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ORIGINAL RESEARCH

GROUP PROCESS AND PSYCHOLOGIST WORK IN PRIMARY HEALTH CARE

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ABSTRACT:

This article aims to discuss the role of psychologists in primary health care from the proposition of group processes alternatively to individualist practices. Those practices keep traditions of hierarchy and user-professional models of normalization and medicalization. Inspired by social constructionist epistemology, group process is discussed as an alternative to individualist practices that maintain traditions of hierarchy between user-professional and to models of normalization and medicalization. Inspired by the social constructionist perspective, we discuss some of the assumptions that inspire this proposal of group process, such as: (1) group process as an alternative to the notion of group as self-contained, (2) user-professional collaborative relationships with the constant negotiation about the type of care offered and (3) self-reflexivity to understand its potential and limits. We believe that this form of assistance can inspire other group practices that can implement the principles of the Brazilian Unified Health System and the ideal of professional training in psychology recommended for working with public health policies.

Key words: group practice; primary health care; psychology.

INTRODUCTION

From the late 1970s, Brazilian psychologists have seen emerge in the field of public health care an important area of professional practice. This happened, according to Dimenstein[1], as an influence of: the changes in the state policies of investment in public health, the economic crisis through which the country was emerged, the decrease of private consultations, the effort of categories that represent the psychologists to show society the importance of their work, and the spread of psychological knowledge in everyday life conversations. Professional performance in health was marked by transformations, especially with international agreements that set new paradigms for health care.

The Declaration of Alma-Ata (1978) and the Ottawa Charter for Health Promotion (1986) were two important documents that expanded and redefined the concept of health care. In Brazil, these discussions culminated in the federal law number 8080 of 1990 which proposed the Unified Health System, a decentralized and hierarchical system, divided by sectors. Specially, this new system responded to the criticism of the hegemony of the biomedical model and the exclusive focus on diseases treatment. From that moment on, prevention and health promotion were the priorities. At that point, the different levels of health care were organized into primary, secondary and tertiary.

As stated by Andrade and Simon[2], the primary health care (PHC) is the gateway for people to enter the health care system, and the level of care in which professionals are more likely to know the socio and cultural context of the user, to know their families, houses, and can keep in touch with these people not only in situations of illness. In this level of care, it is possible to promote diseases prevention and health promotion strategies, because professionals are near the local community. The term primary health care has been used in Brazil often as a synonym for basic health care. However, the prevailing understanding in our culture is that the primary health care is the set of services from

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basic health care, or primary care as the entry point into the health care system. The basic health units are then the place where this level is structured[3].

The onset of psychological treatment in basic health units happened with some difficulties. Many users have abandoned the service; others were absent or late for consultations and their evaluation of the assistance offered were negative. In addition, psychologists complained having difficulties in participating in the multiprofissionals teams[1]. The drop out often taken as something natural to the process and as a result of the characteristics of the population assisted because they would not understand the benefit or the purpose of the interventions proposed. Before we understand drop out, in this scenario, as a result of users' personal characteristics, taking the risk of incurring in a reductionist analysis of the question, we must analyze what are the possible relational scenarios from which such noncompliance is constructed[4].

These scenarios involve micro and macro social aspects, such as users' dissatisfaction with the assistance offered; psychologist's impotence who does not feel prepared to develop his work in this context; the little space offered in the undergraduate training in psychology to work in PHC; lack of recognition from the managers of health institutions about the importance of psychologists work at basic health units, the high demand of work and little qualified work force; and lack of incentives for professional qualification.[2,5-8]

With all these challenges to be overcome, we emphasize the call for a relational, step by step, intersectional and integrated assistance, as pointed out by Andrade and Simon[2]. This form of assistance, according to the authors, focuses on the enhancement of user resources, building social support networks, and professional criticism on the historical character and limits of his practices. As emphasized by the researchers, one of the ways to achieve these goals is to propose collective practices rather than individual ones, with the prioritization of group practices for health promotion in PHC.

