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RESENHA BOOK REVIEW

Social skills in adolescence: Psychopathology and sociodemographic variables

Habilidades sociais na adolescência: psicopatologia e variáveis biosociodemográficas

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Abstract

This study aimed to investigate the relationship between social skills, psychopathology and sociodemographic characteristics among adolescents. Participants were 50 adolescents from *Rio Grande do Sul*, Brazil (30 girls and 20 boys, M_{age}=14 years, SD=1.61) who attended either a public or a private school. The participants answered a sociodemographic questionnaire, the social skills Inventory for Adolescents Del-Prette (frequency and difficulty) and, to assess symptoms of psychopathology, the Self Report Questionnaire 20. Results indicated that there were no differences in the frequency of the social skills investigated with regard to genders, age, type of school attended, and the indication of psychopathology. However, the difficulty score reported on the use of social skills was related with psychopathology. This relationship was further moderated by the type of school. Thus, sociodemographic variables and personal characteristics (such as psychopathology) must be considered in social skills studies.

Uniterms: Adolescence; Psychopathology; Social skills; Sociodemographic.

Resumo

O objetivo deste estudo foi investigar relações entre habilidades sociais, indicativo de psicopatologia e variáveis biossociodemográficas em adolescentes. A amostra foi composta por 50 adolescentes de uma cidade do Rio Grande do Sul (30 meninas e 20 meninos, M_{idade}=14 anos, DP=1,61) que frequentavam ou escola particular ou escola pública. Os participantes responderam a um questionário biossociodemográfico, o Inventário de habilidades sociais para Adolescentes de Del-Prette e, para avaliar sintomas de psicopatologia, o Self Report Questionnaire 20. Os resultados indicaram que não houve diferença na frequência das habilidades sociais investigadas quanto às variáveis sexo, idade, escola e indicativo de psicopatologia. Todavia, foi constatado que a intensidade da dificuldade em habilidades sociais está relacionada com o indicativo de psicopatologia apresentado pelos adolescentes. Esta relação foi moderada pelo tipo de escola. Assim, além do papel de variáveis biossociodemográficas, as características individuais (por exemplo, psicopatologia) devem ser consideradas em estudos sobre habilidades sociais.

Unitermos: *Adolescência; Psicopatologia; Habilidades sociais; Variáveis sociodemográficas.*

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Social skills are characterized by a set of behaviors displayed by individuals in an interpersonal context in which they express feelings, attitudes, desires, opinions or rights adequately for the situation, respecting the same behavior in others (Caballo, 1986). They are therefore characterized by the performance of the individuals given the demands of a social situation. These skills are learned and the performance level differs depending on the developmental stage and on cultural and situational variables (Z.A.P. Del Prette & A. Del Prette, 1999).

The development of social skills is influenced by two distinct factors: the individual temperament (individual characteristics) and environment (contextual variables). The temperament is configured by the tendency that the individual has to relate socially. Thus, for example, children born with a predisposition to behave in a more inhibited way tend to engage less in activities that give them the opportunity to learn and practice social behaviors, which may result in less reinforcement (praise, smiles, caresses etc.) by the people around them. Conversely, it is likely that children who are more outgoing are involved in social interactions in which they will have the opportunity to develop their social behavioral repertoire (Caballo, 2003). The influence of the temperament on the development of social skills can be counterbalanced by the environmental factor. This is because the environment acts to reinforce (or not) social behaviors, as well as enabling the learning of new skills through observation and interactions (Caballo, 2003).

Adolescence is a developmental stage in which the social skills play an important role considering the need for social integration and the search for self-assertion and independence. It is therefore a stage of the life cycle where adaptations and changes in personal and social skills need to be made. However, infancy is often considered a critical period for learning social skills (Caballo, 2003) and many researchers are devoted to the study of this subject (Bandeira, Rocha, Freitas, Z.A.P. Del Prette & A. Del Prette, 2006; Bandeira, Rocha, Pires, Z.A.P. Del Prette & A. Del Prette, 2006; Bandeira, Rocha, Souza, Z.A.P. Del Prette & A. Del Prette, 2006; Bolsoni-Silva, Marturana, Pereira & Manfrinato, 2006; Branco & Ferreira, 2006; Z.A.P. Del Prette & A. Del Prette, 2002; Gonçalves & Murta, 2008).

Although infancy is a phase relevant to the development of social skills, it is known that in adolescence, the peers influence the development, serving as models and sources of reinforcement for the social skills (Caballo, 2003). The period of adolescence has specific characteristics, including the tendency for group interaction, which indicates the propensity that the adolescent has to relate to peer groups. This group tendency (Knobel, 1981) is derived from the individual's need to identify with someone (or something, such as sports activities) so that they can construct their own identity, with this being considered the main task of adolescence (Erikson, 1972). The group tendency and the acquisition of identity are, therefore, relevant aspects in the experience of adolescence, which require social interactions, since it is from the interaction with others that the sense of identity is formulated.

Indications of psychopathology (e.g., depressed mood, anxiety, and somatization) and sociodemographic variables (e.g., gender and age) have the potential to influence social skills during adolescence. For example, Wagner and Oliveira (2007) conducted a review of the literature on social skills and substance abuse by adolescents. The authors reviewed scientific papers in the field of relationships between social skills and psychological disorders, verifying that they are present mainly in disorders such as schizophrenia, depression, emotional disorders, affective and anxiety disorders, invasive disorders, such as autism, and psychoactive substances abuse and dependence (Z.A.P. Del Prette & A. Del Prette, 2002; Falcone, 2000). The results of this study indicate that adolescents who abuse or are dependent upon psychoactive substance may have deficits in social skills, thereby setting up an inverse relationship between social skills and drug use. Deficits in social skills among adolescent substance users are configured in the form of low social skills and specific difficulties such as those manifested in situations of risk to the self-esteem and problem solving. Furthermore, the desire for acceptance by the peer group can be related to the limited ability for refusing (group pressure for drug use ends up prevailing (Wagner & Oliveira, 2007).

Two types of social skills seem to be especially important for a good experience of adolescence: assertiveness and self-control (Bakker, Ormel, Lindenberg, Verhulst & Oldehinkel, 2010). Socially skilled adolescents are able to express their feelings and desires, managing to control their impulses and alter emotions

and thoughts. Furthermore, deficits in social skills favor victimization among the peers and conflict with authorities. The victimization and conflict resulting from deficits in social skills, when lasting, can result in mental problems (Bakker et al., 2010). Individuals with good social skills have a low chance of developing depression and being lonely and socially anxious (Segrin & Flora, 2000). Thus, the studies indicate an interaction of the deficits in social skills with victimization among peers and psychiatric disorders (Bakker et al., 2010; Segrin & Flora, 2000; Wagner & Oliveira, 2007). Conversely, socially skilled behaviors are seen as favorable for the development of strategies when faced with adverse situations, reducing vulnerability and enhancing resilience (Cecconello & Koller, 2000).

In a study carried out with adolescents, Landazabal (2006) investigated the relationships between psychopathological symptoms, social skills, cooperation and personality traits (emotional stability, open-mindedness, sociability and responsibility). The repertoire of behaviors was evaluated in five dimensions: social skills (behaviors such as expressing emotions, making friends and sharing); inappropriate assertiveness (aggressive behaviors, such as mocking and abusing others); impulsivity (getting angry easily and interrupting others); overconfidence (overestimating themselves); and jealousy/withdrawal (loneliness and lack of friends). The results showed that adolescents who presented psychopathological symptoms had low levels of cooperative behaviors and social skills. At the same time, these adolescents presented high scores in inappropriate assertiveness, impulsivity, overconfidence, and jealousy/withdrawal. Regarding the personality variables, higher levels of psychopathologies were associated with low scores in emotional stability, sociability and responsibility. This study supports the hypothesis that psychopathological symptoms and social skills are inversely related, with high levels of psychopathology being associated with low levels of social skills.

By shifting the focus to the influence of context variables on social skills, the study by Campos, Z.A.P. Del Prette and A. Del Prette (2000) examined the values of children and adolescents in homeless situations and their relationship with the development of social skills. A total of 28 boys in homeless situations, from less than ten years of age to 18 years of age, were investigated. Through informal conversations, recorded interviews and the application of an inventory regarding skills, beliefs and feelings, the authors concluded that the children and adolescents developed a set of relevant social skills to cope with the demands of the homeless situation. Skills such as defending their rights, negotiating interests, and refusal and acceptance of requests were the most frequent. Conversely, skills related to the expression of positive feelings, asking questions, dealing with criticism and mockery, and controlling anxiety were presented less frequently. These results show the influence of the context on the social skills, considering that the skills most present in this study population were consistent with their contextual requirements.

The study of social skills, with respect to the sociodemographic variables, is still incipient (Bandeira et al., 2006), even though the social behavior occurs in a given context and is influenced by this. Variables such as gender, age, marital status, family configuration, profession, education, personal and family gains, and living in rural or urban areas, among others, are considered important for the development of social skills (Caballo, 2003). Relevant data in relation to variables such as age, gender, type of School and Socioeconomic Status (SES) are also described by Z.A.P. Del Prette and A. Del Prette (2009). In a comparison between groups of adolescents of different ages (12 to 14 and 15 to 17 years) in which the *Inventário de Habilidades Sociais para Adolescentes* (IHSA, Social Skills Inventory for Adolescents) (Z.A.P. Del Prette & A. Del Prette, 2009) was used, the older individuals presented higher scores on the IHSA-Del-Prette civility, social assertiveness and resourcefulness subscales. Regarding gender differences, the results indicated that, when they appear, these are favorable for adolescent girls, both in the frequency indicators (higher scores) as well as in those of difficulty (lower scores). No differences were found in social skills according to the type of school attended by the adolescents (i.e., private or public). The frequency and difficulty in social skills showed distinct differences between the different socioeconomic conditions. When the social skills were correlated with the SES, the results indicated a positive correlation between the total frequency score of the social skills and the SES, as well as between the total difficulty score and the SES.

Given the above, it can be considered that psychopathology indications and sociodemographic variables have the potential to influence social skills

during adolescence. Thus, this study aimed to investigate the possible relationship between social skills, psychopathology indications and sociodemographic variables among adolescents.

Method

Participants

A total of 50 adolescents, 25 being from a private school and 25 from a public school, girls (n=30) and boys (n=20), aged between 12 and 17 years (Media - M=14 years, Standard Deviation - SD=1.61) from a city of *Rio Grande do Sul*, Brazil participated in this study. The schools and participants were chosen by convenience. The selection procedure for the participants was started in the private school, and later, the formation of a paired sample was sought in the public school using the following criteria: grade, gender and age. The exclusion criteria adopted were: difficulty in comprehending and responding to the instruments, not being included in the 12 to 17 years age group, and the Terms of Free Prior Informed Consent (TFPIC) not being signing by those responsible for the adolescent. The majority of the adolescents were attending the seventh grade of elementary education (30.0%), and 24.0% were in the first year of high school education. The second year of high school and the sixth grade of elementary education presented rates of 22.0% and 16.0%, respectively. The adolescents of the eighth grade presented the lowest frequency, with 8.0%. Regarding the results of the Self Report Questionnaire 20 (SRQ-20), 22.0% of the participants had scores indicating the presence of psychopathology. Of these, 81.8% were female and 18.2% male.

Instruments

The following instruments were used for the data collection:

Social Skills Inventory for Adolescents (Z.A.P. Del Prette & A. Del Prette, 2009): an instrument reviewed and approved by the Federal Council of Psychology, which presented favorable psychometric properties of reliability and accuracy in the original version (α=0.90 for the total frequency score and α=0.90 for the total difficulty score). In this study, the analysis of reliability of the instrument was α=0.96 for the total frequency score, and α=0.94 for the total difficulty score. It consists of 38 items that assess relationship skills with different interlocutors, required in public, private or unspecified contexts. The adolescents have to judge: (a) how often they present the reaction indicated in the item and (b) their difficulties in presenting this reaction; on two Likert type scales, producing an general score for frequency and another for difficulty. The scale for the frequency score has five interval options (i.e., 0-2; 3-4; 5-6; 7-8; 9-10), which indicate the frequency that respondents perform the behavior described in the items having the total number of ten situations as the parameter. Each of these options is converted into points from zero to four, with zero being equivalent to the frequency of 0-2 and four to the frequency 9-10. The options for the difficulty scale also have four answer choices (i.e., Very easy; Fairly easy; Average; Fairly difficult; Extremely difficult), which are converted into points ranging from zero to four, where 0=Very easy, 4=Extremely difficult. The instrument also produces scores on six subscales for both frequency and difficulty: 1) Empathy ("Noting that a colleague is sad or in trouble, I offer my support"), 2) Self-control ("I can control my anger when my brother/sister irritates me somehow"), 3) Civility ("When someone does me a favor or a kindness, I thank them"), 4) Assertiveness ("When I do not like an item of clothing or shoe that the salesperson insists I buy, I say politely that I do not like it and will not take it"), 5) Affective approach ("When I want to make friends, I invite people to go out or do an activity"), and 6) Social resourcefulness ("I talk easily about sex with my parents"). High scores in frequency and low scores in difficulty indicate a more developed social skills repertoire of the respondent. Conversely, the lower the scores of frequency and the higher the difficulty scores, the less developed the social skills repertoire of the respondent. The manual of the instrument suggests that the interpretation of the total raw scores and those of the subscales can be based on the position of the respondents in terms of percentiles, comparing these scores to the reference group of the same gender and age (Z.A.P. Del Prette & A. Del Prette, 2009). However, in this study, the mean raw scores were used for the statistical analysis, without interpreting them by their percentiles. In Brazil, up to 2009, there were no instruments to assess standardized social skills for adolescents, which made research difficult (Z.A.P. Del

Prette & A. Del Prette, 2009). Thus, this study is characterized as one of the first to use the IHSA-Del-Prette considering that this is a recently released instrument.

Self Reporting Questionnaire 20 (SRQ-20): used to generate indications of psychopathology, i.e., the presence of mental disorder symptoms. The SRQ-20 was developed by Harding, Arango, Baltazar, Climent and Ibrahim (1980) and validated in Brazil by Mari and Williams (1986). It is a self-reported instrument composed by 20 dichotomous questions (yes/no) that assess four groups of symptoms: depressed-anxious mood, ("Do you feel nervous, tense or worried?"), somatic symptoms ("Do you have unpleasant sensations in the stomach?"), decrease of vital energy ("Do you feel tired all the time?") and depressive thoughts ("Have you had thoughts of ending your life"). For each affirmative answer, one point is added (i.e., the SRQ-20 scores can range from 0 to 20). The greater the presence of affirmative answers, the higher the likelihood of psychopathological disorders. A score of seven or more for male adolescents and eight or more for female adolescents indicate possible cases of psychopathological disorders, according to the study by Avanci, Assisi, Oliveira, Ferreira and Pesce (2007). In this study the total score on the SRQ-20 was considered, i.e., the four groups of symptoms were not analyzed separately.

Sociodemographic questionnaire: developed for this study in order to obtain data such as age, gender, education and type of school the adolescents attended.

Procedures

The study was approved by the Research Ethics Committee of the *Faculdades Integradas de Taquara* (FACCAT), protocol number 492, and all participants signed the TFPIC. Then, a contact was made with two schools (one public and one private) to request the Terms of Agreement for the performance of the study. After the agreement of the schools, a meeting was held with the adolescents in their respective schools to present the project and invite them to participate. At this meeting the TFPIC were distributed for the parents or guardians of the participants to sign, as the participants were minors. Only in the second meeting with the adolescents, at the premises of each school, were the instruments applied with those that had had their participation authorized. In a group, the students signed another TFPIC rewritten in language adapted to the adolescents, and the instruments were applied in the following order: 1) sociodemographic questionnaire; 2) IHSA-Del-Prette, 3) SRQ-20. The participants responded to the instruments in groups at extracurricular times, with a mean duration of 30 minutes.

Results

Initially, the data from the IHSA-Del-Prette were tabulated and the frequency and difficulty means were calculated. In the manual for the application, calculation and interpretation of the instrument (Z.A.P. Del Prette & A. Del Prette, 2009), the authors worked with the overall score which was calculated from the sum of the items. In this study it was chosen to work with the overall means of frequency and difficulty and their respective subscales so that it was possible to identify the position of the respondent on the frequency (i.e., 0-2; 3-4; 5-6; 7-8; 9-10) and difficulty scales (i.e., Very easy; Fairly easy; Average; Fairly difficult; Extremely difficult), which would not be possible through the overall score. For comparison, the following variables were considered: gender, type of school (public *vs*. private), age (12-14 years *vs*. 15-17 years) and indication of psychopathology (SRQ-20, represented by scores ≥7 for boys and ≥8 girls).

The frequency mean of the IHSA-Del-Prette was 2.31[3] (SD=0.84). The instrument considers the frequency from the number of times that the participant presents a specific reaction on a scale ranging from 0 to 4 (i.e., 0=0 to 2 times and 4=9 to 10 times). That is, the adolescents of the study reported reacting 5 to 6 times in the way described for the items of the instrument. Regarding difficulty, the adolescents presented a mean of 0.97[4] (SD=0.53), indicating a little difficulty in dealing with the situations addressed in the instrument.

[3] One participant (outlier) was excluded from the analysis of the frequency mean of the IHSA (i.e., n=49).
[4] Two participants (outliers) were excluded from the analysis of the difficulty mean of the IHSA (i.e., n=48).

When considering the frequency mean, no significant differences were found in relation to gender, *t*-statistic(47)=-0.36, non significant (ns); age, *t*(47)=-0.65, ns; school type, *t*(47)=0.53, ns; and indication of psychopathology (SRQ-20, present *vs*. absent), *t*(47)=0.47, ns. That is, these variables did not differentiate the participants regarding the frequency in which they experience the situations mentioned in the IHSA-Del-Prette.

The difficulty mean of the participants varied significantly between the boys (M=0.80, SD=0.40) and girls (M=1.09, SD=0.57), *t*(46)=1.95, *p*<0.05 (one-tailed test), and between those who presented indication of psychopathology (M=1.46, SD=0.56) and those that did not (M=0.85, SD=0.44), *t*(46)=-3.70, *p*<0.01. Such differences also appeared when comparing the younger adolescents (M=0.83, SD=0.50) with the older ones (M=1.11, SD=0.53), *t*(46)=-1.86, *p*<0.05 (one-tailed test). The type of school was not a differentiating variable for the difficulty mean in the IHSA-Del-Prette, *t*(46)=1.13, ns.

Two covariance analyzes were performed aiming to verify whether the differences in the difficulty means in the IHSA-Del-Prette between the girls and boys and between the older and younger adolescents would still remain after controlling for the indication of psychopathology. For the gender variable, the results indicated that after the indication of psychopathology mean was controlled, there was no significant difference between the boys and girls, *F*-statistic (1.45)=0.19, ns, *R*-squared=0.16. The same occurred with the age variable, i.e. after indication of psychopathology was controlled, there was no significant difference between the younger and older adolescents, *F*(1.45)=1.20, ns, eta-squared=0.18. Table 1 presents the means and variability of difficulty in social skills for boys and girls and for younger and older adolescents before and after the indication of psychopathology was controlled. There was no significant difference in relation to gender and age after the indication of psychopathology was controlled. This indicates that the difficulty in the IHSA-Del-Prette was not explained by the gender or age of the participants, but by the indication of psychopathology (Table 2).

Considering the frequency mean in the six subscales of the IHSA-Del-Prette (i.e., Empathy, Self-control, Civility, Assertiveness, Affective approach, and Social resourcefulness), there were no differences in the variables analyzed (i.e., gender, age, school type and indication of psychopathology - SRQ-20) (Table 3). The difficulty means in the Empathy, *t*(48)=-3.01, *p*<0.01, Civility, *t*(48)=-2.21, *p*<0.05, Assertiveness, *t*(48)=-3.55, *p*<0.01, and Social resourcefulness, *t*(48)=-3.65, *p*<0.01 subscales, differed significantly considering the indication of psychopathology (SRQ-20). The participants who presented signs of psychopathology (SRQ-20) had more difficulties in the subscales mentioned (for the complete values of the means, see Table 1). The

Table 1
Adjusted and unadjusted (for age and gender) means and variability of difficulty in social skills using the indication of psychopathology as a covariate

		Unadjusted		Adjusted	
	n	M	SD	M	SD
Boys	19	0.80	0.40	0.93	0.12
Girls	29	1.09	0.57	1.00	0.09
Younger	23	0.83	0.50	0.89	0.10
Older	25	1.11	0.53	1.05	0.10

Note: M: Mean; SD: Standard Deviation.

Table 2
Analysis of covariance for the difficulty in social skills mean as a function of gender and age having the indication of psychopathology as a covariate

Variable	df	RMS	*F*	*p*	eta[1]
Indication of psychopathology	1	1.93	8.59	<0.01	0.16
Gender	1	0.05	0.19	0.66	0.004
Error	45	0.22			
Indication of psychopathology	1	2.24	10.17	<0.01	0.18
Age	1	0.26	1.20	0.28	0.03
Error	45	0.22			

Note: df: degrees of freedom; RMS: Root Mean Square; *F*: *F*-statistic; eta[1]: eta-squared.

Table 3
Regression analyzes with the SRQ-20, gender, age and type of school as predictors of the difficulty mean in the IHSA-Del-Prette

Variables	B	SEB	β	*t*(46)	*p*
SRQ-20	0.16	0.08	0.33	2.07	0.05
Gender	-0.09	0.16	-0.09	-0.60	0.56
SRQ-20 x Gender	-0.09	0.22	-0.08	-0.42	0.68
SRQ-20	0.17	0.07	0.34	2.39	0.05
Age	0.15	0.14	0.15	1.08	0.28
SRQ-20 x Age	-0.22	0.15	-0.36	-1.39	0.17
SRQ-20	0.20	0.07	0.39	2.72	0.01
Type of school	-0.07	0.14	-0.07	-0.47	0.64
SRQ-20 x Type of school	0.30	0.14	0.46	2.06	0.05

Note: SRQ-20: Self Report Questionnaire 20; IHSA-Del-Prette: Social Skills Inventory for Adolescents; β: standardized coefficients; SEB: Standard Error of B; *t*: *t*-statistic.

age variable differentiated the participants in relation to the difficulty mean in the Self-control subscale, $t(48)=-2.17$, $p<0.05$. The older participants (i.e., 15 to 17 years) reported more difficulty in this subscale (Table 1). Finally, there were significant differences in terms of the gender variable in the difficulty means of the Assertiveness $t(48)=2.06$, $p<0.05$, and Affective approach $t(48)=2.13$, $p<0.05$ subscales. The girls reported more difficulty than the boys in these subscales (Table 1).

Aiming to investigate in which of the IHSA-Del-Prette subscales the adolescents reported greater frequency and difficulty, analyzes of variance for repeated measures were conducted for the frequency and difficulty means of the six subscales respectively. Regarding the frequency means of the six subscales, a main effect of Subscale $F(4.33, 202.30)=24.18$, $p<0.001$ was found. Through planned contrasts (Empathy, Civility and Assertiveness *vs*. Social Resourcefulness, Affective Approach and Self-control), it was verified that the Empathy (M=2.71, SD=1.00), Civility (M=2.62, SD=1.31) and Assertiveness (M=2.49, SD=1.07) subscales were the more frequent when compared to the Social resourcefulness (M=1.99, SD=0.95), Affective approach (M=1.86, SD=0.93) and Self-control (M=1.80, SD=0.96) subscales, which were less frequent, $F(1.49)=121.34$, $p<0.001$ (Figure 1).

Regarding the difficulty means, a main effect of Subscale was also found, $F(3.60, 176.65)=28.35$, $p<0.001$. Again, by means of planned contrasts (Self-control and Affective Approach *vs*. Empathy, Civility, Assertiveness and Social resource fulness) it was found that the Self-control (M=1.49, SD=0.81) and Affective approach

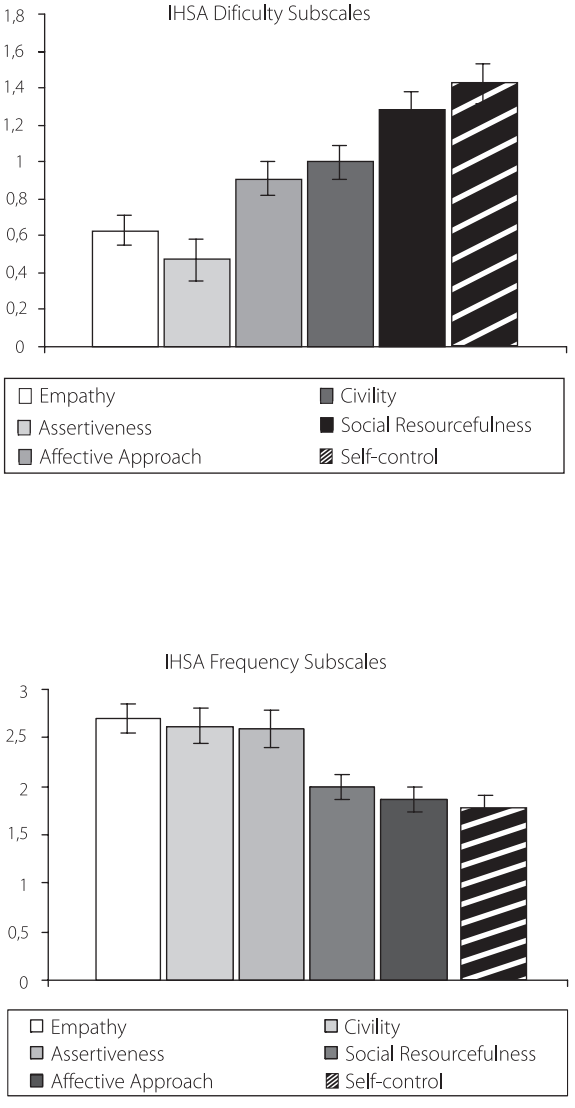

Figure 1. Difficulty and frequency means of the frequency and difficulty subscales of the IHSA-Del-Prette.

(M=1.33, SD=0.75) subscales were the ones with the highest difficulty mean in the IHSA-Del-Prette when compared to Empathy (M=0.73, SD=0.72), Civility (M=0.56, SD=0.89), Assertiveness (M=0.98, SD=0.76) and Social resourcefulness (M=1.08, SD=0.73), $F(1.49)=58.57$, $p<0.001$ (Figure 1).

Analysis of the relationship between indication of psychopathology and difficulty in the IHSA-Del-Prette

From the Analyzes of Covariance (Ancova), the indication of psychopathology emerged as an influencing factor in the difficulty in social skills. Thus, the predictor role of the indication of psychopathology in the difficulty in social skills was tested. A regression analysis was performed with the difficulty mean in the IHSA-Del-Prette as the dependent variable and the indication of psychopathology mean as an independent variable, and a significant relationship was found, $\beta=0.47$, $t(47)=3.61$, $p<0.01$, $R^2=0.20$.

In order to explore the relationship found between indication of psychopathology (SRQ-20) and the difficulty in social skills, the following variables were tested as potential moderators: gender, age and type of school. Thus, hierarchical regression analyzes were conducted, where in the first step, the independent variable (SRQ-20) and the moderator were inserted, and in the second step, the interaction of the two was analyzed. The dependent variable was the difficulty mean in the IHSA-Del-Prette. Prior to the performance of the analyzes, the independent variable (SRQ-20) was centralized and the moderators were converted into dummy type variables (i.e., 0=female and 1=male, 0=private and 1=public school, and 0=12 to 14 years, 1=15 to 17 years of age). The interactions of gender with the indication of psychopathology (SRQ-20), age with indication of psychopathology (SRQ-20) and school type with indication of psychopathology (SRQ-20) were then calculated. The relevant statistics are presented in Table 3.

Gender was not a significant moderator of the relationship between the SRQ-20 and social skills difficulty. The same occurred for age. However, the type of school was a significant moderator of the relationship between the SRQ-20 and social skills difficulty. This relationship was only significant for the public school students ($\beta=0.65$, $t(23)=4.01$, $p<0.01$) without affecting the private school students ($\beta=0.33$, $t(23)=1.63$, ns) (Figure 2).

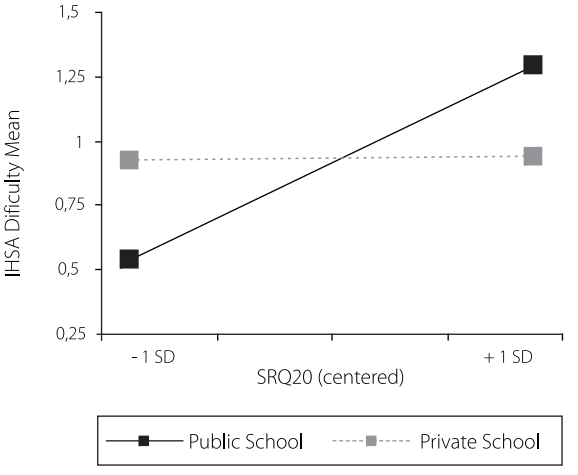

Figure 2. Relationship between SRQ-20 and difficulty of the IHSA-Del-Prette as a function of the type of school.

Note: SRQ-20: Self Report Questionnaire 20; IHSA-Del-Prette: Social Skills Inventory for Adolescents; SD: Standard Deviation.

Discussion

Research highlights the multiplicity of factors influencing the development of social skills. This study investigated the relationships between sociodemographic variables, social skills, and the indication of psychopathology. The results encountered reinforced the idea that there is a relationship between the three dimensions of socially skilled behavior, as previously indicated by Caballo (2003): the behavioral dimension (social skills of adolescents investigated through the IHSA-Del-Prette), the personal dimension (indication of psychopathology, assessed through the SRQ-20, and sociodemographic variables) and situational dimension (type of school attended). Variables such as gender and age were investigated. However, unlike previous studies that reported relationships between these variables and social skills in samples of boys and girls from seven to 10 years of age (Bandeira et al., 2006) and of adolescents from 12 to 17 years (Z.A.P. Del Prette & A. Del Prette, 2009), the sample of this study revealed no differences in the frequency of social skills means according to gender and age. A first

access to the data indicated that there were differences between gender and age in the difficulty in dealing with social skills, however, these differences disappeared when the indication of psychopathology was controlled. Previous studies (Bakker et al., 2010; Segrin & Flora, 2000; Wagner & Oliveira, 2007) have already indicated the relationship between the social skills and psychopathology variables and the present study corroborated this relationship.

The differences between studies on social skills reinforce their contextual character (Caballo, 2003). It is difficult to find consistency among the results, as the context in which the participants are included influences their development. This is due to the fact that different contexts provide varied opportunities for learning social skills and require different social behaviors, which may be useful in one context, but not in others. Other aspects that may interfere with the consistency of the results are sample characteristic: for example, the size and convenience of the sample, and the characterization of the participants (e.g., age, education, and socioeconomic status).

Final Considerations

The main results of this study indicate that the adolescents with an indication of psychopathology also presented higher rates of difficulties in the Empathy, Civility, Assertiveness and Social resourcefulness subscales of the IHSA-Del-Prette. When seeking possible moderators in the relationship between difficulty in social skills and psychopathology, the only variable identified was the type of school. This variable confirms the importance of the context in the development of social skills. For the adolescents of the public school, the relationship between psychopathology and difficulty in social skills was present. However, this relationship was not significant among the adolescents attending the private school, although some of these also presented an indication of psychopathology. The contexts in which the adolescents of the private school develop can provide them with family and social resources that compensate for the negative effect of the psychopathological symptoms on the development of social skills.

The results found indicate the need for further studies for better comprehension of the relationship between social skills, psychopathology and context. The starting point of this study was the hypothesis that the degree of difficulty in social skills is associated with the presence of an indication of psychopathology, as indicated in the studies by Bakker et al. (2010) and Segrin and Flora (2000). However, this relationship is complex and it is not possible to establish a sense of causality. The results corroborate the information that in the presence of high levels of psychopathology there are deficits in social skills (Landazabal, 2006). Although it was not possible to define the direction of the relationship between social skills and psychopathology, this study allowed the importance of a contextualized approach toward social skills in adolescence to be confirmed. It is essential to know the development of social skills considering the characteristics of the context, of the people and of their attitudes faced with the challenges expected in each step of the life cycle.

References

Avanci, J. Q., Assis, S. G., Oliveira, R. V., Ferreira, R. M., & Pesce, R. P. (2007). Fatores associados aos problemas de saúde mental em adolescentes. *Psicologia: Teoria e Pesquisa*, *23*(3), 287-294.

Bakker, M. P., Ormel, J., Lindenberg, S., Verhulst, F. C., & Oldehinkel, A. J. (2010). Generation of interpersonal stressful events: The role of poor social skills and early physical maturation in young adolescents - The TRAILS study. *Journal of Early Adolescence*, *20*(10), 1-23.

Bandeira, M., Rocha, S. S., Freitas, L. C., Del Prette, Z. A. P., & Del Prette, A. (2006). Habilidades sociais e variáveis sociodemográficas em estudantes do ensino fundamental. *Psicologia em Estudo, 11*(3), 541-549.

Bandeira, M., Rocha, S. S., Pires, L. G., Del Prette, Z. A. P., & Del Prette, A. (2006). Competência acadêmica de crianças do ensino fundamental: características sociodemográficas e relação com habilidades sociais. *Interação, 10*(1), 53-62.

Bandeira, M., Rocha, S. S., Souza, T. M. P., Del Prette, Z. A. P., & Del Prette, A. (2006). Comportamentos problemáticos em estudantes do ensino fundamental: características da ocorrência e relação com habilidades sociais e dificuldades de aprendizagem. *Estudos de Psicologia* (Natal), *11*(2), 199-208.

Bolsoni-Silva, A. T., Marturana, E. D., Pereira, V. A., & Manfrinato, J. W. S. (2006). Habilidades sociais e problemas de comportamento de pré-escolares: comparando avaliações de mães e professoras. *Psicologia*: *Reflexão e Crítica, 19*(3) 460-469.

Branco, C. M., & Ferreira, E. A. P. (2006). Descrição do atendimento de uma criança com déficit em habilidades sociais. *Revista Brasileira de Terapia Comportamental e Cognitiva, 8*(1), 25-37.

Caballo, V. E. (1986). Evaluación de las habilidades sociales. In R. F. Ballesteros & J. A. Carrobles (Eds.), *Evaluación conductual: metodología y aplicaciones* (3ª ed., pp.553-595). Madrid: Pirâmide.

Caballo, V. E. (2003). *Manual de avaliação e treinamento das habilidades sociais*. São Paulo: Santos.

Campos, T. N., Del Prette, Z. A. P., & Del Prette, A. (2000). (Sobre)vivendo nas ruas: habilidades sociais e valores de crianças e adolescentes. *Psicologia: Reflexão e Crítica*, *13*(3), 517-527.

Cecconello, A. M., & Koller, S. H. (2000). Competência social e empatia: um estudo sobre resiliência com crianças em situação de pobreza. *Estudos de Psicologia* (Natal), *5*(1), 71-93.

Del Prette, Z. A. P., & Del Prette, A. (1999). *Psicologia das habilidades sociais: terapia e educação*. Petrópolis: Vozes.

Del Prette, Z. A. P., & Del Prette, A. (2002). Transtornos psicológicos e habilidades sociais. In H. J. Guillardi (Org.), *Sobre comportamento e cognição: contribuições da construção da teoria do comportamento* (pp.377-386). Santo André: ESETec.

Del Prette, Z. A. P., & Del Prette, A. (2009). *Inventário de habilidades sociais para adolescentes (IHSA-Del-Prette): manual de aplicação, apuração e interpretação*. São Paulo: Casa do Psicólogo.

Erikson, E. H. (1972). *Identidade, juventude e crise*. Rio de Janeiro: Jorge Zahar.

Falcone, E. M. O. (2000). Habilidades sociais: para além da assertividade. In R. C. Wielenska (Ed.), *Sobre comportamento e cognição: questionando e ampliando a teoria e as intervenções clínicas e em outros contextos* (Vol. 6). Santo André: ESETec.

Gonçalves, E. S., & Murta, S. G. (2008). Avaliação dos efeitos de uma modalidade de treinamento de habilidades sociais para crianças. *Psicologia: Reflexão e Crítica*, *21*(3), 430-436.

Harding, T. W., Arango, M. V., Baltazar, J., Climent, C. E., & Ibrahim, H. H. A. (1980). Mental disorders in primary health care: A study of their frequency and diagnosis in four development countries. *Psychological Medicine, 10*(2), 231-241.

Knobel, M. (1981). A síndrome da adolescência normal. In A. Aberastury & M. Knobel. *Adolescência normal: um enfoque psicanalítico* (pp.24-59). Porto Alegre: Artes Médicas.

Landazabal, M. G. (2006). Psychopathological symptoms, social skills, and personality traits: A study with adolescents. *The Spanish Journal of Psychology, 9*(2), 182-192.

Mari, J. J., & Williams, P. (1986). A validity study of a psychiatric screening questionnaire (SRQ-20) in primary care in city of São Paulo. *The British Journal of Psychiatry*, *148*(1), 23-26.

Segrin, C., & Flora, J. (2000). Poor social skills are a vulnerability factor in the development of psychosocial problems. *Human Communication Research, 26*(3), 489-514.

Wagner, M. F., & Oliveira, M. S. (2007). Habilidades sociais e abuso de drogas em adolescentes. *Psicologia Clínica*, *19*(2), 101-116.

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Recognition of facial expressions in children, young adults and elderly people

Reconhecimento de expressões faciais em crianças, jovens e idosos

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Abstract

The present study evaluated the recognition of facial expressions in different ages, using groups composed of: 1) 21 children with a mean age of 7.7 years; 2) 19 young adults with a mean age of 20.1 years; and 3) 9 elderly people with a mean age of 74.7 years. In the tests, participants were asked to identify facial expressions of happiness, sadness, fear and anger of different emotional intensities. The results indicated that the young adults performed better in recognizing facial expressions when compared to the children and elderly people. The children presented a performance similar to the elderly people, supporting the hypothesis that the ability to recognize facial expressions improves in adulthood and diminishes in old age.

Uniterms: Development; Emotion; Facial expressions; Perception.

Resumo

Desenvolveu-se um estudo para avaliar o reconhecimento de expressões faciais em diferentes faixas etárias, com inclusão de grupos compostos por: 1) 21 crianças com idade média de 7,7 anos; 2) 19 adultos jovens com idade média de 20,1 anos; e 3) 9 idosos com idade média de 74,7 anos. Na situação de teste, foi solicitado aos participantes que identificassem expressões faciais de alegria, tristeza, medo e raiva em diferentes intensidades emocionais. Os resultados indicaram que os jovens apresentaram um melhor desempenho no reconhecimento de expressões faciais, quando comparados a crianças e idosos. Crianças apresentaram um desempenho similar aos idosos, apoiando a hipótese de que as capacidades de reconhecimento de expressões faciais aperfeiçoam-se na idade adulta e diminuem na velhice.

Unitermos: *Desenvolvimento; Emoção; Expressões faciais; Percepção.*

The ability to quickly capture and interpret emotional cues in the social environment allows people to anticipate events and respond appropriately to them (Isaacowitz et al., 2007). Within this perspective, it is observed that humans develop the ability to recognize emotions in facial expressions very early in life.

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Studies from evolutionary psychology and cognitive neuroscience have indicated a different nature of facial recognition, suggesting that faces are perceived as a special class of stimuli, different from other categories of objects (Keightley, Chiew, Winocur & Grady, 2007; Nelson, 2001). The appraisal of the social environment, as well as the establishment of interpersonal relationships, depends largely on the proper recognition of facial expressions (Ekman, 1999; Zebrowitz & Montepare, 2008). In this sense, there has been much discussion about the role of the recognition of facial expressions in the social context (Biele & Grabowska, 2006; Ebner & Johnson, 2009; Thomas, De Bellis, Graham & LaBar, 2007) and the emotional development of the individual (Ko, Lee, Yoon, Kwon & Mather, 2011).

Some authors claim that the perceptual structure of facial expressions remains similar from childhood to adulthood and is organized in two dimensions: pleasure-displeasure and activation-deactivation (Gao, Maurer & Nishimura, 2010). Meanwhile, other studies argue that the ability to identify facial expressions improves with age (Fox, 2001; Herba & Phillips, 2004; Thomas et al., 2007).

To explain this improvement throughout development, the authors believe that there is a progressive increase in the ability to identify configurational properties of faces. Maurer, Le Grand and Mondloch (2002) distinguished these properties as: 1) First-order (relative position of the elements of the face such as eyes positioned above the nose), 2) Second-order (rotation and distance between the elements of the face) and 3) Holistic (the facial features perceived in a single gestalt in an integrated way). The authors concluded that a change in the spatial pattern of faces (placing them upside down or changing the rotation of elements, such as the eyes and mouth) interferes in the recognition of facial expressions. In agreement with the hypothesis of the configurational properties, neuropsychological studies in adults have shown that normal recognition capability is reduced when faces are presented upside down (Farah, Tanaka & Drain, 1995; Valentine, 1988).

Some authors state that throughout development the recognition of positive emotions precedes the identification of negative emotions (Widen & Russell, 2003). Conversely, Durand, Gallay, Seigneuric, Robichon and Baudouin (2007) argue that the increase in the capacity for identifying facial expressions of sadness and joy occurs concomitantly. According to this concept, at around five or six years of age, performance in recognizing emotions of joy and sadness would be similar to adults. The authors also found that the ability to recognize facial expressions of fear only equals the adult ability at around seven years of age, whist the ability to recognize the emotions of anger and disgust, reaches its optimal level between nine and eleven years of age.

Although there is evidence in favor of an increase in the recognition of facial expressions in adolescence (Thomas et al., 2007), some authors have reported a decline in the recognition of facial expressions throughout development. The evidence is corroborated by studies that verify a decline of performance in the recognition of negative emotions from late adulthood on (Grady, Hongwanishkul, Keightley, Lee & Hasher, 2007).

In view of the discrepancies reported in the literature, and considering the lack of studies investigating the recognition of facial expressions throughout development, the present study aimed to evaluate the perception of facial expressions in three age groups. For this purpose, groups were composed of children, young adults and elderly people who judged facial expressions of happiness, sadness, fear and anger in different emotional intensities. One of the main advantages of using emotional expressions of different intensities is to ascertain how individuals evaluate subtle facial expressions that occur with relative frequency in the environment of social interaction.

In this study, we started with the assumption that there would be an increase in facial expression recognition rates in early adulthood, followed by a possible decline in old age. We also carried out a comparative analysis between the recognition rates of the four emotions investigated according to the different stages of development.

Method

Participants

Participants were divided into three age groups. The first group was composed of 21 children (10 boys,

11 girls), students of a public school, participating in a program of continuing education in the city of *João Pessoa, Paraíba* (PB), in Brazil, aged between six and eight years (Mean age - M=7.7, Standard Deviation - SD=0.7 years). The second group was composed of 19 young adults (7 men, 12 women), students of the *Universidade Federal da Paraíba* (UFPB), aged between 18 and 25 years (M=20.10, SD=2.0 years). The third group was composed of nine elderly people (three men, six women) residents of a nursing home in *João Pessoa* (PB), aged between 65 and 83 years (M=74.7 years, SD=6.9 years). The study was approved by the Ethics Committee of the UFPB, under protocol nº 0167, on 27/5/2009, and all participants or guardians signed the terms of free prior informed consent before participation.

Materials

The present study used NimStim Face Stimulus Set (Tottenham, Borscheid, Ellertsen, Marcus & Nelson, 2002), currently available at <http://www.macbrain.org/faces/index.htm>. The NimStim Face Stimulus Set consists of color photographs of people of different ethnicities depicting faces with emotional expressions and neutral faces. For the present study, we used the images of two women (models 1 and 16) and two men (models 37 and 41) outlining expressions of happiness, sadness, fear, anger and a neutral expression. Each picture had a resolution of 506x650 pixels in a Red, Green, Blue (RGB) color pattern.

The original faces were manipulated to produce intermediate levels of emotional intensity through the morphing technique. The intensity is determined by the amount of relaxation of the facial muscles, when compared to a neutral emotional state. We generated six intermediate levels of intensity between the neutral face (0.0%) and emotional faces (100.0%), with the levels corresponding to 14.3%, 28.5%, 42.8%, 57.1%, 71.4%, 85.7% and 100.0% of maximum emotional intensity. Morphing effects were generated with the Morpheus Photo Animation Suite (version 3.10) program and the Adobe Photoshop (CS3 10.0) program was used to attenuate distortions in the photographs.

In the present study, we used expressions with intermediate (42.8%, 57.1%) and high values of emotional intensity (71.4%, 85.7% and 100.0%). Subtle expressions with values 14.3%, 28.5% were not included in this study because they are extremely difficult to recognize and substantially increase the duration of the recognition sessions. Thus, a total of 80 pictures were obtained from the morphing construction (4 models x 4 emotions x 5 intensities). The photographs were printed on mat paper size 15x21cm (width x height) (Figure 1).

Identification of photographs

Each photograph received a three-digit identification code on the back, allowing the computation of the subsequent responses of the subjects. The first digit represented the model number. The second digit identified the emotion outlined in the photo (happiness, sadness, fear or anger). The third digit identified the intensity of emotion. A standardized table was used to record the participant's responses.

Procedures

Tests were applied individually and the participants were instructed to look carefully at the

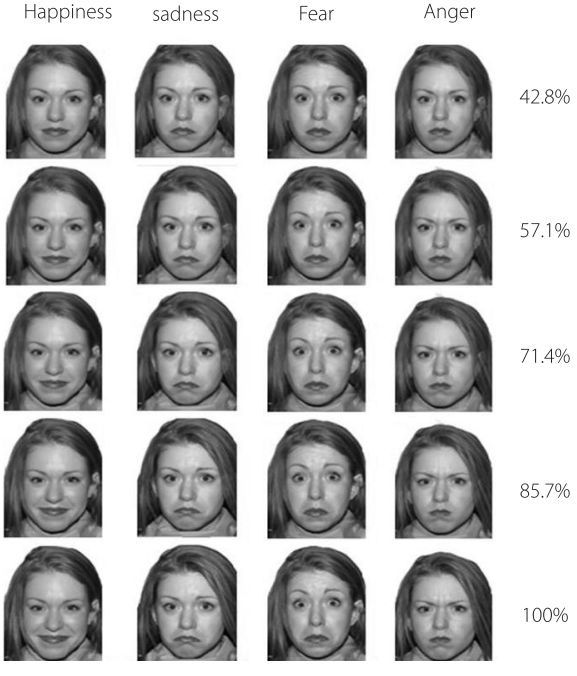

Figure 1. Emotional faces produced by the morphing technique. Faces varied at a rate of 14.29% in emotional intensity.

Note: Original images were taken from NimStim Face Stimulus Set (Tottenham et al., 2002), with permission of the authors.

photographs and to identify which emotion among the four (happiness, sadness, fear or anger) was expressed on the face. The researcher recorded the participant's responses on a standardized table, writing the code of the photograph in the column of the emotion chosen by the participant. Each participant was identified by a number. At the end of the test application the responses were tabulated.

Test procedures were adapted to the different groups of the study. For the groups composed of young and old adults, the pictures were randomly presented and the participants were instructed to examine them carefully and then to record the emotion expressed by the face.

In order to make the task of recognizing facial expressions less tiring for the children, the procedures were adapted according to Gao and Maurer (2009). For the experimental session, children were taken individually to a room in which they found a table. On the table, there were four dollhouses. In the front of each house there was a figure depicting schematic expressions of happiness, sadness, fear or anger.

The experimenter then asked the child, *"inside each one of these houses there are people telling stories of happiness, sadness, fear or anger. Could you tell me which story is being told in each one?"*. If the child identified the emotion presented for each house correctly, the researcher proceeded to the next step, saying: *"Now I'll show you photographs of people with different emotions and you should help them to reach their home. A person can only enter a home if it contains people who feel the same as him or her. Is that ok?"*. After the experimenter certified that the child had understood the instructions correctly, the photos were presented one at a time and the child was asked to place each photo in a matching house according to the facial expressions depicted in the photograph.

Results

Rates of recognition for each emotion were analyzed using a repeated measures Analysis of Variance (Anova) model: 3 groups of participants (children, young adults and elderly people) x [4 emotions (happiness, sadness, fear and anger) x 5 intensities (42.8%, 57.1%, 71.4%, 85.7% and 100.0%)].

Results showed statistically significant effects for age ($F_{2,46}$=21.02, p=0.001), emotion ($F_{3,44}$=55.56, p=0.001) and intensity ($F_{4,43}$=4.20, p=0.001). Tukey's post-hoc test revealed that the group of young adults outperformed the groups of children and elderly people in the facial expressions recognition test (p<0.001) ($M_{young\ adults}$=91.91, SD=6.01), whereas the children and elderly people presented similar patterns of performance (p>0.05) ($M_{children}$=74.34, SD=8.79; $M_{elderly}$=71.80, SD=14.69) (Figure 2).

The emotion of happiness had the highest mean recognition rate for the children ($M_{children/joy}$=98.57, SD=4.60): young adults ($M_{young\ adults/joy}$=98.95, SD=4.40) and elderly ($M_{elderly/joy}$=95.00, SD=13.69) groups. The emotion of sadness had the lowest rate in the three groups ($M_{children/sadness}$=50.00, SD=14.26; $M_{young\ adults/sadness}$=87.89, SD=13.94; $M_{elderly/sadness}$=59.44, SD=28.35). The emotions of fear and anger presented high rates of recognition especially in the young adult group ($M_{young\ adult/fear}$=90.53, SD=12.37; $M_{young\ adult/anger}$=90.26, SD=13.17); and in the elderly group the rates were lower ($M_{elderly/fear}$=66.67, SD=30.15; $M_{elderly/anger}$=66.11, SD=24.51) suggesting a difficulty in differentiating the facial features that distinguish these emotions. The group of children presented a recognition

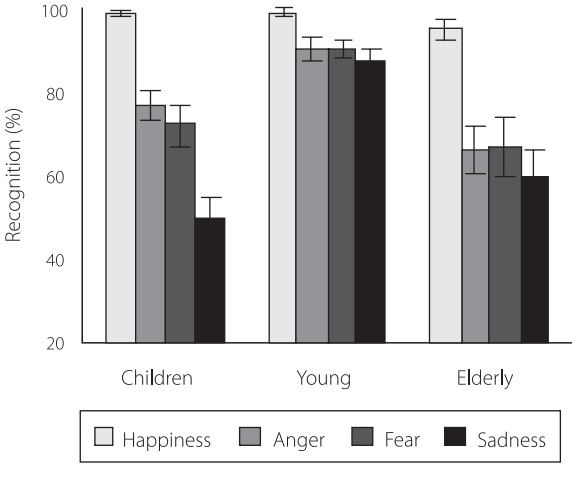

Figure 2. Recognition of emotions of low intensity (42.8% and 57.1%).

Note: Young adults presented better performance in the recognition of subtle emotions when compared to the children and elderly people. The emotion of happiness was recognized more precisely than other emotions.

rate of the emotion of fear of 72.14% (SD=9.20) and anger of 76.67% (SD=16.79) (Figure 2).

Tukey's post-hoc test revealed that facial expressions with less emotional intensity (42.8% and 57.1%) were recognized by the groups with greater difficulty and the accuracy rate of recognition of these expressions were similar between the children ($M_{children}$=67.71, SD=6.10) and elderly ($M_{elderly}$=61.80, SD=2.95) groups. In the young adult group this index was 88.98 (SD=3.49) and, although it was the lowest success rate in this group, this finding corroborates the evidence for the greater ability of young adults to recognize expressions with low thresholds.

Pearson's correlation was performed to determine the influence of age on the recognition of facial expressions. The results showed a significant and positive correlation between the group of children and the recognition of sadness (r=0.45, p<0.05) suggesting that the recognition of sadness increases with age. In the other two groups of participants (young adults and elderly people), the variable age appeared to have little influence on the recognition of facial expressions.

Discussion

The present study investigated the recognition of facial expressions of happiness, sadness, fear and anger into three age groups: children, young adults and elderly people. Photographs with different intensities of each emotion were used for this purpose. We observed that the children and the elderly people showed similar rates of recognition of emotions, which coincides with the observations of Grady et al. (2007).

This similarity supports the idea that the perception of emotions in facial expressions develops in childhood, reaches its optimal state in youth, and eventually starts to decline in old age. Moreover, the young adult group was more sensitive in the perception of these emotions, even when presented at low intensities, presenting superior performance compared to the children and elderly people.

Accordingly to results found in other studies (Ebner & Johnson, 2009; Gao & Maurer, 2009; Palermo & Coltheart, 2004), the emotion of happiness had the highest recognition rate of the three samples at the expense of the other emotions. The facial expression of happiness tends to be better recognized probably because: 1) It may be the first (Widen & Russell, 2003) or one of the first emotions (Durand et al., 2007) to be recognized during development, being very relevant for adaptation in the social environment, and 2) It is a positive emotion that does not need to be hidden and that occurs in interpersonal relationships more often than sadness, fear or anger (Tomkins, 1962).

The lower rate of the three groups for recognizing sadness provokes an interesting hypothesis. In the group of children, according to Gao and Maurer (2009), the difficulty in recognizing facial expressions of sadness is due to the fact that at an early age children are unable to understand typical expressions of sadness, often confusing them with the emotion of fear or simply with a neutral face. Interestingly, statistically significant positive correlations were only found in this group, indicating that age is a variable that influences the ability to recognize the facial expression of sadness.

The difficulty experienced by the children in the recognition of facial expressions of sadness contradicts the statement made by Durand et al. (2007) that says that the increase in the capacity for identifying sadness expressions occurs concurrently with the increase in the capacity for identifying happiness, as happiness and sadness are the first two emotions to be recognized in life. According to this concept, at approximately five or six years of age, performance in the recognition of emotions of happiness and sadness would be similar to that in adults. How then can the poor performance of children in recognizing the emotion of sadness be explained? One hypothesis is that they would have performed better if the emotions presented were depicted using the faces of children as models.

We failed to find studies that used databases of photographs compatible with the age of the study sample, regarding both the children and the elderly people. However, the Child Affective Facial Expression Set (CAFE), a bank of stimuli with photographs of more than 100 children, between 4 and 6 years of age, with facial expressions of happiness, anger, fear, surprise, disgust and neutral is under construction. Cat Thrasher (2011) and Vanessa LoBue are constructing this database (for more information: access http://www.catthrasher.com/child-affective-facial-expression-set/) that will

facilitate future clarification of how the infant perception responds to stimuli consistent with their age group.

Emotions of fear, anger and sadness had a similar recognition rate in the young adults and the elderly people, suggesting difficulty to distingue these expressions. In fact, many expressions of fear were classified as anger and vice-versa. This misclassification of negative emotion expressions can be explained as being due to developmental factors. In the case of children, they are still developing the capacity for recognition of these negative emotions, and the decline showed by the elderly people may be due to the aging process and possible cognitive impairment.

Therefore, the differences found in the performance of children versus young adults reveal that the development of the ability to recognize emotions is still maturing. Furthermore, the children presented a lower performance than the young adults in the perception of emotional expressions at low intensities. According to Gao et al. (2010), the immaturity of the child's visual system can restrict the sensitivity to recognize emotions at low intensities, causing subtle emotions to be interpreted as ambiguous. This is supported by positive correlations found between the age of the child and the overall performance, and between the age of the child and the recognition of emotions at low intensity, suggesting that, in fact, the recognition of emotions in children improves over time.

We found that the elderly people presented a similar performance to the children regarding the recognition of emotions. These results agree with the hypothesis of the recognition ability declining with age. However, it is likely that the performance of the elderly people compared with the young adults may be due to specific characteristics of the study sample, since institutionalized elderly people tend to have greater cognitive impairments, which could be reflected in the facial expression recognition tests. Furthermore, the elderly group showed higher standard deviations in the recognition rates, which may be related to greater heterogeneity of social dynamics and economic conditions prior to institutionalization. It is interesting to observe that the losses that occur with aging do not appear to be restricted to the cognitive field, but also affect the recognition of facial expressions and hence the appraisal of important aspects of the social environment (Ekman, 1999).

Final Considerations

Throughout life, the ability to accurately recognize emotional stimuli becomes the key to successful social functioning, contributing to the promotion of mental health and well-being. The present work constitutes an initial study to expand the understanding of this important skill for social interaction. Future studies, which may involve a more systematic evaluation of cognitive functions in non-institutionalized elderly people or the use photographs compatible with participant´s age, will help to clarify the issues raised by this study.

References

Biele C., & Grabowska A. (2006). Sex differences in perception of emotion intensity in dynamic and static facial expressions. *Experimental Brain Research*, *171*(1), 1-6.

Cat Thrasher. (2011). *Child affective facial expression set*. Retrived February 22, 2013, from <http://www.catthrasher.com/child-affective-facial-expression-set/>.

Durand, K., Gallay, M., Seigneuric, A., Robichon, F., & Baudouin, J. Y. (2007). The development of facial emotion recognition: The role of configural information. *Journal of Experimental Child Psychology*, *97*(1), 14-27.

Ebner, N. C., & Johnson, M. K. (2009). Young and older emotional faces: Are there age-group differences in expression identification and memory? *Emotion, 9*(3), 329-339.

Ekman, P. (1999). Facial expressions. In T. Dalgleish & T. Power (Eds.), *The handbook of cognition and emotion* (pp.301-320). Sussex: John Wiley & Sons.

Farah, M. J., Tanaka, J. W., & Drain, H. M. (1995). What causes the face inversion effect? *Journal of Experimental Psychology*: *Human Perception and Performance*, *21*(3), 628-634.

Fox, J. (2001) *Identifying emotions in faces*: *A developmental study*. Washington, DC: Intel Science Talent Search. Retrieved October 2009, from <http://psych.nyu.edu/pelli/docs/JeremyFoxIntel.pdf>.

Gao, X., & Maurer, D. (2009). Inuence of intensity on children's sensitivity to happy, sad, and fearful facial expressions. *Journal of Experimental Child Psychology*, *102*(4), 503-521.

Gao, X., Maurer, D., & Nishimura, M. (2010). Similarities and differences in the perceptual structure of facial expressions of children and adults. *Journal of Experimental Child Psychology*, *105*(1-2), 98-115.

Grady, C. L., Hongwanishkul, D., Keightley, M., Lee, W., & Hasher, L. (2007). The effect of age on memory for emotional faces. *Neuropsychology*, *21*(3), 371-380.

Herba, C., & Phillips, M. L. (2004). Annotation: Development of facial expression recognition from childhood to adolescence: Behavioural and neurological perspectives. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *45*(7), 1-14.

Isaacowitz, D. M., Loeckenhoff, C., Wright, R., Sechrest, L., Riedel, R., Lane, R. A., et al. (2007). Age differences in recognition of emotion in lexical stimuli and facial expressions. *Psychology and Aging*, *22*(1), 147-159.

Keightley, M. L., Chiew, K. S., Winocur, G., & Grady, C. L. (2007). Age-related differences in brain activity underlying identification of emotional expressions in faces. *Social Cognitive and Affective Neuroscience*, *2*(4), 292-302.

Ko, S. G., Lee, T. H., Yoon, H. Y., Kwon, J. H., & Mather, M. (2011). How does context affect assessments of facial emotion? The role of culture and age. *Psychology and Aging, 26*(1), 48-59.

Maurer, D., Le Grand, R., & Mondloch, C. J. (2002). The many faces of configural processing. *Trends in Cognitive Sciences*, *6*(6), 255-260.

Nelson, C. A. (2001). The development and neural bases of face recognition. *Infant and Child Development*, *10*(1-2), 3-18.

Palermo, R., & Coltheart, M. (2004). Photographs of facial expression: Accuracy, response times, and ratings of intensity. *Behavior Research Methods, Instruments & Computers*: *Special Issue on Electronic Archiving, 36*(4), 634-638.

Thomas, L. A., De Bellis, M. D., Graham, R., & LaBar, K. S. (2007). Development of emotional facial recognition in late childhood and adolescence. *Developmental Science*, *10*(5), 547-558.

Tomkins, S. S. (1962). *Affect, imagery, consciousness*: *The positive affects* (Vol. 1). New York: Springer.

Tottenham, N., Borscheid, A., Ellertsen, K., Marcus, D. J., & Nelson, C. A. (2002). Categorization of facial expressions in children and adults: Establishing a larger stimulus set. *Journal of Cognitive Neuroscience*, *14*(Suppl.), S74.

Valentine, T. (1988). Upside-down faces: A review of the effects of inversion upon face recognition. *British Journal of Psychology*, *79*(4), 471-491.

Widen, S. C., & Russell, J. A. (2003). A closer look at preschoolers' freely produced labels for facial expressions. *Developmental Psychology*, *39*(1), 114-128.

Zebrowitz, L. A., & Montepare, J. M. (2008). Social psychological face perception: Why appearance matters. *Social and Personality Psychology Compass*, *2*(3), 1497-1517.

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Interaction among experience, teaching performance and student's learning at university level

Relação entre experiência e desempenho docente e aprendizagem de universitários

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Abstract

This experimental study approaches characteristics of three university teachers' classes with different levels of experience. According to the literature, experienced teachers more often than not are adaptable to different contexts. However, novice teachers are usually focused on specific class contents to be evaluated. Three teachers were selected, a Professor, and two Assistants (a university level one and an undergraduate). We gave them a source text to teach 10 students each one. After that, students' knowledge was evaluated with a post-test and a self-evaluation. The characteristics of the three classes were evaluated by external judges and the students themselves. Moreover, theme and sequential submission analyses following the source text were made. Results show differences in each of the analyzed aspects according to the literature.

Uniterms: Knowledge level; Learning; Teaching.

Resumo

O objetivo deste estudo foi relacionar a experiência dos docentes com a apresentação dos conteúdos e a aprendizagem de estudantes no nível universitário. É de se esperar que professores com mais experiência educacional sejam adaptáveis a novos contextos e que não apenas ensinem conteúdos a serem avaliados posteriormente. Metodologicamente, o projeto teve esquema quase-experimental tipo pré-teste/pós-teste. Foram escolhidos três professores de Ciências Exatas: *professor experiente, auxiliar com nível superior e auxiliar estudante. Um texto-fonte lhes foi entregue com os conteúdos que deveriam ser ensinados a dez estudantes. As características do ensino foram analisadas quanto ao ajuste das aulas ao texto-fonte e avaliadas por juízes externos à pesquisa e pelos próprios estudantes. A aprendizagem dos conceitos foi avaliada por um pós-teste e uma autoavaliação dos estudantes, ambos de múltipla escolha. Apresentaram-se diferenças nos aspectos analisados nas aulas estudadas. A análise realizada permite evidenciar diferenças nos papéis, possibilitando fortalecer, assim, aspetos diferentes das aprendizagens dos estudantes em futuras aulas que venham a ministrar.*

Unitermos: *Nível de conhecimento; Ensinamento; Aprendizado.*

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It is known that at the university teaching, teachers have different levels of experience. Also, it is presumed that these differences in experience in the classroom influence the characteristics of the teaching-learning process developed by them.

In this sense, the socio-cultural approach argues that it is possible to think that these teaching-learning processes are configured in a social space giving them a particular form. According to González Rey (2008), these forms of action are subjective settings and are embedded in the vital plot and social life of people, in other words, in their context. Teachers as Bariani and Pavani (2008) generally do not easily accept that their roles as educators go beyond the mere technicality, not taking into account, for example, the importance of interpersonal relationships in the process.

The literature on performance of experienced university professors and newly qualified teachers is plentiful (Diaz Barriga Arceo & Nuñez Castillo, 2008; Feixas, 2008; Fluckiger, McGlamery & Edick, 2006; García & Montanero, 2004; Longhini & Hartwig, 2007; Mayor Ruiz, 2008; Orland-Barak, 2008). Although studies addressing this issue do not do so with comparisons of experimental designs, most of them do it in a naturalistic manner, with qualitative analysis or through questionnaires. Despite the importance of this methodology, the rigor of controlled comparisons would give the results the possibility to replica.

Zucchermaglio (2003) claims that experienced teachers are generally characterized by having a complex representation of the teaching-learning situation and their skills are more related to the context, allowing them to consider alternatives in their practice. Therefore, they are more flexible, with the possibility of adding to their script contents and examples of concepts. Unlike experienced teachers, newly qualified teachers have as a goal the classroom itself, not having the ability, for instance, of reflecting on both the classroom and the institution as a whole.

The failure in the ability of newly qualified teachers to think about the complex contexts limits the development of classes to only specific contents, having nevertheless a beneficial consequence to students, especially at the time of evaluation. This is because, according to Durán (2004), the newly formed retain sensitivity to the most difficult contents, since these contents were learned recently. Thus, they use simple language that is similar to that used by students.

Bariani and Pavani (2008) found in a study made with questionnaires to teachers and students that most of them had preferences for practical classes and not theoretical ones. These authors believe that it is possible to understand this preference not only because the practical classes have fewer students, but also because there is a greater differentiation of procedures used and teaching is more interactive, whereas theoretical classes would be more traditional.

The subject being studied can also be thought from the perspective of the Instructional Psychology interested in formal education, focusing on the events that take place in the classroom (Genovard & Gotzens, 1990; González Cabanach, Barca Lozano, Escoriza González Nieto & Pineda, 1996; González Calleja, 1996). The interaction is analyzed in a specific teaching-learning context with subjects, students, and teachers, all them also specific. These studies have helped to identify the characteristics of the interaction itself in the classrooms.

Therefore, this study is inserted in two theoretical frameworks: the socio-cultural approach, in the sense of a cultural look in the data set, and the Instructional Psychology, which promotes studies analyzing the here and now of the classroom. The two approaches do not have a univocal epistemological look. However, both result from the need of specifying the approach used in data presented herein. As it was earlier explained, the contextualization of this study is fundamental to the focus which structures this research and, therefore, it will be described in some detail.

The research was situated at the *Universidad Nacional de Rosario* in *Argentina*. The Argentine University as a public organization has some peculiar characteristics. A particular relevance is the role the students occupy, both for their participation in political decisions - with equal voice and vote as teachers in the University governing bodies -, and in academic life, participating in the teaching career.

It should be noted that all colleges have students working in the disciplines. A typical composition of teachers in a university discipline in descending order of rank is Titular Professor, Associate and Adjunct (Cathedratic professors), Practical Works Chief (PWC),

Assistant with university level (A1) and Auxiliary student (A2). In *Argentina* they are called *Profesor Titular* (T), *Asociado* and *Adjunto*, *Jefe de Trabajos Prácticos* (JTP), *Auxiliar de Primera* and *Auxiliar de Segunda*, respectively. This is because the university demand is very large, since, in most cases, there is not a selection process for incoming students in undergraduate courses.

Cathedratic professors are responsible for the disciplines and, in general, are those who have more knowledge and trajectory. PWC and A1 work in practical classes or laboratories, the A1 are usually newly qualified teachers. A2 are still students who have successfully passed the subject in which they collaborate and have primarily a learning function as future teachers and/or researchers. A2 are not responsible for the planning and execution of teaching and just do it once a year in the presence of more experienced teachers. The A2 are similar to support teachers, very frequent in Brazilian universities (Natário & Santos, 2010), helping out in the classrooms with a more experienced teacher.

The very characteristic of our university has led us to compare the teaching-learning particularities in three of these teaching positions in an Exact Science career: a Titular Professor (T), an A1 and an A2. The main objective of the study was to relate the teachers' experience with the presentation of contents and students' learning.

Method

The design of this study can be described as a pretest/posttest, and it was quasi-experimental because of the restrictions the own field in study imposes. The independent variable "teachers' roles" is evaluated (T, A1 and A2) on the Dependent Variable I (DVI, teaching) and the Dependent Variable II (DVII, learning).

Dependent Variable I, the characteristics of teaching, has three dimensions. The Dimension 1 (D1) was the adjustment to the subject and the sequence of a source text. The Dimension 2 (D2) was the organization (understood as systematization) and the Dimension 3 (D3) was the quality of knowledge in action.

As for the Dependent Variable II, learning, also has two dimensions: D1 was the recall of information and D2 was the self-assessment the students performed on their own learning process.

Participants

The sample consisted of three teachers and 30 students of a discipline of Exact Sciences. The teachers chosen had different positions in it: T, A1 and A2. The participating students took part as students to the same subject ministered by the teachers.

The study was approved by *Consejo Nacional de Investigaciones Científicas y Técnicas* (CONICET) following the ethical standards of Resolution 2857/06 (Argentina, 2006). Furthermore, it fits to Resolution 6164/202 of the university where the study was conducted (Argentina, 2009). All the people participated freely, the research objectives were explained and anonymity in data processing was guaranteed. Therefore, all the principles and ethical standards required were fulfilled.

Materials

Source text: This text was prepared by the researchers with a topic related to the commonly taught, divided into eight sections or sub-topics that would allow the analysis of the subject and the sequence of this text.

Pretest: A general pre-test with open questions was developed. The objective of this test was to eliminate the people who had prior knowledge of the subject that would be taught.

Posttest: Based on the source text, multiple choice questions and open questions were elaborated.

Questionnaire for students: A first part of the questionnaire allowed the student to evaluate the lesson with a closed question in multiple choice (Very good, Good or Fair). The second part allowed a self-assessment of the learning achieved.

Procedures

The subject for this study was chosen according to the teacher's interest in participating in it. The week prior to the experiment, the teachers received a copy of the source text each, informing them that a series of questions would be made from it and the students would answer them after class. The lessons were developed in parallel, observed and audio-recorded for later detailed analysis. Furthermore, 30 students were selected and

they were randomly assigned into three groups. Each teacher taught the same subject to each class.

Firstly, the general pre-test was done. Later, each teacher taught the subject for 30 minutes. After teaching, the post-test and the questionnaire were applied for students.

Data Analysis

a) Dependent Variable I. The characteristics of teaching:

Dimension 1, adjustment to the source text was analyzed as the semantic units spoken by teachers (speech).

The adjustment to the subject of the source text was assessed using two indicators: number of original allusions (not included in source) and omissions to sections of the source text. Each teacher's intervention that was not similar to the text could be classified as directly related or indirectly related to the subject of the lesson. A descriptive-statistical analysis of this indicator was conducted.

The sequential fit analysis was performed from the maximum sequence found that coincided between the source text and semantic units spoken by the lecturer. In other words, the maximum continuous sequence found in each class at any time was registered according to the order of the sections of the source text (for example, if the teacher had the sub-issue seven, followed by 3, 4, 5, 2, the continuum sequence at that moment was three).

Dimension 2, organization (understood as systematization) was measured from the evaluation of the transcripts of audio from five judges external to the experiment. The judges evaluated the organization of the subject and of time. A semantic scale of four options was used.

Dimension 3, the quality of knowledge in action, was also measured from the evaluation of the audio transcripts from the five judges and by the students who were part of the classes. The judges qualified the knowledge quality in action of each class as the clarity and conceptual depth: with a number from "1" to "10" and an evaluative opinion. Students, through the questionnaire, evaluated the class attended as very good, good or fair.

It is important to say that the judges did not know the differences in the experience of teachers and the existence of a source text - to ensure more objectivity in analysis -, and the students only evaluated the class they were part of.

The statistical analysis of the weights of the judges outside the experiment, yielding averages for a comparison between the evaluations were also descriptive.

A qualitative description of the judge's opinions on the teacher's performance in their classrooms was added, bringing a description of the quality of the lessons taught.

b) Dependent Variable II. Learning:

Dimension 1, memory information, was measured objectively by a post-test of content.

Dimension 2 was analyzed through the self-assessment that the students performed on their own learning process.

From the evaluation of the three classes by students and learning outcomes, average and standard deviation for a clearer comparative description was obtained, after bringing up the statistical differences in the calculation of Analysis of Variance (Anova) and *t*-test for independent samples.

