' practice shows a plurality in ideology operation modes, which are reserved for processing both knowledge and practices, such as the materialization of crystallized attitudes that hinder or even prevent these transformations. Therefore, the aim of this study is to analyze the discourse of employees from a CAPS on the ideology operation modes which express the dimension of social practices incorporated in the service.

THEORETICAL-METHODOLOGICAL FRAMEWORK

This study adopted the Critical Discourse Analysis (CDA) as theoretical-philosophical framework.⁸ The methodological framework of interpretation for ideology operation modes was also used along with the CDA.⁹ According to the framework, ideologies can be understood as symbolic phenomena that serve specific social situations and establish or sustain relationships of domination - establish in the sense of creating, instituting those relationships, and support in the sense of keeping or reproducing them.⁹

The interest in studies on ideology and their impact on life events are not (only) located in the need to constitute a system of beliefs or thoughts. In contrast, the fundamental interest in ideological analysis is focused on whether, to what extent and how (if applicable) these symbolic forms serve to establish or sustain relationships of domination. It is also related to the defamiliarization of the ways in the transmission, reception and production of these relationships in the social

context, which materialize both in linguistic and extra-linguistic processes.⁹

In mental health, the ideological discourse analysis allows approaching the reality of contemporary mental health care with the production of new discourses, opinions about freedom, citizenship and the autonomy of individuals in psychological distress. It also enables the understanding of how these discourses produce changes or reinforce crystallized postures, typical of traditional models. Hence, the analysis of the ideological content enables us to understand how the clashes, conflicts and contradictions, that make the psychiatric reform in the daily practice of the worker, move around.

In this sense, the ideological analysis of discursive events is developed from five key categories: legitimation, dissimulation, unification, fragmentation and reification.⁹ This study approached the “unification” ideology operation mode.

Unification concerns the use of expressions that unite individuals or social groups that, *a priori*, form a collective identity, regardless of the differences or divisions that may separate them. The strategies used as unifiers are the standardization and symbolization of units. At first, the symbolic forms are adapted to a standard benchmark to establish collective language, but originated from a particular discourse. As regards symbolization, it concerns the construction of symbols or identity forming units that are broadcast by a particular group or by a plurality of groups.

An initial reading of the responses attributed to the professionals by key question was performed (“Talk about your mental health practice in this CAPS”), for an initial sensitization. It was possible, at this stage, to verify the different implicit and explicit viewpoints in the discursive material, to, *a posteriori*, produce the themes that guided the analysis.

The empirical material was organized from its distribution in two columns. The first one provided the complete interview, with the identification of important notes brought by the employee, whereas the second column showed a pre-analysis of the empirical data, with inferences (still elementary) on the discursive structure of the interviewee.

Secondly, after a thorough reading of all interviews, a systematic grouping was proposed, in which it was possible to establish the first relations of comparison between elements of the discourse and its contradictions. The aim was to realize the power of synthesis of the empirical material, to

the extent that it discoursed on their similarities in terms of meaning and content. At this time, the construction of the first themes came about, which were again submitted to a review.

From the reanalysis of the data, it was possible to verify the consonances and dissonances of the discursive context. For instance, when workers mention uncertainty about the mental health practice in the new services, there are several variables involved (work process, organization of the staff and service, among others). Although complementary, these variables were part of the ideological content of the worker’s discourse.

At the moment when this level of detail emerged, always respecting the complexity of the *corpus* and avoiding incurring reductionism, the information was gathered and the approximation stage was initiated with the ideology operation modes.⁹ Within the “unification” operation mode, the following themes emerged: “the process of mental health work: team organization to meet the demands of the subject in psychological distress.”

As regards the operational aspects, it was a qualitative research, with dialectical orientation. The *corpus* was originated from the transcription of the semi-structured interviews, which were applied to 17 of the 25 workers from a CAPS, in a city in southern Brazil.

The interviews were conducted in the service facilities, at a time previously scheduled and agreed with the professional. The mean duration was 30 minutes and they were recorded as expressly authorized in the Free and Informed Consent Form.

