

# Health/mental health practices and care production during the Covid-19 pandemic

## *Prácticas de salud/salud mental y producción de cuidado durante la pandemia de Covid-19*

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**ABSTRACT** This paper is related to two institutional scientific research projects, which research on mental health care practices during the Covid-19 pandemic. The aim of this paper is to describe and analyze health and mental health practices focused on maintaining the assistance bonds and strengthening of care-producing networks in the context of pandemic, developed in the Metropolitan Area of Buenos Aires, Argentina. This exploratory and descriptive study uses qualitative techniques for data collection and analysis. Several core issues of characterization and analysis of experience are addressed based on the reconstruction of four brief experiences from our own professional practice. It is concluded that these practices recover the perspective of health and mental health care through the humanization of the bond and the inclusion of the affective dimension in mental health care practices. From very diverse institutional territories and through flexible and creative interventions, these practices have managed to maintain participatory processes, consolidate interdisciplinary approaches and strengthen community care networks in an exceptional and complex context.

**KEYWORDS** Mental health. Pandemic. Creativity. Health care. Community networks.

**RESUMEN** *El presente escrito se vincula a dos proyectos institucionales de investigación científica, en los que se ha propuesto indagar sobre prácticas de cuidado en salud mental durante la pandemia de Covid-19. El objetivo de este trabajo es describir y analizar prácticas de salud/salud mental centradas en el sostenimiento del vínculo en la atención y el fortalecimiento de redes productoras de cuidados en contexto de pandemia, desarrolladas en el Área Metropolitana de Buenos Aires, Argentina. Se trata de un estudio exploratorio y descriptivo que utiliza técnicas cualitativas para la recolección y análisis de datos. A partir de la reconstrucción de cuatro breves relatos vivenciales de nuestra propia práctica profesional, se abordan diversos núcleos temáticos de caracterización y análisis de la experiencia. Se concluye que estas prácticas recuperan la perspectiva de cuidados en salud/salud mental a través de la humanización del vínculo y la inclusión de la dimensión afectiva en la atención. Se trata de prácticas que, desde territorios institucionales muy diversos y por medio de dispositivos flexibles y creativos, han logrado sostener procesos participativos, afianzar abordajes interdisciplinarios y fortalecer las redes comunitarias de cuidados en un contexto de excepcionalidad y alta complejidad.*

**PALABRAS-CLAVES** *Salud mental. Pandemia. Creatividad. Atención a la salud. Redes comunitarias.*

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## Introduction

This paper is part of two institutional scientific research projects, in which it has been proposed to investigate the health/mental health practices carried out by interdisciplinary teams during the Covid-19 pandemic: Project PICT-2018 'Community Mental Health and Participatory Practices that recover the local past' (approved by Resolution No. 401/19 of the National Agency for Scientific and Technological Promotion) and Project UBACyT 2020 (COD: 20020190200040BA) Primary health care and community mental health: analysis of participatory and comprehensive practices carried out by networked institutions (approved by RESCS-2020-345-E-UBA-REC of the Secretary of Science and Technology Office of the University of Buenos Aires). Both projects are based at the School of Psychology of the University of Buenos Aires, under the direction of Dr. Claudia Bang.

The beginning of this pandemic in Argentina has given rise to an early and necessary national measure called Preventive and Mandatory Social Isolation (Aspo)<sup>1</sup>. The purpose of this measure was to restrict the movement of people and limit face-to-face activities in order to reduce the possibility of Covid-19 infection.

Shortly before the detection of the first cases, the dynamics of health institutions were radically transformed, focusing on the prevention, detection and treatment of the disease, which meant, at that time, an abrupt suspension of most group and community health/mental health activities that were carried out in person. Likewise, some institutional health/mental health care circuits were incidentally interrupted.

In this sense, many health/mental health practices have rapidly initiated significant transformation processes, which have allowed the creation and sustainability of linking and participatory devices, such as mental health care practices, in the context of Aspo. Most of these experiences continued during the

months after the beginning of the pandemic, uninterruptedly, and often invisibilized.