Results

Teaching

Dimension 1: *Adjustment to the subject and the sequence of the source text*

The adjustment to the subject (Table 1), as it was said, was analyzed following the utterances of teachers. A2 had fewer utterances that did not coincide with the concepts or examples offered in the source text, so her class was more suited to the text. In contrast, T proposed more concepts and examples that were not contained in the written material (46) in comparison with A1 (29) and A2 (6). On the other hand, A2 did not omit any of the eight sections of the source text, whereas T disregarded one and A1 disregarded two.

It can be seen in Table 2 that the A2 class followed a sequential order closer to the source text, as it was the

Table 1
Adjustment to the subject

Original allusions not included in the source-text	T	A1	A2
Directly related	40	29	3
Indirectly related	6	-	3
Total	46	29	6

Note: T: Titular Professor; A1: Upper-Level Assistant; A2: Student Assistant.

Table 2
Sequential adjustment to the source-text

Maximum sequence of continued concepts		
T	A1	A2
3	2	1
4	3	2
5		3
		4
		5
		6
Total		
3	2	6

Note: T: Titular Professor; A1: Upper-Level Assistant; A2: Student Assistant.

one that showed the greatest continuous sequence of concepts in the same order of the source text (6), compared with T (3) and A1 (2). This analysis demonstrates that its class was the one that most fitted to the source text used in the research.

Dimension 2: *Organization-systematization*

Regarding the organization-systematization of the subject, the average of the judges' evaluation was similar. However, as expected, the class of T obtained the highest average in the evaluation of this aspect. Here we describe both the statistical analysis and the qualitative description that judges have done about classes (remember that judges could only read the records, they did not know about teachers' differences).

In turn, there was more consensus in the evaluation about the class of T than the A1's and the A2's. The class of T was evaluated four times as organization of subject Moderate and once as Regular, while the A1 was rated Low to High, the same as that of A2. Time organization was better evaluated in class T than both of the others, being qualified only as Moderate or High. Both, A1 and A2, on time organization were not assessed as high by any of the judges.

Dimension 3: *Quality of knowledge into action*

The conceptual clarity was better evaluated by judges in T. However, it should be noted as important that A2 got better evaluation in this aspect than A1.

While T was criticized by one of the judges, "*She is not clear about the measurement error.... Moreover, it does not clarify the concept of...* ", this criticism was not sustained by the other judges, that qualified the class as "*Very clear and concrete*" or "*Correct, it describes the concepts required and are included in a practical mark*" etc.

As for the class A1, the same judge who highlighted the misconception in class T, noted that in this case "*It properly clarifies the measurement error...*". Another of the judges said "*The subject was referred redrawing some important definitions clearly, without including unnecessary data that would lead to confusion*". The other judges criticized some aspects of the lesson related to conceptual clarity: "*It is not very clear, the teacher repeats definitions, but does not clarify the doubts of the students...*", "*I did not find conceptual clarity*" or "*The class begins and ends in an abrupt way, it is not very clear because sometimes it is stampeded too*".

Regarding the evaluation of conceptual clarity in the A2 class, judges appraised favorably. On the other hand, one of the judges stressed the historical introduction made by A2, unaware that this introduction was part of the text that had been delivered to him for the experiment, "*I liked the historical introduction on the concept of... . It conceptualizes the elements very well*". Another judge evaluated in an intermediate manner saying that "*The concepts that are exposed are clear, though few in number*". Finally, the other three judges gave a negative opinion on the conceptual clarity developed in class: "*The teacher conveys the subject with little clarity, possibly because he has as unclear to himself what he wants to teach*", "*The teacher is not clear to convey her knowledge...*", and, "*If the teacher has the concepts clear to him, this is not evident in the classroom*". "*The students' questions to clarify concepts are not answered properly, expressing insecurity*" (Table 3).

Regarding the conceptual depth, as expected, T has obtained, on average, the highest scores and A2 has gotten the lowest.

Regarding the qualitative evaluation of judges about conceptual depth, three of them qualified class T

Table 3
Summary of the judges' evaluation regarding topic organization, time organization, clarity and conceptual depth of the three classes

Judge	Organization of the topic*	Time organization**	Clarity***	Depth***
T				
1	2	3	6	7
2	3	4	7	7
3	3	4	9	9
4	3	3	7	7
5	3	4	8	8
Average	2.7	3.6	7.4	7.6
A1				
1	3	3	7	8
2	2	2	5	6
3	4	2	7	8
4	1	1	3	3
5	2	3	5	7
Average	2.4	2.2	5.4	6.4
A2				
1	4	3	10	9
2	2	3	4	4
3	3	1	6	5
4	1	2	3	2
5	3	3	7	5
Average	2.6	2.4	6	5

T: Titular Professor; A1: Upper-Level Assistant; A2: Student Assistant.
*Topic organization (organization of the topic of the class): 1. Low, 2. Regular, 3. Moderate, 4. High; **Time organization (organization of the time of the class): 1. Not at all appropriate, 2. Not very appropriate, 3. Moderately appropriate, 4. Appropriate; *** Scale: 1 to 10.

in a positive way: "*Conceptual depth must be directly related to the future needs of the student. I think depth is quite appropriate to the level*"; "*Right, the most important related issues are mentioned, denoting a complete understanding of the subject*", and, "*I think conceptual depth is appropriate to the issues presented*". However, the other two judges criticized negatively, even though they have not disqualified teacher's conceptual depth: "*I do not doubt the conceptual depth the teacher has. Still, I think the development of the class was oriented more to practical than to concept*"; "*Moderately well, I consider he handles the concepts, even if he gets confused during the explanation*".

Regarding A1's class, there were different opinions from the judges. Two of them were positive: "*Despite the dispersion of the subjects, the depth is appropriate*" and "*It is according to the course level*". Another of the judges expressed an opinion fairly critical: "*I think it should go deeper taking into account that we are working with students at the university level*". A fourth judge found that "*It was not conceptually deepened*". And finally, a fifth judge issued no opinion.

As for A2, only one of the judges evaluated the class as appropriate: "*The deepening of the subject was within the general style, but just clearer and concise* ". While all the others criticized negatively: "*Regular, I have the uneasy feeling that the importance of the subject is minimized, depth seems to be poor to the level*"; "*Regular, some concepts... cannot be missing*"; "*There is no deepening in concepts*" and, "*It is not very deep in the concepts because it leaves a lot of contents to be developed later on (something that is not necessarily bad a priori)*".

As for the evaluation of students (Table 4), T was the best rated class.

In short, it could be said that the class taught by the most experienced teacher, T, was the highest evaluation. These results coincide with what was expected, taking into account that T is the one who has more experience teaching.

Learning

The post-test used to measure the learning achieved had six questions: four multiple choice, one

Table 4
Evaluation of the three classes by the students

Class Evaluation	T	A1	A2
Average	1.91	1.70	1.80
Deviation	0.30	0.68	0.42

T: Titular Professor; A1: Upper-Level Assistant; A2: Student Assistant. Scale: Regular (1), Good (2) and Very good (3).

Table 5
Learning results

	Average	Deviation
T	70.45	11.92
A1	59.00	13.90
A2	81.50	9.44

T: Titular Professor; A1: Upper-Level Assistant; A2: Student Assistant. Scale: 1 to 100.

with a relationship between words and their definitions and one open. Students could get a score that ranged from 1 to 100. In the class of T they have gotten an average score of 70.45, in the class of A1 they have gotten 59 and of A2 they have gotten 81.5 (Table 5).

The Analysis of Variance test provides statistically significant differences on the results at p=0.001 for all the three classes. The t Test for two independent samples shows statistically significant differences between the learning outcomes achieved by students of class T and the A2 ($p \leq 0.031$). The same difference between the classes of A1 and T was not registered.

Additionally the students' opinion about the learning achieved was measured. Contrary to the objective results obtained in the post-test, students of class A1 realized that they have learned more (59.38) and A2 (43.75) less.

Discussion

The results of this study show that there are differences between teacher's roles teaching in relation to their experience. It is important to remember that the study was on the characteristics of the teacher's classes with different experience and because of a methodological option, it was necessary to take them all to a similar situation.

Thus, possible intervenient variables were controlled, such as the number of students who work with them every day. We believe that this methodological decision does not change the context of the classroom sufficiently to change the subjective settings mentioned by González Rey (2008).

Therefore, the results describe in the studied variables some of the differential characteristics of the teacher's roles in relation to their experience. This experience implies especially having developed different roles in the classroom.

In regard to teaching (D1), the analysis of the adjustment to the subject and the sequence of the source text (D1) show that A2 is the one that submits better to the text on both of the indicators. The more experienced teacher presents lessons with more conceptual opening, probably due to their knowledge of the worked subject and to their own role in the discipline. Therefore, teachers with little experience would fit more to a predetermined screenplay (script) for education, consistent with the description of Zucchermaglio (2003).

Regarding the organization of the subject and time (D2) and the clarity and conceptual depth (D3), the judges qualified, on average, the class of T better than the others. It is important to remember, as it was stated earlier, that the judges were unaware that teachers had different levels of experience and roles at the university. This analysis of the results would be showing that through academic speech it is possible to see differences in the experience and roles of teachers, axis of this work.

In agreement with these results, students who participated in the class T rated it better than those who participated and qualified the other two classes. This result is different from the one found by Bariani and Pavani (2008) where both students and teachers have preferences for the theoretical classes to the practical ones.

On the learning achieved (DVII), students achieved better results on post-tests of class A2 than the other two (statistically significant differences showed up). These results confirm the alleged prior, that is, the A2 in their explanations would be based on the difficult points to understand and with a close social language and cognitively (Durán, 2004).

Apparently, the characteristics of the guide carried by a pair with more experience would assure immediate learning, similar to that measured in the post-test. It is possible that the knowledge guaranteed by the

most experienced teacher establishes itself more in the long-term and be more complex in its composition, being very difficult to evaluate it in a post-test. As mentioned in the beginning of this section, these were the constraints that an experimental design of this type presents, where the evaluation involves only immediate and specific learning. With another format that included general or meta-cognitive questions, it would have been possible to assess the type of learning guaranteed by the experienced.

As previously written, the distinct types of methodology lead to important results, but focusing on differentiated characteristics of the phenomenon studied. Therefore, different methodological approaches have distinct limits in the conclusions on how far we can go with them.

Final Considerations

The design presented here allowed us to observe features in the context of the classroom with teachers in different roles at the university in a quasi-experimental controlled situation. Although the results cannot be generalized, they allow us to reflect on the characteristics of the education of young and experienced teachers at the university and, therefore, generate reflections on themselves to improve their practices in classrooms reaching the consequences that teaching has on learning.

However, the authors of this paper believe that this study should be replicated in other disciplines of the university for possible comparisons. It is important to highlight the relevance of this type of research to reflect on the teaching-learning practices at this particular level of the educational system, not forgetting the inner characteristics of the studied context.

References

Argentina. (2006). Ministerio da Educación, Ciencia e Tecnología. Resolución 2857/06. *Lineamientos para el comportamiento ético en las Ciencias Sociales y Humanidades*. Buenos Aires: Consejo Nacional de Investigaciones Científicas y Técnicas.

Argentina. (2009). Universidad Federal do Rosário. Resolución Despacho 6164/202 C.S. 855/2009. *Normas éticas en la investigación científica para la Universidad Nacional de Rosario*. Rosario: Autor.

Bariani, I. C., & Pavani, R. (2008). Sala de aula na universidade: espaço de relações interpessoais e participação acadêmica. *Estudos de Psicologia* (Campinas), *25*(1), 67-75. doi: 10.1590150103-166x2008000100007.

Díaz Barriga Arceo, F., & Nuñez Castillo, P. (2008). Formación y evaluación de profesores recién formados: problemáticas y retos. *Reencuentro, 53*(1), 49-61.

Durán, D. (2004). El aprendizaje entre iguales: movilizar la capacidad mediadora del alumnado para sacar provecho de la diversidad. *Aula de Innovación Educativa, 132*(1), 75-76.

Feixas, M. (2008). El profesorado novel: estudio de su problemática en la Universitat Autónoma de Barcelona. *Revista de Docencia Universitaria, 2*(1), 13-29.

Fluckiger, J., McGlamery, S., & Edick, N. (2006). Mentoring teachers' stories: Caring mentors help novice teachers stick with teaching and develop expertise. *Delta Kappa Gamma Bulletin, 72*(3), 8-13.

García, G., & Montanero, M. (2004). Comunicación verbal y actividad conjunta en el aula de apoyo: un análisis comparativo entre profesores expertos y principiantes. *Revista Española de Pedagogía, 62*(229), 541-560.

Genovard, C., & Gotzens, C. (1990). *Psicología de la Instrucción*. Madrid: Santillana Aula XXI.

González Cabanach, R., Barca Lozano, A., Escoriza González Nieto, J., & Pineda, J. A. (Eds.). (1996). *Psicología de la instrucción*: *aspectos históricos, explicativos y metodológicos* (Vol. 1). Barcelona: EUB.

González Calleja, F. (1996). Metodología de investigación en psicología de la instrucción. In R. González Cabanach, A. Barca Lozano, J. Escoriza Nieto & J. A. González Pineda (Eds.), *Psicología de la instrucción*: *aspectos históricos, explicativos y metodológicos* (Vol. 1). Barcelona: EUB.

González Rey, F. (2008). Subjetividad social, sujeto y representaciones sociales. *Diversitas, 4*(2), 225-243.

Longhini, M. D., & Hartwig, D. R. (2007). A interação entre os conhecimentos de um professor atuante e de um aspirante como subsídio para a aprendizagem da docência. *Ciência & Educação, 13*(3), 435-451.

Mayor Ruiz, C. (2008). El desafío de los profesores principiantes universitarios ante su formación. In C. Marcelo (Coord.), *Profesores principiantes e inserción en la docencia* (pp.177-210). Madrid: Octaedro.

Natário, E. G., & Santos, A. A. (2010). Programa de monitores para o ensino superior. *Estudos de Psicologia* (Campinas), *27*(3), 355-364. doi: 10.1590/S0103-166X2010000300007.

Orland-Barak, L. (2008). El impacto de las experiencias prácticas en los profesores principiantes: mentorazgo para formular preguntas diferentes. In C. Marcelo (Coord.), *Profesores principiantes e inserción en la docencia* (pp.155-176). Madrid: Octaedro.

Zucchermaglio, C. (2003). La práctica de la enseñanza y el aprendizaje de los que enseñan. In C. Pontecorvo (Coord.), *Manual de psicología de la educación* (pp.295-308). Madrid: Editorial Popular.

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Individualism, life trajectories and plans of constituting a family

Individualismo, trajetórias de vida e projetos de constituir família

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Abstract

The present paper discusses the results of a research that had as its main purpose to analyze the life projects of individuals belonging to different generations within the last decades, with special emphasis on the role played by establishing a family in such projects. Speeches of 20 individuals (10 men and 10 women) from two generations were analyzed. The study pointed out that the profound contemporary sociocultural changes have led to increasing individualism in the relationships, and consequently have altered the way people engage in building their life courses. Two things have been occurring simultaneously. On the one hand, life courses are being individualized and previous standards are being broken, a phenomenon linked to the reduction of gender asymmetries and to the questioning of the institutions. On the other hand, the family model based on marital stability is being repelled. Due to the instability of love relationships, children are gaining importance in the structuring of the idea of a family.

Uniterms: Family; Individualism; Life course.

Resumo

Este trabalho discute resultados de uma pesquisa cujo propósito foi analisar os projetos de vida de indivíduos de diferentes gerações nas últimas décadas, atentando especialmente para o lugar que constituir uma família ocupa em seus planos. Foram analisados os discursos de 20 sujeitos de duas gerações, 10 homens e 10 mulheres. O estudo indicou que as intensas mudanças socioculturais contemporâneas levaram ao aprofundamento do individualismo nas relações e, consequentemente, à alteração nas formas de engajamento dos indivíduos na construção de suas trajetórias de vida. Vem ocorrendo, por um lado, a individualização e a despadronização das trajetórias de vida, associada à diminuição das assimetrias de gênero e ao questionamento de instituições; e, por outro lado, vem ocorrendo a desestruturação de um modelo de família baseado na estabilidade do casamento. Diante da instabilidade das relações amorosas, filhos passam a ter uma importância cada vez maior na estruturação da ideia de família.

Unitermos: *Família*; *Individualismo*; *Trajetória de vida*.

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Many important changes have occurred, over the last decades, in the way a lot of happenings connected to the universe of the family, such as births, marriage and death, are experienced. *Instituto Brasileiro de Geografia e Estatística* (IBGE, Brazilian Institute of Geography and Statistics) and *Instituto de Pesquisa Econômica Aplicada* (IPEA, Applied Economic Research Institute) data point out, for example, a significant decline in birth rates, a rise in life expectancy, the older age at which men and women get married, as well as a rise in the number of marriages (such rise is due to the legal informal unions acknowledgement, cohabitation of spouses without a civil registration union), a rise in the number of divorces, a rise in the number of families headed by women and a rise in the number of children born outside formal marital relationships.

Those changes are related to family life and to people's life paths, simultaneously. After all, why did people, up to a few decades ago, get married at a younger age, got divorced less, and men were the usual breadwinner? What do these changes mean concerning the relations established within a family?

As Bauman (2008), Giddens (2003) and Hall (2001) point out, the present changes have been causing a transformation in the feelings attributed, by individuals, to relationships. In a world characterized by the grater scope of individuals on their lives and identities, new meanings have been attributed to family relationships.

Based on these questions, a research focused on investigating the transformation process of the life projects of individuals of two generations in *Rio de Janeiro* (RJ), Brazil, was developed. The understanding, mainly of how the idea of starting a family links to life projects was sought.

The results of such investigation are discussed in this article. They have showed that the desire to get married, to have children, to start a family, as well as the way a family is conceived, are articulated to what is presented as a model of life paths for people in each social context. Therefore, the idea of conceiving a family seemed different to people of each generation. Among the older people who were interviewed, the concept of family based on the existence of a stable couple was shared. As for the younger people who were interviewed, their concepts of family are based on the existence of children. That does not mean that children did not play a fundamental role in a family. What has changed was especially the relationship between "having children" and "marriage". For the older generation children were the result of a project of the couple. For the younger generation, many times, children are the result of private projects.

It is also discussed in this article that each of these concepts of family - the family centered on the couple and the family centered on the children -, is related to a socially produced life path. The high level of individualization of life paths that characterize contemporaneity creates an unbalance to the family conception that had the couple as the core, for the vulnerabilities that reach the individual also affect the family universe.

The relationship between individualism and the emergence of new concepts of family nowadays, is an issue that has been discussed in many studies. Authors such as Attias-Donfut, Lapierre and Seagalen (2002), Kaufmann (2007a), Seagalen (2008) and Singly (2007), in France, Carvalho (1995), Féres-Carneiro and Ziviani (2009), Féres-Carneiro (2005), Féres-Carneiro, Ziviani and Magalhães (2011), Figueira (1987) and Jablonski (1998; 2009; 2010),

Rocha-Coutinho (2005), Vaitsman (1994), Wagner (2002), among others in Brazil, have dedicated themselves to the issue of knowing what family can exist within the context of individualization of life paths. This issue will be revisited here, through the data that emerged in this study.

Method

This research was conducted according to the premises of discourse analysis. According to Rocha-Coutinho (1998), discourse analysis has its origins in the field of linguistics, but it is interesting to psychology when the purpose is to perform psychosocial studies. This methodology was considered adequate for the carrying out of this research, once it was our objective to learn the lines of the subjects as texts produced within a socio-cultural context and exploit the underlying ideological systems.

Some semi-structured interviews with 20 people were held, 10 people belonging in the older generation

(ages ranging from 63 to 69), and 10 people in the younger generation, (ages ranging from 27 to 34), half men, half women, all *Rio de Janeiro* middle-classed residents of the southern neighborhoods. The age groups were defined because of the objective to confront the experiences of people from different generations, taking into consideration that it is an interesting way to grasp social changes (Mannheim, 1982).

The research subjects' choice happened according to the following criteria:

They should belong to different social groups, have been born in *Rio de Janeiro* (RJ) or lived there most of their lives. No other condition, such as marital status, living with the family or not, having children etc., was previously established. However, it is noteworthy that the recurrence of single and childless people within the generation of 25 to 35 years old may have influenced the results that were obtained in this study.

The subjects of this research were invited to participate in a survey from their social network. This is a recruiting strategy that according to Heilborn (2004), is used to have access to a minimally controlled material, when middle classes are targeted, an extremely vast and varied segment, difficult to be defined. It is about an attempt to approach people who share a close representation of the world within the "middle classes", making the comparison of their discourses possible.

The script for the interview was made in a way that unforeseen information would not be allowed to emerge. The interviewees were invited to talk freely about their life projects - concerning the people from the older generation, it was sought to know the life projects they had when they were younger, while young generation interviewees were asked about their present life projects. The interviews were recorded in mp4 files, and later transcribed in full. The resulting texts were submitted to discourse analysis.

The analysis of the interviews was influenced by Comprehensive Sociology (Kaufmann, 2007b) concerning the thin articulation between the fieldwork made and the emersion of the analysis categories. It was a type of study in which what is being studied is not the objectivity of the data, but the interpretation of the interviews produced by the researcher.

Before being interviewed, all the interviewees signed a Statement of Consent, in which they expressed agreement in participating in this study and authorized the use of information for academic purposes and publishing, and the researcher is committed to ensuring the confidentiality of their identities and use fictitious names in the dissemination of results. This study was granted with the approval of the Research Ethics Committee of the University.

Results and Discussion

The survey showed that, closely linked to the deepening of individualism in a contemporary social setting, there has been a weakening of the concept of family centered on the couple and the emergence of the concept of a family centered on children. More emphasis has been put on the parent-children relationship than on the ties of a couple in the ways of conceiving a family to be formed, as shown in the words of the interviewees:

> *... Children, I would like to have them. Maybe 5. I wish I had had them... . With a partner. The right partner. But then, with children, I was already going to get married. I would want to marry and start a family, right? To have a traditional family. I believe that a couple has to raise their kids together, stay together, watch the children grow up together* (Antônia, 63 years old, single).

> *Ok. The plan to have a family has always existed. I've always wanted to have children... . Children. Family. A husband? No. I mean, if there is a husband, it's 100% better because it will be the character who will help me take care of the family* (Lígia, 33 years old, single).

The discourses of those two women, from different generations, Antônia and Lígia, clarify two very different concepts of family, in which the centrality of marriage to what a family represents is at stake. The words of Antônia (63), takes us to a concept of family founded at marriage. "Traditional family" actually is that kind of family formed around the core of marriage. That is the family concept which Segalen (2008) talks about, where the couple founded the modern family. Therefore, the children would be part of the Family, but would only come after the consolidation of the matrimony, and were the result of the projects of the couple.

Such family concept directly reflects the influence of modern values on the mentality and speeches of this generation. Within this concept, marriage core results from a formal marriage. It can be noticed through the distinction that Antônia makes between "partner" and "someone to marry". "*With a partner. With the right partner. But then, with a child, I was already going to get married*". So, her discourse demonstrates that it would be important for her that a formal marital relationship existed according to the institutional laws of the time.

The appreciation of the legal formalization of the marital relationship is directly linked to the expectation of long-term marriage. This is an aspect that Antônia's discourse highlights. In a modern concept of family, the idea of solidity and durability of the marital relationship is present. *"Staying together, watching the children grow up together"* indicates the existence of an expectation that the marriage will last for many, many years-another characteristic of the modern family (Segalen 2008; Singly, 2007).

As for Lígia, the idea of starting a family focuses, first of all, on the plan to have children. Marriage stops being a *sine qua non* condition in the constitution of a family, which once more takes us to Segalen (2008), who states that on the verge of divorce, nowadays, it is the child who founds the family.

Therefore, we notice an important transformation in the concept of family from the previous decades, founded around marriage (Féres-Carneiro & Ziviani, 2009).

Currently, it is possible to imagine a family without a couple, only with children, and also accept that children are born outside a stable relationship. Furthermore, children are no longer the exclusive result of couples' projects and also become the results of individual projects.

It is advisable to notice that even though Lígia does not mention the "right family" model - the "happy family", centered on the couple - whenever she considers having children, she refers to the benefits that the existence of a husband could bring. "*If there is a husband, it is 100% better, because he will be the character who will help me take care of the family*". 100% better is not the same as 10% or 50% better. It is actually a meaningful number that could indicate that her modern discourse hides a paradoxical appreciation of a traditional reference. This contradiction also appears when she uses the word "husband" to take care of the Family. It shows that life path and family patterns do not change linearly in time, but as they start incorporating new values and joining old references, which is not done without paradoxes or contradictions.

The analysis has turned, then, into the comprehension of each of these families concept meaning, front to the appreciation of their interrelations with broader social changes. Among such changes stands the individualization of nowadays men and women's life path models.

It was noticed, through the research done, that the idea of making "life projects", frequent to the universe of people from older generations, has been replaced by the idea of "not having definite future plans" when it comes to people of younger generations, as shown below:

> *... at that time, life projects included a professional life and a family.... Society would impose these things and we were supposed to do what was culturally expected from us. It was really hard. Afterwards, there was this whole rebellion, dissatisfaction and the whole, 'how about individual freedom?' thing* (Elias, 65 years old, separated).

> *I was already dating my boyfriend, who has been my husband for 5 years.... I don't know... it was, like, something that I was supposed to do, you know, getting married. Then I got married because I thought it was a consequence of life when I got to that age...* (Gilda, 65 years old, separated).

> *The future plan that I have is my private retirement.... So, I don't plan a lot, like, what I'm going to be doing in 10 years. I don't want to know about 10 years from now* (Flávio, 31 years old).

> *I don't worry today about future preoccupations that I may have, but I have nothing planned, like. I'm going to do that... . Because I think... things, good or bad, happen... . And there isn't much you can do in situations like these...* (Paula, 31 years old).

The analysis of the discourse of the interviewees has also shown that in response to the advance of individualism in society, there is a decrease in the asymmetries alike. A larger proximity between the universes of men and women, and the replacement of

the family as the core of projects and people's life paths is evident.

For people of older generations the distinction between the male and female social roles was very clear. Men were assigned with the responsibility for affairs of public sphere, and for being the breadwinners, while women were in charge of domestic life organization:

> *I only got married when I thought I had conditions to effectively support my family, all by myself... all the subsistence, I always thought it was my exclusive responsibility, all things regarding my wife and kids* (Augusto, 66 years old, married for the 2nd time).

> ... (work) *had some importance because I could make my own money, even if it was little... . But my work revolved around my boys' schedule. My priority was my boys. Then, for example, if they studied in the afternoon, I would work in the afternoon... . Anything they wanted... . Them, the house, the husband, the whole ironing thing, that's what I was responsible for Haha* (Francisca, 65 years old, separated).

In the discourses of the interviewed people of the younger generation, there was more similarity between men and women's speeches of this generation, and their concerns and desires were more similar. Nowadays, men and women tend to be equally worried about their financial independence and about their professional achievements as shown below:

> *Well, I'm in a social class... middle class... . So we have a certain difficulty, how can I say... to progress and grow in life... . Difficulties, I mean, in terms of work. It's a very tough competition; it's hard to get a nice place to work, making some good money, having your own space... . It's so hard! It isn't easy today* (Flávio, 31 years old, single).

> *... I graduated, and when we graduate we expect to get a good job in our areas fast... . I have been working at this job, but it isn't exactly what I want... . Then, my main worry at the moment is to be financially stable and maybe find a job in which I can feel professionally satisfied... . Who said that we work in order to get money to have fun? No, sometimes we work only to make a living, you know?* (Lígia, 33 years old, single).

Therefore, one can notice that men and women of a younger generation were committed to work and aimed at financial independence. For the men of another generation, that was already embedded in their concerns, but not for the women. Women's ambition regarding formal work is something relatively new within the Brazilian culture, and leads to the weakening of a pattern that is strongly incorporated to our society, in which women were destined to be mother-wife, financially dependent on the husband, who corresponded to the "breadwinner-men and housewife-woman" model (Costa, 1989; Maluf & Mott, 2008; Rocha-Coutinho, 1994).

Our research has indicated that on one hand, nowadays women have conquered a new realization space - the world of work -, and men have also started to find a very important place for their personal realization in life inside the house. Reconciling work and family has been considered, even though it does not necessarily mean a change in relation to the sharing of the housework.

> *Ah, I would really like to have time for my wife and kids, travel with them, and at the same time I have to work so hard preparing classes for two courses ... maybe you can't be the professional you want to be and the father you would like to be. I think this is it... to be present, right? To talk to your wife and kids. To watch TV together and ask what they have been doing, to know about their lives, if they're having trouble in school, if they're dating, if they're not dating... to participate, to give opinions, something I don't like to do very much, but that must be done. I don't know... . To give them good examples, to be honest with them... . I think this is it* (Gabriel, 27 years old, single).

According to Gabriel's discourse, participating in Family life is mostly about the desire to participate in the children's life - by talking, watching television together, wanting to know more about their lives - and setting a good example to them. In this speech, the idea of conciliating work and family has a meaning of emotional opening to a universe, previously exclusive to women. Conciliating work and family cares will mean to be able to be emotionally present in the lives of the children and the wife, enjoy a coexistence that was not valued by men in the past.

As long as financial independence and professional realization become part of a world of women, and being emotionally present in the life of the family starts being considered important to men, a meaningful transformation in social patterns arises. There is a weakening of the social conventions that traditionally built the life trajectories of individuals, which were based on a rigid distinction between male and female roles,

with the designation of financial responsibilities to men and emotional tasks to women.

The results of this research also pointed out striking differences in the expectations of individuals from different generations regarding love life. Among the older generation people, it could be noticed that there was hope that marriage would last forever in association with the indissolubility of marriage provided by the social standards of the time.

> *My generation, I guess, is the one of prince charming, that kisses the princess and she wakes up, you know? And then live happily ever after* (Francisca, 65 years old, separated).

> *I've always imagined a marriage was forever. I was in love when I married, wanted so badly to be married that we are together until today* (Norberto, 65 years old, married).

Precisely because there was an expectation of eternal marriage, divorce cases were commonly experienced by the respondents of this generation as something unexpected. A separation revealed the unpredictability of destinies and generated, within individuals, the need to find new parameters to structure their lives. The deinstitutionalization of a rigid pattern of life trajectory, as reflected in the speeches of some of our interviewees was at stake:

> *Ah, I expected that my marriage would last forever, yes, I did... . I expected. But after some time, the situation came to a point that it was no longer possible to stay together. Then, we decided that it was better for us to separate, each one of us heading in a different direction* (Sérgio, 69 years old, married for the 2nd time).

> *We decided to separate. We were probably one of the first couples, There wasn't even divorce. Divorce started at that time. We were one of the first couples to get divorced, which is another problem. We were not even prepared to get married, let alone get divorced. The society... . You could only be considered a happy person if you were married, if you had a family... . If you weren't, you were like some kind of criminal, or outcast or something. Separated... . It as very rigid* (Elias, 65 years old, separated).

> *Then, when this whole thing happened (the separation), I was literally with no air. Then I felt terrible, discovering how cruel the world could be. How am I going to do this without my husband by my side? How am I going to grow up? What now? ...is there this side of life? This whole idea of being alone? How is it? With 3 kids? What is this like? Nobody taught me. There is no school for that, right? I felt completely unprepared. I was never prepared for separation. Because of my upbringing and also because my marriage was good. It wasn't perfect, but it was good* (Francisca, 65 years old, separated).

The social pattern that instituted eternity to marital relationships influenced both the life trajectories of individuals and the way they conceived family. Paths of life were designed for them to live together with their partner forever, raising their children and growing old together. Then the woman would fulfill her role as "mother-wife-housewife" and the man would protect and provide for his family.

Exactly because we believe in the durability of marriage, a kind of family, "the happy family" (Singly, 2007), was configured, in which the financial dependence of women in relation to their husbands, and the inequality of power between them was not a problem. In this conception, the plans to start a family usually started with wedding plans. In other words, the couple founded the family.

The advent of divorce may be considered an important turning point for rupturing with life paths and family patterns established so far. References linked both to the family and to the structure of social male and female roles were questioned. The way power was distributed inside the family - women were economically dependent on their husbands - leading men and women to the need of a search for their autonomy and financial independence was questioned as well. Besides, once marriage was the legal way to socially start a family inside that context, according to Segalen (2008), divorce then, destabilized a concept of a "couple-centered" family, in other words, founded on a stable marital nucleus formation.

It is important to highlight that the advent of divorce happened within a scenario marked by several other major changes. It was a time of escalating values such as an autonomy and emancipation of the individual within society, of emphasis on egalitarianism and claim for individuality in relationships. It was a time of education for women, their march towards the labor market and financial independence, which certainly attacked the social pattern of "housewife-woman" *vs*. "breadwinner-men". Furthermore, an increase in life expectancy and advances in medicine and other sciences have brought new expectations to the life of a

couple (Jablonski, 1998; Lash, 1991; Sarti, 1995; Segalen, 2008; Singly, 2007; Rocha-Coutinho, 1994).

Within this context experienced by interviewees of the older generation, evidence of changes were already seen, which led to the individualization of society and the family, and no standardizing of life trajectories for both men and women (Cavalli, 2003). It was the beginning of a new reality. "Naturalness", which corresponded to certain standards of life course and family, signaling a separation from institutions and opening to penetration of individualistic values into society, was being questioned then. A change in the social bond, which, henceforth, would provide for individuals belonging to society, although those would be free to manipulate their destinies and to be "themselves" as seen in the speech of Gilda, was at stake:

> *One must be in love to get married, right? ...I would never get married to anyone, getting married for the sake of it, I never wanted. I'd rather be single. Most people, many people, get married simply not to be single. But I never wanted that. For me, before getting married, I would have to like my partner a lot. And he would have to be a really nice person. If I have to choose anyone, I'd rather be alone* (Gilda, 63 years old, single).

A claim for love in marriage may be understood as an attempt of opposition to the ideal of marriage as a social pattern for people to follow automatically. Passionate love, a feeling to be revealed, is related to the assertion of an authentic "I" in the marital relationship (Kaufmann, 2007a; Magalhães & Féres-Carneiro, 2003). Finding a reason to get married being in love is having an essentially personal reason to do so, contrary to making the decision of getting married due to a social model in which people did not have the chance to reflect over their desires and to choose their own destinies. That reflects a change in the logical-social bond, in which the more individualism becomes stronger within society values, the greater the possibilities to choose among individuals.

The research evidenced that, unlike the interviewed people of the older generation, the younger respondents do not believe much that loving relationships endure. They think, instead, that they are easily breakable, as observed in the following excerpts from the interviews:

> *... I'm not sure I believe in long-term relationships. I really don't know. Nowadays, looking around, I realize that people stay together 10 or 15 years and then separate, with very few exceptions. And these exceptions are, many times, pure hypocrisy, couples that don't like each other anymore, you know? They are couples that don't like each other anymore and only stay together because of the pressure of society, because they are going to be judged, you know...* (Lígia, 33 years old, single).

> *I don't know if it is in Rio de Janeiro that things happen this way, but people are very... stay together, get married, get divorced ... I think it's because I know few people nowadays that really stay together for the rest of their lives... . My parents got married and, after 13 years, got divorced... and I thought they were better off separated than together. You know?* (Rafaela, 34 years old, single).

> *I think I have a little difficulty with these contemporary values, and I already know that nothing lasts forever, you know? So I have some difficulty imagining that I'll be married to the same woman forever... . I don't know... . I know everything will end. Love relationships will end* (Rodrigo, 32 years old, single).

There are, among the people interviewed, the ones from a younger generation, a demand for individual freedom in relationships, freedom to do what they want and to develop their individuality, as stated below:

> *Freedom. A person's individual freedom. People have their own things, things that are only theirs, you know? I have things that are my own. I can't ask someone to give this up or the other way around, got it?* (Flávio, 31 years old, single).

> *... I love traveling alone. I'm that kind of person who will put their backpack on their back and go away... to spend the weekend... . As I am, many times, dating, this is not a nice thing and people don't always accept it, you know? ... I really like you, but the world is really cool. There are too many things happening. I go out, I travel* (Carla, 32 years old, single).

> *Maybe this is why, when in a relationship, I'm not so attached to the other person. I believe people must have their individualities. I don't know...* (Rafaela, 34 years old, single).

The claim for individuality in relationships is explained by the belief that the loving bond could jeopardize personal identity. In fact, in some forms of marital relationship in which it is expected that each spouse fulfill social established roles, individualities were disguised by statutory masks. However, in the present scenario, where institutions are less appreciated, freedom

becomes an essential ingredient in the chemistry of the couple. As stated by Kaufmann (2007b), Magalhães and Féres-Carneiro (2003) and Singly (2000), there is, nowadays, the expectation that individuals will discover their "authentic selves" in a relationship between two partners, which would be incompatible with the curtailment of individualities.

The instability of love relationships do great damage to the standardizing of a life trajectory centered on the family and shakes the basis of a concept of family in which the marriage of the couple was expected to last for their entire lives. After all, as Segalen (2008) states, up to a few decades ago, marriage was the legal way to start a family; besides, it must be emphasized that there existed an idea of marriage as a stable and long lasting relationship. Nowadays, people of this generation do not believe in the resistance and endurance of love relationships, which reinforces the idea of an person being the center of their path, and moves "the children", who can easily be the result of individual projects, into the center of the concept of family.

Final Considerations

The results of this study indicated that there has been no standardization of life trajectories, resulting from the individualization of society, which reflects directly on the fact that the way of starting a family enters people's life paths. Different ways of conceiving a family have emerged in the interviews. For older people, a family has a stable couple at its core. For younger people, the center of the family is the children. In these two ways of conceiving the family the emphasis given to marital ties or to filiation ties for what starting a family represents is at stake.

Although these possibilities of generalization results are limited regarding the reduced number of participants in the survey, they contribute to the understanding of how life paths of individuals and family concepts respond to present socio - cultural changes. In a society marked by a patriarchal culture in which blood links, kinship and friendship are so important, as they are in the Brazilian society, the appreciation of filiation bonds within the family concepts of the younger individuals, the vulnerability of marital bonds, as well as the lowering of the asymmetries of the kind indicate a deep transformation in the traditional ways of relationships. People, both men and women, have the chance to reinvent themselves, to follow less established paths, but in order to do so, they lose the stability of old references. Bond relationships among families become more fluid and unstable, and the rise of the filiation value is favored.

References

Attias-Donfut, C., Lapierre, N., & Segalen, M. (2002). *Le nouvel esprit de famille*. Paris: Éditions Odile Jacob.

Bauman, Z. (2008). *A sociedade individualizada: vidas contadas e histórias vividas*. Rio de Janeiro: Jorge Zahar.

Carvalho, M. C. B. (Org.). (1995). *A família contemporânea em debate*. São Paulo: Cortez.

Cavalli, S. (2003). Le parcours de vie: entre institutionnalisation et individualisation. In *S. Cavalli, J. P. Franfnière (Eds.), L'avenir: attentes, projets, (dés)illusions, ouvertures*. Lausanne: Editions Réalités Sociales. Consulté le Juillet 29, 2010, disponible <http://cig.unige.ch/institution/team/cavalli/staff_sc_avenir_05042003.pdf>.

Costa, J. F. (1989). *Ordem médica e norma familiar* (3ª ed.). Rio de Janeiro: Graal.

Féres-Carneiro, T. (Org.). (2005). *Família e casal: efeitos da contemporaneidade*. Rio de Janeiro: PUC-Rio.

Féres-Carneiro, T., & Ziviani, C. (2009). Conjugalidades contemporâneas: um estudo sobre os múltiplos arranjos amorosos da atualidade. In T. Féres-Carneiro (Org.), *Casal e família: permanências e rupturas* (pp.83-107). São Paulo: Casa do Psicólogo.

Féres-Carneiro, T., Ziviani, C., & Magalhães, A. S. (2011). Arranjos amorosos contemporâneos: sexualidade, fidelidade e dinheiro na vivência da conjugalidade. In: T. Féres-Carneiro (Org.), *Família e casal: efeitos da contemporaneidade* (pp.43-59). Rio de Janeiro: PUC-Rio.

Figueira, S. A. (1987). O moderno e o arcaico na nova família brasileira: notas sobre a dimensão invisível da mudança social. In S. A. Figueira. *Uma nova família? O moderno e o arcaico na família de classe média brasileira* (pp.11-30). Rio de Janeiro: Jorge Zahar.

Giddens, A. (2003). *Mundo em descontrole: o que a globalização está fazendo de nós* (3ª ed.). Rio de Janeiro: Record.

Hall, S. (2001). *A identidade cultural na pós-modernidade*. Rio de Janeiro: DP&A.

Heilborn, M. L. (2004). *Dois é par: gênero e identidade sexual em contexto igualitário*. Rio de Janeiro: Garamond.

Instituto Brasileiro de Geografia e Estatística. *Banco de dados*. Rio de Janeiro: Autor. Recuperado junho 15, 2010, disponível em <http://www.ibge.gov.br/seculoxx/arquivos_xls/palavra_chave/populacao/registro_civil.shtm>.

Instituto de Pesquisa Econômica Aplicada. *Banco de dados*. Brasília: Autor. Recuperado em novembro 14, 2010, disponível em <www.ipea.gov.br>.

Jablonski, B. (1998). *Até que a vida nos separe*: *a crise do casamento contemporâneo (*2ª ed.). Rio de Janeiro: Agir.

Jablonski, B. (2009). Atitudes e expectativas de jovens solteiros frente à família e ao casamento: duas décadas de estudos. In T. Féres-Carneiro (Org.), *Casal e família*: *permanências e rupturas* (pp.109-134). São Paulo: Casa do Psicólogo.

Jablonski, B. (2010). A divisão de tarefas domésticas entre homens e mulheres no cotidiano do casamento. *Psicologia*: *Ciência e Profissão, 30*(2), 262-275.

Kaufmann, J. C. (2007a). *Sociologie du couple* (4ª ed.). Paris: PUF.

Kaufmann, J. C. (2007b). *L'entretien compréhensif*. Paris: Armand Colin.

Lash, C. (1991). *Refúgio num mundo sem coração. A família*: *santuário ou instituição sitiada?* Rio de Janeiro: Paz e Terra.

Magalhães, A. S., & Feres-Carneiro, T. (2003). Conjugalidade e subjetividades contemporâneas: o parceiro como instrumento de legitimação do "eu". Encontro Mundial dos Estados Gerais da Psicanálise, Rio de Janeiro, RJ, Brasil, 2. Recuperado em junho 15, 2010, disponível em <http://www.estadosgerais.org/mundial.rj>.

Maluf, M., & Mott, M. L. (2008). Recônditos do mundo feminino. In F. A. Novais & N. Sevcenko (Orgs.), *História da vida privada no Brasil 3 - república*: *da belle époque à era do rádio.* São Paulo: Companhia das Letras.

Mannheim, K. (1982). A questão das gerações. In M. M. Foracchi (Org.), *Sociologia.* São Paulo: Ática.

Rocha-Coutinho, M. L. (1994). *Tecendo por trás dos panos*: *a mulher brasileira nas relações familiares*. Rio de Janeiro: Rocco.

Rocha-Coutinho, M. L. (1998). A análise do discurso em psicologia: algumas questões, problemas e limites. In L. Souza, M. F. Quintal de Freitas & M. M. P. Rodrigues (Orgs.), *Psicologia*: *reflexões (im)pertinentes*. São Paulo: Casa do Psicólogo.

Rocha-Coutinho, M. L. (2005). O papel de homens e mulheres na família: podemos falar em reestruturação? *Psicologia Clínica, 15*(2), 93-108.

Sarti, C. A. (1995). Família e individualidade: um problema moderno. In M. C. B. Carvalho (Org.), *A família contemporânea em debate* (2ª ed.). São Paulo: Cortez.

Segalen, M. (2008). *Sociologie de la famille* (6ª ed.). Paris: Armand Colin.

Singly, F. (2000). *Libres ensemble*: *l'individualisme dans la vie commune*. Paris: Nathan.

Singly, F. (2007). *Sociologia da família contemporânea*. Rio de Janeiro: FGV.

Vaitsman, J. (1994). *Flexíveis e plurais*: *identidade, casamento e família em circunstâncias pós-modernas*. Rio de Janeiro: Rocco.

Wagner, A. (Coord.). (2002). *Família em cena*: *tramas, dramas e transformações.* Petrópolis: Vozes.

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The sexual life of women with breast cancer: Meanings attributed to the diagnosis and its impact on sexuality

A vida sexual da mulher com câncer de mama: significados atribuídos ao diagnóstico e suas repercussões na sexualidade

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Abstract

Breast cancer is the main neoplasm which affects women. It brings emotional problems in addition to physical and social problems due to affecting a bodily symbol of femininity. The aim of this study was to investigate the sexual life of women with breast cancer in the first year after the surgical procedure, seeking the meanings they attributed to the diagnosis and its repercussions on sexuality. Ten women who participated in a rehabilitation program were interviewed. In addition to the face to face interview their medical record were analyzed. Two categories emerged from the thematic analysis highlighting the negative and the positive impacts of this disease on the sexual life. This variety of meanings encountered shows that there no single pattern of sexual life after breast cancer. The way each woman reacts to the disease makes the way she experiences her sexuality unique. It follows that issues of sexuality must be incorporated in interventions offered in the context of care for these women.

Uniterms: Breast neoplasms; Mastectomy; Sexuality.

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Resumo

O câncer de mama é a principal neoplasia que acomete as mulheres. Por afetar um símbolo corpóreo da feminilidade, produz alterações emocionais, que se somam às físicas e sociais. Este estudo teve por objetivo investigar a vida sexual da mulher com câncer de mama no primeiro ano após o procedimento cirúrgico, buscando-se demarcar os significados atribuídos ao diagnóstico e suas repercussões na sexualidade. Foram entrevistadas dez mulheres que participavam de um serviço de reabilitação. Além da entrevista individual realizou-se análise de prontuários. Da análise temática emergiram duas categorias, evidenciando o impacto tanto negativo como positivo do câncer na vida sexual. Essa variedade de significados encontrados mostra que não existe um padrão único de vivência sexual após o câncer. A maneira como cada mulher ressignifica o adoecimento contribui para que vivencie singularmente sua sexualidade. Conclui-se que é preciso incorporar questões de sexualidade nas intervenções oferecidas no contexto do cuidado a essas mulheres.

Unitermos: *Neoplasias mamárias*; *Mastectomia*; *Sexualidade*.

Breast cancer is a disease in which the prevalence and incidence has increased over recent years. In Brazil, the estimates of the *Instituto Nacional do Câncer* (INCA, National Cancer Institute) for the year 2010 were 49,240 new cases of breast cancer, while the estimates for the year 2012 indicate the occurrence of approximately 52,680 new cases (Brasil, 2009; 2011). According to INCA, breast cancer is probably the type of cancer that most frightens women, both due to its high prevalence, as well as its psychological and physical effects (Brasil, 2009).

Maluf, Dias and Barra (2006) claim that breast cancer is an important public health problem in Brazil, because it is the main neoplasm affecting women. By causing important physical, social and psycho-emotional changes, this disease is detrimental to the quality of life, and represents a tangible threat that calls into question the ability of the affected person to remain alive (Scorsolini-Comin, Santos & Souza, 2009).

Studies indicate the occurrence of different emotional reactions in the various stages of the treatment, from diagnosis to relapse (Bloom, 2002; Gimenes, 1997; Peres & Santos, 2007). It is noticed that even when good results are obtained with the treatment, the experience of cancer often has a profound impact on the lives of the women affected. Many of them start to fear the threat of a recurrence of the disease and have difficulty dealing with the sequelae left by the treatment (Peres & Santos, 2009; Silva & Santos, 2008). For Vieira, Lopes and Shimo (2007), breast cancer destabilizes the psychic organization of women by bringing insecurity to their existence regarding the maintenance of life, the possibility of recurrence and the uncertainty about the success of the treatment.

Review studies show that breast cancer also produces important alterations in the body image and self-image of the women, which could affect their experience of sexuality and marital satisfaction (Biffi & Mamede, 2004; Peres & Santos, 2009; Santos & Vieira, 2011). Women undergoing surgery for breast cancer report dissatisfaction and non-acceptance of the resulting physical changes. These feelings often negatively affect their sexual satisfaction and marital relationships (Bukovic et al., 2004; Fatone, Moadel, Foley, Fleming & Jandorf, 2007; Santos & Vieira, 2011). Often, during the treatment the affected women become weakened and report that they need to make an extra effort to function normally again, since experiencing breast cancer and the devastating effects of the treatment produce various alterations in sexual (Saegrov & Halding, 2004) and social functioning (Sales, Paiva, Scandiuzzi & Anjos, 2001).

Studies that assess the psychological repercussions of the different types of surgical procedure for the removal of the breast nodule regarding the sexuality of patients indicate that, depending on the extent of the intervention, the emotional impact can be different, affecting the perception of the body and the sexual life. In the study of Gorisek, P. Krajnc and I. Krajnc (2009), women who underwent mastectomy reported a greater decrease in libido and more pronounced difficulties in relation to their interest in sex and to achieving orgasm than those who had conservative surgery. The results showed that the frequency of sexual activity was higher in women who had undergone breast-conserving surgery than in those who had undergone mastectomy. In agreement with these findings, Alicikus et al. (2009) showed that there was a more pronounced decrease in

sexual desire in patients who underwent mastectomy (80%) compared to women who had conservative surgery (61%).

Research findings reveal that, the shorter the surgery time, the more problems related to sexuality tend to be detected, which indicates the need for studies that investigate women with a short time between the diagnosis and/or surgery and the end of primary cancer breast treatment (Avis, Crawford & Manuel, 2004). According to Talhaferro, Lemos and Oliveira (2007), even when there was a satisfying sexual life in the stage prior to the illness, emotional stress, pain, fatigue, significant changes in body image and low self-esteem can disrupt the sexual functioning of the couple.

Such changes in sexual practice are experienced both due to the physical changes caused by the cancer and its treatment (breast loss, vaginal dryness, pain, discomfort), as well as the social coping with the disease, considering the family impact (Ambrósio & Santos, 2011), the cultural beliefs, and the meanings attributed by the women to the breast cancer (Silva & Santos, 2008). Despite the advances in treatment over recent decades, cancer remains a stigmatized disease and clearly associated with death (Gomes, Panobianco, Ferreira, Kebbe & Meirelles, 2003; Silva & Santos, 2010).

According to Lobo, Santos, Dourado and Lucia (2006), each person develops a particular way of dealing with issues related to their health and their body. Thus, regardless of the medical diagnoses and the physical changes that every woman experiences, satisfaction with life and their sense of happiness depend on their individual beliefs. Muniz (2008) complements this line of argument by stating that, in addition to providing the meanings, the culture also affects the response that each individual articulates when faced with the diagnosis and treatment of cancer. Sociocultural factors, therefore, also influence how each person will cope with the disease.

In addition to the concepts and collective representations offered by the cultural context in which the person is immersed, individual beliefs create interpretations and meanings regarding the cancer and the situations associated with it. These meanings directly affect the coping process and the adaptation to the different phases of the development and treatment of the disease, as highlighted by Gimenes (1997). The attitudes and behaviors of women affected by breast cancer depend on the meaning they attribute to the disease (Peres & Santos, 2007). For this reason it is important to emphasize the impact of the cancer diagnosis on the experience of sexuality in women who underwent mastectomies (Araújo & Fernandes, 2008; Rossi & Santos, 2003).

Studies (Barton-Burke & Gustason, 2007; Silva & Santos, 2008) indicate the need to further explore this issue, in order to design new forms of intervention so that the women affected by breast cancer receive integral care from the healthcare professionals. They particularly need to receive support in the management of stress and changes in their sexual lives, caused by the limitations imposed by the disease and its invasive treatments.

Sexuality, the subject of inquiry of this study, is a fundamental dimension of the human being, seen from a broader perspective, it manifests itself in all stages of the life cycle and has just one of its many facets in the genitality (Büchele, Oliveira & Pereira, 2006). In this sense, the concept of sexuality adopted in the present study considers the psychological, social and cultural dimensions involved (Santos & Vieira, 2008). This expanded concept is in line with the thinking of authors such as Barton-Burke and Gustason (2007), who claim that sexuality is a very broad construct that encompasses an integration of the physical, psychological, social and cultural dimensions of the individuals.

This view contrasts with that sustained by other areas of knowledge. In the field of biomedical knowledge, the term "sexuality" has been reduced to the concept of "sexual function" and, more recently, incorporated into the concept of "sexual health". According to this notion, sexual function is constituted independently from reproductive function, so that sex is seen as a natural phenomenon and the sexual response cycle as a universal mechanism that is psychophysiologicaly similar in men and women (Giami, 2002; 2007).

According to World Health Organization (1986), good quality sexual activity or sexual happiness is a basic condition in the promotion of human health. The absence of sexual pleasure can trigger problems such as depression, mood swings, insomnia, and other symptoms indicative of psychological distress. For Talhaferro et al. (2007), our culture prevents clear and

open communication and dialogue with respect to sexuality and sexual problems, which causes this issue not to be addressed by the majority of people, including professionals of hospital institutions and other healthcare professionals in general.

As proposed by Brêtas, Ohara and Querino (2008), the higher education forming agencies must commit to the need to educate students on the topic of sexuality, and the hospital institutions must invest in training their professionals, so that the future generations experience fewer problems related to this issue in the context of health.

The knowledge regarding sexuality generated from the perceptions and beliefs of women affected by breast cancer can contribute to improve the training, awareness and instrumentalization of psychologists and other healthcare professionals with respect to the issue and thus promote more qualified and integrated care. Faced with this problem, the present study aimed to investigate the sexual lives of women with breast cancer in the first year after the surgical procedure, seeking to demarcate the meanings attributed to the diagnosis and its impact on the sexuality.

Method

This is a descriptive, cross-sectional study with a qualitative approach.

Participants

A total of 10 women with breast cancer, between 36 and 62 years of age, attending a mastectomy rehabilitation service, located in the city of *Ribeirão Preto*, state of *São Paulo*, participated in this study. The study included women who had undergone surgery for removal of the breast lump within the period of one year, who practiced sexual activity before the onset of the disease and who agreed to cooperate with the research by signing the Terms of Free Prior Informed Consent, in accordance with the *Conselho Nacional de Saúde* (CNS) Resolution nº 196/96 of the *Ministério da Saúde* (Ministry of Health). Women who had been sexually inactive for a long period prior to breast cancer were excluded, as were those with cognitive or clinical complications that made it impossible to participate in the study, women who had undergone breast reconstruction[5], and cases of impairment due to relapse or metastasis (spread to distant sites) of the primary tumor.

Table 1, produced from the data obtained in the interviews, shows the demographic profile of the women interviewed. This characterization was drawn from the following personal data: age, marital/relationship status, number of children, education level, profession/occupation, and religion.

Table 2 presents the data regarding the clinical profile of the participants, according to the type of

Table 1
Sociodemographic characteristics of the participants. *Ribeirão Preto* (SP), 2010

Participants	Age (years)	Marital status	Children	Schooling	Profession/Occupation	Religion
Amanda	59	Married	3	Incomplete Elementary Education	Housewife	Catholic
Bianca	62	Separated	2	Incomplete High School Education	Massage Therapist	Spiritualist
Clara	55	Married	5	Complete High School Education	Housewife	Catholic
Dulce	46	Married	1	Complete High School Education	Housewife	Catholic
Elisa	52	Married for the second time	2	Complete High School Education	Saleswoman	Catholic
Fabiana	37	Married	2	Complete Elementary Education	Maid	Catholic
Giovana	36	Married	3	Complete Elementary Education	Housewife	Catholic
Heloisa	57	Married	3	Incomplete Elementary Education	Self-employed saleswoman	Catholic
Irene	59	Married for the second time	2	Incomplete Elementary Education	Administrative Assistant	Catholic
Janaina	43	Married and with boyfriend	2	Complete Higher Education	Teacher (kindergarten)	Evangelist

[5] It is considered that the implantation of breast prosthesis during or after the surgical removal of the lump can be a factor that influences the emotional issues raised regarding the perception of the body and sexuality of women.

Table 2
Clinical profile of the study participants, according to the type of surgery, time since the diagnosis and since the surgery, and additional treatments performed: chemotherapy, radiotherapy and hormone therapy. *Ribeirão Preto* (SP), 2010

Participants	Type of surgery*	Time since diagnosis (months)**	Time since surgery (months)**	Chemotherapy (stage)	Radiotherapy (stage)	Length of hormone therapy (months)**
Amanda	Simple mastectomy	15	7	Pre-surgery	Post-surgery	6
Bianca	Radical mastectomy	17	7	Pre-surgery	Post-surgery	9
Clara	Lumpectomy	2	2	Not performed	Post-surgery	1
Dulce	Lumpectomy	13	5	Pre-surgery	Not performed	4
Elisa	Simple mastectomy	15	7	Pre-and post-surgery	Post-surgery	Not performed
Fabiana	Lumpectomy	8	8	Post-surgery	Post-surgery	11
Giovana	Lumpectomy	15	6	Pre-surgery	Post-surgery	11
Heloise	Lumpectomy	9	9	Post-surgery	Post-surgery	Not performed
Irene	Lumpectomy	9	9	Pre-surgery	Post-surgery	1
Janaina	Lumpectomy	11	10	Post-surgery	Post-surgery	Not performed

Note: *lumpectomy: conserving surgery, when a small part of the breast affected by the cancerous nodule is removed; Simple mastectomy: when the entire breast is removed, without compromising the pectoral muscle; radical mastectomy: when, in addition to the total removal of the breast, the chest muscles are removed (Barros et al., 2001).

** The time was calculated taking the date of the interview as the final parameter.

surgical procedure, time of the diagnosis and surgery, and additional treatments: chemotherapy, radiotherapy and hormone therapy.

Instruments

The following data collection instruments were used: individual interviews and documental analysis. The documental analysis was performed using a form for the clinical data obtained from the individual medical records of the participants, through the consultation of the rehabilitation service files.

The semistructured interviews were guided by a script, especially designed to meet the objectives of this study. The questions were formulated from a consultation of the literature of the area and from the experience of the researchers in psychosocial care to women with mastectomies. The semi-structured interviews covered information concerning the sexual life: number of sexual partners, frequency of sexual intercourse, sexual interest and satisfaction, attractiveness, the perception of her own body after surgery for breast cancer, how she thinks others viewed her before and after the disease, and sources of satisfaction and dissatisfaction with her own body and in the relationship with an intimate partner.

The interviews were administered individually, in a face to face situation, in a private room of the rehabilitation service which the participants were attending, ensuring comfortable and private conditions. To ensure greater reliability and objectivity in the recording of the reports, the interviews were audio recorded with the consent of the participants.

The interruption of the data collection occurred through theoretical saturation, which is operationally defined as a "Suspension of adding new participants when the data obtained begin to present, from the assessment of the researcher, a certain redundancy or repetition, with it not being considered relevant to persist in the data collection" (Fontarella, Ricas & Turato, 2008, p.17). Thus, the criterion for the suspension of data collection was considered when it was found that the information provided by the study participants stopped adding new information to the material already obtained, in a way that it no longer substantially contributed to the improvement of the theoretical reflection based on the data collected.

In compliance with the criterion of data saturation, each interview was transcribed shortly after its completion, in order to be able to identify the emergence of possible recurrences and repetitions in the responses obtained. The research *corpus* was composed of the audio-recorded records, transcribed verbatim and literally. The data were subjected to thematic content analysis (Triviños, 1987), from which the units of meaning were highlighted, which in turn

generated the categories. The data were interpreted with the support of the scientific literature.

The research project was approved by the Research Ethics Committee of the *Escola de Enfermagem de Ribeirão Preto* (Protocol nº 1082/2009). Each participant was required to sign the Terms of Free Prior Informed Consent. Ethical care constitutes a delicate part of research, particularly regarding vulnerable populations, such as cancer patients, considering the bioethical issues raised by the theme of cancer (Kovács, 2003).

Respect for the autonomy of the participants was adopted as a guiding principle, according to the standards set by the National Health Council, in Resolution nº 196/96 regarding research with humans. The users of the service were fully informed about the aims and procedures of the study, as well as about the foreseeable risks arising from their participation in the study. They were informed of the possibility of ceasing their participation, at any time, without incurring any form of prejudice to the monitoring performed in the service. They were also assured of the confidentiality that protects the information provided, as well as the preservation of their anonymity.

Results and Discussion

The results are presented and discussed according to the thematic categories (and their respective subcategories) that emerged from the analysis. The present study constitutes a design that includes two analytical categories: "negative impact of the breast cancer diagnosis on the sexual life" and "positive impact of the breast cancer diagnosis on the sexual life". According to the reports obtained, the diagnosis is experienced as both a negative and positive affect on the sexual life of the women affected. The participants have been given fictitious names in order to protect their identities.

Negative impact of the breast cancer diagnosis on the sexual life

Concern with the proximity of death: The concern with the proximity of death was an experience that exerted a negative influence on the experience of sexuality, as can be seen in the statement of Heloisa:

> P (Participant): *I think, for me, it caused a change. Because of the problems. ...You're like this, wanting to cry, you know?*
>
> I (Interviewer): *What factors do you think... disrupted you more?*
>
> P: *I think it also depends, it could be my mind, it could be myself, you know? I think I get very focused on that, you know, on... thinking about the problem... because you see: "Oh, breast cancer. oh, a cancer!". You are like this. When I found out, wow, I was really desperate, you know? Very much so. I thought it was the end of the world, you know? I could not imagine it was like this, that I didn't... I will not die from this. But you become worried, you know* (Heloisa, 57 years, married, lumpectomy).

Trincaus and Côrrea (2006) report that the theme of death frequently permeates the statements of cancer patients. According to Kovács (1992), fear is the most common psychological response faced with death. Studies indicate that fear of death is a feeling commonly experienced by patients with breast cancer and deserves special attention from the healthcare professionals (Berterö & Wilmoth, 2007; Corbellini, 2001).

In the present study it was perceived that the moment of the diagnosis raises worry and fear in the women affected by breast cancer regarding the possibility of experiencing their own finitude, corroborating findings of previous studies (Peres & Santos, 2007, 2009; Rossi & Santos, 2003; Silva & Santos, 2008; 2010). The uncomfortable feelings may hinder the elaboration of the adverse experiences and the enjoyment of a fuller and more satisfactorily sexual life.

Fear of bodily alterations caused by the treatments: The diagnosis of breast cancer brings with it fantasies and fears regarding bodily alterations caused by the treatments, suggesting an anticipatory anxiety, as can be illustrated by the statement of Bianca:

> *It was as soon as I discovered that I had breast cancer, I immediately found a way to end my relationship.... I ended this relationship because I said: I'll lose my hair.... . I will lose the breast...* (Bianca, 62, separated, radical mastectomy).

Upon learning of the diagnosis of breast cancer, this participant developed a belief in relation to the potentially devastating consequences that the treatment could have on her physical appearance, due

to its adverse effects, such as alopecia and mutilation, leading to bodily disfigurement. This anticipation had a negative impact on her relationship, dramatically marking her affective-sexual life. The emotional response to the possibility of harmful effects, even before they solidify, indicates that the physical repercussions of the breast cancer and its treatments are known and envisaged even before they occur. This predictability of the physical discomfort and bodily mutilation, which is perceived from the confirmation of the breast cancer diagnosis, may be, according to the Ministry of Health (Brasil, 2009), one of the major causes of the fear found in the female population in relation to this type of cancer. Such fear can directly influence the seeking of medical care, increasing rates of late diagnosis, which limits the chances of achieving successful treatment.

Sexual intercourse as a risk for developing a new cancer

This thematic category was drawn from the statements that linked sexual relations with the risk of a new cancer - that is, the belief in the possibility of the mammary tumor spreading to other parts of the body related to the female sexual apparatus -, or even the belief in the possibility of transmitting the cancer to the sexual partner - the concept of cancer as a contagious and sexually transmitted disease. This line of thinking can be perceived in the following excerpt from the interview, in which Elisa reports beginning to dread intercourse after breast cancer for fear that the disease would spread to other parts of the body, especially the uterus and ovaries:

> *I think that, maybe, it can give me problems in the uterus, in the ovary, you know? Me? I want to avoid this, I want to avoid this. ...if my cancer goes to the uterus, to the ovary, I'm afraid of that. ...and I think this* [sex] *is going to harm me. ...so sometimes I don't want it. I avoid it, I say no...* (Elisa, 52 years, married for the second time, simple mastectomy).

The extract below indicates the perception of the cancer as a Sexually Transmitted Disease (STD).

> *And I thought it was going to pass to him too. ...because they always say it's in the blood, don't they? ...and ...they say, right, that it would be transmitted if he was having sex with me, I'd pass it to him...* (Giovana, 36 years, married, lumpectomy).

The historical discussion produced by Sant'Anna (2000) about the relationship between cancer and the woman illuminates important aspects of the meanings popularly associated with the disease over the centuries. According to the study, from the nineteenth century to the early twentieth century, cancer was considered a contagious disease and associated with poor physical and moral hygiene and cleanliness. Similarly, it was considered that the disease could be contracted from the abuse of pleasures, especially in the case women, whose illness was seen as the result of their excesses, sins and nefarious vices, mainly related to the exercise of sexuality.

In the national context, several studies have investigated the beliefs and metaphors produced in coping with cancer (Lôbo et al., 2006; Tavares & Trad, 2005). These thoughts will change over time and vary according to the sociocultural context in which they are immersed, however, part of them remains rooted in the Brazilian culture, therefore, it is very important to understand how these beliefs and taboos were constituted and crystallized (or modified) throughout history.

Other studies have reported the emergence of the discourse of cancer as a contagious disease. This perception is reflected in both the accounts of the affected people as well as in the reports of relatives and friends, who started to avoid contact with the affected individuals and with the objects they had touched. These findings confirm that cancer remains fixed in the popular imagination as a contagious disease that often produces reactions of embarrassment and awkwardness, which help to perpetuate the stigma that exists around the disease and the patient (Peres & Santos, 2007; Silva, 2005; Silva & Santos, 2010).

Positive impact of the breast cancer diagnosis on the sexual life

Surprisingly, a positive impact of the illness on the sexual life of women was also detected in this study. For some participants, the changes caused by the disease were positive, as it made them value their lives even more and potentialized new ways of expressing their sexuality, as can be seen in the following subcategories:

- *The proximity of death as a factor in promoting the valorization of life*: The proximity to finitude was considered by some participants as a divine warning, i.e., it acted as a warning for them to become aware of the need to reassess how they had led their life up to then, which contributed to them revising their values and reconsidering some priorities. In the following report it can be seen that the meaning the participant attributes to the cancer does not revoke the suffering of the patient inherent in the disease condition and the experience of illness, but provides encouragement and stress relief when highlighting this painful experience endowing it with a purifying meaning.

> *So, for me the cancer was a way of... god shook me to say: "You need to take care of yourself". ...I mean, I passed... close to death, so I have to live. So I think that, for me, undergoing the suffering was something that I... I was uplifted... . it's something that hurt a lot, but for me it was a, how can I say? One way that God saw fit to call me for life... . I have to live, I can live, it is not that... it is, that I must live for me, for my daughter, for my husband. ...even in the suffering it is... it was something that, that was good for me, right? Us, the relationship improved, right?* (Dulce, 46 years, married, lumpectomy).

The perception of cancer as a transforming agent is present in the scientific literature, indicating that to experience the neoplastic disease can be related to the possibility of death and that this proximity to finitude can, paradoxically, be a potentiator for the revalorization of life (Araújo & Fernandes, 2008; Kovács, 1992; Kübler-Ross, 2005; Peres & Santos, 2007; Silva & Santos, 2008). It can be a transformative experience, in that it encourages women to reevaluate their lives, reviewing their feelings, values and priorities, which provides benefits for the affected person.

In the statement of Dulce it can be inferred that, with the experience of the disease, there seems to have been a positive resignification of her life, finding in the cancer a chance for growth, to view things differently and to develop a sense of self-respect, although under the influence of the suffering. This same interpretative vertex can be found in studies (Avis et al., 2004; Duarte & Andrade, 2003) that show that, despite the problems experienced with the removal of the breast, some women reported that their sexual life had improved, as was mentioned in the discourse extract presented.

- *The valorization of life as a facilitating factor for caring for the physical appearance*: From the valorization of life mentioned, changes may also appear in relation to caring for the physical appearance, which was previously systematically neglected. With this, the woman can experience positive change in her sexual life, as can be glimpsed in the report of Janaina, reproduced below:

> *So, the time that they said cancer, the first thing that I thought... cancer, I'm going to die... . I had a new opportunity for life, so why don't I change my life? I want to change my life, I want it to happen differently... . I think cancer for me was something like... how can I tell you... it's not that it was a good thing, but it made me become better than I was, understand? ...it made me see the... is... I could see life differently..., because before I did not, I did not bother with my appearance, you know, for me any clothes were good, it was always going to work in T-shirts and shorts, you know? Not today, today I want to put on lipstick, which was something I didn't do, I want to care for my appearance... . And, you know, I changed for the better... it was not for the worse, for me, for me it was for the better* (Janaina, 43, married and with a boyfriend, lumpectomy).

This participant seems to have operated a redefinition of the cancer as a critical event that made her perceive life in a different way than previously. With this rotation of perspective, the participant started to care for herself more, giving importance to her physical appearance and her subjective well-being. In the wake of this process in which she could expand her perception, this participant found herself transformed into a better person than she was before the onset, which even drove to seek an extramarital relationship as a way to deal with the deep emotional and sexual dissatisfaction that she experienced maintaining a failed marriage. In this case, the failure of the marital relationship was prior to the advent of the disease.

Final Considerations

In this study there was a wide variety of experiences of sexuality that emerged or were potentiated after the breast cancer. This indicates that there is no single standard that can be deduced to describe the experience of sexuality of women facing the setbacks of breast cancer and the forcefulness of its

treatments. It can be perceived that the way each participant dealt with the issue of the illness and treatment, as well as the meanings attributed to these vital events, made her singularly experience sexuality in relation to herself, her values and positions assumed faced with her own existence, or in the sphere of the relationship established with her sexual partner.

In this direction, it is important to point out that one of the limitations of this study is the lack of listening to the discourses of the intimate partners of the women interviewed, to include more elements related to the study. This view of the partners may be useful to complement the results obtained by this study, which focused on the issue exclusively from the point of view of the women. To ensure integral care for the women in relation to their sexuality it is interesting to help professionals perceive the partner as a possible factor of help in the recovery and psychosocial rehabilitation.

These considerations show the importance that, in future studies, the experiences of sexuality are taken into account when investigating the pattern of adaptation and psychosocial adjustment of women affected by breast cancer. An affective-satisfying sexual life can be one of the protective factors for the physical and emotional health of women facing breast cancer and the rigors of its invasive treatments. The findings of this study are relevant not only in the field of Psychology, but also in other areas of health, since they refer to an aspect of breast cancer that requires greater comprehension for the implementation of integral care strategies.

Considering the findings of this study, some implications of its results can be glimpsed for the psychologist in the health context. It was clear that, due to the different meanings attributed by the women to breast cancer, they experienced diverse problems and difficulties in relation to the sexual life after the diagnosis. In considering this question, the professional who works in the area of oncology psychology should aim for the psychological well-being of the patient, helping them to identify and comprehend the emotional factors involved in their health, allowing these to be redesigned. Furthermore, it is important to assist the patient to comprehend the meanings that the experience of illness have for her and to promote the development of reinterpretations of this process, which will help her to develop adaptive strategies to cope with the stressful situations in the prolonged itinerary of the treatment.

The more the patient is informed about her disease, treatments and prognosis, the greater her ability to cope with the illness, leading to more confidence being placed in the professionals of the multidisciplinary healthcare team. Thus, another relevant role that is worth the psychologist performing in the multidisciplinary team is to promote psychoeducational activities to keep patients informed and supported, in order to offer other possibilities of available discourses to increase resilience and strengthen the coping process.

Spending time in groups composed of people with similar problems provides an experience that can contribute to the development of an emotional climate of therapeutic value. This helps participants overcome barriers created by feelings of loneliness and isolation, enabling them to more fully enjoy the opportunities to receive support, immediate feedback and constructive suggestions offered by others who experience similar problems.

