

## Mapping the provision of care to an adolescent victim of school bullying by the Family Health Strategy in Brazil

Pamela Lamarca Pigozi (<https://orcid.org/0000-0003-0193-924X>)<sup>1</sup>

Ana Lúcia Machado (<https://orcid.org/0000-0003-4240-3441>)<sup>1</sup>

**Abstract** *The provision of care to adolescents who are victims of bullying is necessarily intersectoral and, as such, goes beyond the limits of the school context. Underpinned by this principle, this study mapped the care provided to an adolescent victim of bullying by the Family Health Strategy, using cartography to elaborate an analytical flow chart of the pathway taken by the patient through the health service. The care maps produced by the health professionals involved in the process showed that care was out of step, dry and had a low level of resolvability. Despite these findings, the use of this instrument allowed the health team to propose other forms of support for the adolescent. After visualizing the pathway taken by the patient through the care network, the team was able to rethink limiting approaches to health care and discover other care possibilities that go beyond physical dimensions. The care provided by the Family Health Strategy was shown to be inconsistent. However, the mapping activity clearly showed that primary care services play a crucial role in providing appropriate support to adolescent victims of bullying and breaking the cycle of violence.*

**Key words** *Adolescent health, Bullying, Intersectoral action, Cartography, Primary health care*

---

<sup>1</sup> Escola de Enfermagem,  
Universidade de São Paulo.  
Av. Dr. Enéas Carvalho de  
Aguiar 419, Cerqueira César.  
05403-000 São Paulo SP  
Brasil. pamelapigozi@usp.br

## Introduction

Bullying is a set of aggressive behaviours repeated multiple times and involving a power imbalance, whereby the victim feels powerless in the face of violence. It is important to stress that isolated cases of violence are not defined as bullying and, therefore, to be classified as such there must be intention to harm without apparent motivation<sup>1,2</sup>.

The prevalence of school bullying in Brazil is high. A cross-sectional study conducted by Moura et al.<sup>3</sup> with 1,075 school children showed that 17.6% had been a target of bullying, while, according to Fisher<sup>4</sup>, at least 10% of students reported having been victimized at least three times in the same year. Furthermore, the National Survey of School Children's Health (*Pesquisa Nacional de Saúde do Escolar - PeNSE*), involving 109,104 school children in each of Brazil's state capitals, showed that 20.8% of students reported being perpetrators and 7.2% said they had been targets of bullying<sup>5</sup>.

The third edition of the PeNSE<sup>6</sup> revealed that 19.8% of students reported being perpetrators and that engaging in bullying may be associated with certain characteristics, such as feeling lonely, insomnia, and having few friends. In addition, being abused at home and truancy may also be associated with bullying and victims may display certain characteristics, such as poor academic performance, resistance to going to school, a feeling of insecurity in the school environment, fear, anxiety, unhappiness, depression, headaches, fainting, attempted suicide, and suicide<sup>7</sup>.

Studies show that bullying is a major public health problem directly affecting the physical and mental health of school children<sup>8</sup> and that tackling this complex issues demands an intersectoral approach that goes far beyond the school gates<sup>9,10</sup>. In this respect, it is important that health professionals are able to spot the different signs of bullying to enable early intervention<sup>7</sup>.

The Family Health Strategy (*Estratégia Saúde da Família - ESF*) is a core element of primary care in Brazil and is responsible for building bonds with patients and meeting their healthcare needs. These underlying principles ensure continuity and longitudinality of care. By ensuring a welcoming and comfortable healthcare environment and promoting sensitive listening, the ESF is capable of resolving the majority of health problems in the community. Moreover, local health services should be able to address not only physical health problems, but also psychosocial

problems, including, for example, violence prevention<sup>11</sup>.

In light of the above and given that primary, ambulatory, and hospital care services can collaborate to map patient pathways, we map the journey of an adolescent victim of bullying within the healthcare network from the perspective of the health professionals involved in his treatment in order to provide insight into the care provided by the ESF to victims of school bullying.

## Methodology

The methodological frame of reference adopted by this study was cartography, which draws on Deleuzian and Guattarian schizoanalysis, one of the lines of thinking of institutional analysis<sup>12</sup>. The map presented here was created by the health team members and thus represents a collective and transitory construction comprising their genuine, unique and mutable stories, work context, and experiences.

This method enables the researcher to gain an insight into the procedurality of events and the pathway taken by patients and their relations with the environment they pass through. It also allows us to gain an insight into desire as a triggering force for care processes, the reproduction or production of life-propelling (or not) habits, and encounters of high or low creative power between subjects in their individual journeys through the health service.

