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SOCIOLOGY OF ABSENCES AS A THEORETICAL REFERENCE FOR RESEARCH IN PSYCHIATRIC NURSING AND IN MENTAL HEALTH¹

Edilene Mendonça Bernardes², Carla Aparecida Arena Ventura³

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² Ph.D. in Sciences. Psychologist at the Ribeirão Preto Campus, USP. Ribeirão Preto, São Paulo, Brazil. E-mail: edilenemb@usp.br

³ Ph.D. in Business Administration. Professor, Department of Psychiatric Nursing and Human Sciences, EERP/USP. Ribeirão Preto, São Paulo, Brazil. E-mail: caaventu@eerp.usp.br

ABSTRACT

Objective: to analyze possible contributions of the theoretical reference of the Sociology of Absences; specifically, the Ecology of Knowledge, for the construction of knowledge in the field of psychiatric nursing and mental health.

Method: qualitative study with thematic content analysis. Semi-structured interviews were conducted with people with mental disorders or in mental suffering, and/or their family members, who are users of the Public Defender’s Office service of the State of São Paulo in several offices throughout the state. Seven interviews were conducted with nine users of the service.

Results: the data analysis was organized into three thematic categories: 1) conditions of existence of people who resort to the Public Defender’s Office of the State of São Paulo with mental health claim; 2) Pursuit for access to rights; and 3) Pursuit for access to justice in the Public Defender’s Office of the State of São Paulo. It is possible to identify, in the collected statements regarding mental health claims, that the institution seeks to develop a qualified listening, which allows recognizing the different conditions of existence and needs of a portion of the population that is traditionally invisible for the society: the user with a mental health claim who is a subject of rights.

Conclusion: the results make it possible to identify that the theoretical reference proposed by the Sociology of Absences can be considered as a promising alternative to broaden the theoretical-methodological discussions to those who seek for greater acknowledgment of existence and for greater care and rights for the people with mental disorders or in psychic suffering.

DESCRIPTORS: Mental health. Mental disorders. Right to health. Human rights. Mental health services.

A SOCIOLOGIA DAS AUSÊNCIAS COMO REFERENCIAL TEÓRICO PARA A PESQUISA EM ENFERMAGEM PSIQUIÁTRICA E EM SAÚDE MENTAL

RESUMO

Objetivo: analisar possíveis contribuições do referencial teórico da Sociologia das Ausências, especificamente, da Ecologia de Saberes, para a construção de conhecimentos na área de enfermagem psiquiátrica e em saúde mental.

Método: trata-se de um estudo qualitativo com análise de conteúdo, especificamente, a análise temática. Foram realizadas entrevistas semiestruturadas com pessoas com transtornos mentais ou em sofrimento mental e/ou com seus familiares, usuárias do serviço da Defensoria Pública do Estado de São Paulo em regionais do Interior e da Região Metropolitana. No total, foram sete entrevistas realizadas tendo a participação de nove usuários do serviço.

Resultados: a análise de dados foi organizada em três blocos temáticos: 1) condições de existência das pessoas que recorrem à Defensoria Pública do Estado de São Paulo com demanda de saúde mental; 2) Trajetória de busca por acesso aos direitos; e 3) A busca por acesso à Justiça na Defensoria Pública do Estado de São Paulo. Identifica-se, no relato dos trabalhos desenvolvidos descritos pela demanda de saúde mental, que a instituição procura desenvolver uma escuta qualificada, possibilitando reconhecer as diferentes formas de existências e de necessidades de uma parcela da população tradicionalmente invisibilizada socialmente; o usuário do serviço com demanda de saúde mental e sujeito de direito.

Conclusão: os resultados possibilitam identificar que o referencial teórico proposto pela Sociologia das Ausências pode ser considerado como alternativa promissora para ampliar as discussões teórico-metodológicas àqueles que buscam maior compreensão de existência, cuidados e direitos das pessoas com transtornos mentais ou com sofrimento psíquico.

DESCRIPTORIOS: Saúde mental. Transtornos mentais. Direito à saúde. Direitos humanos. Serviços de saúde mental.

