Interventions and Supervision in Mental Health Services: Experiences of a Working Group in Brazil

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Abstract—The Regional Conference to Restructure Psychiatric Care in Latin America, convened by the Pan American Health Organization (PAHO) in 1990, oriented the Brazilian Federal Act in 2001 that stipulated the psychiatric reform which requires deinstitutionalization and community-based treatment. Since then, the 15 years' experience of different working teams in mental health led an academic working group – supervisors from personal practices, professors and researchers – to discuss certain clinical issues, as well as supervisions, and to organize colloquia in different cities as a methodology. These colloquia count on the participation of different working teams from the cities in which they are held, with team members with different levels of educational degrees and prior experiences, in order to increase dialogue right where it does not always appear to be possible. The principal aim of these colloquia is to gain interlocution between practitioners and academics. Working with the theory of case constructions, this methodology revealed itself helpful in unfolding new solutions. The paper also observes that there is not always harmony between what the psychiatric reform demands and clinical ethics.

Keywords—Mental health, supervision, clinical cases, Brazilian experience.

I. INTRODUCTION

IN 1990, when democracy was already reestablished in Brazil, the adopted policy for mental health was oriented by the Caracas Declaration, produced at the Regional Conference to Restructure Psychiatric Care in Latin America, convened by the PAHO. The conference took place the same year in Caracas, Venezuela [1]. Among other guidelines, the Declaration advocates for community-based, comprehensive and continuous care, integrated with primary healthcare without resorting to psychiatric hospitals. Earlier, in 1989, Congressman Paulo Delgado had proposed to do away with psychiatric asylums in Brazil and, as an alternative, provide protection and rights to those with mental health disorders. Resocialization was one of the aims.

In April, 2001, Federal Act 10,216 stipulated that the preferred treatment should be community-based and that psychiatric hospitals would act only as a last resort. These community-based organizations were then implemented, most of them as Centers for Psychosocial Care (CAPS, in Portuguese), funded by the central government, the states and, above all, the municipalities. Alves et al. observed that this had "remarkable effects on the pattern of Ministry of Health allocation of funds to mental health" and that in "2011 spending on new community services reached 71% of

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Ministry of Health (MS, in Portuguese) expenditures" [2]. Unfortunately, at the present time, the Federal Act is not followed by all of the government organizations. It is necessary for us to examine the effects of the policies which were implemented in the everyday healthcare during the past 15 years as way to verify the importance of the CAPS model.

As a matter of fact, the Caracas Declaration followed a worldwide movement – stated by many articles (for instance, [3]-[6]) – which does not completely disregard the history of psychiatric reforms. One could say that it took 200 years to enforce a movement which has had its ups and downs and has seen many different currents. Which are its orientations? There are probably two main streams: the social one, which follows the great modifications of our world from the socioeconomic point of view, and the scientific one, which introduced mental health care into scientific discourse. Perhaps the most important reference throughout the last 50 years of psychiatric reform in Brazil is the Italian one, initiated by Franco Basaglia [7], which determined "deinstitutionalization as a practical process for the deconstruction and shutting-down of psychiatric hospitals and the construction of a network of community services capable of meeting the mental health needs of a given community" [8]. The premises published by Basaglia were an inspiration to the world. Nevertheless, the author asks us to beware of the serious dangers of a fracture between the scientific approach and the difficulties of each ill person, whose identity could be – and was quite often – gradually disintegrated by the health system [7]. Based on this alert, a working group was formed (WG: "Clinical provisions in mental health") in the Brazilian Association of Research and Doctoral Programs in Psychology (ANPEPP in Portuguese), composed of professors with clinical experience in the field of mental health. The aim was to advance an academic partnership, as well as to organize annual colloquia as a way to share a working methodology developed with the community. This methodology is comprised of the construction of the case, its discussion to improve the theory, and the debate about clinical psychology in public policy and its contribution to the public healthcare network in Brazil.

