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Psychologist's performance (im)possibilities in primary care: demands and attributions based on family health doctors and nurses perception

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Abstract: This study aimed to analyze Family Health (FH) doctors' and nurses' perceptions about what they consider psychologist demands and attributions in Primary Health Care (PHC) and how they request their work. Sixteen professionals from three *Unidades Básicas de Saúde* (UBS) selected from a city in Curitiba's metropolitan region not supported by the *Núcleo Ampliado de Saúde da Família e Atenção Básica* (NASF-AB) but with the support of a psychology professional participated. This scenario was chosen to investigate the insertion of the psychologist in other rearrangements in public health. This is a qualitative study with a semi-structured interview as the data collection instrument, and three categories were created through content analysis. The results pointed out difficulties in the psychological demand analysis, possibilities and obstacles in the psychologist's assignment, referrals without team communication, and a lack of knowledge in psychological practice.

Keywords: Psychological Practice; Family Health Strategy; Multidisciplinary Team.

(Im)possibilidades da atuação do psicólogo na atenção primária: demandas e atribuições na percepção de médicos e enfermeiros de saúde da família

Resumo: O presente estudo teve como objetivo analisar a percepção de médicos e enfermeiros de Saúde da Família (SF), sobre o que consideram demandas e atribuições do psicólogo na Atenção Primária à Saúde (APS) e como solicitam seu trabalho. Participaram 16 profissionais de três Unidades Básicas de Saúde (UBS) selecionadas de um município da região metropolitana de Curitiba não apoiadas por Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF-AB) mas que contavam com o apoio de um profissional da psicologia. Optou-se por este cenário para investigar a inserção do psicólogo em outros rearranjos na saúde pública. Trata-se de uma pesquisa qualitativa, tendo como instrumento de coleta de dados a entrevista semiestruturada, sendo criadas três categorias por meio da análise de conteúdo. Os resultados apontaram dificuldades na análise da demanda psicológica, possibilidades e entraves na atribuição do psicólogo, encaminhamentos sem comunicação em equipe e desconhecimentos sobre a prática psicológica.

Palavras-chave: Prática Psicológica; Estratégia Saúde da Família; Equipe Multiprofissional

Introduction

According to Decree No. 4,279 of December 30, 2010, the Brazilian Health Care System (SUS) is currently organized into Health Care Networks (HCN). These are organizational arrangements of health actions and services with different technical densities: Primary Health Care (PHC), Secondary Health Care (SHA) and Tertiary Health Care (THA), that are integrated through technical, logistical, and management support systems, aimed at systemic integration between the points of attention, through

horizontal relationships, in order to attempt continuous, comprehensive, quality, responsible and humanized care, improving access, equity and clinical, health and economic effectiveness (Ministério da Saúde [MS], 2010).

The PHC is perceived as the main gateway and communication center of the RAS, the coordinator of care and the organizer of actions and services available in the network (MS, 2017). The RAS sees the PHC as the first level of care, emphasizing its primary care function in solving the most common health problems, as well as its responsibility for continuous and comprehensive care, with multidisciplinary attention, shared objectives, and health and economic commitments (MS, 2010). It has staff that aim to expand the scope, and quality and decisiveness of primary care.

In 2008, the *Núcleo Ampliado de Saúde da Família e Atenção Básica* (NASF-AB) was created. It is made up of multidisciplinary teams from different professions or specialties whose aim is to provide technical-pedagogical, health, and clinical support to the reference teams. They are not characterized as gateway or independent services in the physical space, but are integrated into the health services network, seeking for users' physical and mental well-being, based on the needs identified in collaboration with the reference teams (MS, 2008).

According to Nascimento and Alves (2019), due to SUS principles and guidelines, especially that of integrality, new doors were opened, enabling to insert new professionals in public health. That, along with *Estratégia de Saúde da Família* (ESF) and NASF-AB expansion, added to the principles of the Psychiatric Reform, of mental institutions extinction and the establishment of a substitutive services network, psychology began to integrate the teams sharing their goals, assessing the cases of severe and persistent mental disorders, alcohol and other drug abuse, as well as ensuring the quality of care and combating exclusionary and medicalizing practices of individual and social situations common to everyday life (MS, 2008).

According to Jimenez (2011), the ESF proposal and the model that guides the Psychiatric Reform converge to the extent that the object is no longer the disease, expanding the determinants in the illness process, and the means of work migrate from predominantly drug practices to person centeredness as a key agent of treatment, along with the family in the community.

Although psychologists are discussed in NASF-AB, there are still, in Brazil, according to the Federal Council of Psychology (FCP, 2019), many psychologists in PHC working without the ESF format, characterizing by other specific arrangements.

The rules and workflows are different, and other issues may arise in this process, which does not prevent considering the logic of matrix-based strategies as an important parameter to deem psychologists' performance strategies.

According to Mello and Teo (2019), psychology has been reinventing itself regarding its performance to meet the demands of this field. Through an integrative review, these authors found that literature has evidenced both advances and obstacles. Studies point out that psychologists have been updating their practices, inserting themselves in communities; however, limiting situations are reported in which individualizing experiences prevail, naive innovative practices, as well as difficulties in acting in multi- and interdisciplinary teams.

