

## RESPONSIVENESS AND DIALOGISM: CRITICAL MOMENTS IN CONTINUING EDUCATION IN HEALTH

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**ABSTRACT.** This study aims to analyze a process of Continuing Education in Health (CEH) developed with professionals from public mental health care centers in Brazil. The research was guided by social constructionist perspective which considers language as a form of social action and is interested in interactive and dialogical processes involved in knowledge construction. Seven meetings were held with a group of ten professionals. Conversations were recorded, transcribed and analyzed qualitatively by the delimitation of critical moments. We explored the analysis of two critical moments, which indicate the occurrence of transformation of meanings related to the importance of practices developed by professionals and to the possibility of families' participation in care. They were called: "Affection is transformative": ' : building the importance of practice and CEH meetings, and "We are prescribing co-responsibility": ' : transforming the sense of participation of families. Through their analysis, we discuss the centrality of the conversational process in the configuration of dialogical possibilities, with emphasis on responsiveness as a basic facilitating resource to promote dialogue.

**Keywords:** Continuing education; mental health personnel; social constructionism.

## RESPONSIVIDADE E DIALOGIA: MOMENTOS CRÍTICOS NA EDUCAÇÃO PERMANENTE EM SAÚDE

**RESUMO.** Este artigo tem como objetivo analisar um processo de Educação Permanente em Saúde (EPS) desenvolvido com profissionais de Centros de Atenção Psicossocial. O estudo foi orientado pela perspectiva construcionista social, que considera a linguagem como forma de ação social e se interessa pelos processos interacionais e dialógicos na produção do conhecimento. Foram realizados sete encontros com um grupo de dez profissionais. As conversas foram gravadas, transcritas e analisadas qualitativamente, a partir da delimitação de momentos críticos. Exploramos a análise de dois momentos críticos, que indicam a ocorrência de transformação de sentidos relacionados à importância do trabalho desenvolvido pelas profissionais e à possibilidade de participação das famílias no cuidado. Foram nomeados como: "O afeto é transformador": ' : construindo a importância do trabalho e dos encontros de EPS, e "Estamos prescrevendo corresponsabilização": ' : transformando o sentido de participação das famílias. Por meio da análise deles, discutimos a centralidade do processo conversacional na configuração das possibilidades dialógicas,

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com destaque à responsividade como recurso básico de facilitação para promoção da dialogia.

**Palavras-chave:** Educação permanente; pessoal da saúde mental; construcionismo social.

## **RESPONSIVIDAD Y DIALOGISMO: MOMENTOS CRÍTICOS EN EDUCACIÓN PERMANENTE EN SALUD**

**RESUMEN.** Este artículo tiene como objetivo analizar un proceso de Educación Permanente en Salud (EPS) desarrollado con profesionales de servicios públicos de salud mental en Brasil. El estudio se guió por la perspectiva construccionista social, que considera el lenguaje como una forma de acción social y se interesa por los procesos interaccionales y dialógicos en la producción del conocimiento. Se celebraron siete reuniones con un grupo de diez profesionales. Las conversaciones fueron grabadas, transcritas y analizadas cualitativamente, desde la definición de momentos críticos. Exploramos el análisis de dos momentos críticos, que indican la aparición de la transformación de significados relacionados con la importancia del trabajo desarrollado por profesionales y la posibilidad de la participación familiar en la atención. Fueron llamados: "El afecto es transformador": ' construyendo la importancia del trabajo y las reuniones de EPS, y "Estamos prescribiendo corresponsabilidad": ' transformando el sentido de participación de las familias. A través de su análisis, discutimos la centralidad del proceso de conversación en la configuración de posibilidades dialógicas, con énfasis en la responsividad como un recurso básico de facilitación para la promoción del dialogismo.

**Palabras clave:** Educación continua; personal de salud mental; construcionismo social.

### **Introduction**

The care proposal foreseen in the Unified Health System (SUS), including the developments proposed from the Psychiatric Reform, considers the complexity of the human health-disease process, the integrality and the relationships involved both in the production of health/disease and in the health work (Brasil, 2005, 2009b).

