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MUTUAL HELP GROUPS IN MENTAL HEALTH: AN ANALYSIS THROUGH THE THEORY OF SUBJECTIVITY[1]

Grupos de Ajuda Mútua em Saúde Mental: uma análise através da Teoria da Subjetividade

Grupos de Ayuda Mutua en Salud Mental: un análisis desde la Teoría de la Subjetividad

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[1] Part of the initial structuring of this text relied on **artificial intelligence** tools for text organization, which were revised, adapted, and validated by the authors.

Abstract

In this paper, we discuss participatory strategies in mental health and their contributions to the Brazilian psychiatric reform, based on a qualitative study of the social subjectivity of a mutual help group, grounded in the Constructive-Interpretative Methodology, Qualitative Epistemology, and the Theory of Subjectivity developed by Fernando González Rey. The participants were members of a mutual help group in Federal District (Brazil), and the research instrument consisted of conversational dynamics. The results indicate that, on the one hand, the group expresses subjective processes that reaffirm the centrality of health professionals in care; on the other, they reveal tensions and that unsettle and reconfigure this position, opening space for more horizontal, dialogical, and participatory practices of care. We conclude that it is precisely within these spaces of tension and contradiction that processes of deinstitutionalization are produced, highlighting the value of participatory strategies in strengthening and sustaining the psychiatric reform.

Keywords

Mental Health, Mutual Help, Subjectivity

Resumo

Neste trabalho discutimos estratégias participativas em saúde mental e suas contribuições para a reforma psiquiátrica brasileira, com base em uma pesquisa qualitativa sobre a subjetividade social de um grupo de ajuda mútua, fundamentado na Metodologia Construtivo-Interpretativa, na Epistemologia Qualitativa e na Teoria da Subjetividade de Fernando González Rey. Os participantes foram integrantes de um grupo de ajuda mútua no Distrito Federal (Brasil), e o instrumento de pesquisa consistiu em dinâmicas conversacionais. Os resultados indicam que, por um lado, o grupo expressa processos subjetivos que reafirmam a centralidade do profissional de saúde na condução do cuidado; por outro, evidenciam tensões internas que desestabilizam essa centralidade, abrindo espaço para práticas de cuidado mais horizontais, dialógicas e participativas. Conclui-se que é precisamente nesses espaços de tensão e contradição que se produzem processos de desinstitucionalização, evidenciando o valor de estratégias participativas no fortalecimento e na continuidade da reforma psiquiátrica.

Palavras-chave

Saúde Mental, Ajuda Mútua, Subjetividade.

Resumen

En este trabajo discutimos estrategias participativas en salud mental y sus contribuciones a la reforma psiquiátrica brasileña, a partir de una investigación cualitativa sobre la subjetividad social de un grupo de ayuda mutua, fundamentada en la Metodología Constructivo-Interpretativa, la Epistemología Cualitativa y la Teoría de la Subjetividad de Fernando González Rey. Los participantes fueron integrantes de un grupo de ayuda mutua en el Distrito Federal (Brasil), y el instrumento de investigación consistió en dinámicas conversacionales. Los resultados indican que, por un lado, el grupo expresa procesos subjetivos que reafirman la centralidad del profesional de la salud en la conducción del cuidado; por otro, evidencian tensiones internas que desestabilizan esa centralidad, abriendo espacio para prácticas de cuidado más horizontales y participativas. Se concluye que es precisamente en estos espacios de tensión y contradicción donde se producen procesos de desinstitucionalización, lo que pone de relieve el valor de las estrategias participativas en el fortalecimiento y la continuidad de la reforma psiquiátrica.

Palabras clave

Salud Mental, Ayuda Mutua, Subjetividad

Introduction

One of the current challenges of the Brazilian psychiatric reform is prioritising care practices led by health professionals at the expense of strategies aimed at fostering and strengthening social bonds (Cruz, Gonçalves, & Delgado, 2020), which may be associated, among other factors, with the persistence of medicalizing and objectifying care practices even in mental health substitutive services (Goulart, 2019).

In this context, participatory strategies in mental health, such as mutual help groups, represent a potential pathway toward deinstitutionalization – a broad process of reconfiguring knowledge and social practices related to "madness" (Nascimento & Silva, 2020) – insofar as these strategies can configure a space for (re)invention of alternative socialities to hegemonic forms.

