

Dialogues in psychology and nursing in a time of shifting paradigms*

DIÁLOGOS DA PSICOLOGIA COM A ENFERMAGEM EM TEMPOS DE TRANSIÇÃO PARADIGMÁTICA

DIÁLOGOS DE LA PSICOLOGÍA CON LA ENFERMERÍA EN TIEMPOS DE TRANSICIÓN PARADIGMÁTICA

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ABSTRACT

Currently, we are experiencing a paradigm shift in relation to how we understand health and care. The biomedical model has been replaced by a vision of an integral being, and care emphasis is being placed on health promotion and disease prevention. However, the discourse of personal responsibility for health can generate in patients feelings of guilt, shame, fear and paranoia, while in professionals it can cause feelings of powerlessness and frustration. These feelings disrupt attachments and, thus, reduce the effectiveness of care. The objective of this theoretical study is to propose a dialogue between Psychology, with social constructionist sensitivity, and Nursing, to examine the possibilities of improving care from this approach. As an alternative to the discourse of personal responsibility, relational responsibility and understanding health and care in the long time, lived time and short time, is proposed.

DESCRIPTORS

Nursing
Psychology
Education, nursing
Patient care team
Professional- patient relations

RESUMO

No momento atual, passamos por transição paradigmática em relação a como compreendemos Saúde e Cuidado. O modelo biomédico vem sendo substituído por uma visão integral do homem e, na assistência, privilegia-se a promoção de saúde e a prevenção de agravos. Entretanto, o discurso da responsabilidade pessoal pela saúde pode construir nos usuários sentimentos como culpa, vergonha, medo e paranóia, e nos profissionais, impotência e frustração. Estes sentimentos atrapalham a relação de vínculo e, com isto, a eficácia do atendimento. O objetivo deste estudo, de natureza teórica, é propor um diálogo entre a Psicologia, com sensibilidade construcionista social, e a Enfermagem, a fim de analisar as possibilidades de cuidado construídas a partir deste. Como alternativa ao discurso da responsabilidade pessoal, propõe-se a responsabilidade relacional e a compreensão de saúde e cuidado dentro do tempo longo, do tempo vivido e do tempo curto.

DESCRITORES

Enfermagem
Psicologia
Educação em enfermagem
Equipe de assistência ao paciente
Relações profissional-paciente

RESUMEN

En la actualidad, atravesamos una transición paradigmática relativa a cómo comprendemos salud y cuidado. El modelo biomédico viene siendo sustituido por una visión integral del hombre, y en la atención se privilegia la promoción de salud y la prevención de complicaciones. Mientras tanto, el discurso de la responsabilidad personal por la salud puede construir en los usuarios sentimientos como culpa, vergüenza, miedo y paranoia, y en los profesionales, impotencia y frustración. Estos sentimientos dificultan la relación vinculante, y de este modo, la eficacia de la atención. Este estudio de naturaleza teórica objetiva proponer un diálogo entre la Psicología, con sensibilidad construcionista social, y la Enfermería, a fin de analizar las posibilidades de cuidado construídas a partir de tal diálogo. Como alternativa al discurso de responsabilidad personal, se propone la responsabilidad relacional y la comprensión de salud y cuidado a largo plazo, del tiempo vivido y del corto plazo.

DESCRIPTORES

Enfermería
Psicología
Educación en enfermería
Grupo de atención al paciente
Relaciones profesional-paciente

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INTRODUCTION

The paradigms provide us with a set of affirmations regarding what exists (ontology), how this can be known (epistemology), and the way science should work (ethics). The activities to be followed are established from the knowledge of these affirmations. The different scientific practices offer models that are widespread and create particular types of traditions in scientific research and of ac-tuation in the practice⁽¹⁾. However, the paradigms are not eternal and there are possibilities for change. A paradigm shift is a cumulative process, which occurs by articulation or extension of the old paradigm⁽¹⁾. It is a reconstruction of the field within new grounds and during this transition period there will be problems that can be resolved by the old paradigm and others that can be resolved by the new one. This occurs until the transition is complete, when changes are then made in the vision of the field, of the methods, of the objectives and the practices.

