



CHALLENGES OF PSYCHOSOCIAL CARE IN THE BRAZILIAN PSYCHIATRIC REFORM: THE FETISH OF THE CRISIS IN QUESTION

*Desafios do atendimento psicossocial na reforma
psiquiátrica brasileira: o fetiche da crise em questão*

*Desafíos de la atención psicossocial en la reforma
psiquiátrica brasileña: el fetichismo de la crisis en cuestión*



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Abstract

This article reflects on a workshop held at the Escola Franca e Franco Basaglia in Belém in 2025, based on a discussion of the text “Fetichismo da Crise: desafios para a atenção psicossocial,” written by the authors. A critical analysis of the topic was conducted from the perspective of the Brazilian Psychiatric Reform. The psychic crisis was examined as one of the main challenges facing mental health within the context of psychosocial care, and the discussion highlighted conflicts arising in service settings between two still-coexisting paradigms: the psychiatric and the psychosocial. It was concluded that this tension stems from the way psychiatry has appropriated the category of crisis, transforming it into a genuine fetish.

Keywords: Mental Health. Crisis Intervention. Psychiatric Reform.

Resumo

Este artigo reflete sobre uma oficina realizada na Escola Franca e Franco Basaglia, em Belém, em 2025, baseada na discussão do texto “Fetichismo da Crise: desafios para a atenção psicossocial”, de autoria dos autores. Foi realizada uma análise crítica do tema sob a perspectiva da Reforma Psiquiátrica brasileira. A crise psíquica foi examinada como um dos principais desafios enfrentados pela saúde mental no contexto do cuidado psicossocial, e a discussão destacou conflitos que surgem nos serviços entre dois paradigmas ainda coexistentes: o psiquiátrico e o psicossocial. Concluiu-se que essa tensão decorre da forma como a psiquiatria se apropriou da categoria de crise, transformando-a em um verdadeiro fetichismo.

Palavras-chave: Saúde Mental. Intervenção em Crise. Reforma Psiquiátrica.

Resumen

Este artículo reflexiona sobre un taller realizado en la Escola Franca e Franco Basaglia de Belém en 2025, basado en el análisis del texto “Fetichismo da Crise: desafios para a atenção psicossocial”, escrito por los autores. Se realizó un análisis crítico del tema desde la perspectiva de la Reforma Psiquiátrica Brasileña. La crisis psíquica se examinó como uno de los principales desafíos que enfrenta la salud mental en el contexto de la atención psicossocial, y el debate puso de relieve los conflictos que surgen en los servicios entre dos paradigmas aún coexistentes: el psiquiátrico y el psicossocial. Se concluyó que esta tensión proviene de la forma en que la psiquiatría se ha apropiado de la categoría de crisis, transformándola en un auténtico fetichismo.

Palabras clave: Salud mental. Intervención en crisis. Reforma psiquiátrica.

Introduction

This text reflects on the article “Fetichismo da crise: desafios para a atenção psicossocial,” published by Sade and Carvalho (2025) and discussed at a workshop held at the Escola Franca e Franco Basaglia in Belém in the same year. The workshop aimed to examine the issue of psychic crisis within the framework of the Brazilian Psychiatric Reform, discussing how it has become a fetish for contemporary psychiatry and a challenge for care practices guided by the reform paradigm.

It should be highlighted that the crisis operates in both the domain of care practices and the domain of public policy. These two dimensions are not independent; on the contrary, they are deeply intertwined, given that the political organization of the mental health field drives the development of new practices while simultaneously being transformed by them.

The Brazilian Psychiatric Reform is a landmark in the struggle for the rights of people with mental health problems in the country. It is also a symbol of the democratic struggle, which, allied with the Movement Sanitary, galvanized progressive forces in the political landscape of the late 1970s and throughout the 1980s, pushing for the end of the Military Dictatorship and advocating for public health as a universal right. The reform was also a social project, grounded in democracy and human rights, aimed in particular at deinstitutionalizing madness and building a care network. Deinstitutionalization in the mental health field entailed shifting the focus of care from closed, asylum-type institutions to the community and its territory (Hirdes, 2009). For Amarante (1996), deinstitutionalization also refers to an epistemological critique of medical-psychiatric knowledge, which appropriated the experience of madness in order to establish itself as a field of knowledge.