Despite the undeniable advances achieved in qualifying the care provided to people diagnosed with mental disorders since the institutionalization of the Psychiatric Reform, there is still the task of providing psychosocial care, based on transdisciplinarity, in inventive, diverse practices performed collectively, in networking and intersectoral work, with inclusion, solidarity and social transformation at its horizon. However, unlike this, scholars point out that we have focused only on the care techno-assistance apparatus, that is, the institution of substitutive services to asylums, but which still bear the hallmarks of asylums in their practices (Amarante, 2015; Pitta, 2011; Yasui, 2010).

In this sense, different authors point out that traditional training for working in the field of health and mental health, based on techniques, skills and procedures, has not been sufficient to consider the complexity of psychosocial care, much less the political and social issues that support the project of society advocated when planning the SUS and the Psychiatric Reform. Thus, they point to continuing education as a way to encourage critical thinking, with a view to carrying out meaningful, politicized and creative work (Campos, Cunha, & Figueiredo, 2013; Ceccim, 2010; Ceccim & Ferla, 2008; Leite et al., 2020; Pinto et al., 2014; Pitta, 2011).

The term Continuing Education in Health (CEH) started to be used in the Brazilian context by initiative of the Ministry of Health to highlight the differentiated character of the proposal for the field of health, but also to demarcate it as a new policy, instituted by Ordinance GM/MS 198 of 2004 and later modified by Ordinance GM/MS 1996 of 2007 (Brasil, 2009a; Pinto et al., 2014). The main foundation of CEH is the social relevance of the teaching-learning process, based on the combination of technical and scientific knowledge with the ethical dimensions of life, work, people and relationships. This is possible with the production of knowledge *from* and *in* the daily work in health institutions (Ceccim & Ferla, 2008).

In this way, CEH is based on the constitution of work collectives, in which 'learning to learn' is exercised, placing work and care practices – with its population served and challenges – as an object of discussion, study and learning. CEH must be permeable to the contexts, needs and rights of the population and the working conditions of professionals. From the joint reflection on the experiences, the problematization of relationships and practices, it is possible to get in touch with discomforts experienced in the reality of services, seeking to transform it (Ceccim, 2010; Ceccim & Ferla, 2008; Feuerwerker, 2014).

CEH can be systematized into three principles: meaningful learning, problematization of everyday life and construction of critical and transforming subjects. From them derive the appreciation of the professional knowledge, the connection to elements that make sense to them, the focus on everyday challenges and the search for plausible solutions, the consideration of the intrinsic relationship between work and life, the appreciation of learning to learn and breaking with hierarchies in the educational and work process (Brasil, 2009a; Campos et al., 2013; Ceccim & Ferla, 2008; Stroschein & Zocche, 2011).

In order to meet these objectives and guidelines, the main scholars and practitioners of CEH have been in tune with the perspective of institutional analysis, especially the one proposed by Félix Guatarri, as a way of conducting and evaluating CEH processes (Campos, 2015; Feuerwerker, 2014).

Institutional analysis is a very useful epistemology for working with groups and consistent with the CEH proposal. However, we understand that it is not the only possible way. In this sense, we propose to carry out and analyze a CEH process based on social constructionist contributions for the practice with groups. From this perspective, the group is considered a reality constructed in social relationships (Rasera & Japur, 2018), which configure practices considered legitimate and relevant within each context. Thus, it can be understood as a conversational resource (Guanaes-Lorenzi, 2017), being a privileged space for the promotion of dialogism, based on the intervention of the facilitator.

From this, the general objective of this study was to understand how the conversational process developed in a group contributes to the effectiveness of the CEH proposal and to professional training to work in mental health services. As a specific objective, we sought to identify and analyze critical moments in the interaction, taken as milestones in the conversational process, which indicate reflections and transformations of meanings in relation to practices with families in mental health.

## Method

This was a qualitative study guided by the social constructionist perspective, which considers language as a form of social action and is interested in interactive and dialogical processes in knowledge production. This perspective proposes that we examine reality, as well as our individual and psychological existences, as cultural, relationally constructed

artifacts. It is in our everyday interactions with people that we construct the conversational realities in which we live. Thus, social constructionism studies what people do together in their communication processes and what their actions promote as ways of life (Gergen, 2015; Shotter, 2000).

In this sense, this approach proves to be fruitful to guide the implementation and analysis of CEH processes, since it helps to understand how CEH can be a conversational device for transforming the realities of health services. In this way, we take it as a methodological and epistemological guide both in the organization and facilitation of the process, as well as in its analysis.