The authors of this paper have been part of some of these health/mental health practices based on the need to sustain the link in care and the strengthening of care-producing networks. In a global context full of uncertainties about the present and the immediate future, new and novel forms of work have emerged in a period in which the face-to-face link was significantly limited. From very diverse institutional contexts, we understand that these practices have succeeded in sustaining community mental health devices centered on the perspective of care, emphasizing its bonding and affective dimension.

Based on this challenge, we ask ourselves: What are the main characteristics of health/mental health practices that have been able to sustain a relational and participatory dimension in the context of Aspo? Which have been the main transformations that have occurred in these practices according to different institutional contexts and in different community territories? How can we characterize these experiences from a perspective of care and integrality of the practices? Which have been their potentialities, difficulties and obstacles?

Based on these questions, the aim of this paper is to describe and analyze health/mental health practices focused on sustaining and strengthening the bonding and affective dimension in the context of the Covid-19 pandemic. We are interested in investigating the characteristics and processes involved in these practices from a care perspective. Thus, we intend to give visibility to mental health care practices that have been carried out in different territories and institutional contexts of the Metropolitan Area of Buenos Aires (Amba).

## Materials and methods

The present study is included within the framework of qualitative health research<sup>2</sup>. It is a qualitative epistemological approach

strategy in terms of the subject-object relationship of knowledge and theoretical-empirical contrast<sup>3</sup>. The relevance of using qualitative methods and techniques is justified by the exploratory and descriptive nature of this study. This research addresses complex real scenarios, emphasizing the flexibility of its design, which corresponds to the rationale of qualitative research in sociocultural contexts with a high level of complexity<sup>4</sup>.

From an ethnographic perspective<sup>5</sup>, we have focused on recovering health/mental health experiences that have managed to sustain their practices and strengthen the bonding and community dimensions during the first months after the beginning of the Aspo in the Amba territory (which includes the City of Buenos Aires and the Suburbs of Buenos Aires Province). For this purpose, we have started from the reconstruction of four brief situations – experiential accounts of our own professional practice – selected following a criterion of heterogeneity in relation to their institutional contexts. In this sense, we have been interested in approaching, from the experience, the different processes and strategies that took place in diverse institutional and community scenarios.

Based on a thematic and relational analysis<sup>6</sup> in the accounts of the experiences, we have carried out the identification of topics and sub-topics, differentiation and linkage, association and comparison, inseparable from the theoretical reflection and the conceptual context of the research. For the presentation of results, the material has been arranged in four sections, each one beginning with the presentation of a bullet and followed by the analysis of a thematic nucleus of characterization, its conceptual articulation and discussion, trying to sustain in action a dynamic link between theory and practice.

Conceptually, this paper is part of a line of work that understands health and mental health from an integral and non-normative perspective<sup>7</sup>. The socio-historical dimension of health-illness-care processes<sup>8</sup> is

acknowledged focusing on the rights<sup>9</sup>. We refer to the binomial health/mental health as a way of emphasizing an integral perspective in which we recognize mental health as a sub-field of practices, inseparable from general health.

We recognize the importance of the affective bond in medical care from a health care perspective<sup>10,11</sup>, placing subjectivity as one of the dimensions of the health production modes<sup>12</sup>. From this perspective, health practices based on the relational aspect are promoted, where the act of caring is both a means and an end in itself<sup>13</sup>. To describe and analyze the dimension of care, we refer to the conception of health as a process, in which disease, attention and care are aspects that compose it<sup>14</sup>. We also consider care as a necessary aspect in health management processes, where there is a relationship of mutual recognition and reciprocity<sup>11</sup>. Thus, construction of care is an exchange, which takes place in action, since it is a process that develops among individuals and its main idea is the creation, invention and freedom of those who perform it<sup>15</sup>. Acts of care tend to be invisible in care practices, which is why we highlight the possibility of glimpsing some actions that we consider, within their sphere, as spontaneous gestures of care<sup>11</sup>. On the other hand, the idea of care as an event prioritizes the singularity of the person who needs it, being able to overcome the standardization that some institutions apply<sup>15</sup>.