II. METHODOLOGY

Keeping in mind that all the working group's researchers have extensive clinical experience and that they understand that this clinical experience may be carried out in the social field, based on the Freudian premise that all individual psychology is also social psychology [9], the goal is to assimilate the uniqueness of each user of the public healthcare system, as well as that of each provider in the working team,

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without failing to take into account the social, managerial and political issues of which the clinical provisions in mental health are also a product. The WG includes the possibility of evaluating each patient's history, his/her own discourse, and the importance of theoretical references in the clinical work. It is, moreover, based on the doctrine according to which a working ethic is required – going against DSM III's proposition that the work was to be ahistoric, atheoretical and adoctrinal. The WG proposed an annual colloquium to bring together the mental health services, including the participation of different working teams, whose members have different levels of educational degrees and went through different prior experiences, in order to form a dialectic base on possible therapeutic behavior and to increase dialogue where it does not always appear to be possible. In what way does it function?

Each colloquium organized by the WG is held in a different city. Usually, the chosen city is the working place of at least one member of the WG, who, then, takes charge of organizing the event. Mental health workers and members of teams from the region who want to offer their testimonies during the colloquium are invited in order to share the functioning of the clinical provision in which they are allocated and to present, in detail, a clinical case. A member of the team presents the paper and the other members collaborate, adding information they judge to be important for a better elaboration of the case. Then, at least two members of the WG offer their opinions on the presentation, considering the following aspects: the functioning of the working team, the difficulties (or lack thereof) recounted in the paper and the presented case. The primary question – which was also put significantly by the psychiatric reform – was: how to guarantee that the treatment will make a difference in people's lives, allowing for a new position and relationship with the world, without segregating and excluding. At the end of the annual colloquium, after working with at least three teams, a meeting with all participants is held to discuss the results of the event. Finally, these results are published each year by the WG.

III. THE CONSTRUCTION OF THE CLINICAL CASE

Those who work at CAPS (Centers for Psychosocial Care) do not work alone, but are part of a multidisciplinary team that, together, provides care. At the same time, however, each member of the teams perceives the clinical situation in a unique way, not always determined primarily by his/her academic training – since not all members of the team hold a bachelor's degree – nor does it always originate from a long prior experience in the field of mental health. If a multidisciplinary team's work undeniably leads to gains, it is also a fact that it leads to the loss of a single orientation that would be based on a diagnosis and on the resulting therapeutic behavior. The development of the clinical case includes various voices: the ones observed by the team in the speech of the family members and those of the patient him/herself, also including the ones of the technicians and their narratives. The aim is to encourage the actual subject speaking and, based upon that, check possible interpretations of his/her discourse.

This construction of the case is different from its interpretation [10], [11]. Construction constitutes an arrangement of the elements of discourse aiming for a therapeutic conducting of the case, while interpretation is a point aiming for a direction. "The intention of construction must be precisely that of sharing a set of elements from each case in a collective endeavor, which would be impossible in the interpretation track" [12].

It aims for "a democratic construction in which each of the protagonists of the case (the technicians, the family members and the institutions involved) provide their contribution" [10], narrating the context. It involves collecting the narratives of the social network, which follow a case, to find its 'blind spot,' in other words, "the common point extracted from the narratives that points to the 'lack of knowledge' that constitutes the place of the subject and of the symptom that sustains him/her" [13] – symptom understood here not as signs of illness, but as representing the subject him/herself and, therefore, opening paths for his/her singular therapeutic working-through [14].

Here, listening carefully to the narratives is necessary; without it, the 'blind spot' would not be revealed. As much as in the form of assessing the family discourse, as in the way of dealing with the patient in the everyday interactions with the institutions, the attentive ear can finally help in identifying the patient's complaints and his/hers actual symptoms. The blind spot can expose the actual diagnosis or, rather, the difficulties of finding a therapeutic program in a multidisciplinary team, composed of members with different educational backgrounds. The supporting technicians – mostly high school graduates – are not rarely those who have the most contact with the patients.