Mapping "requires the inhabitation of a territory"<sup>13</sup> that is not constituted by its functionality or utility, as, for example, showing the function of school or the health service, yet gives precedence to the ways of feeling and expressing of the actors involved. Such territories may be composed of instituted lines, which strangle or reproduce care, and instituting lines, or "lines of flight", which are more flexible and give way to numerous creative and resourceful ways of caring<sup>14,15</sup>.

The research instrument used in this study, Merhy's analytical flow chart<sup>16</sup>, can be used as a dispositif. Data production takes place when the dispositif is brought into action. For the purposes of this study, the flow chart was used to engender strategies that produce a way looking at things: not based on clichéd images, nor looking to assess a situation to decide how to intervene, or "looking for doing", as Pelbart says<sup>17</sup>, but rather "looking to discern that which is unseen, looking to capture the dimensions of excess, beauty, horror, the intolerable, and the fearful from reality"<sup>17</sup>.

This research tool can create spaces that encourage participants to recount scenes, awaken their mind to a different way thinking, reengage in and rebuild dialogue, reflect upon and discuss difficult and painful (or not) minutiae, and imagine and enumerate what happened before and what will happen or what happened after these scenes<sup>18</sup>.

The analytical flow chart of care delivery can be used “to design a certain mode of organization of a set of work processes that are interlinked around a particular chain of production”<sup>16</sup>. It comprises a comprehensive, user-centred, graphical representation of the way a team works, providing an insight into the micro political aspects of the organization of work and production of services<sup>16</sup>.

This instrument is used to apprehend five actions represented graphically by three different symbols: the ellipse, representing the inputs and outputs of the service production process; the diamond, which indicates moments of decision for work continuity; and the rectangle, which marks the moment of intervention and action over the process<sup>18</sup> (Figure 1).

For example, in the case of Teo’s (fictitious name given to the patient) journey, who was chosen as a case study to trace patient pathways, the following events were detailed on the flow chart: entry into the system; who he was received by; why he entered the system; why he remained in the system; what form of care he received and the decisions taken concerning the patient; who accompanied him; how Teo participated in the process; and how the health professionals worked together to care for the adolescent. The main objective of this tool is to trigger a process of collectivization of work.

The challenge is to conduct an analysis of the daily work routine and translate it into a visible format that can be shared by everyone and, based on this analysis, define appropriate feasible interventions<sup>18</sup>.

Teo was a victim of bullying and was receiving treatment at the ESF. His classmates started to bully him after he lost all of his body hair because of alopecia. This was also one of the main reasons why his mother sought help from the health service.

The group had the basic formation of an ESF team, which is composed of a nurse, doctor, nursing auxiliaries, six community health agents (CHAs), and a receptionist<sup>11</sup>. Almost all team members participated, except for one of the nursing auxiliaries and five CHAs, who were un-

able to leave their activities. In this respect, the team preferred to give priority to the CHA who knew Teo’s case. The group that participated in the activity was therefore made up of five team members (nurse, nursing auxiliary, receptionist, community health agent, and doctor).

The flow chart activity was not recorded because the entire process was described by the five group members and drawn on two sheets of flip chart paper stuck horizontally on the wall to facilitate elaboration. A field diary was used before and after to record observations that were not written on the flip chart paper. The flow chart activity lasted 90 minutes and was conducted with the adolescent’s consent, in accordance with recognized ethical standards and respecting the confidentiality of all participants.

This study is part of a PhD research project in which other research instruments were used under different scenarios. This article is limited to the use of the analytical flow chart with the abovementioned health professionals.

### Teo’s journey

The receptionist and nurse participated actively in the activity, while the doctor participated to a moderate degree and nursing auxiliary participated very little.

### Entry

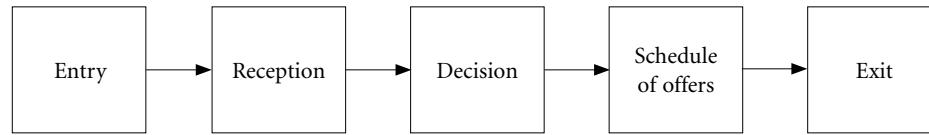
At the time this study was undertaken, Teo was aged 11. Entry did not occur at the normal point of entry of the ESF, but rather via the CHA responsible for the assigned area.

Emília (fictitious name given to Teo’s mother) bumped into the CHA in the street and requested an appointment for Teo in the ESF because he had begun to lose his hair suddenly and without any apparent reason, losing almost all the hair on his body, including his head. She added that she was worried about his emotional well-being and that his academic performance had dropped. Teo refused to go to school because he was being bullied by his classmates because he had no hair.

Mari (the CHA) understood the gravity of the situation and Teo was seen soon after by the nurse (Paula).