The studied mental health system was established in 1993 and accredited as CAPS II in 2001. It is a reference service in the central region of the city, and it operates from 8:00a.m. to 6:00p.m.

Professionals working in CAPS have diverse educational backgrounds and are part of a multidisciplinary team. It is a group of different higher-level and mid-level technicians. There, the following higher-level professionals make up the team: one nurse, two psychiatrists, three psychologists (one being the service coordinator), two social workers, two occupational therapists and a pharmacist. The mid-level professionals are: four auxiliary/technical nurses, two public health agents, one administrative assistant, two servers, two guards and a driver.

Inclusion criteria for the participation of employees were: 1) having an employment bond to the

service studied, for more than six months; and 2) being in effective exercise during the period of data collection, without any days off, leaves or vacation.

The project was previously submitted for review by the Research Ethics Committee at the Faculty of Medicine of the Federal University of Pelotas (UFPEl), obtaining a favorable opinion as per n. 074/2005. The anonymity of the study subjects was guaranteed and all ethical and legal requirements regarding research with human beings were respected, as recommended by the Ministry of Health, on resolution no. 196/96 of the National Health Council¹⁰ and the Code of Ethics for Nursing Professionals. Each subject was identified with the letter "T", followed by the corresponding number from the order in the interview.

RESULTS AND DISCUSSION

The process of mental health work: team organization to meet the demands of the subject in psychological distress.

One of the most significant changes, with the advent of psychiatric reform, is the organization of teamwork in the new mental health services. If order was responsible for supporting work in the mental hospital, i.e., the regulation of the activities according to medical authority, which disciplined bodies and subjects, in contemporary services the logic is reversed. In these institutions, one sees the rebirth of dialog and the inclusion of different disciplines as driving forces for care in the area. The view of madness as a social and multi-factor phenomenon does not allow to assign one profession with all of the load and dominion over the demands of others. It is necessary to share, exchange, dialog, and understand that suffering has multiple views and directions.¹¹

As regards the characteristics and the work organization mode, professionals bring notes to discuss the dynamics of the mental health work process. Among the aspects that stand out, there is the dimension of the management of the mental health work process. One of the first characteristics of the management of the work process is in the very constitution of the teams. Workers claim that the composition is based on multidisciplinary, with emphasis on interdisciplinary articulation.

Okay, well then, our organization is always working as a team, so it is interdisciplinary, right? Our workshops and groups always aim to get at least two professionals from different areas (T.2).

It is not a service that when you enter they will tell you: 'oh, your role is this, this and that.' It's not like that, especially in nursing, where we practically do almost nothing to do with nursing, except for medication, right? The rest is all a joint thing with the psychologist, with the psychiatrist, with the social worker. You end up working with everyone and learning a little bit of everything (T.7).

Everyone needs to be involved in everything, right? Of course, each one has their role, and their training, contribution is important, but we seek to contribute to everything (T.11).

Interdisciplinary appears and crosses an ocean of scientific rationales put to the test, at the time when everyday life is redrawn from a need to understand the complex. It is known that the "new" annoys, but if this "new" cannot be questioned, it is because it is not "new". It is important to remember that interdisciplinarity shifts the center towards the borders (that which can be done together, built together and thought together). From this perspective, what is sought is to interact and to converge the different points of view in a concerted approach, i.e., medical, philosophical, anthropological, psychological, among others, to understand the human facts and phenomena.¹²

In health work, interdisciplinarity emerges as a way to organize the team and understand situations or health problems through the integration and articulation of other knowledge and practices. Opposed to the Cartesian tradition, which fragments knowledge, the interdisciplinary approach levels exchanges and relationships, without disregarding the powers or duties of each professional. This is not an overlap of knowledge, but a recognition of the limits of each field of knowledge, in favor of a collective feat.¹³

In the discourse, professionals understand that their organization permeates a way to operate focused on the multi- and interdisciplinary dimension of mental health work. These professionals have technical specifics, but also unite together to produce care based on assumptions of interaction and collective leadership. T7, for example, states that transiting by a practice, in partnership with other workers from different areas, allows the professional to expand the menu of knowledge, enabling one to know and learn how to cope better with the demands, which are often complex and mutant, coming from the service.

