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# Health care practice in psychosocial institutions: effects of the capitalist mode of production

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**Abstract:** The mode of production of material goods is correlated to the mode of production of health and indicates the possible forms of subjectivation in a society, thus, the mode of production is related to the ways in which the social and psychic impasses materialize. Conflicts of the class struggle produce contradictions, so it is crucial to note that the symptoms that trigger the crises come to enounce an objection to the social context in which they emerged. Based on institutional analysis, we find that mental health institutions in the context of the capitalist mode of production have served to manage these crises in order to dissuade them. It is observed that despite the advances of Brazilian psychiatric reform, psychosocial establishments still serve social adaptation, producing alienated subjectivities and reproducing historical forms of domination-subordination, such as psychiatric hospitalization and medicalization of life and suffering.

**Keywords:** capitalist mode of production, psychiatric reform, psychosocial care.

## Introduction

In the scope of Collective Mental Health (CMH), there are several social representations and ways to understand psychological distress and the process of health production. According to Costa-Rosa (2000, 2013), from these social representations derive different modalities of mental health establishments, among them being the Psychosocial Care Center, Therapeutic Residences, etc.; and various "means" of work, devices that branch out into a multiplicity of therapies. The combinations between institutional establishments and means of work are numerous and constitute different ways of producing health.

At an institutional establishment there is always, explicitly or not, a theoretical-technical and ethical-political reference that directs the treatment practices, which we call a paradigm. "We have learned yet another conception of paradigm from the fields of Health and Collective Mental Health: articulated sets of values and interests that stratify themselves, create devices (light and heavy) and can arrive at polarization" (Costa-Rosa, 2013, p. 76).

Key elements of a paradigm are the conception about the referent of action (object) of the mental health practices and the means of handling it, which is decisive for the consistencies of produced subjectivities, or rather "subjectivityhealth", since we understand that health and subjectivity are necessarily inseparable.

Different ways of conceiving psychic impasses and, consequently, treating them, imply different productive results, which must be analyzed according to their ethico-political status (Costa Rosa, 2013), i.e., according to the type of subjectivityhealth produced, whether it be alienated or individualized.

According to Costa-Rosa (2013), in the field of psychosocial care, the Hospitalocentric Drug-Based Psychiatric Paradigm (HDPP) and its antipode, the Psychosocial Paradigm (PSP) operate. In the HDPP, the object of action in mental health is illness-cure, the working tools are discipline and medicalization, and thus, the mode of "subjectivityhealth" produced is similar to "subjugation" and to subjective and sociocultural alienation.

On the other hand, in the PSP, the referent of action in mental health is the subject, considered in his/her subjective dimension, which refers to the unique way in which he/she experiences psychological suffering, in his/her social dimension, which concerns the collective responses to the health-illness-care process. In this perspective, the conception of subject as well as health is dialectical and does not fall into the movement of producing HDPP objects.

The psychiatric reform (Fleming, 1976) inaugurated a series of questions regarding the practices of the HDPP, above all, it brought to the fore an expanded knowledge about psychic suffering, criticizing hospitalization and medicalization, and inspiring the creation of psychosocial establishments within communities.

However, despite these advancements, as described by Amarante (1995), i.e., the theoretical-conceptual, technical-assistance, juridical-political and cultural transformations, it is possible to say that, in fact, after three decades of struggle, and even with the implementation of psychosocial institutions, the HDPP maintains its hegemony in the field of mental health.

