

### **Women, medicalization and grouping: Experience with autonomous management of medication in the northeast**

*Mulheres, medicalização e grupalidade: experiência com gestão autônoma da medicação no nordeste*

*Mujeres, medicalización y grupalidad: experiencia con gestión autónoma de la medicación en el Nordeste*

*Femmes, médicalisation et groupalité: expérience de gestion autonome des médicaments dans le Nord-Est*

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#### **Abstract**

*Psychiatric discourse has produced the excessive use of psychotropic drugs, being women the largest consumers in primary health care. When we consider the Brazilian Northeastern and countryside scenery and the gender, social, and culturally constituted issues within it, this problem challenges mental health care. Thus, this intervention research aimed to map the participation of medicalized women in psychological distress in an Autonomous Medication Management Group (GAM) in the context mentioned above. The study research was carried out over 6 months, in 24 meetings, and data was analyzed, based on narrative fragments from cartographic diaries and audio records, into three themes: 1. Production of psychological suffering in the bodies of medicalized countryside women and the silencing of discomforts caused by the condition of poor domestic woman-mother; 2. Experiences of these women in affective and sexual work concerning their psychological suffering; and 3. GAM group in these women's lives in the production of collectivity and reflections based on the anti-asylum and health movements. We conclude that gender relations are the components of medicalization in these women's lives, and the group constitutes a co-managing space of resistance, where women recognize themselves as autonomous subjects in relations of power and knowledge in which they are involved.*

**Keywords:** *women, medicalization, mental health, primary care, backlands.*

#### **Resumo**

O discurso psiquiátrico tem produzido o uso excessivo de psicofármacos, sendo as mulheres as maiores consumidoras na atenção primária à saúde. Quando consideramos o cenário nordestino e sertanejo brasileiro e as questões de gênero, social e culturalmente constituídas nele, este problema desafia o cuidado em saúde mental. Assim, esta pesquisa-intervenção objetivou cartografar a participação de mulheres

em sofrimento psíquico medicalizadas, num grupo de Gestão Autônoma de Medicação (GAM), no referido contexto. A pesquisa foi realizada durante 6 meses, em 24 encontros e os dados foram analisados, a partir de fragmentos narrativos de diários cartográficos e de registros de áudio, em três temas: 1. Produção do sofrimento psíquico no corpo das mulheres sertanejas medicalizadas e o silenciamento de mal-estares da condição de mulher-mãe-pobre-doméstica; 2. Experiências dessas mulheres em trabalhos afetivos e sexuais em relação ao seu sofrimento psíquico; e 3. Grupalidade GAM na vida dessas mulheres na produção de coletividade e de reflexões baseadas nos movimentos antimanicomial e sanitário. Concluímos que as relações de gênero são compositoras da medicalização na vida dessas mulheres e a grupalidade constitui espaço cogestivo de resistência, onde as mulheres se reconhecem como sujeitos autônomos em relações de poder e saber em que estão envolvidas.

**Palavras-chave:** mulheres, medicalização, saúde mental, atenção básica, sertão.

### **Resumen**

*El discurso psiquiátrico viene produciendo el uso excesivo de psicofármacos, siendo las mujeres las mayores consumidoras en la atención primaria de salud. Cuando consideramos el escenario nordestino y sertanejo brasileño y las cuestiones de género, social y culturalmente constituidas en él, este problema reta el cuidado en salud mental. Así, esta investigación-intervención objetivó registrar la participación de mujeres en sufrimiento psíquico medicalizadas, en un grupo de Gestión Autónoma de Medicación (GMA), en el referido contexto. La investigación fue realizada durante 6 meses, en 24 encuentros y los datos fueron analizados, a partir de fragmentos narrativos de diarios cartográficos y de registros de audio, en tres temas: 1. Producción del sufrimiento psíquico en el cuerpo de mujeres sertanejas medicalizadas y el silenciamiento de malestares de la condición de mujer-madre-pobre-doméstica; 2. Experiencias de estas mujeres en trabajos afectivos y sexuales en relación al sufrimiento psíquico; y 3. Grupalidad GAM en la vida de estas mujeres en la producción de colectividad y de reflexiones basadas en los movimientos antimanicomial y sanitario. Concluimos que las relaciones de género son compositoras de la medicalización en la vida de estas mujeres y la grupalidad constituye espacio cogestivo de resistencia, donde las mujeres se reconocen como sujetos autónomos en relaciones de poder y saber en qué están involucradas.*

**Palabras clave:** mujeres, medicalización, salud mental, atención básica, sertão.

### **Résumé**

*Le discours psychiatrique a produit une consommation excessive de psychotropes, les femmes étant les plus grandes consommatrices de soins de santé primaires. Lorsque nous considérons le scénario du Nord-Est et du sertão brésilien ainsi que les questions de genre, socialement et culturellement constituées en son sein, ce problème représente un défi pour les soins en santé mentale. Ainsi, cette recherche interventionnelle visait à cartographier la participation des femmes médicalisées souffrant de détresse psychologique dans un groupe de Gestion Autonome de la Médication (GAM) dans ce contexte. La recherche s'est déroulée sur une période de 6 mois, comprenant 24 réunions. Les données ont été analysées, à partir de fragments narratifs de journaux cartographiques et d'enregistrements audio, regroupées en trois thèmes: 1. Production de souffrance psychique chez les femmes médicalisées du sertão et le silence imposé face à détresse de leur condition de femme-mère-pauvre-au foyer; 2. Expériences de ces femmes dans le travail affectif et sexuel en lien avec leur souffrance psychologique; et 3. Groupalité de GAM dans la vie de ces femmes, favorisant la création de collectivités et suscitant des réflexions basées sur les mouvements anti-asilaires et sanitaires. Nous concluons que les relations de genre sont des facteurs de médicalisation dans la vie de ces femmes, et que la groupalité constitue l'espace cogestion à partir de la résistance. Dans cet espace, les femmes se reconnaissent comme des sujets autonomes dans les relations de pouvoir et comprennent leur implication.*

