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Clinical solutions performed in non-conventional settings: Brazilian experiences

SUMMARY

This paper presents the Brazilian specificities of the development of its public health and social assistance policies since the re-democratization process in the 1980s until today. Besides, it presents a wide range of conflicts between the economic interests and the political activism accountable for the advances of the public policies implementation. This evolution is presented as a subsidy to the reader's understanding of the development of a clinical solution for non-conventional settings specific to the Brazilian social and economic reality. Successful clinical experiences in health and social assistance based on phenomenology are presented, not only for diagnosis purposes, namely for understanding the people, for the context in the question, as well as the successful management development. The first case describes the provision of a peripatetic group therapy service, prior as a walking clinical practice, where the notion of territoriality and the dynamics of group interaction facilitate the understanding of the patients, while the intrinsic condition of the work also facilitates the establishment of transferential relationships. The second case describes the complexity of social welfare policy challenges through the clinical intervention while presenting a family in a social and economic vulnerability context.

Keywords: peripatetic therapy, public health, phenomenology, non-conventional settings.

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Introduction

Culturally and historically, we have constructed numerous services that have positioned the scientific discourse out from a positivist tradition[1] as the hegemonic means to unveil truth on an auspicious assignment of advancing the growing progress driven by the Industrial Revolution. Psychology and psychotherapeutic clinics are constituted in this kind of environment and such an influence was reflected in its historical trajectory of searching for a kind of legitimation in this horizon established by the technical-scientific model typical of modernity.

In this context, the dichotomy between subject and object of knowledge, derived from Cartesian thought, gave rise to the dichotomy between doctor and patient, i.e., positioning the clinician/therapist as a subject of knowledge and holder of legitimate knowledge (science), and the patient as an object of study for the confirmation or refutation of a certain logical-formal apparatus, whose ultimate objective is the explicitness of a pathological phenomenon.

Like other health professionals, the clinician/therapist operational horizon is closely linked to the medical tradition while maintaining distinctions based on the body/soul dichotomy. This professional thus shared the configuration of the modern scientific paradigm, which displaced medical authority from magic to rigor, objectivity, and control supposedly achieved through a correct execution of methodical reason. The overvaluation of theory, the controversy regarding the existence of one or more clinical methods, the bet on the effects achieved through the application of a certain technique, and the purification represented by the possibility of obtaining an "objective certainty" regarding "psychic" or psychopathological problems appeared as battlegrounds for discussions between physicians, psychologists, and scientists in general.

Although clinical psychology presents, in its historical constitution, an often explicit commitment to the scientific paradigm, the so-called "natural sciences", the fact is that this commitment has given rise to a series of problems. If we take into account that the "object" of clinics is existence, and if we meditate on the thesis that our understanding of the object starts with a pre-scientific experience (Husserl, 2012), we can admit that the different theories of personality (Hall, Lindzey & Campbell, 1998) bring, in turn, previous delimitations about our relation of meaning with

1 Positivism consists of an epistemological perspective that is still influential in sciences, which understands scientific activity in terms of an investigation of constant and abstract laws that affect observable phenomena through observation, experimentation, comparison, and classification. The term positivism appeared after the publication of *Système de philosophie positive* (1830-1842), *Cathéchisme positiviste* (1852) and *Système de politique positive* (1851-1854) by Auguste Comte, founder and one of the great exponents of this trend. One of Comte's mottos, "order and progress", is even present on the Brazilian flag.

this object that, not being a thing, calls us to think about our own relationship with otherness. The word "attitude" (Mayor, 2009, p. 94-95) has three predominant meanings in today's language. It can mean a way of demonstrating an action or procedure (for example, an "attitude" of distrust), it can denote a body posture (the "attitude" of standing up), or even "attitude" can be related to a mental or emotional state/disposition (he/she has "attitude"). In all these meanings, what is at issue is the possibility of relating to something. In the case of "natural attitude" (Husserl, 1958), the term refers to the subject's correspondence with what is "outside" of him - nature - taken, in turn, as "already given" or "already being there beforehand". Therefore, there is no reflection on the "already given", that is, in the natural attitude, there is no critical reflection on the "given" as such.