The way to produce health is correlated to the mode of production of the various material goods

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and indicates possible forms of existence, social relationship and subjectification in a society, therefore, they are directly related to the ways in which social issues materialize and are experienced at the level of psychological suffering and even physical disorders (Shimoguiri, 2016, Costa-Rosa, 2013). The HDPP is in tune with the capitalist mode of production (CMP), and as for its practices, we see that:

> in the case of the HDPP, the result of production is the indirect realization of surplus value – i.e., the surplus value of other productive sectors; primarily, that of the chemical-pharmaceutical industry – and alienated subjectivityhealth (production in the form of reproduction of dominant social relations); or, in the case of the PSP, the production of new forms of social and intersubjective relations, which is the production of individualized subjectivityhealth. (Shimoguiri & Périco, 2014, p. 43)

Until the rise of capitalism, human labor did not have the reductionist objective of producing commodities, since it was considered to be a device of subjectification, of hominization/humanization (Marx, 1844/2004) in which the act of doing existed – man built himself through working. Through his craft, the individual was constituted as a generic being, i.e., work was not only for subsistence, but, fundamentally, it had social implications.

Production did not follow the ethics of "in the service of goods" (Lacan, 1988, quoted by Costa-Rosa, 2013); Costa-Rosa emphasizes that: "The pre-capitalist modes preserve the immanence of labor and other means of production and the direct relationship of these with the creation of subjectivity are conceived as transforming oneself into an absolute movement to become" (2003, p. 31).

In general terms, we highlight some of the consequences of the CMP: the worker no longer owns the means of labor nor his production; with industrialization and technicalization, there was a brutal separation between knowing and doing; there arose the figure of the non-worker, the one who holds the necessary capital to buy the labor of another, and, finally, the invention of surplus value. As a result of these changes, on the level of subjectivity, we have estrangement and alienation, the objectification of doing as loss and the appropriation as estrangement and alienation.

> Still in regards to estrangement and alienation in the CMP, we find that man is lowered to the condition of object, being himself a worker-commodity. In other words, from lord/owner he became a servant, where he cannot choose to survive without having to sell himself. This human misery has an inverse relationship to productive and creative power. It is observed that goods lead people to the market, not the other way around: more than a speech without words, Marx enunciates a discourse without subjects. This objectification of man compromises the process of hominization/humanization resulting from the human doing, so human genericity ceases to be a priority. (Shimoguiri, 2016, p. 32)

In capitalism, labor ceased to have use value in order to become a value of exchange. Moreover, because of this commodification, the aim became to achieve the greatest volume of production possible, at any price. "Labor is *external* to the worker, i.e., it does not belong to his intrinsic nature; in his work, therefore, he does not affirm himself but rather denies himself, he does not feel content but unhappy" (Marx, 1844/2004, p. 83). There is a social bond fed by the circuits of productivity and consumption – a bond of economic and subjective expropriation.

It is no coincidence that, at the height of neoliberalism, so many people suffer from "compulsive disorders", and there are still subjects who, in their subjective style, object to the market economy, for example, living as homeless people and excluded from the labor market; these are subjects that broke with the productivity imperative.

The are many subjects in psychic suffering, who do not fit in the financial capitalism, and therefore are useless to it and not desirable in the "society of labor" (Arendt, 1995), especially because they denounce their failures and point out the ineffectiveness of public policies in regards to contemplate the subordinate social pole and the exclusionary way in which those who cannot produce and consume at a large scale are treated.

The capitalist mode of production despises those who, because of a certain psychological, organic and/or social conjuncture, cannot adjust themselves to its logic, but at the same time, it is impossible to ignore them completely, thus, health and social assistance policies have historically been in charge of this population, with the usually non-enunciated objective of inserting them in the labor market.

According to Shimoguiri (2016), most of the theoretical-technical references of the Brazilian Psychiatric Reform (BPR) highlight social and labor market integration as important health indicators, bringing the idea of health closely connected to the capacity to develop functions that are (economically) productive, and hence, linked to capitalism.

> From this perspective, (re)producing health, or in other words, promoting rehabilitation, is the same as seeking functionality and adaptation, (re)framing individuals into the logic of capitalism: production and consumption. It's ignored the man's perspective above the objectification, and as a result we have the massification of subjectivities, since human existence boils down to being just one more producer/ consumer/ commodity. (Shimoguiri, 2016, p. 46)

However, the definitions of what health is can be problematized, and even modified, depending on the paradigm in question, on what is sought as a therapeutic and ethical effect. Thus, in this study we are interested in reflecting on the function of psychosocial care institutions in regards to the production of subjectivityhealth and in discussing the effects of an ontological and functionalist perspective of the human condition molded in the capitalist mode of production.