We currently live in times of paradigm shift. Among other things, in this transition the changes have influenced the way we understand health, how we understand care and how we understand the formation of health professionals. In relation to health, from the Declaration of Alma-Ata in 1978, it has been thought of in a positive way. To think of health in a positive way represents a major paradigm shift, since the focus is no longer the deficit, the absence of health or absence of infirmity but the biopsychoso-cial well-being. Based on this perspective, health services have been created and re-structured, approaching the communities, offering care that goes beyond the cure, including promotion, prevention and reha-bilitation. The participation of non-medical professionals has been increased in the care because the physician has stopped being the central figure of the care. The care is also beginning to be comprehended as integral, i.e. it is considered that people should have access to all necessary health services and that the emotional, physi-cal and social aspects of the users should also be consid-ered. In this perspective, the user is regarded not as an individual unit, but as someone who is part of a family, of a community, in a defined social and historical context⁽²⁾.

In order to ensure the integrality of the care, the pro-fessionals and services cannot work alone. Teamwork in the services becomes essential, where professionals with diverse formations and experiences discuss situations and increase the vision and the possibilities of intervention. This dialogue is also envisaged to take place between dif-ferent services, not just those of health, but between these services and those of social welfare, education and com-munity. In this scenario, the professionals who work in health are also rethinking their practices. Nursing has es-

tablished itself as one of the most important professions in the provision of care, having science as the construction of knowledge for the care and art as the application of this knowledge to help people achieve the maximum in health and quality of life⁽³⁾. With this proposal, Nursing has been working with four aims: to promote health, prevent illness, restore health and to facilitate coping with disability and ill-ness. In these four areas, the nurse has the user as the cen-tral focus, working with the physical, emotional, social and spiritual dimensions⁽³⁾. The care can be offered individually, in the family or in the community, considering that Nursing represents the largest contingent of workers who provide healthcare in the world⁽²⁾. With each passing day, Nursing professionals expand their field and their contexts of per-formance and are currently demonstrating their roles to be fundamental in the primary healthcare services.

In order to accompany all these changes, the forma-tion of the nurse has been discussed in detail. The Nurs-ing schools are abandoning the strategies that created a

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dichotomy between theory and practice and which led to a mechanistic, individual-istic formation without criticism, proposing a critical-reflective formation⁽⁴⁾. In this per-spective, it is proposed that the personal and professional dimensions are integrated, seeking the formation of critical profes-sionals, committed to social transformations and competent to act within their field of knowledge and in interaction with others. Among the proposals for the formation of the nurse, a formation aimed toward in-terdisciplinarity is suggested, as well as the expansion of clinical reasoning in order to offer integral care, the perception that the biological, psychological and social are inter-dependent, and the development of com-petences that utilize a variety of resources (knowledge, skills and attitudes)⁽⁵⁾. It is against this back-drop that this article presents a dialogue of Psychology, with social constructionist sensitivity, and Nursing, in or-der to analyze the possibilities for care that can be con-structed from this dialog.

REGARDING PERSONAL RESPONSIBILITY FOR HEALTH

In the field of health, the notion of risk has been an important topic of study and of intervention. The study of risk factors is becoming increasingly legitimate and the individual risks have become the subject of health edu-cation and prevention actions. Health professionals were positioned as important actors in disseminating informa-tion about behavior and habits, including, how individuals should feed themselves, how they should work, how they should raise a family, how they should deal with their sex lives and how they should enjoy their leisure time.

The individual became solely responsible for their health, which began to be understood as something that impacts on the collectivity, because if the individual does not follow the guidance, the collectivity will pay for this through public spending on health services and procedures. This leads us to a discussion of Foucault regarding biopower⁽⁶⁾. According to the author, the current strategies of power, although controlling individuals, are not directed to the individual body, but to the population. Thus, to maintain the governmentality means that we need to ensure and promote the health of the population through the control of birth, mortality and infirmities. For Foucault, the aim of biopower would be to ensure the security and functioning of the societies.