**Mots-clés:** femmes, médicalisation, santé mentale, soins primaires, sertão.

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Butler (2018) proposes a subversion of the identity of the category of women that feminism established to find its representation, considering that the notion of a universal patriarchy does not understand the limits of the singularity of the condition of women, as this concept disregards the specificities of the different cultures in which women are inserted and, consequently, other modes of oppression, which are not restricted to hegemonic male cultures and heterosexual normativity. The philosopher proposes that gender is not constituted and cannot be represented under a fixed or unique identity, but as a phenomenon that is traversed by institutions of power and coercive practices of subjectivities. In this way, gender produces and reproduces meanings and effects throughout history based on performances (behaviors and emotions) that, in different historical and cultural contexts, are related to racial, class, ethnic, sexual and regional issues.

When thinking about the effects of gender on the lives of women from the Brazilian Northeast and the backlands, such as those we found in this study, this discussion connects to what Ballestrin (2020) points out as decolonial or subaltern feminism, which has as its reference “*Abya Yala*” which means living land or modern land. It refers to the importance of history and the geographic space in which subaltern feminist identities are constructed in the Global South, updating post-colonial and third-world feminism. *Abya Yala* feminisms are understood as the movement of historically subalternized women, being at odds with the essentialist and hegemonic identity of universal feminisms, when considering the crossings and erasures of the stories of several subalternized women. Because of neoliberal Eurocentrism, responsible for the erasure and whitening of different bodies, colonial and racial legacies are perpetuated that cross different geographic spaces, ethnicities and nationalities.

Regarding this discussion, Fanon (2020) demonstrates how structural racism, and the effects of colonization create severe wounds in our unconscious, based on a Westernized standard of living in the European world, which reduced black people to an object. For the author, the black body is inferiorized because of the European overvaluation permeated by a colonized episteme. This thought helps to reflect that psychic suffering is in all production of subjectivity of a given culture that (re)directs and permeates it and that is implicated in the exploitation of capital and racial structures. To the extent that medicine, founded on white and Eurocentric knowledge, seeks to individualize the suffering of black people and to absolve the social masks that produce scientific racism present in the ways of life of populations and end up corroborating the process of medicalization of this population.

In addition to these arguments, Federici (2019a) points out that in the 18th century, with the advent of modernity and the consolidation of capitalism in Western Europe, there was a scientific medical project on sexual differences, through the study of women’s physiology permeated by the discourse of rationality. For the author, if in the Middle Ages religious powers were responsible for the extermination of poor, peasant women accused of heresy and prostitution, in modernity the natural and positivist sciences would have a large share of responsibility for the extermination of women considered to be witches. These practices, treated as scientific, would be responsible for leading to the bonfires wise women who had their own healing rituals and did not fit into the bourgeois ideals of femininity and domesticity.

These considerations lead us to understand gender as a performative phenomenon that presents itself as an organizer and standardizer of social practices, crossed by coercive institutions, such as medicine and psychiatry. Thus, since the biological is the object of politics (Foucault, 2010), it is possible to verify the use of medical/psychiatric intervention strategies that seek to place the bodies of people considered deviant within the parameters of medical normality, which produces, today, the medicalization of the lives of subaltern women in specific contexts, such as that of the northeastern backlands.

Medicalization is understood to occur when factors of “non-medical” origin, such as experiences and behaviors inherent to the human condition, become targets for medical intervention, operating mechanisms of production of subjectivity over individuals based on the influence of medical power, which has become decisive in current times (Caponi, 2014). This phenomenon can be seen throughout history, as medicine has established its institutional territory over life in the processes of health and illness based on what is normal or pathological, promoting dependence on the ideal of normality. Although this phenomenon starts from a medical-psychiatric language, it is not restricted to it, invading the social field and other disciplinary fields, and may be present in practices and discourses of other health professionals. Furthermore, in contemporary times, it is possible to verify that the excessive use of this discourse on normality is reflected in diagnoses of mental disorders that corroborate the indiscriminate use of psychotropic drugs (Zorzanelli et al., 2014).

In the field of mental health, medicalization is expressed through the process of psychiatrization of life (Caponi, 2014). In this way, psychiatry’s exercises of power operate through the multiplication of diagnoses of mental disorders, which are increasingly common, leading us to question whether it is, in fact, the current social conditions that promote more illness or a trivialization of the diagnostic task with losses or weakening of the capacity to operate the clinic, restricted to the identification of signs and symptoms, based on diagnostic classifications.

Brazil’s Unified Health System (SUS) created the Psychosocial Care Network (RAPS) through Ordinance No. 3,088 of December 23, 2011, which provides services open to the community to accommodate people in psychological distress and with needs arising from the use of psychoactive substances, such as the Psychosocial Care Centers (CAPS). Also, within the scope of the SUS, the National Primary Health Care Policy (PNAB) was created, which directs the work of professionals in specific territories in the assigned community, to enable health promotion strategies, prevention and reduction of diseases in the population, through Basic Health Units (UBS).

Mental health care in Primary Care (PC) is designed by the teams of the Family Health Support Centers (NASF), which seek to develop multidisciplinary work within the practices of health professionals, aiming at psychosocial rehabilitation, deinstitutionalization, promotion of citizenship and the construction of autonomy for people with mental suffering. However, current research points to difficulties in the relationship between PC and RAPS, some of them as a consequence of the exacerbated growth in the medicalization of social problems and as an effect of the rampant use of psychotropic drugs as the central form of treatment in the latter field (Onocko-Campos et al., 2011). Furthermore, Zanello and Costa e Silva

(2012) state that gender studies have been underestimated in the field of mental health and point to the hypermedicalization of women in this scenario as a consequence.