The results obtained in this study may amplify possibilities of comprehension and discussion of the topic of sexuality in the hospital context, providing elements to enhance the integrality of the care, not only for women who have been affected by breast cancer, but also for their companions, who are also impacted by the context of illness. In this scenario, the role of the psychologist as a healthcare professional is highlighted. Psychologists must be prepared for the range of experience possibilities found in women with breast cancer in order to improve their capabilities to diagnose the subjective needs of the women, incrementing the guidance with qualified advice.

There is a need to incorporate issues of sexuality in the interventions offered in the context of care. However, this need to contemplate the sphere of the emotional-sexual life of patients often collides with the deficient formation of the healthcare professionals, especially regarding the experience of sexuality in the disease process theme, as indicated by the findings in the literature. In this aspect, it is necessary to promote studies aimed at training professionals in order to prepare them to develop health promotion actions, including in the emotional care the issues related to the

experience of sexuality of the women affected by breast cancer.

Another possible limitation that can be identified in this study is that the sample is composed of women who were taking part in psychosocial rehabilitation, in a program that includes integral care, with psychological care, nursing, physiotherapy and occupational therapy. It would be interesting if future studies included patients who receive only medical and hospital care, in order to verify whether there are differences in the impact of the surgery on the sexual lives of these women who have no access to rehabilitation programs. Another factor that may have contributed to limit the scope of the results is that the women who comprised the sample of this study may be part of the patient population that adapted best to surgery, while those that were more emotionally affected tended to refuse to participate in the study upon learning of its aims. Such patients may have difficulty responding or even refuse to talk about issues related to sensitive topics such as the sexual life.

References

Alicikus, Z. A., Gorken, I. B., Sen, R. C., Kentli, S., Kinay, M., Alanyali, H., et al. (2009). Psychosexual and body image aspects of quality of life in turkish breast cancer patients: A comparison of breast conserving treatment and mastectomy. *Tumori, 95*(2), 212-218.

Ambrósio, D. C. M., & Santos, M. A. (2011). Vivências de familiares de mulheres com câncer de mama: uma compreensão fenomenológica. *Psicologia*: *Teoria e Pesquisa, 27*(4), 17-26.

Araújo, I. M. A., & Fernandes, A. F. C. (2008). O significado do diagnóstico do câncer de mama para a mulher. *Escola Anna Nery, 12*(4), 664-671.

Avis, N. E., Crawford, S., & Manuel, J. (2004). Psychosocial problems among younger women with breast cancer. *Psycho-Oncology, 13*(5), 295-308.

Barros, A. C. S. D., Barbosa, E. M., Gebrim, L. H., Anelli, A., Figueira Filho, A., Del Giglio, A., et al. (2001). *Diagnóstico e tratamento do câncer de mama*. In Conselho Federal de Medicina. *Projeto diretrizes* (pp.1-15). Brasília: CFM.

Barton-Burke, M., & Gustason, C. J. (2007). Sexuality in women with cancer. *Nursing Clinics of North America, 42*(4), 531-554.

Berterö, C., & Wilmoth M. C. (2007). Breast cancer diagnosis and its treatment affecting the self: A meta-synthesis. *Cancer Nursing, 30*(3), 194-202.

Biffi, R. G., & Mamede, M. V. (2004). Suporte social na reabilitação da mulher mastectomizada: o papel do parceiro sexual. *Revista da Escola de Enfermagem da USP, 38*(3), 262-269.

Bloom, J. (2002). Surviving and thriving? *Psycho-Oncology, 11*(2), 89-92.

Brasil. Ministério da Saúde. (2011b). *Resolução CNS nº 196/96*. Brasília: MS.

Brasil. Ministério da Saúde. (2009). *Estimativas 2010*: *incidência de câncer no Brasil*. Brasília: MS. Recuperado em outubro 23, 2010, disponível em <http://www.inca.gov.br>.

Brasil. Ministério da Saúde. (2011). *Estimativas 2012*: *incidência de câncer no Brasil*. Brasília: MS. Recuperado em março 13, 2012, disponível em <http://www.inca.gov.br>.

Brêtas, J. R. S., Ohara, C. V. S., & Querino, I. D. (2008). Orientação sobre sexualidade para estudantes de enfermagem. *Acta Paulista de Enfermagem, 21*(4), 568-574.

Büchele, F., Oliveira, A. S., & Pereira, M. D. (2006). Uma revisão sobre o idoso e sua sexualidade. *Interface*: *Comunicação, Saúde, Educação, 3*(1), 131-143.

Bukovic, D., Fajdic, J., Strinic, T., Habek, M., Hojsak, I., & Radakovic, N. (2004). Differences in sexual functioning between patients with benign and malignant breast tumors. *Collegium Antropologicum, 28*(2), 191-201.

Corbellini, V. L. (2001). Câncer de mama: encontro solitário com o temor do desconhecido. *Revista Gaúcha de Enfermagem, 22*(1), 42-68.

Duarte, T. P., & Andrade, A. N. (2003). Enfrentando a mastectomia: análise dos relatos de mulheres mastectomizadas sobre questões ligadas à sexualidade. *Estudos de Psicologia* (Natal), *8*(1), 155-163.

Fatone, A. M., Moadel, A. B., Foley, F. W., Fleming, M., & Jandorf, L. (2007). Urban voices: The quality-of-life experience among women of color with breast cancer. *Palliative and Supportive Care, 5*(2), 115-125.

Fontarella, B. J. B., Ricas, J., & Turato, E. R. (2008). Amostragem por saturação nas proposições qualitativas em saúde: contribuições teóricas. *Cadernos de Saúde Pública, 24*(1), 17-27.

Giami, A. (2002). Sexual health: The emergence, development and diversity of a concept. *Annual Review of Sex Research, 13*, 1-35.

Giami, A. (2007). Permanência das representações do gênero em sexologia: as inovações científicas e médicas comprometidas pelos estereótipos de gênero. *Physis, 17*(2), 301-320.

Gimenes, M. G. (Org.). (1997). *A mulher e o câncer*. São Paulo: Editorial Psy.

Gomes, F. A., Panobianco, M. S., Ferreira, C. B., Kebbe, L. M., & Meirelles, M. C. C. C. (2003). Utilização de grupos na reabilitação de mulheres com câncer de mama. *Revista de Enfermagem UERJ, 11*(3), 292-295.

Gorisek, B., Krajnc, P., & Krajnc, I. (2009). Quality of life and the effect on social status among Slovenian women after breast cancer treatment. *Journal of International Medical Research, 37*(2), 557-566.

Kovács, M. J. (1992). *Morte e desenvolvimento humano.* São Paulo: Casa do Psicólogo.

Kovács, M. J. (2003). Bioética nas questões da vida e da morte. *Psicologia USP, 14*(2), 115-167.

Kübler Ross, E. (2005). Sobre a morte e o morrer: o que os doentes terminais têm para ensinar a médicos, enfermeiras, religiosos e a seus próprios parentes (5ª ed.). São Paulo: Martins Fontes.

Lôbo, R. C. M. M., Santos, N. O., Dourado, G., & Lucia, M. C. S. (2006). Crenças relacionadas ao processo de adoecimento e cura em mulheres mastectomizadas: um estudo psicanalítico. *Psicologia Hospitalar*, *4*(1), pp.1-20.

Maluf, A. S. D., Dias, R. C., & Barra A. A. (2006). Avaliação da qualidade de vida em mulheres com câncer de mama. *Revista Brasileira de Cancerologia, 52*(1), 49-58.

Muniz, R. M. (2008). *Os significados da experiência da radioterapia oncológica na visão de pacientes e familiares* (Tese de doutorado não-publicada). Universidade de São Paulo.

Peres, R. S., & Santos, M. A. (2007). Breast cancer, poverty and mental health: Emotional response to the disease in women from popular classes. *Revista Latino-Americana de Enfermagem, 15*(Esp.), 786-791.

Peres, R. S., & Santos, M. A. (2009). Personalidade e câncer de mama: produção científica em psico-oncologia. *Psicologia*: *Teoria e Pesquisa, 25*(4), 611-620.

Rossi, L., & Santos, M. A. (2003). Repercussões psicológicas do adoecimento e tratamento em mulheres acometidas pelo câncer de mama. *Psicologia*: *Ciência e Profissão, 23*(4), 32-41.

Saegrov, S., & Halding, A. G. (2004). What is it like living with the diagnosis of cancer? *European Journal of Cancer Care, 13*(2), 145-153.

Sales, C., Paiva, L., Scandiuzzi, D., & Anjos, A. C. (2001). Qualidade de vida de mulheres tratadas de câncer de mama: funcionamento social. *Revista Brasileira de Cancerologia, 47*(3), 263-272.

Sant'Anna, D. B. (2000). *A mulher e câncer na história.* In M. G. G. Gimenes & M. H. Fávero (Orgs.), *A mulher e o câncer* (pp.43-70). Campinas: Livro Pleno.

Santos, D. B., & Vieira, E. M. (2011). Imagem corporal de mulheres com câncer de mama: uma revisão sistemática da literatura. *Ciência e Saúde Coletiva, 16*(5), 2511-2522.

Santos, M. A., & Vieira, E. M. (2008). Aconselhamento em contracepção: grupo de capacitação de profissionais médicos do programa de saúde da família. *Interface*: *Comunicação, Saúde, Educação, 12*(26), 589-601.

Scorsolini-Comin, F., Santos, M. A., & Souza, L. V. (2009). Vivências e discursos de mulheres mastectomizadas: negociações e desafios do câncer de mama. *Estudos de Psicologia* (Natal)*, 14*(1), 41-50.

Silva, V. C. E. (2005). *O impacto da revelação do diagnóstico de câncer na percepção do paciente* (Dissertação de mestrado não-publicada). Programa Interinstitucional, Universidade de São Paulo.

Silva, G., & Santos, M. A. (2008). Será que não vai acabar nunca?: perscrutando o universo do pós-tratamento do câncer de mama. *Texto & Contexto Enfermagem, 17*(3), 561-568.

Silva, G., & Santos, M. A. (2010). Stressors in breast cancer post-treatment: A qualitative approach. *Revista Latino-Americana de Enfermagem, 18*(4), 688-695.

Talhaferro, B., Lemos, S. S., & Oliveira, E. (2007). Mastectomia e suas consequências na vida da mulher. *Arquivos de Ciências da Saúde, 14*(1), 17-22.

Tavares, J. S. C., & Trad, L. A. B. (2005). Metáforas e significados do câncer de mama na perspectiva de cinco famílias afetadas. *Cadernos de Saúde Pública, 21*(2), 426-435.

Trincaus, M. R., & Corrêa, A. K. (2006). A dualidade vida-morte na vivência dos pacientes com metástase. *Revista da Escola de Enfermagem USP, 41*(1), 44-51.

Triviños, A. N. S. (1987). *Introdução à pesquisa em ciências sociais*: *a pesquisa qualitativa em educação*. São Paulo: Atlas.

Vieira, C. P., Lopes, M. H. B. M., & Shimo, A. K. K. (2007). Sentimentos e experiências na vida das mulheres com câncer de mama. *Revista da Escola de Enfermagem USP, 41*(2), 311-316.

World Health Organization. (1986). *Basic documents*. Geneva: Author.

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Sons and daughters with a parent hospitalized in an Intensive Care Unit

Filhos com pais hospitalizados em uma Unidade de Terapia Intensiva

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Abstract

The aim of this study, in the area of Hospital Psychology, was to comprehend the experience of sons and daughters whose mother or father was hospitalized in an Intensive Care Unit. Participants were 10 sons and daughters who responded to a socio-demographic questionnaire and a semi-structured interview, which were submitted to Content Analysis. The following were verified in the interviews: feelings of suffering and fear; concerns regarding the fact that the patient spends most of the time alone; lack of trust regarding the treatment offered by the healthcare team for the patient; lack of motivation to continue day by day routines; positive reappraisal such as personal, spiritual and professional growth, and satisfaction with the hospital team's care to the family. This data highlights the needs of these sons and daughters during their parent's hospitalization in an Intensive Care Unit and may support more effective care from the healthcare team for this population.

Uniterms: Coping strategies; Family; Intensive care unit; Psychology hospital.

Resumo

O objetivo deste estudo, na área da Psicologia Hospitalar, foi compreender a experiência de filhos que possuem a mãe ou o pai internado em uma Unidade de Terapia Intensiva. Participaram 10 filhos, de ambos os sexos, que responderam a uma Ficha Sociodemográfica e a uma Entrevista Semidirigida que foi submetida à Análise de Conteúdo. Nas entrevistas, constatou-se: sofrimento, medo e temor; preocupações quanto ao fato de o paciente ficar a maior parte do tempo sozinho, desconfiança quanto ao tratamento oferecido pela equipe de saúde ao paciente, perda da motivação de realizar suas rotinas, reestruturação positiva, tipo: crescimento pessoal, espiritual, profissional e satisfação em relação ao tratamento dispensado à família, pela equipe de saúde. Estes dados indicam as maiores necessidades dos filhos durante a internação de seus genitores na Unidade de Terapia Intensiva e podem subsidiar uma prática mais efetiva da equipe de saúde junto a essa população.

Unitermos: *Estratégias de enfrentamento; Família; Unidade de terapia intensiva; Psicologia hospitalar.*

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Hospital psychology is one of psychology's professional practices. It promotes and develops several activities in different levels of treatment, health promotion and disease prevention. The Federal Psychology Council (FPC) in its 013/2007 Resolution says that hospitals, teaching institutions and research centers are the fields of work of these professionals, and their target public are patients, their relatives and/or the people responsible for them, community members, health staff and management staff. Campos (1995) stated that, when it comes to acting within the hospital, the aim is to contribute to the individual and social well-being, using information from other areas related to a hospital context, such as medicine, nursing, social service, nutrition etc. According to the *Conselho Federal de Psicologia* (2004), the agency that governs the psychologist's professional practice in Brazil, those who specialize in Hospital Psychology act in the secondary and tertiary levels of health care, working with: psychotherapy; psychotherapeutic groups; psycho prophylaxis groups; emergency care; wards; psychomotor issues; diagnostic assessment; psychodiagnostic assessment; consulting; inter-consulting; clinics and Intensive Care Units (ICU).

The Intensive Care Unit is a high complexity section with much technological apparatus, designed for patients with severe or potentially severe health conditions, with the chance of recovering and in need of continuous attention from a specialized interdisciplinary/multidisciplinary health team. However, patients who do not have the possibility of regression in their clinical status are also admitted, which highlights the need to distinguish between this model's curative proposal and palliative care. In the latter case, there is the philosophy of comprehensive care offered to relatives and patients in different stages of illness, aiming to care with comfort and dignity, in order to diminish the disease impact and manage the patients' and relatives' expectations. It is important to emphasize that when patients are in a final stage, the action is directed towards relief of the patients' and relatives' pain and suffering, given the proximity of death. ICU hospitalization may lead to a series of signs and symptoms of physical and emotional destabilization in patients and relatives. The separation process and, perhaps, the expectation of losing someone is a phenomenon that usually spreads throughout the whole family and the moments of worry and stress due to a relative's hospitalization in ICU may product symptoms and dysfunctions.

According to Angerami-Camon (2003), since this process causes emotional implications for the patient's family, the hospital psychologist must act offering emotional support to relatives so that they can find relief faced with the suffering brought on by the withdrawal of a relative. The process of becoming ill and hospitalized is a moment of crisis for the family, who do not always understand the procedures carried out by the health team, requiring care so they can face the hospitalization and its repercussions on the patients' and their own lives. Several studies have been developed aiming to verify how people with relatives in an ICU experience this situation.

The aim of Morgon and Guirardello (2004) was to validate the Relatives in ICU Needs Scale. Participants were 52 relatives of patients in the ICU of a University Hospital in *São Paulo*, most of them were women (71.1%) with a mean age of 41 years. Relatives were: sons/daughters (34.6%), followed by parents (27,0%), partners (21.1%) and others (17.3%). The most important needs for these families were: feeling that the hospital cares about the patient; being sure that the best treatment is being provided; sensing that there is a chance of recovery; knowing that medical treatment is underway and having their questions answered openly.

Moreno and Jorge (2005) interviewed eight mothers in the ICU of (Albert Sabin Children's Hospital) at *Fortaleza* (CE), Brazil, with the aim of understanding the expression of feelings and emotions of these mothers. The leading question used was: "How do you feel in an ICU watching and/or experiencing the care given to your ill child?". Interviews were analyzed using ideographic (individual comprehension of subjects' discourses) and nomothetic (understanding of the main assertions, obtained from the convergence of units of meaning) comprehensions, which is also called a situated phenomenon or existential phenomenology. The main reactions revealed by the mothers that emerged during the process of having their children in the ICU were: change of habits and behavior, frustration, anxiety, fear, guilt, pity, perplexity, sadness, loneliness, uncertainty, stress, and worry.

Paparrigopoulos et al. (2006) used the Center for Epidemiologic Studies Depression Scale and the Impact of Event Scale to assess the level of Depression and Posttraumatic Stress Disorder respectively in 32 relatives of patients in an ICU. It was verified that 97% of them presented depressive symptoms and 81% presented symptoms of Posttraumatic Stress. The authors concluded that such people had high levels of anxiety and distress that persevered during their relatives' hospitalization. Early identification of these cases by a psychologist and the creation of interventions may prevent the development of these disorders.

From analyzing these studies, it becomes evident that they focus on relatives' negative feelings, their needs during the patient's hospitalization and their level of depression and anxiety. No studies were found highlighting a specific type of kinship, except when it came to mothers with children in a Neonatal ICU (NICU). Furthermore, there is a lack of studies with emphasis on positive aspects resulting from the experience.

These reasons led to the interest in specifically investigating the experience of sons/daughters of patients. It is considered that there might be particularities in such experience, as parents represent protection for their children, no matter their age, and sometimes they are still the providers in the family. Such studies may offer theoretical support for hospital psychologist formation and for other health professionals, contributing to the development of programs to enable more timely and effective intervention planning. These programs must be developed with attention to Saunders' et al. (1995) concept of "total pain", which goes beyond merely physical pain, also considering social, emotional and spiritual dimensions. It is the pain that must be faced by the patient when coping with distress involving his/her identity and life objectives, as well as by the family when seeking the strength to deal with mourning and the future.

In this way, the aim of this study was to investigate what it means for a son/daughter to have his/her mother or father hospitalized in an ICU. It should be remember that, when considering a patient's recovery one must also take into account their family members, as they influence the treatment. This influence may be beneficial when well guided by a qualified healthcare professional or maleficent when poorly guided or not guided at all.

Method

Participants

Participants were ten sons/daughters of patients in an ICU of a private hospital in the city of *Recife*, state of *Pernambuco*. Three had their fathers hospitalized in this unit and seven had their mothers in the ICU. The mean age was 44 years, varying from 20 to 59 years.

Instruments

The instruments used were a socio-demographic questionnaire and a semi-structured interview. Andrade (2003) says that this type of interview consists of a conversation that can be guided by open questions, which allows the informant more freedom.

Data collection and analysis

Data collection occurred from March to July, 2010, after the project had been approved by the Research Ethics Committee from the *Universidade Católica de Pernambuco* under protocol nº 033/2009, and after the hospital management gave permission for the study to be carried out. The patients' relatives were approached while waiting for the visiting time to start. The aim of the study was explained and, if they agreed to participate, a time and place of their convenience was set. All of them preferred that it was in the hospital, before or after the visit to their parents.

Prior to beginning the interview, the Terms of Free Prior Informed Consent was presented to the participant, who read and signed it, after any necessary clarification. Next, the socio-demographic questionnaire was completed. The interviews took place in a room provided by the hospital for this purpose.

The interviews were submitted to Content Analysis (Minayo, 1999). At first, they were read and re-read focusing on the aims of the study and on what was recurrently mentioned by the participants. Five thematic categories emerged from this analysis: 1) Feelings most mobilized in the sons/daughters of patients in the ICU;

2) Main concerns and difficulties; 3) How this situation affected the routines of the relatives; 4) Positive aspects of the situation; 5) How the participants perceived the healthcare team's treatment of the patients and their families.

Inferences and interpretations from the interviews were made based on these categories or themes. It is important to highlight that the analysis considered the theoretical framework that guided the entire investigation. When presenting the results, the interviewees are identified as E1, E2 and so on, in order to maintain their anonymity.

Content Analysis of the interviews

The five thematic categories resulting from the content analysis of the interviews are discussed here.

Feelings most mobilized in the sons/daughters of patients in the ICU

According to Soares (2007), relatives have specific needs and present high rates of stress, mood disorders and anxiety during the period of hospitalization of their parents in the ICU. As Angerami-Camon (2003) states, the disease is a factor of maladjustment in the family group. Therefore, it is necessary for the hospital psychologist to care for these families. However, despite professionals indicating the need for a multidisciplinary/interdisciplinary intervention, in which psychologists should give relatives feedback on the patients' psychological conditions, such action does not occur very often. Psychologists' actions are seen as important, however, in a very subtle way, restrictions and prejudice emerge and this practice is not legitimized. In healthcare, action and participation are restricted to support and medical aid, reinforcing the fact that the psychologist is a professional of last resort for the users (Bock, 2003).

Lucchesi, Macedo and Marco (2008) highlight that the beginning of hospitalization is a moment of shock, denial and causes feelings of despair, which can be gradually substituted by a greater ability to cope and deal with the reality. There are many feelings involved in this process: moments of apprehension, despair, relief, fear, anger, and exhaustion, among others. Faced with this, the contribution of psychology for healthcare, especially within a hospital context, is extremely important. As Mota, Martins and Véras (2006) state, psychologists have the role of understanding what is involved in the complain, in the symptoms and in the pathology, so they can have a broad view about what is happening with the patients, to help them through this difficult process, as well as to provide support for relatives to better understand this moment. As healthcare professionals, psychologists must observe and listen patiently to words and silences, since they are the ones, in the field of human therapeutics, who can offer the possibility for patients or relatives to confront their anguish and suffering when dealing with the disease and hospitalization, aiming to overcome moments of crisis. Psychology professionals can propose a discussion on the real conditions of humanization in the hospital, engaging in the role of caregiver with the aim to improve the care system.

In this study, it can be verified that the feeling most mobilized were: suffering, and fear. The following reports confirm this statement:

> *It is complicated to tell you what I am feeling, you know? It is a lot of suffering. And, even though I can see her improving, I am still afraid...* (E1).

> *When they told me my mother was in the ICU, I got scared. I was like: the ICU? Because that is something that scares you, right?* (E10).

It is worth highlighting an aspect presented by E10: the fear provoked by the ICU in some relatives. According to the literature, the ICU is socially seen in a negative way, there is a comprehension that patients in this unit present a severe clinical state with the possibility of death, which causes feelings of anguish in the relatives of patients, due to the fear of an imminent loss (Nunes, 2004). The lack of information on the routine of the ICU causes apprehension in the relatives regarding the health status of the patients, which causes them to become distressed. According to Di Biagi (2002) the psychologist must accompany these relatives, providing conditions for them to express their feelings, doubts, fantasies and false concepts on the disease or the ICU and allowing them to cope with the hospitalization and what may come from it.

During the period of the disease and ICU hospitalization, in addition to the feelings mobilized,

some concerns and difficulties are common. This theme is approached below.

Main concerns and difficulties

Intensive Care Unit hospitalization may cause emotional instability in the relatives of the patients, who become apprehensive and restless. When questioned about their main concerns and difficulties regarding their parent's hospitalization in the ICU, the responses given were as follows: *"We are afraid that our father might die... . That we come to visit him and he is dead. Have mercy! I would never believe that he had died"* (E6).

The fear of death overcomes other concerns for most of the sons/daughters; however some of them have concerns regarding the quality of life their parents might have if they survive. As one of the participants stated: *"My biggest fear is the sequels she might have, if she comes out of here. That she lives in a vegetative state. I think about that a lot. That is what concerns me"* (E2).

For Nieweglowski and Moré (2008), families with relatives in an ICU, in addition to being exposed to various stressors, constantly reflect about death. In this study, it was observed that the relatives were very succinct on that theme. This is similar to the findings of Urizzi and Corrêa (2007). These researchers said that their participants did not express in detail the experience related to the possibility of the death of their relatives, which is more concretely presented in the context of an ICU.

This configures the difficulty of speaking about death, even when considering this to be an inherent condition of the human being. Death is currently associated with pain and suffering, almost always happening in a hospital context in which there is an elongation of life, hence the importance of clarifying palliative caring procedures, with an emphasis on existential dimensions that influence physical pain. Caring for physical pain is not neglected, however, as the treatment is not focus on a cure, palliative care allows the necessary reflection to strengthen the coping mechanisms in a situation of threat to life.

As Kovács (1992) says, there is a myth responsible for one of this century's biggest fears: the belief that death is always accompanied by suffering. For this author, an anticipatory mourning may occur in people when they become aware of certain diagnoses. According to Franco (2010), Londemann, in 1944, was the first one to talk about this kind of mourning, using the experience of wives of soldiers who were called to the battle field. Franco and Mazorra (2007) state that, what allows mourning to be elaborated is a re-signification, a transformation of the relationship with the lost object. Education concerning death may be a good path in the search for new caring perspectives for severely ill patients and their families. When considering the quality of death, palliative care focuses on providing a higher quality of life for as long as possible, which can diminish the suffering of the patients and relatives.

Other concerns indicated in the interviews were: the short period of time for visits and the care provided by the team: *"We are already used to being here with him and here we don't provide the care, there are others who do that, so we become concerned. And the visit is very quick, which is really bad. We want to spend more time, I feel like staying the night with him, but it is not allowed"* (E7).

As Nunes (2004) affirms, many relatives become concerned knowing their parents are alone, without someone to care for them, to hold or to talk with them. Molter (1979) comments that the need to see the patient several times or visit when desired may be a way for the family to rebuilt a broken bond and cope with the anguish caused by the lack of control when the patient is out of their sight.

For Urizzi and Corrêa (2007) the family wishes to stand by the patient; this can reveal that, many times, what matters is not only objective information regarding the patient's status and evolution, which is also relevant, but the family members predominantly want more: they wants to be protected, considered in their suffering and to have their needs provided for. Faced with this, the healthcare team must seriously consider actions aimed at the relatives (Angerami-Camon, 2003). To consider the family as a secondary element is not consistent with a philosophy of humanization. The hospital psychologist must support and make the relatives aware of aspects of the disease and the real need for hospitalization, as well as provide prognostic explanations so that they feel protected and safe (Angerami-Camon, 2003). However, the insertion and practice of a hospital psychologist is not always possible, with the main

difficulties being: hierarchy issues, difficulties with the medical language, the great demand for work considering with the small number of professionals, difficulties in talking with the medical team, lack of recognition by other professionals of the practice of the hospital psychologist. Despite the aforementioned difficulties, which are also mentioned by Vieira (2006). Tonetto and Gomes (2007) say that there is a rise in interest regarding psychologists working in hospitals and that Psychology, as a science, is ready to make its contribution efficiently and safely.

Other concerns indicated by the sons/daughters included a preoccupation regarding the care provided to their parents: *"We also think about the attention he is receiving inside, since we can't be there all the time. When he is on a ward, we can monitor the care, but not in the ICU"* (E9).

For Guimaro (2003) the anxiety of relatives is common due to maladjustment to treatment or distrust of the medical team. This is why there should be open communication between these family members, the psychologist and the technical team that accompanies the patient. According to Doca and Costa Junior (2011), psychological support in the hospital has been recommended in the literature as it might help with higher rates of treatment adherence and provide a decrease in anxiety. For Nunes (2004), the presence of the hospital psychologist is important because this can help patients to better understand their situation in a way that their emotional state is not disturbed, avoiding a worsening of the problem.

How this situation affected the routines of the relatives

According to Lucchesi et al. (2008), and to Romano (1999), the family can be understood as a system in which each member plays a role and allows the existence of a dynamic that has its own functioning. When one of the members becomes ill, especially when they are hospitalized in an ICU, an imbalance is introduced in this system, with a break in the routine. When questioned about changes in their routines after the hospitalization of their parents in the ICU, some of the responses were:

> *... I get anxious to come to the hospital and hear about her, that's why my house is a mess ...* (E1).
>
> *I can say that all of this is like a tsunami. I am a very sociable person, you see? I used to go out with my friends, I am not married and don't have children, I used to go out a lot. But not now. I insist on coming here twice a day... . Everything has changed ... and now, she is like my baby. I am taking care of my baby, who depends on me for everything* (E2).
>
> *I had many things to solve, but I couldn't do anything. My husband is taking care of that. Bills to pay, money to receive. He's got everything... . I feel like I am crystallized. I don't do anything at home, my daughter does it. I really stopped* (E10).

Through the participants' statements, one can realize that they want to spend most of their time at the hospital. It is as if there was an inversion of roles, as they come to see their parents as babies and blame themselves when they cannot be together. The lack of motivation concerning daily activities, such as taking care of their homes, can also be verified. When they have a partner or children, they are the ones that become responsible for the house and daily activities, which highlight the change of roles in these family members.

In addition the participants mentioned that during the hospitalization of their relatives, their social lives finished and professional lives were compromised. A phrase used by one of them is very representative of these sons/daughters feelings: "I feel crystallized". It is as if time stopped while they are waiting for the recovery or death of their parent; while the situation is uncertain, they remain almost paralyzed, living with their parent's disease. They are also in a permanent state of alert due to the expectation of receiving news about the patient's status from the hospital. All of this is in accordance with the literature: Oliveira, Almeida, Araújo and Galvão (2005) state that hospitalization in an ICU causes a state of expectation and anguish, leading to interferences and implications in the rhythm of the social and professional lives of the relatives. This may contribute to them becoming more sensitive, demanding, depressed and/or distressed.

For Bousso and Angelo (2001), in this phase, the help given by other parents, friends and other families is essential. The families who are also dealing with similar situations sometimes even develop meaningful relationships in ICU waiting rooms. Relatives listen to

the same stories told by other families, sometimes facing different historical, cultural, ethical and religious contexts that may help them reflect on what they are going through and create new strategies to deal with this in a way that their routines are not so disturbed. In this moment, group work, guided by a psychology professional, could be useful and could allow the expression and exchange of feelings among the family members of the patients.

Positive aspects of the situation

Throughout this study, the fact that having a parent in an ICU unit causes concerns, suffering and distress in their sons/daughters could be verified. These aspects are already discussed in detail in the literature. However, in order to try and minimize the emotional load in such a situation, it is likely that some relatives try to restructure the event. They can do this by searching for positive elements of the situation. This is a less studied theme. When asked about this, some things the participants said were:

> *I think this is making me a better daughter. . . I am praying more, trusting more in God, you know? My faith is strong* (E1).

> *We learn that we are nothing. We are nothing. Nothing, nothing, nothing. Whoever thinks they are something is very mistaken. I am learning a lot... . I have grown as a person and become more detached from material things* (E6).

> *It is like respect is more important in this moment... . I have always respected him, but today I think there is more respect, you know?... . It also makes us work on our patience, because he is gradually recovering and if you're not patient you can't handle it* (E8).

> *In my case, it helped me grow in the professional area, because I'm a nurse and seeing my father like that is making me become a more human professional when I take care of some patients* (E9).

These statements highlight that this experience may have also been one of growth for the participants. What is shown is a rise in the experience of spirituality and almost mystical faith; some mentioned that they had become better sons/daughters; that they had become more human; that it was a moment to become more patient, and there was a chance of personal growth. According to Bousso and Angelo (2001) these families do not wait passively while their relatives are in the ICU, they do not merely wait for death, but they search for ways and strategies during this situation. When this does not happen, it is relevant to offer other possible perspectives to these families, in order to help them live through the experience.

Pinho and Santos (2008) say that being ill under these conditions (ICU) can provide patients and relatives with a positive experience, as sometimes they start to appreciate small signs linked to the valorization of a religious life or personal growth that perhaps were not so important to them before. This can be observed in the statements, as they indicated the learning of new things, such as not getting too attached to material things, or personal and even professional growth. Regarding the affirmation that this experience made them into better sons/daughters. Kovács (1992) says that, in the context of disease and the ICU, guilt is very common, as well as reparation attempts by the relatives of the patients.

Concerning spiritual growth, Lima and Rosa (2008) claimed that, many times, suffering is transformed into a positive attitude faced with the fear of death and of the ICU, transcending the faith in God. There is trust, up to the very last moment, that their faith is what provides them with strength and hope. Believing in a religion is seen as salvation by the relatives, and religious practices bring peace of mind and hope that the situation will be reversed. The impact of spirituality and the religious experience have been evidenced in several studies, confirming their impact on patients' health and on relatives' hopes, strength and anxiety (Savoli, 2008).

Given the above, it is worth highlighting the importance of a psychologist who assesses and identifies the family member who shows more preserved positive internal resources, as this person can be a facilitator link in the relationship between the health team and the family.

There is also a need for more reflection regarding death and dying. Public policies have to recognize the importance of caring not only for life but for the quality of death too, supporting the requirements of terminally ill people and offering them a worthy and peaceful death. Palliative care proposes a new shared and responsible way of caring for life and death with patients and families. It emphasizes the art of caring in a respectful and calm

way, allowing exposure and reflection regarding the true possibilities for the disease and the treatment, so that decisions and choices can be made to guide the last moments of existence, giving more life to the time rather than more time to the life.

How the participants perceived the healthcare staff's treatment of the patients and their families

The treatment provided by the healthcare staff to the family is fundamental, especially regarding the relatives of critical patients. Anxiety, discomfort and uncertainty felt by relatives may be increased if such treatment is impaired. Regarding the healthcare staff the participants said:

> *They are great doctors... . They go beyond being doctors. They are kind and that helps any family... . The team is very good and explains the diagnosis very well* (E2).

> *Look, better than this, only if there is another hospital of this kind because they provide excellent treatment here. I believe this is a reference hospital* (E5).

> *I have no complaints so far, you see? To start with, the owner made himself available to see my father and asked us if there was anything missing, if there was anything wrong... . Everything here is really good; cleaning, refectory, staff. Everybody is polite* (E6).

> *They are more than professionals, because they don't see a patient, they see a person... . It is good to notice that the hospital has professionals and people who can see the human side and not the patient as just a number... . He's very full of emotion and it is good to have a human staff. They have that here* (E8).

The participants' satisfaction can be noticed in the above statements regarding the health staff's treatment towards them, especially because they could understand the explanations about patients' diagnosis. These findings are in accordance with some other studies: Wallau et al. (2006), when assessing care quality in an ICU, verified that visitors mentioned dissatisfaction concerning medical information, and Kirchhoff et al. (2002) verified the lack of communication between staff and family in their study, as well as a lack of more detailed explanations about the patient's health status, which made them suffer with uncertainty regarding the prognosis.

It is worth recalling that the data collection in the present study was carried out in a single hospital characterized as an ICU Hospital. It is possible that, as it has a structure especially dedicated to this type of treatment, it can offer better conditions for the satisfaction of the relatives of the patients. Although there is no intention to generalize the findings mentioned here, it can be said that they indicate the importance of humanization in all hospital contexts.

It should be highlighted that efficient communication between staff and family prevents conflicts, doubts and distress in the relatives, resulting in greater satisfaction and a positive perception of the care provided to the ICU patient. An integral palliative care proposal may lead to a significant change in healthcare, introducing complex issues about the end of life, which can be reflected in particular attention to patient and family suffering faced with such an ending. According to Soares (2007), the communication process is the cornerstone of family care. One of the most important tasks for an ICU professional is to provide relevant, clear and realistic information, as well as solidarity. This can also be evidenced in the statements of the participants, as they highlighted the humanity of the healthcare staff, saying that this is a characteristic that goes beyond medical services. They speak as if it was not common to find someone who valorizes the subjectivity of the patient.

Some studies confirm this, for example, when Morgon and Guirardello (2004) aimed to validate the Relatives in ICU Needs Scale, one of the most important needs cited was to feel that the hospital team cares about the patient. Bettinelli, Rosa and Erdmann (2007) interviewed relatives of patients in an ICU and perceived that, in addition to the lack of guidance, the availability and welcome were also lacking. Therefore, hospitals must attend to such issues.

Final Considerations

This study aimed to comprehend the experience of sons/daughters who have a parent hospitalized in an ICU. The prevalent feelings that emerged in the interviews were: suffering, worry, and fear, probably based on the interpretation that this unit is related to a situation of imminent loss. Such results show that the feelings

experienced by these sons/daughters are similar to ones felt by other relatives with family members hospitalized in an ICU, such as mothers and fathers etc.

Regarding the main concerns, the emphasis was the distress felt by participants due to the short time for visiting (three times a day for thirty minutes each). They wanted to remain with their parent for longer because they mistrusted the healthcare team's ability to care for them. Therefore, it is suggested that the team - and/or professionals, such as psychologists, direct their guidance towards the family, aiming to clarify actions and routines in the ICU, the reasons why the visiting time is so restricted and their commitment to the patient. This could provide the relatives with more peace of mind. It would be interesting to give them opportunities to express their fantasies and false concepts concerning the ICU, so the ideas they have about this space could be demystified.

Regarding the routine changes of these relatives, it was observed that the sons/daughters lost the motivation to engage in daily activities, and functions once exercised by them were delegated to other family members. Because of this situation, it is proposed that, when supporting patients' sons/daughters or other relatives, staff can give them the opportunity to speak about the experience. This intervention could be carried out in groups of families in which a psychologist would be the mediator, in order for them to jointly construct possibilities for a reversal of the aforementioned situation and gradually rediscover the motivation to engage in daily activities, as this can also serve as a coping strategy.

Another relevant issue observed was that patients reconstruct the fact that their parents are in the ICU in a positive way, they begin to value things that were not noticed before, such as personal, spiritual and professional growth. Therefore, this strategy of positive reevaluation is considered an important asset to be used by healthcare professionals to support sons/daughters and other relatives that are more fragile.

Finally, the importance of humanized treatment and healthcare professionals who see patients and their families as individuals, without forgetting about the disease, was demonstrated. It is important the healthcare professional does not relate death with merely bureaucratic and technical procedures, and is careful not to transform hospitalization and dying into institutional, lonely and impersonal acts.

The level of satisfaction of the sons/daughters with the treatment provided by the health staff is a result that contradicts the literature findings. It is worth mentioning that the hospital where this research was conducted is characterized as an ICU hospital, therefore, it can offer better conditions for the satisfaction of the patients and relatives. However, humanized care can also be found in other types of institutions.

In order for the ICU to be humanized, some simple procedures can be taken: the patients' recovery largely depends on the comprehension that someone cares about them. Staff attention increases patient comfort, identity and integrity. On the other hand, a lack of attention may have harmful effects on the health and recovery. Warmth, love and understanding attention are among the essential elements for any recovery, as well as the ability to assess the intervention limits of the healthcare staff. It is important to highlight that even when the team is humanized, effective integral care for the patient without a possibility of a cure is of extreme importance, as controlling the pain and other symptoms (psychological, social and spiritual) is a priority, with the aim being to achieve a better quality of life for the patients and their relatives.

Given the above, the creation of a space in which professionals can exchange experiences, difficulties and feelings aroused by working in an ICU is suggested. This practice could be the beginning of a meaningful process in the search for more humanized care.

It is considered that the humanization process already occurs in some Brazilian hospitals. Bergamini (2008) aimed to analyze this process in an ICU of the *Instituto do Coração do Distrito Federal* (Incor-DF, Heart Institute of the Federal District), from the perspectives of the healthcare team and the clients. It was noticed that, for the clients, technical competence, attention and care provided by ICU professionals helped them to overcome and accept the treatment, as they felt protected, gratified and safe with respect to their hospitalization. In the evaluation of the healthcare professionals, they considered themselves to provide integral and humanized care, due to the existence of proper working conditions. Simultaneously, they highlighted the use of communication, touch, support, and family participation as conditions to qualify the care.

The results also showed that humanized care, from the clients' perspective, is linked to the appropriate use of available technologies, valorization of material resources, technical-scientific competence and the quality of the relationships between professionals and clients in the ICU. However, technological instruments and institutional procedures cannot prevent relatives from deciding and knowing the patients' real conditions. The evidence shows that the Incor-DF ICU is concerned with the quality of care and the promotion of humanized assistance to their clients. In this way, it is possible to support relatives who become distressed when facing an unfamiliar situation and environment that they see as aggressive and traumatizing.

It is relevant to promote studies on this theme, so that humanized intervention programs for sons/daughters and other relatives of patients in the ICU can be implemented in the city of *Recife* (PE) and other cities. Furthermore, this study allows the work of the hospital psychologist to be recognized, creating a greater demand for them.

References

Angerami-Camon, V. A. (2003). *A psicologia no hospital* (2ª ed.). São Paulo: Pioneira Thomson.

Andrade, M. A. (2003). *Introdução à metodologia do trabalho científico* (6ª ed.). São Paulo: Saraiva.

Bergamini, A. C. A. G. (2008). *Humanização em uma UTI-adulto no Distrito Federal* (Dissertação de mestrado não-publicada). Universidade de Brasília, 2008. Recuperado em janeiro 2, 2011, disponível em <http://repositorio.bce.unb.br/handle/10482/2419>.

Bettinelli, L. A., Rosa, J., & Erdmann, A. L. (2007). Internação em unidade de terapia intensiva: experiências familiares. *Revista Gaúcha de Enfermagem, 28*(3), 377-384. Recuperado em janeiro 24, 2010, disponível em <http://www6.ufrgs. br/seermigrando/ojs/index.php/RevistaGauchadeEnfermagem/article/view/4688/2595>.

Bock, A. M. B. (2003). Psicologia e sua ideologia: 40 anos de compromisso com as elites. In A. M. B. Bock (Org.), *Psicologia e o compromisso social* (pp.15-28). São Paulo: Cortez.

Bousso, R. S., & Angelo, M. (2001). Buscando preservar a integridade da unidade familiar: a família vivendo a experiência de ter um filho na UTI. *Revista da Escola de Enfermagem da USP, 35*(2), 172-179.

Campos, T. C. P. (1995). *Psicologia hospitalar*: *a atuação do psicólogo em hospitais*. São Paulo: E.P.U.

Conselho Federal de Psicologia. (2007). *Título de especialista*. Brasília: Autor.

Conselho Federal de Psicologia. (2004). Pesquisa revela perfil do psicólogo. *Jornal de Psicologia* CRP-SP, *141*, 10-11.

Di Biagi, T. M. (2002). *A atuação do psicólogo hospitalar em unidade de terapia intensiva-adulto*. Recuperado em janeiro 24, 2010, disponível em <www.alapso.org/boletin/teraointensivabrasildic2002.htm>.

Doca, F. N. P., & Costa Junior, A. L. (2011). Preparação psicológica nos serviços de psicologia pediátrica dos hospitais universitários públicos federais. *Estudos de Psicologia* (Campinas), *28*(1), 79-87. doi: 10.1590/S0103-166X2011000100008.

Franco, M. H. P., & Mazorra, L. (2007). Criança e luto: vivências fantasmáticas diante da morte do genitor. *Estudos de Psicologia* (Campinas), *24*(4), 503-511. Recuperado em janeiro 25, 2010, disponível em <http://www.scielo.br/estpsi>. doi: 10.1590/S0103-166X2011000100008.

Franco, M. H. P. (2010). Por que estudar o luto na atualidade? In M. H. P. Franco (Org.), *Formação e rompimento de vínculos*: *o dilema das perdas na atualidade* (pp.17-42). São Paulo: Summus.

Guimaro, M. S. (2003). *Grupos familiares no hospital geral*. Recuperado em janeiro 24, 2010, disponível em <www.einstein.br/psicologia/Geral/pdf/GRUPOS%20de%familiares%20-%Melissa,pdf>.

Kirchhoff, K. T., Walker, L., Hutton, A., Spuhler, V., Cole, B. V., & Clemmer, T. (2002). The vortex: Families' experiences with death in the intensive care unit. *American Jornal of Critical Care, 11*(3), 200-209. Retrieved February 7, 2010, from <http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=ADOLEC&lang=p&nextAction=lnk&exprSearch=12022483&indexSearch=ID>.

Kóvacs, M. J. (1992). *Morte e desenvolvimento humano*. São Paulo: Casa do Psicólogo.

Lamosa, B. W. R. (1990). As peculiaridades da atenção psicológica dispensada em unidades hospitalares de cardiologia. In B. W. R. Lamosa (Org.), *Psicologia aplicada à cardiologia*. São Paulo: Byk Fundo.

Lima, A. B., & Rosa, D. O. S. (2008). O sentido de vida do familiar do paciente crítico. *Revista da Escola de Enfermagem da USP*, *42*(3), 547-553, Recuperado em julho 24, 2009, disponível em <http://bases.bireme.br/cgibin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk&exprSearch= 493371&indexSearch=ID>.

Lucchesi, F., Macedo, P. C. M., & Marco, M. A. D. (2008). Saúde mental na unidade de terapia intensiva. *Revista Sociedade Brasileira de Psicologia Hospitalar, 11*(1), 19-30.

Minayo, M. C. S. (1999). *O desafio do conhecimento*: *pesquisa qualitativa em saúde* (6ª ed.). São Paulo: Abrasco.

Molter, N. C. (1979). Needs of relatives of critically ill patientes: A descreptive study. *Heart Lung*, *8*, 332-339.

Moreno, R. L. R., & Jorge, M. S. B. (2005). Sentimentos e emoções da mãe acompanhante no mundo da UTI: descrição fenomenológica de mudanças existenciais. *Revista Enfermagem UERJ, 13*(2),175-180. Recuperado em janeiro

10, 2010, disponível em <http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&src=google&base=LILACS&lang=p&nextAction=lnk &exprSearch=413363&indexSearch=ID>.

Morgon, F. H. M., & Guirardello, E. B. (2004). Validação da escala de razão das necessidades de familiares em Unidade de Terapia Intensiva. *Revista Latino-Americana de Enfermagem*, *12*(2), 250-257. Recuperado em janeiro 3, 2010, disponível em <http://www.scielo.br>.

Mota, R. A., Martins, C. G. M., & Véras, R. M. (2006). Papel dos profissionais de saúde na política de humanização hospitalar. *Psicologia em Estudo*, *11*(2), 323-330. Recuperado em agosto 25, 2012, disponível em <http://www.scielo.br>.

Nieweglowski, V. H., & Moré, C. L. O. O. (2008). Comunicação equipe-família em unidade de terapia intensiva pediátrica: impacto no processo de hospitalização. *Estudos de Psicologia* (Campinas), *25*(1), 111-122. Recuperado em janeiro 3, 2010, disponível em <http://www.scielo.br>. doi: 10.1590/S0103-166X2008000100011.

Nunes, M. A. A. (2004). A ansiedade dos familiares de pacientes internados em unidade de terapia intensiva. *Travessia, 6*(1), 209-220.

Oliveira, M. M. C., Almeida, C. B., Araújo, T. L., & Galvão, M. T. G. (2005). Aplicação do processo de relação interpessoal de Travelbee com mãe de recém-nascido internado em uma unidade neonatal. *Revista da Escola de Enfermagem da USP, 39*(4), 430-436. Recuperado em julho 17, 2010, disponível em <http://www.scielo.br>.

Paparrigopoulos, T., Melissaki, A., Efthymiou, A., Tsekou, H., Vadala, C., Pavlou, E., et al. (2006). Short-term psychological impacto on family members of intensive care unit patients. *Journal of Psychosomatic Research*, *61*(5), 719-722. Retrieved May 6, 2010, from <http://linkinghub.elsevier.com/retrieve/pii/S0022399906002753>.

Pinho, L. B., & Santos, M. A. (2008). Dialética do cuidado humanizado na UTI: contradições entre o discurso e a prática profissional do enfermeiro. *Revista da Escola de Enfermagem USP, 42*(1), 66-72. Recuperado em julho 24, 2009, disponível em <http://www.scielo.br>.

Romano, B. W. (1999). *Princípios para a prática da psicologia clínica em hospitais.* São Paulo: Casa do Psicólogo.

Saunders, C., Baines, M., & Dunlop, R. (1995). *Living with dying*: *A guide to palliative care.* New York: Oxford University Press.

Savoli, R. M. (2008). *Oração e cura*: *fato ou fantasia?* In C.P., Barchifontaine & L. Pessini. *Buscar sentido e plenitude de vida*: *bioética, saúde e espiritualidade.* São Paulo: Edições Paulinas.

Soares, M. (2007). Cuidando da família de pacientes em situação de terminalidade internados na unidade de terapia intensiva. *Revista Brasileira de Terapia Intensiva, 19*(4), 481-489. Recuperado em janeiro 24, 2010, disponível em <http://www.scielo.br>.

Tonetto, A. M., & Gomes, W. B. (2007). A prática do psicólogo hospitalar em equipe multidisciplinar. *Estudos de Psicologia* (Campinas), *24*(1), 89-98. doi: 10.1590/S0103166X2007000100010.

Urizzi, F., & Corrêa, A. K. (2007). Vivências de familiares em terapia intensiva: o outro lado da internação. *Revista Latino-Americana de Enfermagem, 15*(4), 598-604. Recuperado em janeiro 24, 2010, disponível em <http://www.scielo.br>.

Vieira, M. C. (2006). Atuação da psicologia hospitalar na medicina de urgência e emergência. *Revista Brasileira de Clínica Médica*, *8*(6), 513-519.

Wallau, R. A., Guimarães, H. P., Falcão, L. F. R., Lopes, R. D., Leal, P. H. R., Senna, R. G. A., et al. (2006). Qualidade e humanização do atendimento em medicina intensiva. Qual a visão dos familiares? *Revista Brasileira de Terapia Intensiva, 18*(1), 145-151. Recuperado em janeiro 24, 2010, disponível em <http://www.scielo.br>.

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Suicide attempts: A contingency analysis

Tentativas de suicídio: uma análise de contingências

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Abstract

The aim of this study was to understand, from the perspective of behavioral analysis, the possible antecedents and consequences of a suicide attempt for the individual responsible, using reports from patients that were hospitalized in a psychiatric hospital located in *Curitiba, Paraná,* Brazil, due to their suicide attempts. Three patients that attempted suicide in 2010 took part in this study. Semi-structured interviews were performed, which included questions about the attempt, its antecedents and consequences, and the life history of the patient. Functional analysis showed the presence of risk factors for suicide, as well as reinforcing consequences for the individuals, such as social care only being available after the attempts.

Uniterms: Functional analysis; Risk factors for suicide; Suicide attempt.

Resumo

O objetivo desta pesquisa foi compreender, sob a ótica analítico-comportamental, os possíveis desencadeantes e as consequências para o próprio indivíduo de suas tentativas de suicídio, a partir dos relatos de pacientes que foram internados em um hospital psiquiátrico de Curitiba, Paraná, em decorrência da tentativa. Participaram deste estudo três pacientes que fizeram tentativa de suicídio em 2010. Foram realizadas entrevistas semi-estruturadas, contendo questões acerca da tentativa, assim como de seus antecedentes e consequentes, além de dados sobre a história de vida a partir da análise funcional. Evidenciou-se a presença de fatores de risco para o suicídio, além de consequências reforçadoras para os indivíduos, como a atenção social, disponibilizada apenas após a realização das tentativas.

Unitermos: *Análise funcional; Fatores de risco para o suicídio; Tentativa de suicídio.*

Every year, around one million people commit suicide, and each 40 seconds somebody dies for that reason. This value refers to nearly 15% of all deaths in the world, and as such, is the tenth leading cause of fatalities (Fleischmann, 2009). Furthermore, the estimate of the World Health Organization (WHO) is that, up to the year 2020, approximately 153 million people will die due to suicide, and from 10 to 20 times more individuals will attempt it. This corresponds to one death every 20 seconds, and a suicide attempt once every 2 seconds (Bertolote & Fleischmann, 2002a).

Therefore, the performance of studies on suicide is of utmost importance because, from a clear understanding of this subject, the development of

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treatment strategies for people who attempt suicide becomes possible. In the present study, based on Applied Behavioral Analysis, the possible functions of this behavior were analyzed from the reports of individuals hospitalized due to a suicide attempt, providing the understanding of the life contingencies of individuals who contributed to this act. Through identifying these contingencies (construed as dependency relationships between behavior and environmental events), future studies may suggested the development of strategies aiming to prevent such risk behavior.

In the literature there are some disagreements about the meaning of suicidal behaviors. Thus, it becomes necessary to make some distinctions between different classes of responses involved, such as suicidal ideation, suicide attempt and actual suicide. According to clinical and epidemiological studies (Mann, Waternaux, Haas & Malone, 1999), there is the presence of a steep gradient between these behavioral classes. At one extreme is suicidal ideation, which contemplates the ideas, desires and thoughts of being dead. At the other extreme is actual suicide, the consequence of which is the death of the person. Suicide attempts are situated between these two extremes (Turecki, 1999).

A suicide attempt can be defined as an action that presents a threat to life, requiring medical attention, and was committed with the conscious intention of ending one's own life (Meleiro & Bahls, 2004). The American Psychology Association (APA) defines attempted suicide as self-injurious behavior that was not fatal, with some evidence - that can be explicit or implicit - that the individual intended to die (Jacobs et al., 2003; O'Carroll et al., 1996) The difficulty in assessing and quantifying the intention of dying in these acts must, however, be highlighted (Oliveira, Amâncio & Sampaio, 2001).

Recent studies have sought to determine what the risk factors for suicide are. Regarding gender, in Brazil as well as the majority of other countries, suicide is two to three times more common in men than in women, however, the opposite occurs in relation to attempts, with them being more frequent in women than in men (Meleiro & Teng, 2004). Men have also been found to use more lethal methods for suicide attempts or for the achievement of suicide (Dalgalarrondo, 2000; Meleiro & Teng, 2004).

The presence of a psychiatric disorder is an important factor to be considered regarding suicide rates, suicide attempt rates and suicidal ideation. According to data from the WHO, in 90% of suicide cases, the individual was suffering from a psychiatric disorder and, in the majority of cases, more than one psychiatric disorder was detected (Prieto & Tavares, 2005).

With respect to other factors related to suicide, sociologist Émile Durkheim (1897/1951) analyzed it as a social phenomenon, emphasizing factors as causes external to the individual, but not completely ruling out the individual characteristics of each suicide "We may therefore be sure that there are several sorts of suicide which are distinct in quality from one another. But the certainty that these differences exist is not enough; we need to observe them directly and know of what they consist" (Durkheim, 1897/1951, p.277).

From the Behavioral Analysis perspective, Banaco (2001) states that an issue which needs to be discussed about suicide is the fact that the same topography may present different functions, as well as different topographies having the same function. Therefore, considering suicide, its topography becomes more evident; however, from the view of Behavioral Analysis, attention must also be paid to the function of the behavior. The different types of suicidal responses, such as suicide ideation, suicide attempts and actual suicide, present a function that is clearly different in each response. In the case of the suicide attempt, for example, its consequences can be reinforcing, such as sympathy, punishment or contempt.

Sidman (2001) highlights the inability of the individual to meet the social demands, and guilt for not feeling worthy of these relationships as possible causes of suicide. This inability can cause the person to feel like a failure, which occurs when the actions of the individual produce no further positive reinforcement (the addition of something that causes his behavior to continue, that would be success) but, instead, are ignored or punished. Furthermore, some factors must be considered, such as the loss of important sources of reinforcement, as in the case of the death of a close person, or the possibility of being an escape response from situations of physical violence and humiliation (Banaco, 2001).

From the behaviorism perspective, functional behavioral analysis is an instrument that helps in the

comprehension of the variables related to suicide. According to Matos (1999), to undertake a functional analysis means identifying the adaptive value of a particular behavior, considering the environment aspects and the function of this behavior. Therefore, the purpose of this research is to comprehend the possible antecedents and consequences of the suicide attempt for the individual. From this analysis, hypotheses were produced regarding the contingencies of the life history of these individuals that led them to commit this action.

Method

The study was approved by the Research Ethics Committee of the *Universidade Positivo*, protocol nº 212/2009, in 12/10/2009, and all participants signed the terms of Free Prior Informed Consent prior to their inclusion in the study.

Participants

Participants of this study were two women and one man (P1, P2 and P3), aged 52, 49 and 36 respectively, hospitalized in a psychiatric hospital in *Curitiba* (PR), Brazil, due to suicide attempts.

Location

The study was conducted at the *Hospital Espírita de Psiquiatria Bom Retiro* (Psychiatric Hospital Bom Retiro), located in *Curitiba* (PR).

Instruments

A semi-structured interview script (containing themes concerning the life history of the individual) was formulated, including questions related to the suicidal behavior, the antecedents and the consequences of the suicide attempt.

Data Analysis

Based on the analysis of the participants' reports, a molar functional analysis was carried out in each case, which analyzed the occurrence of the suicidal behavior in a broader sense related to the life history of the individual, and a molecular analysis illustrated by frames was also performed. In the molecular functional analysis, specific situations in the life of the participants were analyzed, differentiating historical, current and immediate antecedents that contributed to the current suicide attempt.

Results

Here the information obtained and analyses conducted of the interviews of each of the cases (P1, P2 and P3) is described.

Participant P1 was 52 years of age, married and had three daughters. She had a history of psychiatric hospitalizations - the first of the 12 hospitalizations occurred at age 18. It was in this period that the suicide attempts began (approximately ten attempts, according to her account).

With regard to her familial relationship, P1 stated that the relationships with her husband and daughters were not good, because they were too distant. There was no communication with her husband and she had difficulty in expressing her feelings to him. P1 reported that she had bad thoughts, such as *"Stabbing my daughter, decapitating my mother-in-law"*, and that she felt guilty afterwards. She also stated that the relationship with her mother was bad because it was characterized by frequent punishment, and her mother usually criticized her for everything she did. When visiting her mother, she ended up feeling angry at her because of the excessive criticism and, as a result, practiced avoidance behaviors: *"So I'm avoiding going there too"* and escape behaviors: *"I leave her there cursing, hitting things and I leave..."*, not to feel bad about what her mother said to her and to avoid the aversiveness of the conflicts. The avoidance behaviors occurred even with telephone contact. When she was a child, P1 reported that she was beaten every day by her mother and, sometimes, by her brothers too. Regarding her father, now deceased, she reported that she felt very angry because he tried to rape her at age 12, and that she had tried to commit suicide several times due to this fact.

In the report of P1, risk factors for suicide present in her life become evident. There was the presence of a psychiatric disorder that was diagnosed at the hospital,

where she was hospitalized with Bipolar Affective Disorder, as well as the presentation of suicidal ideation for at least two and a half years, and previous suicide attempts. Furthermore, she reported that she had no friends, relating only to family members, which demonstrates little social support: *"Ah, I feel a little bit bad because I wish I had someone to talk to, to unburden..."* (Chart 1).

Participant P2 was 49 years of age, married, and had two daughters and a son. P2 received a diagnosis of depression made by a psychiatrist that she consulted about a year prior to the suicide attempt. She had already made other attempts, always by ingestion of medicines.

Concerning her familial relationship, P2 stated that she had relationship difficulties with her husband. According to her, he did not give her attention, did not comprehend that she had depression, did not help with housework or with the children and, furthermore, did not give her affection: *"And he is of a surly kind... . Doesn't give any affection, doesn't talk"*. She also stated that he often shouted at her and abused her. It is possible to hypothesize that, in this relationship, there was much more aversive stimulation than positive reinforcement, since most of her behavior was consequently attached to some sort of punishment. P2 could not tell her husband how she felt, and always *"kept everything to herself"*, avoiding the possible punishments that she could receive if she told him how she felt.

After this suicide attempt, P2 stated that she did not want to try it again, however, also did not know what her reaction would be when she stopped receiving the day-hospital treatment, because she always got sad when returning home. She claimed that one of the reasons for this sadness was the presence of her husband, his shouts and threats: *"Because when he is there I don't feel good I get home and feel like going back, it makes me really sad..."*. Some risk factors for suicide were present in the life of P2, such as a psychiatric disorder (depression diagnosis), as well as the presence of suicide ideation for about a month, and previous suicide attempts (Chart 2).

Participant P3 was 36 years of age, married, and had three children. In his last suicide attempt, he used several methods: blade, knife and scissor. P3 had a history of suicide attempts (did not know exactly how many), and had tried several methods, such as ingestion of medicines and a gun, as well as lying in the middle of a highway. According to his report, the suicide attempts began at the age of 10, lasting until the present moment: *"When I was a child, I already tried to kill myself... .* Then, *at*

Chart 1
Functional analysis of P1's current suicide attempt

Antecedents	Responses	Consequences
Historical History of sexual abuse perpetrated by her father and difficulties in the relationship with him. Abuse history perpetrated by a teacher and a boss (abusive relationships).	Aversive emotional state. Behavioral passivity and submission. Beginning of self-injurious behaviors in late adolescence. Medication abuse.	Continuity of the paternal abuse. Lack of coping responses. Intensification of aversive emotional state. Behavioral deficits throughout the life history. Lack of social abilities, such as communication, expression of feelings and problem solving abilities. Consequent susceptibility to other abuse.
Current Financial problems - Marital problems.	Suicide attempts. Call her mother (to complain). Visit her mother.	Psychiatric hospitalizations. Mother criticizes her and starts verbal conflicts (punishment). She becomes to avoid calling and visiting her mother.
Immediate Presence of bad thoughts. Report: "Of stabbing, of decapitating my mother-in-law", "Because I keep on thinking, keep, keep, keep, keep it in my head... it was really bad".	*Current suicide attempt* Ingestion of medicine. Covert behaviors: bad thoughts. Feelings: anxiety and nervousness. Was voluntarily hospitalized in a psychiatric institution.	Her family did not realize that she had ingested the medicine - absence of reinforcement. The medicine did not have a lethal effect - absence of reinforcement. Physical discomfort, feelings od frustration due to her underachievement, regret regarding the attempt, indifference from the hospital's patients - positive punishment.

Chart 2
Functional analysis of P2's current suicide attempt

Antecedents	Responses	Consequences
Historical Aversive situations. Psychological violence.	Staying quiet, not expressing her feelings. Behavioral passivity. Frequent crying. Internalizing behavior: doesn't demonstrate or talk about her feelings.	Continuity of the psychological violence. Behavioral deficits throughout the life history. Lack of coping responses.
Current Marital difficulties. Marital fights: arguments, physical aggressions by her husband and psychological violence. Privation of social contact.	Behavioral passivity. Feels fear, anguish, tightness in the chest. Depressive behaviors: isolation, sadness, frequent crying.	Continuity of the fights. He behavioral passivity reinforces her husband's aggressive behavior. Her husband gets angry with her depressive behavior, shouting and arguing (positive punishment).
Depression Biological factors. Environmental factors: lack of social support, domestic violence, moving from hometown - father's rule "The woman must follow her husband".		
Immediate Covert behavior and death wishes. Thoughts: that nothing ever goes well in her life. Feelings of sadness.	*Current suicide attempt* Ingestion of medicine.	The husband and the youngest daughter understood the attempt and helped her (positive reinforcement - social attention). Was hospitalized (in an Intensive Care Unit) due to the ingestion of medicine (positive punishment), and received familiar support (positive reinforcement).

Chart 3
Functional analysis of P3's current suicide attempt

Antecedents	Responses	Consequences
Historical History of sexual and physical abuse perpetrated by his aunt, in childhood.	Aversive emotional state. Fear, shame and anger.	Lack of coping responses. Continuity of the abuse throughout the childhood. The people in his environment did not realize the abuse was occurring (possible neglect).
Current Memories of the abuse that occurred in childhood.	Cries, gets "revolted", feels anger because suffered the abuse. Discouragement, low self-esteem, self-devaluation and excessive self-criticism.	Death wishes - Expectation that death would cause the aversive stimulation (suffering and memories of the abuse) to cease. At the time, he did not exposes these behaviors; the lack of environmental changes reinforced the idea that his presence is indifferent. The people in his environment did not pay attention to his behavior (absence of reinforcement).
Immediate Low environmental responsiveness. He was hearing voices that told him he just bothers people, and that he should end his life. He was feeling sad.	*Current suicide attempt* Has used several methods (blade to cut his wrists, stuck a pair of scissors in his neck and stabbed himself). Feeling of sadness, anger, anguish and desire for an end to his suffer.	His wife and children hold him after he carried out several self-injurious behaviors. He was taken to the general hospital. Received social attention from his family (positive reinforcement). Pain as a result of injuries (positive punishment). He exposes the marks of the injuries, thus positive reinforcement is possible, such as social attention.

10 I tried again; at 12, once more... and so it goes on". P3 reported that he suffered a lot and attributed this suffering to the abuse, perpetrated by his aunt, during his childhood; to the goals that he failed to achieve; and to his interpersonal difficulties.

It is possible to identify, in the report of P3, that his suicide attempts perform, at a high level, functions of escape and avoidance, because he reported that he wanted to die to end his suffering. It is also possible to identify, in the report of P3, some risk factors for suicide, such as a psychiatric disorder (diagnosed at the psychiatric hospital), suicidal ideation, and previous suicide attempts (the high level of potential lethality of the attempts should be noted), in addition to the lack of social support, since P3 had no friends (Chart 3).

The data obtained corroborate issues raised by other authors (Barrero, Guerra, Anaya & Lopez, 1997; Bertolote & Fleischmann, 2002b; Prieto & Tavares, 2005; Turecki, 1999) in relation to suicide risk factors, such as the presence of suicidal ideation, previous suicide attempts, and the presence of a mental disorder. These factors were present in the life of all three participants. Furthermore, they allow the discussion of the factors, in each life history of these individuals, which contributed to the realization of this act, as well as the maintenance of this behavior. Considering that, in the three cases, the participants revealed a history of previous suicide attempts, the identification of the consequences of their attempts, through functional analysis, allows the formulation of hypotheses regarding the consequences of these attempts that will increase or decrease the probability of a recurrence of this behavior.

Discussion

In order to expand the epidemiological profile of suicide, quantitative studies are being published each year, emphasizing the risk factors (Barrero et al., 1997; Botega et al., 2009; Hesketh & Castro, 1978; Kuo, Gallo & Tien, 2001; Mello-Santos, Bertolote & Wang, 2005; Nápoles, Sorí, Concepción & Garcia, 1998). Nevertheless, little is known about how these risk factors are related to suicidal behavior, considering the life history of these individuals, as well as the context in which they are included (Hjelmeland & Knizek, 2010).

The realization of the functional analysis with the reported cases allowed the formulation of hypotheses about the function of these suicide attempts, according to the life history of each participant. A common characteristic to all of them was the presence of suicide risk factors, which can be considered as antecedents of the attempt. One of these factors was the report about the diagnosis of mental disorders prior to the current attempt (P1: bipolar disorder, P2: depression, and P3: bipolar disorder and depression). Studies concerning suicide and suicide attempt risk factors highlight the existence of a high correlation between these behaviors and the diagnosis of a psychiatric disorder (Prieto & Tavares, 2005). According to the WHO, in approximately 90% of suicide cases there was the presence of a mental disorder, the most frequent being the mood disorders, schizophrenia, personality disorders and substance-related disorders, with the individual possibly having been diagnosed with more than one disorder (Bertolote & Fleischmann, 2002b; Pietro & Tavares, 2005). Other risk factors present in the life of all three participants were suicidal ideation and previous suicide attempts. According to Botega, Barros, Oliveira, Dalgalarrondo and Marín-León (2005), it is possible to perceive a correlation between suicidal ideation and previous suicide attempts (Barrero et al., 1997; Prieto & Tavares, 2005; Turecki, 1999). The occurrence of one or more previous suicide attempts is the main risk factor for suicide (Botega et al., 2005; Botega et al., 2009; Prieto & Tavares, 2005; Suominen et al., 2004), with the estimate that 12% to 15% of survivors of suicide attempts go on to commit suicide (Meleiro & Teng, 2004; Suominen et al., 2004) - and that this number may increase to 40% (Nápoles et al., 1998).

A history of physical, psychological or sexual violence also has a great influence as a risk factor for suicide (Meleiro & Teng, 2004). In the case of sexual violence, identified in the life histories of P1 and P3, it can affect the development of children and adolescents in several ways, being considered a risk factor for the development of psychopathologies (Habigzang, Koller, Azevedo & Machado, 2005), as well as for future suicide attempts (Brodsky et al., 2001; Dube et al., 2001; Johnson et al., 2002; Meleiro & Teng, 2004; Turecki, 1999; Wilde et al., 1992). In the cases of P1 and P3, the suicide attempts began from the occurrence of the first abuse or abuse attempt, both in childhood. The abuse was reported as

an important historical antecedent for the establishment of the suicidal ideation and subsequent suicide attempts.

Through the reports of the participants of this study, it can be inferred that they were in situations of social attention deprivation (especially from their families) during the period prior to the suicide attempts. According to Sidman (2001, p.133) "The sympathy that becomes available only after 'unsuccessful' suicides encourages further probable attempts". Thereby, the behavior of attempting suicide remains due to the positive reinforcing consequences (social attention of the family). According to Skinner (1953/2005, p.143) "A given act of deprivation usually increases the strength of many kinds of behavior simultaneously". In this way, it can be concluded that, at the time that the individuals were deprived of social attention, other types of behavior were probably started, and suicide attempts were effectively reinforced. Therefore, the double effect of social attention in suicide attempts becomes evident. At the same time that it protects the life of the individual (because the family may be engaged in helping or in contention behavior toward the individual in risk) it can also positively reinforce the attempt (as the only manner for the individual to obtain this reinforcement). In relation to this topic, Sidman (2001, p.133) states that:

> If we follow the practice-pattern of Behavior Analysis, identifying what really succeeded after the attempts of self-destruction, it is probable that we will find the suicidal person becoming an object of attention and caring, the receiver of attention and sympathy. Guilt softens harsh voices, looses restrictions and replaces threats with promises of help.

However, some time after the suicide attempts, the environment again becomes coercive, and, as the previous attempt produced reinforcement, the individual may try to end his own life once more (Sidman, 2001). It is also important to consider that, each time, the environment requires responses closer to the final behavior - in this case, suicide "The environment gradually responds with a requirement for a higher intensity suicide attempt to elicit the same response" (Sidman, p.213). That is, it is necessary that the individual increase the potential lethality of the attempts to gain reinforcement (Banaco, 2001), which becomes evident from the report of P3's suicide attempts, who used more lethal methods in each subsequent attempt.

Based on the reports of the participants, it was established that the suicide attempt presents avoidance and escape functions from the aversive situations experienced by them. Considering that the participants reported a repertoire of problem-solving deficits, they started performing escape and avoidance behaviors, in order to cease or avoid further contact with the aversive stimuli present in their lives.

As is the case for all behavior, the suicide attempt is selected due to its consequences. Thus, it becomes essential to functionally analyze this behavior, in order to reflect on interventions in these reinforcement contingencies. Furthermore, it is necessary to offer guidance to the family and friends of the patient to enable appropriate management of the situation.

It is noteworthy that certain factors may have brought limitations to this study. First, the sample consisted exclusively of patients admitted to a psychiatric institution due to suicide attempts, and all the participants had previously received a mental disorder diagnosis. For a deeper analysis of all the cases, further studies could carry out interviews with the family of the participants, enabling a broader comprehension of the contingencies involved in the cases.

Final Considerations

The results of this study evidenced the presence of several risk factors for suicide present in the life history of the participants, as well as the presence of reinforcing consequences of the attempt. It demonstrates the tendency of such behavior to remain throughout life if there is no intervention. From a thorough comprehension of the factors related to the suicide attempts of each individual in particular, more effective strategies can be developed for each case. Therefore, it becomes extremely necessity to undertake more qualitative studies in the area of suicide, which can complement the various quantitative studies that are realized every year.

References

Banaco, R. A. (2001). Um levantamento de fatores que podem induzir ao suicídio. In H. J. Guilhardi, M. B. B. P. Madi, P. P. Queiroz & M. A. Scoz (Orgs.), *Sobre comportamento e cognição* (pp.210-217). São Paulo: Esetec.

Barrero, S. P., Guerra, L. A. R., Anaya, T. P., & López, R. C. (1997). Factores de riesgo suicida en adultos. *Revista Cubana de Medicina General Integral*, *13*(1), 7-11.