LA SOCIOLOGÍA DE LAS AUSENCIAS COMO REFERENCIAL TEÓRICO PARA LA INVESTIGACIÓN EN ENFERMERÍA PSIQUIÁTRICA Y EN SALUD MENTAL

RESUMEN

Objetivo: analizar posibles contribuciones del referencial teórico de la Sociología de las Ausencias, específicamente, de la Ecología de Saberes, para la construcción de conocimientos en el área de enfermería psiquiátrica y en salud mental.

Método: se trata de un estudio cualitativo con análisis de contenido, específicamente, el análisis temático. Se realizaron entrevistas semiestructuradas con personas con trastornos mentales o en sufrimiento mental y / o con sus familiares, usuarias del servicio de la Defensoría Pública del Estado de São Paulo en regionales del Interior y de la Región Metropolitana. En total, fueron siete entrevistas realizadas con la participación de nueve usuarios del servicio.

Resultados: el análisis de datos fue organizado en tres bloques temáticos: 1) condiciones de existencia de las personas que recurren a la Defensoría Pública del Estado de São Paulo con demanda de salud mental; 2) Trayectoria de búsqueda por acceso a los derechos; y 3) la búsqueda de acceso a la justicia en la Defensoría del Estado de São Paulo. Se identifica, en el relato de los trabajos desarrollados descritos por la demanda de salud mental, que la institución busca desarrollar una escucha cualificada, posibilitando reconocer las diferentes formas de existencias y necesidades de una parte de la población tradicionalmente invisibilizada socialmente; el usuario del servicio con demanda de salud mental y sujeto de derecho.

Conclusión: los resultados posibilitan identificar que el referencial teórico propuesto por la Sociología de las Ausencias puede ser considerado como una alternativa prometedora para ampliar las discusiones teórico-metodológicas a aquellos que buscan mayor comprensión de existencia, cuidados y derechos de las personas con trastornos mentales o con sufrimiento psíquico.

DESCRIPTORES: Salud mental. Trastornos mentales. Derecho a la salud. Derechos humanos. Servicios de salud mental.

INTRODUCTION

A critical analysis of the theme of mental suffering makes it possible to identify the importance of exploring theoretical and methodological possibilities that orchestrate the nursing practice.¹ From this perspective, the reader is led to think of mental illnesses as those whose morbidity has not changed in the course of time: "the therapeutic practices that have been derived from clinical models in the last hundred years are highly unsatisfactory".^{1:193}

While clinical models have admittedly benefited patients, it should be emphasized that this has not happened in a remarkable way, questioning the clinic and thus giving rise to a practice parallel to the clinical model, which still lacks a theory: the Psychosocial Rehabilitation.¹ However, thinking about practices that remain without theories forces Psychosocial Rehabilitation to rely on some ideology. "The ideology of empowering the disabled to take sides in a strong society and, then, thinking of Psychosocial Rehabilitation as a process of strengthening weaknesses, or populist ideologies that think that the weak should be supported because, society, so evil, condemned them to marginality, which is a trace of a very dangerous and ideological rehabilitation-populist rhetoric. All this to avoid the distressing condition of not having a sufficiently strong theory to formalize and justify a practice that is far more advanced than the theory".^{1:195} It is essential to have a reference model that is constructed with due caution in order to not resort, hastily, to

the old clinical model out of anguish for not having a proper model; and also, to refrain from resuming an ideological reference that justifies the practice.¹

In Brazil, the main changes in mental health policies occurred while tackling impasses, and were established in a daring process of paradigmatic transition: "to look at psychic suffering beyond diagnoses that distract us from the concrete life of the subject with their uniqueness, ties, place and time. To rescue life with its mishaps, paradoxes, impasses, but also as possibilities, potentials of ties and encounters, inventing different ways to go forward. Accepting the task of seeing and hearing 'life as it is' goes much further than learning a new technique [...]. The ethical, aesthetic and political dimensions of daily life arise, [...] which point to the inseparability between clinic and politics, management and care".^{2:20-21}

"The transformation of concepts in the area of mental health driven by the Psychiatric Reform Movement enable new ways of conceiving the mental health-illness process, the treatment and the ethical-professional stance in the care to the person with a mental disorder, from the perspective of the psychosocial paradigm, which is seen as one of the challenges in the formation of competent professionals for the mental health practice".^{3:398} Such concerns are present among researchers focused on mental health education, especially nursing undergraduates. This study shows the difficulties in adapting the theoretical-practical content to the health care

reality, highlighting the traces of asylum practices in the conception of mental health professionals and the difficulties of articulation in the multi-professional work.³