The power of biopolitics uses the discourse of the biological body and of biomedicine to look at the health of the population, addressing the needs of different people as equal. Furthermore, it considers that public policies are necessary, as well as performing campaigns and programs where the search for health becomes the moral obligation of each individual. The concept of health is linked to a high morale value, and people who do not adopt behavior proclaimed as healthy, can be labeled *resistant* and *irresponsible*. However, the discourses concerning health never refer only to health, but they carry with them the economic, political and social order in which they are generated⁽⁷⁾. Moreover, the strategies of biopower utilize a powerful resource: guilt. With the discourse of personal responsibility for health, causal links are established between the actions of the people and health events, even without any certainty about these connections existing. An example is the relationship between the consumption of cannabis and schizophrenia. When assisting a youth diagnosed with schizophrenia and a history of cannabis consumption, professionals tend to quickly establish a causal relationship, saying that the cannabis consumption was responsible for the schizophrenia, even though there are no studies which prove this relationship. When indicating that the individual did something that led to their illness, it constructs the guilt. The feeling of guilt assumes that there is a judgment of someone and disapproval in relationship to the fault⁽⁷⁾. The person who received guidance from the professional to perform a behavioral change and does not, may feel guilty when they become sick and hide their problem from the professional. Another feature used for control is embarrassment⁽⁷⁾. In recent years we see this feeling growing among smokers. With the various campaigns performed and, more recently, with changes made in the legislation that restrict where it is possible to smoke, many smokers have reported being embarrassed to light a cigarette. The discourse of individual responsibility for health does not leave space for a person, who knows the problems that can be caused by the cigarette, to continue smoking. If this happens, they can be considered *weak* or *shameless*, needing, therefore, to be ashamed in order to change. Another sentiment constructed with the notion of risk is paranoia⁽⁷⁾. Even being healthy, people

never know if they are doing something that could affect their health. Maybe people do not smoke, but eat too much. Perhaps they have balanced diets, but have unprotected sex. Maybe they are not sexually active, but work too much. When knowing the risk factor discourse, they can become paranoid and fearful.

Guilt, embarrassment, paranoia and fear. These are some of the feelings that can be constructed with the overuse of the discourse of individual responsibility for health. The Ottawa Charter has placed health as a resource for life and not as a reason to live. However, the discourses of health professionals have often placed so many *caveats* and *cautions* that, the care for health becomes the reason for being alive. Thus, it is necessary to work toward improving the living conditions of the population without, however, destroying individual liberties, imposing lifestyles and making healthcare an obligation. The construction of feelings such as guilt, embarrassment, paranoia and fear in order to achieve well-being seems contradictory.

THINKING ABOUT PSYCHOLOGY

Psychology is also undergoing a moment of paradigm shift. Currently, the modern and postmodern paradigms coexist, with the postmodern paradigm emerging as a result of dissatisfaction and criticism of the previous paradigm. Up to the middle of the twentieth century, Behavioral Psychology occupied a prominent position in the West. This Psychology was based on two propositions: that experiments show the causal relationships between stimuli and responses; and that science must have a rational basis⁽⁸⁾. Thus, the scientist should have accuracy to map faithfully their study object, considering this object, as given by nature. At first, behavioral psychologists focused their studies on research related to observing behavior, however, over time they began to carry out experiments that proved the possibility of acquisition or extinction of these behaviors by introducing to their theory some psychological constructs such as *force of habit* and *inhibitory potential*. With this, the researchers started to consider that it was not only the environment that acts determining the behavior, but that the individuals have inherent tendencies that help to seek and process information, formulate hypotheses and set goals. When they opened to the possibility of studying these constructs, they were opening themselves to the study of that which is not observed, allowing the mind to come into the question⁽⁸⁾. This influenced the movement which occurred in the 1950s in the United States and became known as the *Cognitive Revolution*. This movement occurred with the debate among psychologists, philosophers and thinkers regarding the place that had been intended for the study of personal experiences in science and the importance of comprehending the meanings given to the world and how people construct these meanings. However, Cognitive Psychology took other di-

rections. With the development of computers, computing became the model used to study the mind, diverting the interest in the meaning and promoting the emerging concept of *computability*. The cognitive processes were compared to programs that could be run on a computing device. Information processing was talked about and no longer constructing meaning.

Social Psychology was also going through a crisis. This discipline was created after World War II in order to produce knowledge that would serve the American and British governments for propaganda and political manipulation, serving the interests of maintaining the power relationships⁽⁹⁾. In the 1960's and 70's, social psychologists were concerned with how Psychology was helping to promote the values of dominant groups, failing to give voice to ordinary people and decontextualizing them in the research laboratories. They sought to construct a culturally sensitive Psychology, based not only on what people do, but on what they say they do and what they say made them do what they did. Another important movement in Psychology, also influenced by the modern paradigm, was that of Psychoanalysis. Psychoanalytic theories helped to build a vision beyond the biological body and the observable behavior, constructing the idea of the individual and of self, valorizing a view of human beings who act influenced by their internal world, through a psychic apparatus, formed by the conscious, preconscious and unconscious and driven by desires and instincts.