Bertolote, J. M., & Fleischmann, A. (2002a). A global perspective in the epidemiology of suicide. *Suicidologi*, *7*(2). Retrieved October 2, 2009, from <http://iaspinfo/pdf/papers/Bertolotepdf>.

Bertolote, J. M., & Fleischmann, A. (2002b). Suicide and psychiatric diagnosis: A worldwide perspective. *World Psychiatry*, *1*(3), 181-185.

Botega, N. J., Marín-León, L., Oliveira, H. B., Barros, M. B. A., Silva, V. F., & Dalgalarrondo, P. (2009). Prevalência de ideação, plano e tentativa de suicídio: um inquérito de base populacional em Campinas, São Paulo, Brasil. *Cadernos de Saúde Pública*, *25*(12), 2632-2638.

Botega, N. J., Barros, M. B. A., Oliveira, H. B., Dalgalarrondo, P., & Marín-León, L. (2005). Suicidal behavior in the community: Prevalence and factors associated with suicidal ideation. *Revista Brasileira de Psiquiatria*, *27*(1), 45-53.

Brodsky, B. S., Oquendo, M., Ellis, S. P., Haas, G., Malone, K. M., & Mann, J. J. (2001). The relationship of childhood abuse to impulsivity and suicidal behavior in adults with major depression. *American Journal Psychiatry*, *158*(1), 1871-1877.

Dalgalarrondo, P. (2000). *Psicopatologia e semiologia dos transtornos mentais*. Porto Alegre: Artmed.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *The Journal of the American Medical Association*, *286*(24), 3089-3096.

Durkheim, E. (1951). *Suicide*: *A study in sociology*. New York: The Free Press. (Original worky published 1897).

Fleischmann, A. (2009). Suicide prevention in different cultures. In World Health Organization. *World suicide prevention day*. Retrieved March 18, 2010, from <http://www.who.int/mental_health/prevention/suicide/wspd_2009_statementpdf>.

Habigzang, L. F., Koller, S. H., Azevedo, G. A., & Machado, P. X. (2005). Abuso sexual infantil e dinâmica familiar: aspectos observados em processos jurídicos. *Psicologia*: *Teoria e Pesquisa, 21*(3), 341-348.

Hesketh, J. L., & Castro, A. G. (1978). Fatores correlacionados com a tentativa de suicídio. *Revista Saúde Pública, 12*, 138-146.

Hjelmeland, H., & Knizek, B. L. (2010). Why we need qualitative research in suicidology. *Suicide and Life-Threatening Behavior*, *40*(1), 74-80.

Jacobs, D. G., Baldessarini, R. J., Conwell, Y., Fawcett, J. A., Horton, L., Meltzer, H., et al. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American Psychiatric Association, 160*(11 Suppl.), 1-60. Retrieved May 15, 2011, from <http://polsilver chaircom/pracGuide/PracticePDFs/SuicidalBehavior_Inactivated_04-16-09pdf>.

Johnson, J. G., Cohen, P., Gould, M. S., Kasen, S., Brown, J., & Brook, J. S. (2002). Childhood adversities, interpersonal difficulties, and risk for suicide attempts during late adolescence and early adulthood. *Archive of General Psychiatry*, *59*(8), 741-749.

Kuo, W. H., Gallo, J. J., & Tien, A. Y. (2001). Incidence of suicide ideation and attempts in adults: The 13-year follow-up of a community sample in Baltimore, Maryland. *Psychological Medicine*, *31*(7), 1181-1191.

Mann, J. J., Waternaux, C., Haas, G. L., & Malone, K. M. (1999). Toward a clinical model of suicidal behavior in psychiatric patients. *American Journal of Psychiatry, 156,* 181-189.

Matos, M. A. (1999). Análise funcional do comportamento. *Estudos de Psicologia* (Campinas), *16*(3), 8-18.

Meleiro, A. M. A. S., & Bahls, S. (2004*). O comportamento suicida*. In A. M. A. S. Meleiro, C. T. Teng & Y. P. Wang (Orgs.), *Suicídio*: *estudos fundamentais* (pp.13-36). São Paulo: Segmento Farma.

Meleiro, A. M. A. S., Teng, C. T. (2004). *Fatores de risco de suicídio*. In A. M. A. S. Meleiro, C. T. Teng & Y. P. Wang (Orgs.), *Suicídio*: *estudos fundamentais* (pp.109-132). São Paulo: Segmento Farma.

Mello-Santos, C., Bertolote, J. M., & Wang, Y. P. (2005). Epidemiology of suicide in Brazil (1980-2000): Characterization of age and gender rates of suicide. *Revista Brasileira de Psiquiatria, 27*(2), 131-134.

Nápoles, L. A., Sorí, G. H., Concepción, D. A., & García, T. C. (1998). Conducta suicida: factores de riesgo asociados. *Revista Cubana de Medicina General Integral*, *14*(2), 122-126.

O'Carroll, P. W., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (1996). Beyond the Tower of Babel: A nomenclature for suicidoloy. *Suicide and Life-Threatening Behavior*, *26*(3), 237-252.

Oliveira, A., Amâncio, L., & Sampaio, D. (2001). Arriscar morrer para sobreviver: olhar sobre o suicídio adolescente. *Análise Psicológica*, *4*(19), 509-521.

Prieto, D., & Tavares, M. (2005). Fatores de risco paro o suicídio e tentativa de suicídio: incidência, eventos estressores e transtornos mentais. *Jornal Brasileiro de Psiquiatria*, *54*(2), 146-154.

Sidman, M. (2001). *Coerção e suas implicações*. Campinas: Livro Pleno.

Skinner, B. F. (2005). *Science and human behavior*. Cambridge: The B. F. Skinner Foundation. (Original work published 1953).

Suominem, K., Isometsä, E., Suokas, J., Haukka, J., Achte, K., & Lönnqvist, J. (2004). Completed suicide after a suicide attempt: A 37-year follow-up study. *The American Journal of Psychiatry, 161*(3), 562-563.

Turecki, G. (1999). O suicídio e sua relação com o comportamento impulsivo agressivo. *Revista Brasileira de Psiquiatria*, *21*(2), 18-22.

Wilde, E. J., Kienhorst, I. C., Diekstra, R. F., & Wolters, W. H. (1992). The relationship between adolescent suicidal behavior and life events in childhood and adolescence *American Journal of Psychiatry, 149*(1), 45-51.

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Youth leadership: A proposal for identifying and developing creativity and giftedness

Liderança em jovens: uma proposta para identificação e desenvolvimento da criatividade e superdotação

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Abstract

There is a considerable amount of literature on leadership, particularly as it relates to organizations, government, and the military. However, educators and psychologists know considerably less about early precursors of leadership, how leadership develops in youth, possible gender differences, and the relationship of leadership, intelligence and creativity. A global consensus exists that leaders are needed and that we shouldn't delay the early development of leadership skills. The authors propose a model to enhance creative leadership and introduce a teacher-completed rating scale, the Gifted Rating Scales to help accomplish this. As demonstrated, there are possibilities to detect early creative and intellectual giftedness among children and youngsters in the classrooms and expectations to move from a basic level of competence to reach an elite or expert level in any field, facilitating the emergence of leadership.

Uniterms: Creativity; Giftedness; High ability; Intelligence; Leadership.

Resumo

O tema da liderança vem sendo debatido intensamente na literatura, principalmente no ambiente empresarial, governamental e militar. Entretanto, o conhecimento é bastante escasso entre os educadores e psicólogos sobre os indicadores da liderança, ou melhor, como a liderança se desenvolve entre os jovens, possíveis diferenças de sexo, e a relação da inteligência com a criatividade. Os autores apresentam um modelo para estimular a liderança criativa assim como uma escala para professores avaliarem superdotação a fim de atingir este objetivo. Como demonstrado, existem possibilidades de detectar a superdotação intelectual e criativa entre crianças e jovens e expectativas de superação de um nível básico de competência para atingir o de especialista ou esperto, em qualquer área, permitindo assim o aparecimento da liderança.

Unitermos: *Criatividade; Superdotação; Alta habilidade; Inteligência; Liderança.*

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Youth leadership: Relationship to giftedness and creativity

Over 10,000 books and articles in the English language have been written on leadership. Very likely many hundreds of books and articles in Portuguese have been written on this topic, as well. We know a great deal about leaders, particularly when related to organizations, government, and the military. However, educators and psychologists know considerably less about early precursors of leadership, how it develops in youth, and its relationship to intelligence. In fact, it is unclear whether leadership is best viewed as an aptitude or ability, as a set of interpersonal skills, a personality style, or some combination (Pfeiffer, 2001; 2012a).

In the United States (US) a number of youth organizations have played important roles in creating early leadership opportunities for youth. For example, a widely recognized youth organization, the Boy Scouts of America, celebrated its 100th anniversary in 2010. In the US today, nearly 4 million youth are members of the Boy and Girl Scouts. Scouting is hugely popular internationally. In Indonesia this organization exceeds 8 million; there are almost 2,7 million scouts in India and in Brazil there are over 60,000 scouts (União dos Escoteiros do Brasil, 2011; World Scout Bureau, 2008). There are many youth organizations worldwide which emphasize group activities, character development, and civic engagement. This article discusses what we know and don't know in terms of youth leadership development. Can it be taught? Should it be taught? The article proposes how youth leadership fits within gifted education.

What is leadership?

There is no one universally accepted definition of leadership. However, it is clear that leadership is persuasion; it involves influencing other people to pursue a common goal that is considered important or relevant to the group. Leadership should not be viewed as domination; at its best leadership requires others to willingly adopt the goals or mission of the group as their own. Leadership requires creating a shared vision, building trust and confidence in others, and enabling others to act toward a common goal.

Fieldler (1967) developed a contingency or situational theory of leadership, proposing that three situational dimensions influence the leader's effectiveness: leader-member relations, task complexity/ structure, and the power inherent in the leadership position. Fielder's leadership model implied that leadership style is difficult to change. Hersey, Blanchard and Johnson (2007) extended Fielder's model and articulated a 3-dimensional approach for assessing leadership effectiveness. Their situational leadership model suggests that successful leaders do adjust their styles, recognizing the importance of the leader's task and relationship behaviors, and how the individual's leadership style interfaces with the task situation. They contend that successful leaders are those who can adapt their behavior to meet the demands of their own unique situation. Adaptability is central to this model (Hersey et al., 2007).

One influential popular lecturer is Warren Bennis, whose writings introduced leadership to the North-American public. Bennis (2003), a Professor at the University of Southern California, argues that leadership is not a rare skill or inborn trait; he posits that leaders are made rather than born, and that leaders need not be charismatic or brilliant individuals to be successful (Bennis & Biederman, 1997; Bennis & Goldsmith, 2010). Bennis does not view leadership as an innate ability. He would *not* conceptualize leadership talent based on high general cognitive ability ("*g*")-how some in the gifted field view intelligence (Gottfredson, 1997). His believes that effective leaders are able to create compelling visions, elicit trust, optimism and hope in others, and translate their visions into actionable plans.

A broader perspective of leadership was offered by Vroom and Jago (2001), emphasizing the role played by the situation or environment in leadership expression. According to their view, leadership is a process rather than a trait of a person, and the situation shapes how leaders behave. Their theory emphasizes the importance of a favorable climate for leadership emergence and the influence of certain values and support for creative ideas to flourish (Ekvall, 1996). The role of the environment is crucial (Crespo & Wechsler, 2000). Certain leadership styles may be more facilitative in certain settings than others, or more valued according to specific goals sought by the group (Wechsler, 2009a). Leadership styles are also influenced, by gender, as women tend to be more intuitive and look for consensus in a group than men

(Wechsler, 2009b), and these differences should be considered when trying to identify youth with high leadership potential (Pfeiffer, 2012b).

Contemporary views on giftedness

Contemporary theorists no longer view giftedness and high Intelligence Quotient (IQ) as synonymous (Borland, 2009; Foley & Pfeiffer, 2011; Keating, 2009; Pfeiffer, 2012a; 2012b; Sternberg, Jarvin & Grigorenko, 2011). A number of authorities now advocate for a paradigm shift, suggesting that the gifted field adopt a talent development perspective. This perspective envisions optimizing developmental pathways to expertise and accomplishment in culturally valued domains (Pfeiffer, 2012c; Subotnik, 2003; 2009).

This paradigm shift is away from viewing giftedness as the same as high IQ or something permanent. The traditional view of giftedness has long posited the pre-eminence of general intellectual ability, and is perhaps best represented by the work of Gottfredson (1997; 1998). The new *zeitgeist* views giftedness from a developmental perspective. This new perspective views giftedness as emerging expertise, based on more than simply high general intellectual ability - rather, giftedness is conceptualized as the dynamic and synergistic interaction of multiple factors; general aptitude in dynamic relationship with a host of specific abilities, motivation, personality, and passion for a specific field or domain (Pfeiffer, 2012c). This new model views giftedness as the unfolding and transforming of potential into actual outstanding performance and accomplishments in adulthood.

Leadership can also be defined as a synthesis of intelligence, creativity and wisdom as proposed by Sternberg (2004), thus indicating that cognitive aspects interact with social and personality characteristics. Therefore, there is the need of early identification of youth with uncommon general and specific abilities, personality characteristics and attitudes associated with leadership potential, and the importance of having an adult who can serve as a mentor. From a talent development model, the goal is promoting leadership competence and even expertise among a cadre of young adolescents who exhibit early precursors of leadership (Keating, 2004; Pfeiffer, 2009).

This new and contemporary view of giftedness, particularly as applied to leadership, is based on seven principles: 1) Early identification of giftedness remains important. However, early identification should never be based exclusively on one IQ score; 2) Gifted assessment should be multifaceted and multidimensional. General intellectual ability is one important factor, but other psychological measures and constructs should be included, with due consideration of characteristics associated with leadership behavior (e.g., verbal expressive skill); 3) The measures that we use to assess giftedness must change as a child gets older, more aligned with a domain-specific focus on leadership; 4) The goal of gifted education becomes finding ways to nurture and optimize bright students' development in one or more culturally-valued fields - in this instance, the development of leadership; 5) Not all children identified at an early age as gifted will continue on a success path or trajectory toward expertise; many will not distinguish themselves in their later years as gifted leaders; 6) Many children not identified in the early years as gifted are late bloomers; and 7) Gifted programs in the schools will be successful to the extent that they focus on domain-specific curricula which matches each student's unique abilities and interests.

Characteristics of effective leaders

Several taxonomies of leadership behaviors have been proposed. Hundreds of leader behaviors have been written about in both the popular and academic leadership literatures. The following categories of behaviors and characteristics have appeared most frequently: planning; organizing; problem solving and competence; creative; innovative; motivating and inspiring; forward-looking; supportive and caring; managing conflict and team building; delegating; courageous (Pfeiffer, 2009).

A large, international study by Kouzes and Posner (2009) invited participants to comment on what they look for and admire in their leaders. Over 75,000 people participated in this investigation. The top four-ranked leadership characteristics were: honesty, forward-looking, inspiring, and competent. These findings were corroborated in ten countries. Honesty emerged as the single most important factor; leaders are expected to

inspire trust, be principled, know right from wrong, and have integrity. The ability to look ahead and share a vision for the future was consistently recognized as a critical leadership skill. Leaders must also be enthusiastic, energetic, optimistic, and communicate a positive view for the future. Finally, leaders must bring relevant experience and sound judgment to the task-if they hope to inspire confidence they must have a track record of success and ability to get things done. Similar characteristics for effective leaders were identified by Brazilian managers and their employees. The adjectives mostly indicated by them were honesty, comprehension, objectivity, creativity, flexibility and self confidence (Mundim & Wechsler, 2007).

Recent breakthroughs in the study of the physiology of the brain provide fascinating insights into the neuroscience of leadership. Imaging technologies such as *functional* Magnetic Resonance Imaging (*f*MRI) and Positron Emission Tomography (PET), in conjunction with brain wave analysis technologies such as Quantitative Electroencephalography (QEEG), have helped identify important linkages between the brain and how we perceive, think, feel, and act-even with brain processing during creative problem solving (Angelakis et al., 2007; Chang et al., 2002; Collura, Thatcher, Smith, Lombos & Stark 2009; Fink & Neubauer, 2006; Freed, Yanagihara, Hirsch & Mann 2009; Jaušovec, 2000; Mölle, Marshall, Wolf, Fehn & Born, 1999; Rodriguez-Moreno & Hirsch, 2009). These findings have implications for leadership. For example, brain research confirms that change is difficult because it provokes sensations of physiological discomfort. Trying to change any hardwired behavior requires considerable effort and will be resisted by the basal ganglia, the habit-center part of the brain that operates in large part without conscious thought.

Messages from effective leaders must be able to shift our focus from experiencing fear - what Goleman (1995) poetically describes as preventing "amygdale hijack", to drawing our attention and metabolic energy to the frontal and prefrontal regions of our brain. Leaders have the best chance of encouraging others to take risks and entertain change if their message connects with the prefrontal region of the brain, and not the more primitive and older parts of our mammalian brain, remnants of our evolutionary history.

Identifying youth leadership, giftedness and creativity

From the above brief overview, the reader can see that we know a lot about adult leadership. We know considerably less about precursors of early leadership, or how best to encourage, teach or develop leadership skills and competencies in children and youth (Matthews, 2004; Pfeiffer 2009). For example, we know very little about gender differences and early leadership potential or whether there are a set of characteristics that consistently predict to adult leadership competence (Pfeiffer, 2012c). Over 25 years ago in the US, federal definitions of giftedness included leadership ability as one type of giftedness. In Brazil, the definition of high abilities/gifted individuals also include leadership as one of their characteristics (Brasil, 2001). Thus, many gifted authorities contend that youth leadership training is important (Karnes & Chauvin, 2000).

Some have argued that adult leadership models are not applicable to leadership among youth; others see important conceptual parallels and practical similarities between youth and adult leadership. However, youth leadership remains under-theorized and marked by few well-designed studies. For example, many gifted authorities suggest that youth leadership requires creative problem solving ability and at least moderately high intellectual ability. This view represents an "IQ threshold" point-of-view; its proponents suggest that one needs an IQ of at least 115 or 120 to be a successful leader. This idea parallels the view of some authorities in the creativity field who suggest that there is a similar IQ threshold needed for producing creative or innovative ideas or products (Kaufman, 2009). This remains a plausible but untested assumption in both the creativity and leadership fields (Pfeiffer, 2008; 2012c).

Assessing the gifted is a challenging task. The Gifted Rating Scale-School Form (GRS) was developed to help identify giftedness in children ages 6.0 to 13.11 (Pfeiffer & Jarosewich, 2003, 2007). The GRS is based on a multidimensional model of giftedness presenting six scales, including intellectual ability, motivation and leadership. The GRS classification system indicates the *likelihood* that a student is gifted in leadership or one of the other gifted areas.

The Gifted Rating Scale-School Form leadership scale consists of 12 items that reflect the child's ability

to motivate others toward a common or shared goal. Three illustrative leadership items are: demonstrates good social judgment, earns the respect and trust of others, and makes things happen. A number of international studies, including work in Brazil, indicate that the GRS is reliable and valid (Lee & Pfeiffer, 2006; Li, Lee, Pfeiffer, Kamata & Kumtepe, 2009; Li, Pfeiffer, Petscher, Kumtepe & Mo, 2008; Pfeiffer & Petscher, 2008; Pfeiffer, Petscher & Kumtepe, 2008; Rosado, Pfeiffer & Petscher, 2008).

The Gifted Rating Scale-School Form leadership scale has been used in youth leadership development programs to measure student growth and progress. There are other measures of youth leadership (Karnes & Chauvin, 2000), although the GRS enjoys the most research and empirical support as a brief but accurate measure of youth leadership potential. An article in *The School Psychologist* provides a methodology to measure change in leadership skills using the GRS (Pfeiffer, Kumtepe & Rosado, 2006). A pilot leadership intervention program is underway in Florida and includes the following components: leadership curriculum; exposure to a variety of leadership opportunities in the community; interaction with acknowledged adult leaders; challenging service-learning projects; and self-reflection papers. Future research will hopefully further identify reliable and robust early predictors of leadership and help generate one or more new models on early leadership potential among youth.

We do not believe that every youth can develop into a gifted leader. However, almost any adolescent, if provided appropriate opportunities and adequately motivated, can learn new, and refine existing, skills and values which are associated with effective leadership (Pfeiffer, 2001). For example, even young children can learn the nuances of social judgment and become more adept at recognizing the feelings of others. Some children, because of a combination of aptitude, personality, temperament, motivation, and passion for leadership and helping others, will develop into gifted leaders. Participation in community-based and youth leadership programs can provide unique opportunities for early exposure to leadership roles and observing important skills associated with leadership.

Creativity

Just about everyone agrees that creativity is important and valued in today's society (Sternberg et al., 2011). Chief Executive Officers (CEO) of fortune 500 companies and popular business self-help books identify creativity as a critical leadership skill (Pfeiffer & Thompson, 2013). Creativity is valued in almost every field, in both US and Brazilian societies including medicine, the sciences, engineering, the arts, and law. It is almost impossible to think of a profession that doesn't hold in the high regard innovation, ingenuity, and imagination. The importance of innovation to Brazilian society was recognized by federal law (Brasil, 2004).

And yet in today's schools we continue to place too much emphasis on a standardized curriculum, rote learning of facts, and memorization. A great number of schools today still focus considerable time and resources on the learning and recall of information. We ask our students to learn to define, describe, identify, know, label, match, name, recall, and recognize information, when viewed from a well-known taxonomy of learning objectives (Bloom, 1956). Schools demand less of students in terms of higher-level cognitive skills, including understanding, applying, analyzing, evaluating and creating. It is difficult to understand how any country can pursue high creativity and innovation, and be globally competitive, if their schools don't emphasize creative thinking (Wechsler, 2011).

What exactly is creativity? Creativity reflects a particular way in which individuals think, solve problems or produce art or products in a given field. To others, creativity represents certain people who are endowed with certain cognitive and personality characteristics which make them more likely to be innovative. A number of authors distinguish between four different perspectives in defining what we mean by creativity: creativity in terms of how creative a product is, a particular process or way of thinking about things, particular persons with a lot of creative ability, and aspects of the environment that either facilitate or impede the expression of creativity (Kaufman, 2009; Rhodes, 1962). Creativity can be understood as a multidimensional concept, involving a combination of cognitive processes, personality characteristics, and environmental variables (Wechsler, 2008).

Classrooms vary in terms of the degree to which they are conducive or favorable to the development of creativity, including creative leadership. Creativity is one

important component and expression of gifted expertise (Pfeiffer, 2012b). As the student progresses through schooling, he gains increased factual, conceptual and procedural knowledge, and gains increasing experience and competence in one or more fields. As part of this developmental progression, the student begins to demonstrate increased domain-specific creativity. This is consistent with what is known in the creativity field as domain specificity (Baer, 1998, 2011). Individuals demonstrate significant individual differences in terms of their potential for and capacity to be creative, as well as their potential or capacity to be distinguished leaders.

Most of the research with high ability students has been at a crossroads between the *Big C* (expressions of creativity among high ability students on a trajectory toward outstanding - and innovative -, leadership performance) and the *Little C* creativity of everyday life (Kozbelt, Beghetto & Runco, 2010; Richards, 2007). Children and adolescents, even those who test at very high levels of intellectual ability vary in terms of their capacity for creative expression. This does not mean that kids are either creative or not creative, as born either creative or uncreative (Plucker, Beghetto & Dow, 2004). However, individuals demonstrate significant individual differences in terms of their potential for and capacity to be creative and their potential or capacity to be distinguished leaders. This is based on the synergetic interaction of genetic, intellectual, temperamental, personality, attitudinal, and environmental factors. As we have said, classrooms also vary in terms of the degree to which they are conducive or favorable to the development of creativity, including creative leadership. The flow experience, which is the intensive concentration in a task due to great motivation has been emphasized as one important condition to develop creative learning (Csikzentmihalyi, 1990).

To be creative, an idea or work must be original, novel and distinctive. And to be creative, an idea or work must not only be original, novel and distinctive, but also judged to be relevant, appropriate, useful, beneficial, helpful, valuable, and/or aesthetically pleasing (Plucker et al., 2004; Pfeiffer, 2012a; Sternberg & Kaufman, 2010). What remains unclear - and still un-researched at the moment -, is whether there is a causal relationship between giftedness, early leadership potential, and creativity. One would suspect that these three constructs are related, but we will need to be patient and await research studies that investigate this intriguing hypothesis.

Schools represent the existing values in families and the community. Creative students are often seen as non-conformers or questioning the status quo. It is not difficult to understand why creativity is not encouraged; on the contrary, it often is suppressed in the elementary grades. In both the US and Brazil the level of creativity decreases over the course of schooling (Nakano & Wechsler, 2006; Torrance, 1979; Wechsler & Richmond, l982). As mentioned earlier, the emphasis on rote learning of facts and memorization does not encourage divergent thinking and intellectual risk taking. Creative thinking styles in the classroom are often discouraged (Fleith, 2006; Siqueira & Wechsler, 2004).

In Brazil, federal law defines and regulates the pedagogy and guidance provided to students with special needs, including gifted and high ability students (Brasil, 2011). According to this law, schools are required to provide opportunities for talent identification and development, with challenging tasks in the regular or special curricula for gifted students. However, there is a considerable gap between this "desire for excellence" and actual practice. Teachers often lack the preparation, motivation or resources to provide differential learning opportunities (Fleith, 2008; Wechsler & Souza, 2011). There is an urgent need to better prepare teachers to identify and develop leadership talent (Alencar, 2000; Wechsler & Nakano, 2011).

We view creativity as one component of the unfolding of talent in any culturally-valued field or domain, including leadership. The unfolding and nurturance of creativity, as part of gaining expertise and even distinguished status as a leader, recognizes eight components. First, it is still debated if a minimal threshold of general intellectual ability is necessary for students to reach a level or expertise as a leader. Although a high level of intellectual ability is necessary for creativity in certain academic fields, it is not sufficient as other characteristics, such as curiosity and motivation, play an important role for success in these areas (Benbow & Lubinsky, 1996; Wai, Lubinski & Benbow, 2005). Anecdotal reports suggest that a high-average IQ is a minimum for successful leadership, and for some fields, such as engineering and mathematics, a considerably higher

IQ threshold is necessary. There is, however, a lack of agreement among international researchers about a minimal threshold for creative production (Runco, 2007; Wechsler, Nunes, Schelini, Ferreira & Pereira, 2010). IQ is never enough to reach a level of success and expertise as an effective leader. Of course, the same can be said in almost all fields. Specific abilities, well-honed skills, social intelligence, and domain-specific competencies are critical if one hopes to move beyond competence toward expertise in any domain. A model is presented in Figure 1 which incorporates ideas proposed by a number of leading authorities in the gifted and talent development fields, including Bloom (1985), Gagné (2005) and Subotnik (2003).

The model depicts how creativity is conceptualized as one component that develops in a later stage of the unfolding of talent. According to Pfeiffer (2012c), creativity is located near the apex of the talent development model, consistent with a domain-specific theory of creativity, research in the field of expertise, and considerable experience of the authors working closely with high ability children and youth in the US and Brazil. Creativity and innovation are the result of a solid foundational base of factual, conceptual and procedural knowledge (Bloom, 1956), and considerable experience in leadership activities. In other words, bright students require a variety of structured and real-world learning experiences before we can expect that they will display the imagination, originality, and resourcefulness - the hallmark of creative leadership. Third, the model depicts stages along the talent development trajectory that are influenced by person-environment interactions and marked by changes-really transformations-in thinking, attitude, motivation, and even personality. The student who is *competent* in chess, debate, solving mathematical problems or in being a leader is very different from the youngster who has progressed on to a level of *expertise* in chess, debate, solving mathematical problems, or being a leader. One expects to begin to see creative thinking and creative performance as the youngster moves from a level of competence to an elite or expert level in any field, including leadership.

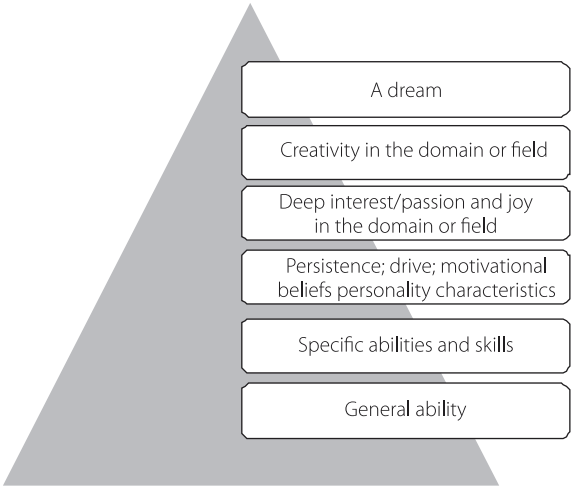

Figure 1. Factors critical to leadership development (Pfeiffer, 2012c).

Fourth, if students of uncanny ability continue to successfully progress along the talent development trajectory to expertise and even eminent status as a leader, the following factors become increasingly important: specific interpersonal skills, drive, persistence, self-confidence, passion for leading others, facilitative motivational beliefs, a willingness to listen and learn from others, and the dream of becoming a leader. Fifth, sustained interest in pursuing one's dream of becoming a leader and a commitment to excellence are critical to reach the highest levels; creativity is much easier to nurture and encourage if the student is passionate about becoming a leader and has a "rage" to learn (Piirto, 2008; Winner, 1996). Lionel Messi, as many readers may know, is an internationally recognized futbol player who plays for the world-renowned team, Futbol Club Barcelona. He is considered one of the most creative players in the world. The celebrated Uruguayan novelist Eduardo Galeano recently wrote an essay on Messi, including this poignant comment, "No one plays with as much joy as Messi does... . He plays like a child enjoying the pasture, playing for the pleasure of playing, not the duty of winning" (Longman, 2011, p.6). Sixth, a substantial investment of time is necessary to reach the highest levels as a leader (Ericsson, Krampe & Tesch-Romer, 1993).

Seventh, only a select number of individuals reach the highest levels of eminent status in any domain or field, including leadership. There is always going to be a small number who reach the pinnacle and are recognized as uniquely creative leaders. This is certainly true for the creative individual, as well; only a small number of students with uncanny potential at an early

age reach the *Big C* level of creativity-irrespective of whether we are considering creative leaders, scientists, artists, teachers, athletes, surgeons, architects, or computer programmers.

Finally, the model consists of four distinct stages with transitional or sub-stages. Each stage is marked by transformations (Pfeiffer, 2012c). First, the child is exposed to knowledge, skills and experience in a specific field or domain-such as leadership, hopefully presented in an enjoyable and reinforcing fashion; second, over time the individual reaches a recognized threshold where they attain competence in the domain; third, the individual continues to gain further experience, guidance and instruction to the point where they reach a level of mastery or expertise in the domain-at this point, we observe clear evidence of domain-specific creativity; finally, further development, experience, and refinement of one's expertise can lead a very select few to a pre-eminent level of accomplishment as a leader. Only the most promising are likely to attain a level of eminence as a creative leader. This final stage is marked by clear evidence of *Big C* creativity, which in fact is one of the defining features of eminence.

This model is consistent with Bloom's (1956) taxonomy, in which creativity unfolds only after the more foundational cognitive operations of remembering, understanding, applying, analyzing, and evaluating-be it factual knowledge, conceptual knowledge, procedural knowledge or meta-cognitive knowledge-are first solidified. Although one may not see creativity expressed in the first two stages of this model, the type of processes required at the upper stages are conducive to creative expression. Personality characteristics such as motivation, persistence, deep interest, passion and joy tend to be all present in creative personalities, as has been observed in international research (Kaufman, Plucker & Baer, 2008; Siqueira & Wechsler, 2009).

Final Considerations

The gifted field lacks even one large scale study that has followed a large cohort of high ability children examining early precursors of leadership. There is no study that has followed over time a large community of gifted children identified at an early age with precocious leadership skills or attitudes.

We know a lot about leadership from the adult leadership literature. We know, for example, that almost all people, irrespective of whether they are from Brazil or the US consider honesty, forward-looking, inspiring, and competence as critical characteristics of effective adult leaders. Honesty emerges as the single most important quality; leaders are expected to inspire trust, demonstrate unwavering integrity, and know right from wrong. The ability to look ahead and the ability to create a shared a vision for-the-future are both important leadership skills. Effective leaders should be enthusiastic, energetic, and optimistic, what Pfeiffer (2012b) labels as "heart strengths."

Effective leaders must bring relevant experience and have sound judgment. And effective leaders must be innovative and creative, particularly at times of challenge and crisis. These are valuable insights to help guide researchers interested in understanding more about early precursors of leadership. And these are valuable insights to help guide educators interested in designing effective youth leadership development programs in the schools and community. It is obvious that if we hope for our youth to develop into effective and ethical leaders as adults, we need to expose them to readings, discussion, and real-life learning opportunities that introduce topics such as interpersonal decision-making, social dynamics, conflict resolution, group behavior, goal setting, and integrity and trustworthiness (Pfeiffer, 2012c).

The proposed model offers a long-range trajectory for developing children's intellectual and creative potential that encourages a future cadre of talented leaders. In order for societies-both large and small-across our planet to grow, thrive, and peacefully cooperate, educators and policy makers must commit resources to leadership development.

References

Alencar, E. M. L. S. (2000). O papel do professor facilitador e do professor inibidor segundo estudantes de pós-graduação. *Boletim da Academia Paulista de Psicologia, 19*(1), 84-94.

Angelakis, E., Stathopoulou, S., Frymiare, J. L., Green, L., Lubar, J. F., & Kounious, J. (2007). EEG neurofeedback: A

brief overview and an example of peak alpha frequency training for cognitive enhancement in the elderly. *The Clinical Neuropsychologist*, *21*(1), 110-129.

Baer, J. (1998). The case for domain specificity in creativity. *Creativity Research Journal, 11*(2), 173-177.

Baer, J. (2011). Why grand theories of creativity distort, distract, and disappoint. *The International Journal of Creativity and Problem Solving, 21*(1), 73-100.

Benbow, C. P., & Lubinski, D. (1996). (Eds.), *Intellectual talent*: *Psychometric and social issues*. Baltimore, MD: Johns Hopkins University Press.

Bennis, W. (2003). *On becoming a leader*. Cambridge, MA: Perseus Pub.

Bennis, W., & Biederman, P. W. (1997). *Organizing genius*: *The secrets of creative collaboration*. Cambridge, MA: Perseus Books.

Bennis, W., & Goldsmith, J. (2010). *Learning to lead*. New York: Basic Books.

Bloom, B. S. (1956). *Taxonomy of educational objectives*: *Handbook I: The cognitive domain*. New York: David McKay.

Bloom, B. S. (1985). *Developing talent in young people*. New York: Ballantine Books.

Borland, J. H. (2009). Myth 2: The gifted constitute 3% to 5% of the population. Moreover, giftedness equals high IQ, which is a stable measure of aptitude. Spinal tap psychometrics in gifted education. *Gifted Child Quarterly, 53*(4), 236-238.

Brasil. Camara dos Deputados. (2004). *Lei nº 10.973, de 2 de dezembro de 2004*. Recuperado em dezembro 2, 2004, disponível em <http://www2.camara.gov.br/legin/fed/lei/2004/lei-10973-2-dezembro-2004-534975-publicacaooriginal-21531-pl.html>.

Brasil. Conselho Nacional de Educação. (2001). Resolução nº 2/2001. *Diretrizes nacionais da educação especial para a educação básica*. Recuperado em dezembro 5, 2012, disponível em <http://portal.mec.gov.br/ seesp/arquivos/pdf/diretrizes.pdf>.

Brasil. Conselho Nacional de Educação. (2011). *Decreto nº 7.611, de 17 de novembro de 2011*. Recuperado em dezembro 5, 2012, disponível em <http://www2.camara.gov.br/legin/fed/decret/2011/decreto-7611-17-novembro-2011-611788-publicacaooriginal-134270-pe.html>.

Chang, L., Emst, T., Speck, O., Patel, H., DeSilva, M., Leonido-Yee, M., et al. (2002). Perfusion MRI and computerized test abnormalities in abstinent methamphetamine users. *Psychiatry Research Neuroimaging, 114*(2), 65-79.

Collura, T. F., Thatcher, R. W., Smith, M. L., Lambos, W. A., & Stark, C. R. (2009). EEG biofeedback training using z-scores and a normative database. In W. Evans, T. Budzynski, H. Budzynski & A. Arbanal (Eds.), *Introduction to qeeg and Neurofeedback*: *Advanced theory and applications* (2th ed.). New York: Elsevier.

Crespo, M. L., & Wechsler, S. (2000). Clima criativo: um diagnóstico para a inovação nas organizações educacionais e empresariais *Psicodebate*: *Psicología, Cultura y Sociedad, 1*(1), 53-61.

Csikzentmihalyi, M. (1990). *Flow*: *The psychology of optimal experience*. New York: Harper & Row Publishers.

Ekvall, G. (1996). Organizational climate for creativity and innovation. *European Journal of Work and Organizational Psychology, 5*(1), 105-123

Ericsson, K., Krampe, R., & Tesch-Romer, C. (1993). The role of deliberate practice in the acquisition of expert performance. *Psychological Review, 100*(3), 363-406.

Fielder, F. (1967). *A theory of leadership effectiveness*. New York: Bantam Books.

Fink, A., & Neubauer, A. C. (2006). EEG alpha oscillations during the performance of verbal creativity tasks: Differential effects of sex and verbal intelligence. *International Journal of Psychophysiology, 62*(1), 46-53.

Fleith, D. S. (2006). Percepção de alunos de ensino fundamental quanto ao clima de sala de aula para a criatividade. *Psicologia em Estudo, 11*(3), 513-521.

Fleith, D. S. (2008). Características personológicas e fatores ambientais relacionados a criatividade no ensino fundamental. *Avaliação Psicológica, 7*(1), 35-44.

Foley, N. M., & Pfeiffer, S. I. (2011). High ability students: New ways to conceptualize giftedness and provide psychological services in the schools. *Journal of Applied School Psychology, 27*(4), 293-305.

Freed, P., Yanagihara, T., Hirsch, J., & Mann, J. (2009). Neural mechanisms of grief regulation. *Biological Psychiatry, 66*(1), 33-40.

Gagné, F. (2005). From gifts to talents: The DMGT as a developmental model. In R. J. Sternberg & J. E. Davidson (Eds.), *Conceptions of giftedness* (2nd ed., pp.98-120). Cambridge: Cambridge University Press.

Goleman, D. (1995). *Emotional intelligence*. New York: Bantam Books.

Gottfredson, L. S. (1997). Why g matters. *Intelligence, 24*(1), 79-132.

Gottfredson, L. S. (1998). The general intelligence factor. *Scientific American, 9*(4), 24-30.

Hersey, P., Blanchard, K. H., & Johnson, D. E. (2007). *Management and organizational behavior: Leading human resources*. New York: Prentice Hall.

Jaušovec, N. (2000). Differences in cognitive processes between gifted, intelligence, creative, and average individuals while solving complex problems: An EEG study. *Intelligence, 28*(3), 213-237.

Karnes, F. A., & Chauvin, J. C. (2000). *Leadership development program*. Scottsdale, AZ: Gifted Psychology Press.

Kaufman, J. C. (2009). *Creativity 101*. New York: Springer.

Kaufman, J. C., Plucker, J. A., & Baer, J. (2008). *Essentials of creativity assessment*. New York: John Wiley & Sons.

Keating, D. P. (2004). Cognitive and brain development. In R. Lerner & L. Sternberg (Eds.), *Handbook of adolescent psychology* (pp.45-84). New York: John Wiley & Sons.

Keating, D. P. (2009). Developmental science and giftedness: An integrated life-span framework. In F. D. Horowitz, R.

F. Subotnik & D. J. Matthews. (Eds.), *The development of giftedness and talent across the life Span* (pp.189-208). Washington, DC: American Psychological Association.

Kouzes, J., & Porner, R. (2009). *The leadership challenge*. Retrived January 24, 2009, from <http://www.leadershipchallenge.com/WilleyCDA>.

Kozbelt, A., Beghetto, R. A., & Runco, M. A. (2010). Theories of creativity. In J. C. Kaufman & R. J. Sternberg (Eds.), *The Cambridge handbook of creativity* (pp.20-47). New York: Cambridge University Press.

Lee, D., & Pfeiffer, S. I. (2006). The reliability and validity of a Korean translated version of the gifted rating scales. *Journal of Psychoeducational Assessment, 24,* 210-224.

Li, H., Lee, D., Pfeiffer, S. I., Kamata, A., & Kumtepe, A. T. (2009). Measurement invariance of the gifted rating scales-school form across five cultural groups. *School Psychology Quarterly, 24*(3)*,* 186-198.

Li, H., Pfeiffer, S. I., Petscher, Y., Kumtepe, A., & Mo, G. (2008). Validation of the GRS-school form in China. *Gifted Child Quarterly, 52*(2)*,* 160-169.

Longman, J. (2011, May 22). Boy genius . *Times Sports Sunday*, pp.1, 6-7.

Matthews, M. S. (2004). Leadership education for gifted and talented youth: A review of the literature. *Journal for the Education of the Gifted, 28*(1), 77-113.

Mölle, M., Marshall, L., Wolf, B., Fehn, H. L., & Born, J. (1999). EEG complexity and performance measures of creative thinking. *Psychophysiology, 36*(1), 95-104.

Mundim, M. C., & Wechsler, S. M. (2007). Estilos de pensar em gerentes organizacionais. *Boletim de Psicologia*, *5*(57), 15-32.

Nakano, T. C., & Wechsler, S. M. (2006). O percurso da criatividade do ensino medio ao ensino superior. *Boletim de Psicologia*, *5*(56), 205-219.

Pfeiffer, S. I. (2001). Emotional intelligence: Popular but elusive construct. *Roeper Review, 23*(3)*,* 138-142.

Pfeiffer, S. I. (Ed.). (2008). *Handbook of giftedness*. New York: Springer.

Pfeiffer, S. I. (2009). Leadership. In B. Kerr (Ed.), *Encyclopedia of giftedness, creativity, and talent* (pp.520-523). Thousand Oaks, CA: Sage Publishers.

Pfeiffer, S. I. (2012a). Current perspectives on the identification and assessment of gifted students. *Journal of Psychoeducational Assessment, 30*(1)*,* 3-9.

Pfeiffer, S. I. (2012b). Lessons learned from working with high-ability students. *Gifted Education International*. Advance online publication. doi: 10.1177/0261429412440653.

Pfeiffer, S. I. (2012c). *Serving the gifted*: *Evidence-based clinical and psycho-educational practice.* New York: Routledge.

Pfeiffer, S. I., & Jarosewich, T. (2003). *The gifted rating scales*. San Antonio: Pearson Assessment.

Pfeiffer, S. I., & Jarosewich, T. (2007). The gifted rating scales-school form: An analysis of the standardization sample based on age, gender, race and diagnostic efficiency. *Gifted Child Quarterly, 51*(1)*,* 39-50.

Pfeiffer, S. I., Kumtepe, A., & Rosado, J. (2006). Gifted identification: Measuring change in a student's profile of abilities using the GRS. *The School Psychologist, 60*(3), 106-111.

Pfeiffer, S. I., & Petscher, Y. (2008). Identifying young gifted children using the gifted rating scales-preschool/kindergarten form. *Gifted Child Quarterly, 52*(1), 19-29.

Pfeiffer, S. I., Petscher, Y., & Kumtepe, A. (2008). The GRS-school form: A validation study based on age, gender and race. *Roeper Review, 30*(2)*,* 140-146.

Pfeiffer, S. I., & Thompson, T. L. (2013). Creativity from a talent development perspective: How can it be cultivated in the schools. In K. Kim, J. C. Kaufman, J. Baer & B. Sriramen (Eds.), *Creatively gifted students are not like other gifted students*: *Research, theory, and practice* (pp.231-255). Rotterdam: Sense Publishers.

Piirto, J. (2008). Giftedness in nonacademic domains. In S. I. Pfeiffer (Ed.), *Handbook of giftedness in children* (pp.367-386). New York: Springer.

Plucker, J. A., Beghetto, R. A., & Dow, G. T. (2004). Why isn't creativity more important to educational psychologists? Potentials, pitfalls, and future directions in creativity research. *Educational Psychologist, 39*(2)*,* 83-96.

Richards, R. (2007). Everyday creativity: Our hidden potential. In R. Richards (Ed.), *Everyday creativity and new views of human nature*: *Psychological, social, and spiritual perspectives* (pp.25-53). Washington, DC: APA.

Rodriguez-Moreno, D., & Hirsch, J. (2009). The dynamics of deductive reasoning: An fMRI investigation, *Neuropsychologia, 47*(4), 949-961.

Rhodes, M. (1962). An analysis of creativity. *Phi Delta Kappan, 42*, 305-311.

Rosado, J., Pfeiffer, S. I., & Petscher, Y. (2008). The reliability and validity of a Spanish translated version of the gifted rating scales. *Gifted & Talented International Journal*, *23*(1), 105-115.

Runco, M. A. (2007). *Creativity*: *Theories, themes, research and practice*. London: Elsevier Academic Press.

Siqueira, L. G. G., & Wechsler, S. M. (2004). Estilos de pensar e criar e desempenho escolar. *Revista Iberoamericana de Diagnóstico y Evaluación Psicológica*, *18*(1), 15-22.

Siqueira, L. G. G., & Wechsler, S. M. (2009). Motivação para aprendizagem escolar e estilos criativos. *Educação Tematica Digital*, *10*(Esp.), 124-146.

Sternberg, R. J. (2004). WICS: A model of educational leaderhip. *The Educational Forum*, *68*(2), 108-114.

Sternberg, R. J., Jarvin, L., & Grigorenko. E. L. (2011). *Explorations in giftedness*. New York: Cambridge University Press.

Sternberg, R. J., & Kaufman, J. C. (2010). Constraints on creativity. In J. C. Kaufman & R. J. Sternberg (Eds.), *The Cambridge handbook of creativity* (pp. 467-482). New York: Cambridge University Press.

Subotnik, R. F. (2003). A developmental view of giftedness: From being to doing. *Roeper Review, 26*(1), 14-15.

Subotnik, R. F. (2009). Developmental transitions in giftedness and talent: Adolescence into adulthood. In F. D. Horowitz, R. F. Subotnik & D. J. Matthews (Eds.), *The development of giftedness and talent across the life span* (pp.155-170). Washington, DC: American Psychological Association.

Torrance, E. P. (1979). *The search for satori and creativity*. New York: Creative Education Foundation.

União dos Escoteiros do Brasil. (2011). *Escoteiros do Brasil*: *a vida ao ar livre*. Curitiba: Autor. Recuperado em dezembro 5, 2012, disponível em <http://www.escoteiros.org.br/institucional/>.

Vroom, V., & Jago, A. (2001). The role of situation in leadership. *American Psychologist, 62*(1), 17-24.

Wai, J., Lubinski, D., & Benbow, C. (2005). Creativity and occupational accomplishments among intellectually precocious youths: An age 13 to age 33 longitudinal study. *Journal of Educational Psychology, 97*(3), 484-492.

Wechsler, S. M. (2008). *Criatividade*: *descobrindo e encorajando* (3ª ed.). Campinas: PUC-Campinas.

Wechsler, S. M. (2009a.). Estilos de pensar e criar: implicações para a liderança. In Z. G. Giglio, S. M. Wechsler & D. Bragotto (Eds.), *Da criatividade à inovação* (pp.39-60). São Paulo: Papirus.

Wechsler, S. M. (2009b). Age and gender impact on thinking and creating styles. *European Journal of Psychology and Education*, *2*(1), 37-48.

Wechsler, S. M. (2011). *Criatividade e inovação no contexto brasileiro*. I Conferência Internacional de Criatividade e Inovação. Recuperado em dezembro 5, 2012, disponível em <http://www.criabrasilis.org.br/arquivos/pdfs/122_anais_trabalhos_ completos.pdf>.

Wechsler, S. M., & Nakano, T. C. (2011). *Criatividade na universidade*: *uma perspectiva internacional*. São Paulo: Vetor.

Wechsler, S. M., Nunes, M. F. O., Schelini, P. W., Ferreira, A. A., & Pereira, D. A. P. (2010). Criatividade e inteligência: analisando semelhancas e discrepancias no desenvolvimento. *Estudos de Psicologia* (Natal), *15*(3), 243-250.

Wechsler, S. M., & Souza, V. L. T. (2011). *Criatividade e aprendizagem*: *caminhos e descobertas em perspectiva internacional*. São Paulo: Papirus.

Wechsler, S. M., & Richmond, B. (1982). Creative strengths of Brazilian and American children. *Interamerican Journal of Psychology, 16*(1), 27-32.

Winner, E. (1996). *Gifted children*. New York: Basic Books.

World Scout Boreau. (2008). *Annexes*: *Triennial report 2005-2008.* Geneva: Author.

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Person centered psychotherapy: An encounter with oneself or a confrontation with the Other?

Psicoterapia centrada na pessoa: um encontro consigo mesmo ou um embate com o Outro?

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Abstract

The paper discusses the possibilities of host of alterity in the therapeutic process of the Person Centered Approach. The debate is based on the ethics of Emmanuel Levinas, for whom subjectivity would be formed from the relationship with the absolute other. The therapeutic change process that aims to further integrate the experience by the self is questioned. On the other hand, from a reading of a Rogerian clinical case, it is pointed out the externality of experience as an estrangement that allows one to recreate themselves. This research shows the interiority eroded by the organism that arises as other-of-self, sieve for the experience. It is conclude that the person-centered psychotherapy, beyond an encounter with oneself, seems to point as one of its purposes the clash with the radically different. Such discussion alludes to a political repositioning of the Person Centered Approach in its ways to deal with the difference.

Uniterms: Alterity; Person-centered approach; Psychotherapy.

Resumo

O artigo discute a possibilidade do acolhimento da Alteridade no processo terapêutico da Abordagem Centrada na Pessoa. Tem-se como referência a ética de Emmanuel Lévinas, para quem a subjetividade seria constituída a partir da relação com o absolutamente outro. Questiona-se o processo de mudança terapêutica que visa uma maior integração da experiência pelo self. *Em direção distinta, a partir de uma releitura de um caso clínico rogeriano, aponta-se a exterioridade da experiência como estranhamento que permite uma recriação de si. O relato analisado mostra a interioridade ser solapada pelo organismo que se coloca como um outro-de-si, crivo para as experiências. Conclui-se que a psicoterapia centrada na pessoa, além de um encontro consigo mesmo, parece apontar como um de seus efeitos o embate com o radicalmente diferente. Tal discussão alude a um reposicionamento político da Abordagem Centrada na Pessoa em sua lida com a diferença.*

Unitermos: *Alteridade*; *Abordagem centrada na pessoa*; *Psicoterapia*.

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Psychotherapy is the central theme in the work of Carl Rogers, founder of the Person-Centered Approach (PCA). Regarding the expansion of his ideas in other areas of human relationships, it was in this field that Rogers produced the largest volume of research and achieved world recognition as the pioneer in empirical investigation in the therapeutic process, as well as its consequences, both for the client and the therapist.

Rogers (2001) defines that the objective of the clients who seeks for psychotherapy is to become what they really are. According to the author, this means that the individual who undergoes the therapeutic process "Moves away from what he is not, from being just a facade. He is not trying to be more than he is, with the attendant feelings of insecurity and the defense mechanisms this implies" (Rogers, 2001, p.199). In another article, Rogers (1978) suggests a description of the person who comes out of a successful process of psychotherapy based on what he calls "fully functioning person". Both descriptions of the objective of the therapy and of the person emerging from this process, value the harmony between the organism and the self, the recognition by the individual of their own experience and, therefore, a kind of harmonical encounter with themselves, or, as put by Rogers, an "internal agreement" (Rogers & Kinget, 1977).

Vieira and Freire (2006) question the PCA in its ethical dimension based on the radical alterity ethics, by Emmanuel Lévinas. According to this perspective of ethics, subjectivity would be built based on the relationship with the absolute Other, in a vertical relation that is not amenable to synthesis (Freire, 2002). Vieira and Freire (2006) postulate the necessity of thinking of an approach that is ex-centric to the person, an approach that understands the individual not based on the idea of integration of the experience, but that recognizes a dimension of estrangement in their constitution. This distances PCA from the perspective under which it is normally thought, that is, of an integration and recognition of the experience by the self.

Vieira (2009 p.17), following the reflections previously mentioned, discusses about something different from the balance so preconized by Rogers in his publications, and claims that "More than an individual who gets to know themselves, psychotherapy produces some subjectivity that is strange, as it is characterized particularly by the unpredictability and surrendering to the flow of existence". Psychotherapy in the PCA, for this author, would be a lot closer to identifying differences than to recognizing oneself.

Amatuzzi (2001), even belonging to a different philosophical perspective than the elaborated by the authors cited, recognizes a dimension of alterity in the therapeutic process when he claims that "... the authentic speech decides and triggers something. It not only translates, but keeps and promotes an intention, which makes it, in a certain way, past as a mere intention, and originating new interventions inside a move" (Amatuzzi, 2001, p.24). Amatuzzi, therefore, as well as Vieira (2009) and Vieira and Freire (2006), point to the consideration of some estrangement present in authentic discourse. Thus, this would be a discourse that could dislocate the individual from a fixed place, which, according to Vieira and Freire (2006), would demonstrate its ex-centric characteristic.

The considerations brought by the cited authors question the notion that psychotherapy would be an encounter with oneself, or the rescue of a lost balance the insertion in the social. We can say that, according to these authors, there is a tension in the human constitution which is evident in psychotherapy and that this tension, rather than being suppressed by an internal agreement, deserves to be heard.

This article seeks to understand how the estrangement referred to by Amatuzzi (2001), Vieira (2009) and Vieira and Freire (2006) are shown in the psychotherapeutic context, as well as to discuss the possibilities of the opening to alterity present in Person-Centered Therapy (PCT). In order to meet these objectives, it is taken as a starting point the premise advocated by Rogers (1994) as an essential aspect for the progress of a therapeutic change of personality, that is, client's perception regarding the process in question. For such, it was used a client's testimonials about her own psychotherapy, taken session by session by Rogers and his assistants published in *"Client Centered Therapy"*, 1951.

We will present the descriptions given by the client as well as the comments made by Rogers regarding these statements. Positions of criticism alternate with these topics, anchored in ethics of the radical alterity, of Lévinas (1998; 2000).

Lévinas and the radical alterity ethics

Speaking of Lévinas, a Franco-Lithuanian philosopher of vast production and complex thinking, means, before anything, subverting the order from which, usually, questions posed by Philosophy are normally thought of. Lévinas, instead of approaching the individual, questions them. Such operation is carried out by this philosopher through the primacy of the relationship with the Other in subjectivity, which gives his theory the denomination of ethics of radical alterity and institutes the relation with alterity as necessarily vertical and of impossible reciprocity. It is the primacy of ethics over ontology (Pivatto, 2000).

Lévinas (2000) contrasts the Same to the Other, a dimension of the human being that cannot be captured by institutional knowledge, something that always escapes. According to Freire (2002), in Lévinas Philosophy, the Infinity within us is what makes us human. This means that, even though we are finite, we are like beings that live beyond our death.

Thus, Lévinas holds in check the project of modern civilization, as the self-sufficiency state, which he calls "fruition", to which modernity has raised the human. It is broken by the relation with the absolute other, in a way that the human is only humanized from the moment that he recognizes the difference. This means that the relationship with alterity is, from the beginning, the subjection of the same (subject centered on his fruition) by the other. Or still, the interruption of the need for the institution of desire, that which goes beyond my being and reveals itself in its own mystery.

> 'The recognition of the difference, for Lévinas (1998), takes place through the revelation of the Face of the Other, which is not phenomenal, because if it were, it could be captured by a definite image. In an interview with Poirié (2007), Lévinas says: the face (visage) is not of the order of the visa, is not an object, it is what the appearance retains an externality that is also a call - or imperative because of its responsibility... . If you conceive it as a photographer's object, surely you are dealing with an object like any other object. But if you find the face, that responsibility is in this strangeness of others and in their misery' (Poirié, 2007, p.85).

The meeting that Lévinas referred to above alludes to another consequence of the relation to alterity, irrespective, that for this philosopher, to paraphrase Dostoyevsky, "We are all guilty of everything and everyone before all, and I, more than the others" (Lévinas, 1998, p.90). Thus, the relationship with the radical Other is also of responsibility. For Lévinas, we are all responsible for others, nontransferable and individually. It is from this, then, that the philosopher in question defines ethics:

> Behavior in which another person, who is strange and indifferent, who belongs neither to the order of his interests nor the one of his affections, however, concerns him. His alterity concerns him. Relation of another order than the knowledge, that the object is invested by knowing, what passes through the only mode of relationship with human beings. Can someone be for onelwithout being reduced to an object of pure knowledge? Situated in an ethical relation, the other man remains another (Poirié, 2007, p.84).

Talking about ethics and alterity, therefore, means opening up for the difference of the other. Not for identification, but host, as warns Pivatto (2000). This means that ethics implies passivity, lack of expectation of possession or control, or, as Lévinas (1998) says, a "Here I am" as a gift to others. That is why Freire (2001 p.) states that Lévinas ethics is a "Consideration about hospitality, as welcome the arrival of the other, that is overturned by the hostage condition" (section *Levinasian Ethics*, paragraph 2) since the other who takes me over who I cannot exercise any control.

The mark of the difference from the other places me the "thou shalt not kill" (Freire, 2000; Lévinas, 1998), because, even if it is possible the murder of his physical organism, the mark of his difference is imposed on any instrument of power. For Bauman (2011), "taking the moral responsibility means not to consider the other as a specimen of a species or of a category, but as a single, and in doing up (becoming 'chosen') the worthy state of the oneness" (p.88). Thus, the impossibility of the murder of the other, more than a powerful metaphor, it speaks of elevating, of the host of his difference and affectation by her.

On these writings, the thought of Lévinas is used to consider possibilities for listening to the strangeness in the field of client-centered therapy. Now we have a discussion about the therapeutic process in PCT and an analysis of the effects of estrangement felt by a client served by Rogers as a theme to think about the issue.

The therapeutic process

More than a concern with developing a theory of personality, it was up to Rogers to describe how that changed along a therapeutic process. In the classic "On becoming a person", 1961, Rogers describes psychotherapy through seven stages that make up a *continuum*, that is, they must be understood as a dynamic process. This means "It is unlikely that in a sphere of their existence the client declares a total fixity, and in another sphere an absolute mobility" (Rogers, 2001, p.149).

The continuum that Rogers refers to in the passage above goes from a perceptual point of fixity about the self, so an unavailability to try new experiences, to openness to the New caused by the modification of the way the individual perceives themselves regarding their own experiences. According to Rogers (2001):

> In the new immediate experiences that occur in these moments, feelings and knowledge interpenetrate themselves, the self is subjectively present in the experience, the will is simply the result of a harmonious balance toward organismic. Thus, as the process approaches this point, the person becomes a unit in motion. The individual has changed, but what seems to be more significant is the fact that the individual himself has become an integrated process of transformation (p.181).

Therefore, for Rogers, the therapeutic change takes place in the direction of a greater integration of the experience to the self. This means that the experience would need to be recognized as belonging to the organization of the individual's personality so that it could be integrated harmoniously in the relation between organism and self.

Following the discussion of the therapeutic process, Rogers (1978) describes what, according to his understanding, would be a person in full operation. According to his clinical observations, the author of PCT describes the following characteristics developed by the individual after passing through a Person-Centered Therapy: openness to his own experience; an experience of the here-and-now, and increased confidence in the organism as the most suitable way to establish a sieve for the experiment.

Rogers (1978; 2001) acknowledges, therefore, features that repeat in people who undergo a successful therapeutic process and lists the various stages through which the subject passes. The author, however, makes an exception by stating that such a proposition is not normative because it only fulfills the role of describing the therapeutic process in general.

Thus, the steps of the therapeutic process described elsewhere and the "fully functioning person" would indicate some regularity in the therapeutic process. This happens as about the direction that often takes regarding the effects on the individual.

In terms of personality theory (Rogers, 1975), we can understand the consequences of psychotherapy from a tension presented in a triangle formed by the vertices of culture, self, and the organism. The person seeking help from a psychotherapist is faced with the following situation: on one hand, culture demands from the individual the fulfillment of the requirement of being someone worthy of love; on the other, there is the need to maintain the coherence of the description that person makes of himself, undermined by the force of an experience that is incongruent with their self-concept, and finally the organism seeks a way of expressing their needs. The conduit, thus, becomes diffuse, as it does not know which need to satisfy.

The goal of psychotherapy, therefore, would be the integration of the experience, which means appeasement of voltage presented at the vertices of the triangle described above. According to the description provided by the creator of the PCT, "Most of the total experience of the organism is incorporated directly into the self, or, more accurately, the self tends to be discovered in the total experience of the organism. The patient follows his 'real' self, his organismic self" (Rogers, 1975, p.513).

The model of personality presented by Rogers (1975) tells us about the initial time of the therapy, a dividing line between self and organism. Then, the therapy having ended, this line would tend to become fluid, so that in the moment the experience occurs, it becomes difficult to discern what is self and what is organism because both would have the experience as a sieve for the meaning assigned to itself, and not an external standard.

There is, however, a problem posed when the PCT deals with the issue of alterity. Rogers overvalues one dimension of integration of the individual with his experience, so that the wanted in the psychotherapeutic process is a greater integration of the experiences, until then denied or distorted by the individual. Thus, one ignores a dimension of strangeness in the constitution of the psyche and seeks to reduce it to what can be recognized by the self.

A finding that deserves relevance in this matter is that both descriptions provided by Rogers himself about the therapeutic work and in the speech made by clients in this kind of process are quite recurrent reports of experiences of estrangement from them. According to Vieira and Freire (2006, p.431). "It is not very rare in the clinic that we hear from clients in therapeutic processes considered successful phrases like: 'I went through a situation in which I did not know myself, I was surprised!'".

As you can see in the passage above, the baseline therapy centered on the person may have as one of its purposes the individual's contact with something that seems strange to them, by unsaying a whole prior conception that they have about themselves. Rogers (2003, p.18), however, thinks this phenomenon in a logical identity when he affirms about the uniqueness of some meanings produced in the therapeutic process: "This is the first time that this organismic topic, which until now was denied to consciousness, is now freely present in consciousness".

The quote above shows us that instead of seeking to understand the meaning of the experience from their estrangement, Rogers prefers to think of it as a dynamic integration already known. This is why, later, he discusses about the experience of the therapy: "It's self-acceptance, because it is recognized as belonging to oneself and not as something unrecognizable... it is an experience of being integrated" (Rogers, 2003, p.19).

In order to have more empirical elements for the discussion of alterity in psychotherapy, we will proceed with the description prepared by a client who recorded her impressions about the psychotherapeutic process each session. As we will see below, it is clear in her speech the presence of the elements that point to moments of profound estrangement of herself.

The description of therapy from the client's and the therapist's points of view: The opening and closing for alterity

In the work *"Client Centered Therapy"*, Rogers presents the therapy relationship as described by a client he calls Mrs. Cam, someone with some knowledge of Psychology and who was willing to describe how she perceived therapy session by session. This is a rich and rare exhibition, not only of facts worked in the sessions, but mainly of the experiences raised by the ongoing process, interspersed with comments by Rogers about an understanding of the process. At first, we will show the speech of the client and the understanding that Rogers elaborates on this. At a second moment, we will discuss the spaces for alterity present in this report, through questions raised from the ethics of radical alterity of Lévinas.

In the report after the second session, Mrs. Cam describes a sense of chaos and disorder, estrangement on a number of factors concerning experiences in the therapeutic encounter. This can be seen, for example, in the following passage:

> ... it is really humanly impossible to impose order and meaning onto this chaos: how wonderful it would be to lose the last drop of self-awareness, to lose my perception of this confusion as confusion… to merge more and more into the pleasant peacefulness and forgetfulness of the not-knowing. How strange it is that I can find peace succumbing to what seems to be chaos and disorder (Rogers, 1975, p.106).

In Rogers understanding, what happens with Mrs. Cam is nothing more than an appropriation of the experience by the self, "Without the necessity of rejecting it or twisting it, so there is naturally a feeling of freedom and unity associated with this experience" (Rogers, 1975, p.107).

If we take the problem of alterity as postulated by Lévinas and here already stated, there is an ethical question to be raised about the understanding developed by Rogers, which is of the assimilation of the strange aspect of the experience by a facet already known of the experience - the self. What emerges from Mrs. Cam's excerpt is that there is more to it than the mere assimilation of an experience: it shows a relationship of

openness and acceptance of foreign elements to the experience.

The client's experience carries a character of exteriority. Instead of the assimilation by the self, her speech seems to indicate that it is the experience that redefines the description that she makes of herself. This shows an inversion of the logics under which psychotherapy is usually thought by Rogers. This reflection can be seen in Mrs. Cam's speech when she says: "We must allow that our experience tell us its own meaning: the moment someone tells us what it means, the same antagonism of a patient in war with himself happens" (Rogers, 1975, p.107).

It is because of thinking based on the logics of assimilation that Rogers (1975, p.108) observes that "If we allow the experience to tell us its own meaning... and we assimilate these fundamental meanings to the structure of the self... we would not have this inner tension so common to all of us. This is what Mrs. Cam seems to suggest". Rogers tries to fit Mrs. Cam's speech in his theoretical schemes and minimizes the positivity of the estrangement pointed by his client, reducing it to a matter of incongruence between self and the organism.

The questioning of the deafness to which we previously referred is based on Lévinas (1998), according to which the Other does not get to us through our vision, as, in spite of presenting itself as a Face and demanding from us "Thou shall not kill!", its Face is non-phenomenal, that is, it can not be captured by an image of itself. Therefore, more than some optics of alterity, Lévinas shows us the need for an otic action (hearing) the externality that makes us human and that tensions interiority all the time. Rogers seemed to be unaware of this hearing, as we can notice in his comments.

The attitudes of the therapist, especially their non-possessive love (Rogers, 1976), create conditions for the client to produce a new speech about herself and that the production of this discourse operate a deconstruction of her perceptual standard. More than a verbalization already ready and only not yet expressed, the report provided by Mrs. Cam shows unprecedented and estrangement, as it can be seen in the following passage: "It is interesting to discover that there are more things to express than I suspected, and there is an obscure satisfaction in the continuous effort to face obstacles; this continues to seem a pleasant and safe atmosphere in which to do things, but, if this atmosphere were weakened, I would incline myself towards another possibility" (Rogers, 1975, p.112).

Once again, Rogers (1975, p.113) emphasizes the idea of acceptance and recognition of the experience when, by commenting on the passage quoted above, he states: "Seeing another person, the therapist, accepting the experience rather than rejecting it... facilitates accepting the experience itself". For the American psychologist it is as if the self changed the perception of exteriority.

What seems to be shown by Mrs. Cam's report is another way, the one through which exteriority is affected by something external and strange in relation to itself - the organismic need. Returning to the point made earlier of a triangle composed of culture, self and organism, we can situate the organism as another-of-itself, because it has the function of expressing itself in therapy and serve as a sieve for the client's experiences. This idea seems to be confirmed in Mrs. Cam's speech when she says: "I am inclined to let myself be and enjoy the results, or let them sweep themselves away if they do not satisfy me; either way, the entire process of a psychological consultation seems to fight against any type of introspection and worry about oneself" (Rogers, 1975, p. 116).

Regarding the previous passage, Rogers (1975, p.117) outlines a recognition of the implied difference in the therapeutic process when he claims that, for Mrs. Cam, "... the intellectualized and introspective interest decays in favor of a more primitive experience" . This outline of reception of the different reappears when the author comments on the despair and hopelessness manifested by his client at a later stage of the therapeutic process: "Such desolation, according to the experience of the author, will only probably happen in situations of basic and ample reorganization of the self" (Rogers, 1975, p.124).

Regarding the reflections taken in this work, the Rogerian work cannot be considered completely allergic to alterity. According to Vieira and Freire (2006), it is possible to think of an approach that prioritizes an ex-centricity of facilitative attitudes, as opposed to principles of identity present in its original formulation. This emphasis on the ex-centricity may do more than refer

the individual to an established truth about themselves, but move them to a center of familiarity toward contact with the strangeness of their experience.

Another point of inflexion regarding the opening to alterity is in the concept of experiencing proposed by Gendlin and taken by Rogers. Messias and Cury (2006) invite us to reflect upon the impact of this conception for the client-centered therapy. Experiencing, according to some authors, would be a neologism which indicates the process and the possibility of direct reference to some affection, instead of valuing its intellectual content. Affection considered as disruptive, as estrangement, loses its power to be captured by the intellect, which, by its nature, tends to shape it to known standards. Insofar as we value its direct access, without a cognitive mediation through language, then we have doors and windows open to foreign visitors, as taught by the metaphor proposed by Lévinas (2000).

Another way to access the difference can be seen in Amatuzzi's (1994, p.25). Idea of "authentic speech" Based on Merleau-Ponty. The author divides psychotherapy in moments of "secondary expression" and "authentic speech". The first concept refers to the speech already ready and recognized by the individual, therefore, mere repetition. The latter, on the other hand, happens in the immediacy of the here-and-now of the therapeutic relationship and opens new possibilities. In this sense, Vieira and Freire (2006, p.430) claim that "... authentic speech triggers new intentions... [moving away from] a perspective of essentiality... the speech acquires … a life of its own, as if it reconfigured the individual's intention and not the other way around" .

Final Considerations

Some factors should be highlighted regarding Rogers dealing with alterity. The first one refers to scientistic claims early in his career and his subsequent commitment to an if-then logic to undergo psychotherapy. Even exposing the resulting conflict (Rogers, 2001), in the article "Persons or Science? A philosophical problem", Rogers took a long time to see that his findings did not fit in the closed world Psychology Academy (Rogers, 1986). His initial commitment to a modern scientific project necessarily kept him distant from a thought he could conceive of the strange, as it is known, it has been up to science, since the beginning, the role of predicting and controlling, dealing with regularity. For this reason, some of his most famous texts, edited by Wood (1994), seek regularity, be it in the therapeutic process or in the transformations deriving from it.

Another important factor that must be taken into account herein is the difficulty thinking of alterity from an applied type of knowledge. The dialogue between Rogers and Buber, which occurred in 1959, shows this challenge, when authors disagree exactly because of the lack of understanding of both regarding the place from which they were speaking - Philosophy and Psychology.

This results in a necessary alert. This work is not intended in any way to fit philosophical reflections on the practice of psychotherapy, as if it recognized in Philosophy a technical dimension that is not intended for it. The intention is more in the field of implications, that is, the proposition of problems for the practice of psychotherapy, beyond its technical facet, to which, many times, it is reduced. It is known that ethical issues are implicated in this process, not to say political ones. After all, thinking approach of Psychology, whatever it may be, having alterity as motto, means alerting for the necessity for it not to contribute in the standardization of the human, and, therefore, ignore what makes us human, that is, the absolute and radical other, which is irreductible to a standardized sameness.

That being said, we can point the need to rethink the understanding of the base of person-centered Psychotherapy in its ethical aspects as significant consequences of this text. If, for Rogers, what mattered was patience, personality, and other topics of the kind, we are given the possibility to redefine concepts and understandings.

This change of perspective is harbored on the conceptions developed by Dutra (2004) and Figueiredo (2004) on Contemporary Clinical Psychology. For these authors, the clinic, more than a place, concerns ethics. It is a way of opening and understanding the unsaid in the social field.

In this sense, the organism, as a privileged arena of expression during psychotherapy, seems to be a way

to understanding the strangeness in the psychic dynamics. The virulence in this strangeness that accompanies the organismic experience is capable of undermining concepts established by the individual about themselves and indicates new possibilities of dealing with the PCA with the other. More than an appropriation and familiarization of the strangeness by the self, as pointed out by Rogers, the speech of Mrs. Cam leads to questioning this construct based on a strange experience, which means it is not necessarily explained.