Some participatory strategies in mental health were imported from so-called "developed" countries and, therefore, still require further study in Latin American contexts, including Brazil, which are often marked by intense social inequality, racism, and sexism.

In this work, we aim to reflect on the potentialities and challenges of participatory strategies in the scenario of the Brazilian psychiatric reform, specifically the mutual help groups (Vasconcelos, 2013, 2017; Figueiredo, 2021; Lainas, 2023; Sevelius et al., 2024; Corradi-Webster et al., 2025), drawing on a study of the social subjectivity of a mutual help group in the Federal District, Brazil.

This was a qualitative study grounded in the Theory of Subjectivity from a cultural-historical perspective, the Constructive-Interpretative Methodology, and Qualitative Epistemology, as developed by Fernando González Rey (González Rey, 2015, 2019a, 2019b; González Rey & Mitjáns Martínez, 2019, 2025).

The psychiatric reform and mutual help strategy in Brazil

One of the early initiatives of the psychiatric reform in Brazil involved the organization of the Mental Health Workers' Movement (MTSM) – the first national movement aimed at transforming the ways of caring for people experiencing psychological suffering.

Initially, the MTSM advocated predominantly technical proposals, expressing health professionals' dissatisfaction with their working conditions. This is interesting as it illustrates both the historical presence of health professionals in the Brazilian psychiatric reform, and the transformative potential of the participation of service users and their families in this process. It was through the participation of the latter, and the influence of other social movements, that the MTSM's proposal took on a genuinely anti-asylum character, defending the replacement of asylum institutions for other forms of care (Emmanuel-Tauro & Foscaches, 2018).

The Brazilian psychiatric reform was driven by a moment of intense social reorganization and articulation during the country's re-democratisation period, when new laws, public policies, and a new public health system were formulated, in which asylums would be progressively replaced by other forms of care in freedom.

Beyond changes in legal frameworks and health services, a fundamental part of the anti-asylum reform has been the organization of initiatives aimed at breaking the social confinement of madness, such as interventions in music, painting, literature, and theatre (Liberato & Dimenstein, 2013; Amarante & Torre, 2018, p. 1100). As Lobosque states:

To assume that the (asylum) institution is ill and needs to be treated [...], without engaging in the invention of resources that allow people to live and produce outside the institutional space, means assuming that the place of the mad person is in the institution and not in culture (2001, p. 18).

Lobosque draws attention to how transforming care for people experiencing mental suffering requires broader social transformations. In other words, the psychiatric reform is not only a matter of changing mental health services.

Since its beginning, the Brazilian psychiatric reform has been marked by alternate periods of progress, stagnation and/or setbacks. For example, the recent conservative political shift in the country has been associated with the strengthening of movements that seek to restore the centrality of health professionals – particularly physicians – in psychosocial care services (Costa Masini & Lagoas, 2022). This movement, evident in various ordinances, policies, and decrees enacted between 2016 and 2019, weakened achievements from previous decades and, as a consequence, psychiatric hospitalization was once again promoted as the main form of treatment to the detriment of community-based approaches (Cruz et al., 2020).

As will be discussed later in this work, the centrality of health professionals' roles in the field of mental health may incur in difficulties in promoting the construction of community ties among users. This can occur even within substitute mental health services, hindering their aim of fostering social (re)integration.

Other studies discuss how care practices in substitute services can generate subtle forms of dependency and chronicity, configuring new forms of institutionalization, through which users' lives become organized around mental health institutions and their forms of functioning (Goulart, 2019; Goulart & González Rey, 2019; Corrêa & Lima, 2024). In this context, there is a shift from valuing interpersonal relationships toward a greater emphasis on medication-based interventions, implying increased centralization of care in health professionals.

In Brazil, there are a number of regulations governing social participation in health, particularly in relation to management processes, as well as mechanisms that allow for less medicalizing forms of care. Examples include Law No. 8.142 and Resolution No. 453, which establish and regulate health councils and conferences – one of the main spaces where users and families can participate in the development and implementation of public policies at municipal, state, and national levels (Brazil, 1990, 2012).