### Reception

Teo and his mother were seen by nurse Paula, who made them feel comfortable and welcome and realized that the patient needed to see a



**Figure 1.** Example of analyzer flowchart.

Source: Franco TB. Fluxograma descritor e projetos terapêuticos para análise e serviço em saúde, em apoio ao planejamento: o caso de luz (MG). In: Merhy EE, et al. O trabalho em saúde: olhando e experienciando o SUS no cotidiano. São Paulo: Hucitec; 2003. p. 161-98.

doctor. An appointment was made immediately. Teo's medical records were accessed by the receptionist and he was sent to patient screening to measure his blood pressure, weight and height.

### Decision

Teo and his mother were seen by doctor João, who conducted a brief medical history and physical examination. The doctor diagnosed alopecia universalis (cause unknown) and cryptorchidism (undescended testicles). Teo's emotional state was not mentioned.

### Menu of options

Teo was referred to the municipality's urology and dermatology services. During the elaboration of the flow chart, the doctor did not mention many details of the appointment and seemed to be a little detached from the problem.

With the referral in hand, the nurse immediately scheduled an appointment at the specialist services, because she inferred that the municipal doctor would not treat alopecia universalis. Nine days after the initial consultation, Emília and Teo went to São Paulo to be seen by a dermatologist (Hospital X).

At Hospital X, Teo was diagnosed with alopecia universalis and he was referred to the municipal specialist. Alternative treatments were not recommended.

The specialist declined treatment claiming that he did not treat alopecia universalis, but failed to present an alternative.

Paula, with no other option, went to the patient appointment centre at the Health Depart-

ment. She explained the situation to a member of staff and an appointment was quickly booked with a dermatologist at Hospital Y.

The CHA handed the referral with the appointment to Emília, who refused to go to the hospital because she did not want to run the risk of not being treated again. She added that she would treat her son's case herself and go to the Health Department to talk to "someone in a senior position" to resolve the problem of the appointment.

As a result, despite his complaints, such as not wanting to go to school and low marks at school, Teo went without psychological support up to the point when the flow chart was elaborated, six months after losing his hair.

### Exit

Paula reported that after these events she lost credibility and contact with Emília, particularly after the "someone in a senior position" managed to schedule an appointment (at Hospital Z) for Teo, thus undermining the autonomy of the ESF. The nurse also tried to approach Teo's mother. Paula, adding tiredly and with an air of disappointment, mentioned that her superiors are "very political", which significantly hampers the local health care service.

Mari also mentioned that Emília said that she would not go back to the ESF because "nothing gets resolved there" and has distanced herself from the service, and that Teo would have to wait a year for the appointment at Hospital Z.

With respect to his other condition, Teo left the ESF with an appointment scheduled with a urologist, a specialist service without a prolonged wait.

### **The encounter with “someone in a senior position”: a new entry?**

The “someone in a senior position” in the Health Department also received Emília and Teo, not necessarily at the primary care level (ESF), but rather as a “bridge” between treatment at the secondary level (ambulatory care), when he/she referred them to specialist services.

### **The encounter with the researcher: a new entry?**

The researcher contacted the ESF at the exit stage of Teo’s treatment. After explaining the study topic, the nurse suggested Teo’s name as a participant with the following caveat: “But there’s just one problem, I think Teo’s mother is annoyed with me”, and went on to recount the story of Teo’s exit from the health service.

After a reflective conversation between the health professional and researcher, it was decided to attempt a rapprochement with Teo and his mother rather than to request them to revisit the ESF. A home visit with the presence of CHA Mari was suggested as a way of restoring a bond with the patient. The home visit could also be an opportunity to extend care to the entire family, which, according to the CHA, had various problems: teenage pregnancy, Teo’s bedridden sister with neurological and mental problems, a large number of children, and precarious socio-economic conditions.

### **Reception**

We were invited into the house. Paula asked how Teo was and said that she would like to see him. Minutes later, Teo appeared sweating and agitated, wearing below knee shorts, a loose t-shirt, and large cap that covered practically his whole face. Teo did not look us in the eye and spoke very quietly with his head down looking as if he wanted to hide from the world.

Teo approached us, said hello without looking us in the eye and sat on the sofa, where he remained the whole time.

Emília recounted that one day she opened Teo’s school book and was surprised to see that all the exercises were blank. She did not know what was happening to her son - his marks were really low and he did not like going to school anymore, he had to be “dragged” to school.

Nurse Paula suggested that Emília should book an appointment at the ESF, where she could talk to her and Teo regarding the needs of the family. Emília agreed straight away.

### **Decision**

Nursing consultation in the ESF; however, Teo’s mother turned up without Teo.

### **Menu**

Paula asked Emília how Teo was dealing with alopecia and she explained that, in addition to getting low marks, he made up “excuses” for not going to school, such as headaches and stomach aches or just being generally ill. Teo told his mother that his classmates “made fun” of him all the time because he had no hair on his body. He complained so much that Emília was forced to go to the school to speak to the school director, which seemed to alleviate the problem “of not going” to school and reduce the complaints.