Figueiredo [10], a member of the WG, identifies three opposing factors to be taken into account when constructing the clinical case:

1) First, there is the distinction between history and case: the details, the scenes and their contents shape the trajectory of a subject both in terms of his/her life and in terms of the often-frequent treatments. This history is rich, when recounted a number of times, becoming pure. Upon it are deposited personal remains and traces, thereby allowing the identification of a subject with the specific characteristics of the case. That leaves us with, on one hand, multiple narratives and a rich history with its details, and, on the other hand, the specificity of a case.

2) Then, between supervision and case construction: if the therapy teams are multidisciplinary, there is no doubt that the presence of at least one theory-oriented methodology is necessary. Often it is the supervisor who leads this orientation. Supervision plays a fundamental role in the functioning of the team by allowing a dialogue between theory and the day to day fieldwork. The supervisor is at a point outside of that field, extraterritorial, and the construction of the case is not limited to the work of supervision because it requires the contribution of team members who are not necessarily – and all of them never are, in reality – theoretically oriented. Each one, no matter

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how experienced or more highly educated they may be, is an apprentice of the clinic. When constructing knowledge about a case, it is important to maintain the unknown in order to prevent the patient's truth from being totalized [15]. Each case is unique and to respect its singularity, it is fundamental not to start with a prior knowledge but, in fact, to allow oneself to be taught by the case. Beyond that, the supervisor is also a colleague and a member of the team – and therefore also a subject –, a participant of the work and in the territory in which s/he is also hired as a mental health worker like any other. "From supervision to construction there is a leap, a hiatus that does not reduce one to the other, just as there is a gap between history narrated and what is purged of it in the case" [16]. Undoubtedly, the construction takes place through the elements brought by the case reports, which should remain distant of any established knowledge – the scientific one or common sense. In the construction of the case, "Both types of knowledge should not be involved, but should be left suspended, in reserve, [...] a detail – a phrase, a scene or a given situation – can make all the difference in the case" [16]. The interweaving of the roles of subject, clinician, researcher, "breaks any rigidity of position before knowledge" [12]. We are left with the unknown as well as, simultaneously, the purification of the narrative, mentioned above – a knowledge that is deposited as a product of the work itself. Different from the blind spot – which depends on the position of the clinical eye to be clarified –, the 'impossible to know' bears modesty at every moment. No supervision could be of any help in face of the unknown.

3) Concepts vs. Distinctions: the third opposition concerns the fact that it is not possible to develop a clinical practice without a good theoretical-conceptual orientation. Whatever should the theoretical choice in the construction of the case be, the uniqueness of each subject, of the patient, of the family members, and of each member of the team, implies an invention for each new situation, a creation. Beyond the construction of a diagnosis, the encounter of good theoretical-conceptual orientation with practice leads to a singular and distinct therapeutic program. To identify and to create that distinction are the ultimate tasks of the very presence of knowledge and experience, facing standardization, generalization and prescription.

Still valuing the difference, it is important to note that the distinction also leads to new failures. In the everyday reality of treatment, when one truly takes into account each involved subject – again including the patients, as well as the family members, and even every member of the team – a mechanism that functions only harmoniously will never be established. The primary reason for this is the fact that a working team of unique parts is not immune to misunderstandings and blunders. To be able to accept that and even to highlight it is not always easy or clear. This acceptance will also undergird the role of constructing the case and the unique contributions that each construction may bring to the enrichment of the team

itself.

Let us try to exemplify it.

IV. GLAUCIA AND THE RESOCIALIZATION ATTEMPT

During one of the events organized by the WG, the case of a woman we will call Glaucia was presented [17]. The 52-year-old knew how to read and write but had dropped out of school. Since then, she had been working in kitchens and domestic services, but stopped a few years prior due to her psychiatric status. During childhood, Glaucia's mother – the subject never met her father – cared little for her daughter, often sending her to do services for other people, even in a brothel – where her mother also worked. In spite of the fact that Glaucia was always rescued by her grandmother or by her aunt, her mother would take her back to the bars, to her "livelihood," and give her to other people. She remembers little of her mother – who had died 30 years prior – only that she was fun, pretty and talkative. Glaucia said that she, herself, was like her mother: lively. She added, however, that she always had the feeling of being an "intruder" in the several houses she lived.