The clinical and diagnostic model is criticized in relation to the model that, in a paradigm transition, values psychosocial dimensions and rehabilitation, while the variety of practices employed by this alternative is, in turn, criticized for generating confusion in the Brazilian mental health scenario.⁴ The following recurrent criticisms stand out: 1) "the existence in Brazil of a 'miscellany of concepts', attempts at a fragmented reproduction of international experiences, structured in different sociocultural contexts",^{4:96} 2) "practices based on spaces of 'entertainment' and 'recreation', and in repetitive and meaningless works".^{4:99}

Despite acknowledging that there are many criticism also directed to the work of Psychosocial Rehabilitation in Brazil, it should be emphasized that the paradigmatic shift from a hospital-centered model to the psychosocial proposal lies in the foundations of the current Brazilian mental health legislation and, consequently, the national policy. Therefore, it is imperative to think of possibilities, strategies, methodologies, and theories that provoke reflections in order to break away from the traditional social isolation of people in mental suffering, as well as from the mental health care paradigm. In short, it is imperative to think of strategies that may act in the development of personal and collective autonomy and stimulate emancipatory practices.

The interest in methodologies that contribute to increase knowledge about people with mental disorder or in mental suffering finds in the epistemological reflection of the sociology of absences a possibility that is both attractive and challenging, which leads us to think of people who carry 'non-existences' and experiences 'on the other side of the line', in the proposed colonial metaphor. In this perspective, the colonies represent a model of exclusion that remains in Western modern thoughts and practices, as it did in the colonial cycle.⁶⁻⁹

The sociological and anthropological theories created in four or five countries of the North Atlantic in the nineteenth century were considered as universal. Consequently, this caused extensive experiences from other parts of the world to be disregarded, especially those of the colonies, because they were not seen as viable, credible alternatives to the European and Eurocentric imaginary.¹⁰ Con-

sidering the experience of the oppressed/excluded as the starting point of the notion of knowledge, we identify the proposal of a 'cosmopolitan rationality' of expanding the present and contracting the future, creating space-time to increase knowledge and to value the social experience, avoiding the waste of experience.⁶ This is how the Sociology of Absences takes form. Five logics or modes of production of non-existence are described: 1) "the 'monoculture of knowledge and rigor of knowledge', in which non-existence takes the form of ignorance or unenlightenment; 2) the 'monoculture of linear time', in which non-existence takes the form of residualization – wild, traditional, obsolete, underdeveloped; 3) the 'monoculture of the naturalization of differences', in which non-existence is produced in the form of natural and therefore unsurpassed inferiority; 4) the 'logic of the dominant scale', in which non-existence is produced in the form of the particular and the local, and 5) the 'logic of productive non-existence', in which non-existence is produced as unproductiveness (sterility, disqualification)".^{6:102-104} Ecologies are proposed for each of the five forms of production of non-existence (admittedly forms of monocultures), in which "ecologies mean the practice of aggregation of diversity by the promotion of sustainable interactions between partial and heterogeneous entities".^{6:105}

The present study will be restricted to the analysis of the Ecology of Knowledge as a replacement for monoculture of knowledge and scientific rigor. The central idea in this sphere is that there is no ignorance in general nor even knowledge in general, all ignorance is considered ignorant of certain knowledge and all knowledge is the overcoming of a particular ignorance. "This ecology is based on the assumption that all relational practices between humans imply more than one form of knowledge and, therefore, of ignorance. It is in the principle of the incompleteness of knowledge that lies the condition of dialogue and epistemological debates between different forms of knowledge".^{6:107} One of the contributions brought by the Ecology of Knowledge is to overcome the monoculture of scientific knowledge and the idea that non-scientific knowledge has a connotation of subalternity. It aims to create a new form of relationship between scientific knowledge and other forms of knowledge, granting equal opportunities to the different forms of knowledge involved in epistemological disputes. The present study aims to analyze possible contributions of the theoretical reference of the Sociology of

Absences, specifically, the Ecology of Knowledge, for the construction of knowledge in the field of psychiatric nursing and mental health.