The research consisted of proposing group meetings with mental health professionals, constituting a CEH process. The proposal was presented to the service managers and, later, to the professionals, in a team meeting. Participation was completely voluntary. Although carried out in a delimited period, not being a continuing education per se, the research was applied to reality, and in its own way it was a way of creating the future, generating transformation in the researched field (Gergen, 2014). Thus, the research and the CEH were carried out in the same process.

Ten professionals from two mental health services in a municipality in southeastern Brazil participated in the research, one CAPS III and one CAPSi ad. These professionals had training in psychology, medicine, social work, occupational therapy and nursing. Seven meetings were held during the professional working hours and at one of the participating services, taking advantage of the usual team meeting hours. All participants attended all meetings, with the exception of Emília and Júlia, who missed two meetings, and Joana, who missed one of them. Meetings took place monthly, with an average duration of 1 hour and 15 minutes and were audio-recorded, enabling their subsequent literal transcription. They were organized in a circle, allowing direct interaction between the participants. The schedule of what would be done in each meeting, as well as the schedule and frequency, were defined together with the participants, according to CEH precepts. Only the first and last meetings had a previous schedule, making it possible to guarantee the ethical questions of the research, the principles of CEH and the care of the group process. The audio transcription of the meetings, plus field notes with descriptions of the context and the conversation process in the groups, constituted the set of information analyzed here.

In the first meeting, the CEH proposal, research and ethical issues were presented, as well as the informed consent and the construction of the group contract. Then, we asked each participant to introduce themselves, telling their specialty and what paths or life choices had led them to work in mental health. With this request, we aimed not only to get to know the professionals, but also to have information about their formal preparation for working in CAPS, in addition to encouraging them to participate in the group, based on their personal experiences.

Finally, together with the participants, we defined how we would organize the group meetings, opting, by consensus, to keep the discussion and themes always open, developing at the time of interaction, based on the spontaneity of the people present at each meeting. The only agreed schedule, proposed by the facilitator, was the reading, always at the beginning of the meeting, of a 'Reflective Record' on the previous meeting, prepared between one meeting and another by the facilitator.

This record, inspired by the proposal of Therapeutic Letters (Chen, Noosbond, & Bruce, 1998), had as main objectives to allow people to remember what had been discussed in the previous meeting and to be an instrument of care for the group process that had been taking place, assisting in facilitating the group. Complying with what was agreed upon by the

group, its reading was done freely, without the commitment to take it as the focus of discussion.

The last meeting began with questions related to the process experienced, with the aim of giving visibility to what we had done together, naming observed changes and learning, and closing the process (Guanaes-Lorenzi, 2017).

The group facilitation, carried out by the first author of this article, was guided by social constructionist principles, which dialogue with CEH precepts. These general guidelines are based on the idea of group facilitator as an expert in the conversational process; their specialty is facilitating and creating space for dialogic exchanges, rather than being an expert in this or that specific content (Guanaes-Lorenzi, 2017). For this, it is essential to pay attention to the relationship process, which McNamee and Shotter (2004) call responsiveness. Responsiveness is characteristic of dialogic conversations and being responsive means “[...] being open to the influence of the other” (Guanaes, 2006, p. 68), legitimately listening and responding in a way that promotes dialogue.

In this way, responsiveness implies appreciating differences, considering the incomplete and collaborative nature of the process of construction of meanings and mutual understanding. It also implies investing in the creative potential of dialogue, in those aspects that surprise or mark us, inviting us to other constructions (Guanaes, 2006; McNamee & Shotter, 2004).

Gergen and Gergen (2010), proposing an approximation between social constructionism and educational contexts, and returning to Paulo Freire’s pedagogy of liberation, emphasize the constructionist invitation to dialogue, relational orientation and collaborative learning, taken as a transformation of meanings. Thus, they bring the importance of valuing everyone’s prior knowledge in the educational context, of dedicating ourselves to explorations of positivity in our practices and of generating a respectful and receptive atmosphere, where everyone feels stimulated and engaged in the task of making use of their abilities.