The phenomenological suspension, that is, the suspension of belief in an "already given" reality, allows us to rethink the relationship between theory and practice to understand the clinic beyond the traditional therapeutic setting. The clinic then appears no longer as an instrument to control or improve performance but as a health service. Minkowski (1999, p. 666), for example, refuses to define "psychotherapy" as a closed set of practices due to the inherent complexity of human existence, pointing out that even a simple conversation can have therapeutic results. He suggests that psychotherapy practices for schizophrenic patients should go in the opposite direction to conventional treatment paths in which a neurotic patient's defense mechanisms are attacked, precisely because the suffering of the schizophrenic patient stems from his vulnerability (Minkowski, 1999, p. 670).

Basaglia (1981) stresses the importance of phenomenological thinking in the purpose of suspending diagnosis in order to redirect the attention to the subject contextualized in the world. Jaspers (1997) deconstructs several conceptions of madness that have been cemented throughout its history of exclusion. The author criticizes notions forged in the Modern Age that link madness and animality, considering madness to be unreason; he takes delirium[2] as an alteration of judgment and states that only those capable of judging would be capable of delirium, placing madness as an eminently human experience. He also criticizes the structural notion of personality, stating that man cannot be conceived as a thing with properties but as a "being in his world" in developing and differentiating himself. Finally, he criticizes the quantitative method of classifying symptoms as the only way to know about the disease, advocating for the phenomenological method and for listening to the patients' reports.

Therefore, several authors of phenomenology addressed the need for an epistemological deconstruction of therapeutic practices in order to create strategies more focused on the concrete spaces of existence, including peculiarities. From this perspective, it is

2 On the definition of *delirium* see Webster & Holroyd (2000).

necessary to consider the historical and social context in which the experiences are developed to create proposals that promote the subject's autonomy.

Thus, the text will present a brief historical contextualization of Brazilian public policies from the second part of the XX century to the current days, aiming to discuss some aspects of the phenomenological influence of the quoted authors in the context of psychiatric reform in Brazil. Simultaneously, this contextualization will help to understand one experience of peripatetic therapy, which will be presented later to illustrate the development of phenomenology-based practices that involve the entire experiential context of its participants. Peripatetic Therapy was developed in Latin America (first in Argentina and Brazil) as a psychotherapeutic solution from the conception of an open setting and inclusive care to help people in their singularity, which is not restricted to the model of the traditional psychotherapy at the office and can occur "outside", a street or the subject's social relations spaces, at homes, in institutions, and other places, seeking to contemplate the Brazilian context, specificity, and challenges. The text concludes by presenting the challenges that a neoliberal policy imposes for the development of better public services.

The historical context of Brazilian health policies

Phenomenology brings a perspective that allows to epistemologically reposition the clinic, encompassing the historical, social, and community dimensions to redirect, simultaneously, the relationship between theory and practice and the relationship between therapist and patient. The discussion on the relationship between theory and practice, the psychopathological phenomena, the therapeutic process, and the overcoming of dichotomous practices participated in the process of constitution of the Anti-Asylum Fight in the Brazilian context, with influences on the psychiatric reform in Brazil and the constitution of the public health system in its services and practices (Farinha & Braga, 2018).

Structuring of the services aimed at madness issues began in Brazil between the end of the 19th century and the beginning of the 20th century. Moreover, until the 1970s, it was misled, as well as misinterpreted by the conceptions based on the premise of a biological substrate for mental illness, and the isolation and social exclusion of patients. The assistance model was focused on practices that became known as nursing homes or asylums in Brazil and centered on drug prescription, diagnostic descriptions, limitation of daily actions, punitive practices, and isolation of those who did not conform to the norm, affecting mostly poorest and minorities populations.