Regarding ethical safeguards, this paper is part of a research project that has been approved and evaluated in its ethical aspects by the National Agency for the Promotion of Research, Technological Development and Innovation of the National Ministry of Science, Technology and Innovation (Project Code: PICT-2018-02008), which has determined that there is no need for an evaluation by a specific ethics committee, since the work plan does not include pharmacological, clinical, surgical, epidemiological or psychological studies. Nor does it include the use of medical equipment, medical records or biological samples.

Furthermore, and in accordance with the characteristics of the research, informed consent was gradually obtained, preserving the anonymity of the institutions and parties referred to.

## Care production and development of non-conventional practices in an Intensive Care Unit

A young woman is admitted to the Intensive Care Unit (hereinafter ICU) of a general hospital in Buenos Aires suburbs due to the severity of her Covid-19 infection and under orotracheal intubation. Quickly from the mental health and social work specialized teams, a telephone call was made to the mother and she was asked if it would be good for the patient to listen to their voices, to which she answered affirmatively. Based on this proposal, the family recorded an audio to be transmitted through a wireless speaker and thus, heard in the ICU.

There is a possibility that an on-call physician from the ICU may transmit the audio. He himself decides to play the audio several times 'as heart rate of the patient was increasing, being an improvement in her critical condition'. He was shocked by the intervention, this being the opportunity to start working together with the mental health and social work specialized team, and to transmit audios recorded by the families and close relatives of the people admitted to the ICU. After working with the ICU physician on the importance of sustaining social bonds at a distance, we received an image of a birthday celebration of a person who was lucid in the ICU, waiting to get better. Happy birthday signs, cakes with candles, nurses and an excited daughter, on the other side of the glass waiting, once again, to hug her mother.

This brief story is set in the 'bubble', as the ICU is known, which usually has characteristics linked to the scarce contact with

the outside: a large glass separating the room from the outside, where all the beds with the patients can be seen, restricted visiting hours, few staff with access to it. This was significantly aggravated since the beginning of the pandemic, since only physicians, physiotherapists and nurses were allowed to enter the ICU. The 'bubble' became the most biomedical, where it was a challenge to think of ways to link the outside with the inside surrounded by machines connected to bodies. Faced with this situation, the mental health and social work teams began to think of ways in which those families and/or relatives who could not go to the hospital, and the people who were seriously affected could establish some kind of communication through voice. Why voice? The only way found in this situation was to transmit some of the care through technology.

Based on this, an intervention protocol for patients in critical conditions for Covid-19 was designed, specifically for those in their last days/hours of life and exceptional situations, from a psychosocial perspective. The aim of this protocol is to guarantee the comprehensive care and rights of people hospitalized in a critical condition, last days and/or with support requirements. This protocol was jointly developed by the mental health and social work services.

According to Menendez<sup>17</sup>, the Hegemonic Medical Model (HMM) is defined as a set of knowledge, theories and practices resulting from the development of traditional scientific medicine, considered the only way of dealing with disease. We understand that the hegemony of certain discourses and narratives in institutions is not exclusive to the biomedical model; however, we find its roots there.

The intervention through the speakers allowed us to incorporate another vision, the dimension of care in the UTI, being the communication through voice and music, a gesture of care. As Elena de la Aldea<sup>11</sup> states, care as a potential for bonding allows the emergence of several practices that were not conventional until now. Being able to incorporate

recreational materials such as word search puzzles, cell phones, pencils, mandalas and even messages for those in critical condition inaugurated another way of thinking about the production of health and care<sup>12</sup>. Therefore, we believe that the concept of care is central, recognizing the importance of the affective bond between the worker and the user<sup>10</sup>.

We believe that active, collective and supportive practices that lead to reunion and care are the ones that allow building and sustaining a humanized bond<sup>11</sup>. Likewise, we understand that being able to have a caring perspective towards a person in critical condition is related to the concept of tenderness developed by Ulloa<sup>18</sup>. This concept refers to having good treatment, care for others with a loving interest, recognizing others as different individuals, and at the same time different from oneself. The author mentions two conditions that characterize tenderness: care and empathy, the latter being associated with the adequate provision of food, warmth and words<sup>19</sup>.

In the bullet that opens this section, we understand that the words transmitted by the wireless speakers were a bridge between people and their relatives being, in many cases, ways of containment, affection and farewell.