Ordinance No. 5.738 of 2024 regulates Community Centres ("Centros de Convivência"), whose purpose is to offer the general population a space for sociability, supported by professionals with training and/or experience in health. However, this ordinance prohibits the promotion of group activities with a "psychotherapeutic" purpose, favouring instead other equally relevant practices aimed at fostering interpersonal connections more broadly (Brazil, 2024).

The National Policy on Mental Health, Alcohol and Other Drugs, and the National Drug Policy do not include specific strategies for the organization and ongoing maintenance of users' and family groups or associations as spaces for social participation *in care*, despite Ordinance No. 3.088 – which established the Psychosocial Care Network (RAPS) in the country – including as a guideline an "emphasis on territorial and community-based services, with participation and social control by users and their families" (Brazil, 2001, 2011, 2019).

The Brazilian legal and regulatory framework can be seen as an international example in terms of social participation in the development of public health policies. However, it is evident that the norms regulating mental health care do not specifically refer to participatory mental health strategies, nor do they propose forms of care less centred on health professionals for those experiencing mental distress.

Mutual help groups are one such participatory strategy, and consist of spaces for reciprocal support among peers. These are non-directive groups, differing from therapeutic groups in general, as care is more or less equally distributed among members rather than being entirely attributed to health professionals (Sevelius et al., 2024).

The mutual help strategy historically emerged in European countries and gained prominence in North America, where it played an important role in the development of the Recovery perspective. This perspective is based on a critique of the notion of mental disorder as a chronic, progressive, and disabling disease, and on the defence of forms of care that recognize the potential of individuals experiencing mental suffering to live meaningful lives (Figueiredo, 2021).

Different terms are used to refer to mutual help groups in the Anglophone literature, such as, mutual support/mutual aid and peer support. These terms are sometimes used to refer to mutual help groups as these have been commonly implemented in Brazil (Vasconcelos, 2013). However, they are also used to describe less reciprocal care strategies, involving individuals who have experienced intense psychological suffering, consider themselves recovered, and act to support others experiencing mental health suffering (Lainas, 2023).

Some authors place mutual aid and peer support strategies along a continuum: mutual aid groups are closer to friendships – due to reciprocity – while peer support groups are closer to professional healthcare roles – due to less reciprocal and more hierarchical relationships with the person receiving care. Even so, self-disclosure of personal experiences by caregivers is more prominent than in relationships between health professionals and service users (Davidson et al., 2006; Sevelius et al., 2024).

In general, participatory mental health strategies enable the construction of identities and forms of sociability less centred on illness and diagnosis, demonstrating their potential as tools for empowerment in mental health (Schneider, 2012). Other studies point to the expansion of such strategies in the Brazilian context (Corradi-Webster et al., 2025) and to their potential to destabilize perspectives that associate incapacity with psychological suffering, opening space for forms of existence and care based on participation, the production of social bonds, and the valorisation of users' situated knowledge (Figueiredo, 2021).

It is worth noting that, when addressing empowerment, caution is needed to avoid falling into individualistic and neoliberal perspectives, as has occurred in contexts where participatory mental health strategies have been used to justify maintaining an inaccessible health system (Agner & Braun, 2018). In the perspective adopted in this work, empowerment is understood as essentially involving collective practices through which bonds of solidarity can be created and pathways for social transformation can be opened, whether in association with state mechanisms or not.

Moreover, it is important not to essentialize the participation of service users and their families, as if it were the "missing pill" for finally fulfilling the psychiatric reform objectives. The diversification of voices is understood here as a means of enhancing dialogical practices and expanding the engagement of different actors in producing change. However, when reduced to

a mere protocol, social participation can lose its transformative potential, becoming just another mechanism for reproducing the institutional logics it seeks to overcome.

Mutual help groups may encourage dialogical practices among the different actors involved in psychiatric reform, a key factor in enabling change (González Rey & Mitjáns Martínez, 2019). For such strategies to effectively contribute to social transformation, further research in our context is needed. Developed in countries with social, cultural, and economic characteristics that differ from from those found in Latin America, these strategies require careful contextual consideration.

In a context marked by intense social inequality, racism, and sexism, it remains challenging to implement health strategies that promote horizontal relationships. It is therefore necessary to avoid the tendency toward idealized appropriation of approaches and social policies from Global North countries, as this ultimately inhibits the development of "our own paths," which are more relevant for understanding and intervening in our reality (Vasconcelos, 2017).

