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Care trajectories of users with severe psychological distress in the Psychosocial Care Network: Existentialist perspectives

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ABSTRACT

This study aims to present partial results of broader research that resulted in the master's thesis entitled “Life Stories and Severe Psychic Suffering from the Perspective of Existentialist Psychology: Existential Narratives.” The study aimed to investigate the processes of constitution of severe psychic suffering from the autobiographical narratives of users of the Psychosocial Care Network (RAPS) in a municipality in the north of Santa Catarina, Brazil. The narratives were elucidated based on the perspective of Existentialist Psychology, outlined by the French philosopher Jean-Paul Sartre (1905-1980) in his intellectual trajectory, in which his ontology and method replace the subject in his dialectical and temporal constitution. The elicitation of the narratives followed a script adapted from the “Life Story Interview” developed by the American researcher McAdams (2012). The division and conduction of the narratives proposed by the script served as a basis analyzing and gatheringng the singular elements present in the axes of meaning. This text aims to discuss the notion of care from an existentialist perspective based on the narratives of these subjects, specifically, at the time of the interview in which they were invited to tell their care trajectories, which refers to the movement they made in the search for help for their suffering condition. The discussion on the notion of care from Sartre sought to bring this theory closer to the logic of an expanded clinic as the foundation of care in Psychosocial Care. Finally, it is considered that the logic of the expanded clinic, associated with an existentialist understanding of human suffering, can enable the construction of emancipatory practices in the territory, effectively breaking with the biomedical logic of a purely curative nature.

Keywords: Psychosocial Care, care practices, expanded clinic, existentialist psychology, Severe Psychic Suffering.

1 INTRODUCTION

In this chapter we intend to present part of the results of broader research that had as its final product the master's thesis entitled "Life stories and severe psychic suffering: existential narratives". The cited research was developed in the period from 2021 to 2023 and aimed to investigate the life histories of users in severe psychological distress of the [1] Psychosocial Care Network of a city in the

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[1] The construct of severe psychic suffering outlined by Costa (2003) in his thesis refers to the so-called "psychotic" experiences, considering that the classical concepts are imprecise in the delimitation of the phenomenon and its complexity. It starts from the phenomenological and existential understanding that the psychopathological experience is, first of all, a possibility of being in the world, which unfolds to any person, materializing as human suffering (Costa, 2003). This experience can become unbearable in the face of the impasses that reality imposes on the singular subject, and the understanding becomes that psychophysical symptoms are, in fact, "a way out forged by the subject to face an unbearable

north of the State of Santa Catarina, to later elucidate them from the perspective of Existentialist Psychology, developed by the French philosopher Jean-Paul Sartre (1905-1980) as a philosopher and writer. The narrative venture followed a script adapted from the "Life Story interview" outlined by the American researcher McAdams (2012).

The results presented here refer to the moment in which users were invited to narrate about their "care trajectory", which refers to the path taken by these subjects to the various treatments, including the insertion in the Psychosocial Care Center (CAPS) until the present moment. Although the objective of this study was not to understand the therapeutic itineraries[2] of each participant in the search for help for their condition of suffering, the intention was to know how they launched themselves in this trajectory, that is, what made each subject seek help for the first time and the sequence of the care process. To understand whether or not it was a spontaneous search, who he turned to, what door he knocked on, etc. The objective was to visualize the period in which the emotional accesses resulting from suffering became unbearable for himself, or for his network of coexistence.

Psychosocial Care reflects a paradigm shift to think about mental health care practices, as a result of numerous struggles and political movements that advocated the overthrow of the asylum logic and therapeutic interventions based on social isolation and behavior control aimed at subjects in severe psychological distress. With the Brazilian Psychiatric Reform, sanctioned in 2001, the provision of care to people in this condition began to be assumed by a network of public policies, devices and equipment articulated among themselves, territorially based, focusing on social inclusion, aiming at interventions at different levels of complexity, characterizing the Psychosocial Care Network (RAPS) (Chaves & Nascimento, 2020).

The Ministry of Health (2009), proposes an analogy to think about this logic, in which a network is woven by interconnected wires and tied by nodes. The nodes spread over several points of the network, which allows their consistency and does not break easily. This analogy aims to reflect on the need for services to be articulated in different points of attention by a line of care. This line, in turn, refers to the paths that the user travels through the network, and accesses the different equipment according to their demand (Municipal Secretary of Health, 2020).