Furthermore, public funding practices for private institutions have turned social exclusion into a profitable strategy. In 1974, the Brazilian Military Dictatorship government (1964-1985) established a Rapid Action Plan (*Plano de Pronta Ação*), an agreement with private psychiatric hospitals that transferred public resources for psychiatric care, absorbing more than 90% of the funds for the mental health in the country (Waidman & Elsen, 2008; Vecchia & Martins, 2009). With it, the number of psychiatric beds grew exponentially: in 1961, there were 140 psychiatric hospitals, 86 of which were private; in 1971, this number increased to 340, with 277 private hospitals; in 1981, there were 425 hospitals in the private network alone (Messas, 2008, p. 93). Public funding of private hospitals in the context of the dictatorship allowed, in some situations, the maintenance of degrading conditions in these places. The most famous case was the Colony Hospital in the city of Barbacena, in the state of Minas Gerais, in which sixty thousand patients died, 70% of whom were never even been diagnosed. This case became widely known as the "Brazilian holocaust" (Rosa & Szaniawski, 2018).

The psychiatric reform in Brazil began in the late 1970s along with the mobilization for the country's re-democratization. The movement for direct elections, known as Diretas Já (Direct Elections Now) (Oliveira & Marincho, 2012), brought together several social movements, with claims on rights such as health care, children, the elderly, people with disabilities, working conditions, housing, distribution of land and wealth, among others. Articulated to the Diretas Já movement, the Sanitary Movement fought for the structuring of a universal and public health system, and the Anti-Asylum Fight, composed of mental health professionals, family members, and patients or users of the public systems, aimed at humanizing mental health care (Farinha & Braga, 2018). The re-democratization strengthened the discussion on the rights of users of public mental health services. On the other hand, the Sanitary Movement and the Anti-Asylum Fight saw their relevance grow beyond the health field, rising to the general political scene of the period. This was because they were movements linked to re-democratizing instances, such as the Brazilian Center for Health Studies (CEBES), the Brazilian Association of Collective Health (ABRASCO), the Medical Renewal Movement (REME), popular religious communities (Ecclesiastical Base Communities), among others. Moreover, in the economic field, recession and hyperinflation made it difficult to maintain high state costs with private asylums, favoring the psychiatric reform.

The Brazilian Unified Health System (SUS) (Law n. 8080, 1990)[3] was born out of the popular demand for an assistance model based on the promotion of citizenship and

3 This act provides conditions for the promotion, protection, and recovery of health, the organization and operation of the corresponding services, and other measures.

the perspective of integrating several dimensions of health in a national conjuncture of fortification of social rights. The motto of its creation was "Health: everyone's right and the State's duty". By law, the SUS is universal, that is, it must attend to all who seek it and integral, attending to any health problem. It also has the legal principle of popular participation, which means that representatives of the population must integrate the system's management advisory councils. The SUS is composed of three levels of care: primary care, which is found in all municipalities and deals with prevention and health promotion, as well as simpler care; secondary care, which addresses specific problems and prevents injuries; and tertiary care, which deals with complex problems, with patients being treated in an institution that is a reference for the region where they live.

Another important achievement of the popular movements was the creation in Brazil of a Unified Social Assistance System (SUAS) to support people in conditions of psychosocial vulnerability. It was foreseen in the Brazilian Constitution of 1988 with the process of re-democratization[4] but only became effective in 2004 after much social pressure (Farinha & Braga, 2018). Two types of protection were defined in the SUAS: basic and special. The basic one takes place at the Social Assistance Reference Centers (CRAS) (Organic Law of Social Assistance, 1993), and it is focused on the prevention, with projects to strengthen bonds and promote employment, education, and income, with programs to transfer money to families under certain conditions, such as school attendance of children and health care attendance. Special attention happens at the Specialized Reference Centers for Social Assistance (CREAS) (Organic Law of Social Assistance, 1993) that focuses on the violation of rights, serving people in situations of violence and negligence, through programs that articulate healthcare, education, justice, work, and protective institutions.

SUAS thus allows attention not only to economic conditions, such as training and direct income, but also to the subject's integrality, through therapeutic services linked to prevention and assistance of violations of constitutional rights such as health, education, physical, psychological, and property integrity. After receiving the complaint, the teams seek to build strategies that interrupt the cycle of violence with psychological, social, labor, educational, and legal support. In serious cases, victims may be referred to temporary shelters or welcoming families or, once all strategies were taken, adoption of minors.