Theory of Subjectivity from a cultural-historical approach

González Rey's work offers relevant theoretical and methodological contributions to the present discussion, as it allows understanding how a mutual help group is experienced by its members, and how the process of deinstitutionalization unfolds at the subjective level.

The Theory of Subjectivity is a cultural-historical approach, emerging from a theoretical effort to elaborate a set of interrelated concepts for the study of subjectivity as inseparable from culture. The author sought to overcome dichotomies that mark modern thought, such as those between the symbolic and the emotional, as well as between the social and the individual. The critique of such dichotomies gave rise to an ontological definition of subjectivity as a symbolic-emotional system, whose basic unit are subjective senses (González Rey & Mitjáns Martínez, 2019, 2025).

The division between social and individual subjectivity in this framework is mostly didactic, for these are mutually constitutive, like "two sides of the same coin". The individual dimension of subjectivity refers to the subjective production regarding an individual's life history, which occurs within a given context and network of relationships, whose subjectivation, in turn, is related to the different spaces of social subjectivity that traverse it. Social subjectivity represents "the complex network of social subjective configurations in which all social functioning takes place" (González Rey, 2015, p. 13), expressing itself through social representations, discourses, beliefs, sexuality, and morality manifested in different social spaces.

Therefore, subjectivity does not consist of an intrapsychic formation isolated from the social dimension, since the individual is constituted within different social subjectivities, while also acting as a differentiated moment of subjectivation of these (González Rey, 2019a). Subjective processes are always a singular production of individuals and social groups historically and culturally situated.

Subjectivity has a dynamic and generative character. Subjective senses are generated through a non-linear and nonconscious flow. As they articulate with one another, they give rise to relatively stable subjective configurations, which in turn generate new subjective senses, organizing how concrete experiences are subjectively.

From this perspective, individuals and social groups are actively implicated in the production of their subjective configurations, although they do not fully control them. Thus, people are not mere epiphenomena of external processes (González Rey, 2019a). However, its generative character

does not necessarily imply that the subjective production of a person or group will break with institutionalized forms of being, thinking, and feeling.

In some contexts, social subjectivity may function in a more limiting way, generating significant consequences in the quality of life processes of those who participate in such spaces. An example of this are forms of social subjectivity that sustain an asylum-based logic, closely linked to the phenomenon of new institutionalization mentioned earlier.

Social subjective processes related to asylum logic refer to relationships among users, family members, and health professionals marked by predominantly pathologizing and minimally dialogical care practices, which end up reducing the other to an object of intervention (Goulart, 2019).

Asylum related subjective processes, like any other form of subjective production, are not clearly articulated in individuals' speech, for subjectivity is not necessarily a conscious or intentional process. Subjective processes related to this logic may be present even in contexts where discourses in favour of psychiatric reform and the anti-asylum struggle prevail (Goulart, 2019).

Understanding new institutionalization as an expression of asylum social subjectivity shows that changes in subjective processes do not occur solely through formal changes in mental health policies. Social, cultural, and institutional transformations are always linked to the production of individual and social subjective senses, which develop through dialogue, understood as a shared relational space that opens possibilities for reflection, tensions, and possible reconfigurations of social practices. Dialogue, as conceptualized in this theoretical framework, constitutes a fundamental resource of deinstitutionalization in the field of mental health, as will be discussed later in this work (Goulart, 2019).

Methodology

This research is part of the research project "Subjectivity, education and health: subjective development in focus," supported by the National Council for Scientific and Technological Development (CNPq) through a Level C productivity grant. It is also associated with the research project "Mental health, subjective development and ethics of the subject: alternatives to the pathologization of life," approved by the Ethics Committee of the Foundation for Teaching and Research in Health Sciences of the Federal District.

In close articulation with the Theory of Subjectivity, this article was grounded in González Rey's Qualitative Epistemology and Constructive-Interpretative Methodology. The articulation between theory, epistemology, and methodology allows greater consistency in research and professional practices informed by this theory (González Rey & Mitjáns Martínez, 2019, 2025). This framework emphasizes the production of scientific knowledge as a process that is (1) constructive-interpretative, (2) dialogical, and (3) oriented toward the legitimation of the singular as a legitimate source of knowledge.