In this sense, the ideology expressed in speeches not only reveals the intention of the team in being fully responsible for the activities of

the service and the demands of the user, but also the feeling of a whole group that sees its practice in mental health in a more innovative, shared, dialogical and less Cartesian way. These assumptions are more compatible with a broader way of understanding madness and with less fragmentary postures, typical of previous models. Thus, mental health practice is closer to the prerogatives of the psychiatric reform movement.

Therefore, it is possible to develop a new care proposal, i.e., a new way of understanding and expanding the horizon of the clinic (the one focused on the patient and practiced in the services). In the context of transforming health practices, this "clinical feat" would result in going beyond the actual needs or possibilities. It involves adopting postures of ethical commitment and respect for the value of life in the context of these practices; striving to build ways and means that are not static, as they are always changing, so they can produce shared knowledge to ensure people's autonomy and strengthen their bond with the health services they seek.¹⁴

Referring to team activities, organized in an interdisciplinary way, one of them deals with the figure of the reference technician in the CAPS context. This technician plays a key role in the construction of the patient's treatment plan, organizing care service strategies and welcoming questions.

So, it's like this, I took a specialization course in psychosocial care in Florianópolis and that's what brought me here, which was very positive and added something. From then on I began to understand what a reference technician was, why CAPS operates like that, because we have to have that different look with the patient, right? You no longer look at them like ill people, you look at the healthy aspects, which they do have, right? (T.9).

One thing that also sticks, which I stopped and thought about a lot, is this role of the reference technician... how can I say it, this flexibility you need to have to do negotiations, to be able to do the mediations, to negotiate with the family, to go out there in the community, to carry out the inter-sectoral approach, to discuss with the staff (T.10).

The reference technician is especially important because he/she provides more precise contours and efforts in the meeting of the worker with the mental health patient. This professional has the duty to conduct a case, be it an individual or a family. Their work is also a device for organizing practice that is closely linked to substitutive

mental health services, focused on rescuing the dialogical potential. The reference technician is the professional who aims to ensure a welcoming space for them, contemplating the ability to "make them see and talk" as paramount to exploit the potential of the user, enhancing their expression and giving them social visibility.¹⁵⁻¹⁶

In the speeches above, a consensus was observed between the role of the reference technician in the functionality of the service. Responsible for the patient, he/she must organize and articulate the different devices that are part of their life (family, network of services, other professionals, social facilities, etc.), so as to take account of their care needs. Even though he/she is the reference, these professionals should contribute to create networks for open and sensitive dialog with all of the social players. That is to say that the reference technician takes on the challenge of enhancing bonds and singling out exchanges in a continued effort to demonstrate that mental health care comprises an ethical, social and health commitment of the team to the subject and in the territory.

If on one hand the reference technician can reposition roles and build new approaches guided at the psychosocial paradigm, there are challenges to overcome regarding the operationalization of this important tool in the work process. The difficulties inherent to the construction process of the reference technician does not relate only to the innermost aspects of the service, but they are also reflections of how the mental health system is organized in the city. The following reports demonstrate this concern:

[...] the reference technician works with one person, then it changes, then he/she goes to another one, so it is difficult, right? Not to mention that the team also suffers, right? Because there comes a person who already has a contract with another for a year, then he/she starts to adapt to the CAPS proposal, then suddenly he/she goes away (T.8).

[...] then, suddenly, that's what starts to happen, right? Faced with the public service, right? Recession of contracts, staff turnover, right? Of the key players, right? (T.3).

[...] there was a nurse who came in, but asked to leave, she did not even last three months, so the patients who took her as a reference technician barely had time to get to know her and they were passed on to another. Therefore, in my view, I think it harms the patient, you know, and this... this change of professionals that takes place, ends up creating disorganization between us, and the patient feels it (T.15).

The testimonies of the team demonstrate that the turnover of professionals could jeopardize the sustainability of the organization of the practices as a whole, which are based preferably on the formation of links between patients and workers. The speeches of T.8 and T.15, for example, evidence that this can change the dynamics of care and harm the bonds this patient has with the team and the CAPS.