Thus, besides an encounter with oneself, to which Rogers many times refers in his texts, the person-centered psychotherapy points as one of its possible effects a clash with the radically different. For such, it needs to disentangle itself from the idea of the assimilation of the experience by the self, and to acknowledge the deconstruction of the self by the exteriority presented by the experience *per se*. More than a theoretical exercise or change of nomenclature, this indicates a political discussion of PCA in the way it deals with the different as different.

Rerefences

Amatuzzi, M. M. (2001). *Por uma psicologia humana*. Campinas: Alínea.

Amatuzzi, M. M. (1994). *O resgate da fala autêntica*: *filosofia da psicoterapia e da educação*. Campinas: Papirus.

Bauman, Z. (2011). *Vida em fragmentos*: *sobre a ética pós-moderna*. Rio de Janeiro: Jorge Zahar.

Dutra, E. (2004). Considerações sobre as significações da psicologia clínica na contemporaneidade. *Estudos de Psicologia* (Natal), *9*(2), 381-387.

Figueiredo, L. C. M. (2004). *Revisitando as psicologias*: *da epistemologia à ética das práticas e discursos psicológicos*. Petrópolis: Vozes.

Freire, J. C. (2000). *O lugar vacante do Outro nas psicologias da modernidade tardia* (Tese de doutorado não-publicada). Programa de Pós-Graduação em Psicologia Experimental, Universidade de São Paulo.

Freire, J. C. (2001). As psicologias na modernidade tardia: o lugar vacante do outro. *Psicologia USP*, *12*(2), 73-93.

Freire, J. C. (2002). *O lugar do Outro na modernidade tardia*. São Paulo: Anna Blume Fortaleza.

Lévinas, E. (1998). *Ética e infinito*. Lisboa: Edições 70.

Lévinas, E. (2000). *Totalidade e infinito*. Lisboa: Edições 70.

Messias, J. C. C., & Cury, V. E. (2006). Psicoterapia centrada na pessoa e o impacto do conceito de experienciação. *Psicologia*: *Reflexão e Crítica*, *19*(3), 355-361.

Pivatto, S. (2000). Ética da alteridade. In M. Oliveira (Org.), *Correntes fundamentais da ética contemporânea* (pp.79-99). Petrópolis: Vozes.

Poirié, F. (2007). *Emmanuel Lévinas*: *ensaios e entrevistas*. Manaus: Perspectiva.

Rogers, C. R. (1975). *Terapia centrada no paciente*. São Paulo: Martins Fontes.

Rogers, C. R. (1976). Algumas lições de um estudo de psicoterapia com esquizofrênicos. In C. R. Rogers & B. Stevens. *De pessoa para pessoa*: *o problema de ser humano* (pp.211-224). São Paulo: Pioneira.

Rogers, C. R. (1978). *Liberdade para aprender*. Belo Horizonte: Interlivros.

Rogers, C. R. (1986). Em retrospecto: quarenta e seis anos. In C. R. Rogers & R. L. Rosenberg, *A pessoa como centro* (pp.29-45). São Paulo: EPU.

Rogers, C. R. (1994). As condições necessárias e suficientes para a mudança terapêutica da personalidade. In J. K. Wood (Org.), *Abordagem centrada na pessoa* (p.155-177). Vitória: Ceciliano Abel de Almeida.

Rogers, C. R. (2001). *Tornar-se pessoa*. São Paulo: Martins Fontes.

Rogers, C. R. (2003). A essência da psicoterapia: momentos de movimento. In A. M. Santos, C. R. Rogers & M. Bowen. *Quando fala o coração*: *a essência da psicoterapia centrada na pessoa* (pp.15-23). São Paulo: Vetor.

Rogers, C. R., & Kinget, G. M. (1977). *Psicoterapia e relações humanas* (Vol. 1-2). Belo Horizonte: Interlivros.

Vieira, E. M., & Freire, J. C. (2006). Alteridade e psicologia humanista: uma leitura ética da abordagem centrada na pessoa. *Estudos de Psicologia* (Campinas), *23*(4), 425-432. doi: 10.1590/S0103-166X2006000400010.

Vieira, E. M. (2009). Sobre a proposta de conhecimento presente na teoria rogeriana ou da sabedoria residente na ignorância. *Revista do NUFEN*, *2*(1), 4-19.

Wood, J. K. (Org.). (1994). *Abordagem centrada na pessoa*. Vitória: Ceciliano Abel de Almeida.

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Atualização do Complexo de Édipo na relação com o bebê: evidências a partir de um estudo de caso

The update of the Oedipus Complex in the relationship with the baby: Evidence from a case study

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Resumo

O complexo de Édipo é um conceito central para a psicanálise, pois alicerça a psicopatologia na medida em que desempenha um papel primordial na constituição psíquica do ser humano e na orientação do seu desejo. No caso da menina, Freud acentuou a importância do período pré-edípico; que funcionará como protótipo pelo qual serão estabelecidas as futuras relações, incluindo as relações com seus filhos. Buscou-se articular, pela descrição de um estudo de caso de uma primigesta, a atualização do complexo de Édipo desde a descoberta da gestação. As falas dessa mãe permitiram pensar no processo de falicização de um filho a partir da equação simbólica freudiana falo-bebê. Sugere-se que a suposição de um lugar fálico para o bebê ocorreu pelos movimentos transitivistas maternos a partir das decodificações daquilo que o bebê lhe dá a ver.

Unitermos: Complexo de Édipo; Constituição subjetiva; Maternidade.

Abstract

The Oedipus Complex is a central concept in psychoanalytic theory, which is at the core of psychopathology, as it has a primary role in the human being's psychic constitution and in the direction of his desire. As far as girls are concerned, Freud stressed the importance of the preoedipal period which would be the prototype for future relationships, including mother-child relationships. Through a case study of a primiparous woman, we aim to illustrate the Oedipus Complex's actualization from when the pregnancy was discovered. This allowed us to think of the phallicization of a child through Freud's symbolic equation phallus-baby. We base our discussion on the supposition of a phallic place for the baby through transitivist maternal movements when the mother translates that which the baby allows her to see.

Uniterms: *Oedipus complex; Subjective constitution; Motherhood.*

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O complexo de Édipo é o conceito central para a psicanálise, pois alicerça a psicopatologia na medida em que desempenha um papel primordial na constituição psíquica do ser humano e na orientação do seu desejo. Laplanche e Pontalis (2001) definem o complexo de Édipo como um construto que "... designa uma estrutura fundamental das relações interpessoais e o modo como a pessoa encontra aí o seu lugar e se apropria dele" (p.116). É um conjunto organizado de sentimentos amorosos e hostis que a criança experimenta em relação a seus pais. Freud elabora, ao longo dos seus escritos, três entendimentos a respeito do complexo de Édipo. O primeiro deles refere-se a uma equivalência do complexo de Édipo na menina e no menino (Freud, 1900/1990); a segunda elaboração amarra o conceito de identificação ao complexo de Édipo e à importância desses processos na constituição do eu e do supereu (Freud, 1923/1990); um terceiro entendimento diz respeito à diferença entre o complexo de Édipo feminino e o masculino, evidenciado quando da descoberta do complexo de castração (Freud, 1925/1990) e amplamente trabalhado nos artigos sobre a sexualidade feminina (Freud, 1931/1990, 1932/1990a). Nesse sentido, o complexo de Édipo refere-se às relações que a criança estabelece com as figuras parentais, as quais serão as responsáveis pela constituição de uma rede de representações inconscientes e de afetos.

O complexo de Édipo ocorre de forma diferente no menino e na menina. Na teoria freudiana, essa diferenciação foi evidenciada tarde e parece não ter sido suficientemente esclarecida pelo autor. Somente em 1931, Freud tenta trabalhar essas diferenças entre meninos e meninas, que vinham sendo elaboradas desde o momento em que o complexo de castração fora colocado como fator fundamental para a estruturação do complexo de Édipo.

O complexo de castração (Freud, 1925/1990) refere-se à fantasia de castração que a criança elabora em uma tentativa de responder pela diferença anatômica entre os sexos. Até determinada época do desenvolvimento sexual da criança, tanto meninos como meninas acreditam possuir pênis. Com a constatação de que existem seres com e sem pênis, meninos e meninas respondem de maneira diferente. O menino sai do complexo de Édipo devido ao medo da castração, e a menina, ao contrário, entra no complexo de Édipo quando se depara com a diferença sexual. Ou seja, o menino submete-se à lei da interdição do incesto sob a ameaça da castração, pelo interesse narcisista por seus genitais (Freud, 1925/1990). Para a menina, a situação é mais complicada, já que, além de ter que se resignar pelo fato de não ter pênis, precisa mudar seu objeto de amor da mãe para o pai (Freud, 1931/1990). Nesse sentido, o autor não vê, como ocorre com o menino, um fato crucial que retire a menina da situação edipiana, mas acentua o valor da relação pré-edipiana da menina com a mãe, chegando a dizer que o complexo de Édipo, na menina, é um processo secundário (Freud, 1931/1990). Por esse motivo, propõe que se chame de complexo de Édipo os vínculos das crianças com ambos os pais e não somente com aquele que é objeto de amor.

Um dos fatos que faz com que Freud (1931/1990) perceba a importância da relação entre a menina e a mãe deve-se ao tipo de relacionamento que a menina edipiana apresenta com o pai é, na maioria das vezes, vivenciado com a mesma intensidade daquele apresentado na relação com sua mãe no período anterior. Um dos exemplos que o autor traz a respeito da importância da ligação da menina com a mãe refere-se ao fato de que, frequentemente, a mulher escolhe um marido para se casar seguindo o modelo do pai, para repetir o tipo de relacionamento que teve com a mãe. Assim, percebe-se como o autor passa a evidenciar, de forma bastante intensa, o aspecto fundamental do relacionamento da menina com a mãe. Esse fato faz com que se pergunte sobre o porquê de a menina afastar-se da mãe. E aqui entra em cena umas das questões mais criticadas da psicanálise, principalmente pelas teorias feministas. O motivo que a menina levaria em conta para se separar da mãe seria o fato de ela não lhe ter oferecido o pênis que ela agora tanto deseja, na tentativa de igualar-se ao menino (Freud, 1925/1990; 1931/1990). Assim, para Freud (1931/1990), a menina tem que lidar com uma *castração consumada*, que faz com que se afaste da mãe e se volte para o pai. A diferença que Freud (1925/1990;1931/1990) pôde pensar sobre o complexo de Édipo entre meninos e meninas diz respeito à diferença anatômica dos genitais, que faz com que nela se amarrem situações psíquicas diferenciadas. Então é a repercussão do complexo de castração que estabelece uma diferenciação fundamental entre os sexos: pela ameaça de castração, o menino sai da

situação edipiana e, no caso da menina, entra na situação edipiana por perceber-se castrada, faltando um motivo claro para que a menina possa sepultar o complexo de Édipo, como ocorreu com o menino (Freud, 1931/1990).

O reconhecimento da castração gera, na menina, uma revolta, e disso decorrem três orientações possíveis para sua sexualidade: a) Inibição sexual pela renúncia ao fazer fálico acarretado pelo descontentamento quando da percepção do órgão sexual masculino; b) Complexo de masculinidade, no qual persiste a esperança de possuir pênis; e c) Esboço de uma feminilidade definitiva, pois consegue tomar o pai como objeto, encontrando, então, a forma feminina do complexo de Édipo. A terceira orientação possível para a sexualidade da menina, de alguma forma, tem que estar referendada pela mãe: "... o endosso de ligações afetivas do objeto-mãe ao objeto-pai constitui o conteúdo principal que leva até a feminilidade" (Freud, 1931/1990, p.232).

> O desejo com que a menina se volta para o pai é, sem dúvida, originariamente o desejo do pênis que a mãe lhe negou e que agora espera do pai. Mesmo assim, a situação feminina somente se estabelece quando o desejo de pênis se substitui pelo desejo do filho e, então, seguindo uma antiga equivalência simbólica, o filho aparece no lugar do pênis... . Com a transferência do desejo filho-pênis ao pai, a menina ingressou na situação do complexo de Édipo (Freud, 1932/1990a, p.119).

Em contraposição ao anatomismo freudiano a respeito do pênis, Kehl (2008) aponta para a indiscriminação, nos textos de Freud, a respeito da dimensão imaginária e simbólica do falo. Para a autora, os escritos freudianos a respeito da mulher sempre a deixam atrelada ao fato de ser ela a portadora de uma evidência imaginária da falta, sendo que os efeitos posteriores da castração encontram-se amarrados aos limites corporais. Roudinesco (2003) refere que a feminilidade em Freud está atrelada à maternidade. Por outro lado, Kehl (2008) aponta para o fato de, havendo uma possibilidade - colocada por Freud -, de uma equação simbólica para pênis-bebê-seio-fezes-falo, logo, o pênis é algo simbolizável, ou seja, que não está necessariamente colocado em um objeto determinado. Esses objetos, para a autora, são prolongamentos do corpo aos quais a criança pode atribuir estatutos fálicos, já que parecem obturar a falta no corpo da mãe.

As possibilidades de deslocamentos dos objetos fálicos, esboçados na teoria de Freud (1932/1990b) pela noção de equação simbólica, foram restituídas por Lacan (1957/1995; 1958/1999) mediante o conceito de falo (Bleichmar, 1988), possibilitando uma releitura do complexo de Édipo um pouco mais desvinculada do destino anatômico. Lacan (1958/1999) amplia o conceito de complexo de Édipo, já que o mesmo passa a ser entendido como aquilo que acontece em uma situação na qual a criança se inclui, sendo que um personagem da situação edipiana se constitui em relação ao outro. Nesse sentido, o complexo de Édipo é uma descrição de uma estrutura intersubjetiva, um personagem definido em função do outro. O conceito de falo toma importância, já que este será o elemento organizador e aquele que determinará o lugar de cada um dos personagens da situação edipiana.

Lacan (1957/1995;1958/1999) teoriza a respeito do complexo de Édipo em três tempos, de acordo com o lugar que o falo ocupará na estrutura familiar:

Primeiro tempo: a criança deseja ser tudo para a mãe; o desejo da criança é ser objeto do desejo do Outro (mãe); identifica-se com o que é objeto do desejo da mãe. Esta é uma relação dual, na qual os dois personagens estão presos pela mesma ilusão de completude. Para agradar à mãe, é necessário e suficiente ser o falo.

Segundo tempo: o pai aparece como aquele que priva a mãe do objeto fálico e aquele que priva a criança de ser o objeto que completa a mãe. Há um reconhecimento, por parte da criança, que algo falta à sua mãe, reconhecendo a castração materna (Assoun, 1993). Se for o pai que detém o falo, é ele que completa a mãe. Nesse segundo tempo, o pai intervém como aquele que priva a mãe do bebê, possibilitando desamarrá-lo da identificação de ser o objeto do desejo materno (a criança deixa de *ser* o falo da mãe para voltar-se para *ter* o falo). Apesar dessa resolução, a criança fica enlaçada nesse outro objeto (o pai), que tem aquilo que a mãe deseja (o falo); a criança se submete à lei paterna.

Terceiro tempo: é aqui que ocorre a saída do complexo de Édipo. Lacan refere que o menino se identifica com o pai porque a mãe vai buscar ali o que ela deseja. O pai realmente possui o falo (já que é a ele que a mãe dirige o seu desejo). Constitui-se o ideal-do--eu, aquilo que o menino vai pretender alcançar dali para frente. O pai é interiorizado como ideal-do-eu. A menina, por sua vez, também sabe que tem que ir buscar

o falo do lado do pai, que ele não se encontra do lado da mãe. Percebendo que o pai, apesar de possuir o falo, também está submetido a uma ordem maior, dá-se conta que ele também não o possui de fato. A menina identifica-se, então, com o lugar feminino, fazendo-se objeto de desejo. Mas esses movimentos subjetivos, tanto do menino quanto da menina, somente são possíveis pela noção de que o pai também não é aquele que tudo pode; a ele também está reservada uma certa submissão a uma outra ordem que está além dos personagens que sofrem esse drama. Isto dá, também, a possibilidade de ir buscar além da família aquilo que se deseja. A criança entra, então, na latência, período no qual adquire valores culturais.

No final das contas, o que parece importar no complexo de Édipo é como as crianças, meninos e meninas, responderão à castração materna e, consequentemente, à sua castração (Assoun, 1993; Millot, 1992). Nessas respostas, a anatomia dos sexos ainda está implicada (Tisseron, 2002). Tisseron propõe que meninas e meninos têm que dar conta da submissão aos cuidados maternos nos quais se encontram:

> ... a angústia de uma mãe constrangedora e invasora, que seria um certo tipo de proprietária do corpo da criança, é partilhada por todos os seres humanos, qualquer que seja seu sexo ... . Porém, esta angústia comum é gerada diferentemente em função do sexo anatômico. Diante dessa ameaça, o menino é levado a investir um órgão exterior a seu corpo, a saber, seu pênis, como uma maneira de tentar escapar desse domínio maternal que ele vive como uma ameaça para a sua identidade ... . A menina não tem essa sorte, e por isso ela inveja o pênis do menino. Mas ela não o inveja senão na medida da maneira na qual ela o idealizou como meio de escapar ao domínio materno. Ela será obrigada, para escapar a esse domínio, a investir um homem de seu meio em relação ao qual a mãe parece aprovar os sentimentos ternos a fim de entrar em uma rivalidade diante dessa mãe para poder assim assegurar uma identidade distinta dela (Tisseron, 2002, p.66).

O autor afirma que, para a menina, a única possibilidade de fugir à submissão materna, em um primeiro momento, é a partir de uma disputa com a mãe pelo mesmo homem que a mãe deseja.

Dessa forma, pode-se pensar que o "destino anatômico", tão criticado principalmente pelas teorias feministas, não pode ser de todo desvinculado das questões edipianas e do acesso à feminilidade e à masculinidade, visto que está intimamente vinculado às possibilidades de identificação que permitem o remanejamento das posições intersubjetivas necessárias para a desvinculação imaginária da criança em relação ao objeto fálico. Nesse sentido, talvez a questão não seja, necessariamente, o fato de possuir ou não o pênis, mas, para sair do lugar de objeto fálico para a mãe, faz-se necessária a objetalização em um outro sujeito que permita o acesso a outras formas de ser. Assim, pode-se pensar na ideia freudiana (Freud, 1921/1990) de que a identificação estaria relacionada com *ser* o objeto e a escolha objetal com *ter* o objeto. Esse processo se dá, dentro da perspectiva lacaniana, no segundo tempo do complexo de Édipo, no qual a criança, percebendo não *ser* o objeto que completa a mãe, passa a querer *ter* esse objeto para reencontrar a completude (narcísica) perdida (Lacan, 1957/1995). No caso específico da menina, o reencontro com a completude perdida dar-se-á no momento em que ela possa repetir (no futuro) a situação vivenciada na primeira infância, quando fazia uma unidade com sua mãe, em uma mudança de posição (ela no lugar da mãe e o bebê no seu lugar).

Quando uma mulher se descobre grávida, atualiza, na relação com o bebê, os processos que a constituíram como sujeito. Nesse sentido, as questões edipianas que a marcaram quando bebê lhe darão as pistas necessárias para, quando da sua gravidez e do nascimento do filho, encene as marcas da sua história na relação com a criança. O caso a ser discutido ilustra como, a partir dos investimentos libidinais maternos, o bebê vai se tornando objeto de desejo privilegiado, passando a ocupar o lugar de falo materno. Momento constitutivo necessário para que o bebê possa transformar seu organismo em corpo erógeno a partir do investimento narcíseo materno (Ferrari, Piccinini & Lopes, 2006), introduzindo esse novo sujeito em um mito familiar constituído na pré-história do bebê, mas também por ele modificado quando de seu nascimento (Ferrari & Piccinini, 2010).

A atualização do complexo de Édipo na relação com o bebê

O caso que se propõe analisar é o de Diana[3], uma mulher de 27 anos, grávida pela primeira vez. Como

[3] Todos os dados de identificação do caso foram modificados. A pesquisa foi aprovada pelo Comitê de Ética da UFRGS (Proc. 98/293).

as demais participantes do estudo, Diana foi entrevistada três vezes desde a gestação até o final do primeiro ano de vida da criança. A primeira autora do estudo foi quem acompanhou Diana ao longo desse período.

Diana morava com os pais e namorava o pai do bebê, a quem foi atribuído o nome fictício Antônio para a realização do estudo, fazia alguns anos. A gravidez ocorreu em um reencontro entre ela e Antônio, quando estavam separados. Diana relata que as separações eram frequentes pela falta de paciência que tinha com ele por "ele ser muito parado". Apesar das brigas, considerava o relacionamento com Antônio estável. Tinham planos de morar juntos quando o bebê nascesse em uma casa que compraram em função da gravidez. Diana trabalhava como vendedora e Antônio tinha uma seguradora. Com o objetivo de analisar o complexo de Édipo e a forma como o bebê vai sendo colocado em um lugar privilegiado frente a seu desejo, serão tratados neste texto somente aqueles recortes que pareceram responder a essas questões.

Diana relata que, quando ficou sabendo da gravidez, preocupou-se com a reação dos pais, pois, apesar de ser financeiramente independente, estava separada de Antônio. Conta que retomaram o relacionamento pela decisão dela de sair da casa dos pais. Uma associação interessante que aconteceu quando contou sobre a decisão de se mudar da casa dos pais foi o fato de ela ter feito certa confusão ao se referir a ela mesma como mãe, ou à sua mãe. Relatando as características da sua mãe - de ser invasiva e controladora -, contou que a relação das duas nunca foi tranquila, pois sempre brigaram muito. Em determinado momento a mãe começou a querer mandar nela e nas coisas relacionadas à gravidez, então resolveu falar com Antônio e decidiram morar juntos, em uma tentativa de se preservar da invasão materna:

> *... com o passar do tempo, Antônio começou a ficar mais perto de mim. Antônio é o pai, começou a ficar mais perto de mim, a gente voltou a namorar. Daí começou* ***aquelas coisas de mãe, não eu, a minha mãe*** [grifo nosso], *achar que o filho ia ser dela. Porque eu brigo muito com minha mãe, desde pequena. Mas ela começou a se "adonar" um pouco do meu filho, e eu comecei a não gostar muito, ah, aqui vai ser o quarto, vai ser assim. Essas coisas que a gente quer fazer pro filho da gente, entendeu? Daí eu resolvi que eu ia sair de casa. Daí eu disse, - 'olha Antônio, se tu não quiser ir morar comigo tudo bem, não tem problema, mas eu não vou conseguir ter meu filho aqui dentro de casa, a minha mãe me mandando nas coisas', - 'agora tu dá de mamar, agora tu faz aquilo', eu fico irritada, eu já fico estressada, porque eu sou bem brava também, né? Daí ele - 'tá tudo bem, então a gente vai morar junto'... .*

Nesse fragmento de discurso pode ser percebida a mudança da posição subjetiva de filha para mãe em uma dupla identificação. Em um primeiro momento, permitiu que a mãe se apropriasse das questões relacionadas ao neto. Em determinado momento, quando começou a se sentir ameaçada de perder o filho, convocou Antônio em uma tentativa de limitar as investidas de sua própria mãe em relação ao seu filho. Colocava-se, assim, a possibilidade de deixar o filho com a mãe (oferecê-lo para a mãe) ou a possibilidade de Diana assumir o próprio filho, retornando o seu desejo para o pai da criança. A disputa pelo bebê começou a ser definida. Diana, convocando o pai do filho dela, permitiu-se iniciar o processo de separação da própria mãe e tomar para si o bebê - bebê este que, de acordo com a teoria freudiana (Freud, 1931/1990; 1932/1990a), está no lugar do falo destituído quando da vivência da castração.

Uma temática bastante trazida ao longo de todas as entrevistas foi sobre o trabalho e o dinheiro. Apesar da gravidez avançada, estava trabalhando com o mesmo nível de exigência que quando não estava grávida. Inclusive, no último mês gestacional chegou a ser a funcionária que mais vendeu no estabelecimento. Sentia-se muito cobrada por Antônio e por sua mãe para que diminuísse o ritmo de trabalho, pois desse jeito não estava sendo considerada uma boa mãe e era por eles caracterizada como desnaturada. Para ela, o pedido da família de se tranquilizar significava ela ficar *"... meio abobada só porque tava grávida"*. Esse entendimento a levava a continuar trabalhando, pois ela tinha que ser forte para *"... mostrar pro meu filho que o mundo é isso"*. Em contrapartida, caracterizava Antônio como "abobado", pois, desde que soube da gravidez, passou a viver em função dela, passando a mão na barriga e falando com o bebê, além de aprender a andar de *skate* para poder fazer isso com o filho. Em relação ao trabalho, ela também o percebia como seu oposto - descomprometido e não se importando com dinheiro.

Diana tinha um sentimento muito forte em relação às expectativas de sucesso para seu filho. Chamou a atenção que, no momento da despedida da entrevista feita no terceiro trimestre da gestação, ela perguntou à pesquisadora o que fazer com o bebezinho para estimulá-lo desde cedo, para que ele aprendesse mais rápido e se tornasse um "gênio". Nessas falas, de alguma forma, percebem-se dois aspectos importantes dessa entrevista: por um lado, ela começa a se colocar como aquela que sabe o que é importante para o filho, destituindo as expectativas e saberes dos familiares que acreditavam que ela tinha que diminuir a exigência ou mesmo achar estranho a infantilização do Antônio frente ao bebê; por outro lado, começou a se esboçar, a partir desses enunciados identificantes (Aulagnier, 1990), uma recomposição narcísea (Ferrari et al., 2006), que lhe permitira reencontrar um lugar privilegiado frente ao desejo de alguém.

Não tinham se decidido ainda por um nome. O nome que ela gostava era Ângelo, mas somente poderia colocar esse nome no filho se a cara do bebê fosse de anjo. Se tivesse cara de capeta, teria que ser outro nome. Queria ver o rosto do bebê antes de decidir-se pelo nome *"... porque eu disse que quando eu olhasse pra cara do meu filho, eu ia dizer qual ia ser o nome dele... . Ou ele vai ter uma cara de Ariel, Vicente ou Ângelo... . Eu vou olhar para a cara dele e vou determinar..."*. A dificuldade da escolha do nome, aliada à exigência de genialidade, fez a equipe pensar que o lugar que esse filho poderia ocupar seria o de completá-la e, com isso, restituir seu próprio lugar de anjo em relação à sua mãe destituído ao longo da vida. Cabe lembrar o nível de exigência no qual ela se colocava, impossibilitando-se, inclusive, de "se abobar" frente à sua gravidez. Além disso, repetidas vezes colocou que, aos olhos de seus pais, nunca foi a filha "certinha".

Um dia antes do parto, telefonou à pesquisadora dizendo que teria que fazer uma cesariana, pois o vírus HPV estava ativo. Em visita a Diana no hospital, no dia seguinte ao nascimento do bebê, a pesquisadora observou que ela estava passando alguns clientes para um colega de trabalho. Contou que o nome escolhido tinha sido Ângelo e um encontro com a pesquisadora dentro de quatro meses foi combinado. A entrevista do quarto mês foi feita na sua residência e o dia escolhido por ela foi aquele no qual ela retomaria o trabalho. Nesta entrevista, a temática sobre o retorno ou não ao trabalho foi bastante intensa. Percebia-se certa tensão entre ela e Antônio, dando a impressão de que vinham discutindo muito. Antônio deu a entender que Diana estava com dificuldades em se relacionar com Ângelo. Diana estava tensa e inibida para falar, bastante diferente dos contatos anteriores. Reconheceu que esses meses tinham sido muito difíceis. Ângelo teve muita cólica e ela não encontrou a ajuda que esperava da mãe, apesar de, em outros momentos, dizer que se a mãe não a tivesse ajudado ela não teria aguentado. Como Ângelo chorava muito, ela não dormia. Fazia isso quando a mãe chegava em casa e dava uma mamadeira ao bebê. Nesse momento, ela relaxava e dormia.

Além disso, referiu que ela chegava a chorar junto com Ângelo por não saber o que fazer, entrando em desespero: *"... te dá um desespero... . Eles são muito pequenininhos, não sabem falar ainda, só berram, berram, berram... . Eu quase morri de pena, vivia indo para o hospital, achando que o Ângelo tava com outra coisa sem ser cólica"*.

Pelo trabalho que deu no início, dizia que nunca mais teria filho, mas que naquele momento as coisas estavam muito mais tranquilas. Ângelo não chorava e nem incomodava mais. A diminuição das cólicas aconteceu quando ele se encontrava com dois meses e meio, o que coincidiu com a mudança de casa. A equipe concluiu que essa coincidência relatada por Diana não podia ser negligenciada, visto os conflitos que Diana referia ter com sua mãe. Afinal, foi em uma tentativa de se tranquilizar frente à maternidade que Diana, no final da gravidez, resolveu que, assim que a casa ficasse pronta, ela se mudaria, para evitar que a mãe se apropriasse de seu filho.

Além disso, a tranquilidade de Ângelo estava relacionada à disponibilidade de Diana de passar o dia brincando com o filho: *"... ele não chora, não me incomoda... . Se tu brincar com ele durante o dia, ele é tri na paz... . Só que ele é bem mal-acostumado... . Ele adora um colo, não gosta de ficar atiradinho que nem criança... . Ele é bem esperto assim"*. Parece que, a partir do momento em que se mudou para sua casa, tranquilizou-se em relação aos cuidados com Ângelo, permitindo-se viver em função do filho. Comparando a descrição do comportamento de Ângelo nos dois primeiros meses e o daquele momento, parecia estar se tratando de duas crianças diferentes - com a primeira, não sabia o que

fazer, pois a criança só berrava; com a segunda, pôde passar o dia brincando. De alguma forma, essa última fala confirmava o que ela dizia durante a gravidez a respeito das características que o filho teria: que seria uma criança esperta. Este esperteza estava intimamente relacionada ao que ela fazia com seu filho e ao que ela mesma era em contraposição ao Antônio.

Queixou-se muito do Antônio, chegando a dizer que ela preferia ficar com Ângelo. Além disso, referiu que Antônio tinha medo de pegar o bebê e que transmitia essa insegurança para o filho, pois cada vez que Antônio se aproximava de Ângelo, o bebê chorava. Isto chamou a atenção porque, em outro momento da entrevista, Diana referiu ter sido a semana anterior ao primeiro banho que ela deu no filho. Até então quem dava banho no bebê eram o pai ou a avó. Adiou esta tarefa por tanto tempo porque, uma vez que ela tentou dar banho no filho, quase o deixou cair, e depois disso ficou com medo. Ângelo tinha mais ou menos dois meses, e quem dava sempre banho nele era sua mãe; primeiro, por causa da cesariana e, depois, por causa do frio (já que Ângelo havia nascido muito magrinho e passava muito frio). Quando começou a primavera, ela se animou a dar banho. Ela estava com a mãe e Antônio porque:

> *... nunca tô sozinha, e só fico sozinha quando não tem ninguém em casa, tá sempre alguém em cima de mim e o Ângelo... . Estão sempre controlando, sempre analisando se está tudo certo ou errado!... . Até o presente momento* [desse banho] *eu tava exausta de cansaço, são coisas que tu não te detém nos detalhes, porque tem outra pessoa fazendo, tu quer descansar... . Daí eu abaixei ele na banheira, ele se levantou, do tipo se levantar, sabe? E ele fez assim, oh, ele subiu um pouquinho e virou para lá e aí eu segurei ele com as duas mãos porque senão ele ia cair.*

Referiu que tanto a mãe quanto Antônio fizeram um escândalo, dizendo que ela estava louca e que não sabia carregar a criança. A partir de então, ficou com medo de machucá-lo, e aquele sentimento de medo relacionava-se à percepção que Diana tinha de que tanto a mãe quanto Antônio ficavam controlando e podando sua relação com Ângelo. Coisa semelhante aconteceu com a alimentação semilíquida. As primeiras papinhas ela não se animava a dar, por medo que o bebê se engasgasse, ficando isto a cargo do pai ou da avó. Porém, quando questionada sobre como estava se sentindo como mãe, disse que *"... é ótimo, adoro. Por mim, não voltava a fazer nada, só ficava com o Ângelo"*. À questão sobre se, quando grávida, acreditava que se sentiria assim, respondeu:

> *... não, na realidade eu achava, assim, que eu ia ser uma mãezona, sabe? Mas não que eu quisesse parar de fazer qualquer coisa para ficar em função do meu filho, entende? Mas é muito bom ficar perto deles, eles assim, o Ângelo é carinhoso, sabe? Ele é assim, eu já ensinei desde pequeno eu fazia assim com a maõzinha dele: carinho na mamãe. Agora ele já faz sozinho, porque eu sei que é carinho, porque só a mãe entende. Quem vê, diz: -'ai, parece uma abobada'.*

Continuando a falar sobre si e o filho, refere:

> *... o Ângelo tem que ser o mais lindo... . Eu me dedico cem por cento para o meu filho, mas é porque eu quero que ele seja. Como é que eu vou te explicar? Hoje, no mundo, se a criança não for esperta, se ela não tiver uma estrutura, se ela não tiver uma base, aí a pessoa fica assim, a ver navios... . Hoje o que eu quero dar para o meu filho, e eu acho que agora é superimportante, sabe? Ele se sentir acolhido, numa casa, sabe, porque eu até andei dando uma olhadinha numa creche, mas as crianças ficam atiradas... .* [As professoras] *ficam batendo papo, se a criança comeu, comeu, se a criança não comeu, não comeu.*

O imperativo de esperteza para o filho mantinha-se na mesma intensidade desde a gravidez. A dificuldade sentida por ela nos primeiros dois meses de Ângelo talvez tenha relação com o fato de que o bebê não tinha ainda condições de lhe responder aos seus pedidos de reconhecimento. Por isso, é bem possível que ele estivesse sendo caracterizado como "abobado", gerando certo estranhamento por parte de Diana. No momento em que Diana passou a perceber que o filho a reconhecia, ela pôde fazer certas leituras de seu comportamento que passaram a caracterizá-lo como esperto. Além disso, ela se responsabilizava pela esperteza do filho. A esperteza dependeria do seu sucesso como mãe. Toda a sua energia estava colocada no filho, tanto que ela chegou a afirmar que não mais se importava com a sua aparência, por estar totalmente voltada para Ângelo. Da mesma forma, colocava Ângelo em um lugar de ser mostrado, como produto do seu narcisismo.

Diana estava se percebendo como boa mãe,

... porque eu vivo em função do meu filho; uma mãe, eu acho, que quer te dar muita atenção, para o seu filho. E agora acho que uma mãe tem que fazer isso. Eu faço tudo o que ele quer, brinco, dou atenção, entendeu... . Cuido, sou uma mãe zelosa, não sou daquelas que quer o filho só para si, que só suga, que não deixa ninguém encostar... . Tudo o que ele me pede, do jeito dele, eu faço. Mais não teria como fazer.

Terminou a entrevista dizendo:

... só faço brincadeiras para ele ficar mais esperto, mais inteligente e, é isso, sabe? Eu acho que se eu tiver um outro filho daqui a algum tempo vai ser bem mais ligth tudo!... . E depois, quando tu tem um outro filho, tu sabe que tudo aquilo vai passar, entendeu? Tu já consegue descansar mais, tu já vê que faz parte da vida de qualquer um, tu já sabe o que uma criança gosta, o que não gosta. Teu primeiro filho é todo novidade, tu não tem noção, eu não tive noção nenhuma de como é que era criar um filho, eu achava que era que nem boneca, mas agora que eu sei... .

Estas falam caracterizam como Diana estava se sentindo em relação ao bebê. Apesar de estar retornando ao trabalho pelo término da licença maternidade, em muitos momentos deixava transparecer a decisão de ficar em casa para poder estar com Ângelo e educá-lo de acordo as suas expectativas. Explicitava que a relação que os dois tinham a completava, sendo Antônio colocado como intruso, alguém que atrapalhava seu projeto para o futuro do filho. Como a entrevista foi feita na sua residência, pôde-se perceber que Ângelo era um bebê bastante ativo e conectado com o ambiente. Percebia-se que o bebê era superestimulado e que dava conta dessa estimulação.

Quando o bebê completou oito meses, a equipe retornou à casa de Diana para fazer a terceira entrevista. Essa entrevista teve uma particularidade em relação às outras: Diana foi bastante sarcástica quando se tratava dos comentários a respeito de Antônio, passando a reclamar *debochadamente* (grifo nosso) do marido, e não perdia uma oportunidade de falar mal dele.

Iniciou falando da dificuldade que seria se tivesse que trabalhar e ser mãe. Achava Ângelo muito esperto para a idade que tinha e contou que, no período que ela retornou ao trabalho, ele fazia chantagem cada vez que ia sair de casa. Comparou o seu comportamento ao de uma sobrinha:

... tu acha que uma criança de quatro meses vai saber que a mãe tá indo trabalhar e olhar na porta? Não sabia, né? fazia chantagem porque ele quer tar sempre grudado com a mãe. Hoje o Ângelo sabe quando a gente vai trabalhar e o dia que não, mas antes era só porque eu tava me afastando, eu acho que ele é chantagista... . É porque eu vejo a minha sobrinha que é uma plasta. A mãe pode largar ela aí, que ela deixa. O Ângelo não, ele se atirava para cima e ahhhhh [choro]. *Eu morria de dó, como é que tu vai deixar teu filho chorando, te querendo e tu indo trabalhar com aquela dor! Foi demais para mim, eu não aguentei a pressão... . E resolvi ficar com meu gurizinho amado.*

A forma de reconhecer o seu desejo era mediante o desejo do filho, que queria ficar grudado com ela.

Encontrava-se tranquila na sua relação com a mãe, não se sentindo mais ameaçada, sendo que muito pouco falou dela durante a entrevista. Parecia que, pacificando-se com o filho, pacificava-se com a sua mãe e, consequentemente, assumia uma certa tranquilidade em relação à maternidade. O conflito surgia, agora, na relação com Antônio, e a ameaça, na sogra. A relação do casal estava beirando à insustentabilidade, e os conflitos relacionavam-se a quase tudo que viesse dele. Se existiam sérias críticas em relação às posturas que ele tomava frente às coisas da vida, naquele momento, além de crítica, era sarcástica e o destituía muito mais do que nas entrevistas anteriores.

O jeito de ser de Antônio a deixava muito preocupada no que se referia à educação de Ângelo. Acreditava que Antônio era assim porque não teve uma estrutura familiar suficiente, culpando a sogra pela má influência no seu jeito de ser (a sogra não soube educar o filho). Dava graças a Deus por Ângelo ser parecido com ela e não com o pai. Exemplificava contando que, quando o filho queria um brinquedo, não sossegava até consegui-lo, ao contrário de Antônio, que não lutava pelas coisas.

O Ângelo é que nem eu, ele é completamente igualzinho a mim. Ele é idêntico ao Antônio fisicamente, mas o gênio do Ângelo é igual a mim. Graças a Deus, o Ângelo não saiu assim [que nem o pai], *senão eu ia morrer... eu acho ótimo. Se ele encucar que ele quer esse brinquedo, ele vai fazer até conseguir. O Antônio não é assim, o Antônio esticou o braço, não alcançou o brinquedo, ficou assim. Então ele é uma pessoa que não luta pelas coisas que ele*

quer. Então eu acho bem bom o Ângelo ser assim, bem bom, porque hoje em dia no mundo tu tem que lutar pelo que tu quer, senão ele vai ser... . O Antônio vai ser sempre o filhinho da mamãe, desse que ganha tudo, e eu não quero isso para o meu filho... . Eu tento não dar tudo na mão dele, sabe? Tento dificultar para ele se superar. Eu acho que isso é bom, não ser um bosta. Imagina, o mundo cada dia está pior e tu ainda vai ter um bosta, o que vai ser do meu filho... . Eu me preocupo bastante como vai ser a educação do Ângelo... . Quem vai educar sou eu, tudo.

Atribui a ela a responsabilidade pelo filho ser persistente e, ao longo da entrevista, tentou destituir qualquer traço identificatório do bebê com o pai. Inclusive chegou a tecer a hipótese de que Ângelo não ganha peso adequado à idade devido ao medo que ela tem que ele se torne "*gordo*" e "*plasta*" que nem o pai: "*... porque o Ângelo não cresce, porque ele não quer saber de comer, até não sei se não é inconscientemente que tô passando isso... . Botando na cabeça para ele não ser gordo... . Vou fazer o que tiver que fazer para ele não virar gordo*".

Referia ter medo que Ângelo ficasse igual ao pai, que não lutasse pelas coisas que queria, mas, ao mesmo tempo, apartava Antônio da relação com o filho, o que possibilitaria que Ângelo se tornasse um "filhinho da mamãe", sem um pai para se interpor na relação dos dois. Não suportava estar próxima do marido, chegando a referir que era frequente ela dormir com o bebê, expulsando Antônio do quarto. A questão que se coloca era se essa repulsa ao marido era devido à relação conjugal ou se estava relacionada ao fato de que, se ela ficasse próxima de Antonio, ele ficaria próximo do filho, e ela poderia ser destituída de seu lugar privilegiado. Não estaria em jogo uma atualização da disputa edípica entre ela e sua mãe quando da percepção, por parte de Diana, da sua castração - e, consequentemente, da castração materna? Nesse momento ela lutava com todas as forças para ser fazer a única responsável pelo sucesso futuro do filho, garantindo, assim, a manutenção de se satisfazer por ocupar esse lugar privilegiado.

Em relação à escolha do nome, referiu que ela sempre quis Ângelo, e que havia um nome que Antônio gostava, mas não lembrava mais qual era. De qualquer forma, ele não teria conseguido escolher um nome tão bom quanto o sugerido por ela:

Na época [da escolha do nome], *eu pensava que ia ser um anjo, né, mas meu filho é um anjo! Não ia escolher um nome tão bem... . Mas eu acho que o Ângelo é um anjo mesmo, ele é todo mimoso, todo bonitinho, mas eu acho que ele é assim por causa de mim, é porque eu cuido muito bem dele.*

Falando da relação com o filho, referiu que eram muito carinhosos um com o outro: "*... nós dois somos bem carinhosos um com o outro; ele vive alisando, agora ele aprendeu a fazer uns carinhos. Então ele acorda, me mexe, me toca ... . Ele vibra*".

Passou a falar, então, de quão maravilhoso era o filho:

... eu imaginava que eu ia ser louca por criança, porque eu amo criança, mas eu não sei se eu imaginava que ele fosse nascer tão maravilhoso... . Além de eu ser muito apaixonada por ele, eu admiro muito o jeito dele... . Ele não pára nunca... . Eu acho bem bom que ele, ele tem que conhecer o mundo. O Ângelo me mostra que ele tem que conhecer o mundo... . Porque eu já te falei que eu detesto criança 'monga'.

Considerações Finais

O caso de Diana traz algumas questões colocadas pela psicanálise a respeito do conflito edípico e sua atualização no acesso à maternidade. Uma delas se refere à importância da relação pré-edípica, que funciona como protótipo a partir do qual serão estabelecidas as futuras relações. Por exemplo, nas entrevistas, Diana relata uma série de conflitos com a mãe, que estão relacionados ao jeito de ser dela, que nunca foi "certinha" como a mãe gostaria que fosse. Por outro lado, o nível de exigência profissional e de vencer no trabalho deu a impressão de que estava relacionado à necessidade de dar conta de um certo ideal materno que se colocava para ela. Assim pareceu à equipe que o Ângelo veio ocupar, de alguma maneira, esse lugar de genialidade e perfeição que ela deixou de ocupar na relação com seus próprios pais. A exigência que Diana tinha em relação ao trabalho foi deslocada com toda a intensidade para o filho, tanto que, quando finalizou a licença maternidade, tentou retornar, mas não conseguiu pelas "chantagens" que o filho fazia para ficar com ela. Além disso, se ela retornasse ao trabalho correria o risco de o bebê se tornar um "monga", assim como as crianças criadas pela família do marido.

Ao longo dos oito meses de acompanhamento deste caso, percebeu-se como, desde a gravidez, Ângelo precisava dar conta de um ideal de genialidade que, com certeza, era uma questão fundamental para Diana. O período difícil que Diana relatou nos três primeiros meses de vida do bebê poderiam estar relacionados à incapacidade de perceber nos atos do bebê algum traço de genialidade e esperteza que o diferenciasse dos outros. Porém, quando Ângelo passou a responder aos seus estímulos e reconhecê-la, alimentou e recompôs seu narcisismo, permitindo-lhe vislumbrar, na pessoa do filho, a superação das falhas ocorridas ao longo de sua vida. Este fato permitiu que ela driblasse a percepção da sua incompletude, acionada quando da percepção da sua castração. Fazendo do filho alguém que a satisfaz plenamente, tentou apagar qualquer traço identificatório que Ângelo pudesse carregar do pai. O filho, até aquele momento, parecia tamponar a falta materna, satisfazendo-a plenamente já que não oferecia resistência às demandas de Diana.

As falas desta mãe permitem pensar no processo de falicização de um filho a partir da equação simbólica freudiana falo-bebê. Esse lugar parece ter sido forçado pela mãe pelos seus movimentos transitivistas. A mãe supõe que ela é tudo para seu bebê a partir das decodificações daquilo que o bebê lhe dá a perceber. Este momento pode ser considerado como o primeiro tempo do Édipo, momento no qual a criança se coloca como falo que completa a mãe, alienando-se ao seu desejo. O que Diana mostra é como ela foi situando Ângelo nesse lugar de ser aquele que a completa. Resta saber o destino desses personagens, se Diana vai passar a olhar para além de Ângelo, acionando o processo de castração dela mesma e de Ângelo, permitindo a separação. Este acionamento permitiria a produção de um sujeito diferenciado daquele que ela previu, possibilitando a passagem de *ser* o falo para a possibilidade de tê-lo, possibilitando o acesso às identificações edípicas.

Referências

Assoun, P. L. (1993). *Freud e a mulher*. Rio de Janeiro: Jorge Zahar.

Aulagnier, P. (1990). Um interprete em busca de sentido. São Paulo: Escuta.

Bleichmar, H. (1988). *Introdução ao estudo das perversões*: *teoria do Édipo em Freud e em Lacan*. Porto Alegre: Artes Médicas.

Ferrari, A. G., Piccinini, C. A., & Lopes, R. S. (2006). O narcisismo no contexto da maternidade: algumas evidências empiricas. *Psico, 37*(3), 271-278.

Ferrari, A. G., & Piccinini, C. A. (2010). Função materna e mito familiar: evidências a partir de um estudo de caso. *Ágora, 13*(2), 243-257.

Freud, S. (1990). Algunas consecuencias psiquicas de la diferencia anatómica entre los sexos. In J. Strachey (Org.), *Obras completas* (Vol. 19, pp.259-276). Buenos Aires: Amorrortu. (Originalmente publicado en 1925).

Freud, S. (1990). El yo y el ello. In J. Strachey (Org.), *Obras completas* (Vol. 19, pp.1-65). Buenos Aires: Amorrortu. (Originalmente publicado en 1923).

Freud, S. (1990). La interpretación de los sueños. In J. Strachey (Org.), *Obras completas* (Vols. 4-5, pp.1-707). Buenos Aires: Amorrortu. (Originalmente publicado en 1900).

Freud, S. (1990a). Nuevas conferencias de introducción al psicoanálisis: 33° conferencia. La feminilidad. In J. Strachey (Org.), *Obras completas* (Vol. 22, pp.104-155). Buenos Aires: Amorrortu. (Originalmente publicado en 1932).

Freud, S. (1990b). Nuevas conferencias de introducción al psicoanálisis: 32° conferencia. Angustia y vida pulsional. In J. Strachey (Org.), *Obras completas* (Vol. 22, pp.75-103). Buenos Aires: Amorrortu. (Originalmente publicado en 1932).

Freud, S. (1990). Psicologia de las masas y análisis del yo. In J. Strachey (Org.), *Obras completas* (Vol.18, pp.63-135). Buenos Aires: Amorrortu. (Originalmente publicado en 1921).

Freud, S. (1990). Sobre la sexualidad femenina. In J. Strachey (Org.), *Obras completas* (Vol. 21, pp.223-244). Buenos Aires: Amorrortu. (Originalmente publicado en 1931).

Kehl, M. R. (2008). *Deslocamentos do feminino* (2ª ed.). Rio de Janeiro: Imago.

Lacan, J. (1995). *Seminário livro 4*: *a relação de objeto*. Rio de Janeiro: Jorge Zahar. (Originalmente publicado em 1957).

Lacan, J. (1999). *Seminário livro 5*: *as formações do inconsciente*. Rio de Janeiro: Jorge Zahar. (Originalmente publicado em 1958).

Laplanche, J., & Pontalis J. (2001). *Vocabulário de psicanálise* (4ª ed.). São Paulo: Martins Fontes.

Millot, C. (1992). *Extrasexo, ensaio sobre o transexualismo*. São Paulo: Escuta.

Roudinesco, E. (2003). A família em desordem. Rio de Janeiro: Jorge Zahar.

Tisseron, S. (2002). Rivalidades e cumplicidades entre os sexos: a rivalidade, por quê? *Pulsional, Revista de Psicanálise*, *15*(161), 64-69.

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Liberation psychology: A constructive critical praxis

Psicologia da libertação: uma práxis crítica construtiva

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Abstract

Can a critical psychology be more than an inward looking critique of the discipline itself? Liberation psychology emerged in Latin America in the 1980s. It is a critical psychology with an action focus, taking sides with the oppressed populations of the continent. The originator of the approach, Ignacio Martín-Baró practiced psychology in the context of the *El Salvador* an civil war, himself becoming a victim of State repression. The consequences of social conflict have since then been an important theme for liberation psychology. Other areas of emphasis have been community social psychology with an emphasis on the role of social movements and social and political commentary and critique. I will present a review of the field covering some key concepts (conscientisation, de-ideologization, historical memory, reconstruction of psychology from the perspective of the other), its geographical spread (in Latin America and other regions), its organization (the emergence of liberation psychology networks and collectives) and some examples of work that is relevant to social trauma, the theme of this symposium.

Uniterms: Dropout; Inclusion; Motivation.

Resumo

A psicologia crítica pode ser mais do que uma crítica que olha para dentro da própria disciplina? A psicologia da libertação surgiu na América Latina na década de 1980. É uma psicologia crítica que tem foco na ação, tomando partido das populações oprimidas do continente. O propositor desta abordagem, Ignacio Martín-Baró, exerceu a psicologia no contexto da guerra civil de El Salvador, sendo ele mesmo uma vítima da opressão do Estado. Desde então, as consequências do conflito social tem sido temas importantes da psicologia da libertação. Outras áreas de foco tem sido a psicologia social Comunitária, com ênfase no papel dos movimentos sociais, e nos comentários e críticas sociais e políticas. Apresentarei uma revisão do campo cobrindo alguns conceitos chaves (conscientização, desideologização, memória histórica, reconstrução da psicologia pela perspectiva do outro), sua abrangência geográfica (na América Latina e em outras regiões), sua organização (a emergência de redes e coletivos da psicologia da libertação) e alguns exemplos de trabalhos relevantes para a compreensão do campo do trauma social, tema deste simpósio.

Unitermos: *Desistência; Inclusão; Motivação.*

I am very honoured to be here in Diyarbakir at this symposium on critical psychology and social trauma and I do hope that I can contribute something useful for the struggles here.

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Extenced version of keynote talk given at the Third Critical Psychology Symposium, Diyarbakir, Turkey, 15-16 September, 2012. I am grateful to colleagues from TODAP for the invitation.

I am going to talk about a Latin American critical psychology. Why might that be relevant? I am struck by the parallels. A middle income country on the periphery of the capitalist centre. A neoliberal regime. A history of military dictatorship. Repression on an 'industrial scale' with torture, imprisonment and extrajudicial killings. Persecution and exclusion of minorities. Social trauma. And a mainstream psychology that serves the system. Where am I? Honduras? Guatemala? Argentina? Honduras? Colombia? Chile?

It may seem strange for an Englishman to be representing the Latin American work and indeed it is. There are better authorities on the subject but distance and language means you have me. However, I am also clear that the approach is not unique to Latin America. There are parallel developments in several other places, some of which go under the name of liberation psychology and others which don't.

There are various critical psychologies and they differ. You now have a translation of a North American approach (Fox, Prilleltensky & Austin, 2009; 2012). There is a very interesting South African version (Hook, Kiguwa & Mkhize, 2004), there is a European approach, generally far too theoretical and abstract for me: too isolated from political praxis, too discursive, too postmodern. So let's first consider what critical psychology is meant to achieve.

Is critical psychology just another academic discipline?[2]

Critical psychology attempts to correct the errors of dominant psychology, but the ways different critical psychologies have understood and attempted that task have differed greatly between different workers and different places.

Critical psychology arose in large part from what has been called the crisis in social psychology dating from the late 1960s well into the 1970s. Dominant, English-speaking (and especially North American), largely experimental, social psychology was criticised as being largely irrelevant to real human needs and contexts, and because it wrongly assumed that its methods enabled the discovery of fundamental principles, processes and even laws of human behaviour, that could be generalised to all situations. To this critique, largely from within social psychology, were added related concerns, for example about the abuses of psychology and of the medicalisation of distress in the mental health system (Anonymous,1970s nd.).

But from that point a number of paths were followed (Armistead, 1974; Parker, 1989; 1999). Some emphasised the dramaturgical metaphor for understanding human action (Harré & Secord, 1972), others emphasised the study of experience using phenomenological concepts and methods. Some assimilated Marxist and Marxian thinking (Ingleby, 1970; Parker & Spears, 1996) and others emphasised social commitment and action. Others still focussed on the oppressive roles and uses of psychological concepts and knowledge (Ingleby, 1985; Rose, 1985) while others focussed on the development of new methods (Reason & Rowan, 1981).

By the 1980s, it was possible to identify some dominant trends. In Europe (predominantly) the 'discursive turn', in the context of a post-structuralist and post-modernist movement away from the structuralism and Marxism of previous generations, was particularly influential. An early statement of this approach was the opening article of the short - lived journal Ideology and Consciousness (Adlam et al., 1977; Potter & Wetherall, 1987). Just as the pretensions of empiricism in revealing general principles and theories had been rejected, so now were the so called grand theories of social systems. Instead there emerged a highly parochial focus on the particularities of social situations and above all of the use of language. In some variants all psychological and social phenomena were reduced to texts (and the term reduced is used here consciously to suggest that this was not unlike the reductionism so criticised in previous psychologies). In some variants the relativism of postmodernism meant a rejection of ethical judgements and also it seemed of methodological standards - say what you like seemed to be the norm. At its worst this meant an individualistic

[2] This section of the paper was not presented at the symposium due to lack of time.

rendering of critical rather than critical as the questioning of a body of theory and practice by reference to another, sharper and more penetrating theoretical framework (such as the analysis of class or patriarchal relations). Indeed the great value accorded to personal experience and the emphasis on the construction of reality through the use of language now seems like a retreat from a really social understanding of people in society since it involves a new dualism - that between an unknowable social reality and the social psychology of language. Concepts of social construction and cognitive representation seem to maintain the bourgeois distinction between individual and society, or at best they fail to theorise the processes by which concrete individuals (Sève, 1978) are formed in contexts of social reproduction, socialisation and social transformation (Bhaskar, 1979).

It would be unfair to suggest that the discursive and poststructuralist turn brought no advances in understanding: to name but three, there was Silverman's use of discursive analysis to show how social discrimination in the medical consulting room reduced the life expectancy of children with Down syndrome (Silverman, 1981), or Figlio's use of a Foucauldian framework to explore what he called the social constitution (at once the causation and the ideological construction) of chronic disease (Figlio, 1978), and finally Rose's analysis of the development of the 'psy complex' through the involvement of psychological testing in the segregative and eugenic social policies on disability in early C20 Britain (Rose, 1985).

However, in my view, such innovations were few and European critical psychology came to be characterised by a hyper-development of ungrounded theory, typically impenetrable to the outsider, with little apparent applicability to the harshening social reality outside the academy. This tendency I call academic in the ivory tower sense of the word: the problem is not the development of theory but the alienation of theory from social causes, experience and struggles. There is not sufficient time to explore the reasons for critical psychology taking this path in Europe, but it would appear to do with the privileged position of academic psychologists in the context of the retreat of progressive ideas in the period from the mid 1970s under the neoliberal onslaught.

A Latin American alternative

In Latin America, another path was being followed - not exclusively since the post-modern virus was contagious (Lacerda, 2010) - but by enough people to demonstrate that another critical psychology was possible. Here the tradition of praxis in fields such as theology and philosophy of liberation, the Theatre of the Oppressed and in Popular Pedagogy, as well as in some of the region's social movements, provided an alternative and more socially engaged model (Chart 1) shows some of the principal currents). In the two originally separate but now linked areas of community social psychology and psychology of liberation, the preferential option for the oppressed majorities was taken, constructing critical psychologies that dealt with social reality, as reality and not as some linguistic chimera. That reality had to be clarified and in the words

Chart 1
Latin American Praxis: Some key currents

Framework	Countries of origin and major development.
Critical/militant sociology participatory action research	Colombia.
Theology of liberation	Argentina, El Salvador, Brazil, Peru.
Philosophy of liberation	Argentina, Mexico.
Popular pedagogy	Brazil, Chile, Guinea, Bissau, United States.
Community social psychology	Venezuela, Puerto Rico, Brazil, Mexico Colombia, El Salvador, Panama, Peru, Dominican Republic, and others.
Psychology of liberation	El Salvador, Venezuela, Mexico, Guatemala, Costa Rica and others.
Community therapy	Brazil.
Organisation workshop	Brazil, Honduras, Nicaragua.
Theatre of the Oppressed/Forum Theatre	Brazil.
Revolutionary Psychology/Cultural historical approach	(Soviet Union), Cuba.

of Ignacio Martín-Baró de-ideologised so it could be seen for what it was, in order that it could be changed (Martín-Baró, 1996a).

Latin America has had its share of post-modern and hyper-theoretical critical psychology and indeed this is perhaps no more than another manifestation of an inferiority complex that leads to the imitation of work from the core countries (de la Torre, 1995). However, other developments can be identified (Gonzalez Rey, in press), pointing to a socially committed psychology characterised by the reconstruction of psychology in dynamic relationship with social issues, social action and social movements. This was exactly the approach taken by Martín-Baró in his programmatic articles and his texts of social psychology (Burton, 2004a; 2004b; Burton & Kagan, 2005; Martín-Baró, 1983; 1986; 1989a; 1996b; 1998). It also characterises the best of Latin American community psychology (Góis, 2005; Montero, 1996; Montero & Serrano García, 2011; Ximenes, Amaral, & Rebouças, 2008) and related work within the framework of liberation psychology (Barrero & Salas, 2010; Dobles & Baltodano, 2010; Dobles, Baltodano, & Leandro, 2007; Guzzo & Lacerda, 2011).

Martín-Baró's proposal and his approach

So what is the psychology of liberation? It should be noted that it has several roots in addition to the critique of Anglo-American psychology, it draws fairly eclectically on the wider Latin American critical tradition, the theology and philosophy of liberation (Martín-Baró was one of a group of radical Roman Catholic priests at the University of Central America, 5 of whom were murdered with him) and the experience of the Brazilian Christian Base Communities, Marxism and the work of earlier critical psychologists from the South and its diaspora (Fanon in particular), and later workers have also made use of radical currents in psychoanalysis, soviet and Cuban cultural-historical psychology and phenomenological approaches in psychology.

It is worth quoting from its originator, Martín-Baró (Martín-Baró, 1996b) at some length to illustrate this approach:

> 1) Latin American psychology must switch focus from itself, stop being preoccupied with its scientific and social status and self- define as an effective service for the needs of the numerous majority... which should constitute the primary object of its work... (p.26).
>
> 2) The objective of serving the need for liberation … requires a new form of seeking knowledge: the truth of the Latin American people is not to be found in its oppressed present, but in its tomorrow of freedom; the truth of the numerous majority is not to be found but to be made... . The new perspective has to be from below, from the numerous oppressed majority... . Assuming a new perspective does not suppose, obviously, throwing out all of our knowledge; what it does suppose is its being made relative and critically revised from the perspective of the numerous majority. Only from there will the theories and models demonstrate their validity or deficiency, their usefulness or uselessness, their universality or provincialism: only from there will the techniques that have been learned demonstrate their potential for liberation or subjugation... (p.27).
>
> 3) All human knowledge is conditioned by the limits imposed by reality itself. In many respects reality is opaque, and only by acting upon it, only by transforming it, is it possible for the human being to gain knowledge of it. What we see and how we see it is certainly conditioned by our perspective, by the place from which we look at history; but it is conditioned also by reality itself. So to acquire new psychological knowledge it is not enough that we base ourselves in the perspective of the people; it is necessary to involve ourselves in a new praxis, an activity that transforms reality, allowing us to know it not just in what it is but in what it is not, so thereby we can try to shift it towards what it should be[3] (p.28).

I can illustrate the approach by referring to the work of community psychologists from the *Universidade Federal do Ceará*, Brazil (Góis, 2005; Ximenes et al., 2008) texts cited above are examples of their output which has a history of some 30 years. Here psychologists work within the context of community social movements, under their leadership, contributing their expertise and contributing to the production of new knowledge for social action. Here for example a radically different

[3] The translation is my own, departing in places from the Harvard version.

approach to intervention with mental distress can be witnessed, it was not designed by psychologists but emerged from the practice of community based social movements, drawing on but transcending the community therapy movement so that people are integrated in social groups and participate in social action, finding new roles capacities and meaning.

Key ideas

I am now going to discuss three key ideas in liberation psychology since these demonstrate its distinctiveness. But note that liberation psychology is richer than this selection suggests. The Attachement indicates some other dimensions. See also <http://libpsy.org/sources-on-liberation-psychology> for English language sources on liberation psychology.

Conscientisation

In Latin America, a notion of liberatory human development has arisen with diverse roots, across a series of disciplines and social movements. A key idea is that liberation is not something that can be given, nor is it a discrete event but rather it is a movement and a series of processes. It often has origins in the interaction of two types of agents or activists: external 'catalytic' agents (which could include psychologists) and the oppressed groups themselves.

Freire's concept of conscientisation (Freire, 1972) is a much-cited formulation of this. Martín-Baró (1986, 1996c) regarded conscientisation as a key concept, explaining it as a person or people being transformed through changing their reality, through an active process of dialogue in which there is a gradual decoding of their world, as the mechanisms of oppression and de-humanisation are grasped. This in turn opens up new possibilities for action. The new knowledge of the surrounding reality leads to new self-understanding about the roots of what people are and what they can become. Anyone who has worked in a facilitative way with oppressed groups for any time will be familiar with this energizing processes that can often seem like an awakening.

De-ideologization

Social reality can be difficult to see for what it is, not just for the people, but for the theory and practice of psychology itself. It is therefore necessary to de-ideologise reality, to peel off the layers of ideology that individualise and naturalise social phenomena. Martín-Baró did this in relation to the problem of conformist fatalism in Latin American societies and the myth of the 'lazy Latino' (Martín-Baró, 1987; 1996d). He also used opinion surveys to counter the propaganda of the Salvadorian government about the opinions of the population (Martín-Baró, 1989b; 1996a), which he both fed back to them (Soto, 2010) and also made available to an international audience, an important contribution to undermining the support given by the United States to the military and a reason for his murder by the forces of the State (Bernabeu & Blum, 2012).

Historical memory

A further tool in the de-ideologisation of social reality, especially important in Latin America is the recovery of historical memory. Martín-Baró pointed out that it is difficult to meet basic everyday needs when the majority live in the psychological present, in a here and now that ignores both past and future. The dominant ideology structures a reality that is apparently natural and a historical, leading to its acceptance without further questioning. This makes it difficult to draw lessons from experience and, what Martín-Baró considered most important, to discover the roots of their own identity, as much to interpret its current meaning as to surface alternative conceptions of what it might become - again combating fatalism and becoming social actors.

It seems likely that the particular importance of recovering historical memory owes something to the specific context of *El Salvador*. A genocide took place in the 1920s: he communist revolutionary Farubundo Martí had led a socialist insurrection, supported by many of the indigenous peasants. It was suppressed, with Martí being murdered and the killing of some 50,000 people, including whole villages, especially in Western *El Salvador* (Chávez, 2012; Equipo Maíz, 2007). It was enough to have indigenous features. As a result people gave up their culture (dress, customs and the Nahuat language) in order to survive. There are always severe psychological and social consequences of such de-culturation and in *El Salvador* this has led to the

depreciation of the Salvadorian, so that for example although there is Salvadorian football the public follows European teams.

So Martín-Baró (1986; 1996c) recommended recovering selectively and collectively elements from the past that were effective for defending the interests of the exploited classes and that could in their turn again be helpful for a conscious struggle for a better world, regaining pride of belonging to a people and gaining a sense of identity with a tradition and a culture.

Reconstruction of psychology from the perspective of the 'other'

As Ignacio Dobles has pointed out:

> It is interesting that in this process of revision and redefinition, [Martín-Baró] didn't adopt a hypercritical stance that devalued the whole legacy of experience and knowledge up to the present... but what he did instead was... . To examine the existing body of work from another perspective, in this case a reading from the point of view of the aspirations and the needs of the popular Latin American majorities. The proposal is not provincial, nor is it limited by absurd regionalism: it is a social psychology from Central America, not a social psychology of Central America (Dobles, 2009a, p.2).

This idea, of a constructive but rigorous critique from the perspective of the oppressed other is central to the models of Latin American critical praxis in a variety of fields, what the philosopher Enrique Dussel calls the analectic method (Burton, 2011; Burton & Flores, 2011; Dussel, 1985; 1997; Flores, 2009).

Liberation psychology as a movement

Since the death of Martín-Baró, and especially from the end of the 1990s, there has been the development of a movement for the psychology of liberation in Latin America. There have been international congresses in a variety of countries; there are established liberation psychology collectives in Colombia and Costa Rica and a developing one in *El Salvador* as well as other less formal groupings elsewhere. There is a e-mail list with (in September, 2012) 948 members. In 2011 an English language liberation psychology network was established with an online presence at <http://libpsy.org/>. It aims to support liberation psychology inspired work going on in countries, North and South, where English is a medium of communication. It also seeks to act as a bridge with the Spanish and Portuguese speaking networks.

A considerable amount of work has been conducted under the umbrella of these networks and movements although the psychology of liberation remains a minority field. Psychologists with a liberatory orientation work in a variety of fields, principally in community social psychology, in relation to social trauma resulting from conflict and oppression, and on the social psychological critique of policy and ideology. At its best liberation psychology brings new insights and perspectives to social movements although at times the networks seem to act as little more than channels for communicating news about various sites of political repression and struggle.

Liberation psychology and social trauma: Memory and collective action

Martín-Baró's approach developed in the context of armed conflict and repression. Such events have characterized the political and social situation in much of Latin America, with particular intensity during the period of the military dictatorships from the date of the military coup in Brazil in 1964 up until the Central American peace accords - *El Salvador* in 1992; Guatemala in 1996; Nicaragua in 1987 and the restoration of parliamentary democracy in other countries from the mid 1980s. In many countries there had been the suspension of civil rights, the imprisonment of political activists, the use of torture, disappearances and murders of activists. In some countries there was civil war between popular revolutionary movements and the forces of the State. In others there were more marginal insurgencies. In some countries (Colombia, Honduras) disappearances still occur, with peasant and trade union activists and journalists particularly targeted by State agencies or groups working for oligarchic interests. Much of the conflict has been tied to United States intervention, for example the installation of the Pinochet junta in Chile, the funding of the military and the deployment of advisors on counter-insurgency and

psychological warfare, collusion with the the removal of elected governments (Haiti, Honduras, Paraguay in the last 7 years), and invasions and interventions in a majority of countries over the last 150 years. Within this context there have been genocidal actions and population clearances and movements of refugees.

With this history, the consequences of social trauma have been a major concern for liberation psychology. Specific foci have been:

1) Work with the victims of torture (Agger & Buus Jensen, 1996; Castaño & López, 1994; Hollander, 1997; Lira, 1994; Lira & Castillo, 1991; Lira & Weinstein, 2000);

2) Work with families of the disappeared or murdered (Girón, 2007);

3) Work with displaced populations and accompaniment of people in 'limit situations' (Tovar, 2007);

4) Campaigns for the acknowledgement of crimes, reparations and against impunity (Barrero & Salas, 2010; Girón, 2007; Portillo, Gaborit, & Cruz, 2005);

5) Analysis of the peace processes (Dobles, 2009b);

6) Research on the consequences of a culture of violence (Estrada, Ibarra & Sarmiento, 2007; Molina, 2005).

Rather than look at each of these areas I will review some common issues and principles that have emerged. They are:

1) The importance of memory and commemoration;

2) Moving from an individual perspective to a collective one;

3) The struggle against impunity.

The importance of memory and commemoration

The importance of historical memory was discussed above as one of the key ideas for liberation psychology. Consistently with this psychologists with a liberatory orientation have worked on the importance of ensuring that events involving violence against individuals, groups and communities is not forgotten.

This is in a context where official policy often recommends forgiveness and forgetting. Collective acts of commemoration are a particular aspect of this work which take a variety of forms including the production and sharing of testimonies, artistic activity and the exhumation and reburial of victims of genocidal acts - especially important in Guatemala where 20,000 people, largely indigenous, were killed, mostly by the army (Comissíon para el Esclarecimiento Histórico, 1999).

Gaborit (2007) identifies four functions of commemoration:

- Firstly, it offers dignity to the feelings of those affected. This is important in a context where the official history has treated such personal or collective feelings as suspect, so that their airing is often surreptitions or clandestine and the feelings themselves become infused with guilt and shame.

- Secondly, commemoration makes the feelings of the affected public and objective rather than something merely personal, private or subjective. Understanding their experience in this socially validated way helps the affected to understand how it impacts on their present social relations and hence on their own identity and well-being. Moreover, this legitimation of personal experience assists in the construction of possible means of promoting reconciliation and repairing the social fabric. As Martín-Baró noted (quoted without citation in Girón (2010), while repression eliminates its target people, it also has the wider effect of terrorizing all those who identify with them. The recovery of memory is the beginning of the process of reversing that dynamic.

- Thirdly, whilst intensifying feelings of pain and injustice, collective commemoration facilitates solidarity and social mobilization. Evidence from the Guatemalan exhumations cited by Gaborit indicates that while participation does not protect people from pain and fear it does reduce social isolation, bringing about intense feelings of belonging and union, not just with the present community but with those that went before.

- Finally, Gaborit suggests that the commemorations also dignify the lives of those who did not survive institutionalized violence, and in many cases this makes it clear to all that there were indeed victims, something that has been repeatedly denied by those responsible for the repression.

Moving from an individual perspective to a collective one

The work on recovering memory and commemorating atrocities then involves bringing memory from the private sphere to the public one, from individualized distress to collective experience. A similar direction of travel takes place in work - with victims of torture. An outstanding example of this is found in the work of *Instituto Latinoamericano de Salud Mental y Derechos Humanos* (ILAS, Latin American Institute of Mental Health and Human Rights), working on the mental health of people affected by violations of human rights during the military regime in Chile, 1973-1990 (ILAS, 2003). ILAS has helped in other situations of political violence, both nationally and internationally, for example in Angola (Agger & Buus Jensen, 1996; ILAS, 2003). Their model was used in Bosnia and has a relevance to people arriving in more peaceful countries as refugees from torture or other trauma. In the United Kingdom (UK), for example, there has also been recent interest in combining frameworks from liberation psychology with therapeutic methods such as narrative therapy (Afuape, 2011).

In the work of ILAS and other teams, there is emphasis on making the suffering a social, shared, thing, rather than a secret, internalized distress, and on again taking up active social roles, of recovering an existential life-project (Lira, 2001; Lira & Weinstein, 2000). The theme of recovering memories, of what happened, and of those who have been taken away, is common to this and similar work (Hollander, 1997). This emphasis is important in terms of the general emphasis in liberatory praxis on the role of collective memory as a political and social resource, but also because of the officially sanctioned denial of what happened.