Glaucia's husband, Genesio (also a fictitious name), was an orphaned boy raised by his uncle, married to Glaucia's aunt. Glaucia was taken in by her aunt when she was 6 years old and met Genesio, already was living with the couple, who was 9 years old. Glaucia and Genesio began to date when she was 19 years old and she married him at the age of 22.

Glaucia occupied a dynamic and active position in her life up to age 39: she was the breadwinner of the family, a dedicated wife and hard-working mother – she and Genesio had two daughters. At precisely this age her life changed with the pregnancy of her oldest daughter, which brought alterations in her behavior. The culmination of those changes was the onset of her psychosis with the following phenomena: distractibility, weeping, insomnia, feelings of culpability, ideas that she was a bother to the family and that she owed someone an apology. Glaucia repeated that the planet's water supply was going to run out and that she was afraid to leave the house. Because of her inability to take care of her personal hygiene even to the slightest degree, Glaucia herself believed that she "was going crazy" and that "everything had changed in her life."

Glaucia's condition worsened after the birth of her first granddaughter and she made an attempt at suicide. She felt like a burden and wanted to run away to the streets, motivated by the fear that she would hang her granddaughter and other family members. Starting at that time, she expressed "not being able to do things anymore." The pregnancy of her unwed daughter led her back to her own mother, also unwed. Her mother's abandonment was brought back as well as her aunt's and grandmother's inclusion in her childhood. At that time, the patient said that everything was strange and that she believed the TV was talking to her.

Glaucia began treatment in mental health, first in an ambulatory setting. Her condition led to the significant rupture of prior relationships and she was then admitted to the CAPS, where her participation grew more and more frequent. Glaucia never went back to work and had difficulty taking care of her

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home. The attacks were constant and the primary characteristics of her condition were anguish, anxiety and episodes of inadequacy, hetero-aggressive behavior and psychomotor agitation. In the worst of the situations, Glaucia was more negativistic and regressed, not taking care of herself even to a minimal degree – episodes of evacuation in her own clothes and bed were perceived without regret.

Following the guidelines of the psychiatric reform, the team that accompanied her made countless attempts at her resocialization. Glaucia was designated a therapeutic staff member to accompany and care for her when she stayed at the mental health unit. Fruitless attempts were made to help her return home, which only worsened her condition. In later years she would sit on a bench in the yard, spending entire days and nights not wanting to set foot inside. Even the help of a therapeutic staff member sent by the team to accompany her at the residence was not successful in managing her relationship with the house and the family. Periods of a certain level of stability, with little verbal contact, a lack of interest and little social interaction would alternate with times of intense anguish, inadequacy, crying and desperation, when she would say: "I want to go away, take me away." When she was asked where she wanted to go, she would say that she did not know and that she had no home. Moreover, she would not comment further on the matter and would just repeat: "I don't know."

The multidisciplinary team realized that the intervention with best result for Glaucia involved activity, primarily with the therapeutic staff member who accompanied her to her house, to the streets, and to the places she chose from her history. With his help she managed to weave, to play cards and to cook well, even though she always needed assistance. Glaucia would frequently observe, however, that the company was useless. At the same time, family members were showing signs of stress and were tired of the patient's state. Therefore, they no longer looked after her and were negligent regarding her welfare. This scenario only confirms Glaucia's exclusion from her family and from her home, i.e., from being social. Ideations of doom and culpability, her fear of entering the house, observations that the house was no longer her responsibility were part of Glaucia's manifestations. She often revealed her discomfort at needing help, saying that she required too much work because she was a lousy person who ruined everything and got in the way everywhere she went. All these manifestations led to a diagnosis of melancholic psychosis. Glaucia would tell her therapeutic assistant (TA): "everything is no good... here it's no good, at home it's no good." There were times, however, when she would say that she wanted to be how she was before; that is, "I want to be a person," for she was feeling like an animal: "I'm just like a jaguar, since I'm so on edge, I break glass". Or even: "I wish I was something else, I wish I was a television, just an image..., please help me be who I was before..." And then she would turn back to the topic of motherhood and to being a grandmother, saying: "... I wish I was another person, washing clothes again, taking care of the house. (...) I wish I could look after my grandkids like the grandmother that I have the right to be," a role which she was, nevertheless, unable to perform.