## The function of health institutions in the management of social demand

All economic and social formation encompasses divergent interests, so that conflicts between the dominant pole and the subordinate pole make up a set of opposing forces that produce crossings and impasses, which is commonly translated into psychological suffering.

In this way, social demand is related to the pulsations resulting from the conflicts of the class struggle that occur in the territory (Costa-Rosa, 2013), understanding it as being beyond the physical and geographical space, but further, into a space crossed by economic, political, sociocultural, ideological, and subjective factors. For the agency of the class struggle, each institution cuts out its referent of action from the social demand.

Society is like a network of institutions that "interpenetrate and articulate with each other to regulate the production and reproduction of human life" (Baremblitt, 1992, p. 27). An institutional establishment is defined by its function (offer of medical, psychological care, education, etc.), its scope of action (health, education, social assistance, etc.), and also by its productive purpose.

It is crucial to consider that the psychological symptoms that trigger crises and ruptures come to state an objection to the context in which they emerged and to which they are direct consequences: "Suffering always expresses, in good measure, what fails to reach the direction of instituting pulsations" (Costa-Rosa, 2013, p. 108).

In fact, given the indissociability between subjective constitution and social reality, collective health work goes beyond the psyche of individuals. It is necessary to consider the subjective, economic, social, cultural and political factors that led the subjects experiencing symptoms and suffering to seek treatment (Costa-Rosa, 2013).

Before being translated into requests for treatment, the social demand goes through imaginary and ideological mediation to come to express itself in orders (Lourau, 1975), which are usually requests for help, and which is how they reaches institutional establishments. The process of transforming demand into order depends on the impasses of subjectivation with which it deals and on how the establishment to which the orders are directed positions itself in the territory is directed.

Considering that demand generates supply and supply also generates demand (Costa-Rosa, 2013), if the mode of production of the establishment is in tune with the capitalist mode of production, the orders will appear as requests for resolution to be obtained by pharmaceuticals, hospitalizations, among others. They will be requests for healing, quick solutions and supplies.

Starting from the hypothesis that the social and psychological impasses that trigger ruptures and crises bring with them a questioning, an objection to the familiary and social dominant instituted (Costa-Rosa, 2013), it is necessary to stress that institutional establishments fulfill a specific function of (re)producing historical forms of domination-subordination that ensure the relations of power that are exercised by the dominant social class over the subordinate class (Baremblitt, 1992).

At an institution there are two important movements: the instituted and the instituting. The instituted corresponds to the hegemonic social relationships and the instituting is the set of forces capable of leading to social transformations. These movements are encompassed in the strategic process of hegemony (Gramsci, cited by Costa-Rosa, 1987).

The strategic process of hegemony is the mechanism in which one seeks to ensure the maintenance of the current social formation, to maintain inherently divergent dominant and subordinate interests in a state of equilibrium. Due to the ideological and material preponderance of the dominant social pole, it generally maintains its interests to the detriment of the interests of the subordinate pole (Costa-Rosa, 2013).

> Thus, it is evident that the instituted play an important historical role, because the created laws, the constituted norms or the habits, standards, are in force to regulate the social activities. Therefore, it is important to know that social life – understood as the process in permanent transformation that must drive towards perfection and aim at greater happiness, greater achievement, greater health and greater creativity of all members – is only possible when . . . the relationship and dialectic between the instituting and the instituted, between the organizer and the organized (process of institutionalization-organization) remain permanently permeable, fluid, elastic. (Baremblitt, 1992, pp. 30-31)

No institution operates alone, there is interpenetration and interlinking that exists between all organizations, establishments, agents, among others (Baremblitt, 1992). There are countless tools to (re)produce adaptation, correction and normalization, or, in other words, to maintain the instituted social dominant.