With this in mind, we can ask: How can we create strategies that enhance the protagonism and autonomy of people with mental health problems in a context in which subjectivities are medicalized in new “open-air asylums”? Are women being targeted for medicalization as a result of their diagnoses? In addition to the category of patriarchy, class inequalities, and racial and territorial issues, should the medicalization of women’s bodies also be a feminist issue? How can women create strategies to confront the medicalization of their lives?

With the aim of questioning the experience with psychotropic drugs, people’s relationship with medical authorities and their participation in mental health care, the Guide for Autonomous Medication Management (GAMM) emerged as a strategy that seeks to address the phenomenon of medicalization. Autonomous Medication Management (AMM), which originated in Quebec, Canada and was later adapted for Brazil, proposes a reflection on people’s relationship with psychiatric drugs, seeking to investigate what role they play in their lives, guiding the creation of strategies within their care networks, as well as access to information about their own treatment. Its purpose is to stimulate autonomy and political participation of users in the public health network (Onocko-Campos et al., 2013).

The GAMM consists of six steps that aim to guide participants on topics related to those who have a mental health diagnosis and use psychiatric medications. In Brazil, it is usually used in groups so that people can share their different experiences with the use of these substances, even if each person has their own Guide. This makes it an interesting strategy for people’s autonomy, because they can discuss the effects and experiences with medications in a shared way (Silveira & Moraes, 2017).

The basic principles of AMM are in line with the Brazilian psychiatric reform. One of them concerns autonomy as an increase in the capacity to manage one’s own life through the construction of social and affective networks and an increase in social contractuality. Thus, in AMM it is assumed that sharing experiences and reflections in the group about health and illness experiences and the use of psychotropic drugs can contribute to the production of autonomy among its participants.

Another principle refers to co-management, which is understood as the involvement of several people involved in the work process and in a group. With it, the exercise of powers is decentralized from the figure of the professional or moderator, making management happen in a shared way, in what will emerge between the protagonisms of the different subjects in question (Passos et al., 2013). Thus, in an AMM group the objective is for users to be able to construct and debate together with professionals about the management of care and the use of psychotropic drugs, in the search for understanding which medication is best for them, respecting the singularity that exists in the mental health treatment of each subject.

Considering this scenario, intervention research was carried out asking: What can the participation of women with psychological distress in a AMM Group can produce in relation to the chronic use of psychotropic drugs and the production of care? With this question in mind, the research aimed to map the participation of women from the backlands with psychological distress in primary care in a AMM group, in a city in the backlands of Northeastern Brazil.

## Method

The study that gave rise to this article was based on qualitative research conducted by the first author and supervised by the second and third authors. We believe that the field can only be understood by intervening in it (Romagnoli, 2014) and that the subject of the investigation is collective and crossed by the composition of forces between the instituted and the instituting and between the object, the institution and the social field (Lourau, 2004), which are engendered to create, intervene and produce plans of consistency in the process of the researched field. Based on these ideas, cartographic-intervention research was conducted, considering that cartography constitutes a valuable research strategy in which the method does not place itself as a determinant and does not seek representations and interpretations of reality, designing predictability in the act of research. Cartography was configured as a path that the researcher was tracing, following, composing and transforming in her field and in the realm of reality between the research process and her professional practice in the scope of primary health care. The researcher’s implications were constituted by the place of a woman, from the Northeast, an activist in the SUS, in the anti-asylums struggle and in the feminist movement, by occupying the place of a psychologist, worker and multidisciplinary resident in training at the SUS, with emphasis in primary health care.

The research was conducted over a period of 6 months, in 24 weekly meetings of approximately 1h30, in a Basic Health Unit in a city in the interior of the state of Rio Grande do Norte, located in the *Sertão do Seridó* region. This city has 45,000 inhabitants and the main economic activities are local commerce, livestock, agriculture, and mining. The study was approved by the Research Ethics Committee (8056319.0.1001.5568).

The study included 10 to 8 participants per meeting, from 6 different areas of the municipality, and higher education health professionals, including: 1 psychiatrist from the NASF; 1 psychologist from the CAPS; 2 psychologists, 1 pharmacist, 1 social worker, and 1 physical education professional with Residency in Primary Care. The average number of professionals participating per meeting was 4. The participants were chosen together with the NASF psychiatrist and the multidisciplinary

team of residents, through whom users from a preexisting group were invited. They are domestic workers, elderly caregivers, cooks, general service assistants, and some are students. They may be married, divorced, single, or in stable relationships. Some had lived in the countryside since childhood and later migrated to the city, while others had always lived in the city.

The inclusion criteria were users who: a) had been using psychotropic drugs for one year or more; b) were 18 years of age or older; c) lived in the territories covered by the PC teams (NASF and Multiprofessional Residency in Primary Care) and by the CAPS II team; d) were professionals who are part of the NASF, CAPS and Multiprofessional Residency in Primary Care teams in the region.

The implementation of the AMM strategy at the UBS was a collective and participatory process, aiming to create a space for discussion on care management and in particular the use of psychotropic drugs, with the GAMM (Onocko-Campos et al., 2012) as the mediator of the meetings. The intervention research involved the following steps: 1) mobilization and awareness of the local PC and mental health team, in mental health matrix meetings between the multidisciplinary teams of the NASF, CAPS and Multidisciplinary Residency in PC. Subsequently, the UBS was selected to carry out the intervention, located in an area that was easily accessible to the participants; 2) presentation of the AMM strategy to the participants who, prior to the research, participated in a benzodiazepine weaning group led by the NASF psychiatrist, the researcher, the pharmacist and the social worker of the multidisciplinary residency in PC; 3) reading and distribution of the term of free and informed consent (TCLE) and the Voice and Image Recording Authorization Term for clarifications and signatures and printing of AMM guides for each participant; 4) choosing a room in the UBS, where noises and voice noises could not be heard, protecting the confidentiality of the meetings; 5) holding of weekly meetings mediated by GAMM.