Rocha, Almeida, and Ferreira (2016) show actions developed by the psychologist in the FHS that range from territorial recognition, group actions with the enrolled population, individual therapeutic actions, technical, care, and pedagogical support to the health team, team planning of actions to be performed and preceptorship and consulting functions. And, according to the authors, although the psychologist is not established in the FHS in some realities, this professional can perform actions that are consistent with the principles of PHC, such as first contact, longitudinally, comprehensiveness, health network arrangement, centrality in the family, and community orientation.

There are numerous possibilities of action; however, from professional experience in the field, individual assistance demands and the importance that management and health secretariats give to these demands make it difficult to perform other types of work, directing the team to individual assistance activities, including the psychologist and other ESF professionals (CFP, 2019). Faced with all the possibilities and considering what is expected from the psychology professional, it is understood that the outpatient clinic in primary care represents a classic practice that is not consistent with SUS principles and AB guidelines.

Dimenstein (2006), cited by Jimenez (2011), points out that when searching a work for integrality in an interdisciplinary way, one cannot decontextualize and especially isolate psychology when facing problems of performance. Obstacles such as the fragmentation of work processes and relationships between the different formations and professions, as well as the assistance network, the predominance of the model of care focused on the complaint-drug relationship, and the poor training of the various

professional categories, which is very distant from the debate and health policy formulation, are some of the problems in Brazilian public health in several areas.

In view of this, this research, driven by questions and experiences in the field provided by a Multidisciplinary Residency program in family health, questions the possibilities of psychology work in this field, especially with multidisciplinary teams. Thus, this study presents the results of research that aimed, as a general objective, to analyze Family Health doctors and nurses perceptions about the demands and attributions of the psychologist and how they request their work in the UBS.

The inclusion of nurses and doctors regarding survey data collection was justified by the responsibility and management that these professionals have over their teams and users, besides the daily demands of reception that involve mental health issues that require a qualified listening according to their specialty, but often entail the psychologist's contribution. Understanding how this request happens is relevant due to work analysis among teams and psychology, as well as the concepts in practice. Furthermore, the literature review is scarce regarding the psychologist's work in units without NASF-AB, because it is another rearrangement (CFP, 2019) in which their work may depend both on the professional profile and the specificities of each UBS and region, and can be built according to the professional, the team, or the local reality and demand for the service.

Method

This is qualitative research that employs the semi-structured interview as a data collection tool. According to Minayo (2008), semi-structured interviews differ only in degree from open interviews in that they have a script that the researcher can follow, allowing for greater flexibility in the study progress and the formulation of new questions for the interviewee that arise during the dialogue.

For the research focus a survey of the UBS in a city of Curitiba metropolitan region was carried out, delimiting it with Primary Care Teams (PCT), with Family Health Team (FHT) and mixed (both teams). Starting there, it was included as field for data collection the size IV UBS, with Family Health Strategy and combined UBS, not supported by NASF, but with in-person psychology support for two days or more in the health unit. The total were three UBS with 10 health teams. From these teams, it were comprised doctors and nurses who had worked for four months or more in a UBS with a

psychologist and who agreed to participate by signing the Informed Consent Form (TCLE) and excluded professionals on leave and away from work during the data collection period, as well as resident doctors and nurses.

The interview analysis took place after listening and literal transcription, which was made in Microsoft Word and later it was runed the encoding process in Microsoft Excel tables. As analysis methodology, the content analysis inspired by Bardin (2010) was applied. Initially, a pre-analysis was performed, the material was organized to make it operational through: (a) floating reading, (b) choosing documents to be analyzed, (c) hypotheses and objectives formulation, (d) indexes references, and (e) indicators elaboration.

In the second stage of the material exploration, for categories definition (encoding process), it was identified registration units (unit / fragment-base that stands out more) and their unit context (the fragment removed environment). In the third stage, the treatment of the results was carried out at the same time the encoding was performed. That consists of a process to transform raw data into codes for representing/expressing the content, classifying the elements by differentiation and regrouping according to their analogy. The steps culminated into three thematic categories that represent the major highlights of the results, which are discussed in a reflexive and critical analysis of the material that were articulated with their context and the literature reviews about the studied theme.

To ensure anonymity and confidentiality, the participants were identified by codes according to their professional category, such as: (N1) - Nurse 1, (D1) – Doctor 1, and so on. The speeches were also corrected according to the formal English language, but without losing their original meaning. This research was approved by the Research Ethics Committee of São José dos Pinhais (SJP) Municipal Health Secretariat - CEP-SEMS/SJP, linked to the Public Health School of SJP, with the report No. 4,114,566. All ethical care was taken, according to the resolution No. 466/2012 of the Ministry of Health (MH) and the National Health Council (NHC), that established the guidelines and regulatory standards for research involving human beings.