Perspectives of this kind have also helped liberation psychologists develop a critique of dominant conceptions of trauma. For example Portillo notes that the standard account of Post traumatic Stress Disorder does not recognize the intergenerational impact of such stress (Portillo, 2005). The 'really social' perspective is shared by other workers with a liberatory perspective in Latin America; for example the community psychology that has developed in *Ceará*, North East Brazil, mentioned earlier, integrates community therapy as part of a process, led by community based social movements for individual and social change and promotion of community health and well-being (Góis, 2005; Ximenes et al., 2008).

The struggle against impunity

The problem of impunity for perpetrators of organized violence is endemic in Latin America. The work of ILAS was important in raising this issue in Chile feeding into the prosecution of perpetrators (Lira, 2000) and the struggle against impunity and there has been work in several locations on the problem.

Again historical memory, testimony and collective action are important in overcoming the externally and self-imposed silence of the victims. This work on a wider scale than attending to personal distress also reflects another emphasis in liberation psychology, the importance of changing society itself and the legitimate role of psychologists in this. The work of liberation psychologists in the struggle against impunity is typically highly engaged with other disciplines and sectors, including social movement organizations, faith organizations, forensic archeologists, health workers, lawyers, political representatives and community leaders, as well as international partners.

This last point leads to my conclusion. Liberation is not something that psychologists can achieve alone, it is essential to work in alliance, as part of broader progressive social movements. Liberation psychology follows Martín-Baró's call to face outwards, focusing not on the problems of the discipline but on the problems of society. In this it is a powerful corrective to the isolation of much critical psychology which at times appears to do just the opposite of what Martín-Baró proposed.

Referências

Adlam, D., Henriques, J., Rose, N., Salfield, A., Venn, C., & Walkerdine, V. (1977). Psychology, ideology and the human subject. *Ideology & Consciousness*, *1*, 5-56.

Afuape, T. (2011). *Power, resistance and liberation in therapy with survivors of trauma*. London: Routledge.

Agger, I., & Buus Jensen, S. (1996). *Trauma and healing under state terrorism*. London: Zed.

Anonymous (1970s n.d). *Rat, myth and magic*: *A political critique of psychology*.

Armistead, N. (1974). *Reconstructing social psychology*. Harmondsworth: Penguin.

Barrero, E., & Salas, J. R. J. (2010). *Memoria, silencio y acción psicosocial*: *reflexiones sobre por qué recordar en Colombia*. Bogotá: Cátedra Libre Matín-Baró.

Bernabeu, A., & Blum, C. P. (2012). The road to Spain: The Jesuit massacre and the struggle against impunity in El Salvador. *Peace and Conflict*: *Journal of Peace Psychology*, *18*(1), 96-100.

Bhaskar, R. (1979). On the possibility of social scientific knowledge and the limits of naturalism. In J. Mepham & D. H. Ruben (Eds.), *Issues in Marxist philosophy*: *Epistemology, science, ideology* (Vol. 3, pp.107-139). Brighton: Harvester.

Burton, M. (2004a). Radical Psychology networks: A review and guide. *Journal of Community & Applied Social Psychology*, *14*(2), 119-130.

Burton, M. (2004b). Viva nacho!: Liberating psychology in Latin America. *The Psychologist*, *17*(10), 584-587.

Burton, M. (2011). *A second psychology of liberation?*: *Valuing and moving beyond the Latin American*. Retrieved from <http://libpsy.org/wp-content/uploads/2011/11/A-second-psychology-of-liberation.pdf>.

Burton, M., & Flores, J. M. (2011). Introducing Dussel: The philosophy of liberation and a really social psychology. *Psychology in Society*, *41*, 20-39.

Burton, M., & Kagan, C. (2005). Liberation social psychology: Learning from Latin America. *Journal of Community and Applied Social Psychology*, *15*(1), 63-78.

Castaño, B. L., & López, P. (1994). Chapter 2. In E. Lira (Ed.), *Psicología y violencia política en América Latina* (pp.37-69). Santiago de Chile: ILAS.

Comissíon para el Esclarecimiento Histórico. (1999). *Guatemala*: *memory of silence*. *Conclusions and recommendations of the report of the commission for historical clarification*. Retrieved from <http://shr.aaas.org/guatemala/ceh/inEnglishandSpanish>.

Chávez, J. M. (2012). The university for social change and the legacy of Ignacio Martín-Baró, S. J. *Peace and Conflict*: *Journal of Peace Psychology*, *18*(1), 68-76.

Dobles, I. (2009a). Ignacio Martín Baró y psicología de la liberación: un desafío vigente. Disponible <http://www.catedralibremartinbaro.org/pdfs/PCL_DoblesI_UnDesaf_ioVigente.pdf>.

Dobles, I. (2009b). *Memorias del dolor*: *consideraciones acerca de las comisiones de la verdad en América Latina*. San José, Costa Rica: Arlekín.

Dobles, I., & Baltodano, S. (2010). *Psicología*: *dominación, compromiso y transformación social*. San José: Editorial Universidad de Costa Rica.

Dobles, I., Baltodano, S., & Leandro, V. (2007). *Psicología de la liberación en el contexto de la globalización neoliberal*: *acciones, reflexiones y desafíos*. San José: Editorial Universidad de Costa Rica.

Dussel, E. (1985). *Philosophy of liberation*. New York: Orbis Books.

Dussel, E. (1997). The architectonic of the ethics of liberation. In D. Batstone, E. Mendieta, L. A. Lorentzen & D. N. Hopkins (Eds.), *Liberation theologies, postmodernity, and the Americas*. London: Routledge.

Equipo Maíz, C. A. (2007). *Vida de Farabundo Martí*: 1893-1932. El Salvador: Asociación Equipo Maíz.

Estrada, A. M., Ibarra, C., & Sarmiento, E. (2007). Regulation and control of subjectivity and private life in the context of armed conflict in Colombia. *Community, Work & Family*, *10*(3), 257-281.

Figlio, K. (1978). Chlororis and chronic disease in 19th-century Britain: The social constitution of somatic illness in a capitalist society. *International Journal of Health Services*, *8*, 589-617.

Flores, J. M. (2009). Praxis and liberation in the context of Latin American theory. In M. Montero & C. Sonn (Eds.), *Psychology of liberation*: *Theory and applications* (pp.1-26). New York: Springer.

Fox, D., Prilleltensky, I., & Austin, S. (2009). *Critical psychology*: *An introduction*. Los Angeles: SAGE.

Fox, D., Prilleltensky, I., & Austin, S. (Eds.). (2012). *Eleştirel psikoloji*. Istanbul: [Ayrinti].

Freire, P. (1972). *Pedagogy of the oppressed*. Harmondsworth: Penguin.

Gaborit, M. (2007). Memoria histórica: aspectos psicosociales en la recuperación de la memoria histórica. In I. Dobles, S. Baltodano & V. Leandro (Eds.), *Psicología de la liberación en el contexto de la globalización neoliberal*: *acciones, reflexiones y desafíos*. San José: Editorial Universidad de Costa Rica.

Girón, C. (2007). La galería de la memoria: una experiencia de trabajo en Colombia con víctimas de la violencia sociopolítica en medio del conflicto armado y la polarización social. In I. Dobles, S. Baltodano & V. Leandro (Eds.), *Psicología de la liberación en el contexto de la globalización neoliberal*: *acciones, reflexiones y desafíos*. San José: Editorial Universidad de Costa Rica.

Girón, C. (2010). El rol reparador y transformador de la memoria: de la eficacia simbólica a la acción política colectiva. In E. Barrero & J. R. Salas (Eds.), *Memoria, silencio y acción psicosocial*. Bogotá: Cátedra Libre Matín-Baró.

Góis, C. W. L. (2005). *Psicologia comunitária*: *actividade e consciência*. Fortaleza: Publicações Instituto Paulo Freire de Estudos Psicossociais.

Gonzalez Rey, F. (in press). Paths, development and discontinuity of some critical approaches to psychology in Latin America: What happened in that history? *Annual Review of Critical Psychology*.

Guzzo, R. S. L., & Lacerda, F. (2011). *Psicologia social para América Latina*: *o resgate da psicologia e libertação*. Campinas: Alínea.

Harré, R., & Secord, P. F. (1972). *The explanation of social behaviour*. Oxford: Blackwell.

Hollander, N. C. (1997). *Love in a time of hate*: *Liberation psychology in Latin America*. New Jersey: Rutgers University Press.

Hook, D., Kiguwa, P., & Mkhize, N. (2004). *Introduction to critical psychology*. Lansdowne: UCT Press.

Instituto Latinoamericano de Salud Mental e Derechos Humanos. Qué is ILAS. (2003). São Paulo: Autor. Disponible en septiembre 6, 2012, disponible <http://www.ilas.cl/presenta.htm>.

Ingleby, D. (1970). Ideology and the human sciences: Some comments on the role of reification in Psychology and psychiatry. *Human Context, 2*, 159-187.

Ingleby, D. (1985). Professionals as socializers: The 'psy complex'. *Research in Law, Deviance and Social Control*, *7*, 79-109.

Lacerda, F. (2010). Notas sobre o desenvolvimento da psicologia social comunitária. In F. Lacerda & R. S. L. Guzzo (Eds.), *Psicologia e sociedade*: *interfaces no debate sobre a questão social* (pt.1, cap. 2). Campinas: Alínea.

Lira, E. (1994). *Psicología y violencia política en América Latina*. Santiago de Chile: Ediciones CESO.

Lira, E. (2000). Verdad, justicia e impunidad: memoria, perdón y olvido. In J. J. Vázquez (Ed.), *Psicología social y liberación en América Latina* (pp.133-153). Mexico City: Universidad Autónoma Metropolitana.

Lira, E. (2001). Violence, fear, and impunity: Reflections on subjective and political obstacles for peace. *Peace and Conflict*: *Journal of Peace Psychology*, *7*(2):109-118.

Lira, E., & Castillo, M. I. (1991). *Psicología de la amenaza política y el miedo.* Santiago: ILAS.

Lira, E., & Weinstein, E. (2000). La tortura: conceptualización psicológica y proceso terapéutico. In I. Martín-Baró (Ed.), *Psicología social de la guerra*. San Salvador: UCA Editores.

Martín-Baró, I. (1983). *Acción e Ideología*: *psicología social desde Centroamérica I*. San Salvador: UCA Editores.

Martín-Baró, I. (1986). Hacia una psicología de la liberación. *Boletin de Psicología*, *22,* 219-231. Recuperado en septiembre 23, 2011, disponible <http://www.uca.edu.sv/deptos/psicolog/hacia.htm>.

Martín-Baró, I. (1987). El latino indolente: carácter ideológico del fatalismo latinoamericano. In M. Montero (Ed.), *Psicología politica latinoamericana* (pp.135-162). Caracas: Panapo.

Martín-Baró, I. (1989a). *Sistema, grupo y poder*: *psicología social desde centroamérica II*. San Salvador: UCA Editores.

Martín-Baró, I. (1989b). *La opinión pública salvadoreña* (1987-1988). San Salvador: UCA Editores.

Martín-Baró, I. (1996a). Public opinion research as a de--ideologizing instrument. In A. Aron & S. Corne (Eds.), *Readings for a liberation psychology*. New York: Harvard University Press.

Martín-Baró, I. (1996b). Writings for a liberation psychology. New York: Harvard University Press.

Martín-Baró, I. (1996c). Toward a liberation psychology. In A. Aron & S. Corne (Eds.), *Writings for a liberation psychology*. New York: Harvard University Press.

Martín-Baró, I. (1996d). The lazy latino: The ideological nature of Latin American fatalism. In A. Aron & S. Corne (Eds.), *Writings for a liberation psychology* (pp.198-220). Cambridge Harvard University Press.

Martín-Baró, I. (1998). Retos y perspectivas de la psicología latinoamericana. In A. Blanco (Ed.), *Psicología de la liberación*. Madrid: Trotta.

Molina, N. (2005). Resistencia comunitaria y transformación de conflictos. *Reflexión Política*, *7*(14), 70-82.

Montero, M. (1996). Parallel lives: Community psychology in Latin America and the United States. *American Journal of Community Psychology*, *24*(5), 589-606.

Montero, M., & Serrano García, I. (2011). *Historias de la psicología en América Latina*: *participación y transformación*. Buenos Aires: Paidós.

Parker, I. (1989). *The crisis in modern social psychology*: *And how to end it*. London: Routledge.

Parker, I. (1999). Critical psychology: Critical links. *Annual Review of Critical Psychology*, *1*(1), 3-18.

Parker, I., & Spears, R. (1996). *Psychology and society*. London: Pluto Press.

Portillo, N. (2005). Juventud y trauma psicosocial en El Salvador. In N. Portillo, M. Gaborit & J. M. Cruz (Eds.), *Psicología social en la posguerra: teoría y aplicaciones desde El Salvador* (pp.249-289). San Salvador: UCA Editores.

Portillo, N., Gaborit, M., & Cruz, J. M. (Eds.). (2005). *Psicología social en la posguerra*: *teoría y aplicaciones desde El Salvador*. San Salvador: UCA Editors.

Potter, J., & Wetherall, M. (1987). Discourse and social psychology: Beyond attitudes and behaviour. London: Sage.

Reason, P., & Rowan, J. (1981). *Human inquiry*: *A sourcebook of new paradigm research*. Chichester: Wiley.

Rose, N. (1985). *The psychological complex*: *Society, politics and society in england, 1869-1939.* London: Routledge.

Sève, L. (1978). *Man in marxist theory and the psychology of personality*. Sussex: Harvester Press.

Silverman, D. (1981). The child as social object: Sociology of health and illness. *Socialogy of Health & Illness*, *3*, 354-274.

Soto, R. (2010). Martín-Baró y el uso de la encuesta como instrumento concientizador. *Revista Salvadoreña de Psicología*, *1*(1), 83-91.

de la Torre, C. (1995). *Psicología latinoamericana*: *entre la dependencia y la identidad.* Havana: Editorial Felix Varela.

Tovar, C. (2007). Acompañamiento psicosocial a personas en situaciones de desplazamiento. In I. Dobles, S. Baltodano & V. Leandro (Eds.), *Ciudad Universitaria Rodrigo Facio*. San José: Editorial Universidad de Costa Rica.

Ximenes, V. M., Amaral, C. E. M., & Rebouças, F. G. (2008). *Psicologia comunitária e educação popular*: *vivências de extensão/Cooperação Universitária no Ceará*. Fortaleza: Universidade Federal do Ceará.

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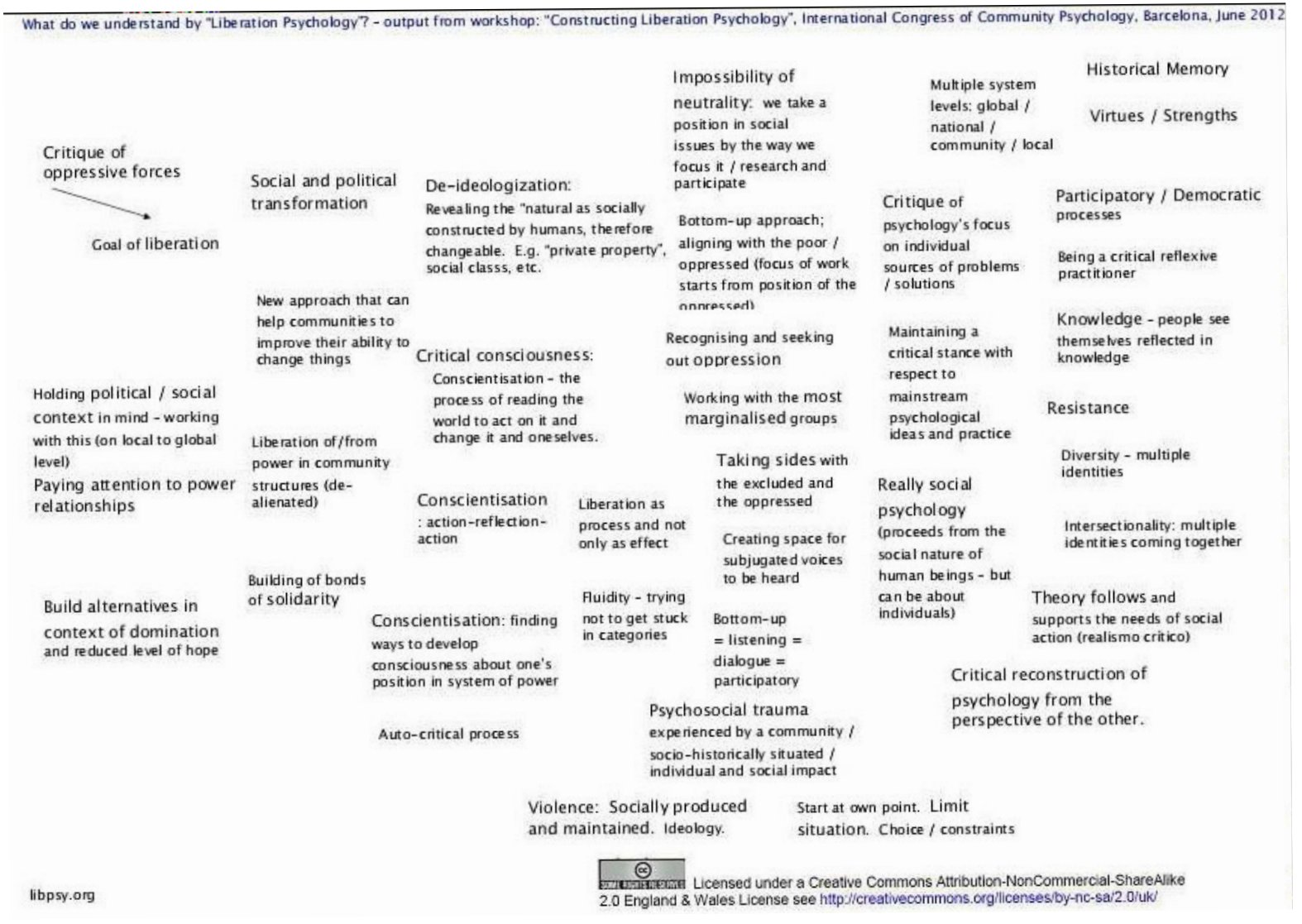

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Da inclusão à evasão escolar: o papel da motivação no ensino médio

From inclusion to dropout: *The role of motivation in high school students*

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Resumo

Neste artigo procurou-se refletir a respeito dos processos de inclusão e evasão escolar no Ensino Médio sob o enfoque de como a motivação pode se associar aos mesmos. Para este fim, foi realizada uma análise sobre as implicações que tais processos acarretam na vida dos estudantes, procurando-se perceber como a variável motivacional pode apresentar-se tanto como consequência do processo de inclusão como estar relacionada às causas da evasão por parte do aluno. Fica evidente a importância que o papel da motivação adquire no contexto escolar, o que vem a fomentar um campo de discussões cada vez mais abrangente e significativo na área de Psicologia da Educação.

Unitermos: Evasão; Inclusão; Motivação.

Abstract

The aim of this article is to reflect on the processes of inclusion and dropout among High School students from the standpoint of how motivation can bring them together. For this, an analysis of the implications that these processes entail in the lives of students was carried out, seeking to comprehend how the motivation variable can appear as a result of the inclusion process or can be related to the causes of the dropout of the student. It is evident how important the role of motivation is in the school context, which encourages a more comprehensive and meaningful field of discussion from the area of Educational Psychology.

Uniterms: *Dropout*; *School inclusion; Motivation.*

No ambiente escolar, muito se tem discutido sobre os processos de inclusão do aluno, assim como sobre as questões relativas à sua permanência na escola. Ao se pensar no termo inclusão, não é difícil associá-lo a pessoas com necessidades especiais, como, por exemplo, deficientes auditivos, paraplégicos, entre outros. De fato, a origem das discussões sobre inclusão escolar teve como ponto de partida sujeitos com algum tipo de deficiência. Para Sant´Ana (2005), nas últimas décadas e especialmente após a Declaração de Salamanca, em 1994, a questão da inclusão escolar de crianças com necessidades especiais no ensino regular tem se tornado alvo de pesquisas e eventos científicos, abrangendo discussões que permeiam desde concepções teórico-filosóficas quanto aquelas associadas à implementação preconizadas por tal declaração. No entanto, os debates

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realizados atualmente já não se restringem somente aos alunos portadores de algum tipo de deficiência. Segundo Sanches e Teodoro (2006), a inclusão escolar "deve contemplar todas as crianças e jovens com necessidades educativas" (p.69).

Neste processo tão amplo, alguns autores advertem sobre como certas práticas podem, ao invés de incluir de forma efetiva o aluno em suas atividades acadêmicas, corroborar para excluí-lo ainda mais do seu universo estudantil. Mittler (2003) relata que, ao encaminhar os alunos que apresentam dificuldades de aprendizagem para turmas de suporte especializado, este ato, por si mesmo, já consiste em uma maneira de segregação, à medida que denota déficits no processo de ensino e aprendizagem. Este autor defende uma mudança no currículo escolar no sentido de integrar os propósitos que a escola pretende atingir a partir das necessidades que os estudantes apresentam.

Os projetos que visam à implantação de uma prática inclusiva no contexto escolar deixam de se tornar efetivos por várias razões. No estudo de Leonardo, Bray e Rossato (2009), foram investigados 26 professores da Educação Básica que possuem alunos com deficiência de escolas do interior do Paraná divididos em dois grupos (1º - Escolas Públicas; 2º - Escolas Privadas). Nos dois grupos, os resultados demonstraram um despreparo tanto por parte dos professores para lidar com a diversidade em sala de aula quanto pela falta de infraestrutura oferecida pelas escolas.

Em outro tipo de discussão sobre a Educação Inclusiva, é possível tecer considerações sobre as implicações que o discurso da mesma revela sobre diversos níveis do processo ensino-aprendizagem. Nesta direção, Cavallari (2010) alerta para o fato de que a prática e política inclusivas denominam alguns conceitos dicotômicos, como, por exemplo, exclusão *versus* inclusão e diferença *versus* igualdade. Segundo a autora, estes conceitos extremamente simplificadores de um processo tão complexo incidem sobre a constituição identitária dos alunos, uma vez que estes recebem as denominações de incluídos e excluídos.

Nesta direção, partindo do pressuposto de que a Educação Inclusiva possui a generalização como um de seus princípios constituintes, uma escola que inclua deve ter, mesmo que implicitamente, propostas que consigam atender a todos os alunos, desde estudantes com dificuldades para chegar à sala de aula até aqueles que necessitem de apoio por superdotação. É sob esta concepção que a inclusão escolar apresenta um ponto crítico e delicado.

Propor a inclusão no sentido de homogeneizar a demanda dos excluídos, sem que estes recebam atendimento especializado para suas necessidades, pode, em contrapartida, gerar outros tipos de consequências. Como aponta Plaisance (2010), colocar em um mesmo espaço não significa que a exclusão foi erradicada. Um aluno pode estar matriculado em uma escola regular e, mesmo assim, sofrer rejeições e ser marginalizado devido às dificuldades que enfrenta. Em decorrência disso, outro fator pode ser afetado: a motivação, ou a falta dela.

De fato, o processo de inclusão pode acarretar efeitos diretos na motivação do aluno e, desta forma, estar associado à sua permanência ou evasão da escola. Para Bzuneck (2009), a motivação é aquilo que move uma pessoa, que a põe em ação ou a faz mudar de curso. A motivação tem sido entendida ora como um fator psicológico, ou conjunto de fatores, ora como um processo. Existe um consenso entre autores a respeito da dinâmica destes fatores, que levam a uma escolha, a uma investigação, fazem o sujeito iniciar um comportamento direcionado a um determinado objetivo (Bzuneck, 2009; Costa & Boruchovitch, 2006).

Pensando no contexto do Ensino Médio, em uma pesquisa de âmbito nacional em que participaram mais de 50 mil alunos e 7 mil professores, foi constatado que o principal problema deste nível de ensino consiste no desinteresse dos alunos frente às atividades escolares. Neste estudo, sob a perspectiva do aluno, este problema foi apontado por 6 em cada 10 estudantes. Em relação aos professores, esta questão ficou ainda mais evidenciada, pois três quartos dos docentes entendem que o principal problema no Ensino Médio são os alunos desinteressados (Abramovay & Castro, 2003).

No estudo desenvolvido por Machado (2005), participaram 30 alunos (17 do sexo masculino e 13 do feminino) do Ensino Médio de uma escola estadual de Campinas, estado de São Paulo, com idade de 16 a 19 anos, aproximadamente, e nível socioeconômico médio/baixo. O objetivo do estudo foi examinar as percepções dos participantes sobre as variadas dimensões do meio escolar, relacionando-as com o desenvolvimento pessoal e a motivação para aprender dos alunos.

Como resultados, os autores obtiveram que menos da metade dos alunos se consideravam motivados a ir à escola e, dentre estes, a menor parte tinha prazer em estudar.

Algumas consequências decorrentes do déficit na motivação do aluno (seja ela considerada em termos qualitativos ou quantitativos) podem ter relação direta em seu processo de aprendizagem. Para Bzuneck (2009), a queda na motivação leva a um declínio no investimento pessoal para realizar as tarefas de aprendizagem com qualidade, o que impossibilita a formação de indivíduos mais competentes para exercerem a cidadania e se realizarem como pessoas. Como relatado anteriormente, tal fato pode contribuir para que o estudante se empenhe cada vez menos em suas atividades escolares e, com isso, acabe evadindo do contexto escolar. A fim de melhor compreender o fenômeno de evasão escolar, é preciso diferenciar seu conceito daquele entendido como abandono escolar. Evasão escolar refere-se ao aluno que deixa a escola, mas com a possibilidade de retorno à mesma. Já o abandono escolar ocorre quando o estudante deixa a escola em definitivo (Abramovay & Castro, 2003).

Segundo Rumberger (2006a), identificar as causas de evasão escolar é extremamente difícil, pois este fenômeno é influenciado por vários fatores, sejam eles relacionados aos estudantes ou às suas famílias, escolas e comunidades. Este autor entende a evasão escolar como um processo, e não apenas como um momento pontual na vida do estudante, considerando este fenômeno como o estágio final de um dinâmico e cumulativo processo de desengajamento da escola.

Outros fatores também estão associados à evasão escolar. No estudo de Silva (2005) realizado em uma escola do Pará, foram investigados os fatores associados à evasão escolar sob a perspectiva de vários agentes escolares. Na visão do diretor da escola, tal processo se justifica devido a uma falta de política de incentivo aos estudos que articule as necessidades profissionais dos alunos com as estudantis. Os docentes relacionaram este fenômeno às condições econômicas das famílias e dos estudantes, relatando que muitas destas são obrigadas a sair do município em busca de empregos. A migração implica, muitas vezes, o trabalho dos jovens estudantes do Ensino Médio, que acabam por ficar desestimulados a estudar e sem muitas perspectivas futuras. Do ponto de vista do coordenador pedagógico, este processo está ligado ao baixo rendimento dos alunos: ao se depararem com uma nota baixa, entram em desespero e não se sentem capazes de ser aprovados, desmotivando-se e evadindo da escola.

Ainda em relação ao processo de evasão escolar, Rumberger (2006a) apresenta duas perspectivas para explicar o fenômeno, uma em relação à visão do aluno e outra relacionada a uma perspectiva institucional. Em relação à perspectiva individual do aluno, este autor discute como os valores, atitudes e comportamentos dos estudantes podem contribuir para a saída destes da escola. Especificamente, como a falta de engajamento acadêmico ou no processo de aprendizagem, assim como o desengajamento social ou nas dimensões da escola, podem influenciar a decisão de se retirar da mesma.

No que se refere à dimensão institucional, não apenas a escola como, também, outras instituições - como a família e a comunidade -, podem influenciar tanto na permanência quanto na saída dos alunos da escola. Especificamente no contexto escolar, os recursos que esta instituição oferece ou deixa de oferecer podem tanto influenciar na efetivação do engajamento e desempenho acadêmico, quanto contribuir para o processo de desengajamento e evasão do estudante (Rumberger, 2006a).

Nesta mesma direção, Abramovay e Castro (2003) discutem as influências da infraestrutura no processo de ensino e aprendizagem no Ensino Médio. As autoras alegam que investigar tais influências é uma tarefa de difícil mensuração, mas afirmam que uma escola organizada, equipada e limpa cria um ambiente favorável ao trabalho de todos, atuando na motivação dos professores e funcionários e auxiliando os alunos a desenvolverem seu potencial (por meio dos recursos que lhes são oferecidos).

Em relação às estratégias para prevenção da evasão escolar, sabendo que o processo envolvendo a mesma não se resume ao momento em que o aluno deixa a escola, Rumberger (2006b) apresenta que as estratégias de prevenção devem começar cedo junto aos alunos, pois as atitudes e comportamentos problemáticos que podem levá-los à evasão também começam geralmente cedo.

Outro apontamento de Rumberger (2006b) para esta prevenção refere-se ao fato de que um programa de intervenção para a prevenção da evasão escolar deve ir além da dimensão do aluno, estendendo-se para o contexto ambiental, fornecendo-se recursos e suporte para famílias, escolas e comunidades. No estudo de Silva (2005), o diretor da escola analisada também defende a ideia de que um programa de prevenção da evasão é um trabalho realizado junto à comunidade.

Tendo em vista os fundamentos descritos, a pesquisa desenvolvida teve como objetivo refletir sobre os processos de inclusão e evasão escolar, discutindo como a motivação pode estar associada a estes processos.

Método

De acordo com os pressupostos de Andrade (2003), este estudo se caracteriza de duas formas. Quanto aos seus objetivos, pode ser considerado um estudo exploratório e, quanto ao seu objeto, caracteriza-se como uma pesquisa de natureza bibliográfica.

Discussão

Partindo do postulado de que a motivação possui um papel significativo na vida do aluno por estar atrelada tanto a um maior engajamento nas tarefas que permeiam o contexto escolar quanto à formação integral de um cidadão crítico e realizado (Bzuneck, 2009), sugere-se, neste artigo, pensar na importância da motivação do aluno no contexto acadêmico, que parece ser um aspecto preocupante no Ensino Médio, uma vez que algumas pesquisas (Abramovay & Castro, 2003; Machado, 2005) evidenciam que um dos principais problemas neste nível de ensino diz respeito à motivação, ou melhor, à falta dela.

Esta variável também está vinculada aos processos de inclusão (ou exclusão) e evasão escolar dos estudantes. No que se refere à inclusão do aluno no contexto educacional, este processo pode apresentar um efeito contrário quando segrega o aluno de seu contexto regular de sala de aula para aulas que, até então, teriam por objetivo dar um suporte diferenciado que outrora este aluno não pudera receber. Salvo casos em que o encaminhamento para classes especiais é muito bem estruturado e supervisionado, quando não realizado desta forma o processo de inclusão pode exercer um efeito direto na motivação do aluno.

Assim, tanto quando os níveis quanto a qualidade da motivação estão prejudicados, tal fato corrobora para que cada vez mais o estudante não se empenhe nas atividades acadêmicas e, assim, contribua para o processo de desengajamento, que pode terminar com a evasão do ambiente escolar. Conforme Rumberger (2006b), alguns fatores relacionados a esse processo de evasão escolar podem estar associados aos valores, atitudes e comportamentos dos próprios alunos, e outros às questões institucionais, como, por exemplo, a falta de recursos escolares e falta de apoio familiar. O fato é que, sejam quais forem os fatores que estão relacionados à evasão escolar, grande parte deles pode ter impacto na motivação do estudante.

A partir destas considerações é possível afirmar que a motivação pode exercer uma dupla função, ora como causa ora como consequência dos processos de inclusão e evasão escolar. Quando os procedimentos pedagógicos e o trabalho planejado e bem estruturado fazem parte do processo de inclusão do aluno no ambiente estudantil, os desdobramentos tenderão a repercutir para a obtenção de um estudante mais motivado e, assim, mais engajado no meio acadêmico. Por outro lado, dentre os diversos fatores que estão associados à evasão escolar, muitos deles provêm da motivação do aluno, fazendo com que esta variável anteceda, ou mesmo, possa ser a causa do desengajamento do estudante do universo escolar.

Considerações Finais

O Ensino Médio possui características singulares no processo de escolarização do estudante no Brasil. Pelo fato de ser a última etapa da Educação Básica e a que antecede o acesso ao Ensino Superior, é possível dizer que o Ensino Médio apresenta uma característica transicional: da escola para a faculdade, da escola para o trabalho, ou mesmo da escola para a família. Diversas são as adversidades com as quais os estudantes deste nível de ensino se deparam, fazendo com que, muitas vezes, estas repercutam na motivação dos mesmos.

Sabendo da amplitude que a variável motivação pode atingir quanto ao fomento de níveis de discussão

na educação em geral, este estudo se restringiu a um pequeno recorte focado nos processos de inclusão e evasão no contexto escolar. Assim, procurou-se refletir o quanto os procedimentos de inclusão do aluno precisam ser bem planejados e estruturados para que estes influenciem positivamente na motivação do estudante. Sob outra ótica, procurou-se também discutir o processo de evasão do aluno, estabelecendo relações entre os fatores desencadeantes de tal processo, dentre eles, o fator motivacional.

Mesmo diante das limitações compreendidas neste trabalho, torna-se necessário ressaltar o importante papel que a motivação adquire no contexto escolar, enaltecendo a necessidade de que, cada vez mais, esta discussão se faça presente nos diversos segmentos da educação pública no Brasil.

Referências

Abramovay, M., & Castro, M. G. (2003). *Ensino médio: múltiplas vozes*. Brasília: MEC.

Andrade, M. M. (2003). *Introdução à metodologia ao trabalho científico* (6ª ed.). São Paulo: Atlas.

Bzuneck, J. A. (2009). A motivação do aluno: aspectos introdutórios. In E. Boruchovitch & J. A. Bzuneck (Orgs.), *A motivação do aluno: contribuições da psicologia contemporânea* (pp.9-36). Petrópolis: Vozes.

Cavallari, J. S. (2010). O equívoco no discurso da inclusão: o funcionamento do conceito de diferença no depoimento de agentes educacionais. *Revista Brasileira de Linguística Aplicada, 10*(3), 667-680.

Costa, E. R., & Boruchovitch, E. (2006). A auto-eficácia e a motivação para aprender: considerações para o desempenho escolar dos alunos. In R. G. Azzi & S. A. J. Polydoro (Orgs.), *Auto-eficácia em diferentes contextos* (pp.87-109). Campinas: Alínea.

Leonardo, N. S. T., Bray, C. T., & Rossato, S. P. M. (2009). Inclusão escolar: um estudo acerca da implantação da proposta em escolas de ensino básico. *Revista Brasileira de Educação Especial, 15*(2), 289-306.

Machado, N. M. L. (2005). *A escola ideal: como os adolescentes percebem e idealizam o meio escolar* (Dissertação de mestrado não-publicada). Pragrama de Pós-Graduação em Educação, Universidade Estadual de Campinas.

Mittler, P. (2003). *Educação inclusiva: contextos sociais*. Porto Alegre: Artmed.

Plaisance, E. (2010). Ética e inclusão. *Caderno de Pesquisa, 40*(139), 13-43.

Rumberger, R. W. (2006a). Why students drop out of school. In G. Orfield (Ed.), *Dropouts in America: Confronting the graduation rate crisis* (pp.131-155). Cambridge: Harvard Education Press.

Rumberger, R. W. (2006b). What can be done to reduce the dropout rate? In G. Orfield (Ed.), *Dropouts in America: Confronting the graduation rate crisis* (pp.243-254). Cambridge: Harvard Education Press.

Sanches, I., & Teodoro, A. (2006). Da integração à inclusão escolar: cruzando perspectivas e conceitos. *Revista Lusófona de Educação, 8*(8), 63-83.

Sant´Ana, I. M. (2005). Educação inclusiva: concepções de professores e diretores. *Psicologia em Estudo, 10*(2), 227-234.

Silva, F. C. S. (2005). *A evasão escolar de jovens do ensino médio de uma escola pública de Itaituba, Pará* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Educação, Universidade Estadual de Campinas.

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Cognitive therapy: Using a specific technique to improve quality of life and health

Terapia cognitiva: *aplicações de uma técnica para qualidade de vida e saúde*

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Tereza Cristina Cavalcanti Ferreira de **ARAUJO**[2]

Abstract

In this study we implemented and assessed a specific cognitive therapy technique - *Decision Making and Quality of Life*, which is used to promote health and improve quality of life. Eighteen employees from a higher education institution participated in the study, which was organized into 12 group sessions. At the admission and concluding phases, we asked participants to complete the World Health Organization Quality of Life - Bref Questionnaire, the Beck Anxiety Inventory and the Beck Depression Inventory. Results showed significant improvement in five of the domains that measure quality of life: physical, psychological, environmental, general, and health. There were no significant changes (p=0.26) in anxiety scores. In contrast, the depression scores got significantly better (p=0.02). The results suggest that the proposed technique is conducive to health promotion and quality of life.

Uniterms: Cognitive therapy; Health promotion; Quality of life.

Resumo

Esta pesquisa teve por objetivo geral aplicar e avaliar uma técnica específica de terapia cognitiva - organizada em 12 sessões grupais e denominada Tomada de Decisão e Qualidade de Vida -, destinada a promover saúde e incrementar qualidade de vida. No total, participaram 18 servidores de uma instituição pública de ensino superior. Nas etapas de admissão e de encerramento, aplicaram-se: Questionário de Qualidade de Vida, Inventário Beck de Ansiedade e Inventário Beck de Depressão. Foram identificadas melhoras significativas nos domínios físico, psicológico, meio ambiente, geral e saúde, relacionados à qualidade de vida. Não se verificaram alterações significantes nos escores de ansiedade (p=0,26). Em contrapartida, os escores de depressão indicaram melhora (p=0,02). Os resultados sugerem que a técnica pode ser empregada para promover saúde e qualidade de vida.

Unitermos: *Terapia cognitiva*; *Promoção da saúde*; *Qualidade de vida*.

According to the World Health Organization (WHO), health promotion can be understood as a process that enables people to take control of, and improve, their own health. From this point of view, an individual and his/her group should be enabled to set and achieve goals, fulfill their own needs, and deal with or change their environment in order to achieve physical, mental and social wellbeing (Marks et al., 2000).

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According to Fortes and Zoboli (2004), autonomous individuals make free and informed choices from the available options, deciding what is best for themselves and expressing their will.

However, making a decision often presents a dilemma, as the person struggles between immediate rewards and future benefits, which often involve mutually exclusive values. In some cases, an individual opts for the least advantageous option as a result of failing to appreciate the long-term benefits (Bechara, 2004; Palmini, 2004).

Health promotion encompasses not only reducing unhealthy behaviors, but also adopting and reinforcing healthy behaviors. As such, it is essential to consider the role that emotion plays in decision-making associated with these behaviors. In fact, as Beer, Knight and D'Esposito (2006) emphasized, it is impossible to disregard emotional factors in any type of decision making. This is supported by Oliva et al. (2006) who consider that when we make decisions and choices, behave in a particular way, or follow moral standards, we depend not only on rational but also on emotional mechanisms.

The World Health Organization defines quality of life as "an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their expectations, standards and concerns" (Fleck, 2008, p.25). Numerous national and international researches have been conducted on the relationship between quality of life and health. A thorough historical examination shows that, since the 1930s, there has been a rapid growth in the number of instruments used to measure this relationship. Gradually, more and more dimensions have been included, moving from factors, which were purely physical and individual, to include subjective, socio-cultural and environmental factors. Such complexity poses challenges to health services in their routine assessment of quality of life. These come in the form of three types of barrier: attitudinal, conceptual and methodological, and practical. Despite these obstacles, it is essential to continue the search for ever more accurate measures, in part in order to better estimate the effectiveness of health interventions (Costa Neto & Araujo, 2008; Matos & Araujo, 2009; Patrick, 2008; Straub, 2007).

Systematization of a specific technique in cognitive therapy

Cognitive Therapy (CT) was developed by Aaron Beck in the 1960s and holds as a basic principle that distorted and rigid thoughts lead to mistaken beliefs about the adversity of a situation, which in turn negatively impacts both a person's mood and behavior (Beck, 1963;1997). Over the years, the application of this principle has proved beneficial for the treatment of psychopathological conditions and in overcoming situational vulnerability. Intervention techniques have been progressively systematized and there are currently more than 300 studies, which attest to the efficacy of CT (Beck, 2005).

Cognitive therapy includes features that encourage patient autonomy. In being empirically collaborative, it focuses on shared decision-making between patient and therapist. In this approach, the guided practice of cognitive skills lays the foundations for a better quality of life and encourages healthy behavior by strengthening decision-making, which is not based solely on emotion, but also on reason. Within CT, modifying underlying assumptions (assumptions, rules and duties) is considered to be more challenging than modifying automatic thoughts (Beck, 2007). From this perspective, a behavioral intervention seeks, above all, to affect changes at the cognitive level, which can bring about emotional changes (Bennett-Levy et al., 2004).

Cognitive conceptualization lies at the heart of CT and is a process by which levels of dysfunctional thinking are identified and the effects of this distortion are studied in order to be better understood. This, then, allows for the best intervention to be implemented (Beck, 2007). At clinical follow-up, cognitive formulation reveals the relationship between three levels of thought: 1) Automatic Thoughts (AT), which occur in various everyday situations, arise spontaneously and are not related to reflection or deliberation; 2) Underlying Assumptions (UA), which is the level of cognition that is activated when a person makes predictions about the consequences of their behavior or behaves according to rules; and 3) Core Beliefs (CB), which are presented in absolutes or rigid thoughts (Beck, 1997; Kunzler, 2011). In general, when an individual presents a particular

problematic behavior, she/he is being driven by an underlying assumption (Kuyken, Padesky & Dudley, 2009).

Despite widespread recognition of the relevance of the restructuring of underlying beliefs in the field of CT, few studies have focused on this essential level. Within this more specialized literature is the work conducted by Cooper, Todd, Turner and Wells (2007) on the effectiveness of intervention in cases of bulimia nervosa through the evaluation of positive and negative beliefs, thoughts of loss of control and permissive thoughts. Another interesting study is that of Dattilio (2006), in which members of the same family underwent cognitive restructuring of their underlying assumptions during eight sessions of CT.

The importance of understanding cognitive restructuring (at the level of underlying assumptions, i.e. "If ... then ..." thoughts) became evident through clinical practice and brought about the development of a specific technique in CT called Decision Making and Quality of Life (Kunzler, 2008a; 2011). It aims at the cognitive restructuring of underlying assumptions in order to encourage decision-making that leads to healthy behavior. The systematization of this technique is based on the concepts of health promotion and quality of life and involves the use of illustrative images associated with disease and health (Kunzler, 2008a; 2011). It provides a form of intervention that can meet the demands of personal and social development and, as such, is not restricted to psychopathological conditions, and thus falls within the scope of health psychology research and practice (Straub, 2007).

Since the 1980s, the effectiveness of group intervention has been widely documented (Fals-Stewart & Lucent, 1994; Himle et al., 2001; Kobak, Rock & Greist, 1995). In fact, this mode is considered efficient not only in terms of therapeutic response, but also because it provides reduced costs. In other words, one therapist can work with a greater number of patients, thus reducing costs. In regions where the supply of qualified professionals is limited, this fact effectively enables health care intervention to take place. In addition, intrinsic elements of group therapy - such as observational learning, flexibility of roles, group cohesion and cooperation - often amplify the therapeutic results (Anderson & Rees, 2007; Cordioli et al., 2002; Fals-Stewart & Lucent 1994; Himle et al., 2001; Kobak et al., 1995; Steketee & Pigott, 2006).

Cognitive therapy not only deals with an individual's difficulties, but also identifies the resources that need to be mobilized in order to achieve established goals. To this end, several techniques can be applied individually or in groups - aimed at couples, families, adults, adolescents, and children and adapted to various situations. There is no uniformity in the size of the groups, but reports from national surveys indicate that they tend to range from 6 to 12 people (Beck & Knapp, 2008; Falcone, 1999; Gomes & Scrochio, 2001; Kuyken et al., 2009; Sardinha, Oliva, D'Augustin, Ribeiro & Falcone, 2005).

In this study, we apply the *Decision Making and Quality of Life* technique and evaluate how it contributes to promoting health and improving the quality of life of our participants. The specific goals of this study were: a) Provide a health promotion/ quality of life intervention using this specific CT technique; b) Evaluate and compare the quality of life of participants in the pre- and post-intervention phases; c) Measure and compare anxiety and depression indicators in the pre- and post--intervention phases; and d) Evaluate the effectiveness of this specific CT technique for restructuring underlying assumptions.

Method

Participants

Initially, we stipulated the following inclusion criteria for the sample: public servants at a higher education institution, regardless of gender, aged between 18 and 60 years and who agreed to participate in the study. The following exclusion criteria were determined: lack of commitment to completing written assignments (that take 5 to 30 minutes per day) and attending therapy concomitantly with the 12 sessions that comprise the intervention. Given that the focus of this study was on health promotion and quality of life, we also excluded potential participants who were undergoing psychiatric care.

This selection process left us with 18 women, which we divided into 2 groups according to their work shifts at the institution. One group was composed of 8 participants aged between 25 and 56 years, 6 married and 2 single, 2 having high school diplomas, 4 bachelor degrees and 2 graduate degrees. The other group

consisted of 10 participants aged between 24 and 58 years, 5 married, 2 divorced and 3 single, 7 having graduated from college and 3 holding graduate degrees.

Instruments

We adopted three assessment measures: the World Health Organization an abbreviated version of the Quality of Life (WHOQOL) - short version' questionnaire proposed by WHO (WHOQOL-bref), the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI). The last two instruments measure anxiety and depression symptoms and have been used in studies addressing the efficacy of CT (Beck, 1963; Beck, Rush, Shaw & Emery, 1997; Strunk, DeRubeis, Chiu & Alvarez, 2007). These instruments were also selected in order to ensure that participants with pathological scores were not included, as data from such participants would not have met the purposes of the investigation. In addition, ascertaining changes in anxiety and depression indicators can serve to complement the measurements taken in the quality of life domains. It should be noted that, according to the literature, the cutoff points in the Portuguese version of the BAI for psychiatric diagnosis are: mild 11-19, moderate 20-30 and severe 31-63. Similarly, the BDI scores are classified using the following levels: mild 12-19, moderate 20-35 and severe 36-63. When composing the participant sample we did not apply a cutoff point. However, for data analysis, relevant literature recommends that the upper limits should be increased to avoid false positives (Cunha, 2001).

Procedures for collecting and analyzing data

We opted for a quasi-experimental design method. The project was approved by the Research Ethics Committee of the Health Sciences Faculty at the *Universidade de Brasília* (protocol number 73/09) and the study was conducted in accordance with the recommendations set out in the National Health Council's Resolution 196/96.

The two intervention groups, one in the morning and another in the afternoon, were guided by the same therapist. She was trained in cognitive therapy by the Beck Institute for Cognitive Therapy and Research and works in the context of private practice and in a public institution. Initially, an invitation was sent via e-mail to public servants at a specific unit of the institution. At the first meeting, called the admission stage, we explained the objectives of the study and asked participants to sign a letter of consent. Shortly thereafter, we applied the three assessment instruments. The whole intervention process took place over a period of three months, with weekly sessions lasting an hour and a half. To prepare for each session, we recommended reading the relevant section of the indicated textbook (Kunzler, 2008b). Written exercises were completed at each meeting and complemented by daily homework.

We applied the Decision Making and Quality of Life technique over the 12 group sessions, each of which was organized around specific goals and tasks. The content of the sessions was as follows: 1) The relationship between the three levels of cognition, unhealthy and healthy emotions (e.g. rejection) and associated behaviors (e.g. avoiding relatives of a spouse); 2) Decision making to establish healthy behavior (e.g. encourage interaction with family); 3) Step 1: Identification of factors that support current behavior (e.g. UA - If I stay away, then I do not have to confront bad emotions); 4) Step 2: Identification of factors that caused the behavior in the past (e.g. UA - My parents acknowledged everything my sister did but did not do the same for me); 5) Step 3: Identification of factors that help to construct healthy behaviors (e.g. UA - If I visit relatives, then I will learn to deal with competition); 6) Step 4: Choice of four behavioral experiments (e.g. invite family for a celebratory event); 7) Cognitive preparation for the behavioral experiment (e.g. UA - If I accept that everyone is responsible for their own behavior, then I will focus on my personal goals); 8) Daily record of healthy behaviors (e.g. depositing coins in a 'piggy bank'); 9) Summary of steps: the complete exercise; 10) Weekly monitoring of planned activities (e.g. talking with husband and children); 11) Construction of reflective thought and coping cards (e.g. UA - If I keep mulling over others` actions, then my progress will stagnate) and; 12) Evaluation of results and feedback from the group. In the closing stage, we reevaluated the quality of life measures, anxiety symptoms and depression indicators.

Data were statistically analyzed by comparing the scores calculated before and after the intervention.

Given the sample size, we used the nonparametric Wilcoxon Signed Ranks Test ($p<0.05$) and, as such, we did not perform homogeneity and normality tests.

Results and Discussion

Although invited, male participants did not come forward at the sampling stage. Thus, our participants were exclusively female, which is in keeping with literature that suggests that women are more concerned with health (Straub, 2007). However, it is worth mentioning that in 19 other groups, which used the same technique, there was participation from both genders (Kunzler, 2008b).

Figure 1 indicates a statistically significant improvement in the following domains: physical (p=0.05), psychological (p=0.04), environmental (p=0.01), general (p=0.01), and health (p=0.01) while within the social relationships domain the increase is insignificant (p=0.47). When it comes the effect of the intervention (r), as measured on the Wilcoxon Signed Ranks Test (Rosenthal, 1991), a moderate effect was found in all domains (0.3 to 0.5) except for that of social relationships. However, if we analyze the 'general' and 'health' scores together (overall), it appears that the effect size is strong (≥5).

It is worth noting that during the process of adapting the long version (WHOQOL 100) into the more concise WHOQOL-bref version, similar psychometric characteristics were noted in both. However, the WHOQOL-bref gathers fewer domains and the social relationships domain showed no discriminant validity. It should also be stated that this domain did not contribute significantly to measuring the variation of the overall quality of life, nor was a statistically significant difference found between patients and people in the general population. In fact, as this domain has fewer questions, it is less stable in psychometric terms (Chachamovich & Fleck, 2008).

The improvements to the quality of life domains may be attributed to the intervention, in that the technique encourages autonomy besides allowing experiences to be shared in the group sessions. In this sense, Costa Neto and Araujo (2008) insist on the need to evaluate the quality of life from two perspectives: 1) Someone from the area (usually a health professional's) opinion on this individual and 2) Their personal perspective on their socio-cultural and environmental situation. The Decision Making and Quality of Life technique encourages both. Thus, each participant determines their own goals; monitors their own performance. With group support, they can begin to see themselves differently and more in line with their desire to live well and feel good.

With respect to anxiety symptoms (Figure 2), the BAI estimates show a decrease in the total 'pre-intervention' and 'post-intervention' scores. This change indicates some improvement, but cannot be considered significant (p=0.26). The effect of the intervention was

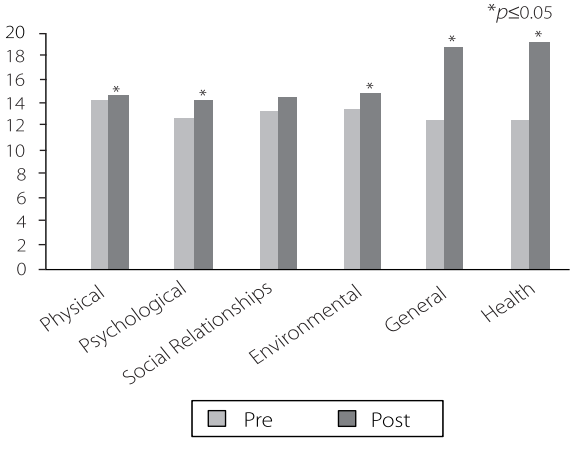

Figure 1. Wilcoxon Signed Ranks Test values for the quality of life domains.

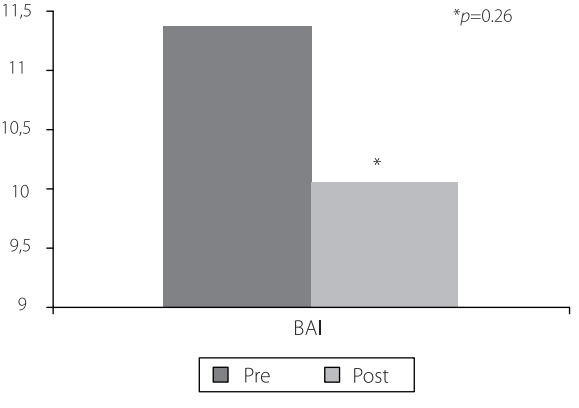

Figure 2. Results of the Beck Anxiety Inventory at pre- and post-intervention stages.

calculated as r=0.19, which indicates a small effect. In part, this discrete result may be explained by the fact that the instrument is composed of items that are designed to register the physical symptoms of anxiety and their intensity, without allowing for a more subjective approach. It should be noted that this study did not specifically address cognitive restructuring at the level of underlying assumptions in the cognitive model of anxiety.

From the point of view of individual analysis, nine participants showed a reduction in their total anxiety scores, while six showed an increase and three showed no difference. It should be noted that, as an emotional response, anxiety is often heightened when a person realizes that she/he is vulnerable and without adequate or sufficient resources to face potentially risky or dangerous situations. In fact, the period of data collection coincided with a critical moment in the participants' workplace, as the institution was involved in two-week strike and salary cuts were threatened (Sessions 10 and 11). Soon after the 12th session (closing stage), a general strike was triggered by failed salary negotiations. These circumstances most possibly had repercussions on the participants' anxiety levels.

As can be seen in Figure 3, the mean scores for depression indicators after intervention are lower than those on admission (p=0.02). This result is particularly relevant because, unlike the BAI, 19 of the 21 items in the BDI instrument are formulated as thoughts, with higher scores indicating greater distortion. As the Decision Making and Quality of Life technique focuses on thoughts, the statistically significant reduction on this scale indicates that cognitive restructuring did indeed take place. When the effect of the intervention (r) is measured, the result (0.39) obtained, represents a moderate effect.

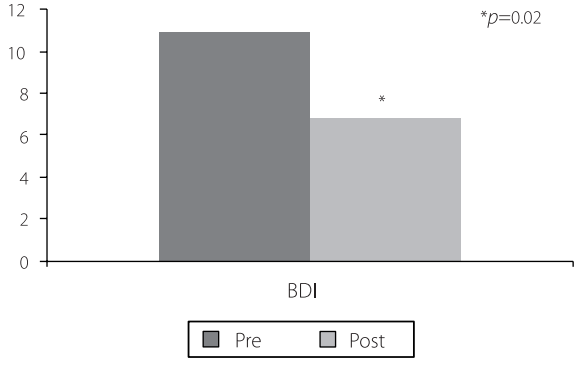

Figure 3. Results of the Beck Depression Inventory at pre- and post-intervention stages.

It is noteworthy that while our sample did not include participants with an established diagnosis of depression or any psychopathological condition, our results still showed a significant change. There are two possible explanations for this: the healthy and unhealthy behavior focused during the intervention has an impact on emotional state; or that some participants suffered from underlying, undiagnosed depressive disorders.

Individually, only six participants increased their depression indicators, though their scores did not justify a condition of depressive disorder. In turn, 12 participants decreased their scores and no scores remained unchanged. Since depression interferes directly with a person's ability to make decisions and thus adopt healthy behaviors, the improvement found is of consequence (Beck, 1997; Beck et al.,1997). Indeed, cognitive restructuring is considered to be an important factor in effective CT treatment (Beck, 1963; 2005; Beck et al., 1997; Rangé & Silvares, 2001). Through this process, patients learn to identify and change unhealthy thoughts in favor of healthier ones (Beck, 2007; Beck & Knapp, 2008; Luty et al., 2007). Moreover, due to the role thoughts play as a mediator between emotion and behavior, a healthier repertoire can be established between the two when cognitive restructuring takes place (Beck et al., 1997).

The most common difficulty reported by participants (33%) referred to interpersonal relationships, followed by *not studying, not controlling emotion and personal carelessness*. It is interesting to note that lack of emotional control and personal carelessness may be reflected in personal relationships and in attitudes to study. As such, although the participants focused on individual unhealthy behaviors, it is possible to distinguish broad categories of difficulties that compromise the quality of life and health.

The healthy behavioral goal of being able to "relate well with others" was chosen by 28% of participants, followed by "study", "emotional control", "self-discipline", "stop ruminating on past events" and "improving self-care". One of the participants restructured

the following assumption: *"If I accept that I cannot change the past, that does not mean I agree or like what has happened. If I accept this, I can stop ruminating and start investing in the present and get my life back"*.

Results support the affirmation that the Decision Making and Quality of Life technique contributes to health promotion. Through developing assumptions and identifying emotions, which is also part of the systematization of the technique, this process identifies unhealthy behaviors and their disadvantages and also allows for a deeper understanding of factors that are potentially able to induce them. With respect to healthy behavior, this also seems to be the case. In summary, the process triggered by the intervention promotes decision-making, autonomy and participants' determination to set goals to improve their quality of life and health.

Final Considerations

This research shows an increase in quality of life in all of the WHOQOL-bref domains - brought about by decision-making, which favors healthy behaviors and evidenced by the participants' higher scores. The only domain in which improvements were not statistically significant was in that of 'social relationships'. This is precisely the domain that was judged in the validation process of this instrument as not contributing significantly to variations of the overall quality of life (Chachamovich & Fleck, 2008).

We recommended that future studies include other instruments for more specifically measuring anxiety, as the State-Trait Anxiety Inventory (STAI). It also seems pertinent to plan an intervention aimed at cognitive restructuring in anxiogenic situations (Spielberger, Gorsuch & Lushene, 1979). In the same vein, comparing the results to a control group (participants on the waiting list) with the results of a similar intervention group may help to clarify the preliminary evidence obtained by this study. Moreover, the expansion of the sample size would determine the ideal number of participants in each group, and enable greater generalization of findings.

We conclude that the specific CT technique - Decision Making and Quality of Life - can contribute to achieving therapeutic goals. Although the effect of intervention on decreasing anxiety symptoms was calculated as being small, in relation to depression indicators it showed a moderate effect. In general, individuals believe that cognitions, emotions, behaviors and healthy physical reactions are only compatible with favorable situations. With the technique discussed in this study, they learn that even in unfavorable situations, healthy cognitions can prevail. Finally, the application of CT for promoting health and quality of life in the workplace converges with the expansion of personal demands, sensitized by institutional actions, which seems to be a growing trend.

References

Anderson, R. A., & Rees, C. S. (2007). Group *versus* individual cognitive-behavioral treatment for obsessive-compulsive disorder: A controlled trial. *Behaviour Research and Therapy, 45*(1), 123-137. Retrieved September 6, 2009, from <http://www.sciencedirect.com>.

Bechara, A. (2004). The role of emotion in decision-making: Evidence from neurological patients with orbital damage. *Brain and Cognition, 55*(1), 30-40.

Beck, A. T. (1963). Thinking and depression: I- Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*(4), 324-333.

Beck, A. T. (2005). The current state of cognitive therapy: A 40-year retrospective. *Archives of General Psychiatry, 62*(9), 953-959.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1997). *Terapia cognitiva da depressão*. Porto Alegre: Artes Médicas.

Beck, A. T., & Knapp, P. (2008). Fundamentos, modelos conceituais, aplicações e pesquisa da terapia cognitiva. *Revista Brasileira de Psiquiatria*, *30*(Supl. 2), S54-S64.

Beck, J. S. (1997). *Terapia cognitiva*: *teoria e prática*. Porto Alegre: Artmed.

Beck, J. S. (2007). *Terapia cognitiva para desafios clínicos*: *o que fazer quando o básico não funciona*. Porto Alegre: Artmed.

Beer, J. S., Knight, R. T., & D'Esposito, M. (2006). Controlling the integration of emotion and cognition: The role of frontal cortex in distinguishing helpful from hurtful emotional information. *Psychological Science, 17*(2), 448-453.

Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M., & Westbrook, D. (2004). *Oxford guide to behavioral experiments in cognitive therapy*. New York: Oxford University Press.

Chachamovich, E., & Fleck, M. P. A. (2008). Desenvolvimento do WHOQOL-bref. In M. P. A. Fleck (Org.), *A avaliação de qualidade de vida*: *guia para profissionais da saúde* (pp.74-82). Porto Alegre: Artmed.

Cooper, M., Todd, G., Turner, H., & Wells, A. (2007). Cognitive therapy for bulimia nervosa: An A-B replication series. *Clinical Psychology and Psychotherapy, 14*(5), 402-411.

Cordioli, A. V., Heldt, E., Bochi, D. B., Margi, R., Sousa, M. B., Tonello, J. F., et al. (2002). Cognitive-behavioral group therapy in obsessive-compulsive disorder: A clinical trial. *Revista Brasileira de Psiquiatria*, *24*(3), 113-120.

Costa Neto, S. B., & Araujo, T. C. C. F. (2008). Qualidade de vida em enfermo oncológico: um panorama sobre o campo e suas formas de avaliação. In V. A. Carvalho, M. H. P. Franco, M. J. Kovács, R. P. Liberato, R. C. Macieira, M. T. Veit, et al. (Orgs.), *Temas em psico-oncologia* (pp.195-208). São Paulo: Summus.

Cunha, J. A. (2001). *Manual da versão em português das escalas Beck*. São Paulo: Casa do Psicólogo.

Dattilio, F. M. (2006). Reestruturação de esquemas familiares. *Revista Brasileira de Terapias Cognitivas, 2*(1), 17-34.

Falcone, E. M. (1999). A avaliação de um programa de treinamento da empatia com universitários. *Revista Brasileira de Terapia Comportamental e Cognitiva, 1*(1), 23-32.

Fals-Stewart, W., & Lucent, S. (1994). Behaviour group therapy with obsessive-compulsive: An overview. *International Journal of Group Psychotherapy*, *44*, 35-51.

Fleck, M. P. A. (2008). Problemas conceituais em qualidade de vida. In M. P. A. Fleck (Org.), *A avaliação de qualidade de vida*: *guia para profissionais da saúde* (pp.19-28). Porto Alegre: Artmed.

Fortes, P. A. C., & Zoboli, E. L. C. P. (2004). Bioética e promoção de saúde. In F. Lefèvre & A. M. C. Lefèvre (Orgs.), *Promoção de saúde*: *a negação da negação* (pp.147-160). Rio de Janeiro: Vieira & Lent.

Gomes, M. J. C., & Scrochio, E. F. (2001). Terapia da gagueira em grupo: experiência a partir de um grupo de apoio ao gago. *Revista Brasileira de Terapia Comportamental e Cognitiva, 3*(2), 25-34.

Himle, J. A., Rassi, S., Haghigthatgou, H., Krone, K. P., Nesse, R. M., & Abelson, J. L. (2001). Group behavioral therapy of obsessive-compulsive disorder: Seven *versus* twelve-week outcomes. *Depression and Anxiety, 13*(4), 161-165.

Kobak, K. A., Rock, A. L., & Greist, J. H. (1995). Group behavior therapy for obsessive-compulsive disorder. *Journal for Specialists in Group Work*, *20*, 26-32.

Kunzler, L. S. (2008a). A contribuição da terapia cognitiva para o tratamento do transtorno obsessivo-compulsivo. *Brasília Médica, 45*(1), 30-40.

Kunzler, L. S. (2008b). *Como dominar o seu pensamento*: *tome uma decisão e não volte atrás*. Brasília: Atalaia.

Kunzler, L. S. (2011). Pense saudável: reestruturação cognitiva em nível de crenças condicionais. In B. Rangé (Org.), *Psicoterapias cognitivo-comportamentais*: *um diálogo com a psiquiatria* (pp.194-205). Porto Alegre: Artmed.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization*: *Working effectively with clients in cognitive - behavioral therapy*. New York: Guilford.

Luty, S. E., Carter, J. D., McKenzie, J., Rae, A. M., Frampton, C. M. A., Mulder, R. T., et al. (2007). Randomised controlled trial: Interpersonal psychotherapy and cognitive-behavioral therapy for depression. *British Journal of Psychiatry, 190,* 496-502.

Marks, D., Murray, M. P., Evans, B., Willig, C., Sykes, C. M., & Woodall, C. (2000). *Health psychology*: *Theory, research and practice*. London: Sage.

Matos, D. R., & Araujo, T. C. C. F. (2009). Qualidade de vida e envelhecimento: questões específicas sobre osteoartrose. *Psicologia em Estudo, 14*(3), 511-518.

Oliva, A. D., Otta, E., Bussab, V. S. R., Lopes, F. A., Yamamoto, M. E., & Moura, M. L. S. (2006). Razão e emoção em cena: a mente humana sob um olhar evolucionista. *Psicologia*: *Teoria e Pesquisa, 22*(1), 53-62.

Palmini, A. (2004). O cérebro e a tomada de decisões. In P. Knapp (Org.), *Terapia cognitiva na prática psiquiátrica* (pp.71-88). Porto Alegre: Artmed.

Patrick, D. L. (2008). A qualidade de vida pode ser medida? Como? In M. P. A. Fleck (Org.), *A avaliação de qualidade de vida*: *guia para profissionais da saúde* (pp.29-39). Porto Alegre: Artmed.

Rangé, B., & Silvares, E. F. M. (2001). Avaliação e formulação de casos clínicos adultos e infantis. In B. Rangé (Org.), *Psicoterapias cognitivo-comportamentais*: *um diálogo com a psiquiatria* (pp.79-100). Porto Alegre: Artmed.

Rosenthal, R. (1991). *Meta-analytic procedures for social research (revise)*. Newbury Park: Sage.

Sardinha, A., Oliva, A. D., D'Augustin, J., Ribeiro, F., & Falcone, E. M. O. (2005). Intervenção cognitivo-comportamental com grupos para o abandono do cigarro. *Revista Brasileira de Terapia Cognitiva, 1*(1), 83-90.

Spielberger, C. D., Gorsuch, R. L., & Lushene, R. E. (1979). *Inventário de Ansiedade Traço - Estado - IDATE*: *manual de Psicologia Aplicada*. Rio de Janeiro: CEPA.

Steketee, G. S., & Pigott, T. (2006). *Obsessive compulsive disorder*: *The latest assesment and the treatment strategies* (3th ed.). Kansas City: Dean Psych Press Corporation.

Straub, R. O. (2007). *Health psychology*: *A biopsychosocial approach* (2nd ed.). New York: Worth Publishers.

Strunk, C. R., DeRubeis, R. J., Chiu, A. W., & Alvarez, J. (2007). Patient's competence in and performance of cognitive therapy skills: Relation to the reduction of relapse risk following treatment for depression. *Journal of Consulting and Clinical Psychology, 75*(4), 523-530.

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O profissional de saúde mental na reforma psiquiátrica

The mental health professional in the psychiatric reform

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Resumo

O objetivo desse artigo é examinar criticamente produções da literatura científica sobre a Reforma Psiquiátrica Brasileira, publicadas entre 2003 e 2011, abordando estudos que focalizaram o trabalhador de saúde mental. A pesquisa organizou-se por meio de leitura sistemática e análise dos artigos, em termos de seus objetivos, metodologia, resultados e conclusão. Foram encontrados 14 artigos, que se revelaram convergentes quanto aos resultados obtidos na medida em que concluem que os trabalhadores manifestam-se favorável e engajadamente em relação ao processo da reforma, ao mesmo tempo em que apontam problemas e desafios no cotidiano - sem superar, como seria esperado, visões conservadoras e reducionistas da doença mental. Por outro lado, considerada em seu conjunto, esta produção indica que o interesse pelo trabalhador não inclui valorização de sua experiência emocional, dimensão certamente mobilizada pela questão da loucura. Esta lacuna deve ser preenchida por pesquisas que incluam atenção aos aspectos emocionais e se traduzam em intervenções que auxiliem os trabalhadores a lidar bem com suas tarefas do cotidiano.

Unitermos: Doença mental; Loucura; Profissionais de saúde; Reforma psiquiátrica; Saúde mental.

Abstract

The aim of this article is to systematically and critically review scientific literature productions, published between 2003 and 2011, regarding the Brazilian Psychiatric Reform, including articles which focus on mental health professionals. This research was performed by means of systematically reading and analyzing the articles, considering their aims, methodology, results and conclusions. Fourteen articles were found. The results obtained in these studies converged, as they concluded that the workers were shown to be favorable and engaging in relation to the reform process. They also indicated problems and challenges in the quotidian, without overcoming, as expected, the conservative and reductionist views of mental disease. There is a gap that must be filled by further studies which include attention to emotional aspects that can be translated into interventions that help workers cope with their daily tasks.

Uniterms: *Mental disease; Insanity; Health professional; Psychiatric reform; Mental health.*

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A Reforma Psiquiátrica Brasileira consiste em longo e complexo processo de reorientação do modelo assistencial em saúde mental, que envolve um amplo questionamento sobre formas de assistência e cuidado à população acometida por sofrimentos psíquicos graves. Seu início pode ser remontado ao final da década de 1970, e sua progressiva operacionalização vem ocorrendo desde a década de 1980.

É importante destacar que tal reformulação envolve uma grande variedade de indagações e críticas, que problematizam não apenas a dimensão do tratamento propriamente dito, mas também questões de ordem política e jurídica, epistemológicas e culturais. Ou seja, a Reforma Psiquiátrica pode ser identificada como um movimento que busca questionar o modelo de atendimento centrado no hospital psiquiátrico tanto na sua concretização em práticas assistenciais quanto nas suas configurações teórico-conceituais, designáveis como campo do saber psiquiátrico. Busca, além disso, superar preconceitos historicamente construídos a respeito da loucura, cristalizados no imaginário social e cultural, bem como na caracterização jurídica do doente mental.

No que se refere especificamente ao campo do tratamento, a Reforma Psiquiátrica caracterizou-se pela desativação de grande parte dos hospitais psiquiátricos, com o objetivo de substituí-los por redes alternativas de atendimento em saúde mental. Em menos de três anos, o número de hospitais psiquiátricos foi reduzido em 8%, ao mesmo tempo em que foram criados 2 156 leitos para atendimento psiquiátrico em 139 hospitais gerais e 3 500 vagas em hospitais-dias, Núcleos e Centros de Atenção Psicossocial (Venturini, 1998).

Em sintonia com os princípios da Reforma Psiquiátrica, instituída no País há 11 anos pela Lei nº 10.216/2001, o Governo Federal impulsionou, nos últimos anos, a construção de um modelo humanizado de atenção integral na rede pública de saúde, que mudou o foco da hospitalização como centro ou única possibilidade de tratamento aos pacientes. O tratamento, de acordo com o discurso oficial que orienta a reforma, deve ser pautado em uma concepção de saúde compreendida como processo, e não meramente como ausência de doença. Busca-se melhorar a qualidade de vida do usuário, com ênfase em ações integrais e promocionais de saúde, garantindo-se o cuidado, a inclusão e a emancipação das pessoas portadoras de sofrimento psíquico (Brasil, 2004).

Dentre a rede de equipamentos, um dos principais serviços substitutivos do Sistema Único de Saúde (SUS) são os Centros de Atenção Psicossocial (CAP), de caráter aberto e comunitário. Esses equipamentos de referência têm o objetivo de oferecer atendimento a pessoas que sofrem de transtornos mentais, psicoses e neuroses graves, entre outros quadros. Devem contar com uma equipe multiprofissional completa e preveem a assistência integral ao usuário de serviços de saúde, incluindo atendimento médico, assistência social, psicoterapia, oficinas terapêuticas, atividades artísticas, atendimento domiciliar e familiar, entre outros serviços (Brasil, 2004). Atualmente, a rede conta com 1 771 Centros de Atenção Psicossocial (CAP), que estão implementados em todos os estados. Essa quantidade é quase quatro vezes maior que em 2002, quando o País contava com 424 centros (Brasil, 2012).