The research participants were members of a mutual help group in the Federal District of Brazil. The inclusion criterion was willingness to participate, with no exclusion criteria related to diagnosis, age, or gender. Following collective acceptance of the invitation to collaborate with this study, visits to the group were conducted over four-month period. Meetings were held every two weeks and lasted approximately two hours.

Research carried out based on the Constructive-Interpretative Methodology involves a process of interpretative construction, based on the articulation of information generated across different moments of the research process with participants. It is understood that creating a space for authentic expression is essential in order to engage participants subjectively and thereby facilitate the expression of subjective senses.

The research instrument consisted of conversational dynamics, understood as a dialogical process between researcher and participant (González Rey & Mitjáns Martínez, 2019, 2025). Rather than following a structured script, these interactions are guided by the flow of conversation, allowing participants to express themselves more freely. This approach aims to create a space of trust and engagement, facilitating the expression of subjective senses.

After each meeting with the group, the researcher (the first author of the article) wrote excerpts of participants' speech, attitudes of group members, events, and perceptions about how the group functioned in a field diary. Based on these records, she selected the most significant excerpts related to the phenomenon studied. In order to ensure confidentiality, the dataset supporting the findings of this study is not publicly available.

Based on this field diary, the researchers formulated *indicators*, that is, meanings attributed by the researchers to the field information, and which don't appear directly and explicitly enunciated in participants' discourse. The articulation of different indicators leads to the elaboration of broader hypotheses about the phenomenon under study, which, in their process of construction and unfolding, culminate in the theoretical model resulting from the research (González Rey & Mitjáns Martínez, 2019, 2025).

Results and Discussion

When the research began, the mutual help group involved in the study already existed for about one year, and consisted of an "open" group, that is, any interested person could attend the meetings. Most participants were regular attendees, primarily adult or elderly women who also attended a nearby Psychosocial Care Centre (CAPS), one of the main mental health services aimed at replacing asylums in Brazil. Both users and family members participated in the group.

The group began in 2018 as an initiative of the local CAPS. It was proposed that the group would be guided by the mutual help model proposed by Vasconcelos (2013), in which mutual help groups are understood as spaces of encounter among people who share experiences of psychological suffering, where experiential knowledge and users' protagonism are valued.

The model of mutual-help group discussed by Vasconcelos (2013) highlights the mediating role of the *facilitator*, responsible for encouraging respectful coexistence and the sharing of experiences among group members. In practice, this function – which includes organizing the duration of speaking and order of speakers – is rotated, ensuring that everyone has a voice and actively participates in the group (Figueiredo, 2021).

According to some long-term attendees, although the group was formally open, there was an informal selection process regarding who was informed about the group or invited to attend it. This informal selection was carried out by the professionals involved in the project, who were concerned about the attendance of individuals in distress who might not be "prepared" to participate in that space.

Regarding the group's initial formation and the possibility of participating in a facilitator training course, D., a CAPS user, shared the following:

When the first facilitator training course took place, I wanted to participate, but they told me (health professionals) that I 'did not meet the requirements.' But then, when this group started, they invited me to participate.

Considering D.'s account, it seems health professionals assumed the role of deciding whether a given individual was suitable to take on the role of facilitator.

The dynamics described so far, regarding the functioning of the group, suggest relationships based on subtle forms of tutelage between health professionals and the other group members. In this context, only certain individuals are seen as capable of participating in this mutual help space, and their invitation to the group relies on meeting certain prerequisites established by health professionals. This representation of the role of participants, and especially facilitators, contributes to maintaining asymmetrical power relations between users and family members and health professionals.

The situation described by D. also supports the construction of the indicator that the role of facilitator in this mutual help group is not represented as a possible pathway for the development of mental health service users, as only those who already met such prerequisites were able to perform this function. At another moment, this indicator was further reinforced when it was observed that one of the reasons a group member was invited to become a facilitator was that she had been discharged from CAPS. This suggests that opportunities to become a facilitator are partly based on the evaluation of users' clinical improvement, implicitly expressing a representation of people in psychological distress as incapable of assuming responsibilities in organizing the group.

The indicators constructed so far suggest that the subjective production regarding the role of the facilitator reproduces the ways in which care is organized and distributed in professionally led support contexts, in which the social representation of the caregiver in the mental health field is that of a person who has undergone some form of therapeutic process and training.