Paula said that, given Teo did not turn up to the appointment, little was done in relation to his condition, but asked Emília to bring him to periodic nursing consultations to support him with respect to his diverse needs and said that she would get in touch with the municipal psychologist to try to arrange a space in her already busy schedule. Care was extended to the family as a whole (gynaecology, child care, social care, and nursing care).

### **Exit**

Teo’s exit from the ESF had not occurred because the nurse understood that he required continuous care, in particular emotional support. According to the nurse, all other professionals except CHA Mari, did not appear to have made active decisions beyond offering Teo prescriptive measures. Furthermore, the team did not mention jointly discussing Teo’s case or the case of other patients.

Despite the absence of a treatment plan addressing Teo’s needs, throughout the elaboration of the flow chart the team was surprised by the long period of time that he had to wait to receive treatment. Doctor João actually said to nurse, with a worried expression: “Goodness Paula... we need to treat this alopecia here”.

### **Decision**

Teo remained in the ESF.

### **Menu**

After visualizing the pathway taken by Teo through the care network, the team was able to observe that there were few examples of effective health care, such that this menu was produced by the team after the completion of the flow chart.

The following decisions were taken: try to treat Teo's alopecia in the ESF, but without discarding the possibility of contacting the municipal specialist again in order to obtain more information about the case and specialized treatment; weave intersectorality with the school by speaking with the school director and/or Teo's teacher, given that the bullying was affecting his mental health and, consequently, his academic performance, and bearing in mind the need for health education addressing school bullying; offer care to the whole of Teo's family, through nursing and home care, considering the teenage pregnancy in the family, and providing Emília support in caring for her bedridden stepdaughter who needs neurological and mental health care; arrange psychological treatment for Emília and Teo; and, finally, create alternative recreational activities to distract Teo, for example, drum lessons, which was mentioned by him in the interviews conducted by the researcher in parallel with the flow chart activity. This suggestion reminded the team of the nursing auxiliary Daniel from another ESF team who saw Teo and was a drummer in a band, thus providing a possible contact so that the team could offer other forms of care to Teo.

### **How many approaches to care are there?**

#### **Attentive care: the Community Health Agent**

The level of participation of the members of the health team in the elaboration of the flow chart varied. Some participated more actively and others less actively, doubling the attention given to the actions of CHA Mari. From the beginning to the end of the activity, this health professional's panoramic perception of Teo's health led to the emergence of details of the care provided that helped produce a rich and creative flow chart.

From Teo's entry into the service, CHA Mari highlighted the suffering caused by the lack of body hair and, particularly, the mental health effects of bullying. It is also important to stress how helpful and prompt she was in resolving problems and communicating information and referrals (of which there were many) to Teo's mother, given that she lives a long way from the health centre (and in an area that lacks frequent public transport services). It is also important to highlight the way in which she mediated conflicts between the health Centre and Teo's mother when the latter wanted to break all links with the service, and the way in which she reestablished this link when the nurse suggested a home visit.

Finally, and above all, it is important to consider the wealth of information she had about Teo and his emotional difficulties resulting from the alopecia, showing a "vibrant" eye for the boy's emerging problems. The professional seems to work in an invisible fabric of "little-seen" actions that were essential to ensuring that Teo received attentive continuous care and that made the "cogs in the machine" go round.

According to Merhy<sup>16</sup>, professionals can weave their networks of production of care each in their own unique way and "operating" (in the gerund) by knowing-doing, permitting novelty, which puts itself to the test and resists ways of doing already in place and given. This creative and resourceful way of doing translates the "self-governance" of the professional and his/her living labour into action, which is in constant motion, always doing, instituting, creating and recreating, modifying, transforming, disturbing, and even inverting certain consolidated and instituted logics of labour.

In this respect, from the schizoanalysis perspective, institutional space may be made up of instituting and instituted forces. The former refers to the production of novelty and does not submit itself to the organization, levels of hierarchy, or reproduction<sup>19</sup>, while the latter works to ensure reproduction and antiproduction, the maintenance of stability, and regulation of standards<sup>19,20</sup>.

Considering these concepts, CHA Mari took an instituting approach throughout the whole care process, breaking with the specialist and disease-centred *modus operandi*, looking beyond Teo's physical body and the alopecia, identifying his emotional suffering caused by being a victim of school bullying. In addition, she resisted the fragmented care trap, with her account of events manifesting a refined knowledge-way of looking at things in relation to what had happened in the patient's life since he lost his hair, providing longitudinal and continuous care.

