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TEACHING, CARE AND SUBJECTIVITY IN MEDICINE: A CASE STUDY

Daniela Viecili Costa Masini [1] [2], Orcid: http://orcid.org/0000-0002-2856-5690
Daniel Magalhães Goulart [3] [4], Orcid: http://orcid.org/0000-0002-0254-0137

ABSTRACT. Considering the current challenges faced in mental health services and their possible relationships with the training of health professionals, this article aimed to discuss how the teaching of medicine was subjectively configured by an undergraduate and the possible relationships of this process with some of the current challenges of the Brazilian psychiatric reform. This study was based on a case study carried out over four months with a medical student from a public college in the Federal District, where active learning methodologies are used. The Theory of Subjectivity, Qualitative Epistemology and the constructive-interpretative methodology of González Rey were used as framework. The results indicate the organization of a social subjectivity of medicine teaching marked by processes related to the biomedical model, despite institutional changes that aim to promote teaching based on a biopsychosocial care model. The participant expresses a subjective configuration in which care is linked to control and medicalization, whose development seems to have been favoured by the social subjectivity of her teaching context. In addition, it can be said that the social subjectivity of medical education is possibly related to a mental hospital social subjectivity, still present in substitute mental health services, such as Psychosocial Care Centers, making the changes proposed by the psychiatric reform more difficult to be accomplished. Finally, this study emphasizes the subjective aspect of learning, through which processes related to different areas of a person's life are articulated, such as education, family and culture.
Keywords: Medical training; mental health care; subjectivity.

ENSINO, CUIDADO E SUBJETIVIDADE NO CAMPO DA MEDICINA: UM ESTUDO DE CASO

RESUMO. Considerando as atuais dificuldades enfrentadas em serviços de saúde mental e suas possíveis relações com a formação de profissionais de saúde, este artigo visa discutir como o ensino de medicina foi configurado subjetivamente por uma estudante universitária e as possíveis relações desse processo com alguns dos atuais desafios da reforma psiquiátrica brasileira. Este trabalho baseou-se num estudo de caso realizado ao longo de quatro meses com uma estudante de medicina de uma faculdade pública do Distrito Federal, onde se faz uso de metodologias ativas de aprendizagem. Foram utilizadas como referenciais a Teoria da Subjetividade, a Epistemologia Qualitativa e a metodologia construtivo-interpretativa de González Rey. Os resultados da pesquisa apontam para a organização de uma subjetividade social do ensino de medicina marcada

[1] Centro Universitário de Brasília, Brasília-DF, Brazil.
[2] E-mail: danivieciliicm@gmail.com
[3] Universidade de Brasília, Brasília-DF, Brazil.
[4] E-mail: danielgoulartbr@yahoo.com.br

por processos relacionados ao modelo biomédico, apesar das mudanças institucionais que visam promover um ensino pautado num modelo de atenção biopsicossocial. A participante expressa uma configuração subjetiva em que o cuidado articula-se ao controle e à medicalização, cujo desenvolvimento parece ter sido favorecido pela subjetividade social de seu contexto de ensino. Além disso, pode-se dizer que a subjetividade social do ensino de medicina está possivelmente relacionada a uma subjetividade social manicomial, ainda presente em serviços substitutivos, como os Centros de Atenção Psicossocial, dificultando as mudanças propostas pela reforma psiquiátrica. Por fim, este trabalho enfatiza o caráter subjetivo da aprendizagem, por meio do qual se articulam processos relacionados a diferentes âmbitos de vida da pessoa, como o educacional, o familiar e o cultural.
Palavras-chave: Ensino de medicina; atenção à saúde mental; subjetividade.

