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Ethics of care and public mental health care: a case study in Barcelona

Ética del cuidado y atención pública en salud mental: un estudio de caso en Barcelona

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ABSTRACT This article aims to analyze public mental health services in the city of Barcelona from a gender-based perspective. We do so through a case study of mental health services for adults in the context of recent community-oriented and transdisciplinary mental health care reforms. Employing a qualitative methodology, we look at the discourses of mental health professionals regarding the ways in which they approach the therapeutic relationship between professional and user, specifically with reference to vulnerability and proposals for addressing it. Between November 2018 and April 2019 we conducted three discussion groups with professionals and another with a group of female users. Data analysis was guided by a categorical content analysis model. The results show a tendency to understand and address vulnerability from an ethics of care based on a community care model, with differences in the discourses of men and women who participated in the research. We conclude that the community-based model promotes the recovery of users' citizenship, as it is based on a notion of interdependence, in contrast to the hospital-based mental health model.

KEY WORDS Mental Health; Community Mental Health Centers; Qualitative Research; Gender and Health; Social Vulnerability; Spain.

RESUMEN El presente artículo tiene como objetivo analizar, desde la perspectiva de género, los servicios de atención pública en salud mental en la ciudad de Barcelona, a través de un estudio de caso: el servicio de salud mental de personas adultas en el contexto de la última reforma en salud mental de orientación comunitaria y transdisciplinaria. Desde un abordaje cualitativo, estudiamos los diferentes discursos que las y los profesionales en salud mental elaboran sobre cómo abordan la relación terapéutica entre profesional y persona usuaria y, de forma específica, la vulnerabilidad y las propuestas de respuesta. Entre noviembre de 2018 y abril de 2019, se realizaron tres grupos de discusión con profesionales y un grupo conformado por mujeres usuarias. Sobre los datos obtenidos se realizó análisis de contenido categorial. Los resultados muestran una tendencia a entender y abordar la vulnerabilidad desde la ética del cuidado a partir de un modelo de atención comunitaria, que diferencia los discursos entre los hombres y las mujeres que han participado en la investigación. Concluimos que el modelo comunitario, al basarse en la interdependencia, promueve la recuperación de la ciudadanía de las personas usuarias, contraponiéndose al modelo hospitalario.

PALABRAS CLAVES Salud Mental; Centros Comunitarios de Salud Mental; Investigación Cualitativa; Género y Salud; Vulnerabilidad Social; España.

INTRODUCTION

This research falls within the crossroads of neoliberalism and patriarchy in a very specific sphere: feminized mental health care in a Spanish and Catalonian context of mental health care reforms over the last two decades. From a critical perspective, our aim is to explore how these two historical processes become apparent in the different agents found in said context. To achieve this, our focus is placed on the study of an ethics of care as a way of interaction in the mental health sphere.

This article results from a larger project entitled *La atención en salud mental desde una perspectiva de género: organización, gestión y subjetividad en el patriarcado neoliberal* [*Mental health care from a gender-based perspective*: *organization, management and subjectivity in neoliberal patriarchy*], directed by Dr. Enrico Mora and Dr. Margot Pujal, within the framework of research conducted by the groups *Lis-Estudis Socials i de Gènere sobre la corporalitat, la subjetivitat i el patiment evitale*, and Des Subjectant, at Universitat Autònoma de Barcelona.

Despite the tendency of the recent community-oriented and transdisciplinary mental health care reforms,(1) mental health care professionals experience, as a collective identity group, a strong tension in the workplace, which resulted in health deterioration(2,3) and emotional discomfort. On the one hand, the services offered by mental health care facilities are aimed at improving the well-being of people resorting to them, a demand that has been continuously on the increase. Nevertheless, the resources that they need have not been substantially modified. According to the World Health Organization (WHO),(4,5,6) the estimated global gap amounts to 11% between the burden of neuropsychiatric disorders (accounting for 13% of global health care costs), and allotted mental health care expenditures (accounting for 2%), and the prospect is that one out of every four individuals worldwide will have a mental disorder at some time in their lifetime, this being one of them main causes of disability worldwide. On the other hand, business management models have been introduced for mental health services, known as *New Public Management*.(7,8,9) Medical and management care is based on different models (for instance, community-, hospital- or home-based care) that entail very different experiences, both for professionals and users.(10) Mental health care models are based on different epistemological assumptions, which range from psychodynamic and psychosocial conceptions of the people to fundamentally biomedical perspectives. However, the plurality of answers regarding the way to offer a basic public service aimed at the well-being of an individual are not distributed in a homogenous way. At present, the hegemonic model in the Spanish and Catalonian context is framed within a globalized psychiatric biomedical and psychopharmacological approach, which articulates a specific type of androcentrism and patriarchal power relationships in mental health as highlighted by Pla, Donat and Bernabeu.(2) In addition, these health care models are increasingly organized according to a market-based management and a general framework of financial precariousness of public health care services.

Socioeconomic determinants and their effect on mental health treatment have been largely studied, but it was not until the impact of the 2008 crisis that important actions were taken in this line of work. The socioeconomic factor is the most significant determinant of the increase in the prevalence of mental health problems.(11,12) These governmental reports establish that mental health is the sphere where there is more influence of socioeconomic factors as a determinant of an individual's well-being. There has been a rise in the demand for treatment and services and the use of psychotropic drugs. Diagnoses of depression, anxiety disorders and sleeping problems have grown markedly across Spain, mainly, within the working class.(13,14)

This rise in health care demand and services have led to new research studies on feminized mental health care and the condition of health care professionals in relation to these changes. This research mostly includes quantitative and biomedical studies which, by way of epidemiologic studies, describe the effects of health care services precariousness shown in the health of health care professionals.(8,15,16) These studies define 'disease' as an individual and quantifiable phenomenon, and consider that burnout is the diagnosis resulting from the discomforts arising out of the professional condition.(17,18,19,20) In particular, as to mental health care professionals, Lanham et al(21) and O'Connor et al(22) show that they are a collective group with high levels of exposure, but this conclusion is drawn without data broken down by sex or gender. Albeit at a quantitative level, these research studies already provide evidence regarding vulnerability contexts where health care services are provided at present.