The records of cartographic-intervention research were made through a field diary of the events and effects inherent to the experience with the AMM group, photographs and voice recordings on a cell phone. The group was led by the first author of this work together with two other health workers, the pharmacist and the social worker from the Multiprofessional Residency in Primary Care. The AMM Guide has 6 steps that guided us in facilitating the group. In part 1 of the Guide, there are the steps: 1. getting to know a little about yourself; 2. observing yourself; 3. expanding your autonomy; and 4. talking about psychiatric medications. In part 2 of the guide, we work on changes and life projects, through the steps: 5. where we have been; and 6. planning our actions. We used some questions present in the Guide that are present throughout the 6 steps of the booklet, such as: Do you know what psychiatric reform is? Why did you start taking psychiatric medication? How do you take care of yourself? Have you talked about your rights? With whom and how have these conversations been? To trigger some discussions highlighted in the results. In addition, we held film sessions, which we called Cine-AMM in some of the meetings.

Data analysis was performed using cartographic diary records and audio recordings of group meetings. The cartographic diary is characterized by producing a plan of intensities composed of forces and affects that emerge during the intervention research. Its writing goes beyond the meaning of recording information in the field of research at an interpretative and individual level. There is a process in the researcher's writing that gives it a collective dimension, enabling joint work to produce research narratives (Barros & Kastrup, 2015).

The narratives present in the cartography – of which we present some fragments, grouped into three themes – were fundamental in revealing implications that guide the researcher about the world and about herself. By “narrative to oneself”, as Butler (2015) points out, several regimes of truth are exposed that are constituted through the “I”, a product of social norms that permeate it and are subjectivized in our bodies and in our stories. By telling our stories we would be evidencing our truths, together with norms that govern these subjectivities, conditioned by daily interactions with others and with the world.

## Results and discussions

In the history of madness, we observe forms of exclusion, segregation and prejudice specifically aimed at women, an effect of gender, class and race relations that produced stories of violence in the lives of institutionalized and medicalized women in Brazilian asylums and in various places around the world (Pereira & Passos, 2017).

Throughout the research-intervention process, the exclusive participation of women in the group draws attention, although we had not defined that it would be restricted to this public, leading us to think about the need to look at psychiatric reform in its possible convergences to feminist studies, based on what the experience with AMM brought in terms of problematizations in this interface.

Below, we present three themes that articulate the work developed with the AMM Group. The first concerns the production of psychological distress in the bodies of the participating women, where psychotropic drugs appeared as a way to silence the “discomfort” caused by the condition of a poor-domestic-woman-mother. The second presents the experience of rural women in affective and sexual work, such as maternal and domestic work, and how these experiences relate to their psychological suffering. The third discusses the unfolding of groupness as a mode of resistance in the lives of rural women, through reflections and memories about the proposals of the anti-asylum and health movement, constructed between the affects and intercessions of the meetings. We emphasize that all the names used in the text are fictitious, to protect the confidentiality of the participants' identities.

## Theme 1 – The production of psychological distress in the bodies of rural women

The participating users reported stories in contexts of machismo, poverty and rurality, with their lives restricted to domestic work and/or agriculture and motherhood, factors that are directly related to the experience with psychotropic drugs. When we spoke about family relationships, narratives emerged, recalling memories of childhood and adolescence, conflicts in which we perceive the privileged place of men and the process of illness due to rural work.

I was kicked out of my house when I was 18 because I fought with my brother and my mother preferred him in the house because he was a man. Then, I went to live with a 55-year-old man and got pregnant. I was both the man and the woman of the house! (Damiana, 52 years old, participant – cartographic diary entry)

Sometimes I would say, Dad, I'm going to school today. "you don't," today you're going to pick beans. The study was with the hoe, the work with the hoe. Dad wouldn't let us study. Then I got sick and I was never able to work because of the medication I take. I started taking it because of the problems with my family. With my son I left home and went to live with my sister. I got it in my head, shocked. I left home when I was 16. I would go to the hospital all the time. In crisis, fainted. I would get to the hospital and not even see where I was. My leg fell asleep. My arm. I got there urinated. People would take me straight away. I didn't live at home anymore, no. I don't even know how many doctors treated me. I spent a year going to the hospital. It was after my husband left me. (Valdeci, 45 years old – Audio recording)

These narratives refer to the condition of women in the field of mental health and, consequently, their medicalization, considering the field of forces in which they are subjectively constituted. First, due to the very fact of being women, then, because they lived their childhood and adolescence in the context of rurality in the backlands and, lastly, because they have diagnoses of common mental disorders.

Women living in rural contexts are more likely to develop common mental disorders (CMD), such as insomnia, irritability and somatic complaints, with the possibility of intense psychological suffering reaching chronic situations or being greater than already established chronic conditions, in relation to the general population of rural workers (Araújo et al., 2005). Women are in an unfavorable socioeconomic position, constituting 70% of the world's poor and supporting gender inequities, access to education and the overload of domestic work. Women's work in family farming is rigid and invisible (Costa & Ludermir, 2005).