ENSEÑANZA, CUIDADO Y SUBJETIVIDAD EN LA MEDICINA: UN ESTUDIO DE CASO

RESUMEN. Teniendo en cuenta las dificultades actuales que enfrentan los servicios de salud mental y sus posibles relaciones con la formación de profesionales de la salud, este artículo tiene como objetivo discutir cómo la enseñanza de la medicina fue configurada subjetivamente por un estudiante universitario y las posibles relaciones de este proceso con algunos de los desafíos actuales de reforma psiquiátrica brasileña. Este trabajo se basó en un estudio de caso realizado durante cuatro meses con una estudiante de medicina de una universidad pública del Distrito Federal, donde se utilizan metodologías activas de aprendizaje. La Teoría de la Subjetividad, la Epistemología Cualitativa y la metodología constructivo-interpretativo de González Rey fueron utilizados como referentes. Los resultados de la investigación apuntan a la organización de una subjetividad social en la educación médica marcada por procesos relacionados con el modelo biomédico, a pesar de los cambios institucionales que tienen como objetivo promover una enseñanza basada en un modelo de atención biopsicosocial. La participante expresa una configuración subjetiva en la que el cuidado está vinculado al control y a la medicalización, cuyo desarrollo parece haber sido favorecido por la subjetividad social de su contexto de enseñanza. Además, se puede decir que la subjetividad social de la educación médica posiblemente esté relacionada con la subjetividad social manicomial, aún presente en servicios comunitarios, como los Centros de Atención Psicosocial, lo que dificulta los cambios propuestos por la reforma psiquiátrica. Finalmente, este trabajo expone el carácter subjetivo del aprendizaje, a través del cual se articulan procesos relacionados con diferentes áreas de la vida de la persona, como la educación, la familia y la cultura.

Palabras clave: Enseñanza de la medicina; atención a la salud mental; subjetividad.

Introduction

Educational processes express the representations of the individual and society that are intended to be formed. The current way of teaching is predominantly based on content,

prioritizing the acquisition of knowledge in a less reflective way, which can be seen as an unfolding of a culture in which repetition is more valued than the exercise of critical thinking. This form of teaching, based on the student passivity, makes creative learning difficult, in which, unlike the simple obtaining of certain knowledge, what is learned starts to function as a subjective resource for the generation of new ideas that confront the established[5] (Muniz & Mitjáns Martínez, 2015). Such a situation can lead to the maintenance of problematic social situations, since it does not promote questioning on the part of those who learn, but adaptation (Freire, 1987). In order to generate alternatives to such reproductive teaching practices, several institutions have adopted active methodologies in the production of their students, which, however, does not necessarily imply a rupture with hegemonic forms of teaching (Prevedello, Segato, & Emerick, 2017).

This discussion is relevant in the context of psychiatric reform, as it can help to understand some challenges that have arisen with changes in mental health services. The deconstruction of dominant psychiatric practices and knowledge are the basis of psychiatric reform and imply a rupture with the disease-cure paradigm, giving rise to projects of health invention and new forms of sociability, less guided by the logic of domination and control (Rotelli, Leonardis, & Mauri, 2001). However, the production of physicians, the focus of this study, is still based mainly on the biomedical model, centered on disease, medicalization and the hierarchical relationship between health professionals and users, distancing itself from the psychiatric reform proposals (Daltro, Jesus, Bôas, & Castelar, 2018).

The psychiatric reform has culminated, among other processes, in the replacement of mental hospitals with other care devices, which aim at the social reintegration of users, in contrast to the mental hospital logic of exclusion. However, this logic may still be present in these substitute services, through hierarchical, medicalizing and disciplinary forms of care (Goulart, 2019a). Hence the demand for an anti-asylum psychiatric reform, as the creation of substitute services for the mental hospital does not necessarily imply a different form of relationship with people in psychological suffering (Ornellas, 2007).

Considering that through a differentiated training of professionals it is possible to transform care practices in the field of mental health, this article aimed to discuss the role of university training in medicine in the psychiatric reform process, based on a case study carried out with an undergraduate from a college in the Federal District, where active methodologies are used, having as framework the Theory of Subjectivity, Qualitative Epistemology and the constructive-interpretative methodology of González Rey (2001, 2012a, 2012b, 2014, 2015, 2019; González Rey & Mitjáns Martínez, 2017).

Medical teaching and psychiatric reform

In Brazil, psychiatric reform emerged in a context of redemocratization in the late 1970s and was led by mental health workers, service users and their families (Amarante, 2017). It did not arise at the university, as the main issue that permeated the process at the time was the invention of practices different from those based on the current *psi* knowledge (Lobosque, 2007).

