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Original Article

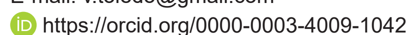
Nursing care based on the perspective of the subject of the unconscious and its contribution to the Singular Therapeutic Project

Laís Angelina Pintor[1]
Vanessa Pellegrino Toledo[1]
Ana Paula Rigon Francischetti Garcia[1]

Objective: to build a proposal of nursing care from the perspective of the subject of the unconscious through the method of the Construction of Clinical Case in Mental Health and pointing out its contribution to the elaboration of the Singular Therapeutic Project. Method: the clinical case of a patient attending a CAPS of the municipal health services of Campinas was carried out. Results: the main signifiers of the subject, family and institution discourse were ordered by collation. Conclusion: Nursing care for the psychotic patient based on the singularity allows the construction of new therapeutic effects, which may favor the restoration of the patient in his position of subject and bring the nurse's contribution for the Singular Therapeutic Project.

Descriptors: Mental Health; Psychiatric Nursing; Psychoanalysis; Individuality.

[1] Universidade Estadual de Campinas, Faculdade de Enfermagem, Campinas, SP, Brazil.

Corresponding author:
Vanessa Pellegrino Toledo
E-mail: v.toledo@gmail.com

https://orcid.org/0000-0003-4009-1042

Cuidado de enfermagem na perspectiva do sujeito do inconsciente e sua contribuição ao Projeto Terapêutico Singular

Objetivo: construir uma proposta de cuidado de enfermagem a partir da leitura do sujeito do inconsciente, por meio do método da Construção de Caso Clínico em Saúde Mental, apontando sua contribuição para o Projeto Terapêutico Singular. Método: realizou-se a construção de caso clínico de um paciente frequentador de um Centro de Atenção Psicossocial da rede municipal de saúde de Campinas. Resultados: foram ordenados, por cotejamento, os principais significantes do discurso do sujeito, da família e da instituição. Conclusão: o cuidado de enfermagem ao paciente psicótico, fundamentado na singularidade, possibilita construir novos efeitos terapêuticos, pode favorecer que o paciente retome sua posição de sujeito e traz a contribuição do enfermeiro ao Projeto Terapêutico Singular.

Descritores: Saúde Mental; Enfermagem Psiquiátrica; Psicanálise; Individualidade.

Cuidado de enfermería pautado en la perspectiva del sujeto del inconsciente y su contribución al Proyecto Terapéutico Singular

Objetivo: construir propuesta de cuidado de enfermería a partir de la lectura del sujeto del inconsciente por el método de la Construcción de Caso Clínico en Salud Mental y señalar su contribución en elaborar el Proyecto Terapéutico Singular. Método: se realizó la construcción de caso clínico de un paciente frecuentador de un CAPS de la red municipal de salud de Campinas. Resultados: fueron ordenados, por el cotejo, los principales significantes del discurso del sujeto, de la familia y la institución. Conclusión: El cuidado de enfermería al paciente psicótico fundamentado en la singularidad posibilita la construcción de nuevos efectos terapéuticos, pudiendo favorecer la reanudación del paciente en su posición de sujeto y aporta la contribución del enfermero al Proyecto Terapéutico Singular.

Descriptores: Salud Mental; Enfermería Psiquiátrica; Psicoanálisis; Individualidad.

Introduction

After the psychiatric reform, new mental health care models were adopted. Nurses began to occupy a position of therapeutic agents, no longer solely performing actions aimed at patient care, but at understanding the relation between psychological, political and social suffering[1].

Therefore, in adopting a new vision toward the patient considering their individuality, it is possible that routines, norms and standardizations are no longer rigid and turn into what is possible to be articulated from the subject's demand, making it the focus and driver of the care scenario[2]. In this context, it is assumed that psychosocial care uses a complex social process that is permanently transformed through the emergence of new elements, promoting investigation into new ways and means of care[3].

One way to achieve such care is through designing and implementing the Singular Therapeutic Project (STP), which is understood as a comprehensive care strategy organized via actions developed by a multidisciplinary team, and defined by individualizing the needs of the patient considering their social, economic, family, biological, cultural and psychological context, in addition to aiming to rescue their citizenship[4].

