



PERCEPTIONS OF THERAPEUTIC LISTENING AS A TOOL FOR MENTAL HEALTH CARE


*Percepções sobre a escuta terapêutica como
ferramenta de cuidado em saúde mental*

*Percepciones sobre la escucha terapéutica como
herramienta para la atención de la salud mental*



Guilherme Gonçalves Maynardes  



Lucas Monteiro Pellá  



Deivisson Vianna Dantas dos Santos  



Sabrina Stefanello  

Abstract

Since the Brazilian Psychiatric Reform, mental health care in the country has undergone significant transformations, resulting in the consolidation of the Psychosocial Care model. The Psychosocial Care Network is composed of various services and points of care, including Primary Health Care (PHC) and the teams of Health Care Units. Mental health care in PHC occurs, among other strategies, through qualified listening, although there is still a lack of studies that explore therapeutic listening as a tool in mental health care. Thus, the aim of this study was to identify the perceptions of PHC professionals regarding listening in mental health care. This was a qualitative study with an exploratory and descriptive design. The results indicate that listening emerges as an important tool in mental health care and appears to align with the principles of psychosocial care and humanized care.

Keywords: Primary Health Care, Mental Health, Humanization of Care.

Resumo

A partir da Reforma Psiquiátrica Brasileira, a assistência em saúde mental no país passou por transformações relevantes, resultando na consolidação do modelo de Atenção Psicossocial. A Rede de Atenção Psicossocial é formada por diversos serviços e pontos de atenção, dentre eles a Atenção Primária à Saúde (APS) e as equipes das Unidades de Saúde. O cuidado em saúde mental na APS acontece, dentre outras estratégias, através da escuta qualificada, embora ainda faltem estudos que se aprofundem sobre a escuta terapêutica enquanto um instrumento do cuidado em saúde mental. Assim, o objetivo do estudo foi levantar percepções de profissionais da APS sobre a escuta no cuidado em saúde mental. Tratou-se de uma pesquisa qualitativa de caráter exploratório e descritivo. Os resultados apontam que a escuta aparece como uma ferramenta importante do cuidado em saúde mental e parece ir ao encontro dos princípios da atenção psicossocial e de um cuidado humanizado.

Palavras-chave: Atenção Primária à Saúde, Saúde Mental, Humanização da Assistência.

Resumen

A partir de la Reforma Psiquiátrica Brasileña, la atención en salud mental en el país ha experimentado transformaciones relevantes, resultando en la consolidación del modelo de Atención Psicossocial. La Red de Atención Psicossocial está compuesta por diversos servicios y puntos de atención, entre ellos la Atención Primaria de Salud (APS) y los equipos de las Unidades de Salud. El cuidado en salud mental en la APS ocurre, entre otras estrategias, a través de la escucha cualificada, aunque aún faltan estudios que profundicen en la escucha terapéutica como una herramienta del cuidado en salud mental. Así, el objetivo del estudio fue identificar las percepciones de los profesionales de la APS sobre la escucha en el cuidado en salud mental. Se trata de una investigación cualitativa de carácter exploratorio y descriptivo. Los resultados señalan que la escucha aparece como una herramienta importante del cuidado en salud mental y parece estar en consonancia con los principios de la atención psicossocial y de un cuidado humanizado.

Palabras clave: Atención Primaria de Salud, Salud Mental, Humanización de la Atención.

Introduction

The Brazilian health reform that took place at the end of the last century brought forward the debate on the need for a universal public healthcare system attentive to the social determinants of health, culminating in the creation of the Unified Health System (SUS). In this process, Primary Health Care (PHC) became an important pillar of the system, since it is structured around territorial care and direct contact with the community (Giovanella, 2012). During the same period, the psychiatric reform proposed transformations in the organization of mental health care in the country, shifting from an asylum-based model to a psychosocial and territorial model, guiding the creation of a Psychosocial Care Network (RAPS). This network proposes the expansion of psychosocial care by directing mental health resources and attention toward territorial actions, encouraging community-based inclusion and care for people experiencing psychological distress (Amarante, 1998).