The reform advanced and was organized through Law No. 10.216, of April 6, 2001 (Brasil, 2001), which addresses the protection and rights of people with mental health problems and the reversal of the care model, that is, the shift from care based on the traditional psychiatric or asylum model to the psychosocial care model and the construction of a new care network.

From then on, a set of regulations gradually consolidated the precepts of the reform, including the progressive reduction of psychiatric beds, investment in services to replace the asylum model, such as the Psychosocial Care Centers in their various modalities, and the Therapeutic Residential Services for housing individuals discharged after long periods of hospitalization in psychiatric institutions, alongside psychosocial rehabilitation supports such as the Return Home Program. In 2011, this structure, which had been gradually built on multidisciplinary and intersectoral collaboration, was reorganized as the Psychosocial Care Network, established through Ministerial Order No. 3.088, of December 23, 2011 (Brasil, Ministério da Saúde, 2011), aiming to provide mental health care for people with mental health problems and/or those who make harmful use of alcohol and drugs, within a network that brings together different points of mental health care in the Unified Health System (SUS), encompassing primary care, emergency networks, general hospitals, and all services and programs that were already part of the then-existing “mental health network.”

The psychosocial care network is part of a broader strategy that aims to address the fragmentation of healthcare actions, which had previously led to the creation of separate care networks. From the perspective of the healthcare reform, the RAPS marked a significant milestone.

The psychosocial care network can be understood as simultaneously a domain of care practices and of public policy. The care practices developed within the network are notably influenced by the precepts of the reform and by the knowledge produced by various professionals and their respective disciplines. The field of public policy, in turn, reflects the political and social organization of a given historical moment and unfolds in the implementation and organization of the network, its objectives, available resources, and so on; care practices and policy are therefore intertwined and present in the countless health actions that develop within the network and beyond, reflecting attitudes, ideologies, paradigms, and modes of practice. It is within the RAPS, with all its complexity, that the psychic crisis is addressed, both from the perspective of care practices and from the political perspective, expressed here in the organization of the network.

The care of psychic crises faces significant challenges in the mental health field, particularly given their urgent nature, the paradigms used to interpret them, and the stigmas and prejudices that accompany them, rendering the crisis a genuine fetish in contemporary times. The crisis is one of the most significant phenomena in mental health, as it is deeply shaped by social standards of normality, causing great suffering in the individual who experiences it and in those around them. This analysis allows us to recognize the importance of approaches to the “crisis” that prioritize the person’s existence and suffering, drawing on a different body of knowledge, not centered on the disease-cure paradigm. The advance of the reform has enabled dialogue with other ways of understanding the crisis, respect for the diversity of experiences, and incorporation of the singularity of the person who suffers. However, this openness has not eliminated the psychiatric paradigm and its reading of the crisis, which continues to hinder its approach within both care practices and the political organization of the network.

The role of services must therefore be reconsidered, with a fundamental emphasis on promoting social inclusion, citizenship, and autonomy, in which service users are the protagonists of their own care, developing coping skills and reducing future crises and medication use, while preserving their individuality. In the psychosocial care model, as advocated by the psychiatric reform, crisis care is primarily associated with the provision of longitudinal care within the contexts of people’s lives and within a community-based network of care aimed at enabling individuals to reclaim their lives in full.

The psychiatric model, by contrast, has consolidated an approach to crisis care that is fundamentally at odds with the psychosocial paradigm, in which containment and hospitalization in psychiatric institutions lead to the individual’s removal from family and community life. Hospitalization has long been the primary response to crisis, grounded in principles of security and control. The Brazilian Psychiatric Reform introduces a paradigm shift, proposing that the psychic crisis should be addressed within the community setting, promoting care in freedom, a paradigm

that recognizes the transformative potential of crisis (Ferigato et al., 2007).