Throughout the research, it was observed that some participants attended the group more due to the desire for individual attention from the health professionals than in search of a space of group interaction. For example, in one of the meetings, a participant behaved as if she were in an individual therapy session, limiting others' opportunities to speak and interacting exclusively with the psychologist present. This event points that care practices centred on the role of health professionals may be associated with a simultaneous disinvestment in mutual support relationships within the group.

It is worth noting that the professionals involved in the group positioned themselves critically in regards to the expectation, shared by some members, that the professionals would lead the group's functioning. These professionals also expressed the expectation that, over time, the group would begin to function more autonomously.

In the following statement, E., a former CAPS user, describes her trajectory until joining the mutual help group:

> I went to CAPS for a year, but I only attended the walking group and didn't see a psychologist during that time. I saw a private psychiatrist, and at CAPS they only renewed my prescriptions. Then I was discharged, and they told me about this group, which has a psychologist. So, I came.

Although the aim of this type of group is to promote mutual help relationships among all its members, E. appears to have joined the group precisely because of the presence of a psychologist. Her tone of implicit criticism when referring to CAPS, particularly when she says she "only" attended the walking group without seeing a psychologist or psychiatrist, points to a devaluation of mutual help relationships with others experiencing psychological distress, as well as to a feeling of dissatisfaction with the mental health service she attended. Similar expressions of dissatisfaction or distancing from other health services were also observed among other group members, supporting the construction of an indicator that this was an important motivation for participation in the mutual help group for some.

In addition, the low attendance at the only group meeting held without the presence of health professionals supports the indicator that the presence of a professional is a precondition for the encounter to happen, at least for some members. In light of these indicators, it is possible to formulate the hypothesis that subjective processes related to the centrality of health professionals in care are dominant in the group's functioning.

In one of the group meetings, the members who had completed the facilitator training were unwilling to take on this role, and the other members did not feel comfortable doing so, stating that they could only act as facilitators if they had completed the training course. On that day, the facilitator role ended up falling to the psychologist.

Even though the psychologist was aware that the support role was being delegated to her, and despite her critical stance toward this, she felt it was her duty to care for the group members as she would do in a CAPS. This illustrates the difficulty in breaking with forms of care transposed from other institutional settings. "Help" ends up being relegated to certain individuals, especially health professionals, rather than shared among the group members – which substantially reduces their protagonism.

Even so, it was possible to observe how the group's dominant subjective productions are in continuous tension with subjective processes related to alternative ways of organizing care practices. For example, in one meeting, J., a man who was usually quiet and reserved, unexpectedly greeted and welcomed new participants, demonstrating a posture clearly different from his usual behaviour.

The researcher was sitting next to J. and another group member, talking casually before the meeting began. Upon noticing the arrival of new participants, J. commented, addressing the researcher: "Look, there are new people arriving, someone needs to welcome them." The researcher signalled that she had noticed, but pretended not to understand the implicit request directed at her. When neither of the two women moved, J. got up and went himself to welcome and speak with the newcomers.

It is worth noting that J. was generally silent and rarely spoke during meetings, sometimes appearing somewhat "disorganized." Therefore, he did not fit the hegemonic conception, in that

space, of someone capable of caring for others. Even so, he performed this function cheerfully and without apparent difficulties.

J.'s example illustrates the potential of mutual help groups to subvert hegemonic criteria through which care is distributed and socialized. By taking the initiative to welcome the newcomers, J. challenged the hegemonic social configuration that would otherwise disqualify him from exercising care, as it is often associated with assumptions linking psychological suffering to incapacity. He also challenged social norms that tend to assign the role of care to feminine figures, such as the researcher.

The group also offered greater openness to critical perspectives regarding the centrality of the role of health professionals in the care of people experiencing psychological distress. This becomes clearer in the following excerpt from D.'s speech:

> The other day I invited a user from CAPS to come to the group. Then he asked that question (laughs): "Is there a health professional there?" Then I said there was a social worker and a psychologist. It seems like people only think about that!