The studied city uses a policy focused on opening up the selection process for hiring temporary professionals that immediately overcome the lack of professionals in specific areas of health. Nevertheless, each contract is valid for a maximum period of one year, with the professional being dismissed right after the expiration of the employment contract. Accordingly, if the turnover is already felt by the team as a major problem, as it is obliged to live year by year with different professionals, it also provides a break with the continuity in care, generating precarious ties between workers and patients.

In one study, it was observed that the high turnover of professionals in mental health has been a hot issue in different countries. In Brazil, it is related to high rates of sick leaves, as well as precarious employment bonds, supported by questionable legal subsidies. Moreover, this high turnover also happens due to significant levels of unemployment, underemployment, duplicate hours of work and scarce social protection of workers. These are factors that end up discouraging prospects of improvement, regardless of conditions of satisfaction or work-related stress. This is a challenge for public health policies that need to establish more accurate indicators in the systematic review of mental health services, to obtain data that allows redirecting care based on these conditions.¹⁷

It is understood that this turnover might even be beneficial in terms of controlling public expenditures and avoiding lawsuits provided by labor legislation. Our understanding, however, is that the bond formed between workers and patients must be superior to administrative matters involving the hiring of personnel, as this bond is part of a whole complex chain of the labor process in health (its beginning, middle and end).

A new policy concept is emerging, i.e., as a product that is not abstracted from the collectivity of citizens and that would make the state become truly democratic. A collectivity that "should be understood as a product of the development of

will and collective thoughts, and not as a result of a fatal process strange to singular individuals".^{18:232} There would be, in the mental health field, the construction of new ideologies, when particular interests were overcome, penetrating in the social core, not to establish unilateral relationships, but to build new ways and means to improve and enhance the care and lives of people.

In this sense, it is necessary to rethink the dimension of the caregiver in mental health as *a priori*, impaired, nevertheless, faced with the high professional turnover. If services are scrambling to invest in strategies to strengthen the ties between workers and patients, such as the constitution of the reference technician, it is also necessary for the local management to start rethinking local policy, differentiating it from a purely technical view of health and the need to contain costs. This would give greater security and satisfaction to the professional, thus generating stronger and more lasting bonds between employees and the people they care for.

Another issue that arose during the interviews and that is related to difficulties in the psychosocial field involves the insecurity in mental health practice. The following statements point out these issues.

I think the nursing staff is not prepared to be reference technicians. Due to fear, uncertainty, looking at the social aspect from the caregiving perspective, for fear of their own culture, I think this has been discussed at all CAPSs (T.4).

[...] and not always, we do not have that preparation... then you feel insecure if you did it right or not (T.12).

Wednesday I had to stay off, due to private problems. I heard some people saying things... as if I could not be absent, but... I feel it today, I believe it, there are some professionals who have a certain insecurity (T.9).

Insecurity with mental health practice is already being discussed in different studies.¹⁹⁻²¹ These studies show that, although workers had a feeling of "change" in their practice, with the use of new technologies, the working process in mental health is still being consumed by inaccuracies in everyday life. For these workers, it often becomes more convenient to focus on what they dominate, i.e., what they have learned to do, than to transit through irregularity, which requires sequential adaptations.

In the statements above, for example, insecurity arises as an element that blocks the creativity of

professionals. In the case of T.9, the team's discomfort with his/her absence due to private problems became clear, because it required some reorganization of the work process. In the speeches of T.4 and T.12, however, the need to prepare the professional to work with mental health issues is evident, as if, in this field, there were precise answers to questions that are almost always much more complex.

