Revista ARACÊ
ISSN: 2358-2472

BETWEEN MADNESS AND THE *INTERPROFESSIONAL PRAXIS* OF CARE: REFLECTIONS ON INTERDISCIPLINARITY IN MENTAL HEALTH

https://doi.org/10.56238/arev7n4-290

Submitted on: 03/29/2025 **Publication date:** 04/29/2025

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ABSTRACT

This paper aims to develop a theoretical reflection on interdisciplinarity in mental health, in order to reflect on madness and mental health in the panorama of Brazilian psychiatric reform; to analyze interdisciplinarity as a background to mental health actions; and to understand how interprofessionality is structured as an interdisciplinary *praxis* in mental health. To this end, a reflection study was undertaken, based on a literature review - books and articles - that contemplated the categories/themes "mental health", "interdisciplinarity", "Brazilian psychiatric reform" and/or "history of madness". Mental health and interdisciplinarity have their genesis in limited knowledge and/or limiting action. On the one hand, interdisciplinarity as an alternative to fragmentation and specializations; on the other, Mental Health, which is framed on the canvas of the Reform opposed to the traditional, standardized and specialized practices of traditional psychiatry (medical specialty). On the very near horizon, the non-straight lines of the two areas of knowledge/study/action meet, more in an infinite elliptical movement of encounters and reencounters, than of parallels. When considering the creative and multicentric character of interdisciplinarity, it remains to be used as a formative principle, in the alleged proposals of multiprofessional and interprofessional education (to the extent that ethical and professional maturity is constituted) in mental health.

Keywords: Madness. Interdisciplinarity. Mental health. Interprofessional relations.

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INTRODUCTION

As much as science has different levels of objects, cataloged documents, instruments and techniques described, methods and interpretable questions, scientific dignity resides in the analysis and criticism of concepts. In fact, approaching categories from the perspective of casting a purposefully reflective look, in the search for interfaces and points of approximation or even how they are intertwined in order to perceive the practical reflection of such intertwining, brings robustness to academic thinking.

Special attention should be paid to the plot that involves interdisciplinarity and mental health, in the guise of understanding this articulation in the historical, conceptual and practical in-betweens. Therefore, the present paper aims to develop a theoretical reflection on interdisciplinarity in mental health, in order to reflect on madness and mental health in the panorama of Brazilian psychiatric reform; to analyze interdisciplinarity as a background for mental health actions; and to understand how interprofessionality is structured as *an interdisciplinary praxis* in mental health.

Madness has no owner, there is no single knowledge that should feel like the owner of this approach, nor treatment, assistance, care. Madness is free, just like the madman, in sensations and essence - just as madness is, it is interdisciplinarity. *The Alienist*, by Machado de Assis, published in Brazil in 1882, briefly discussed the inauguration of a psychiatric hospital and treated madness as an existential phenomenon to which all people have vulnerabilities (Assis, 1882). After all, those who point to other characteristics and/or judgments of insanity are also subject to these "deviations". The old jargon "doctor and madman, everyone has a little", would be applied to the plot of Machado's work.

The theme, the knowledge and the reflections produced in the work *The Alienist* signal the interdisciplinary relationship of Mental Health (or simply and simplistically, of madness/alienation and degeneration, terms coined by traditional psychiatry and perpetuated by the expanded one) with history, literature, political sociology, health, psychiatry, among other types of knowledge (Assis, 1882; Caponi, 2012).

When dealing with the interdisciplinary articulation of science, literature and madness, in this work by Machado de Assis, the refinements of sarcasm are observed, when approaching scientific knowledge through the intersection between Comte's social Physics and the contributions coming from Biology and Physiology. The character Simão Bacamarte calls himself, as a scientist, as the holder of superior knowledge, and thus substantiates and justifies his superiority before everyone in Itaguaí. In the name of order

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and progress, he believed that humanity should submit to the reason-intelligence of which, as a scientist, he was the holder (Assis, 1882).

He even put himself in the position of judging the deviations from normalities of citizens, imprisoning them in the city's sanatorium, for reasons and behaviors – until then considered banal and not so deviant from the rational archetype thought of a reflective and wandering human being (Assis, 1882). In fact, the character's posture refers to the formation of knowledge in the nineteenth century that supported what was provided as mental health care, or more truly, hospitalization/asylum imprisonment of the alienated, insane and degenerate. The influence of these constructs of psychiatric knowledge from afar could meet the demands of people in psychic suffering; starting with the approach by the only category of specialized professionals - psychiatrists - to the growing process of pathologization of behaviors and psychic suffering (Caponi, 2012).