These aspects made up the group contract established with the group (Rasera & Japur, 2006), as well as the entire facilitation process, since, based on the participants’ conversations, the facilitator sought to make critical comments and invitations to reflection, adopting a posture responsive, curious, committed, respectful and focused on potentialities.

It is worth mentioning that, at each meeting, a snack, initially provided by the facilitator and then also by the participants, was shared, having an aggregating effect on the group, inviting more solidary and spontaneous relationships.

For the analysis of data produced (audiorecorded transcripts of the groups), we worked with the delimitation of critical moments, which relate to moments that are of crucial importance to produce the change: of meaning, of relationship, of evaluation, of decision. They are like a moment of epiphany – or the possibility of building this epiphany – based on some collective engagement in the construction of some meaning. For this reason, they are also called ‘Aha!’ moments (Barrett, 2004; Green & Wheeler, 2004). As this definition can be complex, due to the various possibilities of interpretation of an interaction, Green and Wheeler (2004) define critical moments as those in which at least one of the parties recognizes the immediate possibility of a process of fundamental change.

The notion of critical moments was also important for the group’s facilitation process, based on the intention of promoting reflections and transformations of meanings about the practices. It is important to point out, however, that the critical moments delimited were not always configured from an intervention made by the facilitator, which is in perfect harmony

with the CEH proposal, which privileges the non-hierarchy, autonomy and appreciation of the knowledge of each and everyone.

To delimit the critical moments, three aspects were considered: 1- the group's involvement with the discussion, that is, the identification of moments in which the group engaged around some discussion; 2 - the facilitator's theoretical and affective mobilization, that is, moments in which the discussion mobilized her emotionally and/or provoked critical theoretical reflections; and 3 - the reverberations for the participants and subsequent group interactions.

In this way, critical moments were taken as milestones in the conversational process, which indicate something experienced in the group as significant, generating a transformation of meanings. From a delimited critical moment, we sought to analyze the conversational process to give visibility to elements that preceded and succeeded it. Those who preceded it, justify, in a way, the construction of the intervention, be it done by the facilitator or by another participant; those who followed it point to the direction of change (transformation of meanings).

In a systematic way, the steps of the analysis procedure were: 1- listening and full transcription of the speeches of each group meeting held, with the construction of reflective records; 2 - attentive and floating readings of the transcripts and reflective records, aiming to delimit critical moments for the transformation of meanings in the set of meetings held with the group; 3- another exercise of systematic reading of the transcribed material for the delimitation of points, in the interaction, that were related to each delimited critical moment, highlighting the interactions that preceded and followed them, within the same meeting and between meetings; 4 - elaboration of summaries of the interactions, based on the delimitations made in the previous steps, with edition of the literal transcripts, in order to give visibility to the relationship between the points in the interaction that participated in the construction of the critical moments.

It is important to emphasize that this research was approved by the Ethics Committee (number CAEE 32777414.4.0000.5407), complying with all ethical precautions, including the use of fictitious names for the participants and patients mentioned, as well as presenting and discussing the analysis with the participants, before the finalization of the project.

## **Results and discussion**

The course of the meetings took place according to the agreed schedule, with the assiduous participation of the professionals. It was a very mobilizing process, with a lot of commitment, exchange of affection and problematizing reflections, as well as construction and reconstruction of meanings, with the use of theoretical and artistic references, both by the facilitator and by the professionals. In other words, as assumed by Gergen (2014), the research had an immediate impact on the service, helping to build its future, by reviewing practices and proposing actions.

The process of construction of meanings, in the set of meetings, involved the resumption and repetition of some themes, throughout them. However, each time the themes reappeared, they became more complex and richer in meaning. From the exhaustive reading of transcripts, we delimited four critical moments in the conversational process experienced with the group, namely: 'Affection is transformative'; 'We are prescribing co-responsibility'; 'That speech is mine!' and 'More poetry than prose' (reference omitted for non-identification). Considering the focus of this article and considering the limited space, we only present the analysis of two of them: 'Affection is transformative' and

'We are prescribing co-responsibility', which, in our view, illustrate how dialogue, as a CEH tool, allowed the transformation of meanings and, thus, of the practice itself.

### **'Affection is transformative': building the importance of CEH work and meetings**

A relevant discussion during the meetings was related to challenges the difference between theory/legislation and practice posed for the participants, including frustration towards limitations at work and perception of the result of this.