Arising, as a specific area of knowledge, from the Enlightenment view, which placed the individual as the central focus, in the twentieth century, Psychology began to rethink that view. The conception of the *individual as the focus* is still very strong in the health field and has constructed diverse knowledge (individual well-being; individual skills; individual rights; individual responsibility; individual desires; individual choices) and with this, guiding numerous actions in our society⁽⁸⁾. In Brazil, from the 1990's, Psychology has been rethinking its role, in a critical exercise in which many positions are questioned, positions that had and led to social control, to the exclusion of minorities through pathologization, and to the election of a normality model, often represented by the white, European, heterosexual male, coming from the middle socioeconomic classes⁽¹⁰⁾.

Searching for a greater social commitment has expanded its views to other population groups previously marginalized, such as indigenous people and prisoners, and has led to the rethinking of its practices in already known contexts, such as health and education. In these contexts, Psychology is seeking to be positioned in a critical and reflective way, questioning the actions that have a policing and normalizing character, permeated by surveillance and the control of deviations⁽¹¹⁾. Within this context of rethinking Psychology, several authors have proposed ideas, some of which are currently grouped and denominated as social constructionist discourses^(8-9,12).

THE SOCIAL CONSTRUCTIONIST DISCOURSE

The social constructionist discourse has been highlighted as a possibility to comprehend the phenomena that differ from traditional perspectives, among other things, by understanding language as a constructor of reality and understanding that this construction occurs in relationships, thus taking the focus from the individuals and from their internal world. Internationally, in 1973 the first studies in social constructionist Psychology started, however, in Brazil, this discourse in conjunction with Psychology is still being constructed, with this taking place since the last decade⁽¹²⁾.

There is no single definition of what the social constructionist discourse is, because even defining it as something, would reify it, assuming a contradictory posture to the social constructionist assumptions. Despite the divergences between the authors, the literature suggests some assumptions that seem to be common to all^(8-9,12):

1. Critical posture in relation to knowledge taken as obvious: constructionist authors invite us to assume a critical posture against scientific affirmations that are taken as certain, or as obvious. They question knowledge that is taken as objective and valorize reflection on the way we understand the world and ourselves. In the field of health we have the example of a study that questions the discourse of *adherence to treatment*⁽¹³⁾. In this work, users of a primary healthcare service reported not taking the medication prescribed by the physicians when they understood that they had not been well examined or that the prescription was not correct. The authors suggest that the non-adherence to treatment may be considered, in these cases, as self-care, as users protecting themselves from a physician who does not listen, from badly performed examinations and from erroneous prescriptions.

2. Historical and cultural specificity: the ways in which we comprehend the world are constructed within a defined historical and cultural context. An example is the study that describes the construction of smoking as a public health problem⁽¹⁴⁾. The authors propose that this only happened due to the increase of scientific studies that sought to prove the harm of smoking, associated with the new public health discourse of behavioral control to prevent risk factors and also with the transnational political scenario coming from the postwar period, which resulted in the creation of institutions with the aim of organizing world politics, such as the United Nations and World Health Organization.

3. Knowledge sustained by social processes: it is through relationships that people construct meanings about the world and about themselves and maintain these constructions. An interesting example was reported in an article that analyzed a family therapy session, where

the negotiation of meanings about pathological identity occurred⁽¹⁵⁾. Strongly influenced by the medical discourse, the parents of an autistic child reported behavior of their child that described the child as autistic. The therapist tried to question these descriptions, treating them as something that happens with all children of the same age group. The study shows how these meanings were negotiated during the session, opening the possibility for the parents to get closer to the child.

4. Knowledge and social action go together: the meanings constructed regarding a determined object will influence how we relate to this object. Using a social constructionist discourse, authors analyzed the meanings constructed in relation to mental illness in a therapeutic group⁽¹⁶⁾. They describe six different meanings which were negotiated during the group, highlighting the way these meanings constructed different views regarding the possibilities of change. Thus, to describe the mental illness as a result of past experiences of suffering, the group constructed the perspective that it was impossible to improve and change. In the same group, to describe mental illness as a result of current conflicts motivated a large participation of the members, who gave suggestions and advice for resolving the conflict.