The establishment of SUS and SUAS was very relevant to allow a structure for mental health care in a psychosocial care network. The struggles for changes in mental health care produced iconography and activism, which certainly was fundamental

4 On the Brazilian re-democratization and the dispute of political and economic forces for the gradual implementation of the public health and social assistance policies, see in Bravo (2009).

to increasing the visibility of the psychiatric reform process in the last decades and should be part of the documentary collection of the history of the mental health field. This is related to the unique characteristics of the Brazilian psychiatric reform in comparison with other reform processes around the world, demonstrating significant political participation and critical posture, with mottos such as, in free translation, "Up close nobody is normal" (De perto ninguém é normal); "To imprison is not to treat" (Prender não é tratar); "Health is not for sale, madness is not to be imprisoned" (A saúde não se vende, a loucura não se prende); "People are made to shine" (As pessoas são feitas para brilhar); "Freedom even if Tam Tam" (Liberdade mesmo que tam tam); "Asylum never again" (Asilo nunca mais); among many others. One of the most important is the slogan "For a society without jails" (Por uma sociedade sem manicômios), which sought to highlight the punitive character with which madness was often treated (Amarante & Torre, 2018).

The structure of the Brazilian Psychiatric Reform was regulated by Law 10.216 (2001), providing protection and reinforcing the rights of people with mental disorders and redirecting the mental health care model with a focus on day-hospitals and brief hospitalizations in place of long hospitalizations in hospitals. Since the beginning of the psychiatric reform, the care structure in the Brazilian mental health system is no longer centralized in the hospital and has started to rely on several other public services. In primary care, there are mental health clinics, psychiatric and psychological care in basic health units. In secondary care, the Psychosocial Care Centers (CAPS) are places where users receive several types of care, from emergency and psychological and psychiatric assistance to social and income generation groups, depending on the structure of each institution and the population's demands. There are also Community and Culture Centers and Day Hospitals (Ministry of Health, 2005). In tertiary care, psychiatric beds were created in general hospitals, and psychiatric hospitals remain, but with a limitation on the length of stay and a requirement for a minimum multi-professional team, as well as government control of involuntary admissions.

This entire structure allowed for important changes. Between 2002 and 2012, there was a systematic decrease in the number of psychiatric beds (from 51,393 to 29,958) and the percentage of spending on the hospital network (75.24 % to 28.91%), accompanied by an increase in the number of CAPS (from 424 to 1981), an increase in spending on open services (from 24.75 % to 71.09 %), a 68 % increase in investment in CAPS (from €71,38[5] million to €120,41 million) and increased resources for mental health (from €96 million to €279 million).

5 Conversion from real to euro, carried out through the website of the Central Bank of Brazil (2021), https://www.bcb.gov.br/conversao.

Experiences and practices in Brazilian psychiatric reform

The visit of the Italian Franco Basaglia, psychiatrist exponent of the Italian Psychiatric Reform and the author of "Law 180", directly influenced the Brazilian movement with a perspective of phenomenological psychopathology and Basaglia's interdisciplinary practices, valuing the therapeutic plan and the ideas of Jaspers, Binswanger, Minkowski, Strauss, and Freud, as well as building his practice on philosophical bases and better-investigated reflections in the analysis of the complexity of the human being, in dialogue with Husserl, Jaspers, Heidegger, Merleau-Ponty, Sartre (Serapioni, 2009).

The expansion of the traditional therapeutic scenario to allow reflection on clinical training grounded in an ethical aesthetic-political clinic consists of an attitude of epistemological reinvention. In this sense, the phenomenological attitude contributes to listening to people and communities in what emerges in them, creating resources for the humanization of care and response to crises, psychic, relational, and territorial, allowing the inclusion of all actors as co-producers of subjectivity and catalysts of affectivity. This has favored social reinsertion and the promotion of humanized and territorial public health policies, job creation, transformations in social roles, artistic interventions, etc. The Theater of the Oppressed (TO), the cooperatives of work and aesthetic production, and the clinic of Peripatetic Therapy (França, 2020) are examples of these initiatives.