What stands out the most in Glaucia's case are the broken social ties and roles that she had previously performed in contrast with her later position reduced as an intruder or even an animal, lost in the yard. Her condition and her position as an outsider worsened significantly the more time she spent at home. Not even the physical structure of the healthcare unit became a symbolic place for the patient, its function was more that of protection – merely as a place of medication, day-lodging and therapy. Cases like this bring back aspects of the old chronic and leave the team unsteady and unable to help encourage progress and change. These difficulties were then presented at the abovementioned WG colloquium.

As Analice Palombini observed during the colloquium: when a point of implacable resistance emerges from the subjects being followed, we find ourselves faced with an impasse "two pathways are presented: either that impasse is experienced as impotence, throwing us into paralysis, or it is taken as an enigma, challenging us to keep on seeking possible ways to make the clinic work" [18]. If, when faced with a case like this, we throw in the towel and no longer see the light in the end of the tunnel, "what guarantees would the Pedros, Josés, Marias, Antonias we are following have that, for them, some investment is worthwhile?" [18]. In fact, the necessary action includes taking an ethical, clinical position according to which, if there is an impasse at the point of resistance, it must mean that we have not gotten far enough along to offer a new solution. What should we do?

If the case began with a diagnostic hypothesis of neurotic depression, later revealing itself to be psychosis – in this particular scenario, as a case of melancholia with delirium of doom –, the first thing to do is not to be contaminated with the idea that "there is nothing more to be done". The appeal of the patient, "help me be the person I was", is strong! Moreover, it undeniably reveals both the perception of Glaucia herself that there was a radical rupture with the working housewife and mother she was, as well as the consciousness of needing help to break the state in which she finds herself. But it is an impossible appeal, for no one ever goes back to being how they were before. That is what she asked for: to go back to being what she was before, as she preferred what she was prior to what she currently was. If Glaucia's team allowed itself to be contaminated by her appeal, there would be no way out: there is no therapeutic program that could ever respond to a logically impossible appeal. This contamination can lead the team itself "to the same state of doom and impotence that fell on Glaucia and is characteristic of the transferential situation in melancholia" [18].

In the discussion that followed the presentation of Glaucia's case, the possibility was raised to focus on another part of her speech. When she says the house is no longer her responsibility, a new question emerges: "what house could be Glaucia's responsibility? What materials would she make it with? In what way can she design it?" [18]. As it was observed, Glaucia managed to do certain things, for instance weave, play cards and cook well. Perhaps it would be possible to accompany her in the construction of a house she would be responsible for. It would not be her family's house and it

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would probably be very precarious, but the intervention of that construction could help open the doors for a relationship with others. It would not it be a return to what she was before, but a new house, one that Glaucia could build now, after all of the extremely anguishing experiences she had. This new possibility suggests another level of activity, directed by the user him/herself in contrast with the "doing" offered in CAPS, which is oriented by the technical needs and replace the old workshops offered by the occupational therapists in psychiatric hospitals. That is, new activities "which may open pathways to the reconstruction of ties to the world for these subjects [...depending] on the clinical work with each one, in his/her uniqueness" [19]. The construction of Glaucia's case on that colloquium ended up with this proposal: valuing her statements, an attempt was made to figure out what house could be her responsibility; the team had a new orientation on what to do. As a matter of fact, Glaucia had built a house over a long time, precariously made out of paperboard and things she found on the streets.