Psychiatric reform brings at its core the criticism of the notion of scientific neutrality, since this conception does not take into account that science, whether it likes it or not,

[5] Creative learning represents a process related to the concept of subject from the perspective of the Theory of Subjectivity, which will be presented and discussed throughout this article.

brings with it ideologies - theories that unconsciously convey a representation of the world that results in legitimizing practices and masking part of the views of those who defend it (Fourez, 1995). With regard to the theme of this study, this is relevant insofar as psychiatric knowledge is "[…] a knowledge quite committed to the need to exclude people, from the authority that society gives to the psychiatrist to exclude and segregate people" (Rotelli, 2014, p. 151). In line with Freire's pedagogy of liberation (1987), Amarante (2017) argues that psychiatric reform also encompasses a theoretical-conceptual dimension, which is closely related to the need to produce health professionals who are aware of the social function of exclusion that psychiatry can take over.

The National Curriculum Guidelines for medical courses advocate the teaching of forms of care based on the understanding of the person in their complexity and that enable the performance of a critical and reflective professional at different levels of health care. However, training in medical courses still occurs mainly in hospital environments and the explanatory model used to understand psychological distress is biomedical (Silva, Muhl, & Moliani, 2015). In this, diseases are understood as sets of standardized symptoms, which represent a quantifiable way of understanding the disease, consistent with the principles of a positivist science. But this merely descriptive notion of mental disorder has led to the pathologization and elimination of singularities involved in the suffering of individuals (González Rey, 2015; Goulart, 2019b).

A teaching that privileges reproduction is related to a process of standardization of people, which makes it difficult to invent alternatives to problems that tend to be renewed, such as the permanence of a mental hospital logic in substitute health services (González Rey, 2012a; Goulart, 2019a). In substitute mental health services, professionals capable of inventing are needed, going beyond the logic of standardization and reproduction of medical protocols (Rotelli et al., 2001). According to Machado and Lavrador (2001, p. 46),

> Our intervention on the experience of madness always imposes new challenges in which there are no magic formulas and ideals to be followed, but provisional experimentation, problematization, questioning and the exercise of thought. This experimentation points to creation.

Considering this, Merhy (2010) comments on the expectation regarding the production of anomalous people in the field of medicine, that is, of professionals whose training 'went wrong', as this training process has not allowed the construction of differentiated relationships and care practices.

The primacy of the biomedical model in the training process of health professionals is expressed in mental health services through excessive medicalization focused on eliminating symptoms, lack of articulation with possibilities of the territory and centrality of the physician performance in mental health services, that ends up impacting the functioning of the team as a whole (Goulart, 2019a). Such care practices generate cases of chronicity and dependence of users on health services, configuring the phenomenon of the new institutionalization. In this context, both users and non-medical professionals seem to express subjective processes related to the biomedical model and the emphasis on drug treatment (Goulart, 2019b; Goulart & González Rey, 2019).

Psychiatric reform intends to go against this process, by questioning truths and ways in which people relate and live together. Changes are proposed in the conception of health, overcoming its representation as the absence of symptoms, which seems to be accompanied by practices focused on healing and not on social rehabilitation and the production of new forms of existence. In addition, a less medicalizing and more relational

care is defended, to facilitate, from the bond with the other, alternative subjective productions (Goulart, González Rey, & Torres, 2019).

A proposal to implement a form of teaching more consistent with the Curricular Guidelines of Medical programs is Problem-Based Learning (PBL) (Prevedello et al., 2017). PBL is considered a student-centered teaching method, in which the student assumes a proactive role. Regarding teaching in mental health, PBL can allow students to face complex situations that encourage them to think about the process of psychological distress within their social context (Figueiredo et al., 2019). This teaching method is consistent with Freire's thinking, in defense of the need to originate people who are capable of generating alternatives and social changes (Freire, 1987; Macedo et al., 2018). Nevertheless, this teaching method, when used in a protocol and mechanical way - that is, when it is not subjectively configured as a way to assume a condition of agency in the learning process, but only as a way to fulfill an institutional obligation - can distance itself from its transforming objective, not breaking with the centrality of the biomedical model in medical education (França & Maknamara, 2019).