This discussion started in the second meeting, by reading the reflective record about the previous meeting, in which the researchers proposed a reflection on the feeling of insecurity that the work context caused in the participants. From there, the conversation turned into a discussion about the need for external supervision by the group. This conversation was resumed at the fourth meeting and the connection between these themes was the motto for what was defined as the critical moment 'Affection is transformative', whose excerpt is presented below.

Tereza: I think it's cool that you're talking about something that we started at the staff meeting (held before the CEH meeting) talking about, like, it's not getting a SYP (Single Therapeutic Project), reading what it's a STP and applying it without knowing what it means, you know, 'the theory works to unalienate, you understand who invented the STP what they were thinking' (Renata and Tereza laugh, agreeing). Huh?! What is the purpose, where did it come from? There are heads thinking. [...] And [...] and we were talking about this, explaining not only the STP, but other things as well, 'how it would be nice for us to have supervision' (she says laughing).

Renata: A lot! (says laughing) How cool would it be for us to have supervision! (says laughing).

Emília: Really, guys, supervision was going well, right?! It was going really well. Because we end up, on a day-to-day basis, doing it and everything starts to become very mechanical, right?! (Renata speaks together: u-hum). We don't stop to think, to [...] (Tereza speaks together: u-hum) [...]

Júlia: 'Actually, I still don't understand what this supervision thing is'. What you're saying, for me, it's all stratospheric, I'm not understanding very well where these things fall (says laughing). I'm a little too practical! 'Is it here? So, open it here, cut it and take it out!' (speaks laughing and group laughs).

Beatriz: Do you have an ear pain?

Júlia: Yeah! Administer a dipyrone! What is this thing (Maria talks together: it's like that, look [...]), does anyone have an example to give me?

Maria: for example, my supervision, what I do [...] I tell them what I did, what I thought and then they tell me 'Ah, okay, this thing you did, cool, this thing you could have thought of doing it differently, this thing you're telling me, it may not seem important to you, you told me this as if it were anything, but hey, pay attention to this. This is important!'. And then another time I hear someone saying this or something like that, instead of brushing it off, I'll remember that I was told it was important, maybe. And then I'm going to look at it in another way. [...]

Renata: Exactly! [...] 'Supervision is much more a question of reflection than of guidance, necessarily'.

Tereza: It takes you out of automatic mode, right?! [...]

Júlia: It would be good if we had a television to see what would happen to patients if we didn't exist, (group laughs) because 'the impression I have is that it's useless, I don't make any difference (speaks laughing ironically)'. [...] we see so many relapses [...] if we didn't exist, would it be different?

Luciana: Wow, Julia! Do you know?! I think I'm kind of snooty in those things (laughing). [...] Because like that, 'Antônio's joy, people! He asks about you, you know? And the joy he has to see you, like, he

knows he can come here, he relapses, you know, he relapses badly, like, and he comes here, he comes expecting to find you', to meet us, his confidence, I'm very snooty in these things! (laughing)

Júlia: 'But is that good for anything?' (Says crying with emotion).

Luciana: Wow, Julia! Really! [...] 'CAPS for me is a school, like, daily, like, in terms of that, that affection is transformative. (Julia speaks together: okay, okay!)' So, and in the, in the little things, like, I'm not talking about big things, and sometimes for us it can be very small, but for them it's not. [...]

Júlia: 'My supervisors! (says excitedly) I understand what a supervision is! (Group laughs)' [...] (Edited transcript of the fourth meeting).

The excerpt presented begins with a conversation about the importance of understanding the reasons for health policy laws and guidelines, building on the importance of supervision processes, which would facilitate this understanding.

Julia, however, shares with the group her difficulty in understanding what supervision would be and how important it would be, building her medical training as a justification for her misunderstanding, which trained her to take care of physical issues, for which the professional response is punctual and objective. The group then dedicates itself to offering Julia some explanations and examples.

Later, Julia brings up another question that is the trigger for the critical moment presented here. Sharing with the group the anguish of thinking that their practice has no effect on patients, she invites the group to talk about this importance. Luciana, in particular, makes an intervention that can be considered confrontational. She emphatically refuses the meaning brought by Julia, but in a very welcoming way, bringing the memory of a patient and the idea that 'affection is transformative'. This intervention has an overwhelming effect on Julia, who gets emotional and, satisfied, calls her colleagues her supervisors.