V. PRACTICAL AND THEORETICAL MATTERS

There is a kind of resistance specific to madness that rejects policies of inclusion, so that nothing of what could be done based on the advantages of the policy of the reform, result in any therapeutic efficacy. Running the risk of being transformed into orthopedic interventions, "the psychotic subject [is fitted] into a menu of activities that supposedly make his/her recovery possible, based on needs that are not his/hers, running over the subject and, in this way, reinforcing his/her position as an object before the [social] Other" [19]. It is true that sometimes the policy of the reform can become a commandment external to the observations in the day to day reality of the clinic. This can be done to the extent of experiences that, in the name of the psychiatric reform, exile the clinic from attending to the users. Felton [20] pinpointed this risk stressing the "entrenchment of objectification" in our society, which leads to a change of working focus to the reform and not the patients. Instead of subjects of pathos, subjects of suffering, the patients become support for the model of the reform in the same way the proletarian can support capitalism: guaranteeing its survival without obtaining any profit other than maintaining the original position.

More often than not the situation becomes even more serious when a patient does not fit in any way into the discourse of the reform. "To be willing in the place of the user", defers the subject himself and freezes the technician in the position of "knowing what is best for the other." Therefore, the team's efficiency can be compromised by willing in the place of the other, the user [21]. The patient is then excluded of the very discourse of the reform, for not serving to corroborate the efficacy of the multidisciplinary approach. An auxiliary staff member with little training may serve in on a home care visit, doing the work of a counselor or even of a social worker.

Mental health professionals have understanding and knowledge of a clinic without which a professional has no way to work! But, as has been said, that knowledge is renewed every time a new case emerges. It is necessary, for each new case to become audible, to be able to incorporate into what is already known, the unknown specific to encounters with the new. The function of turning audible – that is, ensuring its possibility of being listened to – implies, at the same time, the guarantee of what is already known. The non-knowledge of the new stands out exactly where knowledge was constituted, just like the figure only emerges right where it contrasts from the background.

Rigor, then, refers to taking what is said to its final consequence, without wavering. Telling Glaucia that it is impossible to be what she was before – since she has gained so many more experiences since then – would be the beginning of what she could become now; building her house, perhaps precariously, but in a way she would be able to do it. Rigorously, no "recovery" is possible – in the way Perkins [22] points out or the "Recovery in the Bin" [23] criticizes – it is necessary to create something new. This is the moment where the ethics of clinical work are verified: it does not always go in the same direction as the ethics of the reform. As a guide line we have the fact that for the speaking being there is not actually Good, as discontents prevail over civilization, as Freud [24] already wrote. Based upon this ethical orientation – sustained by the WG according to the ethics of psychoanalysis, which orients the clinic in leading the subject to act in conformity of his own desire [25] – the supervisor should not immediately respond to the request for guidance of the team. Instead, s/he should make it "possible to blow a hole through the established truth," [26]. This does not mean that the supervisor should not intervene or guide diagnoses, let alone avoid taking a position, but that his/her primary role is to make others speak.

VI. DISCUSSION

The colloquia helped the WG observe some advances which, in turn, led to new questions, as we shall see:
1) About supervision: all the participants of a team, assisted by supervision, came to have access to a space where they can speak. A supervisor listens and mediates conflicts in the service units, making an effort to encourage team members to say what was still not said – either because of inhibition or because they were not yet conscious of the rich information they could provide based on the everyday reality of their practices. These rich facts are of great importance to coming up with a diagnostic hypothesis for the case and to directing treatment.

Alberti & Palombini [27] were able to identify this based on a specific example. In this situation, the members of the team with an academic background and many years of professional experience were not given the time necessary to communicate with each other and with the other members of the team, and the auxiliary staff, assistants and professionals with only a high school background did not dare to ask about the treatment of a case. Additionally, auxiliary staff members, assistants and professionals with only a high school background showed inhibition to speak about what they knew,

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where academic knowledge was valued highly to the detriment of practical knowledge gained from their experience. Addressing the valuing of academic knowledge with a dialectical approach became fundamental, since knowledge gained from experience can certainly contribute as much – and sometimes more – than knowledge from the university. The ability to speak openly in the supervision sessions revealed a hole in the position of mastery that the team, in general, ascribed to the psychiatrist and the psychologist, members with a university background and, simultaneously, exposed the lack of knowledge of the team as a unit. This understanding immediately mobilized the team to share knowledge about the clinic in mental health, as well as about its policies and history. It had an immediate effect! And it also influenced the entire workings of the supervision process.