The TO (Freire, 2005) describes theatrical forms that the Brazilian playwright Augusto Boal (1993) created for the first time in the 1970s, initially in Brazil and later in Europe, influenced by Paulo Freire's work, an educator and theorist. Boal's techniques use theater as a means of promoting social and political change here and now, in alignment with the oppression that reality affects people. The oppressed is the one who gets involved and is uncomfortable with the situation. People dramatize their oppression and transform events into a stage in the theater. Among the work cooperatives and aesthetic productions, we highlight the Carnival blocks[6] Mental Zone (Zona Mental), You're Freaking Freaked Freaked Out (Tá Pirando Pirado Pirou), Suburban Madness (Loucura Suburbana), Crazy for Life (Loucos pela Vida), which are born from psychosocial care networks and contribute to psychiatric reform and the anti-asylum fight. In them, intersubjectivity takes shape through artistic expressions in the territory, from works made by artist-users. The Arthur Bispo do Rosário award is also noteworthy, named after this Brazilian artist who was interned

6 Carnival is a long holiday in Brazil, with a strong Afro-Brazilian musical and aesthetic influence and characterized as a popular democratic party, celebrated by everyone. The carnival blocks, as well as the samba schools, are characterized as popular associations that organize parties and parades all over the city. Carnival blocks can be themed, like those organized by mental health activists.

in an asylum for 25 years, producing 804 works during this period, which became one of the symbols of the psychiatric reform.

Peripatetic Therapy has emerged spontaneously in different places, with diverse practices associated with different psychotherapeutic theories. However, regardless of their diversity and lack of standardization, these different practices have two fundamental principles in common which define them as peripatetic therapy: a "therapeutic contract" between patient and attendant, establishing the conditions of the activity as to its quantity, frequency, and duration, and the "outdoors" as the setting for peripatetic therapy; a session can take place anywhere, as long as it takes place outside the office or institution (Coelho, 2007). Such initiatives demonstrate that one can deal more humanely and inclusively with the expressions of human suffering, and witnessing this is fundamental to a social transformation that goes beyond the strict space of treatment. The important point is that we already know what can be done (Basaglia, 1970).

Thus, advances have occurred in the installation of substitutive services more focused on social and territorial inclusion and promotion of autonomy (Ministry of Health, 2005). Many user and family associations and work cooperatives were created and exist today, promoting workspaces, coexistence, re-signification of life in social inclusion, and breaking down prejudices and stigmas (Amarante & Torre, 2018). Other important events were the congresses and forums of the Brazilian Association of Mental Health (ABRASME), established in 2007. In 2020 we had the consolidation of the Broad Front in Defense of Mental Health (Frente Ampliada em Defesa da Saúde Mental), the Psychiatric Reform, and the Anti-Asylum Fight, formed with equal representation of users, family members, activists, professionals, students, teachers, politicians, artists, and the entire community.

However, establishing new spaces does not mean reformulating the care model. In part, the contradictions between political initiatives and their implementation remain, as well as between the perspectives of care focused on the epistemological questioning of the diagnostic and essentialist logic and the maintenance of a biologizing and medicalizing model. For instance, law 10.216/2001 (2001) provides for the creation of sheltered workshops and units to prepare for social reintegration, which has not been systematically implemented. The coverage of the services already installed is still insufficient. There is also a lack of preparation of professionals, families, and communities for living with people in situations of severe suffering (Ministry of Health, 2004). In the current systematization of the Psychosocial Care Network, several services already established in psychiatric reform experiences are little explored in the governmental guidelines for the Brazilian psychiatric reform. The Peripatetic Therapy, developed in the country itself, is not even mentioned by

the Ordinance nº 3088/2011 (2011) as a resource in the construction of the mental health support network; open dialogue, a methodology for preventing hospitalization and psychiatrization in the context of the first crisis, widely used in several European countries, has only isolated experiences in the Brazilian context, generally linked to the academic field (Kantorski & Cardano, 2017). Some of these services based on successful experiences were included in documents developed during the psychiatric reform process but ended up being neglected due to the political influence of representatives opposed to the reform and were never offered comprehensively and continuously in the RAPS (Ministry of Health, 2010).

Furthermore, the public mental health system has been severely attacked by the current Brazilian government. The government wants to revoke all the Public Ministry Ordinances of the last 30 years that support the Psychiatric Reform in the country in line with the Anti-Asylum Fight to encourage the return of non-humanized treatment. While promoting the end of a successful model under arbitrary and unscientific justifications, the destruction of mental health policy is named as a new "non-ideological" technical policy (Cruz, Gonçalves & Delgado, 2020).