Psychosocial care presupposes not only the reorganization of healthcare network services but also a change in the understanding of psychological illness, proposing a shift in the comprehension of the health-disease process from a clinic centered on disease and diagnostic classifications toward an expanded clinic that also considers social determinants of health, contextual aspects of mental health problems, and individuals' life narratives (Costa-Rosa, 2000).

The incorporation of mental health care into PHC is a strategy to make mental health care feasible within the territory, close to the context in which SUS users' daily lives unfold. Many of its principles converge with psychosocial care, such as comprehensive care, territorialization, continuity of care, and the establishment of bonds between professionals and the population under their care (Santos, 2019). However, PHC manifests, within its particular context, broader disputes concerning the directions of psychiatric reform in Brazil. The literature presents a series of difficulties experienced by teams in handling mental health demands, while also highlighting the potentialities of this healthcare setting, given the compatibility of principles between PHC and RAPS. There is a coexistence of two care models, in which the biomedical and prescription-centered model still predominates in many teams, configuring what has been called the "asylum mentality," while practices compatible with psychiatric reform and comprehensive care are increasingly present (Hirdes & Scarparo, 2015; Yasui et al., 2018; Barros et al., 2019; Treichel & Campos, 2022).

Listening frequently appears in studies on PHC care as an important therapeutic and humanizing tool (Santos, 2019; Nascimento, 2020). However, there is still a scarcity of studies in the literature that delve deeper into therapeutic listening as an instrument of healthcare. The available literature seems to indicate that this is an effective therapeutic technology that can and should be implemented in various settings, but which lacks further research regarding its impact at different levels and requires the development of technical skills for its better application (Mesquita & Carvalho, 2014; Nascimento, 2020; Oliveira, 2020; Santos, 2019).

The present study aims to explore the perceptions of professionals working in primary healthcare units regarding therapeutic listening as a care tool for people experiencing mental suffering in PHC, in dialogue with the principles of psychosocial care.

Methodology

This is a qualitative exploratory study derived from the research project "Psychosocial Care in Health Services and Strategies." This methodology was chosen because it allows a better understanding of the

universe of meanings, motives, aspirations, beliefs, values, and attitudes involved in the observed social phenomena (Minayo, 2010).

The study was carried out in the municipality of Curitiba, Paraná. In 2021, the municipality had an estimated population of 1,963,726 inhabitants and a SUS network composed of 109 Health Units, 13 CAPS, 16 General Hospitals, and 9 Emergency Care Units (UPAs), among other services (Curitiba, 2023). The city's RAPS currently includes 4 CAPS II and 6 CAPS III operating under a hybrid model (described later), 2 CAPSi II and 1 CAPSi III; 2 Medical Specialty Centers offering outpatient psychology and psychiatry services; 1 outpatient clinic focused on child psychiatric care; 1 Psychiatric Stabilization Unit (a small hospital unit created for psychiatric crisis stabilization); 1 private psychiatric hospital contracted by the municipal government; in addition to street outreach teams (Curitiba, 2023). Notably, there is an absence of community-based facilities, with the mental health network centered on CAPS and traditional facilities such as outpatient clinics and psychiatric hospitals.

Curitiba organizes its Health Service Network according to sanitary districts. The 10 sanitary districts are heterogeneous in terms of territorial characteristics, population size, vulnerability indexes, and number of BHUs/Family Health Strategy teams, CAPS, and other services. Regarding Primary Care, between 2014 and 2019 there was a reduction of one quarter in the number of Family Health teams (Maros, 2020), and in 2023 these teams covered only 53 of the city's 109 BHUs (Curitiba, 2023). Currently, most of Curitiba's PHC services operate under the Basic Health Unit model rather than the Family Health Strategy model.

The study is based on the hypothesis that there are cognitive, judgment-based, and affective factors (of an individual, social, cultural, and technical nature) operating among PHC professionals in Curitiba within their workplaces, which are expressed in the care provided and may be intensified in the care of users seeking BHUs for mental health-related issues. Through the interviews, we sought to understand the meaning professionals attribute to this experience and its effects on care. The Basic Health Units included in the study were selected because they had healthcare professionals known to the research team whose mental health practices were more closely aligned with psychosocial care principles. Thus, we aimed to identify services with good practices and a perceived quality of mental healthcare. These professionals were all family and community physicians, as this was the professional group with which the research group had the closest relationship. Many interviewees are involved in residency programs in Family and Community Medicine and actively participate in organizations related to this specialty. Other professional categories were included based on recommendations from these initial participants — interviewees were asked to indicate other professionals whom they considered to provide good mental healthcare.