Works with a critical perspective in connection with mental health care are focused on two main health care approaches. On the one hand, a set of research studies address neoliberalism and health care, including strong criticism of the manner in which mental health is attended after the psychiatric deinstitutionalization in the 1980s and other contemporary transformations. Vaccari,(23) Gallo Acosta and Quiñones Useche,(24) Castro,(25) and Verhaeghe and Bracke(26) offer a rigorous X-ray picture of how this process in the neoliberal context took place, from a critical view that reveals the consequences on diagnosed people. In Spain, Disviat(27,28) analyzes the potentialities and limitations of the psychiatric reform on its 25th anniversary. Also there is an incipient interest in the rights and improvement of treatment of people with a mental health diagnosis, encouraged by the United Nations Convention on the Rights of Persons With Disabilities.(29) Along these lines, at present some works are conducted by professionals and by social mental health movements(30,31,32,33,34) or by psychiatry survivors, for instance. In addition, there is an important line of works from a gender-based perspective that problematize gender-based stereotypes and prejudices(2,35) as well as feminization of both professionals and users in therapeutic relationships context.(36) With respect to research with a feminist-oriented perspective,(37,38,39) there are studies that are closely related to our object of study as they introduce the concept of care within the context of mental health attention.

In this work, we understand mental health care professionals from a gender-based health care perspective,(40,41,42) paying special attention to feminist studies on an ethics of care, applied to professional health care relationships, beyond family relationships.(43)

We have seen how, in mental health, epidemiologic and statistical works that understand health as an individual phenomenon prevail. These types of works provide very limited findings regarding social, cultural, and relational factors existing in vulnerability contexts. With that type of research, we cannot grasp contextual significances that health care professionals attribute to the concepts of care, discomforts or autonomy of users, to name but a few. Said concepts are crucial in the day-to-day routine of a therapeutic relationship, especially at this moment in history when so many people find themselves suffering from some type of psychic disorder, which will dramatically increase amidst the Covid-19 pandemic; therefore, it is of great importance to know how a user gets attention and under what circumstances professionals do so, in order to make contributions toward the improvement of services. This is why the high-quality criterion proves significant in this research, following the notions developed by Calderón.(44)

Vulnerability, ethics of care and mental health

Our conceptual framework is based on the concepts of *vulnerability contexts*(45) and *ethics of care* (35) to analyze the transformations that are taking place in feminized professional practice by mental health care staff. When we talk about vulnerability contexts, we embrace a theoretical stance(13,14,45,46) that sees vulnerability as a result of relational and dynamic aspects of social life and not as an individual attribute that comes down to a biopsychological feature. We consider that vulnerability is determined by social inequalities caused by gender, class, ethnos, age, capacity, etc., which characterize our society. Public mental health care services are provided to people on a daily basis whose needs mainly derive from adverse vulnerability contexts and that have had a particular subjective experience of special psychic suffering. Care is one of the main needs to be addressed by mental health care professionals, understanding care as

> ...a type of social relationship that is characterized by the action of satisfying the needs of a person by another person, which is the ultimate purpose of the action and where face-to-face interaction between the care provider and the person receiving care is a crucial element of the activity as a whole. The nature of the need is such that it cannot be satisfied by the person receiving care.(47)

In this article, we explore some specific aspects of health care relationships. In particular, we are focused on two dimensions: an instrumental dimension, that is, those specific and material actions that are adopted with respect to bodies; and a human dimension, the immaterial factor pertaining to the affective-relational bond and the interdependence that is established between the care provider and person receiving care.(40,41,43)

As will be developed below, everybody experiences different vulnerability contexts and, therefore, everyone is likely to need some type of care. The positions of care provider and care receiver are neither fixed nor complete. If they are fixed, the risk is that the person providing care may develop feelings of omnipotence (leading to a denial of the other person) and of resentment by the person receiving care, since they can develop dependence or the idea that the care being received is an form of power.(48) A democratic policy of care needs to be based on reciprocal recognition, and we consider that this way of addressing activities and human relationships amounts to ethics, a framework from which people become aware of the notion of interdependence.

The concept of ethics of care comes from the works on moral development outlined by Carol Gilligan,(47) in which she levels criticism at the idea of a universal moral development based on a male ethics of law. It is a concept that was used as a tool of analysis to study social connections from a gender-based perspective.(49,50,51,52) We define the concept of ethics of care as the way of relating with someone else's vulnerability and one's own, which has nothing to do with the application of universal, disembodied and unilateral solutions. Its raison d'être is based on the logic of network and shared responsibility.(43,53) Therefore, unlike the ethics of justice (or ethics of law) in no case does this view rely on isolated and self-sufficient individualities. It endorses a perception of morality as an interconnected and complex network, in which conflicts in relational terms are understood. The emphasis is placed on the satisfaction of human needs, consideration of the context and the differences existing in society.

In order to consider the role that this ethics can play in mental health care, our interest lies in the implications that it carries in the citizenship that it configures. Ethics of care is closely linked to a concept of citizenship than avoids the liberal logic. The (neo) liberal individual presupposed by the ethics of justice constitutes a citizen's model in concordance with a universal and self-sufficient individual's conception,(54) that is, an adult, middle-class and Western man, whose main activity is the professional practice within the public sphere. This way of understanding citizenship perpetuates the public/private distinction, which confines care to the private sphere associating it femininity. Without a revolutionary change of this concept of citizenship, care cannot be democratized as fundamental ethics in human relationships nor can it modify the sexual division of work. Along the same lines, Kohen(55) develops this concept when affirming that displacement of care-related matters to the private sphere has been a maneuver to hold the fiction that the *citizen* is autonomous and self-sufficient, establishing contractual relationships. We consider that by displacing ethics of care to the public sphere – in our case, public mental health care services – we will be able to analyze whether clinical practices could be seen as resistance practices regarding inequality relationships.

Our research proposal is to analyze the role of an ethics of care in feminized mental health care services from discourses of professionals and users regarding their ways of understanding and addressing vulnerability. In a context where the capital-life conflict is so fierce, where so many people see how their psychosocial vulnerability and impossibility to exercise a worthy and real citizenship get worse,(56,57) we maintain that it is relevant to study the way that answers are given from mental health public services. In this sense, as noted above, we use the concept of ethics of care as a conceptual tool from a gender-based perspective that is based on the importance of the relational aspect and mutual aid as a way of acting in the world. Therefore, we wonder, for the case under review, what discourses are elaborated by mental health care professionals on vulnerability in therapeutic relationships between professionals and users, and whether in these discourses we can identify components of an ethics of care, as well as its implications for a displacement of the androcentric concept of citizenship.