Epidemiological data show that women are the largest consumers of anxiolytics and antidepressants in the Brazilian population, as they are more prone to experiences of anxiety/depression, with the prevalent profiles being black, married, poor women and users of illicit drugs (Amarante & Freitas, 2015). These factors are important for understanding the psychological suffering of women in rural areas, leading us to question the facets of the medicalization not only of women, but also of social issues. Living conditions in rural areas are marked by poverty and other socioeconomic indicators, such as: a considerable rate of illiterates, precarious working conditions, greater dependence on income transfer programs, etc. (Macedo et al., 2016).

Pereira (2019) discusses the staggering increase in the consumption of psychotropic and anxiolytic drugs by women in Brazil, with the largest consumers being black, brown, and poor women, who are unable to reach or reach only precariously through public health, welfare, and cultural policies. These women generally live in peripheral neighborhoods, where state violence and drug trafficking are present, and many end up suffering from mental illness after losing their children to death, prison, or drug trafficking. In addition to working double shifts, they are the main heads of households and caregivers for children, the elderly, and the sick. The mental health services that increasingly run down and are precarious end up being the quickest responses for women with mental illness and who live in serious conditions of social vulnerability (Pereira, 2019).

During the pandemic caused by the coronavirus (COVID-19), the *Conselho Federal de Farmácia* (CFF, 2020) claimed that the number of sales of psychiatric medications has grown dramatically. In a survey conducted by the CFF, from January to July 2020, there was an increase of almost 14% in sales of psychiatric antidepressants and mood-stabilizing medications, used for affective disorders, such as depression and bipolar affective disorder, compared to the same period of the previous year. The number of units sold in 2019 increased from 53.6 million to 64.1 million in 2020.

Men and women experience the pandemic differently (Passos, 2020). Excessive domestic and maternal work, which are invisible because they are considered unpaid work, has increased. In addition, the loss of connection between women, due to social distancing to avoid contagion of the virus, has drastic repercussions on their lives, especially for women who work multiple shifts, inside and outside the home. This is especially true for precarious workers who need other women to help with childcare (Passos, 2020).

Other elements related to the medicalization of women emerged during the meetings, related to heteronormative marriage, the postpartum period, motherhood, domestic work and after weight loss diets. They also pointed out weight changes attributed to the use of psychotropic drugs, pointing to it as a cause of oppression and fatphobic prejudice in clothing stores in the inland town. In addition, they reported suffering stigmatization from their husbands for using these medications.

The first time I had depression was postpartum, after the birth of my second daughter. (...) then, I took weight loss treatment and depression came. (...) I gained weight because some things really affected my metabolism. (Cassinha, 42 years old –

diary entry)

What I saw in the film, I went through all that. Medication and stuff. Calling people this and that. I listened to each one. There were people who said I had tuberculosis because I was so fat. Do you think I'm this fat because I want to be? It was too much medicine. (Damiana, 52 years old – audio recording)

Another debate was about the side effects that caused weight changes, interfering with self-esteem. When they go to stores to buy clothes, they even suffer prejudice because the sizes of the clothes do not “fit”. Some reported being *bullied* by salespeople. They also said that when they started using psychotropic drugs, their husbands disapproved, calling them “crazy”, “lazy” and complaining about the price of the medications.

That was when I had depression and started taking these medications. It was a very serious depression, because that was when my husband left me for another woman. And so. I loved him very much and I lost track of time. It was just me and her at home (pointing to her daughter) so, it was very difficult. I was 37 years old. Then the doctor diagnosed it as a heart problem. Then I went to the cardiologist and he diagnosed hypertension and arrhythmia. So, I got medication for that. Then I couldn't sleep. Lexotan 6 milligrams was so bad, and I couldn't sleep at night with that medication. (Damiana, 52 years old – Audio recording)

I want to get married for the fourth time. But I don't have the courage. I won't get married again because of my daughter. I feel like I only live for her. (...) We do so much for others and forget about ourselves, right? I have pain all over my body, but I have to do my housework, because if I don't, who will? (...) I can't stay at home lying down, otherwise I'll get sick! If I stay indoors for a day, I'm sure the disease will come! (...) I'll never forget when I was depressed.... My body just begged for a bed, I'd go around holding onto the walls.... But I'd go to the laundry room, wash some panties.... I never let myself get down, no... if I didn't have the energy... (Damiana – 52 years old, audio recording)

According to the reports above, we observed how women report the effects on the body of their psychological suffering, caused by marital relationships or perceived in relation to them, which motivated the use of psychotropic medications among other medications, similar to the findings of Costa and Ludemir (2005) and the discussion undertaken by Falci (2018). We thus perceive how the medicalization process has a direct relationship with the psychological suffering presented by women in this context.

## **Theme 2 – Love and care: the dual dimension of maternal and domestic care as a female role in the Brazilian backlands**

In the narrative fragments presented above, we perceive the process of medicalization linked to a social condition and to women's bodies. The experiences with psychological suffering began because they were in social conditions that are restricted to prescriptions socially attributed to “being a woman”, such as maternal roles, domestic work, submission and financial dependence on male figures, and risky diets with the aim of having a body that meets beauty standards, showing that the configurations of normal and pathological are not restricted only to the physiological and organic female body, but also to the social functions that this body must respond to in a society that produces hegemonic and serialized subjectivities (Guattari, 2000).

Federici (2019b), when thinking about what she calls the “patriarchy of wages”, argues that the institutionalization of domestic and reproductive work is not paid with a salary, but with what they call “love”. Thus, the author demonstrates, through the history and social movements of some women in the West, that what capitalism has made a point of naturalizing as love and care are effects of the condition of near slavery in women's lives, making their work invisible.

From this perspective, Hooks (2021) states that care is just one dimension of love and that when we are caring, it does not mean that we are loving. The author mentions black women who are socialized to care for others and to forget about their own self-care. Women in the Brazilian backlands context do not distance themselves from this logic, since the more they are associated with care, the greater their place of subordination.