Interviews were conducted in 9 BHUs distributed across 6 of the municipality's 10 health districts. The names of the units were omitted to preserve participant anonymity, and participants' names were replaced with the letter "P," an abbreviation for "professional," followed by a number.

Contact with interviewees took place through instant messaging applications. The phone numbers of professionals already known to the research team were provided by the supervising professors. First, a questionnaire was administered regarding sociodemographic data, professional background, and place and duration of professional practice. Subsequently, semi-structured interviews were conducted, composed of guiding questions aimed at exploring professionals' experiences and perceptions regarding important elements within the psychosocial care framework.

The interviews were conducted in depth with open-ended questions about everyday work in PHC, mental healthcare, and difficult cases faced by the interviewees, seeking to allow maximum expression regarding the proposed themes. After these initial interviews, professionals were asked to indicate other

healthcare workers from their unit who, in their perception, also demonstrated good mental healthcare practices. Inclusion criteria for healthcare professionals were: being over 18 years old, having worked at least six months in the health unit, and agreeing to participate in the study. Interviewers were master's students in public health and family health — the researcher himself and another graduate student participating in the same research project. They were trained through workshops held during meetings of the research group to which they belonged. The project was approved by the Research Ethics Committee of the Health Sciences Sector at UFPR (Opinion No. 5920.498) and by the Curitiba Municipal Government (Opinion No. 6035-245).

For data analysis, the hermeneutic method proposed by Ricoeur (1988; 2013) was used. Interviews were fully transcribed manually by undergraduate and graduate students participating in the project. The data were then organized into tables, grouping similar reports in an attempt to structure the material into argumentative cores and subsequently into categories. The argumentative cores were created from words and excerpts present in the narratives and later grouped by similarity into categories, organized in spreadsheets.

Some excerpts underwent minor spelling adjustments compared to the original transcription — removal of colloquial language habits, repeated words, and correction of certain spoken words — to facilitate comprehension without compromising the original meaning. The results were discussed in light of concepts and traditions from primary healthcare and psychosocial care. The excerpts were analyzed and discussed based on the theoretical framework of scholars of psychiatric reform, psychosocial care, primary healthcare, and public health, including Paulo Amarante, Gastão Campos, Lígia Giovanella, and Barbara Starfield.

Results and Discussion

The interviews were conducted with 15 healthcare professionals, characterized in Table 1. Information was self-reported. Most participants had a high level of qualification and extensive experience in primary healthcare. Based on these interviews, the content allowed the identification of several themes: how professionals characterize mental health problems, how they provide care, how the work process is organized, and which networks are available for articulating care. In this article, we focus on professionals' perceptions regarding listening as a care tool.

Tabela 1 - Caracterização dos entrevistados.

| Identificação | UBS | Gênero | Cor/Raça | Profissão | Escolaridade | Tempo de experiência na APS |
|---------------|--------|--------|----------|-----------------------------|-----------------------|-----------------------------|
| P1 | UBS 1 | F | Branca | Médica | Pós-graduação | Maior que 20 anos |
| P2 | UBS 2 | M | Pardo | Médico | Mestrado | Entre 10 e 20 anos |
| P3 | UBS 3 | M | Branco | Médico | Mestrado | Entre 10 e 20 anos |
| P4 | UBS 4 | F | Mestiça | Médica | Especialização | Maior que 20 anos |
| P5 | UBS 5 | F | Branca | Médica | Mestrado | Entre 10 e 20 anos |
| P6 | UBS 6 | F | Branca | Médica | Pós-graduação | Maior que 20 anos |
| P7 | UBS 7 | F | Branca | Médica | Mestrado | Maior que 20 anos |
| P8 | UBS 8 | F | Branca | Médica | Mestrado | Menor de 10 anos |
| P9 | UBS 9 | M | Branco | Médico | Mestrado | Maior 10 e 20 anos |
| P10 | UBS 10 | M | Branco | Médico | Mestrado | Entre 10 e 20 anos |
| P11 | UBS 11 | F | Branca | Enfermeira | Pós-graduação | Maior que 20 anos |
| P12 | UBS 12 | F | Branca | Enfermeira | Especialização | Maior que 20 anos |
| P13 | UBS 13 | F | Parda | Agente Comunitária de Saúde | Graduação | Maior que 20 anos |
| P14 | UBS 14 | F | Negra | Agente Comunitária de Saúde | Ensino Médio completo | Maior que 20 anos |
| P15 | UBS 15 | F | Alva | Técnica de enfermagem | Incompleto | Maior que 20 anos |