The path taken is defined from the construction of a Singular Therapeutic Project (PTS), which is characterized as a fundamental instrument in the care process. This instrument is developed by the health teams together with the user and his family, being considered central actors in the construction

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situation" (Havrelhuk & Langaro, 2020, p. 40). The concept of psychic suffering and severe psychic suffering tries to delimit the magnitude of the suffering as it occurs in the lived experience of the subject. Thus, we have a reference to the existential dimension of anguish as an inseparable part of human reality.

[2] According to Cabral *et al.* (2011.p.4434), "therapeutic itinerary" is a term introduced by the socio-anthropological literature, to designate: "the paths traveled by people in search of therapeutic care, which do not necessarily coincide with predetermined schemes or flows. Their choices express individual and also collective subjective constructions about the illness process and forms of treatment, forged under the influences of various factors and contexts. These choices will define actions that, step by step, will constitute a certain path."

of care, conferring autonomy to those who provide care (Brasil, Ministério da Saúde, 2009). The PTS considers the unique demands of these subjects, their historicity and the context in which they are inserted (Schneider et al., 2020).

The notion of expanded clinic refers to the need for an interdisciplinary and horizontal care, which considers all the dimensions that constitute the subject, placing the focus in this look at the integrality of his life, being the process of suffering an expression of this set. Thus, the disease and its symptoms cannot be the only parameter for the interpretation of the occurrences and even the only target of the intervention. In this sense, knowledge intersects in the construction of care, taking into account the specific needs of the subject at each moment of his trajectory. It is on this logic that health actions and practices should be based (Schneider et. al, 2020).

Sartre was an important critic of his time in relation to the hegemonic model of classical psychiatry and the model of asylum as an offer of care. The ontology and epistemology proposed by the philosopher is one of the first that breaks with dualisms and ahistorical views in understanding the phenomenon of the subject and his suffering. For him, human reality is par excellence dialectical, when dealing with the human movement in the world, in which it is made and is made by this real context. It is through the human acts of totalization-detotalization-retotalization that human reality is constructed (Bocca, 2021; Sartre, 2002; Schneider, 2010). In other words, there is no possibility of separating the experience from the human that is implied in it, it is only by the inclusion of the subject in this equation that the experience can be understood (Bocca, 2021; Haverlluck & Langaro, 2020; Schneider, 2009).

Freedom is constitutive of the human condition, it is at the basis of its indeterminacy: "man is not first to be free later: there is no difference between man's being and his free being" (Sartre, 2015, p. 68). When Sartre asserts that there is no difference between "man's being and his free being," he is saying that there is nothing that determines existence, there is nothing that precedes it (Bocca, 2021; Ehrlich, 2002). To escape from its indeterminacy of being is that the subject is elected perpetually, continually puts himself in question, this is what differentiates humanity from other beings (Schneider, 2011). The recognition of the other as freedom, allows him to undertake himself in this way, to recognize himself as autonomous and possible to pursue his own project (Dhein, 2013; Schneider, 2011). It is understood that this perspective accompanies and deepens the principles of Psychosocial Care and the need for comprehensive and longitudinal care, which constitutes the logic of an expanded clinic (Schneider et al., 2020).

In view of the above, this work aims to discuss the notion of care by existentialist logic, based on narratives of the subjects of this research, users of the Psychosocial Care Center (CAPS) of that city. Subsequently, it is intended to carry out interlocutions between the notion of integral care in the

Psychosocial Care Network and Existentialist Psychology, in order to present it as a possible foundation for the provision of care in an expanded clinical logic (Schneider et al, 2020).

2 METHOD AND METHODOLOGICAL PROCEDURES

The research had a qualitative design, with exploratory-descriptive cross-sectional characteristic,[3] aimed to investigate the processes of constitution of severe psychic suffering starting from the autobiographical narratives of users with severe psychic suffering of this city.