Against this backdrop, the following sections examine elements that highlight the complexity of psychic crisis within the context of psychosocial care and the RAPS. The discussion focuses on how the crisis has historically been appropriated by psychiatry and transformed into a genuine fetish. By problematizing this construction, the aim is to clarify its effects on care practices, the organization of the network, and the challenges it poses to consolidating the psychosocial paradigm.

Understanding the crisis

Any definition of crisis must take into account the context and organization of psychiatry itself within a given historical setting (Dell'Acqua & Mezzina, 2005). The word crisis originates from the Greek *krisis*, which denotes a situation or moment of risk requiring a decision to be made. It also derives from the Latin *crisis*, indicating a moment of choice and change. The term encompasses both risk and transformation; in its philosophical sense, it carries its original semantic attributes and can also signify purification (Ferigato et al., 2007; Dassoler, 2022).

Throughout history and across cultures, the psychic crisis has been characterized as a manifestation of the divine, wisdom, possession, witchcraft, and the subversion of social order, until psychiatry reduced it to the label of illness. Stripped of all its symbolic content as “madness,” the crisis becomes the incontestable marker of mental illness, deviance, and dangerousness (Ferigato et al., 2007; Dassoler, 2022).

Even as psychiatry has reshaped reform processes, crisis intervention continues to be approached as something negative: autonomy is taken away from individuals and transferred to professionals, who exercise total control over the person. This occurs because psychiatry has transformed crisis into both a pathology and a form of deviance.

This transformation is evident in the diagnostic systems promoted by the American Psychiatric Association, through successive editions of the Diagnostic and Statistical Manual of Mental Disorders, which label a wide range of behaviors and symptoms as psychiatric diagnoses. These manuals have been widely criticized for their scientific validity, despite being used globally for the diagnosis of psychological distress (Amarante et al., 2018; Zorzanelli et al., 2014).

Despite the progress of the psychiatric reform and the paradigm shift from the asylum model to psychosocial care, two meanings of the psychic crisis have become crystallized: (1) what may be called the psychiatric crisis, which preserves the conceptions produced within psychiatry and evokes feelings of fear and of something uncontrollable that must be contained; and (2) the psychosocial crisis, which approaches the crisis as a lived experience in which something unbearable ruptures the person's system of meaning or threatens the dimensions of their life, potentially compromising their physical and symbolic existence, but which may also serve as a vehicle for transformation, as it enables the individual to communicate suffering they had been unable to articulate.

There is a duality in how the crisis is understood: in the psychiatric paradigm, it is interpreted as a symptom of mental disorder that must be immediately contained, whereas in the psychosocial paradigm, it is understood as an experience that must be traversed. As an experience, it is shaped by the social contexts of life, including family, work, emotions, culture, and relationships. From this perspective, the crisis should be welcomed and its content analyzed by the various professionals involved in the care.

Araújo (2022) argues that the crisis should not be viewed as an isolated event or as the result of “mental illness.” The author proposes that the crisis is a consequence of suffering accumulated through various forms of violence, oppression, vulnerability, and dilemmas that the individual is unable to process, owing to a lack of emotional, cultural, and social resources.

The fetish of crisis

According to the Houaiss dictionary, the term “fetish” carries multiple meanings. It can refer to an object attributed with magical powers, a part of the body considered to possess special or erotic attributes, or, more broadly, something that exerts a strong attraction and fascination (Houaiss, 2025). These definitions reflect the various contexts in which the term has been used and how it has been reappropriated over time. The word itself derives from the Portuguese *feitico*, meaning enchantment, and was used in the context of colonization during the 15th and 16th centuries to describe objects considered magical by African people (Mountain, 2014; Salvador Roberto et al., 2009).

The word itself, in turn, derives from the Latin *facticius*, meaning something artificial, that is, made by human hands. The term was incorporated into French as *fétiche* in the 18th century through anthropological studies connecting it to the magical-religious practices of African people. From anthropology, the term migrated to other fields and evolved, broadening its meaning and giving rise to the expression fetishism, which became an important concept in the human and medical sciences. Initially employed in anthropology and sociology, fetishism was later appropriated by psychoanalysis, psychology, and psychiatry. These successive uses have continuously expanded its meaning, shaping the various senses attributed to it (Mountain, 2014; Salvador Roberto et al., 2009).