The panorama of contradictions between reformist and manicomial discourses and practices has repercussions in the centrality of Psychosocial Care Centers (CAPS) and outpatient clinics, with little emphasis on more properly territorial experiences, such as peripatetic therapy, community projects for income generation, and multiple living centers not focused only on psychiatric diagnosis. Mental health in Brazil struggles to overcome the dichotomy of practice. Franco Roteli states that:

> "The institutions' denial, much more than the dismantling of the asylum, was and is, the dismantling of this linear causality and the reconstruction of a possibility-probability concatenation" (Roteli, 2001, p. 91).

The process and experiences in the context of psychiatric reform revealed a deep articulation between situations of crisis/existential illness and difficulties experienced in the socio-economic and relational experiences spheres. In this regard, the Peripatetic Therapy clinic allows the construction of an effective space of care in and with the territory, articulating social services in the construction of dignity and care spaces. It is in these circumstances that we will present two experiences developed in the context of interventional research.

Peripatetic group therapy in the context of mental health care[7]

The Peripatetic Group Therapy experience described here was developed during the "A Walk in the Afternoon", an activity of a Day Hospital in Brasilia, Brazil, which consisted of weekly walks organized in places chosen by the participants themselves, hospital users, and health team. Although the activity was developed to offer the service users a leisure option without clinical purposes, since the therapeutic work for these patients was carried out in individual and group therapy sessions in the protected environment of the institution, the patients' walk through the streets of Brasilia, mediated by an agreement with a professional team, offered the group experiences of bonding and security, allowing the construction of different situations with therapeutic effect, the expansion of relational, pragmatic, affective, and even cultural experiences.

For research purposes, records of seventeen activities were collected between December 2007 and June 2008, with the participation of patients diagnosed with several disorders according to the ICD, mainly schizophrenic and mood disorders. Mailhiot proposes the action research method, seeking to record the episodes experienced in the subjectivity of the participants and contextualized in the social field (Mailhiot, 1970). Thus, small notes were taken during the activity, and detailed records were written immediately after the walk, supported by these notes, articulating the perception of the participant-researcher and questions asked to patients and professionals to complement the report.

The walks were preceded by health team meetings for planning the walk and sharing information about the patient. Then, the patients and the staff began the tour: they met in front of the day hospital, walked together to the bus stop, and took the public transport to the desired destination. There, all involved parties talked and played together or in smaller groups, then met again for a snack. After the meal, the patients without mobility difficulties returned home alone while the staff and the rest of the patients returned to the Day Hospital. When the activity was over, another team meeting was held to reflect on the tour, ending the day's work. Some moments of the activity (França, 2009) are shown to illustrate how relationships developed in it, using fictitious names to preserve the privacy of those involved.

> "On a tour to an exhibition in honor of Darwin[8], we were waiting for the bus when Maria laid her head on my shoulder and complained that she was already hungry. While Felipe[9] questioned me about which way to go to access the exhibition, Carlos

7 Research carried out to obtain a master's degree. To access the full research, search for França (2009).

8 About the research of the biologist and author of the theory of evolution of species, search for Darwin (1859).

9 The chosen names are fictitious in order to preserve the identity of those involved.

> followed my advice to buy a glass of water to take his medicine, which was already late. After asking me to hold his jacket and glass of water, he joked about how it was my day as a butler. We all had a few laughs".

In the scene described, important elements of the group relationship are exemplified. According to W. C. Schutz[10](1958, as cited in Mailhiot, 1970), the interpersonal needs for *control, affection,* and *inclusion* as the mandatory elements that permeate all communications and relationships within a group. Even though these needs are inherent to all people, their satisfaction is learned and matured individually throughout life. The need for *inclusion* was not observed because it presents itself in the situation of a new member in the group, which did not occur in this period. The need for *control*, concerning the knowledge of the role of each individual within the group, was noticeable when the three patients told me about the medicines they were taking, reported that they were hungry, or even questioned the way forward. In this case, as a member of the health team, I played a leadership role, and it was common for the participants to report to me about their expectations and needs.