This article aims to discuss the role of psychologists in primary health care with the proposition of group processes alternatively to individualist practices with a focus in finding solutions to problems instead of developing resources to deal with such adverse situations.

METHODS

This is a theoretical study that sought to articulate the social constructionist literature on group practices and facilitating dialogue with the philosophy of Brazilian Unified Health System concerning PHC. We take social constructionism as a philosophical stance regarding all knowledge produced, including scientific knowledge[9]. Defined this way, the social constructionist perspective is not a theory strito sensu, does not tell how things actually are, but understands ontology as relational, as discursive option.

To achieve our goal in this study, a brief literature review on group practice, health promotion and PHC was performed. Then we highlight the main traditions in health that may difficult group practices proposition in health care with a focus on collective actions and user's knowledge valorization. Finally, inspired by the works of authors who dialogue with the social constructionist proposal[9-15], we make a proposal for collaborative group processes in PHC with a focus on co-participation between professional, user and community.

RESULTS

Considering the reviewed literature on group practices and social constructionists collaborative practices, we present: (1) the group practices that have been conducted by psychologists at the PHC, (2) health traditions that must be overcome for the proposition of group processes that are alternative to individualistic models and led by biomedical knowledge, and (3) the resources and tools to dialogic conversations that can inspire these group processes.

(1) Group practices and Primary Health Care

As an alternative to individual psychotherapy, group care spaces have been encouraged in PHC. However, in many cases, some postures criticized by the philosophy of the health system remain being repeated in groups. Brazilian psychologists interviewed around the entire country, by a study conducted by the Federal Council of Psychology[6], said that groups performed at PHC ends up being space for disease detection and guidance to users about how they should live their lives to stay healthy, keeping up the tradition of medicalization of health. The group is positively evaluated by psychologists and study participants with regard to the possibility of involvement between users and health professionals.

Ferreira Neto and Kind[7], in their study of group practices and health promotion, point the importance of investing in groups far from the standardization model in health, with opening for collective work. The authors emphasize positively groups that goes beyond the educational format and that does not give ready guidelines about how people should act, with little space to accommodate the popular knowledge. In their research, these researchers found that the groups with satisfactory evaluation from its coordinators and participants are those that were built in response to local demands of users, taking references and theoretical techniques in the field of group dynamics as secondary aspects. Many interviewed professionals said that being in a group with users of the service allows a closer relationship with their daily life,

strengthening institution-community ties. In addition, interviewers said that group activities allow better listening, reflection and discussion between professionals and users than in individual spaces of conversation. Another benefit of the proposed groups is avoiding the necessity of detecting diseases as a way for people receiving care. Thus, in groups, people do not need to produce narratives about problems to receive support, sociability and conviviality. Finally, the most prominent groups were those who maintained a positive attitude with respect to evaluative work.

Ferreira Neto and Kind[7] raised important questions about group practice and PHC. The first is: how to overcome the focus on pathology with homogeneous groups? On this matter, the authors invite reflection about group composition, showing that often homogeneous groups not only maintain prescriptive formats, as they serve to reduce demand and optimize care. In this sense, the bet is not in the potential of exchanges between coordinator and participants in the co-construction of health. The attention remains focused on "individuals in group" with massive education.

Another question is about the limits of user's participation in groups, what the authors named users 'self protagonism'. In their study, these researchers found freedom and boundaries in coexistence in groups at the Brazilian program called Family Health Strategy. As the authors emphasize, the term participation is often understand as just the coordinator's invitation for users to talk about the psychological services, in a paternalistic attitude. Different degrees of co-construing groups are identified in the Family Health Strategy, with the coexistence of the appreciation of specialized technical knowledge and openness to community decisions. The interviewed coordinators believe that the practices could be more participatory, considering that users have much to teach professionals. The interviewed users mentioned that participating in decisions is important, but that they also want to receive information from professionals.