Thus, there were subjective processes challenging institutionalized forms of care and sociality within the group. To allow the development of these alternative ways of being, it would be necessary to foster a dialogical space in which such tensions and conflicts could be recognized and discussed within the group. However, this did not always occur. The following excerpt from a conversation between M. and a health professional took place during one of the group meetings:

> **M.:** The professor said that we need to separate the group of family members from the group of users. So, when are we going to discuss this?
> **Health professional:** Yes, we will discuss this in the facilitators' supervision group, not here – this is mutual help.

In this excerpt, M. questions the group about a matter of common interest, expressing an openness to dialogue with other members regarding the management of care in that space. She refers to the statement of a scholar (the "professor") who usually gives lectures in facilitator training courses mentioned earlier, who argued that mutual help groups should be divided between family members and users. In the case analysed here, both participated in the same group.

In responding to M., the professional establishes that the issue will be discussed in a meeting between facilitators and health professionals, which took place periodically to support facilitators in performing their roles. This indeed occurred, as none of those present opposed the decision. Even so, the fact that M.'s question could emerge in that space points to the tension between different modes of care management at play there.

This is a tension that only becomes possible insofar as it is collectively constructed, albeit in a contradictory way: the same professional who, at that moment, assumes a position of authority by determining what can or cannot be done there, at other moments actively defended the mutual help proposal in the face of criticism from other professionals at the CAPS where she worked.

Likewise, M., who at one moment encouraged dialogue, at others monopolized the conversation, directing herself exclusively to the health professionals present.

The case discussed shows that mutual help groups constitute important spaces of development not only for service users and their family members, but also for health professionals, considering that, in this context, professionals can experience relationships and practices that challenge traditional institutional logics, potentially favouring change in other settings in which they may act.

Final Considerations

The aim of this study was to understand social subjective processes of a mutual help group and to deepen the discussion about the implementation of participatory mental health strategies in the Brazilian context. Based on the findings, an important aspect of the social subjective configuration of the group studied is the search for a space where care is led by a professional. The very proposal of mutual support appears to be secondary in terms of what motivates members to join the group.

In the Theory of Subjectivity, actions are understood as subjectively configured rather than external to subjectivity (González Rey, 2019b). Based on this framework and on the findings of this study, it can be argued that care practices and interpersonal relationships in this mutual help group constitute social subjective configurations that play an important role in the production of new subjective senses.

In this group, the prioritization of care provided by professionals appears to be linked to the association between mental disorder and incapacity, and to the maintenance of a tutelary relationship between health professionals and other members. This subjective configuration unfolds into how care is organized and distributed within the group: those perceived as more suited to the caregiving role, and upon whom this function frequently falls, are individuals who have undergone some form of training and are considered to be in adequate health conditions to care for others.

Nevertheless, gestures of care, openings to dialogue, critical positions, and the effort to sustain the group's existence in a context in which participatory mental health strategies remain poorly valued indicate that social subjective processes related to the centrality of health professionals in care remain in tension within this space, and illustrate the deinstitutionalizing potential of this type of strategy.

Here, we differentiate deinstitutionalization as it is commonly understood – a broad and sometimes vague concept (Nascimento & Silva, 2020) – from deinstitutionalization as it unfolds in the rhythm of everyday life, that is, as a process that takes place in daily relationships and advances unevenly in relation to broader institutional transformations. As Lefebvre (1991) suggests, everyday life constitutes a specific dimension of social experience in which changes occur in a non-linear and frequently contradictory manner.

For the psychiatric reform to fulfil its transformative aims, it is necessary to invest in dialogical spaces that mobilize its actors, allowing family members and mental health service users to assume an active role in this process. As mentioned earlier, the Brazilian psychiatric reform only acquired an anti-asylum character through the participation of service users and their families in this movement.

It is important to emphasize that expanding the participation of mental health service users and their family members in care practices does not imply that their perspectives necessarily support processes of deinstitutionalization. Nor does it assume these actors to be inherently progressive, in contrast to health professionals, who are often presumed to reproduce asylum-based logics as if by nature.

Rather, this study highlights that mutual help groups constitute powerful spaces for the contestation and transformation of institutionalized ways of thinking and practicing care, precisely because they offer a site of (re)invention in which a participant may feel authorized to actively question: "So, when are we going to discuss this?"

The challenges of the psychiatric reform extend beyond the mere affirmation of general principles and protocols, and can only be effectively addressed if the subjective dimension of the human processes involved in mental health field is taken into consideration.

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