## **Building community strategies based on participation and creativity**

Three months after the start of the Aspo measure and during a community supervision meeting held virtually, an interdisciplinary mental health team from a health center in the southern suburbs of the province of Buenos Aires wondered how to continue with a game library activity that had been developed for years in the waiting room, with children from the neighborhood, which was abruptly interrupted at the beginning of the pandemic. The professionals expressed the need to resume this activity in some way in order to 'be able

to leave the mark in the community that something of the game library activity continues to be present in this context'. Taking into consideration that families from the neighborhood had difficulties in accessing virtuality, we concluded that virtualization of activities was unfeasible. Thus, considering the objective of maintaining bonds with the community and with the perspective of the right to play, we thought of a strategy based on the circulation of objects and toys: 'If families can't come to the game library at the health center, why not have the toys go to the families?'. We then planned a toy lending circuit (with the proper protocol and sanitization) that included multiple families with whom we were able to resume contact. After a few weeks, in another virtual supervision meeting, members of this team reported that they were able to put into practice what had been proposed and that this was very significant for the integral support of the families that joined the proposal.

This report highlights two central characteristics of community mental health practices that have succeeded in maintaining the bonds and participatory strategies in the context of a pandemic: creativity and flexibility. Thus, the process of creative transformation of a group and community game library device allowed continuity of the bond kept with multiple families in the neighborhood, despite the temporary impossibility of holding face-to-face meetings. When face-to-face meetings were unfeasible and the generalized response from health institutions was to temporarily cancel or virtualize appointments, this example shows us the power of developing other types of innovative and creative responses. In this case, the effects were multiple: on the one hand, the incorporation of a different toy every week introduced expectation and novelty to family dynamics when children could not perform activities outside home. This was enabled by the presence of a concrete play object, which served as a symbolic support for the health center's promotion of the right to play. Likewise, each toy, as a collective object, by

circulating from house to house, symbolically linked and continued previous ties with the families of the health center. On the other hand, this strategy allowed the sequence of an institutional linkage that could be kept through each ludic element and the necessary contacts to deliver and pick up the toys. Symbolically, it meant the continuity and strengthening of a bond of care between these families and the professionals who performed the experience.

These practices developed in the context of pandemics have allowed us to make visible the importance of the articulation of community health/mental health strategies with the principles of Primary Health Care (PHC), particularly with regard to community participation<sup>19,20</sup>. In the experience described, bonds maintained from previous participatory practices allowed the continuity of practices – including significant transformations – in contexts of exceptionality. In this new scenario, it has been necessary to rethink spaces and ways of meeting with the community and to create new ways based on existing community networks<sup>21</sup>. Accepting new demands, building in heterogeneity and starting from the unpredictable have been some of the competencies to be developed<sup>22</sup>. Likewise, it has been substantial to maintain training, supervision and co-monitoring instances, as care and supportive practices for the mental health teams themselves. In this sense, it has been essential to have joint reflection meetings that have made it possible to generate a time-space for the creation of new forms of intervention.

In this context, creativity has occupied a central place, as a power that has made possible a process of creation of new ways<sup>23</sup>, without falling into repetition or adaptation of practices according to pre-established devices. Giving oneself the opportunity to put radical imagination<sup>24</sup> into play, as that capacity to create new imaginative potentiality, has made it possible to incorporate the force of vitality into institutional practices. Creativity has also provided resources for the

creation and maintenance of community links and inter-institutional networks, through the development of shared activities. This has made possible the articulation of the multiple and the diverse in the design of new strategies.

## Strengthening community networks and broadening territories

A Civil Society Organization (CSO) of women from a suburban neighborhood of the City of Buenos Aires, working as territorial gender promoters, received an inquiry from a neighbor who was concerned about the mental health of her mother, who had found it difficult to return to her home in Paraguay as a result of the Aspo measure. The woman, the sole breadwinner of the family with two school-age girls, worked in a community dining room, and as a domestic employee and found the situation with her mother desperate. At the health center, they only provided consultations for Covid-19 and at hospital for emergencies. The CSO offered her a video consultation with a psychologist from her team to talk to her mother. In the video call, the person related her anxieties, fears and difficulties in relation to her present situation. She also named a psychologist from a health center in Paraguay, a community garden and a women's group in which she participated. After this video consultation, her family in Paraguay got in touch with this professional, who immediately proposed to resume the therapeutic space with the woman, virtually. In turn, the woman consulted a psychiatrist whose contact was arranged by the CSO. The women of the CSO conducted this woman and her family throughout the process until she felt better: they managed the purchase of medicines, telephone charges, food during her hospitalization for Covid-19, and supported her daughter at all times. Finally, the person sent emotional messages of gratitude from her home from Paraguay.