Results and Discussion

The research was accepted by 16 participants: 9 nurses (6 women and 3 men) and 7 doctor (4 men and 3 women).

After transcription, the content analysis steps proposed by Bardin (2010) were followed, culminating in three categories, which will be detailed below: 1) From complementing drug treatment to working with pregnant women and groups: Psychologist demands and attributions in PHC; 2) Between the ease of referral to the difficulty of psychology queues: communication and teamwork potentiality; 3) "How does the psychologist conduct a psychological consultation?": (un)knowledge about psychological practice by professionals and users.

From complementing drug treatment to working with pregnant women and groups: psychologist demands and attributions in PHC

Approximations and divergences were observed in the participants answers as to the types of demands that the interviewees identified as being related to the psychology work routine. In the nurses group, it was observed unanimity of demands related to pregnant women, from issues regarding pregnancy acceptance and planning to anxiety and depression complaints experienced in this period of life.

The hypothesis is that the question asked to fill in the pregnant woman's card: "Was the pregnancy planned?" promotes the appearance of mental health issues, which can be addressed according to each professional nucleus, by welcoming, evaluating, and exploring the singularity of each pregnant woman.

Other demands pointed out by the nurses refer to issues in the several life cycles: Children with emotional complaints, schools and suspected sexual violence situations; adults with "mental disorder/psychiatric patient", in use of psychotropic drugs, suicidal ideation, abuse of alcohol and other drugs, violence against women, puerperal women, "difficulties in dealing with life situations", childcare, and the elderly related to family abandonment.

When investigated what they do to manage the existing demands, both related to pregnant women and others, it is possible to notice the presence of a welcome, of an attempt to listen and of resoluteness in the speeches of the interviewees.

> *We see where it fits, to what extent the person can handle it, but as a human being, we talk, we try (N9). Filter to see if it is really with the psychologist that we can resolve it or if another professional comes in with medication, something (N1). We identify whether it is for the internal*

> *psychology, or if he is dependent, we forward him to CAPSad (N6). We try! We do everything, run to everything, social worker, make the proper referrals (N3).*

However, it seems that most of them have an evaluation to refer the patient immediately, considering the demand specificity and the risk as a resolutive conduct, without betting on actions in the territory itself and with the reference team, as well as the potential and possibility of carrying out the welcoming and qualified listening in mental health made by professionals from/in the territory.

Barros (2008) contributes to think about the welcome in mental health, based on the "hospitality" concept. According to that author, offering hospitality is the offer of a place for the person to deposit the suffering he/she carries within himself/herself, and for this, it is necessary to be vacant, in an ethical and implicit position of offering empty of knowledge, in a listening position, without judgment, impositions, and charges. Many health professionals charge themselves for not knowing how to welcome mental health demands, so that the statement of an interviewed nurse: "We try", corroborates Barros' (2008, p. 60) definition that "there is no form for hospitality, what exists is the desire for hospitality".

Being willing to welcome, to listen, and to try, goes along with a great mental health device that is the bond. According to Campos (2013, p. 68), this therapeutic resource "is something that ties or connects people, indicates interdependence, relationships with two-way lines, commitment of professionals to patients and vice-versa", and this closeness and commitment provided by the bond combined with longitudinally in the territory is what makes the family health strategy so powerful in mental health care.

> *Here is the nurse's room, but we joke, here we listen to secrets (...) and, for example, ah, is it painful to have sexual intercourse? Ah, I have, ah my husband does this, he gets me anyway (...) It is not only a collection of preventive tests, it is all about listening, and you can't keep quiet (...) I think that everything will need a psychologist (N9).*

The excerpt above illustrates how mental health and daily life issues appear to health professionals, not necessarily to a psychologist, because they depend on the established bond - a factor of great potentiality of care.

As Ferrer (2012) points out, when a space is opened for dialogue with the user, a door is also opened for the 'life out there' to enter in the unit dynamics, the complaints, their problems and needs. However, it is not always easy to listen, although it is easier to work with a 'clinical complaint', one part of the body that hurts, or an illness that needs medicine, than to deal with the contents linked to emotion and subjectivity. It is possible that this is related to the training of health professionals, anchored in the curative paradigm, with little space in training to address contents related to subjective aspect.

The curative care, prevalent in the biomedical model, for the management of cases was also identified in the interviewed doctor reports. For them, the demands identified as "from psychology" were related to psychiatric disorders signs and symptoms, as it can be seen in the reports below:

> *For sure, anxiety and depression. Most of the psychiatric care here, I think 90% is that. Every patient accompanied by psychiatry; I ask for a psychology evaluation together (D4). Because many times it is an anxiety disorder, that only with psychotherapy can be solved (D6).*

Less frequently mentioned were mourning, demands from children's school, complaints from teenagers, emotional issues, family problems, violence, unemployment, suicidal ideation, and a "third type of patient that generates a chronic situation, has already been to a psychiatrist, has been discharged, and sometimes relapses" (D3).