This interaction was delimited as important and constituted a critical moment, firstly, due to the emotional impact generated, not only on Julia, but on the entire group, including the facilitator, who engaged in the discussion on a matter of practice in the service. In addition, this interaction constituted an event *in loco* that built the usefulness of the discussions that were being developed regarding the importance of mental health practices and discussions to deal with the difficulties encountered. That is, Julia's question, related to the themes that were being discussed, in addition to providing a deeper understanding of these issues, allows these meanings to be put into action, used in order to help her. And, the fact that this help was effective in the group and by the group, builds the power of team conversations and responsiveness, which was recognized by Julia when calling her colleagues 'my supervisors'.

With that, this critical moment invites us to understand that the potential for transformation through affection occurs not only in relation to patients, but also in the relationship between professionals, who can, through affection, transform meanings and build learning that reinvigorates their practices.

This critical moment invites us to recognize an intrinsic relationship between the way of talking and the content of conversations. The conversational process established between the participants, based on responsiveness and mutual support, led to the transformation of meanings about the relevance of the professional practice developed by them, which, in turn, built the power of the conversational process.

## **‘We are prescribing co-responsibility’: transforming the sense of participation of families**

This critical moment concerns the construction of the meaning, by participants, that they would be prescribing co-responsibility to the users’ families for the treatment. This idea was generated from discussions about the difference between theory and practice, addressed in the critical moment presented above, but also from discussions and problematizations of what would be the care practices for families and the idea of non-adherence of families to the treatment.

These conversations began in the first meeting, when participants were able to reflect that care practices for families took place in different spaces and moments, and not only in family groups, problematizing the common idea of non-adherence of families to the groups offered by the services. In the second meeting, participants talked about the lack of connection and network between the different health and social assistance services, which made it difficult to care for families in the way and at the times when they needed it. This conversation was resumed and deepened in the third meeting, when the team talked about the complexity involved in assisting families who asked for solutions and answers, making professionals responsible for care. From this, the group talked about the controversial role of specialist and the difficulty of occupying it, considering the need and possibilities for families to participate not only in moments of care, but in moments of decision on care practices. In the fourth meeting, the group deepened critical reflections on what was considered non-adherence by families, contextualizing it within the limits of health and social assistance policies and professional performance.

In this way, the conversation led to the transformation of meanings about practices with the family, problematizing non-adherence and the actions as producers of this ‘non-adherence’, building the importance of family participation and co-responsibility. With this background of reflections and problematizations, the group’s reflections on care for families were resumed in the sixth meeting, culminating in a critical moment, as highlighted in the following excerpt.

Maria: ‘I keep remembering a text that we read once in a subject that was the guy who arrived at a UBS (Basic Health Unit) and he had his wrist cut/ [...] Then the people saw the cut wrist, what do you do? Suture! They sent him away, the man killed himself, obviously!’

Tereza: ‘Then you treat the man’s wound and not the man with the wound. [...]

Julia: Guys, this is medullar’. They come and say: ‘doctor, there is a suture’, you go there, close it and leave. It reaches here, doesn’t even go to the brain (doing the neurological path of information with her hands, in her own body), comes here, goes right back, you sew it up and leave (is interrupted by Fabiana)

Fabiana: (says laughing) Medullar! Now that I understand! [...] ‘It’s reflex behavior!’

Julia: It’s reflex behavior! (facilitator laughs). ‘That’s why this CAPS takes work, nothing here is a reflex!’

Facilitador: Nothing is reflex!

Julia: Everything has to go up to the brain, make a connection, wow! (group laughs). [...]

Renata: How can our practice not be mechanistic, right?! [...]

Beatriz: ‘And that gets tired!’

Renata: Get tired! Wow! And get tired! (group laughs). [...]

Tereza: 'I think that's what imprecision and uncertainty are'.

Facilitator: Yeah!

Tereza: 'The last sentence here. (Referring to the Reflective Record of the fifth meeting, which spoke of the need for mental health professionals to learn to tolerate imprecision and uncertainty in their practices). [...] Just like the masseuse, when I went'. 'Wow, it's hard here, huh?! You have to take life lighter!'. I said: 'Okay, with everything I have to think about, now I have an obligation to take a lighter life?!' (group laughs excitedly!). [...]