METHOD

As noted above, the findings presented in this article result from a larger project entitled La atención en salud mental desde una perspectiva de género: organización, gestión y subjetividad en el patriarcado neoliberal [Mental health care from a gender-based perspective: organization, management and subjectivity in neoliberal patriarchy], directed by Enrico Mora and Margot Pujal from Universitat Autònoma de Barcelona. The project is organized in two stages: the first stage consists in an intensive case study, following the developments by Stake,(58) in a mental health care facility. The case study is the device that best suits research studies aimed at discussing a complex phenomenon in its real context while paying attention to a number of limited events and conditions and their interactions, which defines the validity of the findings presented here. A qualitative validity, following the developments by Calderón,(44) whose aim is not to provide data about the quality of this research in terms of statistical generalization of the results, but to offer a semantic field of the differences that allow us to conduct an in-depth analysis of the phenomenon. The second stage consists in a participatory action research, which seeks to accompany a transformation for the sake of the well-being of the professionals and an improvement of medical attention provided to users. This article belongs to the first stage of the study.

The research uses an abductive approach, following Vázquez,(59) by which we conducted an investigation that ranging between deductive reasoning (going from what is general to what is particular) and inductive reasoning (going from a singular result to a general result). The abductive method is an approach that takes general or abstract propositions as provisional formulations, which are revised depending on obtained results, which serve as conjectures to check initial formulations, reorienting the obtained results into a reiterative process. This choice suits the research question, complying with the adjustment criterion in epistemology,(44) as it is a field about which very little empiric evidence is available but whose theoretic elements have not been applied in the field of health. The design was carried out through a discursive procedure.(60,61) This method allows us to have access to past experiences and to future expectations in relation to mental health care; to delve into thoughts, perceptions and opinions in terms of relevant actors in said context; and to know about significant situations such as the consultation, to which it is sometimes difficult to have access.

Technique for data production

We opted for a reflexive group, which is a discussion group, but the particular feature is the focus on collective experience, community reflection and the introduction of historicity to understand change processes. Specifically the groups used in this work are four: three groups of professionals and one group of users of mental health services of the facility under review. They were chosen due to various reasons: the relevant characteristic of this technique is the possibility to take advantage of the discussion atmosphere generated by the group in order to get a great deal and variety of information;(60,61) and in addition, the potentiality provided by the group situation to talk about tough experiences or events linked to the specific collective groups of the participants; and, bearing in mind the second participatory action research stage, this technique is useful to promote a community and cooperation feeling among professionals and users, and also with the research team.

Appropriate context and participants

The metropolitan area of Barcelona was the territory from which the mental health care facility was chosen. This area gathers most of the users and most of the mental health care resources in Catalonia. The data were obtained from a mental public health care health facility in a district of Barcelona. Without giving more details to keep anonymity, the center that took part in the research is one with the greatest level of health care demand and that allowed us to have access to its everyday professional and health care routine. It is a center with a psychodynamic and community-oriented tradition that had to adapt progressively to the contemporary health care mechanism. In this center, we encountered a mental health care facility for adults, a community-oriented rehabilitation service and a program of customized services.

After an introductory session of the project, the professionals took part in discussion groups, divided according to the type of service provided at the center and according to their inquiries and interests. The final outcome is that practically all the workers at the center took part in any of the multiple discussion-reflection groups that were conducted. For each group an average of seven different sessions were organized. The participants of the groups were, on the one hand, both women and men, and included professional with all profiles that worked with users and, on the other hand, there were single-sex professional groups (whose data are not used in this article). Each group was organized making sure that there was an important variability of internal age to discuss experiences they had at the center and facilitate a significant inter-generational bond on experiences and changes that occurred while practicing the profession at the institution. It should be noted that the theoretical sampling and pragmatic sampling supplement each other.(62) That is, the composition and characteristics of the participants coincide with the theoretical requirements necessary for the sampling.

The resulting groups included professions linked with clinical psychology and psychological therapies, psychiatry, nursing, social education, social work, and administrative services. We focused on two big services offered by the institution under review: the mental health care facility for adults and the community-oriented rehabilitation service.

For the research design we also included users, as key agents in therapeutic relationships, in order to better comprehend the practice of the professionals. For the configuration of these groups, the users got organized according to sex to create a favorable and trust space for the users. The internal composition of each group varied according to age, chronification history and term of duration of the mental health services received (Table 1).

For the purposes of the findings shown here, we considered three discussion groups with professionals and the group made up of female users. This has to do with the fact that only in the group of female users it was possible to identify aspects that relate to an ethics of care concerning the therapeutic practice

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Table 1. Number of participants in discussion groups. Barcelona, Spain. November 2018 to April 2019.

Participants	Group	Number of women	Number of men
Professionals	GDc1	6	3
	GDc2	7	2
	GDs	3	2
Users	GDu	14	-
Total		30	7

Source: Own elaboration.
GDc1= Discussion Group 1 of the mental health center for adults; GDc2= Discussion Group 2 of the mental health center for adults; GDs= Discussion Group of the community-oriented rehabilitation service; GDu= Discussion Group of users.

received. We do not believe that this means that the group of male users did not establish a bond governed by an ethics of care. However, we do not have enough data to affirm and describe this fact.

The general topics around which we organized the discussion groups in various sessions were: the history of the health care service and the center in which the activity is developed, the types of professional roles and ways of carrying out the clinical practice, the perception of the users, the ideals of femininity and masculinity in a therapeutic relationship, the sexual division of professional work, the needs and demands of professionals and users, the relationships of power among professionals, and between professionals and users, and the integration of the rights of users into professional practice. These topics are addressed from normative, factual and desiderative dimensions.

For the analysis, the audio of the sessions was digitally recorded. A verbatim transcription was performed of the audio of the groups for its later encoding, bearing the research objectives in mind. As for the quotations reproduced in this article, we applied a stylistic correction without altering or affecting the original meaning of the original statements. We made this correction as a way of respect toward the group participants, since oral register is different from register in writing, and it may often produce feelings of discomfort for the participants when they read what they actually said orally. Similarly, we omitted some details that do not alter the analysis but that reinforce our anonymity commitment.

As to ethical considerations, the type of study conducted was approved by the institution that renders the services being analyzed, through an agreement, and by the association of users of the center, where anonymity and consent mechanisms were established. In that way, in the first session where the project was introduced to the participants, we described the project, we read the informed consent form and their rights, and we explained anonymity and custody safeguards of the data obtained at the facilities of the Universitat Autònoma de Barcelona. After some time of prudential reflection, the persons that wanted to take part in the research signed the informed consent, which is also filed at the university.

Procedure of data analysis

A categorical content analysis or thematic analysis was performed with the aim of explaining and systematizing the content of different types of communicative messages, in our case, transcriptions from discussion groups. Following Braun and Clarke,(63) this process consists in identifying and analyzing patterns found in the data. By grouping and organizing the data in different thematic categories for the data obtained, the objective was to delve into latent content, relating it to our theoretical framework and, ultimately, to a social and historical context.(64,65)

To start with, we organized the material to be analyzed and our aim was to clarify the objectives of the analysis. Then we moved on to the stage of data encoding in which raw data were converted into units of meaning to enable a precise description of their content and to put an end to the categorization phase. The purpose of categorization is to organize and group the obtained codes using criteria of similarity and differences to get an overview of the data. The final outcome reflects two different processes of category conformation. On the one hand, we can see how the same data provisionally respond to those questions put forward by us. And, on the other hand, there are categories that were created thanks to an inferential process from the organization of codes with a more latent content than descriptive that we decided to revise using the abductive approach described above.