METHOD

This is a qualitative study with thematic analysis having the Sociologies of Absences as theoretical reference. Data were collected by means of semi-structured interviews with users of the Public Defender's Office of the State of São Paulo (DPESP by its Portuguese acronym) service. The DPESP was chosen for this study for the following reasons: a) it is an institution guided by democratic principles and provision of well defined institutional spaces for social participation, consistent with the values advocated by the current legislation and policy of mental health in Brazil; b) it is an institution of the Justice System whose mission is to defend and ensure the rights of people who live in greater social vulnerability; and c) it has an institutional proposal of assisting the population through interdisciplinary action, considered as fundamental in dealing with (mental) health issues.

Considering the proposed objectives and the selected theoretical reference – whose emphasis lies on the valorization of different knowledge –, the qualitative approach is seen as a convenient methodology, for its commitment to the interactive nature of the knowledge production process. The qualitative perspective enables the recognition of the constant dynamics in the process of knowledge construction. The researcher acknowledges that the research process, from conception to completion, is a continuous dialectical interaction – analysis, review, reiteration, reanalysis and so on, leading to an articulated construction of the object of study.¹¹

The project was submitted to the Ethics Committee of the Ribeirão Preto School of Nursing, *Universidade de São Paulo*, and approved under Protocol CAAE 16965813.0.0000.5393.

Seven interviews were conducted with nine selected users who met the following criteria: a) be a relative (or legal representative) of people with a mental health claim or be a person with a mental

health claim, who is 18 or older and has legal responsibility for their actions and spontaneously sought the service; b) be nominated by DPESP's interdisciplinary service officers; and c) be a user of the DPESP service in its offices of the state of São Paulo. The interviews were carried out at DPESP's premises, in rooms made available by the local supervisors, which provided adequate conditions for ensuring the privacy and preservation of information. Two scripts developed by the researcher guided the interviews (one script was prepared for the person with mental health claim who spontaneously sought care, and another for the relatives who sought care for a family member with a mental health claim), which had an approximate duration of 1 hour.

The analysis of the interviews followed the proposal of Content Analysis, which is characterized by starting from “a literature of the first plane to reach an in-depth level: one that surpasses the manifest meanings”.^{12,103} Among the different possibilities of content analysis, the Thematic Analysis was preferred, which consists of identifying and interpreting the core meanings that make up the material.¹²⁻¹³ The analysis procedure followed: 1) the transcription of interviews; 2) the reading with an in-depth analysis of the data collected and 3) the final analysis (in which the two previous steps make an inflection about the empirical material), an interpretative and dialectical movement (theoretical and empirical) in search of meaning.¹² The analysis was done under systematic procedures, and the data were organized and classified seeking the specificities and the meaning, emphasizing the participants' perspectives in the various ways different people give meaning to their lives. The researcher constructs the meaning by apprehending the participants' perspectives, deepening the internal dynamics of situations, facts, and their experiences.¹⁴⁻¹⁵ From the transcription of the interviews, it was possible to systematize the results seeking the appreciation of the most relevant aspects of each interview. Following the structuring, the emerging themes were identified, the categories named and organized, and subcategories systematized as follows.

Table 1 – Identified themes and their respective categories and subcategories

The conditions of existence of people who resort to the Public Defender's Office of the State of São Paulo with a mental health claim
Diagnosed existence <i>Incomprehensible existence</i> <i>Labeled existence</i>
Violated existence <i>Existence as a domestic aggressor</i> <i>Existence as a victim of domestic violence</i> <i>Existence as a victim of homelessness violence</i>
Compulsory existence <i>Dependent existence</i> <i>Threatened existence</i> <i>Protected existence</i>
Pursuit for access to rights
Journeys of hospitalizations: impotence and impacts
Journey in out-of-hospital services: the principle of dialogues
The journey in the Psychosocial Care Center
Criticism directed to hospitals associated to the Brazilian Unified Health System (SUS, by its Portuguese acronym) and to mental health management
The pursuit for access to Justice in Public Defender's Office of the State of São Paulo: reasons for seeking the service and institutional procedures in face of the demand
The motivation for seeking the service
The service routine protocol
Listening and identifying the demands
Elaboration of report and preparation of defense
Referral for hospitalization

RESULTS

Participants

The interviews were held with people who sought the service for themselves or for their relatives. Seven interviews were carried out, one of them conducted with two people who had personal mental health claims (mother and daughter); in a second one, two relatives of the person presenting the claim (son and niece) were present, and, in a third interview, the participant sought the service for two relatives (two children). The other four interviews were conducted with one person per claim. In summary, nine people with mental health claims were identified: five women and four men. Five people were identified in offices of the metropolitan area of the city of São Paulo and four from other offices in the state; two were married, two divorced, and five single; just two people declared their jobs (a painter and a confectioner); one was in prison, three had a history of homelessness; one was admitted at a hospital; one person lived in a boarding house; one lived alone and two lived with their family. The participant's ages ranged from 25 to 68: 25, 29, 31, 38, 40 (2), 41, 52 and 68. Of the nine people with a mental health claim, three sought the service spon-

aneously and six resorted to the service upon the family's request.