Active listening during individual consultations emerged in the interviews as one of the main elements of mental healthcare. In many reports, this listening occurs during the first contact with the health service, a process called “welcoming” (“acolhimento”), which appears in the accounts as an important care strategy, both in handling spontaneous demands and mental health crises. It is identified as the first step in user care when they arrive at the BHU — “So the first thing is to understand what’s happening: it’s the welcoming process. From the welcoming process onward, the rest of the flow tries to follow” (P5).

Welcoming is a modality of “light technology” in healthcare proposed by the National Humanization Policy of the SUS (PNH). Launched in 2003, the PNH aims to operationalize SUS principles within health services, improving the quality of care through strategies designed to qualify healthcare professionals to deal with the subjective dimension of healthcare work (Brazil, 2009). Welcoming is presented by the policy as an ethical/aesthetic/political guideline intended to value the encounter between professionals and users, allowing the latter to feel cared for and well attended in their contact with the service, with responsibility and problem-solving capacity. This practice seeks to address difficulties faced by people in reaching healthcare facilities, receiving adequate information from health services, obtaining appointments, and ensuring follow-up consultations, thus avoiding situations such as sleeping in lines or not receiving care (Coelho & Jorge, 2009). Although risk classification is part of the process, welcoming differs from “screening” because it is not merely a work process but rather an attitude that should occur throughout all stages of the user’s journey through the system (Brazil, 2010). Restricting welcoming to the moment users arrive at the unit impoverishes the practice and empties the original meaning of the term (Januário, 2023).

Beyond welcoming and directing users within the unit’s care flow, listening is also described as a therapeutic instrument in itself, often considered sufficient as a treatment strategy for many mental health complaints. Interviewees reported perceiving positive responses in managing the people they cared for when they dedicated time during consultations to listening to them. Regarding technique, professionals generally allow users to speak freely, expressing what they are feeling, and enable them to recognize their suffering and jointly construct an intervention plan with the professional. The importance of respecting users’ speech and avoiding judgment, giving advice, or prescribing what should be done is emphasized — although some professionals report doing so when they deem it necessary or therapeutic, such as during emergency consultations. Since this practice can be performed by any professional, not necessarily from the healthcare field, it is often devalued compared to other technical interventions (Santos, 2019). Nevertheless, the process of qualified listening enables the humanization of care to materialize, making the social, ethical, educational, and psychological circumstances of individuals more visible and the meaning of suffering better understood by professionals (Januário, 2023). P7’s report illustrates these elements:

So, the main thing is listening. I schedule a lot of follow-ups for these patients so they can be listened to. Since I know them very well and have a strong bond with them, often this listening itself becomes the treatment. (...) It’s what we call active listening, right? Listening and then encouraging the person to speak. As I tell the residents: without pretending to have the solution, none of that. Just listening. So I think that’s what makes the biggest difference for most people. And I’m like that. That hug at the end of the consultation, that affection that makes the person feel cared for. I think those are things that make a difference. (P7)

Regarding listening techniques, interviewees generally did not indicate any specific technique. Two psychotherapeutic approaches — systemic therapy and motivational interviewing — were mentioned in two accounts. However, what interviewees reported doing routinely during mental health consultations were counseling sessions or brief therapies during individual consultations, without following a specific psychological approach. They described these consultations as “intuitive,” based on what emerged from listening to users and on the professionals’ previous knowledge. P4 states:

The brief therapy I’m talking about is not classic brief therapy, right? I could say brief approaches. Like, someone going through alcohol or drug detoxification, [they receive] daily appointments for a while until detoxification. People with anxiety or depression issues, weekly appointments with tasks, you know, the whole approach. At follow-up, I propose something for the person to do during the day. Some perception exercise, breathing exercise, or behavioral awareness (...). And throughout the week, usually there were 10 sessions of brief therapy. I won’t call it psychotherapy because I’m not a psychologist. So it was much more intuitive on my part. (P4)

Albuquerque (2022) indicates that there are two types of psychotherapy performed in medical office settings: one conducted in an informed manner, with defined objectives and a predetermined number of sessions; and another carried out in routine consultations through listening and counseling, in which people are often not informed that a psychotherapeutic approach is being used, nor is a predetermined number of meetings established, and it may occur in a single consultation. The author notes that lack of knowledge about the psychodynamic and psychological bases of these interventions does not prevent them from being considered psychotherapy; however, learning psychotherapeutic techniques may contribute to better grounding the practice and increasing professionals’ awareness of what they are doing. The longitudinal contact that Family Health teams have with users, as well as their knowledge of users’ life stories and long-term follow-up, makes consultations with these professionals particularly suitable for this type of intervention (Santos, 2019).

Another theme related to listening is the bond established with users through their contact with healthcare units. Bonding is perceived as a particular relationship established through listening to users, contributing to care. Interviewees demonstrate concern for the individuals they care for, not only regarding adequate treatment but also understanding their life stories and caring about their well-being, identifying this process as therapeutic. Pichon-Rivière defines bonding as the particular way each individual relates to another or others, creating a unique structure in each case and at each moment. According to Rivière, relationships occurring in health services establish what is called a “therapeutic bond,” in which providers and users assign roles to one another, and accepting the role proposed by the other is necessary for the bond to occur (Sant’ana, 2022).

Related to bonding, continuity of care — one of the PHC attributes described by Starfield (2002) — was also mentioned by interviewees. It allows for a large number of encounters between professionals and users, multiplying opportunities for listening and enabling users to bring various accounts regarding their illness process. This allows professionals to construct a narrative of the user’s experience with illness from these reports, enabling exploration of the subjective elements of the lived illness process (Jones & Cutcliffe, 2009; Santos, 2019). In this sense, continuity of care fosters the development of a bond between PHC professionals and users, creating what can be called a “longitudinal bond,” that is, a therapeutically

established relationship between users and the team, recognizing PHC as a regular source of care over time (Santos, 2018).

Many interviewees discussed the limited consultation time, which restricts the possibility of adequate listening. They reported pressure to conduct brief consultations, generating frustration because they are unable to explore users' reports in depth. Listening requires a certain structure, both in organizational aspects — such as adequate consultation time, private spaces, demand compatible with service capacity, and user comfort — and in professional skills, such as the humanization of the team itself (Januário, 2023). Users' narratives may often be confusing, lacking a clear chronological order and emphasizing events with greater psychological impact. Listening attentively, building bridges with elements reported previously, and repeating users' narratives in different words are skills that may be necessary to conduct consultations (Jones & Cutcliffe, 2009). Infrastructure-related factors, excessive bureaucratization of work, lack of time, and other elements preventing users, workers, and health system managers from recognizing the care potential within healthcare environments are identified as factors present in many PHC services that hinder bond formation (Santos, 2018).

Many interviewees mentioned overload in consultations and exhaustion related to the listening process. Starfield (2002) argues that there is a difference between locating the locus of continuity in an individual, a team, or a specific place. When this locus is centered on an individual, the burden of care coordination becomes greater, since it is easier for a team to always be available than for a single individual (Starfield, 2002). Welcoming actions centered on only one professional category tend to produce fragmented and fragile care (Januário, 2023). In many units, feelings of “being alone” and perceiving oneself as the only source of support for users appeared in the reports. While this indicates a certain overload, since the locus of care has become concentrated on that professional, it is also a sign that a bond has been established and that users tend to open up more during these consultations.