This bullet tries to make visible that many social and community organizations played a leading role, during the beginning of the Aspo in the accompaniment and care in health/mental health from a care perspective based on their territorial belonging to the community.

This is how going through the pandemic in another country generated diverse manifestations of subjective discomfort, whether due to the experience of confinement, distance from home and/or cultural rootlessness. The different actions carried out by the territorial gender promoters, as a way of accompanying the situation presented, made possible the inclusion of this lady in a discursive plot that could accommodate some of this manifest discomfort. In this sense, there is social bonding as long as there are other individuals available for exchange and reciprocity, with whom to constitute a social fabric located in a territory, as a determined space and time<sup>25</sup>.

From the perspective of collective health and community mental health, we think of territories as dynamic spaces that are constructed and transformed by the tensions of social collectives that inhabit them and power dynamics that surround them<sup>26</sup>. In this sense and in the same place we can find different territorialities depending on the social fabric that integrates it with different interests, perceptions, values and territorial and care attitudes, generating relationships of complementation, cooperation, conflict and confrontation. The CSO, as a neighborhood community organization, represents a resource previously managed and sustained by a group of women who make up a health care network in their own community.

Women who live in their neighborhood and use the spaces on a daily basis are the ones who provide evidence to hidden potentials of these communities.

Finally, this story allows us to understand community as a complex network of multiple relationships<sup>27,28</sup> and as the main agent of health and mental health care. In this case, it is a care network driven by a group of women located in the same territory, which effect

can be thought of as a strengthening of the previously existing care network. It was a community network that expanded its territory, a trans-border network indeed. The women of the neighborhood, as community health care referents, built once again a bridge to health/mental health in the community.

## Recreational, interactive and virtual activities

Due to the suspension of all face-to-face activities in a day center in the Autonomous City of Buenos Aires, to which attend people with unique disability ID, different daily workshops were adapted to virtual modality. Likewise, the idea of performing activities on specific dates, such as friend's day, was considered. Thus, part of the institution's team worked on the realization of a musical bingo. Bingo is a game of chance in which each participant has a card with numbers, and numbers are called out after being extracted from a raffle ball cage. In this case, numbers were exchanged for songs.

After a few minutes of the proposed time, the squares of the video call platform started to light up. The young people were there, some with hats, others with musical instruments. On the side, some family members helped in the technical part, other relatives, brothers and sisters were encouraged to participate. Little by little, between greetings, comments and exhibition of the different costumes they had chosen, the game began. They were there on the other side, ready to play, to participate and to share the moment. It was not about competing, but about being able to re-signify something of the mystique of a bingo, a traditional game. The cards had been sent previously and the songs had been chosen by the participants. In this format as the numbers came up and the songs played, some participants could be seen dancing, others simply marked their card or looked at their partners in some of those little squares on the screen. Thus, the bingo went on. There was no lack of laughter, comments,

dancing and joy. Each square on the screen meant being in the present moment, alive and sharing this virtual space. Each square meant bodies in movement, families united, people in contact and interaction with others. Each square was a scene, a part of a big puzzle with the same premise: to play, to participate, to share, to be.

This bullet presents us with a snapshot of what we experienced. Faced with the idea that this type of practice could only be carried out in person, a creative adaptation appeared and made it possible to carry out a bingo game. It can be noted that, thanks to the use of mediating technological objects (cell phones, tablets, computers), it was possible to virtualize and recreate this group game. In this context, a ludic activity proposed that reinforces the bond between people where the significant thing has been the support of what Deleuze<sup>29</sup> has called joyful passions, those conducive to the development of power of each subject increasing the ability to act. Following this author, who takes Spinozian notions, the joyful passions are denominated as the effect on oneself in the encounter with other bodies that 'suit us', that is to say, that are related to us.