If Machado de Assis already dialogued with the issue of madness in a broader context than this, he dared to reflect, even in the era of the openings of psychiatric hospitals and asylums in the nineteenth century, the prodomes of interdisciplinarity as the core, from which it is possible to conjecture, understand and articulate notions of madness and interprofessional actions in mental health.

METHOD

This is a study of reflection, based on theoretical-conceptual and epistemological bases that contemplate the history of madness, interdisciplinarity and interface with mental health, and the *praxis* resulting from this interface, understood in interprofessionality. A literature review was carried out through books and articles that covered the categories/themes "mental health", "interdisciplinarity", "Brazilian psychiatric reform" and/or "history of madness".

The theoretical reflection emerged from the perception of similarities and approximations between academically constructed knowledge and the understanding of the contributions of interdisciplinarity to mental health. The various readings of classical authors, philosophers, novelists, historians, thinkers, creators of categories and models that have impacted the studies of the human mind and the ways of interrelating professionals, support the manuscript. Thus, the defense of writing with classical depth is undertaken, to the detriment of the superficiality of the collection of recent studies, as an obligatory methodological background to give credibility to a certain discussion. The classics of gray

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literature and articles published in more distant years consist of validated material and necessarily considered in this construct of reflection (Table 1).

Table 1 - Works examined in full text and included in the review, according to the analytical categories

Categories	Authors	Type of work
Mental health Psychiatric Reform History of madness	Amarante, 1994	Physical book
	Caponi, 2012	Physical book
	Cunha, 2009	Article in electronic media
	Foucault, 1978	Physical book
	Foucault, 1983	Physical book
	Freud, 1937-39	Physical book
	Gomes, 2014	Physical book
	Hirdes, 2009	Article in electronic media
	Lacan, 2010	Book in electronic media
	Scott; Braga, 2005	Article in electronic media
Interdisciplinarity Interprofessionality	Coupe et. al., 2014	Article in electronic media
	Foucault, 1989	Physical book
	Lenoir, 2008	Physical book
	Pigeon, 2004	Physical book
	Trindade, 2008;	Physical book
	Vilela; Mendes, 2003	Article in electronic media
	Yared, 2008	Physical book
	Saraiva et. al., 2020	Article in electronic media

Source: The author.

The text was organized into three themes: 1) Madness and mental health in Brazil in the reformist panorama; 2) Interdisciplinarity and mental health; 3) Interdisciplinarity in mental health: *praxis* based on interprofessionality.

DISCUSSION

MADNESS AND MENTAL HEALTH IN BRAZIL IN THE REFORMIST PANORAMA

All the *en passant themes* in humanity - as well as the edifying knowledge of the signifiers - were responses produced in the ambience of social, political and economic interests of each era. Also, madness, as well as the structures in which it was immersed (specific places to contain/hide, rather than to welcome the insane, for example), had to question itself, overcome itself and reinvent itself.

When analyzing the history of knowledge, it is clear that ideas and discoveries - sometimes inconceivable, sometimes transgressive - were managed in the minds of geniuses, precocious or prodigies (non-synonymous terms) considered crazy. Great names, such as Leonardo da Vinci, Gandhi, Heitor Villa-Lobos, Stephen Hawking, Thomas Edison, Isaac Newton, William Shakespeare, Tim Berners-Lee and Nikola Tesla, are conceived as

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geniuses of humanity in specific areas, after being raised as eccentric, different people, with a touch of madness (Cunha, 2009).

In the past, particularly in the Middle Ages, when Copernicus or Galilei presented propositions said to be "evolved" for the time, it was easy to label them as eccentrics, fortunate with mental faculties or crazy to explain such inconceivability (Cunha, 2009). One of the most expressive and disseminated images to this day - tongue sticking out and hair not very sittingy - is thus timbred, linking Einstein to the transgressive posture and amusingly/emblematically crazy.

Prior to medical rationalism, the semantic dissolution of the concept of unreason, and the invention of mental illness, the insane was not seen as a carrier of disease, nor that his rational capacity could envision a cure. Traditional psychiatry carries with it the genesis of this possibility. It was Modern Science that planted the roots of madness, by making it one of its objects through doctors, in the pathological sense, spread to the present day (Caponi, 2012). However, thinkers such as Foucault, Freud and Lacan presented important proposals on madness.