The third question raised by Ferreira Neto and Kind[7] is about how to avoid an individualistic notion of autonomy, that is, how to prevent the group as space for control over people's lives. The challenge here is for recognition of popular knowledge, user's empowerment and the overcoming of technical knowledge dependence. For example, some psychologists interviewed reported having difficulty in validating groups for physical activity, giving greater value to talk groups, such as group therapy, even when the population mentions higher gains with the first modality and with groups without the professional presence.

New proposals that answer these questions can provide group practices in line with the principles of the Brazilian Health Care System. But in order for that to happen some traditions in health need to be overcome.

(2) The need to overcome some traditions in health

The first tradition is the professional expertise, which enhances appreciation of scientific expertise at the expense of popular knowledge. In this tradition, the most common positioning game is the health care professional as one who has the knowledge and power over the other (user) and the user as someone passive in the face of decisions that involve his life. In this tradition, dialogue can be obstructed when the professional believes that there is only one truth about what happens to the user – the "scientific" truth and that therefore any understanding that the user has about his body and life that is distinct from scientific logic should be ignored or modified[18].

Importantly, this does not mean saying that professional are bad intentioned, but to understand that their actions respond to discourses on health that legitimizes this form of care instead of others. Different discourses sustain different practices. Considering social constructionist discourse, health is considered as social construction, so meanings about what health is and how to promote it, propagated by scientific discourses are not taken as the ultimate truth about how things are, but as historically and socially contextualized productions. Here, we take social construction as the matrix in which the idea of health is formed[19], including discourses, meanings, institutions and material conditions of production.

The second tradition is that of professional neutrality that demands emotional closeness to the user can not interfere with professional technical knowledge, so professional can formulate objectives analyses in relation to the care provided. Promoting dialogical practices is precisely understood as the emotional closeness between people that provides true listening[10]. In Ferreira Neto and Kind[7] study, coordinators and users reported how professional-user emotional closeness promoted elimination of stereotypes and changed both their lives. Given the tradition of emotional neutrality and professional specialty, it is practically a taboo to think health care considering the gains it can offer to the professional. However, those who live the routine of a public health institute knows the importance that these affective encounters are to increase the feeling of power and motivation of professionals. In dialogue, being heard is a relational achievement dependent of the sensitivity and effort of all those involved in the conversation.

The third tradition is the hierarchical relationship between professionals and users, in a difference of positions that would guarantee respect for professional authority. In this positioning game, the professional is who defines the health interventions to be implemented. Although, at present, much is discussed about people's participation in the construction of public health policies, with the advent of social control, the notion of autonomy, that often prevails, put in the hands

of professionals the decision of who is or is not autonomous in decision-making in health[14]. Especially when considering the care of people diagnosed with psychopathologies. In that case, the openness to co-driving treatment can be even smaller. There are few challenges that Professionals are challenged to legitimate therapeutic proposals mentioned by users that differ from what they learned as the most effective ones[11]. The controversy here is related to the possibility of coexistence of multiple realities in health, without thereby losing the importance of professional knowledge[18].

Propagated proposals by contemporary public health policies are against these traditions. These proposals talk about user-professional horizontal and humanized relations, community involvement in the construction of these policies via social control, and insurance that community knowledge is taken as a specialty. We believe that some resources and tools can contribute to the construction of objective conditions for overcoming these traditions. Among the alternatives, we will consider the enhancement of group processes as an instrument to the establishment of a transformative praxis.

(3) Resources and tools for dialogical conversations

We start from the critique of traditional notion of group, propagated by the psychological literature, as an essence or unit. In this conception, group is taken as an individual, with specific dynamics and phenomena[20]. In our work, we take group as social construction[13], as a constant process of transformation, defined and constructed by discursive practices that defines what group is, it's purposes and participate and coordinator role. For these reasons we decided to use the term "group process" in this study rather than "group" to prevent its essentializing and to emphasize group as constant transformation and redefinition.