The need for *affection*, in turn, designates our need to feel valued and irreplaceable in the group, and since its satisfaction is learned, attitudes in this direction may sometimes seem immature or unbalanced. This was the case with Gilberto, who stood behind a therapist during the whole trip, demanding a "hyper-personal" relationship even when she was busy attending to an elderly patient. Gilberto also showed indifference and even anger, rejecting other therapists or patients who offered him dialogue and support, indicating that by placing the object of his affection as the only one capable of satisfying him, limiting the possibilities of new friendships and greater emotional difficulty when the desired person is not available.

In addition to these elements of group dynamics, psychopathology issues also present themselves in these activities. Accompanying Nadir, for example, allowed us to reflect on some situations and also on their impact on the group. She is affectionate and likes to hug and kiss people, but she can often be invasive, trying to pop pimples or even touching more intimate parts of the body. On the other hand, she can be violent if people try to take a picture of her or simply touch her while hugging her back. Nadir also has a very peculiar way of dealing with money and often makes jokes about not having any money to gain the seller's sympathy and get something extra. Occasionally she leaves quietly without paying, pretending to have made a mistake, which requires the staff's attention to avoid repeated embarrassment for the group.

On tour, we got on the bus, and I asked Nadir to pay the ticket to avoid any problems when getting off at the bus stop. She looked displeased and rummaged through her

10 About interpersonal needs for *control, affection, and inclusion*, search for Mailhiot (1970).

purse as if she did not have any money, finally finding a twenty-reais[11] bill. She then explained that she could not pay because she only had that one bill. I answered, laughing, that she could pay the two reals value of the fare and receive the change. Nadir paid the ticket, received the change from the ticket collector, and was satisfied. However, she then took out a two-reais bill, gave it to the conductor, and asked for her twenty-reals back. The conductor laughed because Nadir would be left with thirty-eight reals if this change happened and then explained to her that this would be impossible.

In this scene, it is clear that Nadir's relationship with money is not restricted to its market value but refers to the need for security. My laughter and that of the collector during the episode were consistent with people in *syntony*[12] with reality (Minkowski, 1970). After all, we understand the proposal as absurd and comical. On another occasion, she attacked a patient, saying that he was after her and was going to do something sexual. The loss of vital impetus[13] with reality described in Minkowski's psychopathology (as cited in França, 2020, p. 102) becomes evident when we examine Nadir's experience of the existential axis of space. She and her money cannot be touched or arranged at the risk of losing her integrity, but she is comfortable touching others. For Minkowski, therapeutic transference is essential to facilitate or encourage the resumption of vital contact through experiences.

The reported scenes illustrate the potential of peripatetic group therapy to build mediations between subjects in very rich and thought-provoking settings that revitalize the group, providing a real answer to what Mailhiot (1970, p. 84) describes as social necrosis, that is, complete social stagnation that makes it impossible to meet their social needs, recurrent among chronic patients. Even my communication with Nadir, usually monosyllabic, transcended from simple affection to dialogue about her tastes and other issues during the walks. Nadir's relationship with money and the sense of corporeality could only be observed more explicitly during the walks since the routine of the Day Hospital does not involve money. It is not a matter of identifying whether the patient knows how to use money, but rather of identifying the

11 Brazilian currency.

12 Syntony refers to the affection that space, time, and people awaken in us. When someone realizes in the morning that it is hot and takes off their coat, we have an example of syntony to the temperature of space/environment where this person is. When someone observes the passage of time through a clock or the sunset, their hair growth, or the seasons of the year, this person lives in syntony with the temporal dimension of the human experience. Syntony is experienced with the world and with people. It is a lifelong learning process. Social interaction is essential for human development and learning possible reactions in syntony with the reality we live in. Then, in such an environment, a child normally learns about the cold, the time passage, and even about affective states, such as anger, happiness, and tiredness, through conviviality. See in França (2020).

13 The vital impetus, translated from the French "élan vital", relates to an inherent force that permeates all human experience. However, for psychopathological purposes, we focused on the lived experiences of time and space (França, 2020, p. 102).

value and meaning that one attributes to the object. These moments and situations facilitate the creation and strengthening of transference relations between patients and therapists, allowing patients to get in touch with reality through these emotional exchanges with people and the world.