In adopting the care discourse as being given by the unique relationships established between the nurse and the patient[5], nursing care and nursing clinical practice can be articulated with the needs of the subjects, considering that their difference and demand are related to an unconscious manifestation[6]. Therefore, the singular of the subject in this study is adopted from the determination perspective through an unconscious manifestation[7].

The unconscious is the study object of psychoanalysis and is characterized from the structuring of a language, possessing signifiers and meanings on which the discourse of the I has no control. The subjectivity of the subject is expressed by the way in which it articulates its chain of signifiers, making the subjective experience always singular and governed by the laws of language that will guide the unconscious functioning: each subject assigns a certain meaning to each signifier[8].

In this way, access to the unconscious can occur through language in lapses, faulty acts, jokes and in symptoms. In this sense, the purpose of psychoanalysis is clarify this logic of the unconscious in retroactive temporality, in which the subject presents itself as the singular effect of language[6,9].

For clinical nursing, it is possible to use listening in the psychoanalytic approach, whose principle is creating a space for the word to be spoken, circulated and presented in discourse, being used as a means of expressing an unprecedented and singular desire[6]. The symptom in this perspective is the formation of the unconscious which must be read as the subject's discourse and is understood as the response to be coded in the transference dynamics through the Subject Supposed to Know[10], in this case the nurse.

Considering all the aspects described so far, the following question emerges: How to establish nursing care considering the particularities of the subject and the contribution of this to create and implement the STP?

This work is justified by the possibility of constructing a style of nursing care that involves approaching the patient from reading the unconscious subject in order to incorporate strategies and therapeutic modalities conducive to returning this subject to their position of being reflective, productive and holding desire, in addition to locating the position of nursing care in constructing the STP in a multidisciplinary dimension.

Finally, the objective of this study was established to construct a proposal of nursing care from reading the unconscious subject through the method of Clinical Case Construction and to present its contribution to elaborating the STP.

Materials and Methods

This is a qualitative research developed from an already closed Clinical Case Construction in Mental Health (CCC-MH) and that takes psychoanalysis from recognizing the divided subject and determining the unconscious as a theoretical reference[7,10].

Therefore, 11 nursing consultations were performed with a patient attending a *CAPS* of the Campinas municipal health network in the period between 2014 and 2015.

The adopted CCC-MH method is defined as a dialectic between the parties involved in the clinical case, in which the patient is put into work, and it is important to register their movements and collect everything that is said so that the nurse is ready to listen to their words when they come[11-12].

Thus, case construction is a work that tends to reveal the relation of the subject to the Other, in order to construct the diagnosis of the discourse and not of the subject. The construction serves to operate the subject's displacement within the discourse. The unconscious material will appear in the form of signifiers and the nurse will articulate them, composing a set marked by the unconscious logic of that subject[13].

The signifier is that which is not necessarily connected to the reality of the world, since the representation of the thing itself possesses an unconscious object that makes sense and is thus significant for a given situation[14]. In turn, meaning is an effect of the signifier and is created through its combination, causing the meaning to arise through the substitution of one signifier for another through unconscious action[15]. Thus, analytic listening in nursing consultations contextualized in this work is linked to the parade of signifiers that the patient produces in their speech, defined by speech, as well as attitudes and behaviors[8].

By adopting the CCC-MH method, we respond to the comparison, in which the results are ordered from the discourses of the subject, the family and the institution[16].

Data analysis of this study was performed in two stages; the first stage is characterized by reading the consultation records and the produced academic material (reports with the content of each nursing consultation and equivalent theoretical and practical association), followed by the second stage of re-reading the consultations respecting free association, allowing the appearance of signifiers[14].

Free association is characterized by the free occurrence of thoughts when the subject (in this case the researcher) deals with a theme[17] (in this case, reading the nursing consultations); thus, the nurse operates by transferring the identification of the content in the

patient's discourse, using the clinical rationale between theory and practice to establish structural diagnosis and nursing problems that affect interventions[9].

It is worth mentioning that for the CCC-MH which takes the subject from the psychoanalysis perspective, one must take into account the recommendation to not take a case in progress as the research object due to the risk of the nurse/researcher making it impossible for the patient to have the condition of free association due to their scientific ambition (inserting bias), which might risk leading the subject to produce the expected result on the researched topic[18].