For Freud, the fetish is a concept central to psychoanalysis and sexuality, one that helps illuminate psychic mechanisms. Fetishism, in this framework, refers to an object or thing that substitutes for a sexual desire or a psychic conflict. According to Freud, during the boy’s psychosexual development, he perceives that the mother does not have a penis and associates this with the possibility of castration, generating fear and anxiety. To manage this conflict, a fetish is formed around some object or body part, substituting for the fear and endowing that object with a powerful sexual meaning. The fetishized object, therefore, subjectively replaces the fear while simultaneously preserving and redirecting desire onto the object. The enchantment of the object

ascribes to it a quality it does not truly possess; the sexual fetish creates the illusion that the individual is protected from castration, establishing false relations in place of real ones (Carvalho & Simanke, 2024).

Freud's notion of the fetish helps us reflect on the fetish of crisis. In its drive to establish itself as a science, psychiatry converts the experience of madness into its own domain. To do so, it takes madness as the object of its practice and the figure of the "mad person" as the object of intervention. This conversion into pathology was initially still closely associated with moral deviance. Within this relationship lies psychiatry's underlying desire to become a discipline capable of ordering social life and space through its classificatory system and the exercise of power, resulting in what might be called "normalization."

Psychiatry crystallized the crisis, transforming it into a fetish. That is, substitution and illusion operate within the fetish of crisis: an artificial relationship is created in which the crisis, in and of itself, confirms the existence of mental illness and denies the psychosocial and sociohistorical dimensions of that relationship. In doing so, the crisis takes on magical and tragic attributes. It becomes a mystery and thereby produces an intrinsic fascination. It is tragic because it disrupts the social order and professional certainties, evoking fear and anguish in those who witness it or deal with it. Even with the emergence of new bodies of knowledge that reclaim and resignify the experience of madness, such as those advanced by the Brazilian Psychiatric Reform, the psychic crisis persists as the Achilles' heel of reformist movements.

The crisis is the fetish object for psychiatry because it shields psychiatry from the denial of its authority by other fields, reinforcing the discourse that only psychiatry is capable of managing crisis. For this reason, even professionals who recognize madness as an experience and who strive to approach the psychic crisis as something to be traversed find themselves captured by its mystery and drawn in by its fascination, seeking to contain it, fixated on documenting and categorizing its manifestations, attentive to its signs and to the ways of managing its symptoms.

It is not difficult to find studies in the literature demonstrating this fetish expressed in the opposition between the two paradigms. The fetish is present when, in dealing with the crisis, professionals struggle to understand it, experience fear and distress, and find their conceptions oscillating between the psychiatric and psychosocial paradigms without adequate mediation. The fetish of crisis thus symbolizes the interaction between the two paradigms, despite their inherent contradiction (Moura et al., 2022; Carvalho et al., 2024; Homercher & Volmer, 2021).

Possibilities

It should be highlighted that, at the political level, crisis services are less receptive to changes in mental health policy, maintaining their conservative character in part because of the way the crisis has been fetishized (Dassoler, 2022). In the care provided at CAPS facilities, the fetish of crisis operates in a more diffuse way, since this setting brings together distinct conceptions of

mental health and of crisis. Within the same space, pragmatic interventions guided by biomedical protocols may coexist alongside community-based practices that prioritize the formation of bonds, receptive care, and subjective dimensions (Dassoler, 2022; Dias et al., 2020).

Although other approaches and intervention perspectives exist among professionals, psychiatric knowledge remains the organizing force behind the care. The RAPS is organized around mental health care points across its various network components. One such component is the urgent and emergency care sector, which should provide crisis response through certain services: the Mobile Emergency Service; the Emergency Care Unit; and the psychiatric emergency care units in general hospitals. In this configuration, the psychic crisis is treated as a medical emergency, defined in terms very close to those of clinical urgencies. Approaches in this setting are often highly conservative, aligned with medical-psychiatric knowledge, and involve the use of physical restraint and even police force, as well as well-documented difficulties in accessing care at both the services (Wasum et al., 2024; Almeida et al., 2015). In this context, the senses of risk and dangerousness that characterize the fetish of crisis prevail.