Thereby, the group and mediated contact with experiences of daily social experiences, made possible by the walks, create opportunities for patients to present reactions and reflections that may later echo positively in the Day Hospital, in psychotherapy, and in their lives. The Peripatetic Group Therapy mobilizes affective content on an individual and collective level, with a focus on humanization and the search for specific solutions for each patient through dialogue. As such, it proposes a potential alternative for therapeutic management with possibilities that are different from the conventional therapy normally offered in clinical and mental health institutions.

Final considerations

The achievements and advances of Brazilian public policies and their positive results can be evaluated through the presented quantitative and qualitative indicators, with an evident positive evolution, not only regarding respect for basic rights and guarantees but also regarding therapeutic results and solutions that contemplate individual singularity within the context of Brazilian diversity.

However, neoliberal policies have been consistently implemented from the military regime to the present day. This positivist and "economic" perspective materializes in Brazil through the use of merely financial indicators to organize public policies. However, it is possible to observe the increase of work overload of available services, as well as the worsening of service quality indicators (Trevisan, Haas & Castro, 2019).

Even if publicly disclosed, the negative results of underfunding of public policies did not justify the reversal of this perspective. On the contrary, its implementation in Brazil was accelerated with the approval of constitutional amendment 95/2016, limiting spending on social policies for 20 years, regardless of the increase in population and unexpected events, such as the COVID pandemic. In October 2021, Brazil suffered more than 605,000 deaths (Ritchie et al., 2021) from the virus because the federal government refused social isolation measures under the discourse economic activity restart while minimizing the individual and collective implications of this social crisis (Brum, 2021).

The current situation presents itself as a paradox since policies and services based on legislation to meet rights and guarantees are dismantled under the justification of scarcity of resources. At the same time, political and economic elites negotiate billion-

dollar tax exemptions for companies of private and religious interest. For example, while CAPS dedicated to the treatment of drug abuse are being closed or receiving fewer resources, Christian therapeutic communities and private entities are receiving greater public resources without proving that they have trained professionals. Even if this phenomenon contradicts the secular nature of the state. Mota (2009, p. 46) summarizes the current Brazilian situation with the consolidation of citizen-consumer and citizen-poor figures. Access to a basic right will only happen if it occurs through the payment of private services or precarious and overcrowded services.

While the history and positive results presented are not enough to prevent setbacks in the definition of public policies, the current Brazilian situation points to possible debates for problems and solutions in the provision of public services and services to rights in other countries.

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Klinička rješenja ostvarena u nekonvencionalnim uvjetima: Brazilsko iskustvo

SAŽETAK

Rad prikazuje brazilske specifičnosti razvoja politike javnog zdravstva i socijalne pomoći od procesa redemokratizacije 80-ih godina prošlog stoljeća do danas. Osim toga, predstavlja širok raspon sukoba između ekonomskih interesa i političkog aktivizma koji je odgovoran za napredak u provedbi javnih politika. Ova evolucija predstavljena je kao subvencija razumijevanju razvoja kliničkog rješenja za nekonvencionalna okruženja, specifična za brazilsku društvenu i ekonomsku stvarnost. Prikazana su uspješna klinička iskustva u zdravstvenoj i socijalnoj pomoći temeljena na fenomenologiji, ne samo u svrhu dijagnoze, odnosno razumijevanja ljudi, konteksta, kao i uspješnog razvoja menadžmenta. Prvi slučaj opisuje pružanje usluge peripatetičke grupne terapije, prije kao hodajuće kliničke prakse, pri čemu pojam teritorijalnosti i dinamika grupne interakcije olakšavaju razumijevanje pacijenata, dok intrinzično stanje rada također olakšava uspostavljanje transferencijalnih odnosa. Drugi slučaj opisuje složenost izazova politike socijalne skrbi kroz kliničku intervenciju uz predstavljanje obitelji u kontekstu socijalne i ekonomske ranjivosti.

Ključne riječi: peripatetička terapija, javno zdravstvo, fenomenologija, nekonvencionalni uvjeti.