Furthermore, the patriarchy of wages would be this hidden work, as Federici (2019b) demonstrates, which simultaneously sustains an entire nation and capital. From this perspective, this labor force would not only be involved in conditioning women to the material work of cleaning the house and maintaining its organization, for example. This work also implies that women are absurdly restricted to raising children – whether their biological children or not, when we think of the condition of domestic workers – as well as taking care of their husbands, as is desired by patriarchal and colonial governments.

Women's economic dependence on their husbands is still a form of capital control over women's sexuality, with sexual repression by the family being a function of this domination. There is also subordination to the father and brothers. These “masculinized bodies,” for Federici (2019b), would function as agents of the State to control sex work. Furthermore, because heterosexuality is the only acceptable sexual relationship, the opposite of what does not fit into their ideals is perceived as impure or perverted.

This affective politics of life would be concerned with governing the affections in their bodies in the face of not only domestic work, but of certain family and political arrangements that are socially interconnected, in different historical times, such as heterosexual marriage and motherhood, which may be related to the production of their psychological suffering (Zanello, 2018).

I can't sleep, I get a little tired the next day, but I don't give up, I do everything inside the house! It's noon and I'm doing the laundry! And my laundry room doesn't have a covered area! I was in the middle of the sun and looked like a cockroach ... But I do my household chores, I'm the one who helps out at my daughter's house. I'm the one who washes her clothes and irons and tidies and does everything by myself. I don't want anyone's help! I also help her with the shopping and deliveries and payments (...)

I like my money, buying my own things. I work ordering magazines. If someone asked me if my past life was better than it is now, I would say that it is better today. I had a jealous husband, I couldn't talk to anyone, I couldn't have a friend. He passed away twenty-odd years ago and now I live a normal life. (Regina, 54 years old - Audio Recording)

I don't even know what it is anymore. It's because I feel like I don't want to have sex anymore. With a man you like and enjoy it is one thing and doing it without wanting to is another thing. There's no point. I don't dare anymore. He spends the day mistreating me, fighting with me. Then out of nowhere... (Maria, 45 - audio recording)

Loving ends up being a full-time job for women, especially in the Brazilian context, where those who care are usually women, especially poor and black women, who are rarely cared for. It is also important to highlight that this care is mainly intended for rich white men and also for rich white women, who can pay for this care (Zanello, 2018).

This idea of love is often supported by the colonial logic that supports the signs and ideals of romantic love, which has placed women in the backlands in a regime of servitude since the colonial period (Priore, 2018). These issues demonstrate that marriage between men and women is part of a colonial project that has been inserted into the modern world, through religious and medical knowledge that sought, within the bourgeois ideals of relationships, based on political or family arrangements, to establish monogamy and heterosexuality as a legitimate relationship. White women would be marriageable women in the service of their offspring and family, while black and mixed-race women would be considered impure, lovers of white, European and bourgeois men, and would have the enslavement of their bodies justified. In addition, marriage was seen as a way to combat poverty, since getting married in church would prevent the man from abandoning his wife, being obliged to provide for the household and free her from poverty (Priore, 2018).

Falci (2018) points out that in the mid-19th century, women from the Northeastern backlands were only worthy of social recognition when they were heirs to the wealth of sugar mill owners, local politicians or cowboys. Or when they were slave owners and daughters of farmers, and when their grandmothers, concerned about the whitening of families, considered white men as the ideal for establishing a marital relationship with their granddaughters. It is also worth noting that the slaves from the Northeastern backlands were indigenous and black women captured in wars between indigenous people and European men.

Such discussions become important when we realize the specificities of the femininities of Northeastern women and question their different political and social positions, reflecting on how feminist policies fit into the lives of women in the backlands. Falci (2018) highlights that in the 19th century, women from the elites of the Northeast were destined to specialize in domestic work and were educated to be mothers. Other activities were restricted to occupations considered merely feminine, such as cooking and sewing. Women considered "less fortunate" and widows used to sell sweets and embroidery to help support their families. However, these activities were frowned upon, because in addition to the Northeastern woman not being considered a political citizen at that time, due to moral and political concepts of the time, she was also not supposed to earn money, with the role of providing for the household's financial support being restricted to her husband.

Poor women in the Northeast worked inside and outside the home from childhood and had to fight for their own financial support, regardless of whether they were single or not and the work they had to do at home and raising their children. They worked as laundresses, cooks, seamstresses, farmers, among other professions. In addition to performing these same tasks, slaves were wet nurses and struggled in rural work handling hoes, a role that was considered masculine (Falci, 2018).

Therefore, it is important to highlight that in the backlands of the Northeast, there was an overvaluation of the marital relationship in women's lives. This production of subjectivity trained women for the role of motherhood and domestic life; many did not learn to read and write. When women from the elite were able to exert some intellectual investment, this education took place at home, while their brothers were allowed to attend educational institutions to learn philosophy and other languages (Falci, 2018).

The historical construction of the processes of subjectivation of women from the Brazilian backlands region it reflects in the psychological suffering that the participants experience and in the reality of their relationship with the public health system, which is often limited to prescribing medication as a solution for this suffering, without considering the complexity involved. Thus, it is noteworthy how each woman from the backlands region speaks about the onset of her psychological suffering, stating that when they began to "feel bad", the first contact they had with the public health system was with a psychiatrist or a general practitioner, and the treatment directed at them was limited to the use of psychotropic drugs.

Luce and Valdeci, for example, when talking about their stories during periods of crisis, say that they felt sick with intense anxiety, and almost always ended up in the hospital, where they even took strong injections of diazepam (a medication). Luce reports that she spent about a year in this process. She has been using psychotropic drugs for about 3 years, prescribed by a general practitioner, and only received psychiatric treatment this year. Judith says that she spent 20 years without going to a psychiatric consultation, being treated by general practitioners who always prescribed clonazepam (another medication).