Three users were included in follow-up at CAPS II, two women and one man aged 30 to 50 years, who met the following criteria: a) history of follow-up at CAPS II equal to or greater than 6 months b) who had in their clinical history report of psychotic crises; c) who did not have cognitive impairments that prevented him from answering the interview questions; d) who was not, at the time of the research, in a period of severe psychic crisis; e) who was at a moment in his treatment in which talking about his life history would be considered an important clinical strategy in his care process, according to his Singular Therapeutic Project (PTS) and the evaluation of the CAPS technical team; f) who was over 18 years of age and was not tutored; g) who agreed to participate in the research.

The narrative interview was chosen as a technique for data collection in this study, since the narratives allow access to the experienced, from the experiences shared by the research participants (Flick, 2009). Narrative methodologies have been used in the fields of social research for the study of biographical experiences for a long time (Flick, 2009). It is noteworthy that the life history and experiences of severe psychological suffering are configured as the object of study of this research.

The instrument selected for data collection was the *Life Story Interview* (McAdams, 2012), based on an adaptation of its script. The instrument was designed to allow the subject to construct the narrative in an integrative way, considering the positive and negative experiences in their trajectory, their desires and impasses and their future project.

For McAdams (2012), the biographical narrative allows life memories to be approached in their entirety, in the sense that the episodes narrated follow the perspective of psychic temporality, where the past is experienced when narrated in the present and the future begins to be imagined in the very act of narrating.

In order to stimulate the autobiographical narrative, it is suggested to the participant that he imagines his life as a story or film, to later perform a general summary presenting the chapters and significant periods that make up the plot of his story, highlighting events and characters that, in each

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[3] This study was evaluated by the Ethics Committee on Research with Human Beings of the Federal University of Santa Catarina (UFSC), and was approved by the respective Committee, according to the opinion consubstantiated No. 5,694,923.All these procedures had as a principle to guarantee the ethical aspects that govern Resolution No. 510 of April 7, 2016, of the National Health Council, regarding research in the Humanities and Social Sciences, considering its specificities and research practices.

scene rescued through memory, are central in the episodes narrated. The highs, low points and turning points that he considers to have happened in his life story are highlighted (McAdams, 2012).

This enterprise adopted as perspective the Sartrian phenomenological-existential methodology, with the objective of conducting the analysis of the content of the narratives, using the progressive-regressive method. In this understanding, every biography is a singular-universal, because each individual is singularized by permanently synthesizing the objective reality that is shared (Maheirie, 2002; Maheirie & Pretto, 2007; Schneider, 2011).

Here in this work, part of the results found will be presented, which refer to the moment of the narrative interview in which the users were invited to tell their trajectories in the search for help to their condition of suffering. With this, the objective is to debate the notion of care from the existentialist perspective, as a foundation for thinking strategies and practices of care with these subjects, in a logic of expanded clinic.

3 THE SEARCH FOR CARE AND THE ENCOUNTER WITH PSYCHOSOCIAL CARE

We will begin by presenting brief elements of Anah's story[4] and her search for help for her suffering. The participant reported that she sought psychiatric follow-up spontaneously at the time she was in college, as she reports:

> (...) when I started college, I felt very difficult to get in the classroom (...) there was a person who told me that I had no difficulties relating, I was just quieter, only in my head I had (...) this was very evident to me and I asked for help from a psychiatrist (...). She prescribed me paroxetine, nortriptyline and some other antidepressants... diagnosed me as social phobic... The medication made me more talkative and I started to interact a little more.

The situations that Ana presented about her trajectory help in understanding the difficulty of this moment for her. He spent much of his childhood and adolescence, as he put it, "inside the bedroom." But at the same time, wanting and not being able to socialize, both in childhood and adulthood, was what was most "dubious" to him, according to his own perspective. Ana ends up blaming herself for her socialization difficulties, but when narrating her story brings situations of loss of her very young mother, of having been raised by great-uncles, having received a very rigid education, without freedom to find friends and, even more serious, having suffered sexual violence within her own home:

> I was molested right; it wasn't a pleasant experience at all. I feel like a pretty low point in my life. I feel kind of guilty, I could have said no, avoided it and didn't. I was less than 10 years old and I was becoming a young girl, I was getting my period out. And it was just like that, whenever I remember, guilt comes over me. The one who molested me was my grandfather, actually my great-uncle, who was in my grandfather's place. When my great-aunt would go out

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[4] All names are fictitious and were removed from the IBGE list of the most common names in Brazil in the 2000s, which is available on the https://censo2010.ibge.gov.br/nomes/#/ranking website (IBGE, 2016). None of them resemble or match the actual names of the participants

> to pray a rosary at other people's homes, he would stay with me and it would happen. So, it was a person who was supposed to protect me, had to be on my side. He was in the shoes of a father actually, it was a very remarkable experience, a remarkable thing.