#### **Uncoordinated and tired care: the nurse-doctor-specialist pathway**

Apart from living labour in action, health professionals may also take a care approach that is less creative, restrictive, and less likely to produce novelty<sup>17</sup>. This approach is not necessarily negative or bad. However, it is not "in action", and therefore becomes instituted and not very flexible. Thus, we may regard such crystallized and given logics of labour, which do not change and are stagnated in the way a job is structured and

even how professionals work, as “dead labor”<sup>16</sup>.

In this multiprofessional space, micro powers pulsate continuously. Instituting relational and affective lines are in operation, but are constantly captured by a way of doing normatized in a specialist care that is prisoner to intellectual levels (level of education and training), undermining manual and relational work and thus reflecting a fragmented approach to healthcare. An example is the work of the CHA, who, despite a high degree of freedom in relation to Teo's care - acting on her own initiative when she realized his suffering - was stifled by the information-nurse-doctor-specialist pathway, reducing her job to communicating information to the nurse, thus losing power, affection, and the information itself (about bullying), which ended up not being addressed, neither by the nurse nor the doctor.

The nurse, stifled by the biological approach to care, turned a deaf ear and blocked her ability to be resourceful, forgoing an infinity of care and intervention possibilities. We use the term turned a deaf ear here because she heard but did not *listen to* (internalize/consider) the precious information brought by CHA Mari regarding bullying, which remained unnoticed, suppressed by body and diagnosis-centred knowledge. The adoption of this type of posture by health professionals can lead to feelings of anguish, since rather than alleviating suffering, it extends the search for support to another professional and disregards other health care approaches, meaning that initial treatment was dry and out of step<sup>21</sup>.

During the elaboration of the flow chart, doctor João seemed to be detached from the case and did not participate actively, since he knew little about Teo's life. This professional adopted a biological and fragmented care approach, focusing solely on physical aspects of the patient, completely disregarding psychosocial dimensions.

These dimensions encompass socioeconomic status and living conditions, making the numerous referrals all the more infeasible, given that Teo lived 60 km from the specialist services (in the city of São Paulo) and this decision made by the professional led to significant expense for the family, not to mention physical and mental fatigue. Furthermore, the intriguing refusal of the specialist to treat Teo served only to aggravate the tiring search for access to healthcare, meaning he had to travel to another city.

According to Caçapava<sup>22</sup>, communication and team spirit are some of the most powerful tools for caring, since they engender confidence

and cohesion resulting from sharing information, experiences, doubts, deceptions, and feeling of impotence.

In short, this unidisciplinary setting, with little communication and restricted in healthcare terms, produces “sad” encounters, not only with patients, but also between staff. This approach stamps the visible tiredness of these professionals, reproducing actions full of lamentation and undermining the possibility of powerful and affectionate encounters<sup>23</sup>. According to Guattari and Rolnik<sup>24</sup>, production is inseparable from desire; in other words, little is produced when little is desired.

The desire to care for Teo as a whole was reduced to such an extent that it did not happen. Whole-person care, which considers the care of the production of the patient's subjectivity, was possible in various spaces, yet did not occur, thus remaining suspended and impalpable.

The impression given was that Teo's care was passed through a sieve or a funnel: the CHA provided a wealth of information and “passed” the case to the nurse, who “filtered out” the bullying, but was taken by the patient's “loss of hair” and by the “urgency” of the case (with some demonstration of some affection, creating a bond with Teo and his mother); she then “passed” the case to the doctor, who diagnosed alopecia universalis and cryptorchidism (displaying little or no affection or bond) and “passed” the case on to the specialist, who “passed” it to Hospital X; the hospital then “passed” it back to the ESF, which referred the case to Hospital Y, when it was “passed” to Teo's mother, who did not “pass” the case to anybody and attempted to resolve it by herself.

### Resignified care: Teo and his mother

Something drew our attention in this pathway, where Teo's mother, driven by an intense desire to care for her son, was the protagonist: the trust factor in those relationships. Drawing on the writings of Rolnik<sup>25</sup> about the Hal Hartley film “Trust”, it can be understood that what the patient wants from the health service is, first and foremost, to feel trust, given that this feeling acts like a “line of flight” that shifts that relationship from (serialized) uniformity, bringing it to the territory of continuous and affective care. This trust opens cracks in the traditional care model and creates other modes of subjectivation (autonomous/independent), other worlds (free/resourceful), protection when one falls and courage to fall. It is important to note that trust is another force in play here, which clashes with the teams

approach to health care, making its members inhabit a territory woven from a perspective of affection and placing them in spaces of decision, desire and willingness to care that resist being stifled by the lines of the homogenization of care.