Another difficulty in using this teaching-learning methodology is the crystallization of traditional forms of teaching, which are commonly associated with a notion of learning restricted to the assimilation and reproduction of content (Villardi & Cyrino, 2018). This still hegemonic representation of learning is related, in turn, to an instrumentalist and dogmatic scientific practice, in which reproduction is valued more than creativity (González Rey, 2014), while creative learning is more related to a representation of science as a field of uncertainties and possibilities (Amaral & Mitjáns Martínez, 2009).

Therefore, despite the initiative to generate changes in medical education through curricular changes and teaching methods, it is clear that there are still obstacles in the promotion of medical training more aligned with mental health demands. Bearing this in mind, we decided to discuss aspects related to teaching-learning and care based on the Theory of Subjectivity, since this framework allows to understand subjective processes involved in this problem, which are beyond the immediate capacity to raise awareness in the individual (González Rey, 2012b).

Subjectivity, subject and learning: theoretical contributions to the training process in medicine

From the perspective of González Rey's theory of subjectivity, subjectivity is understood as a symbolic-emotional production on lived experience, which articulates in a complex and dynamic way social and individual subjective processes and whose basic unit is the subjective senses (González Rey & Mitjáns Martinez, 2017).

The category of subjective sense allows to understand human subjectivity as a production, and not as a mere result of external influences and stimuli (González Rey, 2014). In this way, learning can be understood as a subjective production of the person, going beyond its predominant representation of the passive-reproductive process, which has consequences both in the practices and relationships established in educational institutions (González Rey, 2012a, 2014), and, later, on the performance of students as professionals.

The individual dimension of subjectivity refers to the subjective organization that integrates the experiences of an individual's life history. It is not an intrapsychic formation isolated from the social dimension, as the individual is constituted within different social

subjectivities, at the same time operating as a subjectivation moment different from these (González Rey & Mitjáns Martínez, 2017). Social subjectivity consists of an organizing system of subjective senses that are expressed through representations, beliefs and morals present in the relationships between individuals in a given social space, which is crossed by subjective processes from other spaces (González Rey, 2014). Therefore, it can be said that the individual who learns expresses the social subjectivity of the different social spaces in which they live in the learning process (González Rey, 2001).

An example of the expression of subjective processes in the social sphere is the mental hospital social subjectivity, which is associated with subjective processes related to the biomedical model and expressed in care practices that objectify the other in mental health care, hindering their subjective development. This form of social subjectivity can even be present in substitute mental health services, such as Psychosocial Care Centers, being associated with the phenomenon of the new institutionalization, discussed earlier (Goulart, 2019a).

The concept of subjectivity is interesting to also reflect on teaching practices. It can be seen that institutions do not change only with new policies and new ways of operation, as is often the case within the Psychosocial Care Centers (Goulart, 2019a). Similarly, only formal changes in curricular structures of teaching are not enough to produce more reflective and critical professionals, capable of responding to demands of mental health care.

These dimensions of subjectivity – social and individual – are reciprocally constituted in the same complex system, in which their contradictions allow the generation of new subjective senses (González Rey & Mitjáns Martínez, 2017). To a certain extent, social subjectivity hinders the emergence of subjective senses divergent from those socially predominant, which represents one of the forms of resistance to culture changes (Goulart, 2019a). But social subjectivity can undergo changes from the moment individuals or groups assume the condition of subjects. From the perspective of the Theory of Subjectivity, being a subject is not an inherent attribute of the individual, but a subjective quality that allows the production of new spaces of subjectivation in a system of institutionalized practices (González Rey & Mitjáns Martínez, 2017). In the case of learning, assuming the condition of subject is associated with critical and reflective capacity in relation to what is learned (González Rey, 2014), being a condition for the constitution of creative learning (González Rey & Mitjáns Martínez, 2017).

Social subjectivity can assume a limiting character in a more extreme manner, in such a way that it makes difficult the constitution of an active position on the part of those who are involved in it. This process can characterize the social subjectivity of institutions in general, including the university (González Rey, 2012b).