This experience produced deep marks in Ana, who lived these experiences in the deepest solitude and had to elaborate reflexively only with the few affective and rational elements that she had at her disposal, of someone who lived as if in favor in the house of uncles who cared for her. In this direction came his blame for the situation, even though, in fact, he was a victim. This psychic dynamic will mark his trajectory, reaching the moment when in early adulthood, already in college, he is able to seek help for his entire trajectory of suffering.

In Ana's narrative can be identified paradoxical elements to her experimentation reported on this period of graduation, when she mentioned that "a person" (did not specify who) told her that she did not have difficulties of interaction, only was quiet. The paradox in his speech is that there was someone there, and that what was said by the other reveals a certain closeness and some weaving, otherwise he would be unlikely to speak of his suffering to that other. Either way, what is illustrated here is that the experience of being someone with difficulty getting along belongs to Ana's world. For her this is an irrevocable fact, it circumvents her entire being, just as it is an irrevocable fact that she committed "holes", in her form of expression, in several different professional environments, even though she did not know how to tell the interviewer what these "holes" were: "Good question... For those who saw from the outside it was fine, I was doing well, but for me no, I knew I was punching holes." (Ana). We see here, again, the expression of Anah's ontological insecurity and her guilt as a mark of her way of being.

This certainty makes it impossible for them to weave themselves, to be seen as someone who is intellectually and professionally successful, being against the desire to be happy and achieve things in their lives, and perhaps this point is one of the factors that aggravates their suffering. Hence, he sought the psychiatrist in an attempt to seek relief from the suffering that had been with him for some time. In fact, medication provided him with some relief from symptoms by reducing the tension experienced by the self-other conflict (Sartre, 1943/2019, Schneider, 2011). However, having their suffering classified as a mental illness categorized as a "social-phobic disorder" contributed to the experimentation of being crystallized and condemned to be the one that is not woven (Cooper, 1967; Laing, 1975). The influence of psychiatric rationality on his being is visible when he says: "I have diagnosed ADHD and he spoke louder" (Ana).

Ana incorporated the psychiatric diagnosis as a way to understand herself and, in some way, justify her inadequacy to the demands of the social world. The problem is not the diagnosis, it is not the objective to debate the viability or infeasibility of the psychiatric diagnosis itself, because knowing how to identify common signs can be of some value for the construction of interventions that help in suffering (Dalgalarrondo, 2018), to the extent that every subject is a singular-universal (Schneider, 2009). The issue is the organic and psychologizing reductionism to this category, which ends up confirming the know-how of being of these subjects, who end up defining themselves from the perspective of a knowledge of professionals who have recognized technical power, making suffering an insurmountable condition. In addition, the nosological classification removes the understanding of the construction of this suffering in the biography of the existent, that is, it disregards the various experiences lived in a situation (in the sociological, anthropological and psychological dimensions), not accessed by the medical gaze that stops only at the symptoms (Schneider, 2009, 2011, 2017).

When Ana already married ends up getting pregnant, she interrupted the treatment for three years, after a certain time she seeks psychiatric follow-up again in the scope of supplementary health, due to depressive symptoms related to the work environment, being treated by a professional who accompanies her for a period of seven years. Thus, about two years after the interview, she began to have more intense emotional access in one of the schools in which she worked, at which time she was referred to the CAPS and away from work. This brief report by Ana about the paths taken to reach the CAPS demonstrates how much her suffering has evolved over the years, being a process in her history and not isolated occurrences. She also describes how until she arrived at the CAPS, her suffering was reduced to signs and symptoms and the search for control through medications, without seeing Ana's person as a whole, reduced to her disease. It will be in the CAPS that she will receive a more integral care, seeking to insert in therapeutic processes that expand her field of possibilities of insertion in reality.

The second interviewee, Maria, said that the first time she thought about asking for help was due to a suicide attempt, which occurred during the period of her second marriage. The first "door that knocked" was that of a religious institution linked to the egregore of Kardecist spiritism, "*only then I went and I was not well, I was practically surrendered*."