However, this particular health territory was dominated by the loss of trust, such that it is not surprising to see that, in certain moments, the flow chart elaborated by the team was captured (positively) and tumbled to another territory, where the patients were the protagonists. Emilia produced other modes of caring for Teo mediated by a sense of distrust in the health service. When she desisted from the second appointment scheduled by the nurse and produces new ways of caring for Teo, going to the Health Department to speak to “someone in a senior position”, she creates other meanings and possibilities of care.

#### **Another type of care is possible: the flow chart activity**

By mapping Teo and Emilia’s journey through the system, the team were able to question their approach, making its members reflect upon their labour processes. In this respect, Institutional Analysis, the frame of reference adopted by this study, achieved its goal, which is to perform a self-analysis and self-management of work processes, giving rise to possibilities of producing novelty<sup>12</sup>. The flow chart raises powerful questions (some not verbalized), acting like a device for denouncing and interrogating that which is hidden<sup>19</sup>, veiled and massified by traditional care models. These devices – which in this case were expressed by the attentive and questioning lens through which the participants saw Teo’s journey – favour team self-questioning<sup>18</sup>. The professionals are given something to chew on and the moment exposes an indigestible visibility.

The participants took some time to swallow that which was unpleasant and expressed themselves through the unsaid, displaying uneasiness. However, since each device works via the unsaid and the not known, the sayable, previously unthought of and unseen, came undone and came to light. Using the principles of schizoanalysis, which aims to stimulate a heated and emotional debate<sup>19</sup> (at the speed and intensity of affection, dialogue and impressions), it could be sensed that the neglected subjectivity simmering at the bottom of the kettle began to boil over and then some words were said by the doctor: “Paula, we need to do something!”.

It was noticeable that, upon realizing the length of time Teo had to wait to receive treat-

ment and the lack of effective care throughout this process, the team seemed to have perceived something that was invisible, blurred by automated daily tasks. The caring approach gained a certain prominence at the end of the flow chart exercise. However, two professionals (the doctor and the nurse) found it particularly difficult to overcome the barrier of the alopecia diagnosis, which was shadowing Teo’s other needs, such as refusing to go to school, sadness and bullying.

However, despite the above, by the end of the flow chart activity, all participants, albeit some more than others, discovered other care possibilities (Figure 2) that went beyond the physical body. Music and intersectorality via the school emerged as channels for producing other forms of subjectivity that are happy, free and create other worlds, detaching Teo from the territory/diagnosis-centred care approach which only considers the disease and not the patient.

#### **Final considerations**

The activity allowed the participants to take into account all aspects of Teo’s life, rather than just the disease. However, overall, the care provided did not meet the patient’s needs in relation to the psychological distress caused by school bullying. The alopecia, clearly visible and disturbing (principally to the professionals), steals the scene and becomes a protagonist in this teenager’s life. In addition, the bureaucracy and fragmented nature of care undermines any possibility of delivering longitudinal and continuous care. Furthermore, the team failed to work together. Nevertheless, and paradoxically, it “took the wrong way”, giving way to powerful lines that produce intense suffering.

By using the flow chart to map this patient’s journey through the health system, this study provides an insight into the modus operandi of a health team in delivering care to an adolescent victim of bullying. Certain elements of the care process stand out that illustrate the fragility of the health support network (regardless of the existence of bullying): lack of coordination of care strategies between different levels of care (primary, ambulatory, and hospital care); poor communication between the members of the health team; and failure to address the psychosocial dimension, together with a low level of resolvability in relation to the condition diagnosed by the doctor (alopecia). These elements are characteristic of a network that does not provide compre-



hensive and resolute care, thus calling for the urgent and adequate implementation of current policies with a view to enhancing service provision and ensuring the effective coordination of health interventions targeting adolescents.

With regard to bullying, it is clear that there is a low level of awareness among the health professionals of the health consequences of bullying. It is believed that fatigue may be a factor that affects how the team structures its team work process-