The Freudian idea that nothing is but a dream (Lacan, 2010) and phrases such as "the Whole itself is Madness" (Foucault, 1978, p. 38) and "[...] everyone is crazy, that is, delusional" (Lacan, 2010, p. 31) support the need to remove madness from the pathological scope, to denaturalize the madness-mental illness association (in Foucault) and to incorporate it into the spectrum of the speaking being (in Lacan). Foucault's notes underline the approximation between madness and social exclusion, through the institutionalization of the insane and the silencing of his experiences. The Lacanians reflect that madness is inherent to the being that desires.

However, the understanding that madness is the whole does not consist in trivializing it, but in capturing that, if everyone is taken by something called "real", entities also need to build their *modus vivendi* in the face of the meaningless, imposed by the real, and attach madness inherent to the speaking being (Lacan, 2010). Freud and Lacan have, through their works, the discussion between the limit of being or not being insane, as well as the definitions of neurosis and psychosis, the theoretical-clinical positions of madness, psychic reality and diagnosis (Lacan, 2010; Freud, 1937-1939).

The idea embedded in current discourses and practices that the misdemeanor of reason is unreason, or simplistically, madness/mental illness, denies inclusion and speech, while reverberating in the domains of knowledge, hindering healthy practices in mental

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health and perpetuating actions inspired by traditional psychiatry. Considering that the most pressing challenge of contemporaneity lies not in discovering what we are, but in refusing that we are (Foucault, 1983), it is up to the various entities involved in mental health issues to overcome the stage of tedious discovery of the roots of their actions, reaching the level of overcoming them.

The most evident praxis for this proposal of overcoming may reside in the Psychiatric Reform, embryonic in the post-war United States, and, in Italy, of the iconic Franco Basaglia, anchored in the fixation of the subject's existence-suffering in relation to the social body (Silveira & Braga, 2005). In Brazil in the 1980s, the Basaglian movement influenced the effervescent discussions on the transposition of the current asylum model, which took place at the 8th National Health Conference (1986), the 1st, 2nd and 3rd National Conferences on Mental Health (1987, 1992 and 2001, respectively). Historical milestones, such as the Caracas Declaration and practical milestones, such as the medico-legal intervention at the Anchieta Health Center (Santos/SP) and the construction of the Dr. Luís da Rocha Cerqueira Psychosocial Care Center (known as CAPS Itapeva in São Paulo, capital) and the Community Center for Mental Health of São Lourenço do Sul (Rio Grande do Sul) were part of the relevant scenario for transformations that occurred in Brazilian mental health (Amarante, 1994; Hirdes, 2009).

The Brazilian panorama, therefore, sought in the reform the production of life, to the detriment of productive life or utopian cure of madness as a unison solution in the care of people in psychic suffering. The production of life has been denied since the actions of removing the insane from the field of vision and comfort of the holders of political power and wealth, in Brazil, which was developing economically under the colonial petticoats and wigs of a Royal Family that fled from Napoleon in 1808 (Silveira & Braga, 2005; Hirdes, 2009; Gomes, 2014).

With emphasis on the 1980s, in Brazil, the constant struggle for a model that would break with such colonial achievements and that would consider the subject as the protagonist of his own care, desiring, with madness not recognized as a disease to be extirpated/controlled/doped, is interspersed with periods of resistance and resilience. The first, when faced with direct violations against everything that has been historically conquered; the second, after the recognition, sometimes momentary, of the rights of subjects in psychic suffering, health workers and family members. It is worth noting that the challenge carried on the back of the reform is not restricted to mental health workers, but to

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diverse and interprofessional social actors, in order to develop strategies of resistance to the fixation of identities and the serialization of the processes of subjectivation (Tasso & Navarro, 2012).

The Psychiatric Reform, with ideals of territorial-based multidisciplinary care, based on non-asylum institutional devices (CAPS), in addition to non-institutional ones (places of life of people assisted in mental health), points to the real appropriation of interdisciplinarity as a daily act and basis for practices. It is also understood that, as these are inter-articulated thematic axes, madness, mental health and interprofessionality are under the custody of interdisciplinary knowledge. Without this understanding, the breadth and totality of knowledge and practices is fragmented as a potentiation of the individual in his social reinsertion, opportunity/spaces for speech and expression of desires.