Based on this analytical level, we infer that health and care establishments are created to metabolize and obliterate the tensions that arise from the instituting pulsations, which were unsuccessful and exist by virtue of social requests for attenuation of the suffering, of reintegration of the individual in production, family and society.

Health care institutional establishments operate as State Ideological Apparatus (SIA) (Althusser, 1983), as they exist to manage human miseries and buffer the organic, psychological and social problems that arise as (d)effects of the Capitalist Mode of Production and its corollary, the HDPP.

It is clear that the aim of the State is to rehabilitate those who suffer, to reintegrate them socially to make them return to society, especially as workers, namely labor for capitalism. The ideological discourse of psychosocial rehabilitation veils the social tensions of the class struggle.

> its function as an Ideological State Apparatus (IEA) is also achieved through the smoothing of social conflicts through medicalization, by distributing diagnoses and medicines under a specific mode of social and intersubjective relationship, the Medical Discourse . . . corresponds to the displacement of these conflicts, originating from production, attempting to undo them in the sphere of consumption. (Costa-Rosa, 2013, pp. 138-139)

In order to broaden its political-economic powers and at the same time maintain divergent interests in homeostasis, the capitalist mode of production overlaps some claims outside its ideology, for example, those made by Brazilian psychiatric reform. But we cannot be naive, they are easily recovered tactical concessions, insofar as their existence is only meant to water down tensions and undermine the instituting movements, without ever firing criticisms that are radically contrary to the HDPP.

It is explained why in public policy making, psychic suffering, poverty and misery are classified as causes of "situations of vulnerability and personal and social risk" (Brasil, 2005, 2009a, 2009b), not as consequences of a sickening, wild economic system such as capitalism is. Under this bias, we can understand the reasons why, in the Capitalist Mode of Production, it is possible and desired to harmoniously combine health and alienation, as if one were not exclusive to the other.

## Considerations about the overall picture of the Brazilian Psychiatric Reform and psychosocial care

Starting from the movements of psychiatric reform, practices in mental health were amplified, seeking forms of resistance to the Cartesian principle of "disease-cure", proposing the aggregation of social factors as constituents of suffering. According to the guidelines of the Brazilian Ministry of Health (Brasil, 2002a, 2002b), the treatment proposals from the BPR should be substitutive rather than complementary to the psychiatric hospital.

Psychosocial care has emerged as a public policy of mental health care. The Psychosocial Care Network (PSCN) was established through Decree # 3.088 (Brasil, 2011), due to the need for the Unified Health System (SUS) to offer an integrated, effective and articulated service network, in order to serve people in psychological distress.

The PSCN aims to guarantee the population's access to psychosocial care, and especially, it assumes the construction of spaces for socializing and sustaining differences in the community. In order to achieve this, it was necessary to expand traditional clinical practice so that there could be various types and levels of health care.

The PSCN comprises Basic Health Units (UBS); Community Centers (CC); Psychosocial Care Centers (PCC); emergency and emergency services; 24-hour Emergency Care Unit (ECU); specialized wards in General Hospital; Therapeutic Residences (TR), among others. The psychosocial devices, due to their non-hospital character and refusal of the biomedical and symptomatological model (Brazil, 2011), must ensure that Collective Mental Health demand management moves in the opposite direction to asylum institutionalization (Amarante, 1995).

For our discussion of the overall picture of the BPR, regarding the practices in psychosocial establishments and the type of subjectivityhealth that they produced, we will analyze data from the 2008 psychosocial census in the state of São Paulo (Barros & Bichaff, 2008) and, later, the 2014 census (Cayres, Ribeiro, Elias & Coutinho, 2015), we will also use our work experiences in Psychosocial Care Centers in the western region of the state of São Paulo.