Group processes in healthcare are spaces of constant negotiations between coordination and participants about process, negotiations marked by limitations that include institutional aspects and group meanings that coordinators and participants bring to the conversation. Social constructionist perspective does not teach groups techniques to be followed, but from their assumptions, inspires the creation of resources and tools that can be used in the search for dialogic conversations. We consider a dialogical group process one in which two or more people become responsive to one another and to what happens in the conversation in order to allow the difference to appear, to be legitimized from the discursive logic that sustain sit , and to be explored with curiosity[9,21].

One interesting tool is the pre-preparatory group process talks. Rasera and Japur[12] proposed that tool for group therapy; however, it can be exported to other contexts. In these pre-preparatory conversations, the coordinator proposes that a person anticipate his participation in the group process thinking about what he would talk about in this space and how he would like this group process to happen. Among other things, these sessions allow, according to the authors, the anticipation of possible difficulties that the participant imagines that he will live in relation to other participants, and the designing of possible strategies to deal with them. Also, allow contracts of co-responsibility about how the group process should be in order to meet participants' expectations. Thus, the participant is taken as professional partner in the successes and failures of any group process.

Another useful tool for proposing group processes is the conversational context construction[22], which is the collaborative construction of group contract. In this contract, negotiable and nonnegotiable aspects are mentioned (for example, possibilities of place and time for the meeting, maximum number of participants, who would coordinate, group process objectives, the format of the conversations, the themes that would animate dialogues, among others). In each group process different nonnegotiable aspects will be considered, with more or less flexibility. In the conversational context construction participants are invited to talk about what they need to feel comfortable in group meetings, about what their expectations are, about their role in relation to coordination and how they can evaluate the success of what they are producing together.

A valuable resource for promoting group processes is reflectivity, a concept borrowed from the field of knowledge production studies[16] to think the possibility of coordinators to adopt a self-reflexive posture in conducting group practices. Reflectivity is the search for the coordinator to analyze his meanings about the world that support his practice, and also evaluates his values, beliefs and ways of life and how these aspects are intertwined with his history of socialization, with the specific social groups that he belongs, offering specific discursive repertoires for the definition of well-being and care delivery. A self-reflective attitude allows the definition of the potential and weaknesses of health actions. From the social constructionist perspective, this assessment of who we are, about to whom we address our actions and about production of meanings contexts are not synonymous of a precise and true analysis about the potential and limits of professional practice, but the opportunity to not lose sight of the historical and cultural specificity of any assistance proposed.

Finally, another important resource is the appreciative attitude of coordinators in relation to the users' qualities valorization. From the social constructionist perspective, discursive practices participate in the construction of realities therefore problematic descriptions favor the production of problematic situations and can keep people in a

state of helplessness and hopelessness about their life situation[17]. The social constructionist perspective proposes identity as fluid and unstable. This position favors the exploration of the multiplicity of selves that constitute people, in order to take advantage of each of their abilities to handle different situations[15]. It is not on the agenda the question of who really are the participants of the group, and the definition of reality, in this case, depends on the discursive exchanges of participants. The coordinator emphasis is on who the participants can be, how they want to perform their relationships and what they want to produce from that. Especially in groups formed by people usually described in health services from their illnesses, thinking the self as multiple is a bet in self definitions capable of facing challenges, to seek creative solutions to create good relationships and to live life in a positive way.

DISCUSSION

We believe that the use of these resources and tools to promote health group processes may facilitate the production of more horizontal relationships between professionals and users, with generous listening and appreciation of the multiplicity of meanings about health. Moreover, it can stimulate the establishment of good professional-professional and professional-management relationships. Before a group process is proposed, it is interesting to hear all people involved about their expectations about the intervention being proposed. Here we are talking about professionals who coordinate the group process, other professionals who occupy other spaces in the health care institution, the cleaning staff, the concierge, security and other related services to the institution. This sharing encourages these people to produce meanings about the service that will allow this space to be valued in the service, with other professionals respecting the time and room for the group process to happen. Also, these professionals can motivate user's participation and fell free to ask questions about this practice.