RESULTS

As a result of the encoding process, we constructed a total of 19 codes that the participants relate to mental health care. Using the process detailed above, we elaborated three topics or main categories: vulnerability contexts, proposals for addressing vulnerability, and precarious professional health care. Some of them were broken down by sub-categories that were useful for a more profound analysis, organizing and identifying elements that constitute the concept of a general category (Table 2).

Table 2. Categories and subcategories of analysis.

Categories	Subcategories
Vulnerability contexts	1. Contextual discomfort determinants - Social and economic - Relational
	2. Discomfort deriving from health care - Stigma - Violated rights - Otherness
Proposals for addressing vulnerability	1. Professional health care - Bonds - Therapeutic relationship
	2. Reciprocal professional care - Work organization - Reciprocal support among professionals
	3. Community-oriented model - Ecological intervention - Comprehensive intervention - Firs-person activism
	4. Hospital-based model - Medication - Hospital attention - Paternalism
Precarious health care	- Health care individualism - Care pressures - Lack of resources - Professional training required

Source: Own elaboration.

Vulnerability contexts

In this category we find aspects that users and professionals consider to be fundamental to understand the origin and endurance of vulnerability situations with respect to mental health. Both groups place themselves far from biological determinism of the genes and neurotransmitters to explain psychic suffering. We see that they attach a strong role to socioeconomic reasons, which are directly related to lack of basic resources for a dignified life (housing, employment stability, etc.) as a contextual root of the vulnerability of users and their psychic discomfort. In addition, they give importance to the fact of having good family relations and support networks as protective factors of psychosocial well-being.

> *There are people that need a long time, because there are very serious situations. Not because one has been diagnosed with schizophrenia... No, nothing to do. Because there are vital situations that are really complex, because there are situations full of violence and precarious economic resources*. (GDs, professional C1)

However, this point of convergence between what is expressed by female users and professionals regarding the origin of psychic suffering is not found when in the discourse we identify the discomfort generated by health care services. This is only reported by female users, in biographical terms, and encompasses all the periods where, to a certain extent, they found themselves linked with mental health care devices, including very different professionals, periods, and establishments. A paradigmatic example of said discomfort generated by mental health systems is the institutional re-victimization in gender-based violence cases. The prevailing biomedical paradigm treats gender-based violence as an individual and psychopathological problem, resorting to the use of psychotropic drugs, thus making it invisible(66) since it lacks an inter-sectional gender-based perspective in an ethics of care and without

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considering the context of social inequality that is created by the gender-based system.

The professionals of the facility being studied do not express in their discourse relationships between the clinical intervention performed by them and whether or not it can contribute to psychic discomfort. This is certainly one of the touchiest aspects of clinical practice and that more ambivalence can create when it comes to reflecting on the therapeutic practice itself, since intervention is governed by the principle of supporting processes toward well-being and never toward causing damage. Nevertheless, in the case being studied here, the professionals started a change process in the therapeutic dynamics and in the way of understanding users, which signals their will and desire of collective transformation, which requires a time and a space of reflexive transformation. Female users express how, throughout at certain moments of their lives, their relationship with the network of mental health services in Barcelona had harmful effects or contributed to maintaining their discomfort. These experiences have to do specifically with the "violation of rights," "stigma," and "otherness." As to the violation of rights, female users refer to such cases as the one explained by female user 2: "*I was even forced to follow a treatment that I didn't want to*." Stigma is mainly related to the vision of the professionals:

> *... and most of all the professional not having stigma. Because there are many that have stigma. The way they see you.* (GDu, female user 6)

Finally, by "otherness," we refer to situations in which a relationship of power has taken place, exercised in some cases by professionals toward users, even generating a feeling of dehumanization.

> *As all my rights were actually violated and everything was admissions, admissions, and more admissions, this directly didn't contribute to my recovery* [...] *Therefore I was a dog chasing its own tail.* (GDu, female user 2)

> *But the only thing I want from my professional is to be treated like a person, someone who listens to me and doesn't treat me like a number.* (GDu, female user 2)

Apart from identifying those adverse effects for their well-being, they also acknowledge, regarding the present-day institution where they receive health care services, how things have changed and how they have found a facility where they feel recognized.

Addressing vulnerability

The professionals and users that participated in the reflexive groups of the institution being studied here understand that the way of tackling psychic suffering should swap from a hospital-based model to a community-oriented model. However, this model transition is not always easy, given that it involves bringing significant changes in epistemological and clinical events within the whole mental health care system, and public health care administrations still have not provided the necessary resources. To the participants, the way in which the professionals and female users relate in the health care sphere is central. We called this bond "professional health care," requiring that this bond should be governed by care, as the core element of the relationship. For both professionals and female users, horizontality and respect are good care tools.

> *And I need to be taken into account because, at the end of the day, it's me that is suffering.* (GDu, female user 2)

> *I feel that I managed to change. In the sense of getting a better understanding of the power that the other can have on me, their capacities and the risk of my power.* (GDc2, professional C2)

Together with the need to establish care relationships between professionals and female users, it is also necessary to promote and maintain "reciprocal professional care." As it is a profession with a strong emotional component, this serves to show how professionals give too much importance to mutual aid offered among fellows, as well as accompanying each other in complex situations arising from professional duties. But providing care to someone else and taking care of oneself is not relationship that can be established in the vacuum or as a result of an individual will without contextual and institutional conditionings. In other words, the capacity to take care of oneself and of users has previous conditions. The professionals regard some suitable working conditions, with a good work organization, as crucial to be able to perform duties as care providers.

> *To me, care implies other things that we are not taking into account* [...], *a timetable that suits you, a salary that compensates you, workload that is easy to handle.* (GDc1, professional A2)

But the central aspect of care in the way of addressing vulnerability is not compatible with any model of health care intervention. The participants identify this, drawing a difference, according to experiences as professionals or as users, between two main parts of the approach that provide well-differentiated significances and evaluations.

The "community-oriented model" emerges in a sphere of recent changes in health care and a horizon where professionals and users state that they hope to reach. From the community-oriented perspective, an ecological intervention is sought through a linkage of the relational setting of the affected person, transcending their individuality. What is understood by "ecological interventions" is work with the user's family, home care or activities that seek to strengthen the relational network with the community.