Mary was in a very intense state of psychic suffering, she needed support, not only spiritually, but mainly in the field of mental health. She continued: "So my daughter went with me to the hospital and there they decided to admit herself. I was in a suicidal crisis and I was all scratched" (Maria). Although she stated during the interview that since she was a child she experienced as if she had, in her words, "a voice inside the mind", there was a long journey to get to the care for her serious situation, and only after the suicide attempts in adulthood, that she began to receive help, with the support of her daughter. She went through four psychiatric hospitalizations, until she was referred to the CAPS. In her case, she described arriving at this care center as one of the great "watersheds" in her life, a "turning point." He highlights the psychosocial accompaniment in the referred service as something that provided him with support in changing course for the plot of his "film".

When she resumes her story Maria discusses that if her life were a movie, it would be the horror type. Like Anne, Mary lost her mother at an early age and was raised by a relative. And in the same way, she ended up being abused by her adoptive parent, from 2 to 5 years of age, and ended up contracting syphilis, a fact that was only discovered at the age of 40 when diagnosed with Neurosyphilis, a condition that had serious complications due to the absence of early treatment. His existential trajectory was marked by much suffering, lived in the most absolute solitude, without having with whom to share his emotions and thoughts, from the earliest childhood. This situation may be the basis of the voices he had been hearing for a long time and the worsening of his psychosocial condition.

It is striking how Mary recognizes in the CAPS the service that will treat her not only as a patient, but as a person, who has desires, projects and who would like to rebuild her life. Therefore, he sees in CAPS and his team of professionals one of the main mediators to be able to rebuild his life and authorize himself to dream of new possibilities.

Likewise, Joseph said that at the age of 17 he began to see "figures", however, for him, it was a spiritual experience, so much so that these occurrences were not the reason why he sought help. She mentioned that, approximately, in 2016, she began to experience depressive symptoms (she did not eat or get out of bed), which were intensifying more and more, to the point of not being able to work. He says that he had been working at a car dealership for about three years, and that he was expecting career promotion, a fact that did not occur.

The first request for help was to his mother, who welcomed him promptly and assisted him in the search for a psychiatrist. He did not make clear the occurrences that led him to the CAPS. He mentioned, however, that in the same period in which he sought help, he was unable to leave the house because he believed that someone was chasing him in the street.

As was done in the case of Maria and Ana, it is also worth resuming some points of the history of this interviewee. He played football from the age of seven to 17, even participating as a reserve player for a professional team, and was almost hired as a starter, however, he said he did not achieve this title because at the time he did not make himself viable in the desired career. At the age of 17 he narrated having lived hallucinatory experiences (via figures), understanding such experiences as phenomena of a spiritual order. Moreover, the concomitance between the career break and the narrated experience is perceived, which raises suspicions about being correlated, suspicions that could only be verified by a longitudinal follow-up.

Joseph may not have brought a whole experience of suffering before the age of 17. Joseph's narrative of his story focuses less on experiences of suffering arising from his social relationships and he perceives himself as having been a cheerful boy who liked to have fun. He speaks of the death of a friend, as a teenager, as a point that affected him greatly. However, in his narrative, there are not many occurrences that make very clear the social determinants in the construction of his suffering. Thus, his entry into the psychotic condition still appears to him as magic, as if "suddenly" that he began to hallucinate. The narrative of her story is of a common story, of any child who had his development without more destructuring sociological or anthropological conditions, unlike Ana and Maria. But is that really how your existential trajectory happened? What family or socio-cultural facts did he not perceive as significant and fail to tell us?

Perhaps José's situation is even more vulnerable, because as he does not locate concrete social conditionings, his emotional lack of control is attributed to himself, to his neurochemical decompensation, to his psychopathology, as if he were a morbid entity, corroborating with a medical and pathologizing logic to which he is subjected. In this way, José, even more intensely than his two colleagues, who were able to locate effective occurrences in their stories that provoked psychic suffering, attributes his suffering to a mystique and, subsequently, the condition of illness, without being able to establish, in a very clear way, situations of his life history and the development of his schizophrenia process. In any case, the need to ask for help in the face of the intensification of suffering occurred in the professional profile, which points to the possibility of this profile being a major issue for this interviewee.