2) At the same time, to value what each person has to say, leverages a wager on *scilicet*: it is possible to know. That is, any member of the CAPS team can and wants to know, even if it is not always understood. It was observed that the wager on *scilicet* is crucial for a repositioning of the teams.

3) As a consequence of this, better integration and autonomy of the teams were verified and better interaction with the mental health networks, which benefits the care of the user. Two experiences of supervision at CAPS [27], resulted in the construction of projects: in one case, therapeutic projects for each patient assisted, in the other one, a project of collective work. At both CAPS, the importance of internal assemblies was verified, as well as of the institutionalization of visits to other services and joint work in the territory; that is, the efforts were valued in the sense that members of the CAPS team broadened their relationships with other mental health teams that work in the same territory to better coordinate possible referrals of patients and also to be familiar with the services where the cases sometimes originated.

4) There were also issues not elaborated and not possible to address in supervision. When taking turns speaking, the individual difficulties of some members of the team began to surface more. Sometimes, issues specific to members of the team with individual conflicts – not necessarily originated in the work together, but in the subjective constitution itself of each one of those team members – became evident. Mental health workers also have problems that affect their own mental health and those problems clearly cannot be addressed in supervision. Nevertheless, these problems still influence the supervisions, manifesting the difficulty the team has in dealing with workers who present serious psychic fragility. While, on the one hand, it is fundamental for progress in the work of the team to allow a space where each contribution is valued, on the other hand, this also has consequences that are not always resolvable. Within the possibilities, it is fundamental for these subjects to find in another member of the team, a companion who may listen to and orient them in their search for treatment.

5) In one of the colloquia organized by the WG, a case was presented by the team nurse in a way that led all those present to assume that the patient was an autistic child [28]. But "precipitating a diagnosis can suppress the subject, anticipating an identification" [29]. Unfortunately, it is not possible to go into the details of that case, but suffice it to say that, while all the phenomenology of the case presented by the nurse was leading to a diagnosis of psychosis, the instant it was the speech therapist's turn to speak, the child appeared to be perfectly normal. What variables were involved? The speech therapist saw the child away from the parents, and according to her, the child could breathe freely and presented "an excellent interaction with the therapist in the absence of the parents" (sic). Now, the autism diagnosis was dismantled for, no matter how competent and experienced the technician may be at the time of an initial consult, if the child was autistic, he would not have reacted normally to that technician, let alone have had an "excellent interaction" with him. The other variable that only became apparent towards the end of the meeting with the team was that the nurse, who had presented the case, was the mother of a child diagnosed with autism. Thus, the nurse transferred to the case discussed at that WG colloquium all of the phenomenology that she observed in her own son. The patient was described using parameters that belonged to another child. Again, we noticed a team member's personal issues. If we had not been paying attention to some idiosyncrasies in the presentation of the case, we would never have been able to reveal the drama that she herself was living.

6) The final issue that was observed concerns the resistance of some team members to come to supervision. In one of the teams discussed it was perceived that most members were expecting "a more energetic posture" from the supervisor. They were demanding a master who would command the team and not, as the supervisor was, someone who abstained from the position of control.

The outcomes of supervisions at CAPS in the intersection between clinical ethics and mental health are not always measurable, both for the team and for the supervisor. This is fundamentally so, due to the richness of the experience and the effects it can have on each person. From the experience gathered so far, supervision has allowed the constitution of teams that saw themselves, henceforth, as mental health workers involved in the policy and management of the construction of collective processes in the field of psychosocial care. This was only possible because supervision also involves a factor of discovery by the team member when s/he is given the possibility of producing his/her own knowledge. The starting point is the hole in the pre-established knowledge. The discovery is not always immediate, it can take as much time as it needs to be elaborated, an elaboration of which the subject is not always conscious.

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MS and Alice A. FARIA, for their assistance in English.

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