For workers in mental health services, who already incorporate the singular dimension of the subject in their practice (focused on their expectations and quality of life), it is easy to develop strategies that invest in coexistence, autonomy and a therapeutic project focused on the experiences of these people. Even those with still very traditional training, there is already a consensus in the intention of expanding the practice, but this requires the adoption of increasingly complex instruments in care. In this sense, this intention does not mean that it is actually accompanied by a conceptual change in the mental health model itself, as that is which builds and sustains the entire web of services, players and relationships.²²

Part of these explanations is supported by the argument that there is a trend in the health field to repeat certain standards or benchmarks that have been learned previously, that give a margin of safety for the practice of the worker. Clearly there is a need to re-situate the clinical in the context of knowledge and within the services, as contemporary mental health concerns a set of policies and ethically oriented actions that seek to respect the uniqueness of an entire group, with the marks of "madness". Following crystallized patterns mediated by institutional routines would strengthen the risk of bureaucratization and alienation of the object and purpose of the work, especially in workers in mental health than compared to others in the health field in general. It is possible to realize the simple reason that living with madness and its consequences is not an easy event to handle, the reason why any society creates its defense mechanism, precisely what it is currently expected to overcome.²¹

Knowledge in symbolic forms and how they manifest themselves through ideologies or not, says much about the functioning of society. Demonstrating the connection between the possible relations of domination opens up the possibility that participants in the "field-object" can appropriate this interpretation, seeking to overcome the possible asymmetries between them.⁹ In mental health, ideologies that permeate the support of the

traditional care relationships - giving security to workers and organizing the services that are not always under the patient-centered logic - can be overcome with the birth of "doing it differently", as in the case of the constitution of the reference technician. Despite the insecurity, it involves a strategy, the result of promising and ongoing dialog between workers, patients and managers.

In this sense, it is believed that mental health care is a process materialized by the active presence of social players, as well as consolidated in the process of satisfaction, fulfillment and the use of distinct technological and therapeutic resources for the care of people. In this care, the production of techniques and procedures is inherent, but should not be totalizing for the work process in the area. This is because, although it can give a sense of institutional security, mental health care is the result of an interactive game between people and services. This can not be standardized or framed, like the mold of traditional services; work that is complete and incomplete at the same time, in a dialectical movement that produces the story through different interests, needs, realities and processes of negotiation.

As observed, the staff lives with technological innovations and is constantly pressured to produce new knowledge, new seams, new care ideologies and new interdisciplinary arrangements, to account for the complexity of the manifestations of madness. There is, within the speeches, the feeling of belonging to a group and valuing care as a fundamental dimension of the exchanges. While expanding the caregiving potential of the service, implementing new strategies, workers are also faced with insecurity in changing the practice, blocking the power of everyday creativity and innovation. In our view, this fact should be worked on in the daily life of the services, so as to build new scenarios and challenges to reform.

FINAL CONSIDERATIONS

This study approached concerns that mark the current psychiatric reform movement in the Brazilian context. It was possible to note some of the innovations brought by the practice, such as the inclusion of the reference technician in the service, as well as interdisciplinarity as a principle organizer of knowledge and practices in the field of mental health.

Nevertheless, while the changes are activated in daily life, they also come accompanied

by conflicts and clashes. In a more structural context, which would position policy, the great staff turnover stands out, mainly caused by poor employment relationships of workers. According to them, this is an issue that undermines both the operationalization of the new care strategies (reference technician), as regards the relationship between workers and patients.

Insecurity with the practice was also observed as another challenge for the team. Some professionals feel that their practice is imprecise, making the path between right and wrong difficult. Nevertheless, it is worth remembering that something new is liable to both resistance and doubts, being up to the team to establish permanent dialog to resolve conflicts and build a shared practice in mental health.

As regards the theoretical-methodological approach, the identification of ideology operation modes proved to be appropriate to reveal the contradictions, the potentials and the challenges inherent in the discursive construction of the workers. It is known that the reform has brought great advances to the Brazilian context. In this sense, the discourse analysis of its protagonists reveals how these changes are, or not, incorporated to mental health services, revitalizing the construction of other agendas and new debates in the field.

The results of this study are expected to reveal how the dialectical relationship between workers and their work takes place in the social context of the psychiatric reform. The analysis of their discourses not only corresponds to what they experience in everyday services, but represent the building of new ideologies to re-signify old practices in the psychosocial field, in order to rethink the role of Brazilian society, with the differences and those who are different.

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