This study was approved by the ethics committee in research with human beings of the Faculty of Medical Sciences of Unicamp under the opinion no. 59385616.6.0000.5404.

Results

Subject discourse: the nurse-patient relationship and listening for the signifiers

The first signifier that emerged during the first consultations was from the patient's (R.) positioning, always perpendicular to the nurse without maintaining visual contact and rarely outlining any type of reaction, regardless of the subject matter, which varied between the weather, football and living in the therapeutic residence.

Capillary glycemia measurements were performed in the first 4 consultations, ranging from 305 mg/mL to 365 mg/mL. These values were always shown to him in an attempt to observe what his reaction would be, and his response was always "*it's low*" regardless of the number shown, although R. proved that he knew the normal capillary glycemia values.

The second signifier was adopted from understanding the particular effect that capillary glycemia has for this subject, which despite the indicated and read value there is always the recognition that his blood glucose is low, exposing a paradoxical fact. Such consideration of high glycemia taken as low occurs at the same time that the patient is positioned perpendicularly to the nurse.

While the patient remains in a perpendicular position in the consultations, the appearance of the third signifier emerges, in which he addresses the issues of his illness and treatment based on a demanding "*them*", the pronoun that he uses to name the team that takes care of him through medication and dietary regimen, his roommates who always asked for favors, and even the nurses to whom he asked permission for everything he would do. Therefore, we ask: does he remain perpendicular to the treatment itself?

The reading of the first 3 signifiers (perpendicular position, followed by the high/low glycemic paradox, which led to the appearance of the demanding 'them') allowed for a change in the positioning regarding the relation, called the discursive turn moment. To do so, the first nursing intervention adopted by the nurse was to put herself in the place of the one who was not there to pressure her and who did not prioritize his weight and glycemia (elements very important for the other members of the team).

In order to achieve such a change in positioning, a consultation was carried out with the patient in the place where food was offered.

Once this intervention was performed, something changed in the subsequent consultations, meaning that the patient began to ask about the nurse to the other members of the team, considering her as he had not before, changing the way he sat, and establishing eye contact, as well as bringing up issues that bothered him such as "*the pressure exerted by the CAPS*" team regarding the new drug therapy, in addition to subjects in which the patient was placed as the focus. In the last consultations, R. spoke more fluently and showed feelings of anger and frustration, such as soliloquies not seen until then and unmotivated body movements. In short, R. could appear as a subject beyond the demanding '*them*'.

As an effect, he was also interested in objects (a camera bought from a market and a table found on the street) and obtained them for himself. These objects were always of great interest to the patient, making a point of showing and detailing their operation and how to restore/maintenance them, in addition to effectively repairing them. However, in the subsequent consultations to which the patient obtained the objects, he had always already exchanged them as a form of debt payment.

Family Discourse

R. never spoke about his family, which is only present in the information on the medical record, which presented a history of family abandonment followed by 6 years of living in shelter, reports of an overprotective foster mother and siblings with whom he has no contact.

Even this little information obtained from the medical record demonstrates a void and absence of the patient's family.

The institution's discourse

The institution's employees, who are the demanding '*them'*, presented discourse for the patient as '*he's*

useless, he eats too much, he doesn't obey the staff and he doesn't follow the treatment'. This information was repeated by the team, by the nurse, and by R. himself during the period that the nursing consultations occurred. This fact evidences the valorization of certain clinical data by the team, which are: The diagnosis of mild mental retardation, characterized by difficulty in school, history of previous psychiatric hospitalizations due to his social condition and his aggressive behavior. The team currently emphasizes diagnoses of morbid obesity, hypercholesterolemia, hypertension, T2DM, as well as a history of non-adherence to treatment and dietary reeducation, associated to the context in which R. is a resident of the therapeutic residence linked to *CAPS*.

R. has a diagnosis of schizophrenia, presenting recurrent alterations on the mental state examination observed by the nurse and the team: blunted affect, hypoprosexia, avolition, with hypomodulated moods and congruent affection, diminished critical judgment of reality, and just once presenting palilalia, soliloquies, psychomotor alteration with repetitive, involuntary and unmotivated movements in the upper limbs[19].

Regarding medication classes: antidepressant - selective serotonin reuptake inhibitor, thiazide diuretic, statin class, non-steroidal anti-inflammatory, Angiotensin converting enzyme inhibitor (ACEI), oral hypoglycemic and antidiabetic.