Facilitator: There's that myth of the Baron of Münchhausen, right?! That he has to save himself from quicksand by pulling his own hair. [...]

Tereza: But the idea is that it doesn't work, right?! The idea (Facilitator speaks together: yes, exactly!) is that 'you need help and the person tells you to do exactly what you asked for help'.

Rosana: 'You have to stop using drugs!'.

Facilitator: Yeah!

Rosana: 'You have to stop getting tense!'. [...]

Luciana: 'Doesn't this help us to think about the approach with the families?'

Fabiana: I thought about that too!

Luciana: 'Because, wow, we were discussing this so much these days and so, in a way, I think we seek to form a co-responsibility partnership with the families, right, but do they understand it that way or do they' (interrupted by Teresa)

Tereza: 'We don't understand it that way, Lu!' (says laughing)

Luciana: No, right?! I was just thinking about that (speaks laughing). [...]

Tereza: [...] 'we are so used to prescribing, solving the problem, we solve it because the patient is patient, they don't do anything, right?!' [...] Then you prescribe, prescribe, prescribe. Then, when I see that everywhere, 'when we think about co-responsibility, when we sit down to talk to patients, we are prescribing co-responsibility'. (speaks laughing)

Renata: Wow! It is true!

Rosana: For those who never had anyone responsible for him!

Facilitator: That's right!

Tereza: Yeah! 'We shove co-responsibility down their throats!' (Rosana speaks along: he suffered neglect most of the time). [...]

Facilitator: 'If I understand, you're thinking, yeah, to what extent trying to build co-responsibility is giving the person their problem back'.

Tereza: Uh-huh! (someone says: that!). [...] It's the worst, right?! 'Tereza, I won't see you anymore because your shoulder is very stiff!'.

Facilitator: Yeah! (speaks laughing).

Fabiana: 'My hand is going to hurt!' (speaks laughing)

Rosana: 'But she comes with a very stiff shoulder', under the supervision of the masseuses! (lively, loud laughter). [...] (Edited transcript of the sixth meeting).

As observed, based on Maria's citation of a text, the group talks about the specificity of work in mental health and in CAPS, engaging in a good-humored conversation about the process of making people responsible for resolving the issue to which they sought expert help. It is in this conversational context that the delimited critical moment occurs, when Luciana invites the group to connect those reflections to the issue of working with families and, based on her speech, Tereza complements the reflection, proposing a self-criticism about the prescription tradition that exists in the health area, which would lead them to prescribe co-responsibility to families. In this way, the idea of the importance of co-responsibility of families in care processes is also problematized based on the consideration that this co-responsibility was being done in a prescriptive manner, an idea for which the facilitator seeks to give visibility, in her speech in the interaction.

As already mentioned, the construction of this critical moment leads us to discussions that permeated the entire CEH process carried out so far. And, taking place in a moment of relaxation, it tells us about the power of personal conversations and humor, that is, of group relationships, in the production of transforming conversations, the main reason for its delimitation.

This critical moment happened when the group seemed involved in a useless chat, detached from the group's objectives, full of jokes and stories from the participants' private lives, which, in the interactional moment, led the facilitator to be concerned with the process, making her to imagine that she should do some intervention to call the group to the task of discussing the work. Nevertheless, sustaining this interactional moment that seemed disconnected from the work was important because it was precisely from this context that a fundamental reflection on practices with families could emerge.

Barret (2004) states that humor works as an invitation for people to leave aside their usual roles and functions to see the silly character that exists behind them. Thus, it must be taken seriously, as a potentially and morally instructive intervention, which interrupts unproductive patterns, with the capacity to restore the vitality and unpredictability of human relationships. According to it, the construction of critical moments requires an ironic conscience, an openness to new scenarios of self-questioning and mutual questioning, which can be provided by humor.

This critical moment, therefore, dealt with a transformation of meanings that gained contours of an epiphany, in the group interaction, about the construction of the families' co-responsibility. In addition, it had a special impact on the facilitator, due to characteristics of the interaction that preceded it, as already mentioned. But it was also of special importance for Luciana, who, in the seventh and last meeting, in the conversation about the entire CEH process developed, highlighted this moment as a special learning experience.