INTERDISCIPLINARITY AND MENTAL HEALTH

Interdisciplinarity carries with it the prefix (inter) that denotes movement in the existing and possible relationships between disciplines (Yared, 2008). It rescues the understanding of the facts that was distanced with the specialties, in addition to stimulating seeing the other as a collaborator (Antiseri apud Yared, 2008). By provoking science, interdisciplinarity stimulates the questioning of what is posed as truth and protests about knowledge plastered by science, understanding that science is created by men who do not detach themselves from mythical, mystical, artistic, alchemist, religious and subjective portions (Yared & Trindade, 2008). It is not a matter of denying science and its contributions, but of inviting the understanding of phenomena through multiple articulated perspectives in search of flexible and changeable answers, generating other questions for other answers; calls for cooperation, partnerships and exchanges between people; it provides transformations (Trindade, 2008; Pombo, 2004).

Therefore, it is urgent to consider that science itself, when it is unable to unveil the greatest questions of humanity, is limited, distant from life and not resolving serious social disparities, in short, at the height of a crisis. The present "multi-risk world" (Vilela & Mendes, 2003) is characterized by a marked class difference; phenomenon of globalization, with current emphasis on cultural, technological and communicational; cultural proliferation of world powers and consequent erosion of the specificities of less developed traditional communities and countries; internal and inter-nation civil conflicts; and a challenge related to fragmented thinking, pervasive in the spectrum of modern rationality.

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Thus, similarly, Japiassu's (1976) reflection on interdisciplinarity is cited more as a symptom of the current pathology of knowledge than as a real progress of knowledge. The "pathology" mentioned comes from the exaggeration of specializations that produces shattered intelligence and leads to a knowledge of crumbs. Comprehensiveness would be the remedy to this pathological condition, in an attempt at real integration between the disciplines of a pedagogical project.

It is true that scientific knowledge is guiding the judgments, reflections, innovations and resignifications to be materialized in the constant constructions of new knowledge. And of these, the practices of teaching, research and care, whether in the universe of education or health, are constituted and projected until the validity of others reinvented, according to the need and feasibility of the contexts and conjectures of the social structure, mediated by interests established in power relations (Foucault, 1989). Fazenda (apud Trindade, 2008) points out that interdisciplinarity can consist of an exercise in confronting the scientific crisis (of theories, concepts, dominant/dominant paradigms). A science populated by doubts and uncertainties, which segregates the vital chain, gives room for creativity, a characteristic that interdisciplinarity intrinsically presents (Trindade, 2008).

By defending a more open and flexible, supportive and democratic type of man - who, by knowing more about himself, set in the inseparable web of life, understands the other more - interdisciplinarity includes categories such as interaction, cooperation, collaboration, integration, interdependence, attitude, learning, sharing, humility, curiosity, interested listening, reciprocal action and protagonism. Categories such as alienation of labor, specialization, crystallization of knowledge, segregation, fragmentation, impersonality, linear thinking, and isolated disciplinary perspective do not concatenate with the principles of interdisciplinarity (Yared, 2008; Trindade, 2008; Lenoir, 2008; Pombo, 2004).

In the field of Mental Health, interdisciplinary attributes are useful and worth efforts to implement. However, there is a double path, both in terms of contributions from interdisciplinarity to mental health, and from the militancy of the Psychiatric Reform to strengthen interdisciplinary practice. It is mature that mental health care is not feasible with a single area acting, or knowledge, or a professional or a discipline, nor a fragmented education.

Both mental health and interdisciplinarity have their genesis in limited knowledge and/or limiting action. On the one hand, interdisciplinarity as an alternative to fragmentation and specializations; on the other, mental health, which is framed in the canvas of the

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Reform opposed to the traditional, standardized and specialized practices of traditional psychiatry (medical specialty). On the very near horizon, the non-straight lines of the two areas of knowledge/study/action meet, more in an infinite elliptical movement of encounters and reencounters, than of parallels.

The aforementioned multi-risk world requires differentiated work dynamics; it generates new processes of illness/psychic suffering; aggravates old mental health problems; it requires skill in handling these complex issues; and they lack clearly interrelated, non-rigid and creative actions. An emerging theme for the Sanitary and Psychiatric Reform and consolidation of the SUS, interdisciplinarity needs to be discussed in the most diverse aspects, including in the professional sphere.