The conditions of existence of people who resort to the Public Defender's Office of the State of São Paulo with a mental health claim

People with mental disorders were considered as mental health claimants, as were those with mental suffering, who did not necessarily present such disorders but who have reported life histories of violence and intense emotional conflicts. Data analysis allowed observing three central themes that emerged from the reports of the users of the service and intertwined repeatedly: mental illness, drug abuse, and violence. Such themes were systematized in order to describe forms of existence: the Diagnosed existence, Violated existence, and Compulsory existence.

Diagnosed existence

The theme of mental illness, regarding the medical diagnoses and nomenclatures, mingles throughout several definitions presented by the participants, evidencing different efforts aiming

at understanding and defining themselves or their relatives. Comments about treatments and diagnoses are present in the reports, in two different manifestations: as information that is vague and distant from the repertoire of the service users (Incomprehensible existence); and as information that is borrowed and reproduced according to the technical jargon of psychiatry (Labeled existence).

Violated existence

Violence was observed as constantly present in the stories. The emphasis lies on situations in which the person who presents a mental health claim is described as having violent behavior, both physical and psychological, against family members in the domestic setting (Existence as a domestic aggressor). There were also reports of violent manifestations in which people with mental health claims experience the condition of victims in a domestic setting (Existence as a victim of domestic violence), as well as statements in which hostility and violence were evidenced in homelessness situations, in which people with mental health claims were in the condition of victims (Existence as a victim of homelessness violence).

Compulsory existence

The mental health claim related to drug abuse (Dependent existence) emerges from the narrative of family members, since, in this kind of situation, subjects did not seek the service spontaneously. However, circumstances were mentioned in which children explained the need for parental intervention for treatment because they had admitted the risk of non-survival or insanity. There are aspects of vulnerability and risk to users, involvement in acts of vandalism and infractions, situations of abandoning the parents' home and refusing ambulatory care. There are cases in which the drug abuse claim coexists with other mental disorders.

Situations in which abusive consumption threatened the conditions of existence were recognized, as well as suicide risks; lack of personal and nutritional care; risk situations due to involvement in fights; vulnerability in homelessness situation and exposure in rural areas (Threatened existence). References to the engagement of different institutions and/or authorities to protect the existence of people interceding before the mental health claims (Protected existence) were also observed.

Pursuit for access to rights

The focus of the present analysis will be the statements in which users express the pursuit for services, considered by them as alternatives in their journey for access to health care. These topics were grouped into hospitalizations, out-of-hospital services found in the healthcare system, more specifically in the Psychosocial Support Center (CAPS), and critiques directed to the hospitals associated to the Brazilian unified Health System (SUS) and to mental health management.

Journeys of hospitalization: impotence and impacts

When addressing the topic of hospitalizations, the active, painful, and ambivalent role of the family member becomes evident in the following situations: in seeking the hospitalization of the person with mental health claims; in the difficulties the family faces to implement hospitalization before the Mobile Emergency Service (SAMU) and the police; in the impotence of the hospitalized person before the decision of the family member and the conduct of the professionals of the receiving institution.

Journey in out-of-hospital services: the principle of dialogues

When references to out-of-hospital services are observed, the presence of different health professionals and the possibility of greater dialogue between service users and professionals are detected. However, although the relationship with the professional can be established in a more dialogical way and with greater acceptance of the treatment by the person with mental health claims seeking the service (when compared to the references presented in the hospitalization journeys), such acceptance does not turn into adherence to drug treatment. A dialogical exercise is also identified in statements that refer to community coexistence, the exchange of experiences among residents of the same neighborhood on mental health issues, and the initiative of an educational institution to discuss experiences of people with such demands.