Final Considerations

Listening appears in the study as an important element of care. The privileged position within the system where this practice occurs — PHC — seems to favor the strengthening and formation of bonds between users and healthcare teams, since continuity of care and the therapeutic bond established between professionals and users tend to be enhanced in PHC compared to other levels of care, given the proximity between healthcare teams, users, and the territories where they live. This aligns with the idea of territorial, non-institutionalized mental healthcare promoted by psychiatric reform and psychosocial care.

The reports point to listening as a care tool with therapeutic potential in itself. This potential has been mentioned in other studies, but it tends to be undervalued in health education compared to pharmacological treatments and other non-relational approaches. Thinking about ways to qualify professionals to ensure therapeutic listening may be a way to provide more humanized care and bring mental healthcare in PHC closer to the concept of an expanded clinic. The reported content indicates that the most important aspect for good listening is not necessarily mastering a specific psychotherapeutic technique or approach, but rather practicing nonjudgmental listening, establishing longitudinal relationships with users, and maintaining careful attention to people's life contexts and trajectories. However, knowledge of some psychotherapy fundamentals among all professionals involved in public care may contribute to better management of these consultations. Teamwork and ensuring that listening is not concentrated in a single professional also appear to contribute both to improved care — by creating more opportunities for listening — and to reducing the

overload that may arise from this type of care.

The present study has methodological limitations, since the interviewees were predominantly physicians and users were not interviewed. Broader studies incorporating the perspectives of users and other professionals may contribute further to a more comprehensive understanding of the scenario.

References

- Aguiar, D. S. (1998). *A "Saúde da Família" no Sistema Único de Saúde: Um novo paradigma?* (Master's Thesis, Escola Nacional de Saúde Pública). Rio de Janeiro.
- Albuquerque, M. A. C. (2022). *Psicoterapia para médicos de família: A arte de conversar com o paciente* [E-book Kindle]. Blucher.
- Amarante, P. (1995). *Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil* [online]. 2nd ed. rev. and enl. Rio de Janeiro, Fiocruz. ISBN 978-85-7541-335-7. <https://doi.org/10.7476/9788575413357>.
- Barros, S., Nóbrega, M. P. S. S., Santos, J. C., Fonseca, L. M., & Floriano, L. S. M. (2019). Saúde mental na atenção primária: Processo saúde-doença segundo profissionais de saúde. *Revista Brasileira de Enfermagem*, 72(6), 1609–1617. <https://doi.org/10.1590/0034-7167-2018-0743>
- Brasil. Ministério da Saúde. (2009). *O HumanizaSUS na atenção básica*. Brasil. Ministério da Saúde. (2010). *Cartilha da Política Nacional de Humanização: Acolhimento nas práticas de produção de saúde*.
- Campos, G. W. S. (1997). *Uma clínica do sujeito: por uma clínica reformulada e ampliada*. Campinas, Mimeo.
- Coelho, M. O., & Jorge, M. S. B. (2009). Tecnologia das relações como dispositivo do atendimento humanizado na atenção básica à saúde. *Ciência & Saúde Coletiva*, 14(1), 1523–1531. <https://doi.org/10.1590/S1413-81232009000800026>
- Costa-Rosa, A. (2000). O Modo Psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante, P. (Org.) *Ensaio: subjetividade, saúde mental, sociedade*. Rio de Janeiro, Fiocruz.
- Curitiba. Secretaria Municipal de Saúde. (2023). *Relatório detalhado do quadrimestre anterior (RDQA): 3º quadrimestre de 2023*. Retrieved April 29, 2024, from <https://saude.curitiba.pr.gov.br/a-secretaria/instrumentos-de-planejamento-emsaude.html>
- Giovanella, L. & Mendonça, M. H. M. (2012). Atenção Primária à Saúde. In: Giovanella, L., Escorel, S., Lobato, L. V. C., Noronha, J. C. & Carvalho, A. I. (org.). *Políticas e sistema de saúde no Brasil*. 2nd ed. rev. and enl. Rio de Janeiro, Fiocruz. <https://doi.org/10.7476/9788575413494.0019>
- Hirdes, A. & Scarparo, H. B. K. (2015). O labirinto e o minotauro: saúde mental na atenção primária à saúde. *Ciência & Saúde Coletiva*, 20(2), 383-393. <https://doi.org/10.1590/1413-81232015202.12642013>
- Januário, T. G. F. M., Varela, L. D., Oliveira, K. N. S., Faustino, R. S., & Pinto, A. G. A. (2023). Escuta e valorização dos usuários: Concepções e práticas na gestão do cuidado na Estratégia Saúde da Família. *Ciência & Saúde Coletiva*, 28(8), 2283–2290. <https://doi.org/10.1590/1413-81232023288.05952023en>
- Jones, A. C., & Cutcliffe, J. R. (2009). Listening as a method of addressing psychological distress. *Journal of Nursing Management*, 17, 352–358. <https://doi.org/10.1111/j.1365-2834.2009.00998>