DIALOGUES OF PSYCHOLOGY WITH NURSING

Although Nursing has already developed its own body of knowledge⁽¹⁷⁾, dialogue with other sciences can promote comprehension of the situations and open new possibilities for the practice of the nurse⁽¹⁸⁾. Facing the challenges experienced in these times of paradigm shifts, Psychology, with social constructionist sensitivity, has much to contribute to this dialogue.

In our professional practice, with undergraduate Nursing students, we perceive the suffering of those facing the limits of their performance in the guidance in health. It is worth noting that having care as the object of study, the report of seeking the course as a possibility to help other people, to care for others, is common among Nursing students. Added to this, the content learned during the course, regarding risk factors for illness, the care to prevent harm, the guidance and health education. We are often faced with the conflict of the students: *If he has various health problems, why not stop smoking and start exercising? I have advised him several times already, I do not know what more I can do.* With these statements, we perceive that the discourse of personal responsibility for health, also constructs, in future care professionals, feelings of impotence and frustration, which can distance the professional from the user⁽¹⁹⁾.

Using social constructionist assumptions, Psychology seeks to question the discourse of personal responsibility for health and the obligation to adopt determined health

behavior. It invites the undergraduate students to reflect on their guidance for users of health services, comprehending how people construct meanings about health. For the comprehension of this construction, the consideration is suggested of the long time (relative to the cultural content, to the social reproduction, to the space of knowledge prior to the person, which is present in the form of institutions, rules and discourses), the lived time (which refers to the process of reinterpretation of historical content from the processes of socialization, i.e. the experiences of the person in the course of their life, translating the historical memory into emotions) and the short time (where the dynamics of production of meanings occur, where the voices belonging to the long time and lived time are combined; an interactive moment, between the professional and user)⁽²⁰⁾.

With this, it is sought to strengthen the relationships between professionals and users, investing in light technology, those technologies developed in the professional and user relationship, through listening, the bond and the joint construction of the health needs⁽²¹⁾. Instead of individual responsibility, social constructionist authors invite us to think of the relational responsibility, paying attention to what people do together, since the construction of meaning is understood as a result of joint actions. In this sense, some postures are proposed for the professionals that help construct more responsible relational practices⁽²²⁾: 1) a posture of not knowing, in which the professional leaves the position of specialist and adopts an posture of curiosity about the knowledge of the other, 2) a posture of cooperation, in which the user is a specialist in their life and the professional assists in the construction of the conversation and in the search for a solution to the problems, positioning the user as active; 3) a focus on the communicational process, in which the interaction is understood as more important than the content; 4) a posture of deconstruction and reconstruction, in which the professional encourages diversity and invites other descriptions and perspectives, in order to expand the possibilities of comprehending and coping with the situation. With the relational responsibility, it is not sought to take the responsibility of the individual person, but to invite other people to engage in this process of change. The professionals, the family and the community can be engaged, adopting different postures.

CONCLUSION

In the last century, Psychology was in dialogue with the health sciences in order to broaden the vision of the human being, considering the person beyond their biological body. The current view of health, with a strong focus on disease prevention, can also produce feelings of guilt, embarrassment, paranoia and fear in the users and feelings of impotence and frustration in the professionals. These feelings can distance users from professionals, making preventive measures ineffective.

Psychology is rethinking its actuation, reflecting on practices that can be considered as disciplinary and normalizing, used in favor of maintaining the *status quo*. Psychology with social constructionist sensitivity invites the expansion of the view of the behavior to be modified, for a comprehension of this within a historical and cultural moment with meaning constructed in the relationships, seeking new possibilities of comprehension of the situations, focusing on the interactions. It invites the focus to be placed on professional and user interaction, adopting

dialogical postures and assisting in the construction of the life project.

In undergraduate Nursing course, Psychology can help in the reflection about the health-disease process, in the comprehension of the man as an integral being, in the discussion about the limits of professional performance and in the questioning of hegemonic scientific discourses, seeking to construct a professional-user bond relationship which generates new discourses and, thus, constructs new professional and health practices.

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