The journey through Psychosocial Support Center

The search for care in the CAPS arises with different approaches in the statements. In some places, statements point out the absence of the service. In

the places where CAPS is present, the participants demonstrated they attend the center, they know the routine, and understand how the staff works. Although they acknowledge the importance of CAPS in proposing a different type of care, avoiding long-term hospitalizations and introducing different professionals for a closer monitoring of the reality and needs of people, clinical evaluations, and multidisciplinary work, there are some significant critiques to the service. Allusions to the abandonment of the service by the person with mental disorders and the low adherence to the medical treatment are frequent, as well as the difficulty of the person with a mental disorder to comply with the schedule and attend the programmed activities. In face of the discontinuation of drug treatment, and the non-attendance in activities scheduled by CAPS, reports of continuity in homelessness situations, experiences of violence and deprivation are common.

Criticism directed to hospitals associated to the Brazilian Unified Health System and to mental health management

Mental health management appears in the participants' statements as the "worst health service", "victim of political neglect", and the service "that is not taken seriously in the country". CAPS professionals are considered as "very stressed" and "constantly having tasks assigned out of their scope of work". In hospitals, there is "a lack of physical space, no proper food, lack of beds for crisis management", and "lack of responsible professionals". Greater criticism is made in relation to the hospitals associated to the SUS and to therapeutic communities: "relatives verbally mistreated", "absence of contact with professionals", "meetings with former chemically dependents only", "social worker contact only for requesting hygiene products", "lack of monitoring, audit and supervision of the Judiciary on associated hospitals".

The pursuit for access to Justice in Public Defender's Office of the State of São Paulo: reasons for seeking the service and institutional procedures

The motivation for seeking the service

Among the reasons mentioned by the users for seeking the DPESP service, the following stand out: claiming the right to custody of sister, interdiction of mother, defense in the process of interdiction by son

and brother, compulsory hospitalization of child, defense of son arrested for robbery for buying drugs, intervention in process of accusations of daughter and custody of grandchildren, lawsuit against the National Social Security Institute (INSS) to request brother's retirement, protection in face of threats and persecutory thoughts, claiming support for children, dispute over custody of children; access to medical treatment, request for defense in face of situations of violence, and claiming benefits.

Regarding the themes of the procedures adopted by DPESP that could describe the work routine implemented, aiming to provide the population with access to the Justice system, the statements were organized in 1) service routine protocol; 2) listening and identification of demands; 3) elaboration of report and preparation of defense and 4) referral for hospitalization.

The service routine protocol

Description of service routine and the different roles performed, as well as the procedures adopted for each stage of the work: the reception and screening work, psychosocial care and/or trainees' support for guidance on referrals or regarding the necessary documentation for preparing the defense in case of a lawsuit.

Listening and identifying the demands

Identification of statements that illustrate the dialogical relations between professionals and service users with an emphasis on individual appointments ("conversations") that aimed to seek information, orientations and a better understanding of the needs of service users. Those statements also addressed the difficulty of understanding the real life conditions of service users (and their verbal expression) by trainees and/or service professionals.

Elaboration of report and preparation of defense

Presentation of the procedures for collecting information that can guide the action and assist in the referrals to be adopted: interviews and annotations of the information collected; home visits; interviews with family and neighbors; judicial referral or mediation of conflicts. In such procedures, contact with trainees and different service professionals – public defender, social worker and psychologist – were mentioned.

Referral for hospitalization

Evaluations regarding the procedures adopted in cases in which hospitalization was the alternative before the service users' mental health impairment.

DISCUSSION

Analyzing theoretical and methodological possibilities for research in (psychiatric) nursing and (mental) health leads us to impasses. Such impasses originate in epistemological disputes rooted in the clinical reference model (and its scientific recognition) and in the proposal of psychosocial rehabilitation that arises from questioning this model, specifically, from criticisms directed to the hospital-centered performance. Thus, the Brazilian mental health scenario faces a paradigmatic transition process, exhaustively discussed by the movements of the Psychiatric Reform and the Brazilian Anti-asylum Movement, with repercussion in the elaboration of the mental health legislation and the policies in force in the country. The emphasis on ensuring human rights is at the center of the discussions, based on reports of violations in hospital settings.