Essa breve panorâmica dos princípios e objetivos que guiam a Reforma Psiquiátrica evidencia que esta, por apresentar tantas ambições em seu projeto, deve ser encarada como fenômeno complexo que pode e deve ser abordado por diversos ângulos. De fato, se for considerada a amplitude de áreas e temas que busca articular, pode ser vista como um campo aberto, plural e em movimento, que engloba discussões e práticas diversas. Aponta-se, desta maneira, que a Reforma Psiquiátrica requer mudanças paradigmáticas consistentes e não apenas alterações pontuais no cuidado e na postura dos profissionais. É um processo que caminha entre avanços e retrocessos, o que pode dificultar a apreensão, por parte dos trabalhadores de saúde mental, do paradigma psicossocial e sua aplicação cotidiana com os usuários.

Neste contexto, a investigação sobre seus sucessos, impasses, conquistas e fracassos demanda uma avaliação criteriosa e contínua e, para tanto, é necessária a adoção de uma postura crítica, entendida como um modo de diagnosticar problemas não resolvidos e contribuir para a conquista de avanços relevantes. Ao analisar a Reforma Psiquiátrica, deve-se ter em mente que a realidade cotidiana coloca constantemente desafios para a concretização, na prática, dos modelos ideais. Ou seja, nem sempre as intenções veiculadas pelos discursos oficiais encontram condições

de trabalho adequadas para se realizarem. Sem negar reconhecidos progressos, é preciso evitar o risco de nos restringirmos a uma visão idealizada do processo, o que, evidentemente, não implica defender um retorno a práticas e discursos reacionários.

Segundo alguns autores (Amarante, 1995; Desviat, 1999; Venturini, 1998), a implantação do novo modelo de assistência preconizado pela Reforma Psiquiátrica teve expressivo e rápido desenvolvimento no País, em curto espaço de tempo, tendo se beneficiado de grande apoio político e legislativo. Além disso, mobilizou profissionais de saúde, órgãos governamentais e não governamentais e a sociedade em geral, estando todos de acordo sobre a falência da assistência psiquiátrica centrada no manicômio.

Entretanto, vale a pena considerar que o processo de operacionalização da reforma se constituiu historicamente, e consiste, ainda hoje, em um campo mais heterogêneo do que tal visão poderia fazer supor. Assim, é temerário afirmar que todos os setores envolvidos nas discussões sobre a reforma venham seguindo em pleno acordo sobre todos os pontos da mesma, ou que todos os grupos políticos e sociais defendam mudanças por motivos ideológicos comuns, embora possam concordar em algumas reivindicações gerais.

Pode-se afirmar que a implantação de um modelo de assistência extra-hospitalar no Brasil, em si, é um assunto complexo, e que sua concretização ainda coloca constantes dificuldades. Tal quadro provavelmente explica o motivo de a Reforma Psiquiátrica ser um tema muito pesquisado, fato facilmente constatável quando se realiza um levantamento bibliográfico por meio da base de dados *Scientific Electronic Library Online* (SciELO), na qual encontram-se trabalhos científicos dedicados a esse assunto, o que deixa clara a importância e relevância de analisar como esse movimento de desconstrução do modelo manicomial vem ocorrendo no Brasil.

Considerando o exposto, pretende-se com este artigo contribuir particularmente com uma investigação sobre o modo como os trabalhadores de saúde mental estão enfrentando, atualmente, as dificuldades concretas da implementação efetiva da Reforma Psiquiátrica. Para tanto, serão examinados estudos recentes que focalizaram a figura do trabalhador. Justifica-se a relevância de enfocar estes profissionais porque são eles que realizam no dia a dia as mudanças preconizadas pelo movimento antimanicomial, lidando com os impasses, problemas, dúvidas e angústias que o contato próximo e diário com os usuários pode gerar. A experiência destes profissionais pode ser verdadeiramente instrutiva se puder ser utilizada como material para reflexão e crítica. Além disso, investigações sobre diversos profissionais e o adoecimento no ambiente também parecem oportunas a partir do que tem sido apontado por alguns autores que concordam com a necessidade do desenvolvimento de estratégias de cuidado ao próprio trabalhador (Guimarães & Martins, 2010; Malagris & Fiorito, 2006; Souza & Silva, 2002).

Método

Em termos metodológicos, este trabalho foi organizado realizando-se um levantamento bibliográfico de artigos brasileiros, publicados no período de 2003 a 2011, em periódicos científicos incluídos na base de dados SciELO. Esta escolha justifica-se por se tratar de uma base que abrange todas as áreas de conhecimento, permitindo o acesso a periódicos de diversas ciências, biológicas, humanas, sociais, da saúde, entre outras. Além do mais, é reconhecida no meio científico, em virtude de suas exigências, permitindo acesso fácil e direto a textos completos. Procedeu-se a uma busca inicial usando as palavras-chave "reforma psiquiátrica", "doença mental", "loucura" e "saúde mental". Em um segundo momento foram selecionados, dentre os artigos encontrados, aqueles que apresentavam pelo menos uma das seguintes expressões em seus títulos: "profissional(is)", "trabalhadores", "equipe".

Realizou-se uma leitura sistemática dos textos selecionados adotando-se como guia o exame das dimensões que estruturam a comunicação de investigações científicas: objetivos; metodologia, incluindo procedimentos de coleta, procedimentos de registro, modos de interpretação; resultados e interpretação dos resultados. Essas divisões foram consideradas tanto na análise das pesquisas quantitativas quanto nas qualitativas, pois, mesmo que estas últimas não adotem formalmente este tipo de organização, não deixam de seguir a mesma lógica de pensamento.

Resultados

A primeira busca realizada em 9/8/2011, organizada a partir dos assuntos "reforma psiquiátrica", "doença mental", "loucura" e "saúde mental", considerando o período de 2003 a 2011, resultou em uma lista composta por 690 artigos. Foram encontrados 61, 11, 95 e 523 trabalhos científicos dos assuntos respectivamente citados.

Dentre o total de 690 artigos, foram encontrado - listado em ordem crescente da publicação -, 14 artigos que focalizaram diretamente a figura do trabalhador de saúde mental e sua prática profissional (Bernardes & Guareschi, 2004; Campos & Soares, 2003; Carvalho & Felli, 2006; Honorato & Pinheiro, 2008; Jorge, Randemark, Queiroz & Ruiz, 2006; Nardi & Ramminger, 2007; Pinho, Hernández & Kantorski, 2010a; Pinho, Hernández & Kantorski, 2010b; Rabelo & Torres, 2006; Rodrigues & Figueredo, 2003; Santos & Cardoso, 2010a; Santos & Cardoso, 2010b; Silva & Costa, 2010; Silveira & Santos Júnior, 2011) (Quadro 1). Tais pesquisas foram selecionadas pelo critério de apresentarem pelo menos uma das seguintes expressões em seus títulos: "profissional(is)", "trabalhadores", "equipe".

Quadro 1
Descrição do objetivo, procedimento de coleta, procedimento de registro e tratamento e análise dos dados

Artigo	Objetivos principais	Procedimentos de coleta	Procedimentos de registro	Tratamento e análise dos dados
Campos & Soares (2003)	Identificação e análise de concepções de trabalhadores.	Questionário aberto.	Autopreenchimento.	Análise temática.
Rodrigues & Figueiredo (2003)	Identificação e análise de concepções sobre a doença mental.	Entrevistas individuais.	Transcrições de gravações em áudio.	Análise temática.
Bernardes & Guareschi (2004)	Identificação e análise sobre autocuidado.	Entrevistas individuais e em grupo.	Não especificado.	Análise de modos de subjetivação.
Carvalho & Felli (2006)	Identificação e análise de concepções sobre serviços.	Intervenção grupo.	Transcrições de gravações em áudio.	Análise temática.
Rabelo & Torres (2006)	Identificação e análise de percepções sobre serviços.	Questionário aberto.	Autopreenchimento.	Análise temática.
Jorge et al. (2006)	Identificação e análise de percepções sobre reabilitação psicossocial.	Entrevistas individuais semiestruturadas individuais e observação livre.	Transcrições de gravações em áudio.	Análise temática.
Nardi & Ramminger (2007)	Identificação e análise sobre modos de subjetivação dos trabalhadores de saúde mental.	Revisão da literatura, análise de documentos e entrevistas individuais.	Não especificado.	Análise de modos de subjetivação.
Honorato & Pinheiro (2008)	Identificação e análise de percepções sobre serviços.	Entrevista individual, observação direta e intervenção grupal.	Diário de campo.	Análise ergológica.
Pinho et al. (2001a)	Identificação e análise de discursos sobre as famílias de usuários.	Entrevista individual semiestruturada.	Transcrições de gravações em áudio.	Diagrama axiologia discursiva.
Pinho et al. (2001b)	Identificação e análise sobre serviços.	Entrevista individual semiestruturada.	Transcrições de gravações em áudio.	Diagrama axiologia discursiva.
Santos & Cardoso (2010a)	Identificação e análise de manifestações de *stress* e de *burnout*.	Inventários e escalas.	Autopreenchimento.	Procedimentos estatísticos.
Santos & Cardoso (2010b)	Identificação e análise de manifestações de *stress*.	Inventários e escalas.	Autopreenchimento.	Procedimentos estatísticos.
Silva & Costa (2010)	Identificação e análise de opiniões sobre o profissional de referência.	Intervenção grupo.	Anotações do pesquisador.	Análise temática.
Silveira & Santos Júnior (2011)	Identificação e análise de percepções sobre serviços.	Entrevista semiestruturada e observação sistemática.	Diário de campo.	Análise temática.

Quadro 2
Descrição e interpretação dos resultados principais

Artigos	Descrição e interpretação dos resultados principais
Campos & Soares (2003)	Identificação de duas diferentes concepções de saúde-doença: multifatorial e centrada no indivíduo e determinação social, interpretada, muitas vezes, como reducionismo da doença mental, o que afeta diretamente o processo da Reforma Psiquiátrica.
Rodrigues & Figueiredo (2003)	Identificação de seis subcategorias das concepções de doença mental: instabilidade emocional; perda do padrão de normalidade; visão biológica; predisposição hereditária; estigma; conflitos sociais. Interpretação de que existe uma estereotipia dos conhecimentos adquiridos, o que interfere na não possibilidade de novos modelos de intervenção, afetando o processo da Reforma Psiquiátrica.
Bernardes & Guareschi (2004)	Identificação de dificuldades no processo de humanização tanto no cuidado ao paciente como no próprio. Interpretação de que a possibilidade de autocuidado é um avanço dos trabalhadores no processo da Reforma Psiquiátrica.
Carvalho & Felli (2006)	Identificação de que as condições de trabalho provocam intenso desgaste mental, além do próprio convívio com o objeto de trabalho. Interpretação de que isso interfere negativamente no cotidiano dos profissionais, afetando o processo da Reforma Psiquiátrica.
Rabelo & Torres (2006)	Identificação de ênfase nos aspectos técnico-assistenciais, reduzindo questões de ordem jurídica, política e sociocultural no processo de desinstitucionalização. Interpretação de um reducionismo do processo, o que interfere diretamente na Reforma Psiquiátrica.
Jorge et al. (2006)	Identificação de que os trabalhadores ainda exercem as atividades sob uma visão tradicional, o que interpretam como um impasse no processo da Reforma Psiquiátrica.
Nardi & Ramminger (2007)	Identificação de embates e tensões em relação ao adoecimento dos trabalhadores, interpretada como um impasse no processo da Reforma Psiquiátrica.
Honorato & Pinheiro (2008)	Identificação da dificuldade de relacionamento entre o louco e a sociedade civil, inclusive dos cuidadores, interpretada como uma dificuldade no processo de trabalho, o que afeta diretamente a Reforma Psiquiátrica.
Pinho et al. (2001a)	Identificação da importância da família no tratamento dos usuários, com paradoxal distanciamento problemático, o que interfere diretamente no processo da Reforma Psiquiátrica.
Pinho et al. (2001b)	Identificação de uma indefinição no operacional dos objetos e instrumentos de trabalho devido à complexidade da própria atividade, interpretada como uma dificuldade no trabalho em equipe, o que interfere no processo da Reforma Psiquiátrica.
Santos & Cardoso (2010a)	Identificação de 36% dos participantes com indicadores de presença de manifestação de *stress,* interpretadas como possivelmente relacionadas com as novas exigências e demandas que o trabalho requer, interferindo no processo da Reforma Psiquiátrica.
Santos & Cardoso (2010b)	Identificação de que 36% dos participantes apresentaram indicadores de presença de manifestação de *stress*, interpretada como pouca utilização de estratégias de enfretamento, apontando a necessidade de intervenções, já que isto interfere diretamente no processo da Reforma Psiquiátrica.
Silva & Costa (2010)	Identificação de três categorias: vínculo de mais responsabilidade com o usuário; organização precária do trabalho; suporte precário institucional. Interpretação sobre a falta de suporte institucional e a própria dificuldade clínica, o que interfere no processo da Reforma Psiquiátrica.
Silveira & Santos Júnior (2011)	Identificação de dificuldades enfrentadas de base estrutural, insuficiência de recursos humanos e/ou falta de capacitação e de apoio social e de avanços em relação à terapêutica, interpretadas como pontos que interferem nos avanços do processo da Reforma Psiquiátrica.

Os Quadros 1 e 2 apresenta uma breve descrição dos artigos levantados, que serão apresentados em ordem crescente pelo ano de publicação. O Quadro 1 expõe os objetivos e o método adotado, especificando procedimento de coleta, procedimento de registro, tratamento e análise dos dados. No Quadro 2 podem ser apreciados os resultados das pesquisas examinadas e sua interpretação. Optou-se por este tipo de apresentação dada a natureza qualitativa da totalidade dos textos examinados, que apresenta seus achados já sob uma perspectiva interpretativa.

Discussão

Este estudo permitiu uma constatação bastante interessante, relativa à ocorrência de evidente conver-

gência nos resultados de pesquisas realizadas a partir de referenciais teóricos distintos entre si. Tal quadro aponta que os profissionais estão sendo escutados pelos estudiosos em termos de discurso manifesto - aquele que expressa os aspectos sobre os quais estão conscientes. Assim, todos averiguaram o fato de que a implantação dos princípios da Reforma Psiquiátrica, em andamento desde a década de 1980, ainda é um grande desafio, principalmente quando deixa o plano da discussão ética e política para se colocar como prática cotidiana no contexto institucional. Este quadro geral suscita, aparentemente, inúmeras questões, que apresentam, por seu turno, diversos desdobramentos. Contudo, é possível identificar uma tendência claramente predominante, que merece ser considerada de modo atento.

Percebe-se claramente, avaliando as pesquisas selecionadas, que os profissionais declaram-se, em seus discursos, favoráveis aos tratamentos propostos pelo movimento da Reforma Psiquiátrica. Entretanto, é possível notar, a partir do que foi dito, que sua prática ainda está impregnada por uma compreensão do processo de adoecimento fortemente calcada nos pressupostos teóricos do saber psiquiátrico tradicional. Consequentemente, a causa da doença é buscada, primária e essencialmente, na dimensão biológica do ser humano, sendo a cura concebida fundamentalmente como resultado de intervenção medicamentosa. A atuação da equipe multiprofissional apenas complementaria o ato médico (psiquiátrico) da prescrição farmacológica.

Para os objetivos deste texto, considera-se que a persistência de tal concepção do adoecer constitui um problema grave, tendo em vista que, conforme destacado anteriormente, as diretrizes políticas e legislativas que norteiam a Reforma Psiquiátrica preconizam outra visão do sofrimento psíquico, chamando atenção para seu caráter fundamentalmente complexo e pluridimensional. Entretanto, os agentes efetivos do processo de desinstitucionalização - que são os trabalhadores da área de saúde mental -, ainda mantêm uma visão etiológica conservadora, pelo que pode-se inferir a partir dos resultados das pesquisas analisadas. Esta perspectiva seria, num sentido radical, não compatível com as mudanças nas leis e políticas de assistência em saúde mental. Tal aspecto pode explicar profundas divergências entre o plano das ideias e discursos e o plano das atitudes concretas realizadas no cotidiano profissional. Assim, pode-se levantar a hipótese, com amparo em uma perspectiva psicanalítica, de que muitas das ideias preconcebidas acerca do louco e/ou doente mental emergem de um campo de sentido afetivo-emocional que não é consciente para os próprios trabalhadores.

Praticamente todos os estudos mencionaram reações emocionais dos técnicos perante os usuários, ainda que não tivessem estabelecido a análise deste dado como objetivo do trabalho. Contudo, mesmo escutando-as e argumentando a favor do reconhecimento de sua importância, tendem, coerentemente em relação aos seus pressupostos, a tratá-las como informações objetivas veiculadas por sujeitos puramente racionais. Deste modo, as dimensões afetivas presentes nas manifestações dos profissionais de saúde deixam, compreensivelmente, de ser suficientemente consideradas.

Como psicólogos que adotam uma abordagem psicanalítica, os autores deste texto reconhecem a importância do discurso manifesto e acreditam ser possível produzir conhecimento relevante mesmo quando os pesquisadores se limitam à sua focalização, sem se propor ao estudo de determinantes afetivo-emocionais inconscientes. Por outro lado, consideram que uma escuta psicanalítica ingênua - que realiza traduções apressadas entre o plano das condutas e supostas motivações inconscientes profundas, ignorando planos intermediários nos quais a vida transcorre -, deve ser desestimulada. É perigoso tanto desqualificar o chamado discurso manifesto, como se este fosse sempre um mero truque de ocultação de algo mais verdadeiro - desvalorizando-se, assim, a fala do outro -, quanto o pensamento que considera que o discurso verbal é unívoco e destituído de ressonâncias que apontem para questões emocionais encobertas.

É legitima a queixa de despreparo técnico enunciada pelos profissionais. Ao formular esta queixa, no entanto, estes profissionais expressam também, de modo indireto, dificuldades de ordem afetiva. Até em casos nos quais os profissionais dos serviços referiram esgotamento físico em decorrência do cotidiano com os doentes mentais, é possível encontrar - obviamente não ignorando as condições concretas de exigências feitas ao corpo no cotidiano de trabalho -, manifestações de desgaste emocional. Portanto, sugere-se que o

problema tem duas faces: a do despreparo técnico-profissional e a do despreparo afetivo-emocional. A primeira seria solucionável por meio de cursos de atualização e aperfeiçoamento técnico e clínico; a segunda demandaria medidas diferenciadas, da ordem do cuidado emocional ao trabalhador, não porque este seria inerentemente frágil ou problemático, mas por reconhecer que o trabalho, em si, é inerentemente desgastante.

Em realidade, é preciso ter em mente que essas dimensões não são rigidamente separadas, o que fica especialmente evidente em profissões que lidam com situações de vida que as colocam em relação muito próxima com o sofrimento humano. O trabalho em saúde mental mobiliza intensamente questões de ordem emocional, não podendo ser reduzido ao seu aspecto técnico. O saber teórico-técnico só encontra sua razão de ser no encontro humano concreto com a alteridade, tal como se realiza no cotidiano de trabalho, configurando uma relação complexa entre teoria e prática, na qual a dimensão emocional se faz sempre presente.

A partir do momento em que se focaliza a atenção na dimensão emocional envolvida no trabalho em saúde mental, faz-se urgente constatar que simples mudanças na política, nas leis e nas redes de atendimento, ainda que inegavelmente necessárias, não são suficientes para promover automaticamente mudanças na relação com um tema complexo como a loucura, que se insere em um imaginário povoado por crenças preconceituosas que, por sua vez, estão ligadas a angústias profundas.

Neste quadro, os próprios trabalhadores destacam a importância de combater o preconceito contra usuários dos serviços de saúde mental, mas eles mesmos aparentam encontrar alguns entraves ao realizar tal objetivo, expressando grande dificuldade em lidar com os sentimentos despertados no cotidiano do trabalho.

A partir de tais considerações, algumas questões se colocam: as dificuldades emocionais devem ser resolvidas individualmente e de forma isolada por cada profissional, em processos psicoterapêuticos individuais ou na escola da vida? Como o próprio serviço de saúde pode desenvolver maneiras inovadoras para o cuidado de sua equipe, sem que a solução precise ser buscada fora da instituição e vista como uma necessidade não do coletivo, mas de cada sujeito individual?

Por fim, pode-se concluir que essa investigação permitiu visualizar que, tanto pesquisadores quanto profissionais de saúde, mesmo que vindos de linhas e vertentes teóricas diferentes, estão engajados em uma corrente defensora da causa inclusiva, que valoriza o fortalecimento de vínculos éticos, solidários, igualitários e respeitosos entre pessoas e grupos. Estão, em suma, mobilizados pela busca de melhoras a serem realizadas no âmbito da saúde mental. Entretanto, percebe-se também que o fato de o movimento, como um todo, não focalizar suficiente e satisfatoriamente a dimensão afetivo-emocional que se mobiliza quando a questão da loucura está em foco, possivelmente retardará avanços necessários e significativos.

Referências

Amarante, P. (1995). Novos sujeitos, novos direitos: o debate em torno da reforma psiquiátrica. *Cadernos de Saúde Pública, 11*(3), 491-4.

Bernardes, A. G., & Guareschi, N. M. F. (2004). Trabalhadores da saúde mental: cuidados de si e formas de subjetivação. *Psicologia USP, 15*(3), 81-101.

Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. (2004). *Saúde mental no SUS*: *os centros de atenção psicossocial*. Brasília: MS.

Brasil. Portal da Saúde. (2012). *Padilha reafirma em defesa da Reforma Psiquiátrica.* Recuperado em maio 20, 2012, disponível em <http://portalsaude.saude.gov.br/portalsaude/noticia/2617/162/padilha-reafirma-defesa-da-reforma-psiquiatrica.html>.

Campos, C. M. S., & Soares, C. B. (2003). A produção de serviços de saúde mental: a concepção de trabalhadores. *Ciência & Saúde Coletiva, 8*(2), 621-8.

Carvalho, M. B., & Felli, V. E. A. (2006). O trabalho de enfermagem psiquiátrica e os problemas de saúde dos trabalhadores. *Revista Latino-Americana de Enfermagem, 14*(1), 61-9.

Desviat, M. (1999). *A reforma psiquiátrica*. Rio de Janeiro: Fiocruz.

Guimarães, F. A. L., & Martins, M. C. F. (2010). Valores e prazer-sofrimento no trabalho: um estudo dos profissionais de nível superior. *Estudos de Psicologia* (Campinas), *27*(2), 133-145. doi: 10.1590/S0103-166X2010000200001.

Honorato, C. E. M., & Pinheiro, R. (2008). O trabalho do profissional de saúde mental em um processo de desinstitucionalização. *Physis*: *Revista de Saúde Coletiva, 18*(2), 361-80.

Jorge, M. S. B., Randemark, N. F. R., Queiroz, M. V. O., & Ruiz, E. M. (2006). Reabilitação psicossocial: visão da equipe

de saúde mental. *Revista Brasileira de Enfermagem*, *59*(6), 734-739.

Malagris, L. E. N., & Fiorito, A. C. C. (2006). Avaliação do nível de stress de técnicos da área de saúde. *Estudos Psicologia* (Campinas), *23*(4), 391-398. doi: 10.1590/S0103-166X2006000400007.

Nardi, H. C., & Ramminger, T. (2007). Modos de subjetivação dos trabalhadores de saúde mental em tempos de reforma psiquiátrica. *Physis*: *Revista de Saúde Coletiva, 17*(2), 265-267.

Pinho, L. B., Hernández, A. M. B., & Kantorski, L. P. (2010a). Reforma psiquiátrica, trabalhadores de saúde mental e a "parceria" da família: o discurso do distanciamento. *Interface, 14*(32), 103-113.

Pinho, L. B., Hernández, A. M. B., & Kantorski, L. P. (2010b). Trabalhadores em saúde mental: contradições e desafios no contexto da reforma psiquiátrica. *Escola Anna Nery, 14*(2), 260-267.

Rabelo, I. V. M., & Torres, A. R. R. (2006). Os significados da reforma psiquiátrica para os trabalhadores de saúde mental de Goiânia. *Estudos de Psicologia* (Campinas), *23*(3), 219-228. doi: 10.1590/S0103-166X2006000300001.

Rodrigues, C. R., & Figueiredo, M. A. C. (2003). Concepções sobre a doença mental em profissionais, usuários e seus familiares. *Estudos de Psicologia* (Natal), *8*(1), 117-125.

Santos, A. F. O., & Cardoso, C. L. (2010a). Profissionais de saúde mental: estresse, enfrentamento e qualidade de vida. *Psicologia*: *Teoria e Pesquisa*, *26*(3), 543-548.

Santos, A. F. O., & Cardoso, C. L. (2010b). Profissionais de saúde mental: manifestação de stress e burnout. *Estudos de Psicologia* (Campinas), *27*(1), 67-74. doi: 10.1590/S0103-166X2010000100008.

Silva, E. A., & Costa, I. I. (2010). O profissional de referência em saúde mental: das responsabilizações ao sofrimento psíquico. *Revista Latinoamericana de Psicopatologia Fundamental, 13*(4), 635-647.

Silveira, M. F. A., & Santos Júnior, H. P. O. (2011). Que eles falem por si: relatos dos profissionais sobre a experiência nas residências terapêuticas. *Ciência & Saúde Coletiva, 16*(4), 2089-2098.

Souza, W. C., & Silva, A. M. M. (2002). A influência de fatores de personalidade e de organização do trabalho no burnout em profissionais de saúde. *Estudos de Psicologia* (Campinas), *19*(1), 37-48. doi: 10.1590/S0103-166X2002000100004.

Venturini, E. (1998). Prefácio à primeira edição. In P. Amarante (Coord.), *Loucos pela vida*: *a trajetória da reforma psiquiátrica no Brasil* (2ª ed., pp.13-16). Rio de Janeiro: Fiocruz.

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Dispositivos institucionais filantrópicos e socioeducativos de atenção à infância na assistência social

Institutional philanthropic and socioeducative mechanisms of childcare in the social care

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Resumo

Estudou-se a Assistência Social como instituição que faz dispositivos de produção de subjetividade na atenção à criança e ao adolescente. Para tanto, utilizaram-se algumas coordenadas analíticas conjunturais e estruturais para mapear modelos de atenção assistencial em confronto no campo da Assistência Social. Concluiu-se que haveria dois paradigmas contraditórios, no sentido dialético, organizando a Assistência Social: um seria o modo filantrópico, o outro o modo socioeducativo. Ao primeiro, que é hegemônico no campo, corresponderia uma entidade assistencial ainda organizada a partir de uma atenção filantrópica pautada em uma lógica menorista, articulada por um discurso criminalizante das classes populares, informalmente baseada na noção jurídica da situação irregular, que desenvolveria práticas assistenciais preventivas, repressivas, correcionais e moralizadoras. A construção do modo socioeducativo implica uma atenção socioeducativaque visa à promoção efetiva dos direitos das crianças e dos adolescentes, a partir da sua condição de sujeitos e de cidadãos, por meio de práticas institucionais democráticas, dialógicas, participativas, multiprofissionais e transdisciplinares, fundamentalmente emancipadoras.

Unitermos: Análise institucional; Assistência social; Políticas públicas; Psicologia social.

Abstract

This study investigated Social Care as an institution that creates mechanisms for the production of subjectivity in the care of children and adolescents. For this, we used some analytical coordinates, both conjectural and structural, models of care for mapping care in confrontation in the field of Social Care. It was concluded that there was two contradictory paradigms, in the dialectical sense, organizing social care, one being the philanthropic mode and the other the socioeducative mode. The first, which is hegemonic in the field, corresponds to a care entity still organized from philanthropic care and is guided by a minority age logic, articulated by a discourse of criminalizing the lower classes. It is informally based on the legal concept of irregular situations, which would develop preventive, repressive, correctional and moralizing care practices. The construction of a socioeducative mode implies socioeducative care that aims for an effective increase in the rights of children and adolescents, based on their status as subjects and citizens, through democratic, dialogic, participatory, multi-disciplinary and fundamentally emancipatory institutional practices.

Uniterms: *Institutional analysis*; *Social care*; *Public policies*; *Social psychology*.

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A interface da Psicologia com a assistência social

A temática da Assistência Social no cenário brasileiro tornou-se profundamente relevante nas últimas décadas, tendo atingido o estatuto de política pública de Estado (Brasil, 2011; Constantino, 2010; Cruz & Guareschi, 2009; Gonçalves, 2010; Rodrigues, 2010). Juntamente com a Educação e a Saúde, ela vem se tornando também objeto de interesse da Psicologia, como se pode verificar por uma literatura crescente, tanto por parte de seus órgãos oficiais (Centro de Referência Técnica em Psicologia e Políticas Públicas, 2007, 2009; Conselho Federal de Psicologia, 2010; 2011; Conselho Regional de Psicologia da 6ª Região, 2007; Murta & Marinho, 2009; Silveira, Cobalchini, Menz, Valle & Barbarini, 2007), quanto por parte de pesquisadores (Alberto, 2008; Barreto, 2011; Benelli & Costa-Rosa, 2010; Bock, 2004, 2007, 2009; Botarelli, 2008; Constantino, 2010; Cruz & Guareschi, 2004; Cruz, Hillesheim & Guareschi, 2005; Dadico & Souza, 2010; Eidelwein, 2007; Ferreira, 2010; Fontenelle, 2008; Gonçalves, 2010; Lemos, 2007; Paiva & Yamamoto, 2010; Rogone, 2006; Saliba, 2006; Santana, Doninelli, Frosi & Koller, 2004; Scarparo, 2008; Senra, 2009; Silva, 2008; Zaniani, 2008).

O campo da Assistência Social circunscreve um conjunto de problemas sociais variados e complexos que demandam a atuação de equipes multiprofissionais para buscar promover seu equacionamento (Conselho Federal de Serviço Social, 2007). Nesse âmbito de trabalho específico, um grande número de alunos de cursos de graduação, bem como de pós-graduação em Psicologia, vêm se engajando em múltiplas atividades de estágio, de pesquisa e de extensão. Além disso, é crescente a contratação de profissionais psicólogos para trabalhar no campo da Assistência Social, atuando em equipamentos institucionais públicos e privados que desenvolvem os mais diversos programas, projetos e serviços assistenciais, nos quais devem prestar serviços psicológicos variados para usuários de todas as idades.

Buscando oferecer uma contribuição para o desenvolvimento científico, técnico, ético e político no âmbito da Psicologia como ciência e profissão, este artigo é derivado de uma pesquisa original que apresenta um caráter crítico e inovador na abordagem do tema da atenção assistencial oferecida a crianças e a adolescentes considerados em situação pessoal e social de risco (Brasil, 2004; 2005; 2009a), propondo uma análise histórico-conjuntural e lógico-estrutural do campo da Assistência Social, a partir das entidades que oferecem atenção assistencial à infância.

Assim como a política nacional de saúde mental faz dispositivo no contexto mais amplo da política nacional de Saúde Pública, a política nacional de atenção à criança e ao adolescente faz dispositivo no âmbito das demais políticas públicas, tais como as de Educação, de Assistência Social, de Saúde etc., muito embora ela também produza uma legislação específica (Brasil, 1990) e alguns dispositivos próprios (Assis, 2009; Brasil, 2007a; 2007b), buscando articular um sistema de garantias de direitos que funcione em rede.

Como área específica, a Assistência Social possui sua singularidade e complexidades próprias, que nem sempre são conhecidas pelos psicólogos que nela vão trabalhar. A pesquisa realizada permitiu a construção de duas categorias conceituais essenciais: os conceitos de filantropia e de socioeducativo, elaborados na reflexão crítica quando da análise dos dados de campo, bem como da documentação bibliográfica compulsada. Esses dois conceitos fundamentais tornaram possível uma organização científica rigorosa do pensamento, permitindo a elaboração de um texto dotado de uma estrutura teórica sólida, com apresentação de informações fundamentais, de conceitos precisos e objetivos, configurando um mapa que permite situar-se com certa clareza no campo.

A publicação deste artigo se justifica por sua relevância acadêmica, pois apresenta uma abordagem original de uma temática cada vez mais importante para o contexto da Psicologia como ciência e como profissão, oferecendo análises que poderão contribuir para orientar a formação, a pesquisa e a ação profissional de psicólogos inseridos no campo da Assistência Social. Sua relevância social se depreende da contribuição que representa na discussão de aspectos essenciais da atual interface Psicologia e Assistência Social, bem como na indicação de possíveis pistas para o equacionamento de um problema nacional de primeira ordem: a construção de uma cultura de cidadania e de direitos integrais para crianças e adolescentes pobres. Nesse sentido, tanto a pesquisa realizada quanto o artigo dela derivado se pautaram rigorosamente pela opção ética que a Psicologia adotou no cenário brasileiro atual: o compro-

misso social implicado na promoção e no fortalecimento de processos de transformação social da realidade (Bock, 2009; Conselho Federal de Psicologia, 2011; Gonçalves, 2010).

Mapeando o campo da assistência social

Quais seriam os modos paradigmáticos de funcionamento da instituição da Assistência Social como política pública na atualidade? Como tais modos de produção de realidade social incidiriam nos dispositivos instaurados por essa instituição social? Quais seriam seus efeitos na organização das entidades assistenciais ditas socioeducativas que atendem a crianças e adolescentes pobres? Para responder a essas questões, realizou-se uma investigação participante no campo de análise constituído pela Assistência Social como instituição que faz dispositivos e também no âmbito das políticas públicas para a criança e o adolescente, num município de médio porte do interior do Estado de São Paulo. O que se pretende é fornecer uma perspectiva estratégica para os psicólogos que atuam no campo da Assistência Social, de modo que possam desenvolver uma atuação informada, contextualizada e avisada sobre a problemática central que perpassa a área. Essa investigação foi aprovada pelo Comitê de Ética em Pesquisa da Faculdade de Ciências e Letras da Universidade Estadual Paulista "Júlio de Mesquita Filho" (Unesp), *campus* de Assis (SP), Protocolo nº 030/2008, em 30 de outubro de 2008, e todos os participantes assinaram um Termo de Consentimento Livre e Esclarecido antes de sua inclusão na pesquisa.

Exerceu-se um longo mandato como conselheiro municipal participando de 23 reuniões de trabalho do Conselho Municipal dos Direitos da Criança e do Adolescente (CMDCA) e de 21 reuniões do Conselho Municipal de Assistência Social (CMAS) no ano de 2008, bem como de diversas atividades, tais como visitas a entidades e organização e participação em diversos eventos na área. No ano de 2009, participou-se de 22 reuniões do CMDCA e de 21 reuniões do CMAS, sendo que também se colaborou com a organização e a realização das Conferências Municipais dos Direitos da Criança e do Adolescente e da Conferência Municipal de Assistência Social. No ano de 2010, participou-se de 15 reuniões de trabalho do CMDCA e de 17 reuniões do CMAS. Nos anos de 2009 e 2010 também foram realizados trabalhos de supervisão institucional em entidades assistenciais e em um Centro de Referência Especializado da Assistência Social (CREAS). Toda essa rica experiência de imersão institucional no campo da Assistência Social e de um conjunto composto por 25 entidades assistenciais que atendem a crianças e adolescentes considerados em situação pessoal e social de risco, num processo de participação observante, foi acompanhada de um intenso trabalho de apropriação da literatura pertinente, bem como de reflexão, de análise e de escrita. A perspectiva de estudo adotada pautou-se pelos operadores da Análise Institucional (Baremblitt, 1998; Barus-Michel, 2004; Benelli, 2004, 2009; Donzelot, 2001; Foucault, 1999; Goffman, 1987; Lourau, 1995). Para a análise e interpretação dos dados da pesquisa também se operou com quatro categorias de análise histórico-conjuntural propostas por Amarante (1995) para mapear modelos de atenção psicossocial e, ainda, com uma grade analítica de base lógico-histórica e de inspiração marxista dialética, desenvolvida por Costa-Rosa (2000; 2011), instrumental de análise institucional que pode ser utilizado para mapear paradigmas contraditórios em um determinado campo de análise.

Análise institucional dos modos de produção de subjetividade

Costa-Rosa (2011) tem-se ocupado com a pesquisa e a discussão das práticas de atenção em Saúde Mental contemporânea, procurando colaborar na criação e na contraposição de experiências alternativas ao hospital psiquiátrico e ao modelo de suas práticas. Sua tese é de que há dois modos básicos de práticas em saúde mental no contexto atual: o modo asilar e o modo psicossocial. Propõe ainda o modo psicossocial como um paradigma das práticas substitutivas ao modo asilar. A elaboração das práticas do modo psicossocial emerge a partir de diversos movimentos sociais e científicos e de vários campos teóricos: análise política das instituições, análise institucional, teoria psicanalítica da constituição subjetiva e elementos de análise histórica dos principais movimentos na área de saúde mental. É de uma síntese de sua teoria que se partiu para a elaboração deste estudo. Aplicou-se seu instrumental teórico e analítico para pensar a Assistência Social como

instituição e também como dispositivo de produção de subjetividade.

Em sua gênese, uma instituição pode ser entendida como sendo "o agenciamento das pulsações da demanda social (falta em sentido amplo que emerge dos conflitos e oposições presentes no espaço social), mediadas pelo imaginário (conjunto de imagens ideais) e a ideologia (representações sociais)" (Costa-Rosa, 2011, p.46), numa conjuntura que pode ser compreendida por meio do conceito de Processo de Estratégia de Hegemonia (PEH) (linhas de composição das Formações Sociais em termos das pulsações que as organizam e que nelas se atualizam) (Costa-Rosa, 2011). Portanto, trata-se de entender as instituições como produção da ação social coletiva no contexto sócio-histórico no qual elas emergem e funcionam, na interação entre saberes e poderes, produzindo sujeitos, subjetividades diversas, inclusive em suas diferentes modalizações (Costa-Rosa, 2000).

A sociedade capitalista caracteriza-se por uma divisão que se polariza em dois blocos conflitantes: um polo dominante e outro subordinado. O PEH é a forma estratégica pela qual o movimento social coletivo procura manter o equilíbrio dinâmico da sociedade (Costa-Rosa, 2011). O polo dominante articula um conjunto de práticas produtoras de efeitos repressivos e ideológicos, além de um conjunto de concessões táticas, seguidas de sua recuperação: *cede os anéis para não perder os dedos*, como diz o ditado popular e, mais tarde, procura retomá-los. Já o polo subordinado desenvolve um conjunto de práticas que, por um lado, o identificam de modo alienado com o polo dominante; por outro, possui um conjunto próprio de interesses específicos (que podem apresentar-se de modo passivo e inclusive inadvertido). Além disso, também desenvolve várias práticas alternativas que, algumas vezes, chegam a aspirar à elaboração de uma hegemonia dos interesses subordinados, em contraposição à dominante, então vigente.

A consistência de uma instituição é dada pela articulação de saberes e de práticas, mediante um discurso lacunar (Costa-Rosa, 2011). O saber institucional justifica a ação, a prática coletiva que institui a própria vida no contexto institucional, criando todos os seus habitantes e estabelecendo suas funções. Mas as instituições fazem mais do que expressam seus estatutos, e também fazem menos, pois possuem funções positivas e negativas. O saber busca racionalizar e tornar plausível a existência da instituição, produzindo um discurso lacunar, esburacado, que tenta recobrir a prática concreta, muitas vezes em franca contradição com os objetivos explícitos em função dos quais ela foi criada. Para conhecer realmente uma determinada instituição, é preciso não apenas ouvir os discursos que nela circulam e estudar seus estatutos, mas é necessário prestar atenção naquilo que fazem seus diversos agentes e sua clientela, investigando suas práticas não discursivas.

Baseando-se em Hegel "*A ciência da lógica*", Costa-Rosa (2000; 2011) afirma que se pode compreender a instituição como a conjunção de momentos articulados: o nível das práticas discursivas (plano lógico) representa o aspecto universal; o nível das práticas não discursivas (plano dos dispositivos: aparelho capaz de realizar determinadas funções), representa o aspecto particular; finalmente, o nível da *práxis* (plano da articulação do universal e do particular), representa a instituição em sua singularidade. Neste momento da singularidade é que se pode conceber a instituição como dispositivo.

O funcionamento institucional expressa os movimentos diversos de um conjunto segmentar e articulado de pulsações e ações instituintes e efeitos instituídos (Costa-Rosa, 2011). Os diversos atores que emergem no contexto institucional são produtos e produtores dele, movidos por necessidades as mais diferentes. Os interesses segmentares podem ser apreciados num espectro que vai dos simplesmente diferentes até os que são incontestavelmente contraditórios. Toda produção institucional pode ser entendida como produção de subjetividade, de sujeitos produzidos a partir de uma subjetividade serializada ou singularizada.

A instituição consiste, então, em uma formação social instável, amálgama de conflitos múltiplos, de pulsações da demanda social. Ela se desdobra em uma ordem latente e outra manifesta. É imprescindível, portanto, realizar um trabalho de análise, de interpretação do sentido do discurso e das práticas institucionais para não se inserir nelas de um modo funcionalista.

As instituições tendem a explicitar, sobretudo, suas funções positivas em seu discurso institucional, geralmente plasmado em estatutos, regimentos, projetos e normas. Por exemplo, as entidades assistenciais

afirmam, em seus planos de trabalho, que seus objetivos consistem na proteção, na defesa, na promoção e na educação de crianças e de adolescentes considerados em situação pessoal e social de risco. Mas elas tendem a fazer não apenas isso. Será a análise do discurso que revelará as funções negativas das instituições. Somente uma interpretação desse discurso e das suas relações com o saber e com as práticas possibilitará o acesso às suas funções negativas.

De acordo com Costa-Rosa (2011), as instituições, situadas no contexto sócio-histórico do Modo de Produção Capitalista (MPC), apresentam invariavelmente as seguintes funções negativas: a) Produção de mais-valia, articulando-se com a produção de bens e serviços de outras instituições (no caso das entidades assistenciais, elas consomem alimentos, materiais e serviços pedagógicos, esportivos e educativos etc.); b) Reprodução das relações sociais dominantes: domínio e submissão, subjetividade alienada e serializada (é comum que as práticas educativas nas entidades assistenciais sejam predominantemente autoritárias e repressivas, buscando modelar um comportamento dócil e obediente nas crianças e adolescentes); c) Produção de novas formas de relações sociais que expressam os interesses do polo subordinado, podendo produzir subjetividade singularizada (nas entidades assistenciais podem ser produzidas relações sociais inéditas, a partir de práticas concretas que promovam a participação, a democracia, os direitos sociais, a cidadania efetiva e a transformação social).

A análise das contradições indica o estado dos conflitos que se atualizam e se metabolizam na instituição em relação à demanda social de que ela é o efeito. Para analisar o estado do jogo de forças institucionais é preciso especificar as principais contradições ativas no contexto, distinguir entre contradição principal e contradições secundárias e compreender os antagonismos decorrentes das diferenças essenciais. Analisando a proporção de forças que possui cada um dos polos dos interesses presentes em determinada conjuntura particular, pode-se detectar o índice do estado das contradições.

A partir dessas coordenadas analíticas, procurou-se mapear quais seriam os paradigmas em confronto no campo da Assistência Social como instituição e política pública. Em seguida, tomando um conjunto singular de entidades que compõem essa instituição num dado município do interior do Estado de São Paulo, estudou-se o modo como tais coordenadas paradigmáticas incidem nessas entidades que atendem a crianças e adolescentes que estão vivendo em situação de pobreza, aplicando os parâmetros de Amarante (1995) e também a grade analítica de Costa-Rosa (2000; 2011) nesse âmbito particular da realidade social. Já de partida pode-se supor, a partir das investigações realizadas, que nas entidades assistenciais que atendem a crianças e adolescentes, situadas no contexto sócio-histórico capitalista e no campo da Assistência Social, predomina um paradigma que se pode denominar de modo filantrópico, atraindo com sua força gravitacional os saberes, as práticas, os discursos e a produção de subjetividade nesse campo institucional. Seu oposto dialético seria um paradigma que poderia ser denominado de modo socioeducativo, configurando-se, atualmente, mais como uma possibilidade lógica e estratégica no campo, do que como efetivamente constituído.

Assistência social como instituição e política pública

Embora não adotando uma perspectiva linear e mecanicista da história, é possível localizar nas práticas de caridade desenvolvidas por grupos religiosos diversos ao longo do tempo um tipo de atendimento aos membros pobres e ditos desvalidos da comunidade: crianças pobres e órfãs, idosos, doentes etc. A filantropia benemerente dos ricos, com seu viés moralizante e profissionalizante dos indivíduos pobres, também foi uma figura histórica importante quanto às práticas sociais relacionadas com os cuidados oferecidos para essa faixa da população. Tais práticas históricas podem ser consideradas eminentemente funcionalistas, não críticas e promotoras de ajustamento e de adaptação social integradora (Benelli, 2010).

As ações do Estado com relação ao que se denomina de questão social, termo que inclui os múltiplos efeitos do funcionamento estrutural do MPC, tais como a pobreza e todo o seu corolário, gerada pelo desemprego, pela exploração e dominação exercidas pela elite sobre a classe trabalhadora e por práticas de exclusão social, podem ser chamadas de políticas públicas. Os

diversos problemas sociais podem ser capazes de mobilizar os membros da sociedade civil organizada, que passam, também, a pressionar agências estatais, cobrando encaminhamentos e soluções para tais dificuldades.

Quando um determinado problema, no caso, a pobreza e os pobres, alcança o nível de objeto de preocupação e de debate nas instâncias diversas do Estado, tais como as de Segurança Pública, do Legislativo, do Executivo e do Judiciário, dentre outras, as respostas e ações do Estado, relacionadas com tentativas de equacionamento do problema em pauta, podem ser consideradas como sendo políticas públicas. Nesse sentido, políticas públicas são ações do Estado que visam a equacionar determinado problema específico, sendo que normalmente são criados, então, dispositivos institucionais para lidar com esse objeto social: instituições são criadas, leis são formuladas e promulgadas, organizações e estabelecimentos são inventados e instituídos, equipamentos são produzidos e implementados, atores sociais são produzidos e convocados para lidar com esse novo objeto institucional, recortado no campo social, emergindo como uma nova figura social. Desse modo, saberes e discursos, poderes e práticas políticas, ordenamentos jurídicos, profissionais, instrumentos e técnicas de trabalho, figuras sociais novas, sujeitos e objetos são inventados e institucionalizados no campo social, criando novas realidades sociais.

Considerar a Assistência Social (Brasil, 1988; 2004; 2005; 2011) como instituição implica problematizar a constituição de um campo original formado por um conjunto de saberes e de práticas, inseridos num contexto sócio-histórico mais amplo, de ordem político-social, ideológico-jurídica, técnico-científica e ética, que inventam, criam e recortam figuras sociais específicas sobre as quais atuam. A instituição da Assistência Social pode, assim, ser considerada como um dispositivo de produção de subjetividade, sendo atravessada por uma série de outras instituições com as quais faz interface.

O discurso oficial afirma que o Sistema Único de Assistência Social (SUAS) (Brasil, 2005), cujo modelo de gestão pretende ser descentralizado e participativo, constitui-se na regulação e organização em todo o território nacional dos serviços, programas, projetos e benefícios socioassistenciais, de caráter continuado ou eventual, executados e providos por pessoas jurídicas de direito público sob critério universal e lógica de ação em rede hierarquizada e em articulação com iniciativas da sociedade civil. Além disso, diz-se que o SUAS procura definir e organizar os elementos essenciais e imprescindíveis à execução da política pública de Assistência Social, pretendendo alcançar uma normatização de padrões nos serviços (Brasil, 2009a), buscando promover a qualidade no atendimento aos usuários, estabelecendo indicadores de avaliação e de resultados, bem como nomenclatura uniforme para os serviços e a rede prestadora de serviços socioassistenciais, tanto pública quanto privada.

Parece pertinente considerar que, com o SUAS, a instituição da assistência social se torna propriamente política pública no Brasil (2005), fazendo dispositivo. Sem negar as lutas de categorias profissionais específicas em torno da formulação da Assistência Social como política pública de dever do Estado e de direito do cidadão, não se pode deixar de considerar que ela representa, sobretudo, uma concessão estratégica do Estado por meio da qual se procura gerenciar as refrações diversas do problema social, recortando-o em diversos segmentos aos quais se fornecem serviços, projetos, programas e benefícios, mas de modo focalizado e predominantemente paliativo, sem jamais problematizar as causas estruturais que produzem esses problemas sociais. O discurso oficial da Assistência Social é profundamente lacunar, parecendo visar mais a produzir efeitos simbólicos que deem legitimidade ao Estado e ao governo do que a incidir concreta e eficazmente na transformação da realidade.

Enquanto instituição social, a Assistência Social (Brasil, 2004; 2005; 2011) representa uma construção lógica que segue parâmetros semelhantes aos da área da Saúde. Ela trabalha com as noções de níveis diferentes de prevenção e de atenção aos problemas da população, lançando mão de práticas educativas básicas, por meio de orientações e esclarecimentos, disponibilizando informações sobre direitos, legislações, localização de serviços, projetos, programas e benefícios, configurando um conjunto de ações de Atenção Assistencial. O SUAS (Brasil, 2005) estabeleceu níveis primários, secundários e terciários de atendimento e de encaminhamento das demandas sociais, sendo denominados de Proteção Social Básica (PSB) e de Proteção Social Especial (PSE) de média e de alta complexidade.

A prevenção de situações de risco por intermédio do desenvolvimento de potencialidades e aquisições e o fortalecimento de vínculos familiares e comunitários são os objetivos da PSB do SUAS. Esse nível de proteção é destinado para a população que vive em situação de vulnerabilidade social decorrente da pobreza, privação (ausência de renda, precário ou nulo acesso aos serviços públicos, dentre outros) e/ou fragilização de vínculos afetivos relacionais e de pertencimento social (discriminações etárias, étnicas, de gênero ou por deficiências, dentre outras).

O nível da Proteção Social Básica prevê o desenvolvimento de serviços, programas e projetos locais de acolhimento, convivência e socialização de famílias e de indivíduos, conforme identificação da situação de vulnerabilidade apresentada. Devem incluir as pessoas com deficiência e ser organizados em rede, de modo a inseri-las nas diversas ações ofertadas. Tanto os benefícios de prestação continuada como os eventuais, compõem a PSB dada a natureza de sua realização. O estabelecimento que configura a PSB nos municípios e no Distrito Federal são os Centros de Referência de Assistência Social (CRAS) - (Brasil, 2006a; 2009b). As equipes multidisciplinares de referência dos CRAS devem executar os serviços de proteção social básica e organizar e coordenar a rede prestadora de serviços socioassistenciais locais do SUAS.

O Centro de Referência de Assistência Social (Brasil, 2006a; 2006b; 2009b) é uma unidade pública da política de assistência social de base municipal, integrante do SUAS, localizado em áreas com maiores índices de vulnerabilidade e risco social, destinado à prestação de serviços e programas socioassistenciais no nível de PSB às famílias e indivíduos e à articulação destes serviços no seu território de abrangência, e uma atuação intersetorial na perspectiva de potencializar a proteção social. Algumas ações da proteção social básica devem ser desenvolvidas necessariamente nos CRAS, como o Programa de Atenção Integral às Famílias (PAIF), enquanto outras, mesmo ocorrendo na área de abrangência desses centros, podem ser desenvolvidas fora de seu espaço físico, desde que a eles referenciadas. O CRAS também deve organizar a vigilância sobre os processos de exclusão social de sua área de abrangência, em conexão com outros territórios.

A Proteção Social Especial do SUAS (Brasil, 2005) é destinada a famílias e indivíduos que se encontram em situação de risco pessoal e social por ocorrência de abandono, maus tratos físicos e/ou psíquicos, abuso sexual, uso de substâncias psicoativas, cumprimento de medidas socioeducativas, situação de rua e/ou de trabalho infantil, entre outras situações de violação dos direitos. Os serviços de proteção social especial têm estreita interface com o Sistema de Garantia de Direitos, exigindo muitas vezes uma gestão mais complexa e compartilhada com o Poder Judiciário, o Ministério Público e outros órgãos e ações do Executivo. Como se pode notar, a lógica da rede é fundamental, enquanto estratégia técnica de gestão para o bom funcionamento da política de Assistência Social.

No caso da Proteção Social Especial, há dois níveis de complexidade: média e alta. No nível de média complexidade estão incluídos aqueles que oferecem atendimento às famílias e indivíduos com seus direitos violados, mas cujos vínculos familiares e comunitários não foram rompidos. A proteção social de média complexidade é organizada nos Centros de Referência Especializados de Assistência Social (Brasil, 2006c), que são unidades públicas estatais que realizam diversas ações de Atenção Assistencial, tais como acompanhamento de indivíduos e famílias com um ou mais de seus membros em situação de ameaça ou violação de direitos. Seus objetivos consistem em fortalecer as redes sociais de apoio da família; contribuir no combate a estigmas e preconceitos; assegurar proteção social imediata e atendimento interdisciplinar às pessoas em situação de violência visando à sua integridade física, mental e social; prevenir o abandono e a institucionalização; fortalecer os vínculos familiares e a capacidade protetiva da família. Neles, são ofertados serviços socioassistenciais que requerem acompanhamento individual e maior flexibilidade nas soluções protetivas. Da mesma forma, requerem maior estruturação técnico-operacional e atenção especializada e mais individualizada, comportam encaminhamentos monitorados e sistemáticos, apoios e processos que assegurem qualidade na atenção protetiva e efetividade na reinserção almejada. Já os serviços de Proteção Social Especial de Alta Complexidade são aqueles que garantem proteção integral - moradia, alimentação, higienização e trabalho protegido -, para famílias e indivíduos que se encontram sem referência e/ou em situação de ameaça, necessitando ser retirados do convívio familiar e/ou comunitário.

Além do Centro de Referência de Assistência Social e do Centro de Referência Especializado de Assistência Social, enquanto novos estabelecimentos assistenciais que estão sendo implementados nos municípios brasileiros, ainda existe todo um conjunto constituído pelas denominadas entidades assistenciais e filantrópicas tradicionais privadas. Tais estabelecimentos normalmente foram sendo criados ao longo do tempo por diferentes atores sociais: indivíduos e grupos religiosos, membros da elite local, políticos, empresários e filantropos, visando atender a demandas de crianças, adolescentes, jovens, adultos, gestantes, doentes e idosos pobres. Esse conjunto de entidades históricas, tais como os orfanatos, os asilos, entidades beneficentes e filantrópicas que atendiam a crianças e a adolescentes pobres e a indivíduos pobres de outras idades, foi incluído como parte da rede socioassistencial por meio do vínculo SUAS, acordo por meio do qual todos esses estabelecimentos tiveram que se adequar institucionalmente à Lei Orgânica da Assistência Social (LOAS) (Brasil, 1993; 2011) e também ao Estatuto da Criança e do Adolescente (ECA) (Brasil, 1990), buscando obter certificado de inscrição junto ao Conselho Municipal dos Direitos da Criança e do Adolescente e também do Conselho Municipal de Assistência Social, para assim poder manter suas antigas isenções fiscais junto ao Estado e continuar em funcionamento.

As considerações que se seguem resultam de um conhecimento profundo da realidade das entidades de atendimento socioassistencial à criança e ao adolescente que não cometeram ato infracional, num determinado município do interior do Estado de São Paulo. Essas análises são fruto de um intenso trabalho de elaboração do pensamento, a partir de um amplo conjunto de observações obtidas por meio de uma imersão longa, engajada, operativa e problematizadora nesse campo.

Paradigmas contraditórios no campo da assistência social e na atenção à criança e ao adolescente

Os termos socioeducativo e socioassistencial têm sido empregados para designar algumas das atividades pretensamente inovadoras que a Assistência Social, enquanto política pública de Estado, tal como definida pelo SUAS (Brasil, 2005), vem procurando implementar no âmbito nacional, sobretudo nos contextos municipais, no atendimento a indivíduos de todas as faixas etárias. Crianças, adolescentes, jovens, adultos e idosos podem ser atores sociais incluídos em diversos projetos, programas e serviços que podem ser qualificados genericamente como sendo socioeducativos ou socioassistenciais. Tanto as ideias quanto as práticas da Assistência Social e da política nacional para a criança e o adolescente, consubstanciadas no ECA, têm sido associadas a esses termos, de acordo com o que indica a literatura oficial (Brasil, 1990; 1993; 2004; 2005; 2011).

Será que o termo socioeducativo poderia aspirar a se constituir/instituir como um conceito capaz de designar um tipo de Atenção realmente alternativa à atenção filantrópica, que ainda seria hegemônica no campo da Assistência Social? Afirma-se que, a partir da nova Política Nacional de Assistência Social (PNAS) (Brasil, 2004) e SUAS (Brasil, 2005), a Assistência Social se tornou um direito do cidadão e um dever do Estado. Mas será que a Assistência Social realmente superou sua histórica determinação social enquanto ajuda samaritana, favor, benesse, assistencialismo e tutela? Observa-se que no plano jurídico os discursos são avançados, mas a prática política e técnica, no âmbito municipal, costuma se manifestar avessa ao novo reordenamento institucional proposto, assepsiando-o de suas características mais politizadas, democráticas e participativas e mantendo ações tradicionais e predominantemente tuteladoras.

A atenção psicossocial pode ser considerada um tipo de atuação profissional desenvolvida por profissionais da área de Psicologia - embora não exclusivamente -, envolvendo um conjunto de procedimentos técnicos especializados, com a finalidade de estruturar processos e ações de atendimento a indivíduos e a grupos que procuram por serviços públicos de Assistência Social (Lancetti, 1996), de Saúde e de Saúde Mental (Costa-Rosa, Luzio & Yasui, 2003), dentre outros. De um modo geral, pode-se considerar a Atenção como uma ação constituída por uma série de elementos técnicos instrumentalizados e empregados por diversos profissionais nos campos da Assistência Social, da Saúde e da Saúde Mental, da Educação etc. Atenção, com inicial maiúscula, designaria, assim, o conjunto de ações realizadas em diversas áreas do campo social, focadas em

práticas múltiplas, nas quais estariam incluídas as noções de tratamento, cuidado, promoção e, inclusive, atenção.

Há um conjunto de práticas de Atenção orientadas por perspectivas teóricas, técnicas, éticas e políticas encontradas no campo das abordagens psicossociais (Vasconcelos, 2008a; 2008b; 2009) que precisam ser explicitadas, configurando propriamente o que se denomina de atendimento psicossocial, que é oferecido por uma equipe profissional multidisciplinar. Atendimento significa ato ou prática de atender; remete à oferta de uma atenção sistemática para o sujeito que procura por um determinado serviço público. Inclui o conjunto organizado de atividades do processo técnico de trabalho desenvolvido por uma equipe multidisciplinar, no qual as especialidades profissionais se complementam e se superam na direção da integralidade da atenção.

Para que a Atenção Socioeducativa possa representar uma mudança radical da Assistência Social, e não apenas meras transformações técnicas localizadas e limitadas, que não podem superar a Atenção Filantrópica, é preciso entendê-la como exigindo um processo social complexo, no qual ocorram simultânea e articuladamente transformações nos planos técnico-científico, político-jurídico, teórico-conceitual e sociocultural, tal como proposto por Amarante (1995) e também por Costa-Rosa (2000; 2011), num plano distinto.

Aqui pode ser bastante útil um esclarecimento sobre a relação dos quatro parâmetros mínimos que Costa-Rosa (2000, 2011) propõe como definidores de um determinado paradigma de produção na Saúde Mental: 1) Concepções de objeto e dos meios de ação; 2) Concepções das formas de organização do dispositivo institucional - formas das relações intrainstitucionais; 3) Concepções das formas de relação instituição-território e população-instituição; e 4) Concepções dos efeitos terapêuticos e seus desdobramentos éticos - com as quatro categorias de análise da Reforma Psiquiátrica propostas por Amarante (1995) -, transformações teórico-assistenciais, técnico-assistenciais, jurídico-políticas e culturais. Trata-se de duas modalidades de categorias de análise de estatuto teórico e epistemológico bem diferentes: análise lógico-histórica (estrutural), no primeiro caso, e análise histórica (conjuntural) no segundo.

Com base nesses operadores, procurou-se elaborar uma caracterização de como seriam os paradigmas presentes no campo da Assistência Social na atualidade. Inicialmente, aplicaram-se as quatro categorias de análise histórica e conjuntural de Amarante (1995) para caracterizar o que seria a Atenção Filantrópica e a Atenção Socioeducativa no campo da Assistência Social. Depois, num esforço analítico e dedutivo, utilizaram-se os parâmetros de Costa-Rosa (2000; 2011) para configurar de modo mais detalhado o perfil do modo filantrópico e também do modo socioeducativo e demonstrar sua incidência na organização das entidades assistenciais de atenção às crianças e aos adolescentes pobres.

É possível afirmar que a Atenção Filantrópica visaria primordialmente promover uma integração subordinada dos indivíduos pobres no sistema social.

a) No plano científico, o atendimento assistencial é assistencialista e filantrópico, sendo pautado por uma perspectiva disciplinar-correcional que se explicita pelos seguintes binômios: marginalidade - integração social; ociosidade - reeducação profissionalizante; desvio de conduta - reeducação em valores morais; problemas e desajustes psicológicos (cognitivos, carências afetivas e emocionais, agressividade) - tratamento clínico psicoterapêutico individualizado adaptativo e/ou medicalização (ritalina, concerta, anticonvulsivantes, ansiolíticos, calmantes etc.). Predominam as práticas que visam à readaptação, reabilitação e reinserção social, com a intenção de que o indivíduo retorne a uma situação anterior de integração social (na qual provavelmente ele nunca esteve).

b) No plano técnico, a acolhida, as atitudes e o posicionamento dos profissionais técnicos e educadores no atendimento assistencial seriam efetuados por meio da realização de atividades assistenciais, esportivas, recreacionais, culturais e artísticas, tradicionalmente escolares, improvisadas e aleatórias. Tais procedimentos seriam baseados no saber tradicional do mestre (autoritário, corretivo, ortopédico, pedagógico, educativo, terapêutico, preventivo e reabilitador), sendo incorporados pelos diversos trabalhadores, desde os voluntários sem qualificação profissional até os educadores e técnicos em geral: pedagogos, professores de educação física, assistentes sociais, psicólogos etc. O indivíduo é considerado como um objeto de intervenção da equipe institucional.

c) No plano teórico-conceitual, predomina implicitamente a teoria filantrópica que, fundamentada numa concepção liberal do homem, estigmatiza naturalmente os pobres, entendendo-os como pessoalmente responsáveis por sua condição social, devido, por exemplo, à preguiça e, inclusive, por causa de uma possível degeneração biológica e moral; criminaliza a pobreza, considerando os oprimidos, os explorados e os excluídos do sistema como sendo potencialmente perigosos para a paz e a ordem social, constituindo as classes perigosas. A prática assistencial tradicional, não teorizada nem problematizada pelos profissionais, baseia-se em teorias filosóficas inatistas e empiristas; a Psicologia é tradicional, eminentemente clínica e fortemente patologizante do indivíduo; a Pedagogia oscila entre uma tendência tradicional e autoritária (sem preocupar-se com a transmissão de conteúdos) e uma tendência renovada (psicologizante e espontaneísta); a Sociologia revela-se de matiz funcionalista e reacionária.

d) No plano político-jurídico: a autoridade é considerada a figura legítima e incontestavelmente detentora do poder político, econômico e social que distribui benesses, favores e auxílios aos desfavorecidos, carentes e necessitados. Mesmo que a lei (Brasil, 1988) reconheça os direitos de cidadania e procure regulamentá-los, ela é estrategicamente reduzida a uma mera formalidade vazia e, assim, neutralizada. Os pobres são tratados com paternalismo, por meio de práticas assistencialistas, benemerentes e samaritanas, focalizadas, mínimas, sem planejamento sistêmico e descontínuas.

e) No plano sociocultural, os pobres também são estigmatizados e culpabilizados pessoalmente por sua situação. Isso pode ser sintetizado pela afirmação lapidar de Patto (1990, p.209): "... o protótipo das representações sociais do pobre na cultura brasileira inclui as seguintes características: sexualmente promíscuo, primitivo, anômico, vadio, pouco inteligente, violento e com vocação para a marginalidade e delinquência". Os pobres e os miseráveis são percebidos como um peso que onera os cofres públicos de modo indevido.

O modelo dialética e diametralmente oposto seria constituído pelo que poderia ser denominado de Atenção Socioeducativa, cujo objetivo maior seria a viabilização de direitos para famílias e indivíduos, considerados como cidadãos e como sujeitos. Sujeito é o homem enquanto ator social e indivíduo agente, pessoa autônoma e cidadão - na ordem da política, é ainda o ego cognoscente -, o "eu" centrado na consciência racional e reflexiva, no plano da epistemologia tradicional. Mas, fundamentalmente, inclui as noções lacanianas de "sujeito do inconsciente", de "sujeito dividido" e de "sujeito de desejo" (Cabas, 2009; Fink, 1998; Olgivie, 1988), segundo as quais, "... o ego ou o eu não cobre a totalidade do sujeito" (Vallejo & Magalhães, 1979, p.158).

a) No plano científico, o atendimento socioeducativo é baseado na concepção do sujeito como cidadão de direitos, traduzida pelos conceitos de defesa, de proteção integral, de controle social popular, de promoção e de transformação social. O sujeito é entendido como sendo produtor e, ao mesmo tempo, uma produção coletiva e dialética do contexto social, e suas demandas e necessidades precisam ser acolhidas a partir de uma compreensão sócio-histórica. A análise crítica da produção coletiva da vida social torna compreensíveis as características do sujeito e seus problemas, superando hipóteses inatistas, ambientalistas e adotando uma compreensão dialética crítica e histórica da vida social. Supera-se a naturalização da pobreza na busca de suas causalidades sociais estruturais.

b) No plano técnico, as atitudes dos diversos profissionais incluem a acolhida, a escuta, a visita, o encaminhamento, o acompanhamento, o monitoramento e a avaliação do processo de atendimento. O atendimento também pode incluir a oferta de projetos, de programas e de serviços socioeducativos, conforme as características do estabelecimento assistencial, oferecendo atividades educativas, esportivas, recreacionais, culturais e artísticas, pautadas pelo ideário da Pedagogia Dialética e pela Educação Popular (Pontual & Ireland, 2006). No processo participativo e democrático institucional e social, todos são sujeitos: usuários, educadores, técnicos etc. Os trabalhadores da Assistência Social são sujeitos viabilizadores e mediadores de direitos para outros sujeitos, promovendo um processo de politização do atendimento, orientando os usuários para as questões relacionadas com direitos de cidadania, democracia, democratização e participação popular.

c) No plano teórico-conceitual, a prática socioeducativa baseia-se em múltiplas perspectivas: na Psicanálise do campo de Freud e Lacan, instrumentalizando-se com os conceitos de sujeito do inconsciente, de transferência e ética, procurando superar uma forte

tradição na Psicologia quanto a formulações essencialistas da subjetividade (Lacan, 1998). Ela tende a conceber o homem como um sujeito dotado de uma interioridade psicológica, de um psiquismo que habitaria a interioridade do seu corpo, utilizando alguns conceitos que explicitariam esse objeto psicológico pretensamente natural, substancial e a-histórico, tais como: consciência racional, identidade ou personalidade una e indivisa, conduta, comportamento, psiquismo etc. Já a Psicanálise do campo de Freud e Lacan (Elia, 2004; Garcia-Rosa, 2009) postula que o homem vivencia um complexo processo de subjetivação ou de constituição da subjetividade, processo que estrutura a subjetividade ou a realidade psíquica sob a forma de modalidades diversas (recalcamento, foraclusão, renegação), propensas a impasses variados (Lacan, 1979; 1998). Essa perspectiva é importante, pois, entre muitas outras questões relevantes, permite a superação de inúmeras dicotomias que pululam no campo psi: interno/externo; psíquico/orgânico; comportamento/vivências subjetivas; natural/social; autonomia/determinação; doença-cura etc. Também se baseia nas vertentes filosóficas e sociológicas do materialismo histórico dialético (Marx), da genealogia (Foucault) e da filosofia da diferença (Deleuze). A Pedagogia fundamenta-se numa concepção dialética e crítica (Educação Popular). A Sociologia é crítica e dialética, alinhada com os interesses do polo subordinado, visando à emancipação popular e à transformação social. O Serviço Social alinha-se com uma perspectiva crítico-dialética (materialismo histórico), buscando avançar na implementação do Sistema Único de Assistência Social e da política pública de atendimento à criança e ao adolescente. O nível de formação dos trabalhadores é complexo e exigente, visando lidar de modo complexo e transdisciplinar com questões igualmente complexas.

d) No plano político-jurídico, parte-se daquilo que a lei estabelece, institui, fundamenta e regulamenta quanto aos direitos de cidadania, à criação de mecanismos democráticos de participação social e de controle social sobre o poder político (Sistema Único de Saúde (SUS), ECA, LOAS, SUAS). O objetivo é implementar efetivamente a lei e promover a conquista de novos direitos, ampliando a cidadania na direção de uma democracia popular.

e) No plano sociocultural, faz-se circular discursos que deem visibilidade às práticas dialeticamente alternativas à Atenção Filantrópica: escuta psicanalítica das demandas inconscientes, formação da consciência crítica e política, processos de organização popular, movimentos de reivindicação, processos institucionais que se pautem pela cidadania dos sujeitos de direitos, trabalhando coletivamente para a materialização efetiva de tais direitos. É fundamental desconstruir os discursos hegemônicos que associam, sem mais, a pobreza com a criminalidade, e todo o imaginário autoritário, intolerante e repressivo típico do reacionarismo político ainda vigente.

O modo filantrópico

Ao indagar pelas condições de existência das entidades assistenciais para crianças e adolescentes, procurou-se estudar a conjuntura sócio-histórica mais ampla nas quais elas emergem. Assim, detectou-se a existência de dois paradigmas contraditórios, no sentido dialético, no campo da Assistência Social: um denominado modo filantrópico e outro que estaria emergindo, ainda de modo lento, chamado modo socioeducativo. A seguir, será apresentada a incidência de ambos na forma de funcionamento e no sentido da produção social de entidades assistenciais que atendem a crianças e adolescentes vítimas de processos sociais causadores de pobreza, procurando produzir sua caracterização paradigmática.

Com base nos dados levantados sobre as entidades assistenciais que atendem a crianças e adolescentes, elaborou-se uma síntese a partir do esquema lógico-histórico e estrutural proposto por Costa-Rosa (2000) para a realização de um trabalho de análise institucional. Procurou-se problematizar o funcionamento dos estabelecimentos assistenciais que atendem a crianças e a adolescentes, focalizando as relações de poder, de saber e de produção de subjetividade que os organizam na atualidade. Pode-se afirmar que o modo filantrópico é hegemônico e predominante nos diversos estabelecimentos assistenciais atuais.

O modo filantrópico como organizador das práticas, dos saberes e dos poderes no campo da Assistência Social corresponde a uma entidade assistencial que se organiza a partir de uma lógica menorista, ainda articulada por um discurso filantrópico autoritário e crimi-

nalizante das classes populares, baseada na noção jurídica - já superada legalmente pelo Estatuto dos Direitos da Criança e do Adolescente (Brasil, 1990) -, da "situação irregular" e desenvolvendo práticas preventivas repressivas, correcionais, moralizadoras e essencialmente adaptativas.

1) Quanto à concepção do objeto institucional, crianças e adolescentes são tomados como objeto de atividades assistenciais, pedagógicas e psicológicas, com exclusão da sua subjetividade (que, quando emerge, costuma ser tomada como problemática e dificultadora do trabalho assistencial), visando à normalização das condutas individuais, por meio de práticas ortopédicas. O usuário é considerado um aluno ou um educando, um carente assistido - quando não um delinquente ou marginal, e deve manifestar condutas previamente esperadas e adequadas: docilidade, obediência, cooperação, capacidade de aprendizagem e de desenvolvimento positivo de suas qualidades e potencialidades pessoais, tornando exitoso o trabalho social realizado com ele.