One of the factors in the indiscriminate use of psychotropic drugs in Brazil is associated with the fact that any doctor can prescribe them, and this is not an attribute of psychiatry. This fact is consistent with the findings of national and international studies that indicate that Primary Health Care (PHC) doctors are the ones who prescribe antidepressants most frequently (Amarante & Freitas, 2015). The medical and psychiatric order, as the holder of power/knowledge of social practices in a society governed by the imperialism of masculinity, in addition to not offering forms of mental health care that are not restricted to the use of psychotropic drugs, has also not offered strategies that specifically address the suffering of women and that perceive gender relations as determinants of this process (Zanello, 2018).

### Theme 3 – Co-management practices: “AMM-Women” and groupality as resistance

The temporary but significant visit of a “crazy woman” to denounce asylum practices at “AMM-woman” produced other thoughts and sensitivities in us and in other female users who had not experienced this place. It made us think about which side we are on in the public health system and the importance of understanding how this place is composed. At one point when we were talking about the Psychiatric Reform and the rights of mental health users, Stela intervened and denounced it, shouting: “*asylums never again!*” She soon began to talk about her history of periods of hospitalization in public and private psychiatric hospitals, claiming that during the days she spent in these places, she woke up dirty, without hygienic care, barely showered and was forced to take a lot of medication. Right after she spoke, we asked her: “—and *does it also happen at the CAPS or here at the health center?*” She said no, that it is very different (Stela, 37 years old, Diary entry).

Among Stela’s reports on violence in mental institutions, Virginia suggests we watch the film “*Nise, o coração da loucura*” (Berliner, 2015), to also discuss in an aesthetic way about asylum treatment and its interfaces with mental health, and that is how “Cine AMM” was born. After the first session-meeting, when we talked about our affects, we remembered Stela’s memories, making us reflect on the relevance of care in freedom:

(...) when we remember her stories, in addition to reflecting on all the violence she told the group about within mental institutions, we also ended up reflecting on the concept of “patient”, triggering a discussion about our rights as users of the SUS, highlighting how important the model of care in freedom is today. (Record from a cartographic diary)

Stela’s interventions and the first “Cine AMM”, among other discussions, had a strong impact on the lives of the participants. We could see this in 2019, when we received the news that the Ministry of Health had made changes to the RAPS, advocating for the expansion of beds in psychiatric hospitals and therapeutic communities and starting to finance the purchase of electroconvulsive therapy equipment. Thus, one day, we observed a political movement by women that surprised us.

We received a message from Virginia in our WhatsApp group, saying: “— Guys, did you notice that you want the mental hospitals back?” When we saw this message, it seemed to us like a movement to remember everything we had discussed in the meetings, regarding the Psychiatric Reform and a certain desire to know which side we are on. We immediately responded that, unfortunately, the Public Prosecutor’s Office has taken this position. Then Virginia asked if we could discuss this at the next AMM meeting, because she had been confused because a psychiatrist, who is a reference doctor for many of them, had posted a message on Facebook defending this reformulation in the RAPS. Other users, like Hilda, said that it would be good to discuss it, because, “how come she is in favor of shock therapy? When we learned, especially from Stela, that this was not therapeutic, but inhumane.” (Mapping diary entry)

By accepting women’s desires to understand this setback in mental health policy, the audiovisual resource was once again used as a strategy for mediation and encouragement of political participation. In a second “Cine AMM”, we watched the documentary about the Barbacena asylum, the “Brazilian Holocaust” (Arbex & Mendz, 2013). After the screening, the discussion circle revolved around psychiatric power and the social changes that its rise has produced throughout history. We also talked about the rights achieved in public health through social movements.

(...) in this debate, the pharmacist pointed out that the documentary reported how electroshock therapy used to be for upper-middle-class people, and then it was introduced to people with less social privileges. She made the comparison: “it’s very similar to these transformations now, isn’t it?” Then, under Cecilia’s observation, she brought up the fact that women were institutionalized in the past, when they were considered crazy for moral reasons, signaling that this was also something that was still very common. This generated a discussion about the achievements of our public health policies and why the SUS is a right that we had achieved through many social struggles. (Mapping diary entry)

We observed the resonances of the macropolitical effects on the micropolitical ones in the group and we realized the political importance of cinema as a device (Deleuze, 1999), that is, as a “machine for making people see and say”, creating new forms of perception and enunciation in social life. A device that produced criticality and affectations in the participants, interconnecting the realities of the films to their social and subjective existences.

We affirm these practices of women’s autonomy and participation, since the participants continued to seek to construct the thought about what mental health care made sense to them:

(...) when we resumed the agenda regarding the new technical note on mental health, we asked: — Are you in favor or not of the return of psychiatric hospitals? Do you think they should be part of the SUS that we have achieved? Damiana suggested: “— Let’s study more about it!”. We suggested holding a workshop at the next meeting to think more about the subject, we committed to bringing the new printed technical note, the rights of users, a little of the history of psychiatric reform and some posters to display our concerns... everyone agreed! (Mapping diary entry)

By reporting difficulties with the health network regarding psychiatric care and denouncing negligence regarding the invisibility of the right to this access, the participants demonstrated how much the group had increasingly promoted practices of autonomy and co-management of care. It is worth noting that autonomy and co-management presuppose, respectively, the construction of actions linked to a collective and the decentralization of the mediator function in a group with shared management of the experience (Rosa et al., 2020).