Current science, under the influence of empiricism and rationalism, has often become a dogmatic domain, in which knowledge has been transformed into a truth to be respected, with little room for creativity (González Rey, 2019). In medicine in particular, the predominance of quantitative research based on the notion of scientific neutrality and the elimination of the researcher as a subject is remarkable (Taquette & Villela, 2017). From the perspective adopted here, it is not the use of quantification as a knowledge production operation that is criticized, but its conversion into an absolute principle of legitimacy of the information produced, disregarding the theoretical construction about the information that arises through the instruments (González Rey & Mitjáns Martínez, 2017).

This representation of knowledge is present in the social subjectivity of universities (González Rey, 2012b), which may be associated with the inertia of medical programs in

relation to innovations in the field of mental health, since one of the bases of the psychiatric reform as a whole was the criticism of the supposed scientific neutrality of psychiatry – which supported practices of standardization and exclusion (Rotelli, 2014).

Science is part of a broader social scenario, articulating itself to the political and moral dimensions of a given historical period. Thus, some ideas are more accepted in social spaces in which scientific practice is constituted, while others are not so much (Goulart & González Rey, 2016). Teaching centered on the biomedical model in institutions whose students, for the most part, are inserted in an upper-middle class context seems to make it even more difficult to understand the social and economic aspects involved in psychological distress (Silva et al., 2015). One can question the consequences of this in the practice of these future health professionals.

From the perspective of the theory of subjectivity, the concept of subject category contributes to thinking about both new forms of care and learning in the context of mental health (González Rey, 2012a; Goulart, 2019a). In this view, a mental disorder is not defined as a list of symptoms, but as a subjective configuration that becomes predominant in the person's subjective production process, in order to make it difficult to produce alternative subjective senses to those associated with their suffering (González Rey, 2012b). This makes it possible to think about mental health in a close relationship with the concept of subject, proposing, then, a care based on an ethics of the subject: in which care practices allow the production of new spaces of subjectivation and the invention of new forms of life (Goulart, 2019a). This perspective is opposed to the biomedical one, in which the main objective of treatment is the elimination of the symptom, which excludes the individual from their own care process, imposing a place of passivity and consumption before health professionals (Goulart, 2017; Goulart et al., 2019).

In the context of teaching, the subject category refers to a form of learning in which the production of subjective senses integrates the learner's personal development. Learning is no longer a standardized and mechanical process of assimilation, and becomes a singular process of subjective production, in which emotions, experiences and reflections are articulated, allowing the student to use what they have learned creatively in different contexts (González Rey, 2012a).

Both in education and in health care, practices that allow the emergence of the other as a subject also favor their subjective development. Subjective development does not imply the notion of progress, but the possibility of producing new subjective resources, allowing the person to assume a qualitatively different position in the social spaces they live, such as in the family, community and work (González Rey & Mitjáns Martínez, 2017).

To understand the subjective processes related to teaching expressed by the participant of this study and how they are articulated to care in the field of mental health, the constructive-interpretative methodology, developed by González Rey (2019) was used to account for the study on human subjectivity, whose characteristics are articulated to the assumptions of Qualitative Epistemology, also elaborated by the author (González Rey & Mitjáns Martínez, 2017).

Methodology

For the research that underlies this article, the constructive-interpretative methodology was used, which is based on Qualitative Epistemology. This epistemological perspective aims to support the construction of scientific knowledge about human subjectivity, which is marked, among other aspects, by the unpredictability and complexity

of its processes (González Rey & Mitjáns Martínez, 2017). The theoretical categories of the Theory of Subjectivity are inseparable from epistemological principles of this proposal, which permeate the entire research process. They are: (1) knowledge derives from a constructive-interpretative process; (2) singularity is a legitimate source for the production of scientific knowledge; (3) knowledge is conceived as a dialogic process (González Rey & Mitjáns Martínez, 2017).

Participant

The participant in this study was a third-year medical undergraduate at a public medical school in the Federal District. Amanda (not her real name) is a 26-year-old single, religious woman from a lower-middle class background. Her educational institution makes use of PBL and has two teaching axes that aim to produce professionals able to work based on a biopsychosocial care model during the first three years of the program: (1) clinical axis, in which students come into contact with the community through the Family Health Strategy; and (2) theoretical axis, which aims to allow the discussion of psychosocial aspects of illness.