The majority of the psychology demands seem to be defined by the patients complaints focused on the psychiatric diagnosis (signs and symptoms) and the use of psychotropic drugs, in a biomedical trend of traditional model, centered on the grievance -conduct (symptoms/diagnosis-medication/referral), putting in abeyance the singularity approach and the patient assist family and community context. Thus, demonstrating a reduction of the mental health practice once the person and his/her particular suffering are excluded from the case evaluation and follow-up scene.

About this view, Onocko-Campos (2001, p. 102) proposes a change in the clinic paradigm when facing subjectivity issues. The author states that there is the possibility of moving from a "degraded clinic" - which focuses on the grievance-conduct, does not evaluate risks, treats symptoms and is considered efficient due to the high quantity of

consultations and procedures it produces - to an "expanded clinic", that is, a clinic of an individual that is understood as biological, social, subjective and historical.

Conceptually bringing these models of clinic contributes to the reflection on traditional, fragmented practices and assesses possible advances. One of the examples is the risk criteria, as reported by one of the psychologists interviewed: "We attend here, if it is a severe case, we have the criteria, we have the score, to characterize that if it is serious, we can ask for the help of psychology together" (D4). The attempt to fit the patient into a "score" follows a degraded clinic assumptions in which the singularity seems to be cut into a score and the relationship, the bond, and the subject desire are not questioned.

More than having an instrument to validate the risk and associate it to a procedure - to refer to a psychiatrist or psychologist - it is necessary to consider the relationship, analyzing what the patient presents, the symptoms severity at that moment and for that person, exploring his/her support network and how he/she faces the referral to psychology and psychiatry. Historically, in biomedical logic, as Costa Val, Modena, Campos and Gama (2017) indicate, the symptom represents a sign of the presence or the possibility of a detectable disease in the body that can be technically controlled.

When this does not happen, many professionals feel embarrassed, others feel powerless, outraged and angry. However, as Costa Val e cols (2017) rightly point out, symptoms do not always correspond to an organic dysfunction. In the particular case of subjectivity, the symptoms warn a functioning or a defense of something that the individual is trying to communicate and that is part of him/her, and it is necessary to carefully evaluate the consequences of its removal.

The symptom perception and the attention supply expansion imposes limits to degraded clinical practice, especially that which is strictly biological. Still, it is important to be careful and avoid the mere pathologizing of affective states, "psychologizing" all forms of suffering and leading, consequently, to purely medicalizing practices, as one of the interviewees exemplifies: "I don't know how the psychologist approaches (...) I can't work on the symptoms, I can only medicate the symptoms, so it's a complement to the drug treatment, right? Because we end up not knowing how to approach it" (D7).

"Complementation", which seems to be grounded on the mind/body split, so that the treatment complementarity comes in the sense that the psychologist or the "mental health" team must address the emotional and psychological complaints and the

singularity of each case in its social context, which escape from diagnosis and from its predicted symptoms. In contrast, there is a recognition of the multi-professional actions during the conduction of the cases.

The way in which psychology work is demanded appeared either implicitly or explicitly in the interviews by means of individual care and psychotherapy. Less frequently, it appeared as other attributions such as home visits, screening, psychological evaluation, psychological support to patients, case discussions, and group work that were later addressed.

Archanjo and Schraiber (2012) and Oliveira et al. (2004) affirm that the traditional clinic (individual psychotherapy and psychodiagnosis) is still the main reference for the psychologist's work in PHC. When restricting the work to psychotherapeutic care, there is a risk of compliance failure with SUS, cases chronification and to impose a single model of action against users' uniqueness. In this same sense, Alexandre and Romagnoli (2017) assert that the practice of individual clinic is only one of the dimensions of the psychologist's practice in PHC. Psychotherapy was not extinguished from the institutional health space, it was only diluted among the other actions and remains the main instrument of psychologist's work, however, it cannot be considered as the only one.

Thus, it is necessary to reflect to whom the model of individual and weekly clinic applies, considering that the multiple modalities of care also serve to build different approaches to specific needs (CFP, 2019) and contribute, as Onocko-Campos (2001) points out, for health planning, when a certain "range of clinical models" is available. This serves for psychology as well as the other professions.

The professionals interviewed considered psychotherapy and individual care as the main psychologists' work in the UBS interviewed. However, they verbalized limitations to this work when it is the only one, due to the restricted agenda, to the great demand and to the lack of professionals:

> *We need to schedule as soon as possible. When you look at the agenda, it is full (N1), there are few professionals and few times that she or he comes (D7), and there are a lot of demands (D6). And, as these will concentrate on a single professional (...) to perform the screening, to do the individual attention, and to maintain the therapy of the ones that need this constant therapy (N6), it could have a reference center just for this, with more professionals. It*

> *can be left here for one part of the group; make the first evaluation and see who will need to and who will need a referral for more time (N4).*

Difficulties that come up against patient attention and limitations of what psychology can perform in PHC, as reported in the need for screening and evaluation as to the cases complexity and the need for a psychology outpatient clinic for referral of cases that may require a longer time of care, something that is unfeasible to be maintained in PHU due to the difficulties pointed out by the interviewees. Other limitations emerged regarding the group actions proposed by psychologists:

> *I do not agree with this group screening. Patient doesn't adhere (...) in many cases that we refer and they don't go, it doesn't get solved! (N6). Now she attends 95% - 100% of the group (...) I think that this alone does not work! I think it should be a group and more clinical also (...) Only group, I think it fails a lot (N5) this ends up keeping the patient away (D3). What is best for the patient (D4).*

According to Melo, Miranda, Silva, and Limeira (2018), these dichotomies between individual activities (consultations) and collective actions (group and educational), or even clinical-supportive-technical-pedagogical activities are present in the ESF work and possibly arise from the notion of matrix support translating difficulty when it comes to NASF-AB and the fear of operating as a traditional specialties outpatient clinic. Conversely, there is an attempt to homogenize the different categories, losing the specificity of each one.

The issue of one or another action extreme and the importance of having a range of possibilities is criticized, as well as the professionals' sensitivity to perceive what the patient demands beyond what is verbalized, which is found in the symbolic field, so, what is not said, but expressed through symbols and representations (Schutel, Rodrigues, & Peres, 2015). Considering this field in the assessment of the territory is essential for the formulation and planning of its practices, exposing the limits that the team and the service can offer, providing clarity for both management/professionals and users. In view of this, the centrality in the singular rebalances the influences of institutional structures and their tendency to produce cycles of repetition, namely always performing the same activities and framing the subjects in this configuration.

The results presented an interlocution to the extent that the professionals demanded specific attributions of psychology, mainly individual and less frequently in groups. The group work was associated with actions that go in a multi-disciplinary logic, which is the demand of psychology participation in groups expected for an ESF such as: pregnant women group (maternity, breastfeeding), childcare (child development), at school (children and adolescents), family planning, hyperdia, obesity, drug addiction, elderly group and smoking. As reinforced in the results of Souza, Santos, and Romão (2020), there is an expectation of acting with therapeutic actions in groups aimed at softening diseases (such as hypertension, diabetes, obesity, and smoking).

> *Since it is in the basic, it has to blend into the basic things, understand? I work the groups that have in the basic, because otherwise it will be a psychologist attending things of high and medium complexity, and what is basic he is not seeing (...) not to be a psychologist's office in the basic unit (D4).*

These data are opposites to the results raised by Anchanjo and Schraiber (2012). These authors state that team activities, home visits, community activities, matrix support, team meetings and educational groups are not within the scope of psychology. Although, the understanding showed by the large majority of professionals interviewed is considered an important advance for psychology actions beyond strictly mental health, as strengthened by Nascimento and Alves (2019). They enhance that the psychologist's practice in PHC goes in the direction of breaking old paradigms focused on the traditional clinic, assuming collective, creative, dynamic, innovative and ethical action, in other words, focused on prevention and promotion in mental health, working in an interdisciplinary and intersectoral way.

Even with this promotion and prevention work expectation and the groups by psychology construction, this form of work is incipient in the ESF. Not all PHUs have these groups and the professionals themselves report the difficulties that prevent this practice from being carried out by them as well:

> *We should be doing groups... if we worked with the ESF in its entirety, we would absorb a lot more of these patients. But we don't have the proper structure, the proper room to hold a group meeting (...) we do a pseudo-family health strategy, but it is not ESF (N7). There is a repressed*

> *demand. It is not only in psychology (...) There is a lack of agenda, lack of professionals (...) there is the issue of physical space (...) there is no office for everyone (N3).*
> *(The psychologist) cannot give support to the teams in the prevention part because, really, all his time is absorbed by both spontaneous and repressed demand (N7).*

These difficulties, therefore, are related to the institutional, political, and training context, the physical and financial structures, the human resources, and the work processes among teams. Almeida and Silva (2019) note the troubles due to the lack of infrastructure for psychologists to work, both for individual consultations that allow the guarantee of privacy and ample spaces for group consultations.

Between the easiness of referral and the difficulty of psychology queues: The communication and teamwork potentiality

The second category concerns the form of referral to the psychologist since it impacts on the organization of the service and exposes the work processes in the territory.

Investigating the ways in which referrals to psychology are made in UBS, according to the interviewees, three ways that ended up representing possibilities of local organization were found. The first is done electronically, through a software (computerized system that is used in municipality network services). The second happens when printing the referral form, the patient himself delivers at the unit reception desk for immediate scheduling and/or insertion in a waiting list. The third one is when patients are directed by UBS reception desk to a psychology welcoming group. Thus, the contact of the professional interviewed with the health unit psychologist occurs only in urgency cases and when prioritization is needed, showing a very restricted communication:

> *The direct conversation with psychologist occurs mostly when prioritization is needed (...) in urgent cases and attempt to fit (N2) is very informal (...) corridor conversation (N6) look I'm referring this patient to you, have you seen? (D1).*

While the discussing work cases and meetings between teams is not present, as illustrated by the words of a nurse - "it is different to discuss a case than me passing on a case" (N3), the prevailing logic is to refer the case with prioritization intention, of "fitting in". In addition, as another excerpt points out: "I can talk directly to her, if I want to. It's just that, many times, the agendas don't match, you can't chase the professional" (N7), it can be inferred that there is a lack of work processes instituted in the teams that prioritize meetings and joint discussions. The interviews show that, in practice, the communication between professionals is based on personality, that is, it depends on psychologist x, nurse z and doctor y seeking to discuss the case, demonstrating how much an individual, isolated and reductionist practice is in place.