INTERDISCIPLINARITY IN MENTAL HEALTH: *PRAXIS* BASED ON INTERPROFESSIONALITY

The search for the specialty, by the professional, focuses on prevention, promotion, cure and rehabilitation, with care focused on cognitive, ethical and technical competence, specifically in the areas of knowledge. However, this knowledge needs to be interconnected, so that the results are effectively evaluated and replanned, according to new needs and perspectives, which is one of the contemporary purposes and needs of the science intended for the interdisciplinary field (Lenoir, 2008).

Interdisciplinarity can be operationalized from four fields of purpose: scientific, school (curricular, didactic and pedagogical), professional and practical (Lenoir, 2008). Each one has relevance and social role, not consisting of synonyms, but of stems of the same axis or lines of the same web.

Suape et al. (2005), when they state that professional interdisciplinarity is the articulated relationship between the different health professions, with the various collectives of thought, based on a specific and differentiated education with an identified conceptual framework. In order for it to be well understood, interdisciplinarity with a professional purpose needs theoretical bases that minimize the polysemic confusion of the concepts of multi, pluri, trans and interdisciplinarity and that these are reflected in professional practice in health. Practice currently permeated by social, epidemiological, environmental, labor, epistemological, economic, political, productive and cultural challenges. Territories are as dynamic as professional actions should be; the health-disease process as changeable as the speed of technological evolution; In an era in which the lack of control of chronic

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diseases and violence is discussed, the contemporary world is faced with an affection that recalled the time of feudal/medieval pandemics.

It is necessary to debate these issues and the possibilities of time/conditions/stimulus to be creative, respectful, communicative, tolerant, humble, empathetic, listeners, transformers, ethical, committed and other attitudes that are presented as interdisciplinary professionals. Acting in an interdisciplinary way in the organization of mental health work is something challenging for the professional, but which, when feasible, demonstrates successful results in the services and territories.

Some developed and developing countries dialogue with Collaborative Care (CC) as an interprofessional proposal for integration between Primary Care and mental health. CC strategies demonstrate efficacy and positive effects in the management of more frequent disorders such as depression and anxiety, improvement in detection and treatment, as well as in the clinical outcomes of patients (Saraiva, Zepeda, & Liria, 2020).

By considering a structured, proactive, and evidence-based model, the CC involves assisting a primary care physician and a case/care manager (e.g., psychiatric nurse and/or mental health specialist) in the systematic follow-up of the patient, with a management plan structured by manuals for psychological intervention, protocols for medication management, and improved communication between health professionals (through shared records, team meetings, and supervision) (Wong et al., 2017; Pagianoti et al., 2016).

In cases of depression, collaborative care was practiced in initial face-to-face meetings to establish interprofessional relationships, followed by weekly supervision by telephone, previously structured and scheduled; and use of Patient Case Management Information System (PC-MIS) (Coupe et al., 2014).

In Puerto Rico, collaborative care was defined as a comprehensive intervention composed of at least two (out of three) types of professionals in the primary care setting (care manager, primary care physician, and mental health specialist). It involved multicomponent intervention, including program supervision and teamwork. Also, in the format of weekly scheduled sessions, the SC in Puerto Rico initially took place with the care of a consultant psychiatrist; It recommended initial medication and dosage, as well as changes in medication or combined drug treatment if the patient had limited response. Subsequently, the care manager provided follow-up for the cases in progress, based on the tracking of the severity of the depression, carried out during the meetings with the patients.

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It also had the function of forwarding the psychiatrist's recommendations for consideration by the patient's physician (Vera et al., 2010).

The figure of the case manager is considered relevant in maintaining regular contact with the person being cared for and organizing care, together with the doctor and the specialist, in addition to offering help with medication or access to 'speech therapy' to help the patient. Case managers work closely with the primary care provider (who retains overall clinical responsibility) and may receive regular supervision from a mental health specialist (Archer et al., 2012).

Collaborative care consists of complex intervention, with necessary improvement of interprofessional communication, introduction of mechanisms to facilitate this dialogue among those who care for the patient, through team meetings, case conferences, individual consultation/supervision, shared medical records, and patient-specific written or verbal feedback among caregivers (Archer et al., 2012).

To this end, the training of those involved is considered fundamental in the process of building the model (Coupe et al., 2014), since professionals who do not have training for this care format do not feel able and comfortable to develop it (Overbeck et al., 2016).