> *To me the ideal of future would be including the people from the outside, the people in the streets. The community, I mean.* (GDs, professional E3)

> *As my family took part, they understood the situation better and then the support was really adequate and positive.* (GDu, female user 7)

Also it is based on a "comprehensive intervention," understood as the articulation with different agents and institutions to address vulnerability from different dimensions and not just the individual clinical aspect. Co-therapy and involvement of social services or labor advice would be examples.

> *And, besides, a lot of administrations should participate, shouldn't they? Not only health care spheres but also Social Welfare agencies, the Department of Work* (GDc1, professional P6)

Simultaneously, along with this community-oriented mental health care model, what is promoted is to listen to the voices of users, which were historically ignored. This represents a significant change that directs an incipient change in health care practices: from hierarchy to mutual acknowledgement. All in all, the community-oriented model seeks to open mental health care to new agents and to listen to silenced voices.

In turn, when participants narrate experiences about the community-oriented model, they refer, by contrast, to the "hospital-based model," which for the professionals and users still has an excessive weight in the conception of care and in the institutions of the mental health network.

> *I was accustomed to working on acute disease services and, of course, to start working in first-aid was an important change for me. I came from a very biologist school and it was hard to come here.* (GDc2, professional E1)

> *... I was with sub-acute patients and she told me straight away that it was not a service to work nothing but to stabilize.* (GDu, female user 6)

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For the participants, the hospital-based model is supported in "paternalist interventions" whereby professionals make decisions on behalf of users. The goal is immediate stabilization with a special focus on "medication." Rigidity, hierarchy and male presence also stand out in this health care model.

> *Or perhaps it was easier for men to work at hospitals because they were possibly better paid.* (GDc1, professional P2)

> *It's true that with acute patients there are more men.* (GDc1, professional E1)

Precarious care

In the reflexive groups of the professionals they usually reported the limits and actions that go beyond their individual control, understood by them as harmful to what they believe constitutes good care. By precarious care we refer to those social processes that lead to difficulties encountered by the professionals when it comes to providing care; barriers that they face when addressing the vulnerability of individuals from different dimensions and also addressing the needs of the care providers themselves. And this precariousness is divided into four pillars: "care individualism," "care pressure," "lack of resources," and "necessity for training."

> *I have a waiting list of 180 patients and there are people that have been waiting for a psychologist here at* [...] *for a year.* (GDc2, professional C2)

> *Perhaps at the beginning when I came here, when I began, it was more... I don't know, I thought things over and over again. Or I don't know... I had more time for reflection. Now it is just consultation, you come into the office and... Rush! Rush! Rush!* (GDc1, professional P1)

The professionals are not working in accordance with the needs that they detect or with the tools that they would like to have. We identified two dimensions of these limits or difficulties. In the first place, the professionals report that they have an important health care pressure that limits the time they can devote to each user and, at the same time, the lack of resources for mental health services favors this saturation dynamics. In addition, a demand for a reorientation of the training received by the professionals and the individualization of care are facts that have to do more with the effects of the traditional ways of psychiatric attention. A rigid training that is founded on health care individualism and its maintenance. Far from clinical guidelines and diagnostic "super-techniques", the professionals affirm that they miss training in therapeutic relationships and community-oriented services.

> *In the past we used to get more in the cave. Each one in their office doing the required job. How does this affect the patient? Well... it amounts to less, worse therapeutic quality.* (GDc1, professional P6)

> The professionals that are entering the network are trained in therapeutic relationships rather than in super-techniques. (GDs, professional C1)

They understand this fact as an impoverishment of the quality of professional care and the whole health care service provided within the mental health care network.

DISCUSSION

In the light of the findings for the categories *vulnerability contexts* and *proposals for addressing vulnerability*, there is a link between the concept of an ethics of care proposed in this paper and the community-oriented ambition across the mental health service that we studied. Let us focus on the concept of vulnerability. The participants conceptualize it in a way that the root of the discomfort of the user is not a brain alteration requiring psychopharmacologic intervention, but as described by professional C1 *"they are vital situations that are really serious."* At a socioeconomic level, it is very clear how the dynamics of crisis and of lack of protection of the people and protection of the markets required by a neoliberal model has considerably damaged the psychosocial health of individuals, mainly women from working classes. Both the professionals and female users mentioned this issue along the same lines, as did several research studies that discussed the relationship between mental health and economic precariousness.(11,13,14) In this sense, the Human Rights Council within the United Nations Organization has issued a recent resolution encouraging the strengthening of conditions for a dignified life such as policies of prevention in mental health.(46) The centrality to be acquired by the contextual etiology linked to the needs of how mental health is understood is a characteristic of an ethical perspective in which care is beyond the biomedical, individualistic, and androcentric standard.

As to the proposals for addressing vulnerability, we found results that may be analyzed from an ethics of care and of justice. It is important to highlight how, in spite of fully understanding their role as care providers, the professionals also refer to their own needs as a community, and collective ways based on mutual aid to achieve sustainable health care services with better quality to satisfy those needs. Permeability, which is obvious in some fragments, in the care provider/care receiver frontier proves very suggestive. The fact that professionals see themselves as vulnerable individuals and demand some basic conditions to exercise their role of care providers (especially evident when they talk about the organization of health care work) constructs a new representation that faces autonomy and self-sufficiency, which presupposes citizenship from a liberal perspective and from an ethics of justice. When we talk about ethics of justice, we refer to the principles that govern

> ...the objectives of the actions that do not address contextualized singular needs of each person, or if they do, it is in instrumental terms. The achievement of the purpose of the action is blind to any consideration alien to one's own objective. The objective is the end. To achieve this, the objective is attained in terms of universal standards and/or by force.(43)

Therefore, again through an ethics of care, we can see a way to understand individuals that take part in a therapeutic relationship close to the recognition of an ontological interdependence. Here we can also see a rupture of the gender-based norm that links vulnerability with the female gender and the private space, because, as stated by Tronto,(67) the practice of an ethics of care has nothing to do with allotting care tasks to women within the family sphere, but understanding them as a "cross-sectional human activity to maintain and repair a common world," that is to say, to support life.

The professionals within the reflexive groups express that, in spite of the difficulties that they encounter daily, they have a care, self-criticism and respectable vocation toward the person they are attending, which has nothing to do with certain conceptions of the figure of an evil psychiatrist prevailing at certain times and contexts, or that are often projected from certain criticism perspectives. We do not know if it is a way to understand the specific clinical practice of the case study or if it is more generalized. In this sense, it would be necessary to conduct further research.