Oliveira et al. (2004) pointed out a similar result stating that most professionals do not work together with the UBS team, working independently and at most receiving referrals. The teamwork, therefore, takes up to the realization of some referrals, requests for reports and/or opinions or scattered joint actions, quite different from what is imagined of a multi-disciplinary team.

Oliveira et al. (2004) found the same results, there is an "easiness of referral": "We can refer calmly, there is no restriction" (D4), but the referral is not co-responsible, leading to the psychology waiting lines increase in the UBS. Another relevant aspect says how much the assistance to the patient may become unviable due to the growing demand, "the demand is only increasing and psychologists are decreasing" (N4), and to the restriction of specialized care linked only to the "mental health team" and the lack of referrals qualification.

The importance of the criteria and the form of referral have impacts on the referring professional, but on the user, who may not be assisted or have an assistance that tawdry in the qualified listening, in the bond strengthening and in the improvement of FH team practice and management of mental health.

As presented in the previous category, for the doctors interviewed, the referral criteria and the demands for psychology have similar aspects, essentially focused on psychiatric complaints/demands. As for the nurses, most of them identified,, as a criterion the presence of a risk when it comes to priority groups (pregnant women, children and the elderly). Despite this, it can be seen that the criteria are not so clear, and many professionals interviewed had difficulties to explain them:

> *You even asked me, what are the criteria we use to make referrals to the psychologist... I myself, sometimes I get a little lost, so if you make some guidelines, a flow, to help us (D6) we as doctors are very confused about what it is, and up to where the psychologist goes. So suddenly, having a material, meeting (...) I honestly don't know the border, I don't know if there is a border, a demarcated thing (D4).*

Therefore, as improving possibilities for this work process, the interviewees highlighted the importance of discussing cases, exchanging information, having close contact among professionals, matrix support and an increase in the number of professionals, including psychologists with a greater workload in the UBS.

> *We should work more on team meetings (...) psychology could give this support (N6). It should have time for case discussion (D1). We could have a notion of what to do, how to do, how to proceed (N1), a greater exchange of information (D3), have meetings with doctors, explain, no! When it is a patient like that, when it is not, there is no need (to refer) (D6). It would be nice to talk to the psychologist to see what he thinks, like a matrix support (D5), I think that the integration of the psychologist in NASF at the site would be interesting, much better than a specific one (N5).*

In view of these results, in addition to infrastructure issues and human resources, it is clear that, besides the clinical-assistance support, there is an implicit demand for technical-pedagogical support, which is another NASF-AB team proposals of action, according to Alves, Bruning, and Kohler (2019), together with the health interventions (survey of demands in the territory for intervention projects with users). Although the latter two are rarely mentioned, possibly due to lack of knowledge and because they are UBS not supported by the NASF-AB team, it is possible to infer that the logic (mainly technical-pedagogical) could contribute to bring the different categories closer, since it consists, according to the authors, in empowering the ESF to provide users reception that are at psychosocial risk, promoting a joint discussion space for clinical cases, assessing priorities, and carrying out continuing education.

The question - "is there a border, something signaled, how far can psychology contribute?" (D4) - can be understood as an example to trigger discussions about the subject centrality, and not in his/her diagnosis or in a body-mind split, discussing care comprehensiveness and the demands social/historical crossings that are presented to each professional, stressing towards a notion of expanded clinic.

The expanded clinic, in this sense, refers to the shared construction of diagnoses and therapies as an attention plan, an expanded look at the individual and the territory. However, professional training in PHC is an issue that hinders (Ferrer, 2012), because interprofessional and collaborative practices are little part of the training. The concept of matrix support can question and reinvent ways to overcome producing health model that resembles an assembly line (CFP, 2019).

Another aspect to be highlighted is the overload of mistaken referrals to the psychologist who alone represents the mental health specialty in the UBS, meaning production of endless waiting lines when there is no minimum qualification of referrals from the case discussion, the exchange of information according to the complexity and the development of a unique therapeutic plan. The latter was not mentioned in any interview, showing how locked professionals still are in their specialties, with little integration of knowledge and actions based on the logic of emergency care (Ferrer, 2012).

Based on these training difficulties and on the established work and care logic, it is believed that the mere presence of NASF-BA team in the territory would not be able to easily bring all the necessary changes, since these impasses stem from an already established work logic added to the existing difficulties in the ESF: "we cannot structure what is expected from primary care, we end up putting out the fire" (N6). However, considering that, in the UBS studied, even if not supported by NASF-AB, there was the presence of other professional categories beyond the slightest expected team, the practice of matrix support and the expanded clinic emerge as possible and powerful strategies for teamwork care and strengthening expansion.