The CC in mental health is similar to the matrix support for Primary Health Care (PHC), recommended in Brazil. There are those who call matrix support as Brazilian collaborative care. In addition to being a prospect for democratizing the organization of mental health services, matrix support consists of a model that operationalizes the integration of health professionals and teams for the purposes of back-up care support, regulation of guidelines and definitions of care, shared and educational co-management between PHC professionals and specialists (Saraiva, Zepeda & Liria, 2020).

The interprofessional agreements proposed by matrix support stimulate dialogues on cases, formation and consolidation of therapeutic groups, regular meetings on workflows, intersectoral activation, waiting list management, case monitoring in the Psychosocial Care Network (RAPS), face-to-face or remote consultation, support in emergency situations, training of workers, construction of unique therapeutic projects and definitions of roles in RAPS, with full user participation and endorsement of social control (Saraiva, Zepeda & Liria, 2020; Brazil, 2004).

As a HumanizaSUS strategy, matrix support is organized based on the territory, from the health unit, the local reality and the available resources. The unit needs to be composed of a multidisciplinary multidisciplinary team (as in the case of the Family Health teams).

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While the CC has a case manager, matrix support recommends the existence of a territorial reference team, that is, in reference units in mental health care (hospitals, outpatient clinics, CAPS, rehabilitation centers), the cases are managed by the territory team (for example, Primary Health Care). The reference team is responsible for the comprehensive care of the individual and his or her family, with the support of a team of specialists and, instead of making referral to more complex services routine, it should request support for the co-management of these cases (Brasil, 2004).

In the arrangement proposed by matrix support, the specialized services are responsible for both the users and the service based on the territorial relationship of this user. Reference teams can count on specialists and professionals who are closer to users in the creation of therapeutic bonds (Brasil, 2004).

Despite the approximations between the interprofessional perspectives exposed, matrix support reverberates a greater plurality of practices, dialogue with the territory, protagonism of the user and family, freedom of movement of ideas, playful sharing, support meetings and discussions, community involvement and the network of workers and coverage of the therapeutic perspective. It proposes to break with the institutionalization of the subject in psychic suffering, without leaving him helpless by the services. He must be and live in the territory, be cared for in it, with the support of an interprofessional network that focuses on the case.

Collaborative care is perceived as restrictive, which could encompass - in addition to three types of health professionals and pre-established protocols - forms of care that value speech/listening, the subjects and the interfaces of each one's madness, even the so-called "normal". CC also seems to be restricted to cases of depression and anxiety and is more practiced in European countries. The idea of systematized care with the figure of the articulator (case manager) and various professionals may seem attractive; However, most of these professionals are physicians and other categories, such as nurses, therapists, psychoanalysts, psychologists, social workers, nutritionists, and physical educators, are not incorporated into the model, in general.

CONCLUSIONS

In the research effort on the archaeological constructions of madness, mental health and interprofessionality, it is pointed to the breaking of the chain that links human suffering to medicalization and psychiatry and proposes to place in the hands of many the enterprise

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of the continuity of the reform and the understanding/incorporation of interprofessional practices in mental health care.

The link between madness and error is not exclusive to psychiatric knowledge, as well as in the fact that the moral connotation about reason and unreason is not located exclusively, for example, in legal, medical, scientific or philosophical discourses, but is even present in the most classic literature.

The creative and multicentric character of interdisciplinarity leads to its use as a formative principle, in the alleged proposals for multiprofessional and interprofessional education (as ethical and professional maturity is constituted) in mental health. As propositions for interprofessional practices in mental health, the integration and symbiotic articulation of specific, contextual and comprehensive knowledge, in articulation with the needs of its users, is existential. Just as the sciences unite in favor of evidence and *praxis* in search of successful results, the elementary knowledge of the professions has the potential to be materialized and reverberated in people's lives. Here, it is understood not only the person with psychic unpleasantness/suffering, but also the person with psychic suffering. But also the family and community in which it is inserted (or which has become marginalized by traditional approaches to care).

The perspective of matrix support can consist of the materialization of this interprofessionality in mental health and the CC, unless it is carried out with the interdisciplinary characteristics to which it is proposed, as it is considered interprofessional, would be nothing more than another fragmented model of mental health care and, when taken as structured, it points, in fact, to sequential and overlapping actions of those involved, bordering the cared for, the speech, the desires, the family and the *modus vivendi*.

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