Discussion: care proposal and its contribution to the STP

In order to start CCC-MH, it is important to emphasize that the established relationship between nurse and patient emerged the already mentioned signifiers, but another professional could take a different course, since listening based on the relationship counts on the subjectivity of the two subjects in a scenario[14,16].

It is important to emphasize that for the proposal of nursing care from the perspective of the subject's unconscious, it is important to define the diagnostic, symptomatic and transferential functions of the established care relationship[10].

To advance this discussion, it is proposed to first look at the question of structural diagnosis, the psychosis, diagnosed from reading the symptom dissociation function of R. between his body and his choices, characterized by the paradox between the capillary glycemia results and the critical lowering of his perception of these values, which favors him choosing hypercaloric foods. Reading the perpendicular position which can configure his blunted affect and his condition of object enjoyment in confronting the demanding '*them'*, as if the professionals taking care of his health remained in the position of an invading Other, characteristic of the psychosis[20].

In psychosis there is the Name-of-the-Father foreclosure, meaning that the subject does not pass through the second Oedipal time in which they are presented to law, to loss. Since it is the articulation of the Name-of-Father metaphor that inaugurates symbolization, the foreclosure of the Name-of-Father into psychosis is corresponding to non-insertion into symbolic law, so that the subject is not subjected to symbolic castration[20].

In this sense, the Other of the psychotic does not inscribe to law and to loss, being an absolute and demanding Other, who reproduces the first logical time of the Oedipus and keeps the individual in the mirror phase with the mother function (a'), in which the subject associates its existence with that of another[20]. We observe the movement of the psychotic structuring determined by the foreclosure of the Name-of-the-Father metaphor in every moment that the patient locates the professionals as '*them'*, who imperiously determine the action that R. must do.

In this case, the empty place of R.'s family could collaborate with the psychic structuring, insofar as the affective relations in the beginning of life of a subject are the entry door to the inscription of the Name-of-the-Father metaphor. Thus, the speculative and rival relationship between R. and the demanding '*them'* remains under the condition of their existence referred to an Other, who knows everything and can command everything[20]. The perpendicular positioning of the patient can be read in this case as a defense, which could only be overcome when the nurse established their intervention, characterized by putting themself in a place of one who was not there to pressure him and who did not prioritize the institution's discourse, in this case the demanding '*them'*.

The psychotic remains identified to the position of enjoyment, offering himself as an object in the place of the loss that was not inscribed by the castration[7]. It is through the object of enjoyment of the Other that the patient is signified in the real (body)[20], which leads to a dissociation between body and choices in the psychotic, thus constituting the shattered body of the psychosis[21].

In the case of R., the shattered body appears in the dissociation between the glycemic values and his judgment about them, which maintains it within the option for foods that are not appropriate to his diet, thus leading the team to respond with invasive actions to prohibit food, reinforcing his condition of object of enjoyment of the Other. When there is such an invasion, professionals occupy the position of the great Other,

preventing R. to construct the subject condition of life itself, which corroborates with the history of non-adherence to treatments.

Still in relation to the diagnostic function, the debilitated patient, in the clinical psychoanalytical context, works in order to respond to the demands of others, who do not assume their own desire and take the desire of others as their own, doing what the Other demands. Thus, the clinical debilitated patient always reveals an inability of the subject to access their unconscious knowledge and their own desire, causing a great difficulty of diagnosis and clinical management[22]. Thus, it can be considered that mental debilitation and cognitive deficit are factors that contributed to the patient's difficulty in getting to work in the consultations, and have become additional elements to the psychosis to keep him in the submissive position, thus resistant treatment.

There is also reading the symptom function, which can be defined as the patient's request addressed to the nurse (from the clinical perspective of the subject), and which is posed as a question to the subject, so that he is instigated to clinically decipher it unconsciously[10]. In the case of R., there was an alternation between perpendicular and non-perpendicular positioning in front of the nurse, a movement that characterized the pathway through which the blunted affect symptom emerged.

In this context, one can think of the transferential relationship, in which the patient offers the nurse the place of the absolute Other[20], through the Subject Supposed to Know[10] identified by the initial posture adopted by the nurse in consonance with the team, to mainly focus on the physiological issues, making the demanding '*them'* emerge and invading them.