As observed in the analysis of the two critical moments presented, in the movement of coordination of meanings between participants and between participants and the facilitator, the resources used to exercise responsiveness generated dialogical effects, expanding the possibilities of meanings. During the meetings, several possibilities of transformation of meanings happened, including the transformation of meanings about the usefulness of the practice and about the practice with families, both central to psychosocial care (Yasui, 2010). This openness to new possibilities, considering the generative character of dialogues, tells us about the quality of the conversational process.

Thus, the two critical moments analyzed highlight the importance of building dialogic conversation spaces, with facilitation based on responsiveness (Guanaes-Lorenzi, 2017). In this way, 'how to do' CEH processes becomes the fundamental question, to the detriment of contents to be addressed in these processes. In other words, from the research carried

out, we could understand that the facilitation process is of fundamental importance for the construction of CEH processes. This facilitation, understood as the construction of conversational contexts based on responsiveness, promoted dialogue, autonomy, joint construction and transformation of meanings, key points of the CEH policy. It also allowed valuing the team's existing knowledge and seeking to expand it based on the analysis of concrete challenges experienced by the team on a daily basis. In this way, the facilitator could be the catalyst of potentialities, built together with the participants.

In this sense, it is essential to understand that specific themes are linked to the broader social, historical and cultural context, as well as the particularities of organization of each service and team. It is essential that CEH facilitators are sensitive to understanding how conversations that apparently could be taken as deviations from the subject are closely related to it. And the understanding of how, when talking about these issues, the construction of care and the team's power to exercise it are favored.

It is important to emphasize that several participants involved in this process already had a lasting experience of team meetings in their services, having the habit of participating in spaces for discussion and joint reflection on the practice. Probably, this previous experience facilitated compliance with the guidance provided for in the CEH policy of starting from the professionals' daily practices, as well as facilitating the use of dialogical resources by them. As observed, the open format of the discussions, which were guided by the spontaneous interaction between the participants, maintained the group's involvement and created possibilities for the transformation of important meanings for the practice.

## **Final considerations**

The analysis presented here seeks to give visibility to the transformation of meanings through the conversational process, emphasizing responsiveness as a central posture in facilitating the promotion of dialogue. In this way, this study represents a contribution to the evaluation of CEH processes, especially in the cultural context of valuing objective goals and indicators. The notion of critical moments, despite not responding to the demand for quantifiable data, can be a useful way to give visibility and communicate the 'results' of training processes inspired by the CEH proposal. It helps to build a form of evaluation that encompasses the specificities of each context and the complexity of mental health care, allowing to identify and highlight small movements of change and transformation of meanings, connecting them to the form of relationship that provided them, that is, to the conversational process.

Understanding the centrality of language in the construction of reality, that is, understanding that the way we dialogue builds the realities in which we live, investing in the potential of conversation becomes investing in the transformation of reality. It is about the joint creation of new futures, in moments of imagination and reflection on reality and the meeting of common guidelines that reveal new perspectives of moving forward together in work contexts (Gergen, 2014). The ideas of dialogue and responsiveness invite us to take the proposal of joint construction to the fullest, promoting horizontal relationships. As some conversations about work processes are made possible, meanings that build new possibilities for governability and action can be made viable.

It is important to recognize that the analysis based on moments of conversation about practices does not allow to affirm the extent and durability of the identified transformations, even because we understand that realities and practices are in constant transformation, in the countless exchanges that take place between people. Despite this, constructionist

researchers, engaged in building dialogic relationships, expect participants to take the different voices, meanings and discourses that emerge in the research process to various situations outside the research setting (Moscheta, Souza, & Corradi-Webster, 2015).

In other words, we believe that participants, by expanding their repertoires of themselves and the world, have increased chances of responding in different ways in situations in which they want a change. Thus, it is not possible to guarantee that meanings that were helpful in promoting resources and dialogic potentials in the context of the CEH process carried out will be exported to other contexts – which no perspective of education or group process guarantees, by the way. Even so, conversational spaces built collectively are highlighted in their creative and transforming potential of life possibilities, understanding that, if a change can happen, it starts in the interaction between people, through language.

In summary, we expect that this study can encourage facilitators and professionals to invest in dialogic conversations and discussions, expanding the potential for transforming practices.

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