Instruments

From the perspective of the constructive-interpretative methodology, instruments do not represent standardized procedures and validated a priori, but appear as dialogic resources that aim to favor the expression of participants and involve them subjectively, to facilitate the emergence of subjective senses in the course of the research (González Rey & Mitjáns Martínez, 2017). The instruments used herein were conversational dynamics and the preparation of an essay by the participant. Instruments were used throughout the field research process, which had an average frequency of one weekly meeting, over four months.

Conversational dynamics are a dialogic process between researcher and participant, which aims to allow the latter to express themselves freely and openly, taking the form of an open conversation, not an interview centered on the question-answer logic (González Rey & Mitjáns Martínez, 2017). In the research that underlies this article, the conversational dynamics took place both in individual sessions, in informal spaces in the city, as well as accompanying the participant in some of her activities at her educational institution, such as tutorial group discussions[6], lectures and practical activities. The essay written by the participant had as its theme her personal experiences in the field of mental health and in health services that she attended as a medical undergraduate, and allowed her expression to be qualitatively different from the moments of conversational dynamics.

Construction of information

In the information construction process, we sought to identify significant speech excerpts for the interpretation of subjective processes related to the phenomenon studied. In the constructive-interpretative methodology, the construction of information is based on

[6] Tutorial group discussions are moments of group discussion of clinical cases, used in the methodology of Problem-Based Learning.

the production of indicators, which consist of meanings attributed by the researcher to excerpts of the participant's expression. From the convergence of different indicators, which will be explained in the presentation of the case below, hypotheses were constructed, whose articulation allowed the production of a theoretical model, aiming to generate intelligibility on the question studied (González Rey & Mitjáns Martínez, 2017)[7].

Amanda's case

Amanda's mother was primarily responsible for her upbringing and was, according to the participant, a sometimes authoritarian and even violent person. Her family seems to have played an important role in her decision to study medicine. In the following excerpt, the participant talks about her mother's reaction, when commenting on her intention to study music, an area for which she had an affinity at the time: "She gave me 5 options: medicine, law, international relations, social communication and engineering. She said: 'choose one of the 5 and you won't have any problems with me [...]'. 'I was supposed to be a shitty person today, if my mother wasn't my mother'". Her mother even physically attacked her at that moment. Despite this, in this excerpt, Amanda values her mother's authoritarian attitude, representing it as a necessary form of care, through her understanding that at that moment she was unable to make choices for herself. Taking this into account, this excerpt allows the construction of the indicator that Amanda expresses subjective senses related to care as an exercise of control over the other.

Before entering medical school, Amanda went through difficult times, in which she felt sad and thought about suicide frequently: "[…] every 5 minutes, I thought about killing myself. I looked at a car and thought about throwing myself in front, I looked at a building and wanted to throw myself from there". She started a follow-up with a psychiatrist, but, according to Amanda, who really helped her during this period was her cousin. In the following excerpt, the participant reports an event in which she fell ill due to a health problem and her cousin helped her:

> She treated me so well that day, [...] I think a physician should be like that. [...] 'And she didn't give me a drug, something like that, effective of medicine, you know? But the way she touched me, took care of me, made all the difference'.

The excerpt above can be considered an indicator of subjective senses related to the appreciation of a warm relationship as a form of care, to the detriment of the medicalizing approach and in opposition to the representation of care articulated with control, which she expressed when talking about her mother.

Regarding her treatment with a psychiatrist, Amanda commented that she did not like the physician and that she did not adhere to the use of medications, interrupting the follow-up after a few months. In the following excerpt, she reports the failure of psychiatry from her perspective:

> 'I'll tell you what the fault was. The fault was that he prescribed me medicine, now you ask me if I took the medicine'. I didn't get to take the medicine. Because I took it and I saw that I was retarded. [...] I said: 'Man, I'm just slow. I got worse that way'. [...] 'I think that one of the difficulties of psychiatry is this one. Because you have no control over the patients, you know'?

[7] In the case report below, excerpts of the participant's expression considered significant for the purpose of the article were selected. Likewise, the indicators and hypotheses presented refer to the focus of the article. Thus, not all analyses constructed from the expression of the research participant were described in detail.