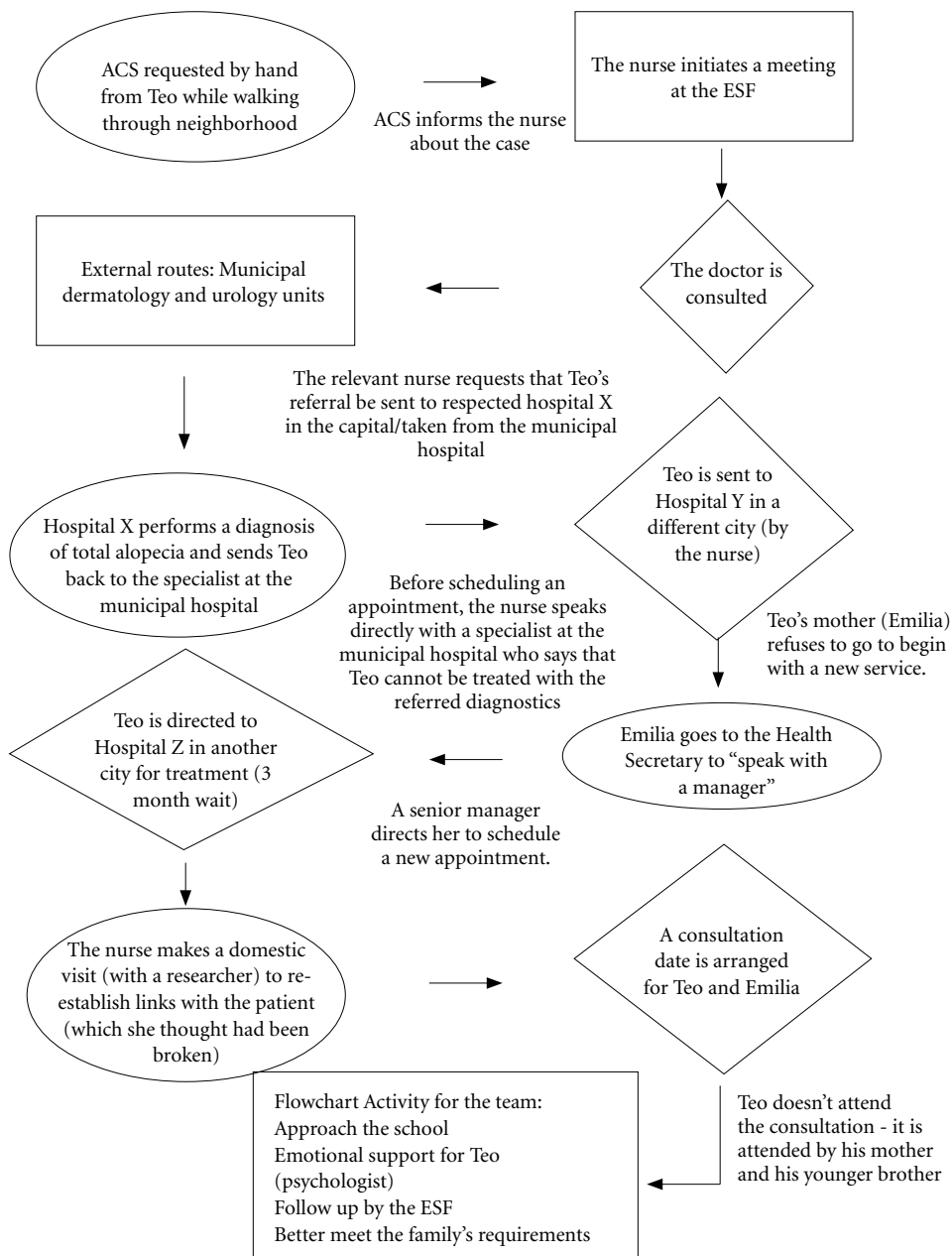


Figure 2. Analyzer flowchart.

Source: Elaborated by the author.

es (poor communication and verticalization of care), contributing to inattentive and negligent care. Addressing this complex problem would require a probe into what happened (What happened? How did it happen? Where did it happen? Who did what? What are the teenager's feelings? What are his points of support?) and time for listening. This probe and listening would result in attentive care tailored to the teenager's individual needs and experiences, giving way to protagonism, valuing life, and creating common spaces for the joint construction of care with the school.

Considering the high prevalence of bullying

in Brazilian schools<sup>3-5</sup>, its devastating health consequences<sup>1,2</sup>, and the victims' difficulty admitting they are targets of this practice<sup>7</sup>, knowing how to identify this problem and being prepared to tackle this behaviour are essential to breaking this cycle of violence. It is important to highlight that primary care services can play an important role in both identifying bullying and assisting the school and family in dealing with this problem. However, health professionals should have the adequate guidance and training to deal with this type of violence, which is potentially harmful to teenager's physical and mental health.

### **Collaborations**

PL Pigozi worked on the conception, analysis, interpretation of data, writing of the article and approval of the version to be published and AL Machado worked on the analysis, interpretation of data and the version to be published.

### **Acknowledgements**

PL Pigozi thanks CAPES (Coordenação de Aperfeiçoamento de Pessoal de Nível Superior) for the PhD scholarship during the development of this study.