If it is true that such situations provoked outrages and evoked demands for change, it is also true that the clinical model came to be considered as the true "scapegoat" in the face of violation practices. Such a scenario facilitated the emergence of psychosocial rehabilitation practices based on human rights principles. People in mental suffering who remained isolated in psychiatric hospitals are then considered as subjects of rights and capable of occupying public spaces, hitherto denied to them, challenging both structures and services to adapt to this new reality, as well as researchers to rethink their theoretical models.

By drawing attention to those historically invisible (non-existent) people placed 'on the other side of the abyssal line', we are instigated to think of the justice system and scientific production without repeating the different forms of production of non-existences. An ecological way of thinking is proposed, as opposed to the monoculture of knowledge; an ecology of knowledge practices that comes from the assumption that in all relationship between human beings there is more than one kind of knowledge and, therefore, of ignorance. In this perspective, social injustice is based on cognitive injustice, because scientific knowledge is not distributed socially in an equitable way and, consequently, the interventions it favors tend to be those

that provide the social groups that have access to knowledge. The goal of an Ecology of Knowledge is to fight against cognitive injustice.^{6,8}

Analyses that approach the proposal of thinking about health from the perspective of Ecology of Knowledge are recent and at the same time promising, indicating that the reflection proposed by the present study finds similar questions in different contexts. A study on the Brazilian Sanitary Reform Movement, characterized as radically democratic, inclusive and participatory, analyzes it under the perspective of an Ecology of Knowledge.¹⁶ The counter-hegemonic nature is approached in the political and epistemological dimensions of the Movement and its relevance in the creation of the collective health field of knowledge, with the objective of aligning the Movement of the Brazilian Sanitary Reform to the post-abyssal thinking.

Bringing the reflection specifically to the field of mental health, we find a study that analyzes the mentioned movement as a radical and creative response to the "unreason/madness" dehumanization, proposing innovative forms of collective action, redefining knowledge and modes of expression. In this process, the recognition of the aesthetic dimension as a central element of the decolonization of mental health knowledge and practices, and of the invention of ecologies of knowledge, would radically decentralize the authority of hegemonic knowledge.¹⁷ This idea is corroborated by a study that presents the theoretical-methodological articulation between the Theater of the Oppressed, as a data builder, and the Sociology of Absences and Emergencies as a reference for analysis.¹⁸ According to the authors, this articulation is identified as a powerful tool for the democratization of knowledge, valuing knowledge and experiences considered marginal. They present the Theater of Emergencies "as a tool of the Theater of the Oppressed committed to expand the present and to take risks in translations of cultures, groups, and knowledge, contributing to the inter-knowledge and the emancipation of the participants through the cultivation of Ecology of Knowledge [...]. The Theater of Emergencies is considered an invitation to the construction of collective actions and knowledge".^{18:558-60}

In studies that specifically address nursing, it is possible to think of two important aspects analyzed in recent publications. In one of them, the authors invite us to reflect on the innovative teaching of nursing from the perspective of the Epistemologies of the South. They emphasize the concepts of decolonization of knowledge, post-

abyssal thinking, and ecology of knowledge, which would offer subsidies to think about the effectiveness of the teaching-learning process based on the recognition of the plurality of knowledge in sustainable and dynamic interactions between them, without compromising everyone's autonomy. The teaching technologies are proposed as integrated to a broader pedagogical process, resulting from theoretical reflections and dialogic skills of the nurse as an educator. The authors believe that this theoretical reference can support the innovative teaching of Nursing, in accordance with the understanding of the epistemological diversity necessary for teaching that includes the co-participation between the subjects involved in the teaching-learning process and the acknowledgment of the diversity of knowledge as an enriching aspect of teaching.¹⁹

In a second study, the author argues that nursing presents and affirms itself as a science, within a framework of paradigmatic transition, characterized by being a knowledge in action, a practical human science of plural knowledge (scientific knowledge that intersects with other knowledge). Therefore, it proposes nursing as a blend of knowledge that co-exists and acts among themselves, and between themselves and the context, making their knowledge a true ecology of knowledge.²⁰

When reflecting on the present study's results, guided by aspects based on the Ecology of Knowledge found in recent literature, it is possible to consider, initially, that the very possibility of listening and analyzing the mental health claim in the justice system is an advance in a democratic perspective of participation of this new subject of right in society; specially because, historically, the justice system has remained entrenched in its rituals and specific legal language, distancing itself from the conditions of existence and the different forms of communicating demands of greater social vulnerability. These observations lead us to the aspects introduced by the studies that address a counter-hegemonic reflection on the principles of the Sanitary Reform Movement, which inaugurates new spaces for the participation of different social actors in defense of their rights to health and increase the possibilities of experiencing citizenship.