- MAROS, A. Reduzida em 26%, Saúde da Família poderia ajudar a frear Covid-19 em Curitiba. *Jornal Plural*, Curitiba, 14 de setembro de 2020. Disponível em < <https://www.plural.jor.br/noticias/vizinhanca/reduzida-em-26-saude-da-familia-poderia-ajudar-a-frear-covid-19-em-curitiba/>> acesso em 15/09/2024.
- Mesquita, A. C., & Carvalho, E. C. (2014). A escuta terapêutica como estratégia de intervenção em saúde: Uma revisão integrativa. *Revista da Escola de Enfermagem da USP*, 48(6), 1127–1136. <https://doi.org/10.1590/S0080-623420140000700022>
- Minayo, M. C. S. (2010). *O desafio do conhecimento: Pesquisa qualitativa em saúde* (12ª ed.). Hucitec.
- Nascimento, J. M. F., Carvalho Neto, J. F., Vieira Júnior, D. N., Braz, Z. R., Costa Júnior, I. G., Ferreira, A. C. C., Santos, L. E. S., & Oliveira, A. K. S. (2020). Escuta terapêutica: Uma tecnologia do cuidado em saúde mental. *Revista de Enfermagem UFPE on line*, 14, 244–257. <https://doi.org/10.5205/1981-8963.2020.244257>
- Oliveira, A. B., Barbosa, V. F. B., Alexandre, A. C. S., Santos, S. C., & Santos, D. C. S. (2020). O acolhimento na rede de atenção psicossocial: Estudo descritivo-exploratório. *Online Brazilian Journal of Nursing*, 19(2). <https://doi.org/10.17665/1676-4285.20206374>
- Ricoeur, P. (1988). *O conflito das interpretações: Ensaio de hermenêutica* (M. F. Sá Correia, Trad.). Rés.
- Ricoeur, P. (2013). *Hermenêutica e ideologias* (3ª ed.). Vozes.
- Sant’Ana, M. R. L. V. (2022). *A produção de vínculos entre usuários com sofrimento psíquico grave, seus familiares e equipes de Saúde da Família* (Master’s thesis, Universidade Federal de Minas Gerais).
- Santos, A. B. (2019). Escuta qualificada como ferramenta de humanização do cuidado em saúde mental na atenção básica. *APS em Revista*, 1(2), 170–179. <https://doi.org/10.14295/aps.v1i2.23>
- Santos, R. O. M. (2018). Vínculo longitudinal na Saúde da Família: Construção fundamentada no modelo de atenção, práticas interpessoais e organização dos serviços. *Physis: Revista de Saúde Coletiva*, 28(2), e280206. <https://doi.org/10.1590/s0103-73312018280206>
- Starfield, B. (2002). *Atenção primária: Equilíbrio entre necessidades de saúde, serviços e tecnologia*. UNESCO; Ministério da Saúde.
- Treichel, C., & Campos, R. (2022). Avaliação da atuação da rede comunitária de saúde mental em um município paulista de médio porte. *Saúde em Debate*, 46(132), 121–134. <https://doi.org/10.1590/0103-1104202213208>
- Yasui, S., Luzio, C. A., & Amarante, P. (2018). Atenção psicossocial e atenção básica: A vida como ela é no território. *Revista Polis e Psique*, 8(1), 173–190. <https://doi.org/10.22456/2238-152X.80426>