Like Ana, some of José's statements in the interview also make a clear influence of psychiatric rationality on how one experiences oneself in the world. The first answer he gave about what he believed to be these "figures" was: "*I think it was a lack of medicine.*" (Joseph). When the interviewer asked him if he made any correlation between his symptoms and the events of his life, he replied: "I'*ve always been nervous, I think I was born like this, my whole family is like this, it's a family thing*" (José). This is the only cue about his family, who are all nervous, but do not cite concrete facts and real events.

There are other statements of José in the interview that illustrate this same point, however, the above expressions are already sufficient to correlate the influence of psychiatric rationality on elements of his know-how, as was observed and discussed in the case of Ana. Thus, if on the one hand he knows himself to be like someone "nervous", on the other, he says he experiences himself "much better" and that he is already almost gaining "high" and, paradoxically, says he thinks: "that *what I have is not even a disease, it is a phase of life*."

The divergence in the discourse of this interviewee points to the crossings of two distinct rationalities that conflict in today's anthropological context (Schneider, 2010), namely: the thesis of mental illness and the antithesis of this same thesis, responsible for the overthrow of the asylums, and which consequently influenced the Psychiatric Reform in Brazil, constituting what is meant by Psychosocial Care (Amarante, 1995). These statements of José point out that, even in a slow process, there are possibilities of deconstruction of the reductionisms implied in suffering.

Given this, it is worth highlighting some passages that illustrate the importance of accompaniment in this service of Psychosocial Care, for the process of deconstruction of suffering: *"I like to come here, I know several people, we create a bond"* (José); "*I like to come here, here I get along* *with everyone, here no one will judge me, because everyone has their issues, here I can be myself.*" (Mary)

The two interviewees are talking about the relationship with the other users and professionals of the service, clearly expressing the logic of welcoming the singularity that the psychosocial mode brings, unfolding in the affective weaving to this place. Mary also brings the experimentation of being able to be herself, that is, of being able to be recognized in her subjectivity and also recognize other singularities. The continuous exercise of being-with-others, of being recognized and cared for in its idiosyncrasy, little by little, enables the reconstruction of the desire to be and, consequently, openness to the future (Sartre, 1943/2019).

4 THE LOGIC OF CARE IN AN EXISTENTIALIST PERSPECTIVE

The word care has its origin linked to the Latin word *cogitatus* (Contatore, et al., 2017), whose meaning refers to: "meditated, thought and reflected". The meaning of this word for the Portuguese language takes several forms: "special attention, restlessness, concern, zeal, care that is dedicated to someone or something, object or person of this care

As seen, the term assumes a range of different meanings, but that, in general, refer to the forms of relation/mediation of a person or group of people towards others (Contatore *et al.*, 2017). Relationship of being *implicated-with-the-other; together-with-the-other; interested-by-the-other* (Contatore *et al.,* 2017).

The care taken in an existentialist sense, must start from this same principle: "being-with-the-other". What is only possible when the subject is recognized as existence, that is, as freedom (Freitas, 2018). To clarify this point of this debate, we will briefly discuss this "being-with-the-other", or else, "we" within this perspective For Sartre, there are concrete experiences in which the "I" and the "other" are not in conflict, but in community, as the philosopher says:

> (...) There are certain concrete experiences in which we find ourselves, not in conflict with the other, but in community with him. And it is true that we often say WE (...) the subject we do not seem conceivable except **by referring, at least, to the thought of a plurality of subjects that apprehend themselves simultaneously and mutually as subjectivity, that is, as transcendences – transcendent, and not as transcendences-transcended. (Sartre, 1943/2019, p.512)**

Sartre refers to a distinct way of relating subjects, and that takes place in contradiction: "with the experience of my being-object For-another or with the experience of being-object of the Other for me. In the "we" subject, no one is an object, it is "a plurality of subjectivities that mutually recognize each other as such" (idem, p.512). The recognition of others as subjectivity therefore involves overcoming the conflict of the I-object-for-other and the other-object-for-me. The crossing of these two possibilities of relation, results in being-with-the-other constituting the "we" (Freitas, 2018;

Schneider, 2011). These premises are at the basis of the Sartrian theory about groups, a conception that the philosopher evolves and deepens *in the work Crítica da razão dialética* (1960), in which he outlines the progressive-regressive method (Freitas, 2018).