The integration of this service with other strategies offered by the healthcare institution depends, according to our experience, to the opening of coordination in telling people about what is being proposed, encourage them to ask questions about this space and allow partnerships with other service professionals. Often the psychological care in PHC is synonymous with mystery, with the psychologist saying little of his work and operating according to individualist care logic.

Besides the necessary sharing of meanings, we highlight the possibility of the group process to be conducted by a team and not just one coordinator. When we propose to work with the valuation of different logics in health, multidisciplinary work is important, with the assurance of exchanges about how the service can be done. The high demand for psychological care in public health care institutions often inhibits this collaborative work. However, we realize that often these partnerships do not happen because the psychologist fear working with colleagues that direct their practices by distinct theories. Considering the social constructionist discourse, psychological theories are seen not as a faithful representation of how things are, but as discursive options, with different potential for building actions in health.

Some strategies may be useful to "work in the difference." One is conversation rounds between professionals that will coordinate the group processes about their expectations concerning the work and their relationships with each other. Some questions may help in these conversations among team members before starting the group encounters, with each person reflecting and responding: What do you consider the best that you can offer to our work? What do you need us to do to help you offer your best? What you need to feel comfortable in this work together? How could you help us know when you're not feeling comfortable? What would have to happen for you to feel you're doing a good job or to feel that you could effectively meet users' needs? This conversation makes people realize that often, disagreements between coworkers happen because we take as obvious what the other needs or should do. By asking each other, for example, how he will show me that he is not satisfied with something I'm doing, I'm implying the other in the success to be achievied from our relationship. The answers to these questions show that, in many instances, people may differ with respect to their way of understanding the human being, but may have interests in common in relation to what they think is necessary for users. In this sense, it is no longer important which technique will be used to propose group process, but whether to check if it will achieve common goals.

In that moment, it is also important to explore how each participant understands what a group or group process is. If the group process is understood as a weekly meeting in a limited space, for example, other possibilities, such as moving with participants to other environments and proposing activities outside the health care institution are left out. These different possible formats for the group process and its malleability say a lot about social displayed meanings about what a group is and how it should be done. The more the proposal of group is aligned to the expectations of local managers, professionals, coordinators and users, the greater the possibility for its success.

Regarding the criticism mentioned by Ferreira Neto and Kind[7] about the emphasis on diseases in the case of homogeneous groups, we understand that often the group composition of people waiting for psychological assistance is done considering their psychopathology, and/or the user's desire to

participate in the group, and /or the evaluation about user's ability to adapt to this type of intervention. In the latter case, usually the degree of introversion of the person and his moment in life is taking into account, examining whether the person has the possibility of listening to the other participants, among other criteria mentioned in the literature regarding group selection and composition, such as degree of mental organization and the presence of severe psychopathology[23]. Each criterion will build a distinct group process, with specific limits and potential. In public health institutions, the diagnosis is present in the psychologist routine and may be something that he takes as a descriptor of who the user can be or just another way of description among other that can be exploited in the group process.

Thus, considering the use of appreciative resource, we highlight the exploration of the multiplicity of "selves" of participants in a group process. In this case, coordinators do not need to take the diagnosis to group selection and composition. Group composition does not need to be based on a priori criteria, but can be an active process of producing descriptions of who the participants are[12]. These descriptions are produced not only during the selection of participants, but throughout the group process, and the emphasis can be placed on their positive descriptions, descriptions of strengths and resources to deal with what is being taken as difficulty to be overcame. These descriptions are produced by the participants themselves or by other members of the group process.