It should be noted that, throughout the course of the Brazilian Psychiatric Reform, greater concern was directed toward institutionalized service users, who were victims of all forms of violation. At that time, crisis situations occurred largely within those hospital settings. With the deepening of the reform and the creation of the care network, services now contend with new crisis situations involving not only individuals diagnosed with serious psychological distress but also those with no psychiatric history who experience significant suffering related to abrupt life events such as violence, major losses, unemployment, inadequate housing conditions, illness, and related adversities (Dassoler, 2022).

For Basaglia (1985), the principle of placing mental illness in brackets refers to the individuation of the person, that is, to engaging not with mental illness as a psychiatric concept in its ideological function, but rather with everything that has been constructed around the illness. Services aligned with the asylum model treat the psychic crisis as a mere object, depersonalizing it and stripping it of all symbolic content. In this context, psychiatric practice operates through physical and pharmacological restraint and the isolation of individuals. Medications serve to interrupt all manifest content expressed through the crisis. These situations frequently become a grotesque performance of inhumanity, further reinforcing the sense of urgency and danger that already pervades the social imaginary surrounding them.

For Araújo (2022), the experience of suffering produces a continuum in which the abrupt experience becomes entangled with other difficulties in the person's life, leading to an intensification of suffering. When the objective, subjective, and symbolic resources needed to process the experience are lacking, the individual enters a crisis state. When these individuals are seen in psychiatric emergency services, their entire lives may be determined by that encounter, since, as already noted, the fetish of crisis operates in the struggle between paradigms, stripping subjects of their place and reducing them to mere objects of fascination and fear.

Final considerations

Overcoming the fetish of crisis requires a paradigm shift that places the individual at the center of care, recognizing their singularity and promoting inclusive practices. Only in this way will it be possible to provide quality care that respects human rights and promotes mental health care in its entirety.

The analysis of the fetish of crisis reveals how psychiatry, throughout history, has shaped the perception of madness and crisis in rigid and normative terms, obscuring the psychosocial and sociohistorical dimensions essential to an understanding of this experience. The crisis, transformed into a fetishized object, dehumanizes the individual, reducing them to a mere case and perpetuating the notion of danger and urgency that demands immediate and controlling intervention.

According to Dell'Acqua and Mezzina (2005), crisis unfolds within a collective space, and the social actor should be able to move through it without losing connection with their environment and the significant people in their life. This process allows possibilities to expand and new ties with the service to be established. However, most social actors identified as being in crisis by services and family members receive high doses of psychotropic medications, becoming idle and drowsy, trapped within the crisis itself, sitting or pacing back and forth. Professionals often limit themselves to observation and questioning what can be done beyond medication management.

The crisis, by disrupting the established order of health services and the routine of professionals, reveals the tension between the psychiatric and psychosocial paradigms. This tension is manifested in the competition for authority over crisis treatment and in the search for methods that respect individuality and promote personal transformation without resorting to pathologization.

To address these challenges, the role of the professional must be transformative, attributing new meaning to the complexity of the crisis rather than interpreting it as incapacity, insanity, or illness, and simply caring through a lens of diversity, respecting the social actor's way of living and their different way of relating to the world. Knowledge must therefore not be used as a normative technique but as a means of creating subjectivities. Technique ceases to be an instrument of violence when practice functions as a deconstruction of clinical convention.

It should be emphasized that clinical practice in crisis care must be guided by deinstitutionalization, which, according to Rotelli (2001), is a practical-critical process that reorients institutions and services, energies and knowledge, strategies and interventions. Its goal is not cure, but emancipation. In other words, it seeks to recognize the potential within the crisis, enabling the person to constitute themselves as the subject and author of their own history, grounded in a new paradigm centered on care and on demystifying the fetishization of crisis.

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