It is also possible to think that people who have a mental health claim, by making their needs explicit and participating in the construction of the defense of their rights, together with an interdisciplinary team in the justice system, innovate the practices of approaching the demands of mental health. In this regard, we must bear in mind that the

referral of each particular situation is constructed from the reports of the conditions of existence and the relations of this demand with the different public services, providing both individual defense and public civil actions in cases of State omissions in relation to the rights to mental health. Such situation is similar to that addressed by a study that emphasized the Psychiatric Reform Movement as a radical and creative response to the "unreason/madness" dehumanization, proposing innovative forms of collective action and redefinition of knowledge.¹⁶

The interviews showed that people with mental disorders or in mental suffering and/or their relatives demonstrated being aware of claiming the right to be treated as subjects of rights in the justice system and, consequently, claiming the right to speak, in denouncing precarious and violated conditions of existences in different social spaces, as well as denouncing the violation of their rights by the State itself in the different public services that should ensure their fundamental rights. In this context, the interviews can be thought of as data builders and the Sociology of Absences as a theoretical reference, approaching a study proposal on the Theater of Emergencies and corroborating the idea of this articulation as a powerful tool for the democratization of knowledge, valuing knowledge and experiences considered marginal.¹⁸

During the interviews, the approach of the Sociology of Absences enabled, in a complementary way, the reflection upon the process of knowledge construction, identifying the importance of thinking of science without disregarding the scientific way of seeking knowledge, but alerting to the fact that no form of *a priori* knowledge should be ruled out.⁶ In the perspective of an Ecology of Knowledge, the service user (study participant) is no longer considered a passive addressee of the professional activity of the institution (research), and is from now on considered a citizen who participates in the construction of this institution (and of the scientific knowledge produced) with a democratic objective. The participants have gained an active voice and social visibility, and are no longer 'on the other side of the line' of science and the justice system. This way, our work is consistent with what is proposed by the Sociology of Absences, valuing the experiences that were previously wasted (non-existent), so that they become present. By incorporating available experiences in the analysis, the perception of the present is expanded and it becomes possible to think of the future not as something indeterminate, but as possibilities resulting from different alterna-

tives, starting from an amplified reality multiplied by an ecology of knowledge, amplified by clues and signs, which can be identified if the conception of present is not wasting experiences with the production of nonexistences.⁶⁻⁹ It is precisely in this aspect that is thought to reside the promising nature of the Sociology of Absences as a theoretical reference for future studies that approach research activities for psychiatric nursing and mental health.

CONCLUSION

Recent studies demonstrate that the Sociology of Absences has subsidized reflections upon health studies addressing both the participatory and democratic nature that guided the Brazilian Sanitary Reform Movement and practices implanted under the participatory emancipatory perspective of the Psychiatric Reform in the country. The direct relationship between the Ecology of Knowledge and nursing is manifested by references about the training of undergraduates, reflections on the presence of different knowledge (scientific and non-scientific) in the nurses' work, as well as on the approach to nursing as a knowledge field that develops in a process of paradigmatic transition, which can be enriched by expanding the perception of reality and the recognition of socially produced knowledge hitherto considered as nonexistent. The results of the present study with users of the Public Defender's Office in the State of São Paulo show the presence of people and/or their relatives in mental suffering (socially produced as nonexistent) in an institution of the justice system, participating in the construction of defense of their rights.

In conclusion, we understand that in aiming at horizontalizing the knowledge of those who historically remained on the 'other side of the abyssal line' of scientific knowledge, theories and methodologies that seek to develop knowledge in psychiatric nursing and in mental health, the person in psychic suffering begins to occupy the effective space of subject of right, having a say in their demands of existences. In this way, the coherence of this referential is identified with the proposal of humanization in health, based on the principle of human dignity. However, there is much work to be done so that the academy can better assimilate the recent idea that the Ecology of Knowledge, by valuing the importance of recognition of non-existences, proposes its overcoming by means of an ecological thinking that can contribute to the advances of knowledge. The challenge is set.

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