As a first characteristic of the mental health care network, contrary to the objectives of PSCN, we were able to find a high number of psychiatric hospitals and a great demand/offer for treatment on an inpatient basis. In addition to the regional hospital, which had beds and psychiatric emergency rooms, there were four more fully functioning psychiatric hospitals in the region.

At the time of the first census, the data indicated that around 7% of the psychiatric hospitals in the entire state were concentrated in the western part of São Paulo where the population of hospital dwellers totaled 253 persons (Barros & Bichaff, 2008). In 2014, it was estimated that this group was approximately 202 people (Cayres et al., 2015). Based on this very small reduction, we presuppose the ineffectiveness of (dis)hospitalization and deinstitutionalization strategies, since the reduction in the number of dwellers was mainly due to deaths.

It was noticed that the activity and number of psychiatric hospitals, instead of having decreased, following the paths of the BPR, increased, with the 2010 inauguration of the pole of intensive care in mental health. This is the only service of this type (clinic for hospitalization) in the countryside of São Paulo and the third in the state; its implementation occurred by means of the implausible justification that there were not enough beds in the psychiatric hospitals.

The 2014 psychosocial census of the state of São Paulo in the region was coordinated by one of the authors of this article, in which it could be seen that even the priorities of the BPR have shown to be practically

unattainable. During the six years between the two censuses, no mental hospital inpatient was discharged following improvement, and other subjects who arrived for a brief hospitalization period became permanent residents.

We emphasize that, not infrequently, the PCC were mentors of referrals for hospitalization, hospital teams complained that the PCC asked for beds, but did not accompany the subjects during hospitalization, so the discharges were not viable because there were no proposals for treatment in the community, nor were there individuals to pick up the subjects from the hospital. In this way, given the long period of stay at the facility, they became residents, with no hope for (social) reintegration.

Shimoguiri and Périco (2014) presented an important statistic about the number of hospitalizations directed by a CAPS from that region. In 2011, there were 86 hospitalizations in psychiatric hospitals and religious therapeutic communities. This statistic corroborates the conclusion that the mode of production of subjectivityhealth is strongly marked by the use of discipline (Foucault, 1972/1997) and control (Deleuze, 1990/1992) technologies.

As characteristics of the HDPP, there are vigilance, moral treatment, punishment, custody and interdiction. The subject is seen as ill and the center of the problem; there is little or no consideration of his existence as a desiring subjectivity, psychological and even social impasses are considered "diseases" for which cure must be sought within the symptomatological and hygienist biomedical logic.

In this regard, it should be emphasized that the permanent resident status of most of the patients in psychiatric hospitals was not necessarily justified by situations of crises resulting from intense psychological suffering. On the contrary, from this standpoint, all of them were eligible for treatment in the community, at most, it would be necessary to build some therapeutic places to meet the more complex demands.

Social and family conditions were still crucial determinants to keeping these patients at the asylum. Approaching the apex of the contradiction, if we think about the fundamental differences between mental and physical health, hospitalization and its long duration are justified by the subjects' dependence for their daily life activities and special needs arising from strictly organic and/or neurological disorders, for example, Down syndrome, physical disability, visual impairment, among others.

Often we witness hospitalizations induced in the name of social hygiene, especially when it comes to street people using crack and other drugs. The somewhat Manichean solution was their exclusion from public spaces, regardless of their wishes, the causes of inequalities, and the socioeconomic problems closely associated with their modes of subjectification, or at least the achievements of the BPR and its efforts for deinstitutionalization.

Often, admissions of people using alcohol and other drugs give the implicit notion that this is a crime-prone population. So demands for social assistance and health care are conducted as public safety cases, and from this policing and exclusionary perspective, policies that induce repressive actions and violations of human rights are disseminated.