There are also different ways of experiencing this "we", as a collective experience of object for a "third party", or as "we-subject" that goes through the sharing of a common project. The philosopher warns that this last experience is not a constituent condition of human reality, it is a psychological experience (Schneider, 2011). This third possibility is produced by the quality of the collective experience, it must be built hard by the subjects engaged with each other, on a daily basis, it is about this "we" in community (Freitas, 2018; Schneider, 2011)

This brief sketch of the notion of "we" in Sartre was to illustrate what is recognized, here in this work, by relationships and feasible care practices. It is understood that care in health care networks should start from this need pointed out by the philosopher to be-with-the-other, to understand him as a subject in his integrality, recognizing that he must actively participate in the construction of his care, giving coordinates about his own singular therapeutic project, as the protagonist of this project, and the health professional as the mediator in **therelationship between the subject his suffering and his actions in the world, or rather, between the person and himself, in the sense that mediation, when viable, can help in the deconstruction of the knowledge in which the subject is alienated, that is, the objective of care as mediation is to mark/flexibilize** *the crystallized cogito*, facilitating the resumption of autonomy over his project of being, as long as being responsible for your choices and actions in the world. (Schneider *et. al.*, 2020).

To keep in mind that this weaving process is not something "given" or "natural", is to consider that the abandonment of the classical biomedical conception about the disease, as an object detached from the subject who falls ill, is a continuous and daily process in which each action matters, both of the team that cares and of the subject that is cared for, (Contacte) *et al.*, 2017; Schneider *et. al.*, 2020;).

An expanded clinic is a powerful tool for the construction of care practices for the promotion and prevention of diseases in the psychosocial sphere, allowing the overcoming of biomedical rationality of only a curative nature, breaking with the institutionalizing logic still very present in substitutive services, which maintains the traditional practices of "intramural" care, as Rotelli (1991) warned.

To the extent that one understands the dialectical process between the objective and subjective conditions in the constitution of severe psychic suffering, the presuppositions of another clinic (psychosocial, extended) that goes beyond the simple control of symptoms is placed, since it does not focus on the subject himself, but on his context of relations, promoting a reconstruction of historical sociological bond or the construction of new enabling bonds, in the direction of a critical social integration of the subject in the world.

For this reason, existentialism is invested as an important foundation in the understanding of human psychic suffering and in the constitution of strategies that are in fact linked to an expanded clinic, providing subsidies for a psychosocial care clinic that emancipates the subject.

5 FINAL CONSIDERATIONS

It is necessary to reflect on the invisibility of psychic suffering in childhood, which has its roots in concrete events that occurred in the lives of these patients and bring deep marks to their life stories, making care only arrive when the situation is already very serious and has already become a crisis, with all the severity and impacts that this situation brings. It is interesting to note how the process of loneliness and the need for these children to solve their dilemmas and impasses in the face of their social experiences and the resulting sufferings, without having many cognitive and emotional parameters and without sociological mediations, which leads them to a guilt and an understanding that "it is something in my head", losing the nexus with the fabric of the social determinants in which they were involved. In this direction, the psychiatric diagnoses "fit like a glove", for the person to understand that the problem of suffering is his, of a "disease" that takes him, leading to a pathologization of what should be seen as a victimization and an unfolding of the social game and the troubles of family life. (Szasz, 1979).

Although it was verified in the narratives of the interviewees a great importance of the CAPS in the process of overcoming suffering, which demonstrates a certain advance in care practices, it is still known that the logic of the expanded clinic referred to just above is far from reaching its full potency (Schneider et. al., 2020). The intervention should not only take place with the user, but also in their sociological and anthropological context, considering that social relations and sociological mediations are what in fact promote the constitution of this process of suffering (Schneider, 2010, 2011). Therefore, the intervention must also take place at the root of the problem, that is, in the territory of belonging of these subjects, which is recommended by an expanded clinic. This is a great challenge for the psychosocial mode, to get out of the walls of the services and the clinic developed there and win the streets and cities. Or also, on the other hand, to make the families and the city itself understand that that space of care is also theirs and that the quality of life of the users who transit there need this sociocultural mediation.

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