In addition, as to the proposals for professional care and the community-oriented model, the professionals gave special importance to the horizontality in the therapeutic relationship between professional and user, mutual assent, and listening to what the user has to say. That is, the factor pertaining to the affective-relational bond and the interdependence that is established between the care provider and the person receiving care,(56) which is one of the characteristics belonging to the democratic practice of care. The results show that the construction of a strong bond and, most of all, with a less hierarchic relationship, helps users to feel treated as persons. On the part of the professionals, it is a process of waiving privileges and thinking new ways of understanding the profession and the very discomforts attended by them, but it is a fact that is experienced as an improvement of their health care tasks that contributes to well-being and reduces psychic suffering. To this end, the way to be able to sustain this type of bond and to address vulnerability is, according to the participants, the community-oriented model. According to this way of attention, the core of care is the look on contextual processes undergone by users and social connections that cause or maintain psychic suffering. This model proposes a collective approach to rebuild a person's community link or to share health care with other institutions nearby. The main idea is that, if the discomfort takes place due to complex and relational phenomena detected in the community, it should be within the community that the work for recovery must be developed. Following Grandón Fernández et al.(68) and Rendueles,(69) the networks of community links also strengthen prevention interventions in mental health care. After analyzing the data, we believe that a comprehensive, ecological, and participatory care is crucial when it comes to mental health in our communities.

Furthermore, as this collective group has been feminized in a progressive way since the second half of the 20th century, in the framework project of this study, we should ask ourselves about the influence of the gender-based perspective (still in tension with neoliberal patriarchy) in the professional tendency emerging in this study, oriented toward a democratization of care in a public and professional sphere, as is the mental health care.

CONCLUSION

The community-oriented perspective facilitates the complex and dynamic understanding of the construction of subjectivity and suffering, as well as its approach, changing the perspective that understands people as merely sick individuals to start conceptualizing them as citizens. A concept of citizenship that walks away from the implied association with the hegemonic concept: man, adult, middle-class, healthy and capable of liberal fables. From this perspective, an autonomous citizen is not the one thought from an ethics of justice. The autonomy that human beings can construct, from a perspective aimed at the reduction of evitable suffering and its sources of social inequality, is based on our shared existence,(52) which is vulnerable and interdependent. This involves establishing a framework of democratic relations aimed at desexualizing delicate practices of care, challenging sexism and the sexual division of work that conceals the systematic transference of well-being and psychic support to hegemonic male positions at the expense of other people.

In such a hostile context as the present-day one, which the Covid-19 pandemic has focused and exacerbated, at the same time, there are authors that maintain that it is impossible under these conditions to exercise a non-liberal citizenship with rights.(54,70) Although we share their analysis, we believe it is important to consider a community-oriented intervention in mental health as a guide to walk toward a citizenship contrary to the individualistic, patriarchal, neoliberal and market logic model. Far from false universalism, the only universal characteristic that we claim from an ethics of care is the vulnerability inherent in human species together with the vulnerability arising from the multiple inequalities of our society and the central role played by care in the path leading to new ways of understanding and acting in society as much in the private and professional-public spheres.

The conventional hospital-based model, in spite of being theoretically redefined in the last mental health reform,(27,71) in the Catalonian and Spanish contexts it continues to be in use in professional practice, which is incompatible with the ideal proposed by the health care professionals and users based on mutual assent and the community. Although we have detected in the discourses of the participants an obvious orientation toward an ethics of care as a proposal for addressing vulnerability, we identified a central contradiction in the articulation between the ways of organizing the health care network and the professional practices promoted by the various intervening institutions. There is a immense diversity of kinds of care and organizational models that hinder the possibility of carrying out a community-oriented model useful for both users and for professionals. That way, it can be oscillating between different devices whose assumptions and principles contradict themselves and that may imply swapping from mutual recognition and respect to diagnostic reification, deleting precarious social contexts and silencing their voices, a contradiction that not only takes place due to different models for understanding mental health. The precariousness dynamics of life spheres deriving from neoliberalism is creating multiple vulnerability contexts for wide layers within society, apart from the increasing market-based and profitable privatization of public services and the complicated and contradictory situation of their professionals, and this implies an enormous difficulty and a great effort to include in the daily practice an ethics of care to correct an exclusive and unsustainable ethics of justice. Otherwise, the risk is the application of an individualistic policy that involves that a care relationship should be in charge of professionals, without the organizational and institutional support of care centers and networks, the main consequence being a professional collective discomfort, their emotional and physic exhaustion and ethical stress resulting from the contradictions of the crossroads of the current neoliberal patriarchy.

In the light of the research findings, community-oriented interventions can be powerful tools to direct new ways of relating with our shared vulnerability and how to address it. This perspective is based on an ethics that is placed under the logic of the complexity of human needs and that, therefore, is against the existing interventions which come down to psychopharmacology and hospital centers. The community-oriented model promotes the recognition of the person beyond its condition of sick person. It recovers their condition as human being and as a citizen unlike the habitual conception of most traditional hospital institutions still in operation. Consequently, it is crucial to establish working networks and mobilize collective resources in the neighborhoods and health care facilities, as well as reinforcing the reorganization of the health care network itself.

REFERENCES

1. Departament de Salut. Pla Director Sociosanitari 2006. Barcelona: Generalitat de Catalunya; 2006.

2. Pla I, Donat AA, Díaz IB. Estereotipos y prejuicios de género: factores determinantes en Salud Mental. Norte de Salud Mental. 2013;11(46):20-28.

3. Baranda L. La salut, els estil de vida i les condicons de treball dels pediatres a Espanya. Barcelona: Fundació Galatea; 2014.

4. Organización Mundial de la Salud. Promoción de la Salud Mental: Conceptos, evidencia emergente, práctica. Ginebra: OMS; 2004.

5. Organización Mundial de la Salud. Plan de Acción sobre Salud Mental 2013-2020 [Internet]. 2013 [cited 19 Jan 2019]. Available from: https://tinyurl.com/er3sb27s.

6. World Health Organization. Mental health atlas 2014. Geneva: WHO; 2015.

7. Espino A. Reformas de la salud mental en España. In: Salud mental en Europa: políticas y práctica Líneas fu-

turas en salud mental. Barcelona: Ministerio de Sanidad y Consumo, Observatorio Europeo de Políticas y Sistemas Sanitarios; 2007. p. 489-532.

8. Ferlie E, Mcgivern G, FitzGerald L. A new mode of organizing in health care? Governmentality and managed networks in cancer services in England. Social Science & Medicine. 2012;74(3):340-347.

9. de Vincent G, Mercier A. Manifeste pour sortir du mal-être au travail. París: Desclée de Brouwer; 2012.