These actions, if not analyzed in detail, can be considered to be effective practices, since they promise resolving measures. A clear example of this is the public-private partnerships between the Federal Government and religious therapeutic communities; advertised as good deeds, the "Crack can be beaten" program, which regulates public financing of admissions for drug users, as well as being a threat to the ideals of the Brazilian Psychiatric Reform and psychosocial care in regard to overcoming practices of isolation, brings with it the logic of privatization and outsourcing of healthcare, thereby relieving the state of its social duties.

In this sense, treatment proposals follow, in a veiled manner, the pattern of the Middle Ages by maintaining its character by social cleansing. Recalling that the old general hospitals "secluded all sorts of marginalized, perverted, miserable, delinquent and, among them, crazy individuals" (Amarante 1996, p. 40). The ethics of guardianship prevails as guiding human relations and possible treatment experiences. The hospitalizations that we analyzed used the social vulnerability in which the subjects existed as a justification, so as to attenuate the historical issues of social inequalities through medical and psychiatric treatments.

The National Secretariat for Drug Policy (1999) has produced a report on drug addiction treatment, whose goal is the supposed cure of the disease, i.e., the cessation of drug use. Initiation of treatment prioritizes the promotion of abstinence, so "hospitalization can be accepted as the concrete definition of abstinence promotion, by alienating the individual from his habitat, which includes consumption environments and the drug itself" (p. 4). The text further argues that "hospitalization is indicated as being a safe refuge for patients less able to resist drug cravings by themselves" (Senad, 1999, p. 5).

For example, a thirteen-year-old boy was placed in compulsory detention for marijuana use, not so much for the use of the drug itself, but based on the belief that the adolescent would soon commit offenses. What is most out of tune in this case is that this young man was homeless excluded from school and without any basic guaranteed rights, however, the drug use was presented as a priority intervention , as if it did not refer at all to the socio-family context.

## Some conclusions

In spite of all the struggles in the political-ideological sphere and also the theoretical-technical innovations to overcome the HDPP (Costa Rosa, 2013), in the context of the CMP, it is still the hegemonic paradigm, which is also the case in psychosocial establishments (Costa Rosa, 2013, Shimoguiri & Périco, 2014, Périco, 2014).

Hospitalization and the medicalization of psychological distress are still quite accepted and requested, even within the institutional settings of the PSCN. In addition to the architectural asylums, we currently have the figure of the chemical asylum as a major expression of the advances in the chemical-pharmaceutical industry and the medicalization and psychopathologization of life.

If psychosocial establishments work in the service of social adaptation, we emphasize that a critical analysis is needed on the social production of health and on the effects of the CMP on the subjectification processes. In addition, it is necessary to think of a critical practice in the CMH, one that considers its ethical-political effects.

Luz (1979) defines institutional establishments as a "stage for social struggle". In this sense, Costa-Rosa (1987) highlights the role they play as fundamental parts of the Strategic Process of Hegemony (EPH), since they can both guarantee (re)production of dominant social relations within their practices and produce new intersubjective relationsships, and thus impart a different movement to the EPH, a paradigmatic transition, in favor of the subordinate pole.

Moreover, if capitalism "produces misery and needs it for existing, since in its functioning logic the existence of poverty is essential" (Coimbra, 2001, p. 80), we consider that psychosocial establishments are privileged activity loci, as we have in them the dimension we are most interested in: institutions thought as devices, "as the act of instituting, immediate action, verb, that which is always alive. . . it is in the dimension of institution as verb that one can both reproduce it as established logic and introduce transformation in that logic" (Costa-Rosa, 2013, p. 59).