Despite not recognizing the use of medication as something that has helped her, Amanda still seems to associate the failure of her treatment with the lack of use of such drugs. This can be seen as an indicator of subjective senses related to the biomedical model, in which the medicalizing approach takes a central place in care. Such subjective processes may also be related to the social subjectivity of their teaching context, in which the biomedical model still seems to be predominant.

In addition, this excerpt corroborates the first indicator constructed, related to subjective senses related to care as an exercise of control over the other, since the participant associates the lack of control the physician had over her with her non-adherence to drug treatment, referring, therefore, to the way she also represents her mother's care. Such subjective processes of controlling care are linked to the emphasis on the medicalizing approach, to the detriment of building a warm and dialogical care relationship.

At another time with the participant, in a room discussion about a clinical case, Amanda made the following comment:

> Professor: I think this physician induced the patient to accept the treatment she (the physician) wanted.
>
> Amanda: 'But isn't that what we have to do?'

Amanda expresses, once again, a representation of care supported by the manipulation or control of the other, in the name of what the physician believes to be the best for them, so that the relationship with the other seems to be represented from an instrumental perspective. This interpretative construction is reinforced by another expression, when Amanda comments: "I am an undergraduate and I will not help the person in any way". This statement can be seen as an indicator that professional care is subjectively configured by Amanda as a technical and biochemical intervention, and not as a process linked to the type of relationship that is built with the user, referring again to subjective processes related to the biomedical model.

Considering that the participant positions herself in relation to care in a convergent way in different areas of her life, as expressed by the previously constructed indicators, it is possible to build the hypothesis that Amanda expresses a subjective configuration of care in a way that is significantly articulated to the control and the biomedical model. A subjective configuration consists of a relatively stable system of organization of subjective senses, which promotes the production of new subjective senses in different contexts (González Rey & Mitjáns Martínez, 2017).

The subjective configuration of care is expressed both in the production of subjective senses related to their relationship with the mother, as well as the social subjectivity of teaching medicine. The subjective processes the participant expressed related to the appreciation of a warm care relationship, to the detriment of the use of medication, do not seem to have had enough space for development in the social subjectivity of medical education. This articulation between Amanda's life story and her subjective production in her teaching context concerns the subjective quality of the learning process, which is a singular production, not an appropriation of a priori content (González Rey, 2012a).

Furthermore, as previously mentioned, the student is in tension with the social subjectivity of the different spaces in which they learn (González Rey, 2001). It is possible that the subjective social processes of health services the participant attends also play a

role in her subjective configuration of care. This can be supported by excerpts from the participant's expression in which she emphasizes drug treatment in services such as Psychosocial Care Centers:

> They were very focused on the medication, they were 'suspicious if the person was really taking it', you know? They asked what the pill was like. Because if you're taking it, you know the color of the pill, how many milligrams, what the package looks like [...]

This passage can be understood as an indicator of the expression of subjective social processes related to a policing and predominantly medicalizing care in the participant's teaching context – an indicator reinforced by the way she described other teaching scenarios (such as mental hospital institutions) in her writing. Although Amanda reports this situation that she witnessed in a health service with a critical tone, at various times she still expresses a subjective production aligned with this representation of care, as discussed above, which exemplifies how the subjective production of a person does not express themselves explicitly in their speech or in their conscious intentions (González Rey & Mitjáns Martínez, 2017).

During the research, reports of psychological distress by college students raised reflections in the academic environment regarding the relationship between undergraduate psychological distress and the way of teaching in medical programs. However, such reflections did not generate significant changes in the forms of relationship and teaching existing in this context, which can be associated with the validity of a biomedical and individualistic representation of psychic suffering in this space. The construction of a biomedical representation of psychic suffering is related to the very forms of relationship built and maintained in the medical program, marked by the absence of dialogue and the excessive use of psychotropic drugs by undergraduates (Ferraz, Plato, Anzolin, Matter, & Busato 2018). In this context, the biomedical view of mental disorders makes it difficult for undergraduates to generate subjective resources and build collective strategies to deal with a 'sickening' situation, functioning as a way of sustaining certain socially valued teaching practices. It can be said that this situation may be linked to the maintenance of medicalizing and objectifying practices in the health services in which these individuals work later on.