In relation to the difficulties reported regarding the increasing demands, summarized by a nurse interviewee: "there is no agenda for everyone" (N3), the need to establish priorities according to the vulnerabilities and complexities of each case is understood. In this regard, Campos (2013, p. 72) states that "between what we imagine as ideal - not always the most appropriate - and nothing there is an infinity of possibilities for practical intervention".

And this concerns assessing the risks in a clinical way, intervening with the necessary resources of each service, such as: individual and group care, inter-consultation, home visit, co-responsible referral, guidance, team discussion, preparation of Family Therapeutic Project (FTP). Giving special attention to those who need it most, evaluating intervention intensity and frequency with the Community Health Agent (CHA) of the area, prioritizing risk groups with HM (ESF), trying to perform intervention as soon as possible (to avoid "waiting lines" or aggravation or chronification) and, if necessary, carefully referring to other levels of complexity in the network (Campos, 2013). But this only happens with spaces creation that allow reflection on the service provided improvement, breaking the isolation and hierarchization in the work field (Dias & Silva, 2016).

The professionals' difficulties in identifying the criteria for referral to the psychologist reflect isolated and reductionist practices, as well as the lack of ongoing training, because what may be explicit for a professional category, in this case the psychology, is not for others. Especially when there is no knowledge exchange of each profession core, the actions of the field - where we can situate the referral coupled with the lack of team meetings and/or communication between professionals - end up being impaired, leading to the discussion of the third category presented below.

"How does the psychologist conduct a psychological consultation?" (Mis)knowledge about psychological practice by professionals and users

How to expect knowledge about demand, assignment and qualified referrals if the results point to a lack of knowledge about psychological practices?

> *Ah! Psychologists can't dispense medication, but that's not all! Do you do therapy? What kind of therapy? How far does he go? How different is his conversation with the psychiatrist? (...) Does he do the same interview? What does he evaluate? I think that the doctors themselves don't know how to differentiate much (...) Understand what I can, even what I can demand from the psychologist in this follow-up (D4).*

Oliveira et al. (2004) corroborate on the existence of difficulties for the insertion of the psychologist in the multidisciplinary team, precisely due to the ignorance of other

professionals of what their function would be or even the importance of their work. It is necessary to clarify not only for the team, but also for the community.

> They *don't want psychology, they come with that head of medication (D4) Why? If I'm going to talk. I prefer to talk to a friend, or else, talking won't solve anything (D2) Difficulty of the population itself to understand what the psychology service is. That sometimes, I think the patient ends up seeing the nurse, the doctor, more often than the psychologist in the unit (...) you say: I will refer you to psychology, the person thinks he is crazy (...) he does not accept that the problem is psychological (N5) they do not want, they have that prejudice, of psychiatric disease, psychological, they do not want to know they have (D4).*

According to Almeida and Silva (2019), there is still resistance on seeking psychology help due to the fact that many people minimize the emotional and psychological problems. It is of great importance the psychologist's bond with the teams he supports, as well as the users being mediated in this approximation and mental health care importance relationship that a field work can offer.

Cultural issues are crossed by the medicalizing practice and the way mental health was historically "understood". Amarante (2007, p. 19) makes a provocation stating that "until very recently, 'working in mental health' was the same as working in hospices, insane asylums, outpatient clinics and psychiatric crisis emergencies", a kind of work that was often based on the crazy aggressive idea, in prison environments, as of a violent segregation.

This "imprisoned" understanding of mental health reinforces the patient's stigma and has repercussions in the request for individual care and non-adherence to the groups offered (Eichenberg & Bernardi, 2016), as it is related to the region cultural issues, for example: the difficulty in exposing oneself, the requirement for clinical care or the topic does not meet the user's interest (Alves, Bruning & Kohler, 2019), and also crossed by the type of groups offered.

According to Ferrer (2012), group practices have been performed in PHC without much questioning, without reflection and with little or no theoretical basis. Many of the so-called groups, according to the author, are lectures or reports on a specific topic or on a collective consultation, a practice usually used to minimize repressed demand. The latter ends up permeating the interviewees' statements: (group)

"it is a way to see several patients at the same time. Takes some of this waiting list away (D5). I understand that it does this to meet the demand (N6)". The group can contribute to the reduction of waiting lines and to the attendance of a larger number of people, but this cannot be its main objective. The "why" has to be present in the professionals' praxis (Onocko-Campos, 2001).

For Jimenez (2011) the demand is a problem for psychologists to the extent that there are no methods, techniques and prompt answers that will meet all the needs. Linked to this, both professionals and users have their own representations about psychology. In his research, Ferrer (2012) found in the professionals speech that some users say they do not participate in group activities because they do not like to expose their problems, but others say they like it, as they perceive their problems as small compared to others.