Seu objeto institucional seria a educação social da clientela: a cidadania obedeceria a um modelo universal a ser inculcado e introjetado (trata-se de um objeto com estatuto ontológico, constituído pelo modelo pequeno burguês de existência: o indivíduo livre, talentoso, trabalhador, consumidor, membro da sociedade das pessoas de bem, como propõe o discurso filantrópico enunciado por atores institucionais que atuam em entidades assistenciais). As práticas e técnicas sociais, pedagógicas e psicológicas formativas implementam procedimentos microfísicos disciplinares: observação do comportamento em meio aberto, controle, vigilância, exame, correção, ortopedia, normalização.

2) Predomina uma centralização autoritária e vertical na organização das relações intrainstitucionais (poder público municipal, judiciário, conselhos municipais, estabelecimentos assistenciais, diretores e educadores das entidades). O fluxo do poder decisório está concentrado na hierarquia piramidal e na heterogestão. O organograma formal e informal é verticalizado, os cargos baseiam-se na capacitação profissional dos atores institucionais e no privilégio. Predomina uma divisão taylorizada do trabalho: os técnicos pensam, decidem, mandam e os educadores dos estabelecimentos são executores tarefeiros. A organização arquitetônica e do mobiliário manifesta-se na centralidade dos estabelecimentos de assistência e nos privilégios dos dirigentes, em detrimento da precariedade das condições dos educadores e da clientela. O trabalho educativo também obedece a uma divisão taylorizada; dirigentes, educadores e demais funcionários ocupam-se, de modo segmentado, da clientela: esportes, artes circenses, lazer, atividades escolares, informática, alimentação, higiene, atendimento clínico psicoterapêutico individual e grupal etc.

A organização das relações intrainstitucionais está centralizada no diretor e na equipe de educadores: há poucos canais de participação no estabelecimento e os que existem acabam se tornando instrumentos formais, destituídos de eficácia deliberativa e autogestiva. A roda de conversa - instrumento pretensamente democrático e participativo utilizado com os usuários no início das atividades diárias -, também não funciona como instância de espaço dialógico verdadeiro para a equipe de educadores e para a direção do estabelecimento.

O fluxo do poder decisório e de execução é hierárquico, escalonado, heterogestivo. O organograma formal e informal tende a ser verticalizado: os educadores sociais não chegam a constituir equipes de trabalho multidisciplinar, tendendo a trabalhar de modo isolado, numa estratégia de cumprimento burocrático das tarefas, imperando a lei do menor esforço. A equipe de gestão técnica trabalha de modo isolado, sem maior interação com os demais grupos da entidade. A equipe de educadores sociais desempenha um papel de vigilância e de controle da conduta das crianças e dos adolescentes, no processo assistencial institucional. Predomina, na cultura institucional, o desperdício e uma certa irresponsabilidade no uso dos bens - a estratégia da "mamata" por parte dos funcionários, com o objetivo de obter vantagens pessoais indevidas e a improvisação no trabalho, fazendo de conta que se trabalha e demonstrando estar ocupado.

Com relação a isso, seria necessário educar a equipe de profissionais para a responsabilidade e a economia, para o compromisso ético e para o planejamento participativo (incluindo a questão do financiamento, da execução, do monitoramento e da avaliação). Sobre dinheiro, custos e salários, não se fala

abertamente na entidade, reproduzindo as relações patronais tradicionais da sociedade capitalista. Também seria preciso criar e desenvolver motivos, interesses e necessidades humanizadoras e humanizantes, tanto nos usuários quanto nos educadores: o gosto pelo conhecimento, o valor da expressão artística, a importância da reflexão filosófica, do posicionamento ético congruente e, também, da militância política crítica.

3) Quanto à relação da instituição assistencial com a clientela, no plano geográfico, predomina o atendimento da encomenda social e a entidade apresenta-se como espaço depositário e de confinamento, arregimenta crianças e adolescentes e procura desenvolver com eles atividades assistenciais, sendo percebida como espaço de proteção, que proporciona a guarda, a tutela e a ocupação do tempo dos usuários, mantendo-os longe das ruas, da mendicância, da criminalidade e da violência, de modo preventivo. O espaço geográfico aberto e amplo é visto como potencialmente perigoso e prenhe de situações de risco para crianças e adolescentes; por isso, o processo de atendimento assistencial é desenvolvido num estabelecimento de contenção que funciona com base na vigilância, no controle do comportamento e na persuasão - pretensamente não ostensivos ou violentos -, próprios da pedagogia, da Psicologia e do Serviço Social.

Há uma forte tendência em reproduzir a dinâmica problemática da instituição escolar, com clausura e fechamento, com atividades de reforço escolar, lista de chamada e monitoração das presenças, livro de ocorrências para registrar o mau comportamento dos usuários, aplicação de castigo às crianças (mantendo-as sentadas num lugar durante longo tempo, privando-as da refeição, de passeios etc.), recebimento de broncas dos educadores e, inclusive, a possibilidade de expulsão do estabelecimento devido a problemas de comportamento. Não há critérios claros para os procedimentos pedagógicos desenvolvidos pelos educadores, que tendem a trabalhar a partir do senso comum. Os educadores desempenham mais o papel de professores tradicionais do que de educadores sociais. Normalmente, eles não fizeram uma opção ética para trabalhar em um estabelecimento assistencial que atende a uma clientela pobre e não costumam estar alinhados com os interesses dos grupos populares, apenas realizam um trabalho profissional que visa à sua sobrevivência pessoal e familiar.

A escolarização das políticas públicas voltadas para crianças e adolescentes aumenta na mesma proporção em que os educadores sociais são recrutados entre os professores da rede municipal de educação escolar - que são cedidos pelo poder público como benesse e favor pessoal -, trazendo para os estabelecimentos assistenciais os hábitos, os vícios e os problemáticos esquemas de funcionamento da instituição escolar (Patto, 1990). A formação técnica e profissional das equipes dirigentes e dos educadores deixa muito a desejar, com relação à opção política pelas classes populares e quanto a estratégias de educação social que se pautem pelo trabalho de escuta, de conscientização, de organização com vistas à mobilização e à emancipação popular. O principal mecanismo e operador microfísico da entidade baseia-se na vigilância em meio aberto, na suplência da família e da escola no processo de normalização social de crianças e de adolescentes. No estabelecimento assistencial já se prefiguram as eventuais possibilidades delinquentes e antissociais da clientela pobre. Os complementos assistenciais de ordem pedagógica e psicológica acabam funcionando como uma cobertura que se sobrepõe a uma tecnologia disciplinar-correcional, produzindo, desse modo, efeitos pouco consistentes no cotidiano institucional, quanto aos sujeitos cidadãos de direitos, que são as crianças e adolescentes.

No plano do imaginário coletivo, a entidade aparece como provedora, como local que oferece proteção, alimentação, educação e oportunidades positivas para crianças e para adolescentes, pois desenvolve práticas filantrópicas e assistencialistas buscando uma certa promoção social por meio da escolarização e de tentativas precárias de profissionalização dos adolescentes, visando à sua inserção no mercado de trabalho. Espera-se que o estabelecimento possa educar as crianças, ajudando-as a ter sucesso na escola e preparando-as para o futuro profissional. Além disso, a participação em estabelecimentos assistenciais é também porta de acesso para a obtenção de auxílio familiar, por meio de ajudas municipais (cestas básicas) ou estaduais e federais (bolsas variadas), estando incluída como uma das condicionalidades desses auxílios.

No plano simbólico, verifica-se no estabelecimento assistencial a contradição entre um discurso que proclama a "proteção integral e a defesa dos direitos

fundamentais da criança e do adolescente" (Brasil, 2007b) e uma tutela em meio aberto, informal, incompleta, precária, filantrópica, caritativa, com práticas amadoras, benemerentes, assistencialistas, repressivas e correcionais. O discurso é liberal, os direitos constitucionais da criança e do adolescente como cidadãos são reduzidos a valores formais, abstratos e observa-se que as práticas são inevitavelmente autoritárias nesses estabelecimentos. Os instrumentos (práticas, saberes e discursos) utilizados pela entidade estão em dissonância, quando não em franca contradição com seus objetivos oficiais, e não podem produzir aquilo a que se propõem. As próprias crianças sentem vergonha de frequentar as entidades, pois isso as sobrecodifica com um estigma social: são identificadas pela população como sendo crianças pobres, carentes e assistidas pelas entidades assistenciais. Elas não se percebem nem são percebidas como cidadãos sujeitos que têm direito à educação, ao lazer, à atenção assistencial de qualidade, cuja oferta é de responsabilidade do Estado.

4) Quanto aos efeitos típicos da instituição assistencial em termos de performance ética, ela acaba produzindo um certo tipo de mais-valia, fazendo o capital girar no terceiro setor (Montaño, 2007), pois a gestão e a administração da pobreza gera lucros, empregos, investimentos e dividendos empresariais e também políticos para o governo municipal; muitas vezes reproduz as relações sociais de dominação-subordinação-exclusão, numa imitação muito precária da escola e, finalmente, tende a produzir uma subjetividade normalizada, serializada, submetida, dócil, politicamente inócua e útil, predominando a adaptação social.

Caracterização do modo socioeducativo

A partir do referencial lógico-estrutural de Costa-Rosa (2011) para a análise institucional, pode-se delinear um paradigma diametralmente oposto ao modo filantrópico mapeado no campo da Assistência Social no qual se encontram os estabelecimentos assistenciais que atendem a crianças e a adolescentes empobrecidos, oprimidos e excluídos. O desenho do Modo socioeducativo é uma dedução lógica que o instrumental analítico permite esboçar, sendo que ainda são raros os indícios que dele se podem encontrar no campo social concreto.

No campo da Assistência Social, o modo socioeducativo seria dotado com as seguintes características:

1) Quanto à concepção do processo social que identifica de modo intrínseco a pobreza-delinquência e dos meios teórico-técnicos empreendidos para lidar com esse processo, propõe-se para a Atenção Socioeducativa: determinação e consistência sociocultural e psíquica dos problemas, e não orgânica ou psicológica/subjetiva individual; os conflitos e as contradições devem ser considerados tanto como constitutivos do sujeito, quanto contingentes à sua situação e, portanto, não são necessariamente removidos como efeito das ações socioeducativas; tratamento da demanda e não dos problemas e das dificuldades emergentes; oferta de atenção psicossocial, de escuta e de uma clínica da construção de si, e não clínica da observação e da reabilitação (integração social), tomada do indivíduo como sujeito de projeto, como propõe Heidegger (1995), o homem como infinito projetar-se, infinito cuidar-se; e do inconsciente, como se propõe na psicanálise, e não tomada do sujeito como objeto de tutela ou de intervenção. A desinstitucionalização do paradigma pobreza-delinquência e sua substituição pelos conceitos de cidadania e de "sujeito cidadão de direitos" (Brasil, 1988; 1990; 2007b), conjuntamente com a configuração interdisciplinar e da atitude transdisciplinar do conjunto dos trabalhadores e de suas ações, são pré-requisitos necessários para a implicação subjetiva dos usuários e da população.

Exigências: desinstitucionalização e não institucionalização da questão pobreza-delinquência-criminalidade; despatologização e não patologização do indivíduo (abolindo a clínica individual terapeutizante e/ou medicalizada como resposta única ou preponderante e *a priori*); implicação subjetiva e sociocultural e não reificação ou objetificação; "sujeito cidadão de direitos" e não pobreza-cidadania que promove apenas uma inclusão social subordinada; clínica ampliada interdisciplinar e transdisciplinar (Educação Popular; Psicanálise, Materialismo Histórico, Filosofia da Diferença) e não clínica psicológica/psiquiátrica ou das especialidades.

2) Quanto à concepção da organização e das relações intrainstitucionais, inclusive da divisão do trabalho interprofissional, são exigências da Atenção

Socioeducativa, principalmente: horizontalização das relações intrainstitucionais, e não verticalização (sabe-se que qualquer relação da instituição como dispositivo e de seus agentes com a clientela e com a população depende da relação dos agentes institucionais entre si); distinção entre poder decisório (de origem política) e de coordenação (com possível origem no plano do saber), e não amálgama saber/poder; livre trânsito do usuário e da população em forma de autogestão e cogestão, e não heterogestão; divisão do trabalho interprofissional integrada em profundidade (superação da divisão do trabalho típica do modo capitalista de produção) e não divisão do trabalho interprofissional segundo o modelo taylorista. No limite das possibilidades do Modo socioeducativo, deve-se pautar por uma postura que pode ser mais bem designada pelos conceitos de interdisciplinaridade e de transdisciplinaridade.

Exigências: horizontalização e não verticalização das relações intrainstitucionais; participação e não exclusão segregadora; autogestão e cogestão e não gestão por delegação; interprofissionalidade integradora do processo de produção do produto e não interprofissionalidade fragmentadora segundo a lógica do modo capitalista de produção; transdisciplinaridade como horizonte mais amplo: superação dos especialismos e do esquema sujeito-objeto.

3) Quanto à concepção das relações da instituição e de seus agentes com a clientela e com a população em geral, são exigências essenciais da Atenção Socioeducativa: o estabelecimento institucional deve se situar como exterioridade em relação ao território (porosidade), garantindo nele o livre trânsito de todos, visto que o estabelecimento não é espaço depositário e aprisionante dos usuários e, eventualmente, da população, como no Modo filantrópico; as relações devem ser de interlocução, de diálogo entre sujeitos e não do tipo autoridade-subordinado; as ações visam à integralidade em extensão (no território) e em profundidade (considerando toda a complexidade das demandas), e não ações de atenção estratificada por níveis (proteção básica, proteção especial de média e de alta complexidade). Instituições típicas: associações de moradores, entidades assistenciais abertas, cooperativas populares, CRAS, CREAS, todas pautadas pelo ideário da Educação Popular e não pelo da filantropia. Desinstitucionalizar as políticas e as práticas de Assistência Social, na lógica do Modo socioeducativo, significa superar a organização de serviços baseados nos níveis de proteção, propiciando a unicidade de responsabilidade sobre o território; superar o fechamento institucional em favor da consideração das sociedades locais com seus conflitos e contradições reais; superar o monopólio das especialidades profissionais, utilizando as múltiplas potencialidades dos trabalhadores institucionais para a ativação de todos os recursos disponíveis, inclusive os dos usuários das instituições.

Exigências: interlocução, diálogo horizontal entre sujeitos; livre trânsito e não interdição e clausura ou espaço depositário; atenção integral e territorializada e não estratificada por níveis. Desinstitucionalização do Modo filantrópico e sua substituição pelo Modo socioeducativo.

4) Quanto à concepção efetivada dos efeitos éticos e de suas ações em termos políticos, educativos e terapêuticos, propõe-se como ética da Atenção Socioeducativa: por um lado, reposicionamento do sujeito (ética da singularização) e, por outro, destituição subjetiva (com superação do imaginário) e não integração social (adaptação social ortopédica). Este reposicionamento pode ser pensado tendo como horizonte a recuperação-construção-reivindicação dos direitos de cidadania, passando pela conquista do poder de contratualidade social, até a implicação subjetiva (entendida como a capacidade do sujeito de situar-se de modo ativo frente aos conflitos e contradições que atravessa e pelos quais é atravessado). A implicação subjetiva, como forma de singularização, supõe, ainda, a apropriação do desejo com seus vetores inconscientes e de devir; e a possibilidade de abrir-se para uma dimensão do saber que transcende o enciclopédico e o de mestria, para objetos que não se esgotam nos objetos imediatos, de "valência imaginária" (Valas, 2001, p.69).

Exigências: relação sujeito-desejo e carecimento-ideais (Costa-Rosa et al., 2003; Marx, 1978) e não ego-realidade ou carência-suprimento; implicação subjetiva e sociocultural (singularização) e não integração social (adaptação social ortopédica).

Ao Modo socioeducativo no campo da Assistência Social corresponderia uma entidade assistencial na qual a Atenção Socioeducativa estaria organizada a partir da lógica dos direitos de cidadania, que se articularia

num discurso crítico, dialético e politizado, baseando-se na noção jurídica de proteção integral e desenvolvendo práticas institucionais educativas populares e emancipadoras. Constata-se que algo dessa ordem é ausente ou, quando muito, absolutamente incipiente na realidade das entidades assistenciais pesquisadas.

Considerações Finais

Certamente pode ser mais fácil entender os problemas que a teoria e a perspectiva de análise apresentam e discutem do que explicitar quais são as propostas para o equacionamento das questões em pauta. Se não é fácil propor soluções para problemas complexos - e soluções simples não existirão, já que os problemas são complexos -, explicitar problemas mal colocados e opor a eles a precisão de um problema talvez já seja uma contribuição importante, embora modesta, procurando evitar qualquer atitude onipotente.

Ainda com base na grade analítica histórico-conjuntural utilizada, é possível perceber que há um imenso trabalho crítico e inovador a ser realizado nos diversos campos: teórico-assistencial, técnico-assistencial, jurídico-político e sociocultural, na esfera da Assistência Social, para potencializar a emergência do que pode ser denominado como modo socioeducativo, ainda em construção.

No campo teórico-assistencial é preciso desconstruir conceitos e práticas sustentadas pela perspectiva filantrópica autoritária e reacionária que ainda predomina na Assistência Social, no Serviço Social conservador e alienado, na Psicologia patologizante, psicologizante e culpabilizante do indivíduo e da família, na Pedagogia tradicional e elitista e na Sociologia funcionalista acerca da questão social em geral e da pobreza em particular. A pobreza é uma questão fundamentalmente política e é preciso situá-la nesse campo concreto, de lutas e embates sociais pela construção de uma sociedade mais justa. É preciso construir noções de direitos humanos, de cidadania, de democracia popular, de Atenção Socioeducativa, de atenção psicossocial, de educação popular e de pensamento crítico e dialético, fazendo frente ao paradigma filantrópico hegemônico.

No campo técnico-assistencial é preciso criatividade para inventar e ousar criar outras estratégias educacionais, pedagógicas, psicológicas e assistenciais, aprimorando a formação das equipes de profissionais. É fundamental superar o atendimento aos pobres e partir da Atenção e do atendimento ao cidadão de direitos, rompendo com práticas disciplinares-correcionais e aumentando a possibilidade de que o indivíduo se construa a partir do *status* de sujeito de direitos, sendo capaz de autonomia crescente e de maior contratualidade social. Mais do que capacidade técnica, é fundamental a adoção de um posicionamento ético, profissional e político, alinhado com os interesses das classes populares.

No âmbito jurídico-político, é possível constatar transformações fundamentais que vêm ocorrendo no ordenamento jurídico nas últimas décadas, começando pela Constituição Federal (Brasil, 1988), passando pelo ECA (Brasil, 1990), pela LOAS (Brasil, 1993; 2011), pela PNAS (Brasil, 2004), pelo SUAS (Brasil, 2005). Há muito de lutas populares por trás dessas construções legais e também há muitas concessões estratégicas por parte do poder político da elite que domina o Estado. Todo esse arcabouço jurídico contém aspectos louváveis e pontos bastante problemáticos. Contudo, diante das lideranças políticas, no âmbito municipal, que ainda são extremamente patrimonialistas, autoritárias, concentradoras de poder, corporativistas e clientelistas, orientadas por um ideário filantrópico profundamente elitista e reacionário, elas até podem ser consideradas leis arrojadas, apesar de suas diversas limitações. Por exemplo, as prefeituras municipais instalam todos os conselhos municipais que a lei ordena: Conselho Municipal dos Direitos da Criança e do Adolescente, Conselho Tutelar, Conselho Municipal de Assistência Social, Conselho Municipal de Educação, do Idoso, do Deficiente etc., mas não admite partilhar o planejamento, a deliberação política, a destinação orçamentária, a execução técnica e a avaliação com os conselhos municipais, que normalmente são reduzidos a instâncias burocráticas que simplesmente sancionam tudo o que o executivo determina, de modo cartorário e subordinado. De acordo com a experiência de imersão realizada no campo da Assistência Social, verificou-se que ainda não há quadros de profissionais no poder público nem na sociedade civil que estejam à altura do nível democrático e participativo que a legislação propõe. É preciso lutar para

conseguir exercer e implementar efetivamente as prerrogativas legais estabelecidas, buscando sempre aperfeiçoar a legislação vigente, em um direcionamento constante para a criação e o afiançamento de novos direitos.

No plano sociocultural, deparou-se com a persistência da perspectiva enviesada da filantropia reacionária, presente na mentalidade de gestores municipais, de técnicos, de conselheiros, tanto do poder público quanto da sociedade civil, de pais, de educadores sociais, de dirigentes de entidades, assim como em planos de trabalho, em atitudes, em práticas, em discursos. É surpreendente a pregnância do paradigma filantrópico, aliado com o clientelismo assistencialista do poder público e com sua resistência às inovações jurídicas e institucionais promovidas pelo Estado, no âmbito das políticas públicas para a Assistência Social e para a criança e o adolescente no País. Afirmar que a Assistência Social é uma política pública de dever do Estado e de direito do cidadão e que crianças e adolescentes são sujeitos de direitos ainda é muito mais um projeto a ser construído do que uma realidade constatada.

Referências

Alberto, M. F. P. (2008). O papel do psicólogo e das entidades junto a crianças e adolescentes em situação de risco. *Psicologia, Ciência e Profissão*, *28*(3), 558-573.

Amarante, P. (1995). *Loucos pela vida*: *trajetória da reforma psiquiátrica no Brasil*. Rio de Janeiro: Fiocruz.

Assis, S. G. (Org.). (2009). *Teoria e prática dos conselhos tutelares e conselhos dos direitos da criança e do adolescente*. Rio de Janeiro: Fiocruz.

Baremblitt, G. F. (1998). *Compêndio de análise institucional e outras correntes*: *teoria e prática*. Rio de Janeiro: Record.

Barreto, A. F. (2011). Sobre a dor e a delícia da atuação do psicólogo no SUAS. *Psicologia, Ciência e Profissão*, *31*(2), 406-419.

Barus-Michel, J. (2004). *O sujeito social*. Belo Horizonte: Puc Minas.

Benelli, S. J. (2004). A instituição total como agência de produção de subjetividade na sociedade disciplinar. *Estudos de Psicologia* (Campinas), *21*(3), 237-252. doi: 10.1590/50 103-166X2004000300008.

Benelli, S. J. (2009). A cultura psicológica no mercado de bens de saúde mental contemporâneo. *Estudos de Psicologia* (Campinas), *26*(4), 515-536. doi: 10.1590/50103-16 6X2009000400012.

Benelli, S. J. (2010). *Cartografia das instituições de Assistência Social a crianças e adolescentes num município do interior do Estado de São Paulo* (Tese de pós-doutorado não-publicada). Programa de Pós-Doutorado em Psicologia e Sociedade, Universidade Estadual Paulista.

Benelli, S. J., & Costa-Rosa, A. (2010). A construção de redes sociais: entre a conexão e a captura na gestão dos riscos sociais. In E. P. Constantino (Org.), *Psicologia, estado e políticas públicas* (pp.25-85). Assis: Unesp.

Bock, A. M. B. (2004). A perspectiva sócio-histórica de Leontiev e a crítica à naturalização da formação do ser humano: a adolescência em questão. *Cadernos Cedes*, *24*(62), 26-43.

Bock, A. M. B. (2007). A adolescência como construção social: estudo sobre livros destinados a pais e educadores. *Revista Semestral da Associação Brasileira de Psicologia Escolar e Educacional*, *2*(1), 63-76.

Bock, A. M. B. (Org.). (2009). *Psicologia e compromisso social*. São Paulo: Cortez.

Botarelli, A. (2008). *O psicólogo nas políticas de proteção social*: *uma análise dos sentidos e das práxis* (Tese de doutorado não-publicada). Programa de Pós-Graduação em Psicologia Social, Pontifícia Universidade Católica de São Paulo.

Brasil. Presidência da República. (1988). *Constituição da República Federativa do Brasil*. Brasília: Presidência da República Casa Civil. Recuperado em março 10, 2008, disponível em <http://www.planalto. gov.br/ccivil_03/ Constituicao/constitui%C3%A7ao_ compilado. htm>.

Brasil. Presidência da República. (1990, julho 16). Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o estatuto da criança e do adolescente e dá outras providências. *Diário Oficial da União,* Seção 1. Recuperado em março 10, 2008, disponível em <http://www.planalto. gov.br/ccivil/ Leis/L8069.htm>.

Brasil. Presidência da República. (1993; dezembro 12). Lei nº 8.742, de 7 de dezembro de 1990. Dispõe sobre a organização da assistência social e dá outras providências. *Diário Oficial da União,* Seção 1. Recuperado em março 10, 2008, disponível em <http://www.mds. gov.br/cnas/ legislacao/leis>.

Brasil. Ministério do Desenvolvimento Social. (2004). *Política nacional de assistência social e norma operacional básica de serviço social*. Brasília: MDS. Recuperado em março 10, 2008, disponível em <http://www.mds.gov.br/cnas/ legislacao/leis>.

Brasil. Ministério do Desenvolvimento Social. (2005). *Norma operacional básica do sistema único de assistência social*. Brasília: MDS. Recuperado em março 10, 2008, disponível em <http://www.mds.gov.br/cnas/politica-e-nobs>.

Brasil. Ministério do Desenvolvimento Social. (2006a). *Orientações técnicas para o centro de referência da assistência social - CRAS*. Brasília: MDS. Recuperado em março 10, 2008, disponível em <http://www.mds.gov.br/cnas/ politica-e-nobs>.

Brasil. Ministério do Desenvolvimento Social. (2006b). *Orientações técnicas para o Programa Bolsa Família - PBF*. Brasília: MDS. Recuperado em março 10, 2008, disponível em <http://www.mds.gov.br/cnas/politica-e-nobs>.

Brasil. Ministério do Desenvolvimento Social. (2006c). *Orientações técnicas para o centro de referência especializado*

em assistência social. Brasília: MDS. Recuperado em março 10, 2008, disponível em <http://www.mds.gov.br/cnas/politica-e-nobs>.

Brasil. (2007a). *Conselho Municipal dos Direitos da Criança e do Adolescente e Conselho Tutelar: orientações para criação e funcionamento.* Brasília: Conanda.

Brasil. (2007b). *Parâmetros para criação e funcionamento dos Conselhos dos Direitos da Criança e do Adolescente*. Brasília: SEDH.

Brasil. Ministério do Desenvolvimento Social. (2009a). *Tipificação nacional de serviços socioassistenciais*. Brasília: MDS. Recuperado em dezembro 12, 2009, disponível em <http://www.mds.gov.br/cnas/politica-e-nobs>.

Brasil Ministério do Desenvolvimento Social. (2009b). *Orientações técnicas para o Centro de Referência da Assistência Social - CRAS*. Brasília: MDS. Recuperado em dezembro 12, 2009, disponível em <http://www.mds.gov.br/cnas/politica-e-nobs>.

Brasil. Ministério do Desenvolvimento Social. (2011, julho 7). Lei nº 12.435, de 3 de julho de 2011. Altera a Lei nº 8.742, de 7 de dezembro de 1993, que dispõe sobre a organização da assistência social. *Diário Oficial da União,* Seção 1. Recuperado em julho 30, 2011, disponível em <http://www.mds.gov.br/cnas/legislacao/leis>.

Cabas, A. G. (2009). *O sujeito na psicanálise de Freud a Lacan*: *da questão do sujeito ao sujeito em questão.* Rio de Janeiro: Jorge Zahar.

Centro de Referência Técnica em Psicologia e Políticas Públicas. (2007). *Referência técnica para atuação do(a) psicólogo(a) no CRAS/SUAS*. Brasília: CFP.

Centro de Referência Técnica em Psicologia e Políticas Públicas. (2009). *Serviço de proteção social a crianças e adolescentes vítimas de violência, abuso e exploração sexual e suas famílias*: *referências para a atuação do psicólogo*. Brasília: CFP.

Conselho Federal de Psicologia. (2010). Política de assistência social. *Diálogos*, *7*(7), 3-56.

Conselho Federal de Psicologia. (2011). *VI Seminário Nacional de Psicologia e Políticas Públicas*: *democracia e promoção de Direitos.* Salvador: CFP.

Conselho Federal de Serviço Social. (2007). *Parâmetro para atuação de assistentes sociais e psicólogos(as) na Política de Assistência Social.* Brasília: CFP.

Conselho Regional de Psicologia da 6ª Região. (Org.) (2007). *A psicologia promovendo o ECA*: *reflexões sobre o sistema de garantia de direitos da criança e do adolescente*. São Paulo: CRP.

Constantino, E. P. (Org.). (2010). *Psicologia, estado e políticas públicas.* Assis: Unesp.

Costa-Rosa, A. (2000). O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In P. D. C. Amarante (Org.), *Ensaios de loucura e civilização* (pp.141-168). Rio de Janeiro: Fiocruz.

Costa-Rosa, A. (2011). *Operadores fundamentais da atenção psicossocial*: *contribuição a uma clínica crítica dos processos de subjetivação na saúde coletiva* (Tese de livre-docência não-publicada). Programa de Livre-Docência em Psicologia Clínica, Universidade Estadual Paulista.

Costa-Rosa, A., Luzio, C. A., & Yasui, S. (2003). Atenção psicossocial: rumo a um novo paradigma em saúde mental coletiva. In P. Amarante (Org.), *Archivos de saúde mental e atenção psicossocial* (pp.13-44). Rio de Janeiro: Nau.

Cruz, L. R., & Guareschi, N. (2004). Sobre a psicologia no contexto da infância: da psicopatologização à inserção política. *Revista Aletheia*, *20*(2), 77-90.

Cruz, L. R., & Guareschi, N. (Orgs.). (2009). *Políticas públicas e assistência social*: *diálogo com as práticas psicológicas*. Petrópolis: Vozes.

Cruz, L., Hillesheim, B., & Guareschi, N. (2005). Infância e políticas públicas: um olhar sobre as práticas psi. *Psicologia & Sociedade*, *17*(3), 42-49.

Dadico, L., & Souza, M. P. R. (2010). Atuação do psicólogo em organizações não-governamentais na área da educação. *Psicologia, Ciência e Profissão*, *30*(1), 114-131.

Donzelot, J. (2001). *A polícia das famílias*. Rio de Janeiro: Graal.

Eidelwein, K. (2007). Psicologia social e serviço social: uma relação interdisciplinar na direção da produção de conhecimento. *Textos & Contextos*, *6*(2), 298-313.

Elia, L. (2004). *O conceito de sujeito lacaniano*. Rio de Janeiro: Jorge Zahar.

Ferreira, C. R. C. (2010). *As contribuições da psicologia histórico-cultural aos psicólogos que trabalham junto às políticas públicas de assistência social voltadas às crianças entre zero e seis* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Psicologia, Universidade Estadual de Maringá.

Fink, B. (1998). *O sujeito lacaniano*: *entre a linguagem e o gozo*. Rio de Janeiro: Jorge Zahar.

Fontenele, A. F. G. T. (2008). *Psicologia e Sistema Único de Assistência Social - SUAS: estudo sobre a inserção de psicólogos nos Centros de Referência da Assistência Social - CRAS* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Psicologia Social, Universidade Federal do Ceará.

Foucault, M. (1999). *Vigiar e punir*: *nascimento da prisão*. Petrópolis: Vozes.

Garcia-Roza, L. A. (2009). *Freud e o inconsciente.* Rio de Janeiro: Jorge Zahar.

Goffman, E. (1987). *Manicômios, prisões e conventos.* São Paulo: Perspectiva.

Gonçalves, M. G. M. (2010). *Psicologia, subjetividade e políticas públicas*. São Paulo: Cortez.

Heidegger, M. (1995). *Ser e tempo.* Petrópolis: Vozes.

Lacan, J. (1979). *O seminário*: *os quatro conceitos fundamentais da psicanálise*: *Livro 11*. Rio de Janeiro: Jorge Zahar.

Lacan, J. (1998). *Escritos.* Rio de Janeiro: Jorge Zahar.

Lancetti, A. (Org.). (1996). *Assistência social e cidadania*: *invenções, tensões e construção da experiência de Santos.* São Paulo: Hucitec.

Lemos, F. C. S. (2007). *Crianças e adolescentes entre a norma e a lei*: *uma análise foucaultiana*. (Tese de doutorado não-publicada). Programa de Pós-Graduação em História e Sociedade, Universidade Estadual Paulista.

Lourau, R. (1995). *A análise institucional.* Petrópolis: Vozes.

Marx, K. (1978). *Manuscritos econômicos e filosóficos (1844) e outros textos escolhidos.* São Paulo: Abril Cultural.

Montaño, C. E. (2007). *Terceiro setor e questão social*: *crítica ao padrão emergente de intervenção social.* São Paulo: Cortez.

Murta, S. G., & Marinho, T. P. C. M. (2009). A clínica ampliada e as políticas de Assistência Social: uma experiência com adolescentes no Programa de Atenção Integral à Família. *Revista Eletrônica de Psicologia e Políticas Públicas*, *1*(1). Recuperado em julho, 2010, disponível em: <http://www.crp09.org.br>.

Olgivie, B. (1988). *Lacan*: *a formação do conceito de sujeito (1931-1949)*. Rio de Janeiro: Jorge Zahar.

Paiva, I. L., & Yamamoto, O. H. (2010). Formação e prática comunitária do psicólogo no âmbito do "terceiro setor". *Estudos de Psicologia* (Natal),*15*(2), 153-160.

Patto, M. H. S. (1990). *A produção do fracasso escolar.* São Paulo: T.A. Queiróz.

Pontual, P., & Ireland, T. (Orgs.). (2006). *Educação popular na América Latina*: *diálogos e perspectivas*. Brasília: MEC.

Rodrigues, M. M. A. (2010). *Políticas públicas.* São Paulo: Publifolha.

Rogone, H. M. H. (2006). *Psicanálise e cidadania*: *correndo riscos e tecendo laços* (Tese de doutorado não-publicada). Programa de Pós-Graduação em Psicologia Escolar e do Desenvolvimento Humano, Universidade de São Paulo.

Saliba, M. G. (2006). *O olho do poder: análise crítica da proposta educativa do Estatuto da Criança e do Adolescente.* São Paulo: Unesp.

Santana, J. P., Doninelli, T. M., Frosi, R. V., & Koller, S. H. (2004). Instituições de atendimento a crianças e adolescentes em situação de rua. *Psicologia & Sociedade*, *16*(2), 59-70.

Scarparo, M. L. D. E. (2008). *Em busca do sujeito perdido*: *a psicanálise na Assistência Social, limites e possibilidades* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Psicologia Social e Institucional, Universidade Federal do Rio Grande do Sul.

Senra, C. M. G. (2009). *Psicólogos sociais em uma instituição pública de Assistência Social*: *analisando estratégias de enfrentamento* (Tese de doutorado não-publicada). Programa de Pós-Graduação em Psicologia, Pontifícia Universidade Católica de Campinas.

Silva, G. H. (2008). *A construção da identidade do educador social na sua prática cotidiana*: *a pluralidade de um sujeito singular* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Educação, Universidade de São Paulo.

Silveira, A. F., Cobalchini, C. C. B., Menz, D. M., Valle, G. A., & Barbarini, N. (2007). *Caderno de psicologia e políticas públicas.* Curitiba: CRP.

Valas, P. (2001). *As dimensões do gozo.* Rio de Janeiro: Jorge Zahar.

Vallejo, A., & Magalhães, L. C. (1979). *Lacan*: *operadores de leitura.* São Paulo: Perspectiva.

Vasconcelos, E. M. (2008a). *Abordagens psicossociais*: *história, teoria e trabalho no campo.* São Paulo: Hucitec.

Vasconcelos, E. M. (Org.). (2008b). *Abordagens psicossociais*: *reforma psiquiátrica e saúde mental na ótica da cultura e das lutas populares.* São Paulo: Hucitec.

Vasconcelos, E. M. (2009). *Abordagens psicossociais*: *perspectivas para o serviço social.* São Paulo: Hucitec.

Zaniani, E. J. M. (2008). *Sob os auspícios da proteção: Moncorvo Filho e a higienização da infância* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Psicologia, Universidade Estadual de Maringá.

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Resenha

Depression: Causes and treatment[1]

Depressão: causas e tratamento

Vivian **MASCELLA**[2]

In relation to the first edition of the book published in 2009, this second edition, brings significant advances, specifically regarding new terminology and in the classification of disorders, today's terms replace older ones or are included side by side, and new material published since then is coved.

The book is organized into four parts: clinical aspects, experimental aspects, theoretical aspects, and treatment of depression. Part I describes the definition, symptoms, course and prognosis of depression, as well as ratings of mood disorders, depression, psychotic versus nonpsychotic depression, bipolar disorders, involutional depression and schizoaffective disorder. Part II reports biological and psychological studies of depression, including psychoanalytic theory tests. Part III investigates theories of depression, cognition and psychopathology and the development of depression. Part IV describes the main treatments for depression, including the somatic therapies, psychotherapy and the assessment of treatments for depression: random controlled trials.

Part I presents the questions about depression that are present throughout human history. Even though it has been recognized as a clinical syndrome for over two thousand years, an entirely satisfactory explanation of its intriguing and paradoxical features has not been found. There are few psychiatric syndromes in which the clinical definitions are so constant throughout consecutive periods of history. The nature and etiology of depression are subject to different concepts. Some scholars ensure that depression is a psychogenic disorder, while others claim that it is caused by organic factors. A third group believes in two different types of depression: one psychogenic and the other organic.

Schizophrenia and depression constitute the first and second most common diagnoses, respectively, for admissions to psychiatric hospitals in the United States, and the prevalence of depression outside psychiatric hospitals is evaluated as being five times that of schizophrenia. According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) of the American Psychiatric Association (APA), the likelihood of developing major depressive disorder during life is from 12% to 15% for men and from 10% to 25% for women. Major depressive disorder is the main reason for disability in strengthened market economies around the world.

In *Symptoms of depression* systematic studies are described, along with the main complaints and symptoms, including emotional manifestations, such as depressed mood, negative feelings about oneself, reduced satisfaction, loss of emotional bonds, crying spells, loss response to mood, cognitive manifestations, negative self-evaluation, negative expectations, self-

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[1] Beck, A.T., & Alford, B.A. (2011). *Depressão causas e tratamento* (2ª ed.). Porto Alegre: Artmed.

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recrimination, self-criticism, indecisiveness, body image distortion, motivational events, paralysis of the will, desires avoidance, escapism and withdrawal, suicidal desires, feelings of worthlessness, and increased dependency. Some vegetative and physical manifestations are included, such as loss of appetite, sleep disturbance, loss of libido, fatigability, and retardation.

In the *Course and prognosis of depression* systematic studies are presented in detail related to the onset of depressive episodes, remission and chronicity. In *Classifications of mood disorders*, history, validation and reliability are elucidated from the publication of the first DSM-IV of the APA.

In the chapter presenting *Non-psychotic depression versus psychotic depression* the depressive "psychoneurotic" reaction is described, as well as severe depression with psychotic features and some clinical cases. Regarding bipolar disorders, the history and definition, criteria for diagnosis of bipolar disorder, the relationship between manic and depressive episodes, symptoms of manic phase, behavioral observations of the manic phase, periodicity of manic-depressive behavior, the pre-morbid personality of manic-depressive patients, and questions for further study are explained. Regarding *Involutional Depression*, it can be concluded that there are serious doubts about the usefulness of this nosological category. A very common belief that involutional depression can be distinguished from other types of psychotic depression based on symptoms was excluded through controlled studies. In the *Schizoaffective disorder* section, the scarcity of studies in this area is approached, with the lack of data concerning prevalence rates used as an example. This section also mentions the need for further research into the nature, causes and proper classification of this combination of psychosis and mood disturbance.

Part II of the book presents the *Experimental aspects of depression* and it demonstrates that, despite millions of studies on depression, there is little basic knowledge on the biological substrate of depression. No laboratory discovery related to the diagnosis of a major depressive episode or a manic episode was identified. The results of studies on the neurobiology of suicidal behavior also remain controversial. Positive results regarding exaggerated levels of depression have been consistently related to steroids, sodium retention and changes in patterns of electroencephalogram sleep.

In *Theoretical aspects of depression* some theories on depression are presented, such as Behavioral Theories, Cognitive and Evolutionary Theories, Psychoanalytic Theories, Psychotherapy and Psychological Theories, Existentialist Theories, Neurological Theories, Neuropsychological Theories and Biochemical Theories. In the chapter on *Cognition and psychopathology* the primary triad of depression is described in detail, in order to better clarify the relationships between the diverse phenomena of cognitive, affective, motivational and physical depressions. In *The Development of depression* the predisposition to depression is exposed, including the formation of concepts, judgments of value and affection, and specific vulnerabilities, with the relationship between stress and depression, and personality organization in depression also revealed.

In part IV *Treatments for Depression* the main somatic therapies are explained, together with current pharmacotherapy and its main side effects, and resistance to treatment. In *Psychotherapy* the first therapeutic approaches are illustrated, emphasizing cognitive therapy. The authors analyze the results of randomized controlled trials, with special attention to comparisons between psychotherapy and antidepressant medication. The data show the positive outcome of relapse prevention with cognitive therapy compared to medication treatment, illustrated from a comprehensive review of studies showing that depressed patients treated with psychological interventions had a relapse rate of 30%, in contrast with a relapse rate of 69% for those treated with pharmacotherapy alone.

The appendix of the book presents *Score instructions for negative dreams* which indicates a set of unpleasant dreams characterized by a specific thematic content, and representations of *a negative dream* are exemplified.

The book fulfills the needs of Psychology and Psychiatry professionals, as well as carefully describing the history and evolution of studies on depression. This edition contributes to the development of scientific knowledge of doctors, psychologists and other healthcare professionals. It also evidences the lack of studies on depression, and the divergence that some systematic studies present in relation to one another, which is richly reported.

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Instruções aos Autores

Estudos de Psicologia é uma revista científica trimestral (ISSN: 0103-166X), vinculada ao Programa de Pós-Graduação em Psicologia, do Centro de Ciências da Vida, da Pontifícia Universidade Católica de Campinas (*home page* da revista: http://www.scielo.br/estpsi). A Revista foi fundada em 1983 e, atualmente, está classificada como A2 na lista Qualis/Capes. É indexada nas seguintes bases de dados nacionais e internacionais: SciELO, Lilacs, PsycINFO, Latindex, Clase, Index Psi.

I - TIPOS DE TRABALHOS ACEITOS PELA REVISTA *ESTUDOS DE PSICOLOGIA*

Estudos de Psicologia incentiva contribuições da comunidade científica nacional e internacional, e é distribuída a leitores de todo o Brasil e de vários outros países. Todos os artigos devem ser submetidos de forma eletrônica pela página <http://www.scielo.br/estpsi>.

Aceitam-se trabalhos originais de pesquisa, em qualquer área da Psicologia, com objetivo de promover e divulgar o conhecimento científico, bem como discutir o significado de práticas, tanto no campo profissional, como no da pesquisa em Psicologia. Antes do envio do manuscrito para avaliação dos consultores *ad hoc* ele é submetido à pré-análise pelo Conselho Editorial. As seguintes categorias de trabalhos são aceitas para publicação:

- **Estudos Empirícos**: artigos originais baseados em dados empíricos. Estes artigos consistem das seguintes seções: introdução, método, resultados e discussão.

- **Artigos Teóricos**: revisão crítica da literatura sobre temas pertinentes à Psicologia, levando ao questionamento de modelos existentes e à elaboração de hipóteses para futuras pesquisas.

- **Artigos de Revisão de Literatura**: apresenta síntese de resultados de estudos originais, quantitativos ou qualitativos, respondendo a alguma pergunta específica e de relevância para a área da Psicologia. Descreve o processo de busca dos estudos originais, os critérios utilizados para seleção daqueles que foram incluídos na revisão e os procedimentos empregados na síntese dos resultados obtidos pelos estudos revisados.

- **Estudos de Caso**: relatos de trabalhos feitos com indivíduos, grupos ou organizações indicando um problema e uma maneira de solucioná-lo, baseando-se na literatura.

- **Resenha**: apresentação e análise crítica de livro publicado na área há, no máximo, 1 ano anterior a submissão.

Todos estes tipos de artigos deverão apresentar no máximo 25 laudas, incluindo tabelas, figuras, quadros e referências. A contagem de páginas começa pela página de rosto, numerada como página 1. O manuscrito que se enquadra nas categorias acima será submetido à pré-análise da Comissão Editorial.

II - PARECER DO COMITÊ DE ÉTICA

Resultados de pesquisas relacionadas a seres humanos devem ser acompanhados de cópia de aprovação do parecer de um Comitê de Ética em pesquisa. Além disso, deverá constar, no último parágrafo do item Método, o número do protocolo e data de aprovação do Comitê de Ética.

III - APRECIAÇÃO PELO CONSELHO EDITORIAL

Os originais serão aceitos para avaliação desde que não tenham sido publicados anteriormente e que venham acompanhados de carta de encaminhamento, assinada pelos autores do trabalho, solicitando publicação na Revista.

O processo editorial só terá início se os manuscritos encaminhados obedecerem às condições das Instruções. Caso contrário, serão devolvidos para adequação às normas, inclusão de carta ou outros documentos, antes mesmo de serem submetidos à pré-análise da Comissão Editorial e à posterior avaliação de mérito do trabalho pelos revisores *ad hoc*.

Ao passar pela etapa de pré-análise, pode-se ter como desfecho:

(1) encaminhá-lo para os consultores *ad hoc*.

(2) devolver o manuscrito aos autores, solicitando modificações.

(3) recusá-lo quanto a: (i) conteúdo, no que se refere à linha temática da revista; (ii) originalidade, relevância do tema e qualidade da metodologia científica utilizada.

(4) o manúscrito será enviado ao processo de avaliação pelos revisores *ad hoc*, caso atenda aos critérios supracitados.

1) Avaliação de manuscritos

O processo de avaliação por pares é o sistema de *blind review*, procedimento sigiloso quanto à identidade tanto dos autores quando dos revisores. Por isso, os autores deverão empregar todos os meios possíveis para evitar a identificação de autoria do manuscrito. Os originais serão encaminhados, sem o(s) nome(s) do(s) autor(es), a pelo menos dois revisores *ad hoc*. São necessários dois pareceres favoráveis para a aceitação final da publicação. Caso ocorra um desacordo, o original será enviado para mais um revisor, para nova avaliação. No caso de identificação de *conflito de interesses* por parte dos revisores, o Comitê Editorial encaminhará o manuscrito a outro revisor *ad hoc*. A identificação dos pareceres emitidos será mantida em absoluto sigilo. Aos autores, será comunicada a decisão de aceitação ou recusa do trabalho. Os trabalhos que receberem sugestões para alterações serão devolvidos aos autores para as devidas correções, com os pareceres emitidos, devendo ser devolvidos no prazo máximo de 30 dias.

Os pareceres dos revisores comportam quatro possibilidades: a) aprovação; b) recomendação de nova análise, após pequena reformulação; c) recomendação de nova análise, após extensa reformulação; d) recusa. Em quaisquer desses casos, o autor será comunicado. No último número de cada volume da revista, será publicada a *nominata* dos consultores *ad hoc* que colaboraram na avaliação dos manuscritos, no ano corrente.

O processo de avaliação dos manuscritos terminará na segunda versão. A decisão final sobre a publicação ou não do manuscrito é sempre dos editores. Pequenas alterações no texto poderão ser feitas pelo Conselho Editorial da revista, de acordo com critérios e normas de revisão internas.

2) Provas

Serão enviadas provas tipográficas aos autores para a correção de erros de impressão. As provas devem retornar ao Núcleo de

Editoração na data estipulada. Outras mudanças no manuscrito original não serão aceitas nesta fase. Cada autor de artigo publicado receberá dois exemplares do fascículo no qual seu estudo foi publicado.

IV - FORMA DE APRESENTAÇÃO DOS ORIGINAIS

Estudos de Psicologia adota as normas de publicação da *American Psychological Association* (APA) (6ª edição, 2010). Os originais deverão ser redigidos em português, inglês, francês ou espanhol. Todos os originais deverão incluir título e resumo em inglês.

Para submeter o artigo para avaliação pelo Conselho Editorial da Revista *Estudos de Psicologia* os manuscritos deverão ser enviados via eletrônica e inserido no *site*: <http://www.scielo.br/estpsi>. Manuscritos recebidos por correio convencional, *fax*, *e-mail* ou qualquer outra forma de envio não serão apreciados pelos editores.

O texto deve ser preparado em espaço duplo, com fonte *Arial* 12, e deverá ter entre 15-25 laudas. O arquivo deverá ser gravado em editor de texto similar à versão 97-2003 do *Word*. O papel deverá ser de tamanho A4, com formatação de margens superior e inferior (2,5cm), esquerda e direita (3cm).

Importante: a avaliação dos manuscritos é feita às cegas quanto à identidade dos autores. É responsabilidade dos autores garantir que não haja elementos capazes de identificá-los em qualquer parte do texto. Não serão aceitos anexos, tampouco notas de rodapé no corpo do texto.

Publicação em inglês: em caso de aprovação, os artigos indicados pelo Conselho Editorial serão publicados na versão em inglês. Nestes casos para que o manuscrito seja publicado, os autores deverão providenciar sua versão completa (tal como aprovado) para o inglês, arcando com os custos de sua tradução. Para assegurar a qualidade e uniformidade dos textos traduzidos para a Língua Inglesa, esse trabalho deverá ser realizado, necessariamente, por um tradutor altamente capacitado e com experiência comprovada na versão de textos científicos, indicados e credenciados junto à Revista.

Versão reformulada

A versão reformulada deverá ser encaminhada via *site* <http://www.scielo.br/estpsi>. **Os autor(es) deverá(ão) enviar apenas a última versão do trabalho**. As modificações deverão ser destacadas em fonte na cor azul, sendo anexada a uma carta ao editor, reiterando o interesse em publicar nesta Revista e informando quais alterações foram processadas no manuscrito. Se houver discordância quanto às recomendações da consultoria, o(s) autor(es) deverão apresentar os argumentos que justificam sua posição. Caso os autores não encaminhem o manuscrito revisado e a carta-resposta no prazo estipulado, o processo editorial será encerrado, em qualquer etapa da submissão.

Os trabalhos deverão apresentar os seguintes elementos, respeitando-se a ordem aqui sugerida:

1) Folha de rosto com identificação dos autores, contendo:

• Título completo em português: deverá ser conciso e evitar palavras desnecessárias e/ou redundantes, como "*avaliação do...*", "*considerações acerca de ...*", "*Um estudo exploratório sobre...*".

• Sugestão de título abreviado para cabeçalho, não excedendo cinco palavras.

• Título completo em inglês, compatível com o título em português.

• Nome de cada autor, por extenso, seguido por afiliação institucional. Não abreviar os prenomes.

• Todos os dados da titulação afiliação deverão ser apresentados por extenso, sem nenhuma sigla.

• Indicação dos endereços completos de todas as universidades às quais estão vinculados todos os autores.

• Indicação de endereço para correspondência com o editor para a tramitação do original, incluindo *fax*, telefone e endereço eletrônico.

• Poderá ser incluída nota de rodapé contendo apoio financeiro, agradecimentos pela colaboração de colegas e técnicos, em parágrafo não superior a três linhas. Este parágrafo deverá informar, também, a origem do trabalho e outras informações que forem consideradas relevantes.

• Caso haja utilização de figuras ou tabelas publicadas em outras fontes bibliográficas, deve-se anexar documento que ateste a permissão para seu uso.

2) Folha de rosto à parte

Deverá conter somente o nome do artigo e sua tradução em inglês, sem identificação dos autores.

3) Folha à parte contendo resumo em português

O resumo deverá conter, no mínimo 100 e no máximo 150 palavras. Não é permitido o uso de siglas ou citações. Deverá conter, ao final, de 3-5 palavras-chave que descrevam exatamente o conteúdo do trabalho. As palavras-chave ou descritores deverão ser obtidos na Terminologia Psi <http://www.bvs-psi.org.br> ou na Terminologia em Ciências da Saúde (DeCS) <http://decs.br>. As palavras-chave ou descritores deverão estar escritas em letras minúsculas, separadas por ponto e vírgula.

O resumo deverá incluir breve referência ao problema investigado, características da amostra, método usado para a coleta de dados, resultados e conclusões. Apenas a resenha dispensa o resumo. O resumo segue a numeração da capa com identificação dos autores, e da folha sem identificação dos autores, devendo ser numerado como página 3.

4) Folha à parte contendo *abstract* em inglês

O *abstract* deverá ser compatível com o texto do resumo. Deverá seguir as mesmas normas, e vir acompanhado de *keywords* também obtidas nos *sites* da Biblioteca Virtual de Saúde (BVS) <http://www.bvs-psi.org.br> e <http://decs.br>. Esta página será numerada como página 4.

5) Organização do trabalho

O texto de todo trabalho submetido à publicação deverá ter uma organização clara e títulos e subtítulos que facilitem a leitura. Para os relatos de pesquisa, o texto deverá, obrigatoriamente, apresentar: introdução; método com informações consistentes sobre os participantes, instrumentos e procedimentos utilizados; os resultados mais importantes, que respondem aos objetivos da pesquisa; a discussão deverá explorar, adequada e objetivamente, os resultados discutidos à luz de outras observações já registradas na literatura. As considerações finais devem apresentar as conclusões relevantes, considerando os objetivos do trabalho, sendo baseadas na literatura revisada na introdução do artigo. Devem ser apontadas as limitações do estudo assim como sugestões para futuras pesquisas.

6) Ilustrações

Tabelas, quadros e figuras deverão ser limitados ao total de 5, sendo numerados consecutiva e independentemente, com algarismos arábicos, de acordo com a ordem de menção dos dados. Deverão ser apresentados em folhas individuais e separadas, com indicação de sua localização no texto. A cada um se deverá atribuir um título breve.

O autor se responsabiliza pela qualidade das figuras (desenhos, ilustrações e gráficos), que deverão permitir redução sem perda de definição, para os tamanhos de uma ou duas colunas (7 cm e 15cm, respectivamente), pois, não é permitido o formato paisagem. Figuras digitalizadas deverão ter extensão JPEG e TIFF e resolução mínima de 500 Dpi.

As palavras **Figura**, **Tabela e Anexo**, que aparecerem no texto, deverão ser escritas com a primeira letra maiúscula e acompanhadas do número (Figuras, Tabelas e Anexos) a que se referirem. Os locais sugeridos para inserção de figuras e tabelas deverão ser indicados no texto. Os títulos deverão ser concisos. Imagens coloridas não serão aceitas.

7) Citações

Não serão aceitas referências secundárias, ou seja, a citação de citação do autor original.

As citações de artigos de autoria múltipla deverão ser feitas da seguinte forma:

- Artigo com dois autores: citar os dois autores sempre que o artigo for referido.

- Artigo com três a cinco autores: citar todos os autores na primeira aparição no texto; da segunda aparição em diante, utilizar sobrenome do primeiro autor seguido de et al. e a data.

- Artigos com seis autores ou mais: citar o sobrenome do primeiro autor seguido de et al. e a data, desde a primeira aparição no texto.

No caso de **citação literal**, com até 40 palavras, devem vir no corpo do texto entre aspas, com indicação do sobrenome do autor, a data e a página.

As citações com mais de 40 palavras devem vir em um novo parágrafo, com espaçamento simples, fonte tamanho 11 e com recuo de 4cm da margem esquerda.

Obras antigas e reeditadas

Em caso de citações antigas, com novas edições da obra, a citação deverá incluir as duas datas, a original e a data da edição lida pelo autor. Por exemplo: Freud (1912/1969, p.154). Caso haja outras citações ou referências de outros textos da mesma publicação consultada, diferencie com letras minúsculas. Por exemplo, Freud (1939/1969a) e assim sucessivamente.

8) Referências

Trabalhos com um único autor deverão vir antes dos trabalhos de autoria múltipla, quando o sobrenome é o mesmo. Em caso de trabalhos em que o primeiro autor seja o mesmo, mas os coautores sejam diferentes, deverá ser assumida como critério a ordem alfabética dos sobrenomes dos coautores. Trabalhos com os mesmos autores deverão ser ordenados por data, vindo em primeiro lugar o mais antigo. Trabalhos com a mesma autoria e a mesma data. Deverão ser diferenciados em "a" e "b". Artigo no prelo deverá ser evitado.

A formatação das referências deverá facilitar a tarefa de revisão e de editoração; para tal, entrelinhas de 1,5 e tamanho de fonte 12. Sugere-se a inclusão de referências de artigos já publicados na revista Estudos de Psicologia como forma de aumentar o seu fator de impacto.

A exatidão e a adequação das referências a trabalhos que tenham sido consultados e mencionados no texto do artigo são de responsabilidade do autor, do mesmo modo que o conteúdo dos trabalhos é de sua exclusiva responsabilidade. Todos os autores, cujos trabalhos forem citados no texto, deverão ser seguidos da data de publicação e listados na seção de Referências. As citações e referências deverão ser feitas de acordo com as normas da APA (2010).

Exemplos

Artigo de revista científica

Garcia del Castillo, J. A., Dias, P. C., & Castelar-Perim, P. (2012). Autorregulação e consumo de substâncias na adolescência. *Psicologia*: *Reflexão e Crítica*, *25*(2), 238-247.

Livros

Fernandes, J. M. G. A., & Gutierres Filho, P. J. B. (2012). *Psicomotricidade*: *abordagens emergentes*. Barueri: Manole.

Capítulos de livros

Böhm, G., & Tanner, C. (2012). Environmental risk perception. In L. Steg, A. E. van den Berg & J. I. M. Groot (Eds.), *Environmental psychology*: *An introduction* (pp.16-25). Oxford: BPS Blackwell.

Obra antiga e reeditada em data muito posterior

Sartre, J-P. (2012). *The imagination*. New York: Routledge. (Original work published 1936).

Teses ou dissertações não-publicadas

Vasconcellos, T. B. (2012). *Um diálogo sobre a noção de autenticidade* (Dissertação de mestrado não-publicada). Programa de Pós-Graduação em Psicologia, Universidade de São Paulo.

Autoria institucional

World Health Organization. (2012*). Safe abortion*: *Technical and policy guidance for health systems evidence summaries and grade tables*. Washington: The Author.

Trabalho apresentado em congressos publicado em anais

Malabris, L. E. (2006). A terapia cognitivo-comportamental frente ao stress ocupacional e a síndrome de Burnout. *Anais do VI Congresso Latinoamericano de Psicoterapias Cognitivas* (Vol 1). Buenos Aires.

Material eletrônico

Artigos de periódicos

Romanini, M., & Roso, A. (2012). Psicanálise, instituição e laço social: o grupo como dispositivo. *Psicologia USP, 23*(2), 343-365. Recuperado em outubro 8, 2012, disponível em <http://www.scielo.br>. doi: 10.1590/S0103-65642012005000002.

Teses ou dissertações

Bruckman, A. (1997). *MOOSE crossing*: *Construction, community, and learning in a networked virtual world for kids* (Doctoral dissertation). Massachusetts Institute of Technology. Retrieved December 13, 2012, from <http://www.static.cc.gatech.edu/ãsb/thesis/>.

Autoria institucional

Instituto Nacional de Câncer. (2012). Estimativa 2012: incidência de câncer no Brasil. Recuperado em outubro 8, 2012, disponível em <http://www.inca.gov.br/estimativa/2012/>.

Trabalho apresentado em congresso publicado em anais

Herculano-Houzel, S., Collins, C. E., Wong P., Kaas, J. H., & Lent, R. (2008). The basic nonuniformity of the cerebral cortex. *Proceedings of the National Academy of Sciences of the United States of America*, Washington, DC. Retrieved December 13, 2012, from <http://www.pnas.org/content/105/34/12593.full.pdf+html>.

9) Anexos

Evite. Só poderão ser introduzidos quando contiverem informação indispensável para a compreensão dos textos.

V - LISTA DE VERIFICAÇÃO

1 - Declarações de responsabilidade e de transferência de direitos autorais assinadas por cada autor.

2 - Página de rosto com a identificação dos autores e suas instituições.

3 - Incluir título do original, em português e inglês.

4 - Incluir agradecimentos com os nomes de agências financiadoras, caso necessário.

5 - Incluir título abreviado, não excedendo cinco (5) palavras, para fins de legenda em todas as páginas impressas.

6 - Página de rosto sem identificação de autores, contendo apenas o título em português e inglês.

7 - Resumo em folha à parte, no máximo 150 palavras, contendo, ao final, com 3-5 palavras-chave.

8 - *Abstract* em folha a parte, máximo 150 palavras , contendo ao final 3-5 *keywords*.

9 - Verificar se o texto, incluindo resumos, tabelas e referências, está reproduzido com letra *Arial*, tamanho 12 e espaço duplo, e com formatação de margens superior e inferior (no mínimo, 2,5cm), esquerda e direita (no mínimo, 3cm).

10 - Verificar se as referências estão normalizadas segundo o estilo da APA - 6a. ed. (2010).

11 - Incluir permissão de editores para reprodução de figuras ou tabelas reproduzidas de outras fontes.

VI - DIREITOS AUTORAIS DA REVISTA *ESTUDOS DE PSICOLOGIA*

 A aceitação do trabalho para a publicação implica na transferência de direitos do autor para a revista, sendo assegurada a mais ampla disseminação da informação.

DECLARAÇÃO DE RESPONSABILIDADE E TRANSFERÊNCIA DE DIREITOS AUTORAIS

Cada autor deve ler e assinar ambos os documentos:

1) Declaração de Responsabilidade e

2) Transferência de Direitos Autorais.

1. Declaração de responsabilidade

- Título do manuscrito:

- Nome por extenso dos autores (na mesma ordem em que aparecem no manuscrito):

- Autor responsável pelas negociações:

Certifico que:

- Participei da concepção do trabalho e torno pública minha responsabilidade pelo seu conteúdo;

- Não omiti quaisquer ligações ou acordos de financiamento entre os autores e companhias que possam ter interesse na publicação deste artigo;

- Trata-se de artigo original e o trabalho, em parte ou na íntegra, ou qualquer outro trabalho com conteúdo substancialmente similar, de minha autoria, não foi enviado para outra revista, e não o será enquanto sua publicação estiver sendo considerada pela revista Estudos de Psicologia, quer seja no formato impresso ou no eletrônico.

Assinatura do(s) autores(s) Data_____/_____/_____

2. Transferência de Direitos Autorais

- Título do manuscrito:

- Nome por extenso dos autores (na mesma ordem em que aparecem no manuscrito):

- Autor responsável pelas negociações:

Declaro que, em caso de aceitação do artigo, a revista *Estudos de Psicologia* passa a ter os direitos autorais a ele referentes, que se tornarão propriedade exclusiva da revista, sendo vedada qualquer reprodução, total ou parcial, em qualquer outra parte ou meio de divulgação, impressa ou eletrônica, sem que a prévia e necessária autorização seja solicitada e, se obtida, farei constar o competente agradecimento à Revista.

Assinatura do(s) autores(s) Data_____/_____/_____

Toda correspondência deve ser enviada à revista de *Estudos de Psicologia* no endereço:

Núcleo de Editoração SBI - *Campus* II

Av. John Boyd Dunlop, s/n. - Prédio de Odontologia - Jd. Ipaussurama - 13060-904 - Campinas, SP, Brasil.

Fone/Fax:+55-19-3343-6875

E-mail: sbi.estudosdepsicologiapuc@puc-campinas.edu.br

URL: http://www.scielo.br/estpsi

Guide for Authors

Psychological Studies is a scientific quarterly journal (ISSN 0103-166X), entailed with the graduate course in Psychology, in the department of Life Sciences of the Pontificial Catholic University of Campinas (*Pontifícia Universidade Católica de Campinas)*. Home page: htttp://www.scielo.br/estpsi). The journal was founded in 1983 and currently is ranked as A2 from the Qualis/Capes list (http://www.capes.gov.br/avalicao/qualis). The journal is indexed in national and international data bases: SciELO, Lilacs, PsycINFO, Latindex, Clase, Index Psi.

I - TYPES OF PAPERS ACCEPTED BY THE JOURNAL *PSYCHOLOGICAL STUDIES*

Psychological Studies stimulates the contributions of national and international scientific community, and it's distributed in Brazil and in several other countries. All articles must be submitted online through the home page: <http://scielo.br/estpsi>.

The journal accepts originals research in any area of Psychology, aiming to promote, and disseminate scientific knowledge as well as to discuss the significance of practices in the professional and research fields in Psychology. Before submitting the manuscript for evaluation to the *ad hoc* consultants it is submitted for pre-analysis by the academic editorial board. The following research categories are accepted for publications:

- **Empirical Studies**: Original papers articles based on empirical data. The articles must present the following sections: introduction, method, results e discussion.

- **Theoretical Articles**: Critical review of the literature on topics relevant topics to Psychology, questioning current concepts and developing hypotheses for future research.

- **Literature Reviews**: Synthesis of quantitative or qualitative studies answering a specific and relevant question in the psychology field. Description of the process for searching the original studies, the criteria used to select those that were included in the review as well as the procedure to synthesize the obtained results.

- **Case Studies**: Reports of studies with individuals, groups or organizations, indicating a problem and a way to resolve it based on literature.

- **Book Reviews**: Presentation and critical analysis of a book reladted to psychology area, one year ago, at the most.

All articles must present a maximum of 25 pages including charts, images and references. The counting will start by the cover page, it must be numbered page one. The manuscript that meets the above categories will be submitted for pre-analysis to the Editorial Board.

II - REPORT OF THE ETHICS COMITTEE OPINION

Results of the studies with human beings must be accompanied by a copy of the Research Ethics Committee's approval. In addition, it should be stated in the last paragraph of the method section the protocol number and the approval date from Ethics Committee.

III - CONSIDERATION BY THE EDITORIAL BOARD

Original manuscripts will be accepted for evaluation if they have not been previously published. They should be submitted together with a covering letter which should be signed by the authors, requesting publication in the Journal.

The editorial process will only begin if the submitted manuscript follows the Journal requirements. Otherwise, it will be returned for adjustment to the Journal standards, or to include a letter or other documents, even before being submitted to the pre-analysis of the Editorial Committee Board and for the later merit evaluation by *ad hoc* reviewers.

After the pre-analysis stage, the following may occur:

(1) The manuscript will be forward to the *ad hoc* consultants.

(2) The manuscript may be returned to the authors, requesting modifications.

(3) The manuscript may be rejected due to: (i) contents, considering the Journal main themes; (ii) originality, relevancy to the theme and quality of the scientific method used.

4) The manuscript will be send for peer reviewed by *ad hoc* if the manuscript meets the above criteria.

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The peer review process used is the blind review, where the identity of the authors and the reviewers is not mutually known. With this in mind, the authors should not identify themselves in the manuscript. The original manuscripts, without author's identification, will be sent to at least two *ad hoc* reviewers. Two favorable reports are needed for final acceptance for publication. If there is any disagreement, the original will be sent to a third reviewer for analysis. If the reviewers identify any interest conflict, the Editorial Board will send the manuscript to another *ad hoc* reviewer.

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Books

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Book Chapters

Böhm, G., & Tanner, C. (2012). Environmental risk perception. In L. Steg, A. E. van den Berg & J. I. M. Groot (Eds.), *Environmental psychology*: *An introduction* (pp.16-25). Oxford: BPS Blackwell.

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Sartre, J-P. (2012). *The imagination*. New York: Routledge. (Original work published 1936).

Doctoral Dissertations and Master's Thesis

For an unpublished doctoral dissertations

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Malabris, L. E. (2006). A terapia cognitivo-comportamental frente ao stress ocupacional e a síndrome de Burnout. *Anais do VI Congresso Latinoamericano de Psicoterapias Cognitivas* (Vol 1). Buenos Aires.

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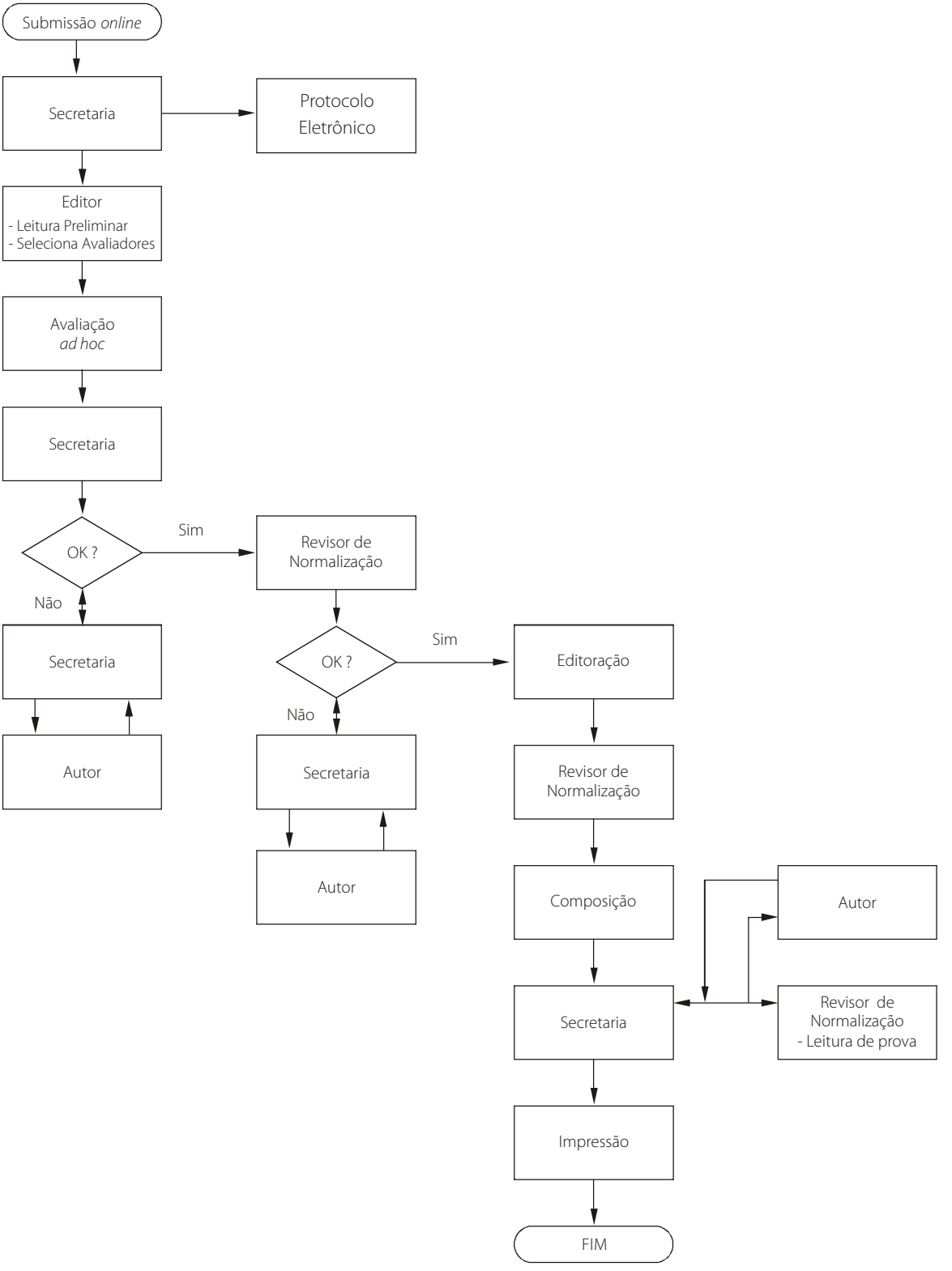

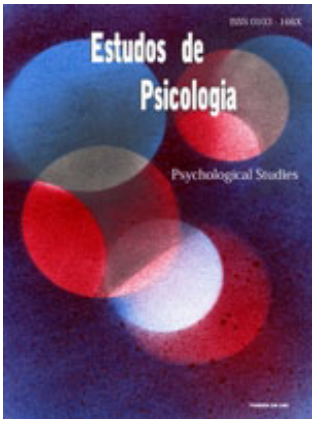

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