In this social space, psychic suffering seems to be represented in a predominantly mechanistic way, establishing linear causal relationships between certain conditions – such as obesity or aging – and mental disorders. Based on the following excerpt of expression, it can be said that Amanda also represents psychic suffering in this way:

> 'Today when I look back, I think it was whining.' Man, I didn't really have a problem, you know? [...] 'I was not a person who was abused', I was not a person who had anything like that [...] 'Then you realize that your biggest problem is yourself'.

The participant belittles her own suffering for not seeing any punctual and verifiable cause that justifies it, such as, for example, having suffered sexual abuse. In this sense, her speech can be understood as an indicator of subjective senses related to the disqualification of her own subjective processes. This mechanistic representation of psychic suffering seems to make it difficult to understand how the individual's life experience is subjectively configured in a singular way and how this can be a source of suffering even without apparent causes that justify it in a linear way. This logic implies the standardization of what is valid as a 'cause' of suffering, in line with the principles of quantification of the positivist science that supports the biomedical model (González Rey, 2015). The singularity of the other and the dialogic processes in professional practice, in

this sense, are deeply neglected. This is related to a passive-reproductive representation of learning, which makes it difficult for students to emerge as subjects who learn (González Rey, 2012a).

Regarding the participant, Amanda frequently takes a stand in discussions based on the statements of one of her professors, who had been her psychiatrist before entering the medical program (the same psychiatrist who was mentioned in one of her previously quoted speech excerpts). Such an attitude of the participant can be seen as an indicator that she has difficulty in positioning herself more autonomously in this hierarchical space, often relying on an authority to express herself - authority that, in this context, articulates that of a professor and that of a physician. In a discussion of a clinical case of an individual diagnosed with schizophrenia, the participant commented: "I think this issue of not taking a bath is related to a fear of persecution, of someone devising something against them during the bath. At least that's what I learned, 'that's what the physician said'". In this speech, the participant attributes a pre-established meaning to the behavior of the individual in question, which may indicate a reproductive teaching-learning process. It can be said that this form of learning impairs the understanding of the singularity of users of health services, since the student has difficulty using what they have learned as a subjective resource for the production of new ideas.

With this in mind, it can be reiterated that the use of the PBL methodology in the medical context does not necessarily favor the development of autonomy by the student. The notion of scientific neutrality, the representation of science as a 'truth' to be respected and the maintenance of sometimes extremely hierarchical relationships between professors-physicians and undergraduates, and between physicians and patients, observed in Amanda's program, may also be related to the difficulty in practicing a form of teaching that is really problematizing and oriented to favoring the critical exercise of health professions.

Final considerations

This study aimed to discuss aspects related to teaching-learning and care in the field of mental health based on the Theory of Subjectivity and the constructive-interpretative methodology of González Rey. It can be concluded that, despite making use of the Problem-Based Learning method and having a syllabus with subjects based on a so-called biopsychosocial model, the participant's educational institution presents a social subjectivity marked by subjective processes related to the biomedical model. This contradiction between institutional initiatives and the practices and relationships that take place in this social space can be understood by the unconscious character of subjective processes, that is, the intentionality declared by the person does not coincide with the subjective production that is expressed (González Rey, 2012b).

This form of social subjectivity in a context of reproductive teaching-learning practices makes it difficult for undergraduates to emerge as subjects who learn and the production of subjective resources that would allow the understanding of the singularity of the person in psychological distress. One of the consequences of this in the field of mental health is the tendency to represent psychic suffering in a standardized and individualistic way, which seems to have implications for the mental health of the students themselves. Subjective processes expressed by the participant point to the hypothesis that the social subjectivity of medical education favors a subjective production in which care is articulated with control and medicalization, to the detriment of the construction of a care relationship

that allows the emergence of the other as a subject, and it can be said that this is possibly related to the mental hospital social subjectivity expressed in substitute mental health services (Goulart, 2019a).

The Theory of Subjectivity and the constructive-interpretative methodology are resources favoring the intelligibility of the subjective character of learning, breaking with the characteristic segmentation between the processes of teaching, care and life history of the individual. In this context, psychological distress of medical undergraduates and other specialties in the field of health is an interesting topic for future investigations and interventions, aimed at improving the quality of life of these individuals and also at building practices of care oriented to the emergence of subjects, not to medicalization and objectification.

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