### A prática de atenção à saúde nos estabelecimentos psicossociais: efeitos do modo capitalista de produção

**Resumo:** O modo de produção de bens materiais é correlato ao modo de produção de saúde e indica as formas de subjetivação possíveis em uma sociedade, portanto, está relacionado às maneiras como impasses sociais e psíquicos se materializam. Os conflitos da luta de classes produzem contradições, de maneira que é crucial observar que os sintomas desencadeadores das crises vêm enunciar objeção ao contexto social no qual emergiram. Partindo da análise organizacional, constatamos que os estabelecimentos institucionais de saúde mental no contexto do modo capitalista de produção têm servido para agenciar essas crises no sentido de dissuadi-las. Observa-se que, apesar dos avanços da reforma psiquiátrica brasileira, os estabelecimentos psicossociais ainda servem à adaptação social, produzindo subjetividades alienadas e reproduzindo formas históricas de dominação-subordinação, como a internação psiquiátrica e a medicalização da vida e do sofrimento.

**Palavras-chave:** modo capitalista de produção, reforma psiquiátrica, atenção psicossocial.

### Les pratiques d'attention à santé dans les établissements psychosociaux: les effets du mode de production capitaliste

**Résumé:** Le mode de production des biens matériels est corrélatif au mode de production de santé et indique les façons de subjectivation possibles dans une société, donc, soit lié à la manière comme les impasses sociales et psychique se matérialisent. Les conflits de lutte de classes produisent contradictions, de manière qu'est cruciale regarder que les symptômes que déclenchent des crises viennent à énoncer une objectivation au contexte socioculturel dans lequel ils ont émergé. À partir de l'analyse institutionnelle, on a constaté que les practices de santé mentale au sein du mode capitaliste de production ont servi pour traiter ces crises afin de les dissuader. On observe que, malgré les progrès de la réforme psychiatrique brésilienne, l'établissement psychosocial sert encore à l'adaptation sociale, en créant des subjectivités aliénées et en reproduisant formes historiques de domination-subordination, comme l'hospitalisation psychiatrique et la médicalisation de la vie e de la souffrance.

**Mots-clés:** mode capitaliste de production, réforme psychiatrique, attention psychosocial.

### La práctica de la atención a la salud en los establecimientos psicosociales: efectos del modo de producción capitalista

**Resumen:** El modo de producción de bienes materiales se correlaciona con el modo de producción de salud e indica las posibles formas de subjetivación en la sociedad, por tanto, se refiere a la manera en que los puntos muertos sociales y psíquicos se materializan. Los conflictos de la lucha de clases producen contradicciones, por lo que es fundamental señalar que los síntomas desencadenantes de las crisis vienen a declarar una objeción al contexto en que surgieron. Con base en el análisis organizacional, constatamos que los establecimientos institucionales de salud mental han servido para administrar esas crisis en el sentido de disuadirlas. Se observa que, pese a los avances de la reforma psiquiátrica brasileña, los establecimientos psicosociales todavía

sirven a la adaptación social, producen subjetividad alienada y reproducen formas históricas de dominación-subordinación, como la internación psiquiátrica y la medicalización de la vida y del sufrimiento.

**Palabras claves:** modo de producción capitalista, reforma psiquiátrica, atención sociopsicológica.

## References

Althusser, L. (1983). *Aparelhos ideológicos do Estado*. Rio de Janeiro, RJ: Graal.

Amarante, P. (Org.). (1995). *Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil*. Rio de Janeiro, RJ: Fiocruz.

Amarante, P. (1996). O paradigma psiquiátrico. In P. Amarante, *O homem e a serpente: outras histórias para a loucura e a psiquiatria* (pp. 39-63). Rio de Janeiro, RJ: Fiocruz.

Arendt, H. (1995). *A condição humana* (7a ed.) São Paulo, SP: Forense Universitária.

Baremblitt, G. F. (1992). Sociedade e instituições. In G. Baremblitt, *Compêndio de análise institucional e outras correntes: teorias e prática* (2a ed., p. 25-36). Rio de Janeiro, RJ: Rosa dos Tempos.

Barros, S. & Bichaff, R. (Orgs.). (2008). *Desafios para a desinstitucionalização: censo psicossocial dos moradores em hospitais psiquiátricos do estado de São Paulo*. São Paulo, SP: Secretaria da Saúde de São Paulo.

Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Secretaria Nacional de Assistência Social. (2005). *Norma Operacional Básica NOB/SUAS*. Brasília, DF: Secretaria Nacional de Assistência Social.

Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Conselho Nacional de Assistência Social. (2009a). *Tipificação Nacional de Serviços Socioassistenciais*. Resolução nº 109, de 11 de novembro de 2009. Brasília, DF.

Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Secretaria Nacional de Assistência Social. (2009b). *LOAS anotada*. Brasília, DF: Ministério de Desenvolvimento Social e Combate à Fome.

Brasil. (2011). Portaria nº 3.088, de 23 de dezembro de 2011. Brasília, DF: *Diário Oficial da União,* n. 251, de 26 de dezembro de 2013.

Cayres, A. Z. F., Ribeiro, M. C., Elias, R. & Coutinho, R. A. (Orgs.). (2015). *Caminhos para a desinstitucionalização no estado de São Paulo: censo psicossocial 2014*. São Paulo, SP: Fundap.

Coimbra, C. (2001). *Operação Rio: o mito das classes perigosas: um estudo sobre a violência urbana, a mídia impressa e os discursos de segurança pública*. Rio de Janeiro, RJ: Oficina do autor.

Costa-Rosa, A. (1987). *Saúde mental comunitária: análise dialética das práticas alternativas* (Dissertação de Mestrado). Universidade de São Paulo, São Paulo, SP.

Costa-Rosa, A. (2000). O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In P. Amarante (Org.), *Ensaios: subjetividade, saúde mental, sociedade* (p. 141-168). Rio de Janeiro, RJ: Fiocruz.

Costa-Rosa, A. (2013). *Atenção psicossocial além da reforma psiquiátrica: contribuição a uma clínica crítica dos processos de subjetivação na saúde coletiva*. São Paulo, SP: Unesp.

Debord, G. (2004). *A sociedade do espetáculo (e comentários sobre a sociedade do espetáculo)*. Rio de Janeiro, RJ: Contraponto.

Deleuze, G. (1992). *Conversações*. São Paulo: Editora 34. (Trabalho original publicado em 1990).

Fleming, M. (1976). *Ideologias e práticas psiquiátricas*. Porto, Portugal: Afrontamento.

Foucault, M. (1997). *História da loucura na Idade Clássica*. São Paulo, SP: Perspectiva. (Trabalho original publicado em 1972).

Lourau, R. (1975). Introdução. In R. Lourau, *Análise institucional*. Petrópolis, RJ: Vozes.

Luz, M. T. (1979). *As instituições médicas no Brasil*. Rio de Janeiro, RJ: Graal.

Marx, K. (2004). *Manuscritos econômico-filosóficos*. São Paulo, SP: Boitempo. (Trabalho original publicado em 1844).

Périco, W. (2014). *Contribuições da psicanálise de Freud e Lacan a uma Psicotherapia outra: a clínica do sujeito na saúde coletiva* (Dissertação de Mestrado). Universidade Estadual Paulista, Assis, SP. Recuperado de https://repositorio.unesp.br/handle/11449/110673.

Secretaria Nacional Anti-Drogas. (1999). *Aspectos Básicos do Tratamento da Síndrome de Dependência de Substâncias Psicoativas e Prevenção ao Uso Indevido de Drogas – Diga Sim à Vida*. Brasília: SENAD.

Shimoguiri, A. F. D. T. (2016). *Contribuições da psicanálise de Freud e Lacan e do materialismo histórico para a terapia ocupacional: uma clínica do desejo e do carecimento na saúde coletiva*. (Dissertação de Mestrado). Universidade Estadual Paulista, Assis, SP. Recuperado de https://goo.gl/q8WToX.

Shimoguiri, A. F. D. T. & Périco, W. (2014). O centro de atenção psicossocial como dispositivo social de produção de subjetividade. *Revista de Psicologia da Unesp*, *13*(1), 33-51. Recuperado de http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1984-90442014000100004.

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