## References

1. Smith PK, Sharp S, editors. *School bullying: Insights and perspectives*. London: Routledge; 1994.
2. Smith PK, Morita Y. Introduction. In: Smith PK, Morita J, Junger-Tas J, Olweus D, Catalano R, Slee P, editors. *The nature of school bullying: A cross-national perspective*. New York: Routledge; 1999. p.1.
3. Moura DR, Cruz ACN, Quevedo LA. Prevalência e características de escolares vítimas de bullying. *J Pediatr* 2011; 87(1):19-23.
4. Fisher RM. *Bullying escolar no Brasil: relatório final*. São Paulo: CEATS/FIA; 2010.
5. Malta DC, Porto DL, Crespo CD, Silva MMA, Andrade SSC, Mello FCM, Monteiro R, Silva MAI. *Bullying em escolares brasileiros: análise da Pesquisa Nacional de Saúde do Escolar (PeNSE 2012)*. *Rev Bras Epidemiol Suppl Pense* 2014; 17(Supl. 1):92-105.
6. Mello FCM, Silva JL, Oliveira WA, Prado RR, Malta DC, Silva MAI. A prática de *bullying* entre escolares brasileiros e fatores associados, Pesquisa Nacional de Saúde do Escolar 2015. *Cien Saude Colet* 2017; 22(9): 2939-2948.
7. Lopes Neto, AA. *Bullying: saber identificar e como prevenir*. São Paulo: Brasiliense; 2011.
8. Yen CF, Yang P, Wang PW, Lin HC, Liu TL, Wu YY, Tang TC. Association between school bullying levels/ types and mental health problems among Taiwanese adolescents. *Compr Psychiatry* 2014; 55(3):405-413.
9. Smith PK. *Understanding school bullying: Its nature and prevention strategies*. London: Sage; 2014.
10. Lisboa CSM, Wendt GW, Pureza, JR. *Mitos e fatos sobre o bullying: Orientações para pais e profissionais*. Novo Hamburgo: Sinopsys Editora; 2014.
11. Brasil. Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). *Diário Oficial da União* 2017; 21 set.
12. Barenblitt G. *Compêndio de análise institucional e outras correntes: teoria e prática*. Rio de Janeiro: Rosa dos Ventos; 1992.
13. Alvarez J, Passos E. Cartografar é habitar um território existencial. In: Passos E, Kastrup V, Escóssia L, organizadores. *Pistas do método da cartografia: pesquisa-intervenção e produção de subjetividade*. Porto Alegre: Sulina; 2009. p. 131-149.
14. Passos E, Barros RB. A cartografia como método de pesquisa intervenção. In: Passos E, Barros RB, Kastrup V, Escóssia L, organizadores. *Pistas do método da cartografia: pesquisa-intervenção e produção de subjetividade*. Porto Alegre: Sulina; 2009. p. 17-31.
15. Barros LP, Kastrup V, organizadores. Cartografar é acompanhar processos. In: Passos E, Kastrup, V, Escóssia L. *Pistas do método da cartografia: pesquisa-intervenção e produção de subjetividade*. Porto Alegre: Sulina; 2009. p. 52-75.
16. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. *Agir em saúde: um desafio para o público*. São Paulo: Editora Hucitec; 2002. p. 71-112.
17. Pelbart PP. *A vertigem por um fio: políticas da subjetividade contemporânea*. São Paulo: Iluminuras; 2000.
18. Franco TB. Fluxograma descritor e projetos terapêuticos para análise e serviço de saúde, em apoio ao planejamento: o caso de luz (MG). In: Merhy EE, organizador. *O trabalho em saúde: olhando e experienciando o SUS no cotidiano*. São Paulo: Hucitec; 2003. p. 161-198.
19. Barenblitt G. *Compêndio de análise institucional e outras correntes: teoria e prática*. 6ª ed. Belo Horizonte: FGB/IFG; 2012.
20. Kastrup V, Passos E. Cartografar é traçar um plano comum. In: Passos E, Kastrup V, Tedesco S. *Pistas do método cartográfico: a experiência da pesquisa e o plano comum*. Porto Alegre: Sulina; 2014. p. 15-41.
21. Lage AMD, Moura LR, Horta NC. Abordagem ao Adolescente e ao Jovem na Atenção Primária. In: Souza MCMR, Horta NC. *Enfermagem em saúde coletiva: teoria e prática*. Rio de Janeiro: Guanabara Koogan; 2012. p. 213-228.
22. Caçapava JR. *A Produção Do Cuidado Em Saúde Mental Na Atenção Básica À Saúde: Um Olhar Dos Trabalhadores Sobre O Acolhimento* [dissertação]. São Paulo: Universidade de São Paulo; 2008.
23. Deleuze G. *Espinoza, filosofia prática*. São Paulo: Escuta; 2002.
24. Guattari F, Rolnik S. *Micropolítica: cartografias do desejo*. 11ª ed. Petrópolis: Vozes; 2011.
25. Rolnik S. Hal Hartley e a ética da confiança. *Trafic. Révue de Cinéma* 1994; 12:104-114.

---

Article submitted 30/10/2017

Approved 23/05/2018

Final version submitted 25/05/2018