Regarding the preparatory conversations with users, we understand that they are an opportunity to negotiate how the group process may become satisfactory. The focus is not in the narratives of users about their emotional problems (assuming they sought or were referred for psychological treatment), but in the group process itself. Some questions that can be asked at this point: Have you ever participated in any group process before? How was it? What was good? What do the coordination needed to do for the process to be good? What you needed to do? What do you think would need to happen in this group process to maintain your interest in participating? What could discourage your participation? In this case, how coordination could do help? How other participants could? What is the best you can offer to other participants? What would you like to receive from them? And from the coordination? These are some of the questions that invite user to explore possible doubts regarding the group process, remembering the social tradition of valuing individualist spaces of care. It is anticipated, therefore, possible problems that might be experienced during the group process. Furthermore, user and coordinator are both responsible on how overcame them[12]. What is sought here is an alternative to the passive position of user sustained by the tradition where the professional is the expert and authority on health[7].

Not rarely, users are surprised with that possibility of negotiation. It is common the sense of relief for having someone to listen to what the user thinks is important in his treatment. In the other hand, he can get suspicious to trust in a professional that asks "the sick person" what he needs. Coordinators must be alert to these effects, remembering that contradictory logics in health are present in the construction of more intensive community participation. In our experience, these talks highlight preferences and difficulties of users, increases user's trust in professionals and guarantee user`participation in the first group process session.

The first session is fundamental in the adherence to the group process, understanding adherence as a responsibility of all people involved in health care decisions[4]. The construction of a conversational context favors that people easily feel comfortable in the group process, safe to talk and excited to go back in the next sessions. One important question to the participants is: What do you need to feel comfortable and calm during our conversations? This question allows users to talk about concrete aspects such as: I need to sit away from ventilator, I need a ride to go home when I'm too tired, I need to be sure that no one will tell my secrets for other people; and even aspects related with the relationship with other participants: I need everyone to share their life stories, I do not want to be called this or that, I need a glass of water in case I feel sick during the group encounters, and so on. The usual effect that this question has is to make people less shy, stimulating a comfortable environment. Besides that, the feedback offered by users is that this question made them feel respect by professionals that were looking after their comfort and safety in the group process.

Another interesting question: What needs to happen in our conversations so you can feel it was worth coming? In response to this question people can talk honestly about past experiences in which they did not feel heard and how this could be avoided. Coordinators should conduct this conversation in a no judgmental posture, respecting the requests so they can be negotiated with all participants, taking group as a dynamic and contextualized process. The contract is done considering the people involved in the conversation and their life moment. The coordinators also mention their requests that usually are related with non negotiable aspects imposed by the institution structure (such as time for group sessions to happen, maximum number of participants) or personal preferences and needs of coordinators, for example, how they would like to be called, or how they can feel comfortable to listen to the participants.

As the contract gets established, negotiations about the goals of the group process begin with

the definition of its objective. It is the microcosm of these conversations that defines what will be taken as problem, as challenge and as desire. Every co-responsibility process conducted hitherto can guarantee, at this point, that participants define goals involving everyone, beyond the logic of a group for individual care. The posture of coordination helping participants define their goals, in order to turn them into common goals to all, allows social support networks to be built. Themes for future conversations may be listed. The group process as a space to talk about how one can acquire and maintain a good health condition should enhance the exchange of meanings between all about what health is and how one can promote it. Other aspects to be negotiated: the frequency of meetings of the group process, the locations for these meetings, the number of meetings, whether a group process will be open to the entry of new people, whether it is a problem people not attending all meetings, what is the limit of tolerance for delays, whether the group process should always be coordinated by a professional, among others. Over time, all these aspects can be renegotiated.

Nevertheless, one forewarning must be made: in many instances we are talking about group process from categories that are backed up by some theories about group dynamics that indicate the need for coordination, selection of participants, definition of setting, different roles within the group, among other requirements. However, we encourage the exploration of other forms of group processes that can deconstruct these categories, if that deconstruction can respond more adequately to the demands of each local community.