In this way, this activity took place in the face of an adverse context that did not provide spaces that allowed a moment of recreation and participation. An impact on the participants and workers can be noted, where the group game – within a virtual environment – restored games as a health promoter. Thus, we can notice how this device, usually thought for a face-to-face interaction, favors participation. We understand participation as a fundamental concept within the perspective of community mental health, as it implies sharing and doing with other individuals, and each participant may have different degrees of commitment<sup>30</sup>. At the same time, participation took place in a dynamic of exchange since, although the proposal came from the team of workers of the institution, the construction of this activity was jointly developed: the bingo songs, which were of fundamental importance for

the activity, were chosen by the participants. In this way, it is possible to glimpse a playful and creative strategy that takes into account the preferences of those involved.

Regarding the group and the possibility of reproduction through digital media, it is pertinent to point out that even when each participant was in front of a screen, virtuality allowed the group to be sustained. We can say that in some circumstances, the virtualization of the meeting space made possible different ways of being in groups than the traditional face-to-face ones.

Consequently, in the face of a complex context, where daily life was completely disrupted, where sad passions, characterized by the decrease of power in the actions of each individual<sup>28</sup>, the threat of infectiousness and the lethality were the curtain of reality, it was possible to provide a space that recognizes the right and the need to participate and have a legitimate moment of play. A space where joy and reunion are contagious and where an ethic of tenderness and good treatment is developed<sup>18</sup>.

## Conclusions and final considerations

The presentation and analysis of short stories of health/mental health practices developed in very diverse institutional settings have allowed us to extract some of their main characteristics. In the first place, these interventions incorporate a humanizing, bonding and affective perspective to the care model, constituting true care practices that have managed to creatively overcome multiple obstacles in a context of significant exceptionality. The difficulty of face-to-face and group meetings in health institutions, as well as the necessary distancing as a preventive measure, has forced health and mental health teams to seek and find other forms of relationships that contain and protect the gestures of care.

We found that flexibility and creativity have been two central characteristics of the transformation processes that have carried out these experiences, where it was possible to incorporate other strategies, forms of relationship and innovative elements that allowed sustaining the relational dimension as a measure of promotion and production of mental health in a highly complex context. In these processes, it has been essential to have interdisciplinary training and reflection meetings as a practice of care for the professional teams, who made possible constant revisions of strategies. In teams where these spaces have been available, this was a great opportunity to consolidate the articulation between knowledge and to strengthen work networks within the institutions. Moreover, the participation of health/mental health workers in relational devices make possible for these professionals to re-signify their own institutional practices, incorporating the subjective dimension and the importance of the bond in care, which is necessary in every act of care.

Likewise, the possibility of sustaining and redefining participatory and networked practices (in the context of Aspo) has been a discovery and an opportunity in areas where community and institutional networks existed as a result of previous participatory processes. This has allowed us to visualize the need for the continuous development of participatory processes articulated to the principles of integral PHC, with a focus on mental health. Finally, we have made visible the fundamental place occupied by social, community and civil society organizations, since they have been the most strongly linked to community care networks. It is still a necessity and a challenge

to articulate, from institutional care practices, the organizational and community processes present in each territory.

Among the innovative practices, we found that all the reported experiences use different objects to maintain the bond and communication, where face-to-face meetings have not been possible: the use of speakers in a UTI, the loan of toys from a game library to families in a neighborhood, the use of virtual communication technology in a day care center and in a CSO. We understand that these are mediating objects that have made it possible to symbolize in action the continuity of a health care bond.

Finally, from different territorialities, this work has sought to give visibility to bonding and care practices which, in the context of the pandemic, have been essential for the production of health/mental health. We have also found significant the possibility of recovering joyful passions and the institution of tenderness as a gesture of care that shelters subjectivity in the approach to human suffering. We know that, in today's market society, gestures of care, since they have a non-marketable value and they cannot be expressed as monetary values, are made invisible. However, according to Elena de la Aldea<sup>11</sup>, it is these gestures of care that become unavoidable practices for the continuity of health and life.

## Collaborators

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