Valdeci and Damiana stated that they have not had an appointment with a psychiatrist for over a year, and that, due to the lack of this professional in the city, it is difficult to get care. Tilda raises the following question and complaint: – How can you talk to a professional about your medications, paying for an appointment? In a private appointment? In response, Judith says that she realizes that she can now count on more than just psychiatry when her crisis is getting worse, since she now talks to the nurse at her clinic and seeks a referral for an appointment with a general practitioner. Even though it is difficult, she knows that it is her right. Frida said that she is about to run out of medication and has not yet been able to get an appointment with a general practitioner. Virginia and Judith approached Frida and said: – Well, you will get it! And they suggested that she talk to the nurse at the health clinic, try to explain the situation to a professional, because as Judith told her, “it is your right to do this.” (Diary entry)

Co-management in the “AMM-womans” was associated with group management that was created based on the experience among users in the unfolding of their process, together with the researcher and other professionals involved. There was a decentralization of the moderator role, the different people involved assumed shared management of the group process as a strategy to seek to achieve rights related to the use of psychotropic drugs within the scope of the SUS (Passos et al., 2013), which was extended to thinking and action in relation to other rights of these women as users. Among the co-management processes producing autonomy in the last meetings, the group had generated a movement of political participation, expressed by the desire to demand solutions to recurring problems in mental health in the municipality, such as: the lack of general practitioners and psychiatrists and the difficulty of renewing their prescriptions in health units. The reason for all this desire for political movement is not without reason, we conclude. We ended the group with several narratives from the users, defining the experience as something that produced other voices, observing protagonist forces emerge:

The AMM group is about knowing the rights we have. It is about enjoying the SUS. (...) today we can shout, I want my rights! (Judith, 45 years old – audio recording)

The experience that AMM gave us was very important. It empowered me! (Cecilia, 62, audio recording)

The AMM group provided a new collective vision (...) new knowledge about our rights as users of the SUS, about the use of medications, not only psychotropic drugs but also others. Today I am more curious when it comes to consultations and diagnoses. (Virginia, 26 years old, audio recording)

We would like to point out that, even after the meetings mediated by GAMM ended, the group did not end. The meetings between women at the UBS continued even after the researcher left and we have news that this experience is having repercussions on the organization of these women, with the support of other residents and workers.

## Conclusion

The experience of the group “AMM-womans” was an opportunity to question the medicalization of subjectivities and the lives of women suffering from mental health issues in the context of rural, backlands and the Northeast, and had the power to act increased by the collective flows of the group, by breaking with biopolitical captures, governed by normalizing discourses.

The study shows that mental health care is restricted and focused on the use of psychotropic drugs in primary care, because general practitioners and psychiatrists often fail to consider historically and contextually the processes of subjectivity

present in the production of psychological suffering. This is due to the medicalization of both social problems and women's bodies, because the social determinants of poverty and gender asymmetries are not seen as factors that condition illness. Women's suffering is reduced to their biological functions, to the detriment of the social and historical determinations in the health-disease process and the processes of subjectivation at play. The group's experience allowed us to question this reduction, the centrality of medications in women's lives, and the effects this produces.

Another circumstance concerns the institutional (macropolitical) management of mental health problems, since the participants point to the lack of general practitioners and psychiatrists in the municipality to negotiate the use of psychotropic drugs. Prescriptions are only passed on and there is no effective clinical or psychosocial follow-up, certainly due to the lack of singular therapeutic projects and organizational problems in the network, related to the disarticulation between primary care and the RAPS in mental health production, despite the actions of the NASF. The users appear to be people who are only assisted through medicalization, showing that there is much more control of these bodies than comprehensive care linked to the health networks.

We conclude by bringing to the debate other questions that the experience raised: How has madness been thought of through gender relations, specifically in the condition of women from the backlands? How do feminist studies inspired by decolonial discussions approach the condition of subordination of these women from the backlands? What place has psychiatric knowledge given to these women in psychological distress? Given the scarcity of research to answer such questions, these questions have accompanied us, inspiring our analyses and directions for further studies, since we did not find research and experiences in AMM groups with women in the backlands context that address them, which caused limitations in our studies.

These issues indicate that the field of mental health and autonomous medication management practices still appear to have failed to hold the necessary intersectional debates on race, gender, class, and territory. As a result, they end up not embracing the subjectivities of many women who are suffering from mental illness. Often, in the field of psychosocial care itself, women are reduced to their symptoms and diagnostic classifications, without considering their unique ways of life, their ways of living, and, furthermore, their ways of getting sick and healing. It is important to consider that their forms of illness are permeated by a range of different social complexities. Furthermore, they are constituted by collective and political issues structured in the capitalist, colonial, racial, patriarchal, and classist system in which we live, and are not restricted to something merely individual and intrapsychic.

Thus, we understand that new studies and practices must be developed in order to promote mental health care that is sensitive to the specific issues of women and their life contexts, especially in the context of the Northeastern backlands. Further in-depth analyses of the experiences of these women are also needed from the perspective of decolonial feminisms that have advanced the discussion of these singularities in the Latin American context in its diversity, inspiring the production of "sertanejas-sensitive women" forms of care.

Thus, we conclude that, because women recognize themselves as subjects in institutional power relations and with the capacity to produce autonomous movements, they question certain institutionalized powers of normalities that capture their singular ways of existing. In such a way as to show us that "where there is power there is also resistance." (Foucault, 2017), understood here also in the Spinozian sense, here also understood in the Spinoza sense, as an effort present in the experience of everything that exists, as an active force not only for perseverance in existing, but also for expanding the possibilities of existing. In our encounters with these women, we noticed resistance to the institutional forces that decompose their lives (machismo, medicalization, etc.), creating new compositions, new ways of being together and living, which makes us affirm the importance of other experiences based on this premise and aimed at women in contexts where life calls for affirmation and expansion.

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