Another important forewarning is that the whole process of negotiation does not happen apart from the aforementioned health traditions. We understand that open negotiation with users is an attitude that can only be sustained if it is endorsed by a professional belief that the community knowledge is as legitimate as the scientific. The social constructionist epistemology helps us to bet on this joint production, especially in moments in which the proposals of users are distinct from what we take as needed for health promotion. And these bets have shown us that co-produced interventions usually have greater success and are best evaluated by users and coordinators. And that does not mean that the professional could not bring to the group talks his truths in health, but especially because he is often positioned as an authority figure, the way to put them must be designed so that the educational model in health is trespassed[6-7].

A useful way for the coordinator to present his knowledge for the group without imposition is offering it in the form of suggestions, explaining why these suggestions seem interesting and in which way he imagines that they might be useful. To make clear what is sought with what is being suggested, the user can respond with a different idea about how to get to the same goal sought by professional. Another way is the coordinator not to position as always certain about the conduct of the group, but sharing his doubts with other professionals and participants regarding the way that the group is being carried out. For participants, hearing this conversation is an opportunity to see models of relating where there is room for forgetfulness, uncertainties, doubts, changes, reformulations of combinations and exchanges between professionals.

Reflexivity, in this relational scenario, should serve to make coordination constantly evaluating the results of their work, and also inviting users to this meta-analysis. This attitude of self-reflexivity can happen during the group meetings, with the team exchanging, transparently, opinions on the proposed meetings. Usually, users understand these moments of conversation as a care to the service proposed, and they demonstrate that such relationship was one of the motivator to attend the meetings.

Different evaluation methods can be proposed to users. The more coordination stake in a partnership with users, the more game positioning professional-specialist/user-target care is transformed. Thus, it is possible to perceive the richness of the conversations in which users are invited to outline future health assistance, being active producers of care and not just delegating this function to professionals. Evaluate, in this way, is not just to ask the user what he liked or not, but invite him to participate in decision making and legitimize his opinion on the structuring of actions to be offered by that health institution. At this point, the concept of autonomy is not being taken as a quality that the user may or may not have, depending on the professional to recognize its existence. Autonomy, here, is redefined as the ability for the user to participate in the construction of his health, in dialogue with professionals, making their own evaluation of his ability to engage in this task.

Regarding the tradition of affective neutrality of the professional, the modern psychological theories greatly contributed to defense a distance between the psychologist and the user. In the proposal of group processes, informed by social constructionist perspective, affective distance or proximity in the psychologist-user relationship are not judged *a priori*, but evaluated from their effects in building a positive relationship between them. It becomes clear that the criteria is not the scientific validation that attest how best to position the psychologist anymore, but the usefulness of these positions may in building relational fruitful meetings.

Finally, in this study we sought to establish a dialogue between the social constructionist literature on group practices (and dialogue facilitation) and the philosophy of Unified Health System in Brazil, aiming the proposition of group processes at the PHC that seek to respond to the criticisms and challenges in this field of psychological work. These analyses contribute to think in new

practices for psychologists (and, in some extent, other health professionals). However, in a specific way, they criticize the use of psychological theories about the group and about psychopathology, reflecting on its effects on a crystallized way of doing group and comprehending its participants. In an attempt to point out a way to overcome this essentialization, we proposed some tools, resources and ideas on how to conduct group processes, opening the conversation to think about group process and identity as social constructions.

We believe that the proposal of working together in the coordination of group processes can help in overcoming the powerlessness feeling of psychologists working in UBS, regarding the results of their work in order to find support and mutual learning. Moreover, the proposed group practices, open to constant negotiation of the intervention itself, in our view, meets ways of involvement with professional-user with privilege on the quality of links established and respond to the specific demands of each context.

The appreciative focus, reflective posture and openness to user participation are tactics that can help so that it is not necessary to structure group processes from psycho diagnostics, but from the resources that coordination and users have to offer for the work to happen. Future researches will certainly tell other possible configurations of group processes, more permeable to popular knowledge and independent of biomedical knowledge, for the construction of community health. In this context, psychologists will be asked not only to transform their practices, but their way of looking at their role in producing the wellbeing of others.

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