10. Nogueiras Garcia B. La teoría feminista aplicada al ámbito de la salud de las mujeres: discursos y prácticas (España, 1975-2013). [Tesis doctoral]. Madrid: Universidad Complutense de Madrid; 2018.

11. Observatori del sistema de salut de Catalunya. Desigualtats socioeconòmiques en la salut i la utilització de serveis sanitaris públics en la població de Catalunya [Internet]. Agència de Qualitat i Avaluació Sanitàries de Catalunya; 2017 [cited 5 Jan 2019]. Available from: https://tinyurl.com/kf3z3and.

12. Organisation for Economic Co-operation and Development. Health at a Glance: Europe 2018: State of Health in the EU Cycle [Internet]. OECD Publishing; 2018 [cited 10 Jan 2019]. Available from: https://tinyurl.com/mzj995rh

13. Arias-de la Torre J, Artazcoz L, Molina AJ, Fernández-Villa T, Martín V. Inequalities in mental health in the working population of Spain: a National Health Survey-based study. Gaceta Sanitaria. 2016;30(5):339-344.

14. London School of Economics and Political Science; Centre for Economic Performance, Mental Health Policy Group. The depression report: a new deal for depression and anxiety disorders. London: Centre for Economic Performance, London School of Economics and Political Science; 2006.

15. Brazil K, Kassalainen S, Ploeg J, Marshall D. Moral distress experienced by health care professionals who provide home-based palliative care. Social Science & Medicine. 2010;71(9):1687-1691. doi: 10.1016/j.socscimed.2010.07.032.

16. Sejersted TS. Mortality among Norwegian medical doctors 1960-2000. BMC Public Health. 2011;11:173. doi: 10.1186/1471-2458-11-173.

17. Flórez J. Salud pública: El síndrome de burn out en médicos y enfermeras que atienden a pacientes oncólogicos. Medicina integral: Medicina preventiva y asistencial en atención primaria de la salud. 2000;36(10):405-411.

18. Gálvez Herrer M, Moreno Jiménez B, Mingote Adán JC. El desgaste profesional del médico: Revisión y guía de buenas prácticas. Madrid; Diaz de Santos; 2011.

19. Lacy BE, Chan JL. Physician Burnout: The hidden health care crisis. Clinical Gastroenterology and Hepatology. 2018;16(3):311-317. doi: 10.1016/j.cgh.2017.06.043.

20. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being. Mayo Clinic Proceedings. 2017;92(1):129-146. doi: 10.1016/j.mayocp.2016.10.004.

21. Lanham M, Rye M, Rimsky L, Weill S. How gratitude relates to Burnout and job satisfaction in mental health professionals. Journal of Mental Health Counseling. 2012;34(4):341-354. doi: 10.17744/mehc.34.4.w35q80w11kgpqn26.

22. O'connor K, Pitman S, Muller D. Burnout in mental health professionals: a systematic review and meta-analysis of prevalence and determinants. European Psychiatry. 2018;53:74-99. doi: 10.1016/j.eurpsy.2018.06.003.

23. Vaccari P. El fin del manicomio en tiempos del Neoliberalismo. [Tesis Doctoral]. Bellaterra: Universidad Autónoma de Barcelona; 2013.

24. Gallo Acosta JE, Quiñones Useche A. Subjectivity, mental health and neoliberalism in public health politics in Colombia. Athenea Digital: Revista de Pensamiento e Investigación Social. 2016;16(2):139-168.

25. Verhaeghe M, Bracke P. Associative Stigma among Mental Health Professionals: Implications for Professional and Service User Well-Being. Journal of Health and Social Behavior. marzo de 2012;53(1):17-32. doi: 10.1177/0022146512439453.

26. Castro X. Salud mental sin sujeto: Sobre la expulsión de la subjetividad de las prácticas actuales en salud mental. CS. 2013;(11):73-114.

27. Desviat M. La reforma psiquiátrica 25 años después de la Ley General de Sanidad. Revista Española de Salud Pública. 2011;85(5):427-436.

28. Desviat M. La Reforma Psiquiátrica. Valladolid: La Revolución Delirante; 2020.

29. Comité sobre los Derechos de las Personas con Discapacidad. Observaciones Finales sobre los Informes Periódicos Segundo y Tercero Combinados de España [Internet]. 2019 [cited 10 Dec 2019]. Available from: https://tinyurl.com/2dz89hku.

30. Leamy M, Bird V, Boutillier CL, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. British Journal of Psychiatry. 2011;199(6):445-452. doi: 10.1192/bjp.bp.110.083733.

31. Lolas F. Salud mental global como bien público: sugerencias para la reflexión ética. Revista de Neuropsiquiatría. 2013;76(3):131-136.

32. Pérez B, Eiroá F. Guia de drets en salut mental: no hi ha recuperació sense drets [Internet]. Federació Veus; 2017 [cited 10 Dec 2019]. Available from: https://tinyurl.com/bv3rna2d.

33. Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, et al. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry. 2014;13(1):12-20. doi: 10.1002/wps.20084.

34. Organización de las Naciones Unidas. Convención Internacional sobre los derechos de las personas con discapacidad [Internet]. 2007 [cited 7 Dec 2020]. Available from: https://tinyurl.com/49f6p5bn.

35. Kortteisto T, Laitla M, Pitkäen A. Attitudes of mental health professionals towards service user involvement. Scandinavan Journal of Caring Science. 2018;32(2):681-689. doi: 10.1111/scs.12495.

36. Oliveira MCP, Toassi RFC, Matos IB. Profissões e ocupações de saúde e o processo de feminização: tendências e implicações. Athenea Digital: Revista de Pensamiento e Investigación Social. 2013:13(2):239-244.

37. Amorim RG, Lavrador MCC. A perspectiva da produção de cuidado pelos trabalhadores de saúde mental. Psicologia: Ciência e Profissão. 2017;37(2):273-288.

38. Bruno Silveira C, Suelen Pontes Costa L, Bessa Jorge MS. Redes de atenção à saúde como produtoras de cuidado em saúde mental: uma análise reflexiva. Revista Portuguesa de Enfermagem de Saúde Mental. 2018(1):61-70. doi: 10.19131/rpesm.0203.

39. Pires RR, Ximenes VM, Nepomuceno BB. Práticas de cuidado em saúde mental no Brasil: análise a partir do conceito de cidadania. Avances en Psicología Latinoamericana. 2013; 31(3):507-521

40. Velasco S. Sexos, género y salud: Teoría y métodos para la práctica clínica y programas de salud. Minerva: Minerva Ediciones; 2009.