Thus, there are several representations, and there is no problem in the type of offer, but in the way it is carried out, in the basis, in the users and in the territory demands reading and in the coordination with other professionals. The group is able to be coordinated by a psychologist, but the "invitation", the "referral", that serves as a "bridge", can be performed by other professionals. So, there is a co-responsibility of the team for the group, contributing to bond power use for any treatment and team communication strengthening.

One solution pointed out by the professionals interviewed, before the lack of knowledge about the psychologist's practice, refers to the request for a guideline: "Some guideline, a flow (...) of what can be referred to the psychologist or not" (D6) "having a material, having a meeting with the doctors, from the psychologist himself explaining how far he can go" (D4), meaning greater communication and approximation between the various professional categories, based on a mental health work in a psychosocial and matrix logic.

This issue has to do with the recent entry of psychology in PHC, where the access is expanded from the constitution of NASF-AB (Alves, Bruning & Kohler, 2019) or in other settings as the one researched. This is so true that all interviewees strengthened the need to hire more psychologists, working more time in UBS as themselves daily lives. Such needs are in line with what Dias and Silva (2016) raise, which is the difficulty of the psychologist that is not included in the core ESF team.

Oliveira et al. (2004) showed that the professionals interviewed are not clear when expressing what is expected from psychology in PHC, a statement enhanced by

Dias and Silva (2016) affirms that among multidisciplinary team professionals, the psychologist is the one whose role is the most "obscure", in which their performance is not clearly defined, often not knowing how it should happen and what its meaning is. Or, as found by Souza, Santos and Romão (2020), nurses and doctors were unaware of the theory, but they know some of the practices – these conditions were also found in this research.

In this study, the professionals interviewed pointed out questions about the psychologist role, generating doubts about demands, attributions, limits and referral criteria. They brought desire for practices beyond psychotherapy and actions that are not found in their daily lives, but they perceive demand for work. One of the factors that contributes to this movement is the psychology inserted in the ESF, since to know the practice is also necessary to be with the professionals: "after we had this service with us, we had this faster, more direct access, (...) all the work progress, how the line has grown... We can give psychology the value it deserves!" (N1).

Final Considerations

With this research it was possible to raise particularities and possibilities for psychology to act in PHC. Regarding users complaints and demands, it was possible to understand that they are still identified following a biomedical logic, in other words, the one that locates signs and symptoms of mental disorders. Despite this, the survey of interviews and the establishment of analysis categories indicated that doctors and nurses, even if intuitively, demand an expansion of the psychologist's work in PHC. Besides psychiatric diagnoses, conditions related to each life cycle were identified as susceptible to psychological suffering.

The psychologist's way of acting generated several questions, from the need for individualized care and psychotherapy to an effective participation in the groups already coordinated by PHC. Other possibilities presented, besides the work with users, were the multi-professional and interdisciplinary teamwork, something that the work reality in PHC demands. The results pointed to the need for a psychologist to collaborate more closely with the teams, discussing cases, exchanging information about conduct and management through team meetings.

The importance of teamwork and of the psychologist's performance was identified both to expand the care support and for continuing the education of a technical-pedagogical nature. The need for permanent education, exchange of

knowledge about each professional category and its limitations, constructions of joint and co-responsible actions facing the reality of users and health context (which can be included the FTP, inter-consultation, promotion and prevention actions), discussion of prevalent themes in daily life, ways to improve communication and internal and network referrals, constituent elements of matrix support and practice of an expanded clinic were evidenced in this study.

However, challenges were also identified, and they come up against psychologist's practice "impossibilities" within SUS context, which influences everyone, as the nurses and doctors who participated in this research verified. They emerged from common problems of lack of physical structure, rooms for different professionals and spaces for groups, insufficient professionals and high turnover, growing demand, lack of time to discuss cases and barriers of access to the professional, low financial investment in collective actions, work processes rigidity; as specific problems "of psychology" namely: waiting lines, crowded agenda, delays in attendance, lack of communication and flow, lack of professionals and users knowledge about psychological practice, questions about individual and group assignment exercised, little workload in the UBS and no guaranteed insertion of the psychologist in the core ESF team.

Despite being didactically separated, it is known that in the daily work difficulties mix together influencing everyone. Whether when they come from a macro reality and an institutional, social, historical, and political context, or when they come from training and work process among the team. As pointed out in this study, the great demand, whether for psychology or for the ESF teams, growing and complex, requires an expanded clinic composed of critical and innovative practices, having the "why" of the actions and the "how" with a range of possibilities that can address in different ways the life issues presented in the health unit, through tools such as welcoming, qualified listening, bond strengthening and each case practice and management improvement.

Even noting the main difficulties found in the reality of PHC and the complexity of applying these concepts in practice, they can be recognized as guidelines to face individual and collective limitations and constructions for PHC and SUS work.

Finally, it is pointed out as limitations of this study the number of professionals interviewed, that, although it reached a representative number of interviews in the health units selected for this research, it is a local context, which is also important to conduct interviews with other professionals in the ESF, as well as psychologists who work in

this context. It is also pointed out the possibility of further research, comparing psychologists working in NASF-AB teams reality and in contexts like the one researched in this study.

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