Thus, in articulating the diagnostic function, symptoms, and transference, the nurse was able to locate the transfer from the Subject Supposed to Know[10] in the care recommendations made to respond to the hypertension and diabetes conditions. However, clinical psychosis organization demands the necessity of constructing the delusional metaphor, which substitutes the lack of the Name-of-Father metaphor, which makes it possible to foreclose the enjoyment of the other[23]. Thus, in the case of R., the nursing intervention is constituted by the turn in the relationship, displacing the nurse from the position of Subject Supposed to Know, configuring a "different doing", which in this case was defined by doing the inverse of the expected, inviting him to eat. From this invitation, R. was positioned in front of the nurse and brought to the care scenario of his choice of objects, withdrawing from the object condition, thus constituting the delirious metaphor for the restoration of objects found on the street and which are reported during the nursing consultations.

It is reinforced here that management of the incorrect team is not considered, it is only considered that it was necessary in addition to what was already done; someone to interpret the symptom in the way that it was constituted, and to serve as an intermediary for the patient to enable his signifiers and so he could foreclose on the enjoyment of the Other, so that a distance between him and the Other could arise so that the patient could establish himself as the subject[20].

Finally, it is considered that the forms of care need to be rethought each day for each subject, with there being no specific model to be followed, repeated or subject to standardization[2]. Therefore, it is proposed to develop a care model that considers the subject in their singularity, and their difference should be welcomed and thought of[6] in order to incorporate strategies and therapeutic modalities conducive to the recovery of the patient to their place of subject[2].

However, in the midst of so many possibilities, there is an essential tool that must always be used: listening, since it is considered that approaching the subject will only be viable due to the possibility of the patient resorting to speech itself[6]. It is through speech that the subject will emerge in the unique effect of language, which presents itself in the form of a chain of signifiers constructed in its own way[6,9].

The essence of nursing consultations is also that the nurse is the one who offers support for all the demands and who does not respond to any demands[24]. Thus, the strategy elucidated herein shows an option of introducing a therapeutic relationship with the patient, in which the nurse moves from the position of Subject Supposed to Know, which in the case of psychosis corroborates with the invasion, and invites the patient to occupy a different position than the desired object of the Other[20].

The therapeutic project itself has as its essence the consideration of the singularity of the individual discussed up to now, valuing their way of understanding life, their subjectivities and singularities[25], being determinant for the offered health action, aiming to care for and improve the quality of users' lives, to increase the knowledge and appropriation of the health-disease process, among others[3].

It is important to always remember that each strategy should be used for that patient, at that moment, based on that developed relationship. This work does not intend to provide an idea for an intervention to be used with other patients, but rather to provide support for actions that are often considered as alternatives and unusual to be justified when considering the whole context of that

patient and the relationship established with the specific care provider, and the STP proposal can be used as a case-by-case working tool and not as a protocol to be followed[25].

When thinking about the strategy of changing positions in the therapeutic relationship with the patient exemplified in this study, if it was thought out of context and without knowledge of the outcome of the consultations, it could be seen as inadequate, when the patient is invited to feed in spite of restrictions because of their clinical condition. However, when considering the proposed STP, we can see that an action which would not have any meaning for another patient resulted in positive effects for R.

Finally, it is also worth noting that STP assumes the characteristic of providing the team with a reflection on clinical practice, be it individual or collective, enabling recognition of possible weaknesses, potentialities, needs and demands, promoting a necessary change in psychosocial care by implementing alternatives and actions based on new technologies in health, such as relational methodologies that consider singularity and co-responsibility[3].

Final Considerations

Constructing a nursing care proposal from reading the subject's unconscious through the Clinical Case Construction method was organized by comparing the discourses from the subject, the family and the institution, which promoted identifying the diagnostic, symptomatic and transferential functions. This theoretical course was characterized as a contribution to nursing, since it enabled constituting care based on a 'different doing', which may often seem contradictory to the practice/ actions developed in daily life. Thus, an innovative response was obtained from the possibility of displacing the subject to a position in which his responsibility for living and suffering is highlighted. Such construction is the collaboration that the nurse can bring to elaborating STP from the clinical perspective of the subject.

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