41. Pujal M. Apuntes para una salud mental inclusiva: duelo a la identidad de género y reconocimiento de la heterogeneidad de la experiencia. In: Climent Clemente MT, Carmona Osorio M, coord. Hacia una transpsiquiatría: abordaje queer de la salud mental y las relaciones de poder. Madrid: AEN Digital; 2018. p. 159-207.

42. Pujal M, Amigot P, Calatayud M. Subjetividad, desigualdad social y malestares de género. Una relectura del DSM5. Revista Internacional de Sociología. 2020;78(2):e155. doi: 10.3989/ris.2020.78.2.18.113.

43. Mora E, Pujal i Llombart M. El cuidado: más allá del trabajo doméstico. Revista Mexicana de Sociología. 2018;80(2):445-469.

44. Calderon C. Criterios de calidad en la investigación cualitativa en salud (ICS): apuntes para un debate necesario. Revista Española de Salud Pública. 2002;76(5):473-482.

45. Pujal M, Mora E. Contextualizar la vulnerabilidad: el diagnóstico psicosocial de género: El caso de la Fibromialgia. In: Montesó-Curto P, Rosselló Aubach L, coord. Compartir experiencias, combatir el dolor Una visión de la Fm desde el ámbito "bio-psico-social". Tarragona: Editorial de la Universitat Rovira i Virgili; 2017.

46. United Nations General Assambly, Human Rights Council. Right of everyone to the enjoyment of the highest attainable standard of physical and mental health [Internet]. 2019, Report No. 41 session [cited 15 May 2020]. Available from: https://tinyurl.com/yzu4wb9s.

47. Gilligan C. La ética del cuidado. Cuadernos de la Fundació Víctor Grífols i Lucas. 2000;30.

48. Izquierdo MJ. El cuidado de los individuos y de los grupos: ¿quién cuida a quién?: Organización social y género. Intercambios, Papeles de Psicoanàlisis / Intercanvis, Papers de Psicoanàlisi. 2003;(10):70-82.

49. Bellon E. Liderazgos femeninos: tránsitos hacia la ética del cuidado en las relaciones de género. Debate Feminista. 2017;54:84-100. doi: 10.1016/j.df.2017.03.002.

50. Burgos-Saelzer CB. Nursing care from the perspective of ethics of care and of gender. Investigación en Educación y Enfermería. 2013;31(2):243-251.

51. Castillo Cedeño I, Castillo Cedeño R, Flores Davis LE, Miranda Cervantes G. La ética del cuidado en la pedagogía saludable. Educación: Revista de la Universidad de Costa Rica. 2015;39(1):1-11.

52. García Moyano L. La ética del cuidado y su aplicación en la profesión enfermera. Acta Bioethica. 2015;21(2):311-317. doi: 10.4067/S1726-569X2015000200017.

53. Izquierdo. Del sexismo y la mercantilización del cuidado a su socialización: Hacia una política democrática del cuidado [Internet]. 2003 [cited 10 Dec 2019]. Available from: https://tinyurl.com/373rjuy8.

54. Cabanas E. La felicidad como imperativo moral: Origen y difusión del individualismo "positivo" en el capitalismo neoliberal y sus efectos en la construcción de la subjetividad. Madrid: Universidad Autónoma de Madrid; 2013.

55. Kohen B. Ciudadanía y ética del cuidado. In: Carrió E, Maffia D. Búsquedas de sentido para una nueva política. Buenos Aires: Paidós; 2005.

56. Orozco AP. Amenaza tormenta: La crisis de los cuidados y le reorganización del sistema económico. Revista de Economía Crítica. 2006;(5):7-37.

57. Rendueles C. César Rendueles: Este capitalismo es incompatible con la vida humana» [Internet]. Filosofía&co.; 2018 [cited 20 Dec 2019]. Available from: https://tinyurl.com/yx4a8xwe.

58. Stake R. Investigación con estudio de casos. Madrid: Ediciones Morata; 1999.

59. Vázquez L. La abducción como alternativa del método científico en la educación superior. Uni-Pluriversidad. 2009;8(2):1-12.

60. Elejabarrieta F. El método linguístico: técnicas de obtención de información. Barcelona: Universitat Autònoma de Barcelona; 1997.

61. Rolando PS, Víquez-Calderón D. Los grupos de discusión como metodología adecuada para estudiar las cogniciones sociales. Actualidades en Psicología. 2010;23 (110):87-101.

62. Sanz J. La metodologia qualitativa en l'avaluació de polítiques públiques [Internet]. Institut Català de Polítiques Públiques; 2011 [cited 10 Dec 2019]. Available from: https://tinyurl.com/2ppwdkak.

63. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3(2):77-101.

64. Abela JA. Las técnicas de análisis de contenido: Una revisión actualizada [Internet]. Fundación Centro de Estudios Andaluces; 2002 [cited 10 Dec 2019]. Available from: https://tinyurl.com/cb523paw.

65. Cáceres P. Análisis cualitativo del contenido: una alternativa alcanzable. Psicoperspectivas: Individuo y Sociedad. 2003;2(1):53-82. doi: 10.5027/psicoperspectivas-vol2-issue1-fulltext-3.

66. Tremoleda J. Suicidio y violencia de género: relación invisibilizada en los servicios de atención en salud mental. Mosaico: Revista de la Federación Española de Asociaciones de Terapia Familiar. 2019;(74):8-26.

67. Tronto JC. Moral boundaries: A political argument for an ethic of care. New York: Routledge; 1984.

68. Grandón Fernández P, Bustos Navarrete C, Tapia Cárdenas C, Cova Solar F. Evaluación de la restrictividad de dispositivos residenciales para personas con un diagnóstico psiquiátrico en el modelo de Salud Mental Comunitaria en Chile. Universitas Psychologica. 2015;14(4):1359-1370. doi: 10.11144/Javeriana.upsy14-4.epbs.

69. Rendueles C. Emancipación, cuidado y codependencia. Isegoría. 2014;(50):167-187. doi: 10.3989/isegoria.2014.050.09.

70. Vidal-Molina P, Vargas-Muñoz R. Ciudadanía en tiempos del Capital: Una crítica desde la tradición marxiana. Convergencia. 2019;26(80):07. doi: 10.29101/crcs.v26i80.10418.

71. Huertas R. De la reforma psiquiátrica a la salud mental colectiva: A propósito de la obra de Manuel Desviat. Revista de la Asociación Española de Neuropsiquiatría. 2020;40(138):163-170. doi: 10.4321/s0211-573520200020009.

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ERRATA

An earlier version of this article was published with errors in the numbering of references. As this first version had begun to circulate, we were forced to unpublish the article, incorporate the corrections, and republish the article as a second version.