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ORIGINAL ARTICLE

Mental health: where do gender issues arise? Cisgender women roles

Saúde mental: onde se colocam as questões de gênero? Os papéis das mulheres cisgêneras

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ABSTRACT The article discusses how workers in the psychosocial care network and activists in the anti-asylum struggle understand issues related to gender hierarchies and their possible implications for comprehensive mental health care aimed at cisgender women. Considering that the asylum served to isolate and control female bodies, and the transformations proposed by the psychiatric reform, which allowed free care based on respect for human rights and the promotion of citizenship, we sought to analyse how stereotypes about the role of women in society permeate care practices in the approach to motherhood and situations of violence experienced by women in the psychosocial care network. In despite of the recognition of gender hierarchies and the need to transform practices in the mental health services, from the interviews emerge a hegemonic discourse about women stereotypes.

KEYWORDS Gender. Mental health. Women. Unified Health System.

RESUMO *O artigo discute como os trabalhadores da Rede de Atenção Psicossocial (Raps) e militantes da luta antimanicomial compreendem as questões relativas às hierarquizações de gênero e suas possíveis implicações no cuidado integral em saúde mental direcionado a mulheres cisgêneras. Considerando que o manicômio serviu para o isolamento e o controle de corpos femininos e as transformações propostas pela reforma psiquiátrica permitiram o cuidado em liberdade com base no respeito aos direitos humanos e na promoção da cidadania, buscou-se analisar como os estereótipos acerca do papel da mulher na sociedade atravessam as práticas de cuidado na abordagem da maternidade e das situações de violências experimentadas pelas mulheres na Raps. Embora se observe o reconhecimento das hierarquizações de gênero e da necessidade de transformação das práticas nos serviços de saúde mental, emergiu, das entrevistas, um discurso hegemônico vinculado aos estereótipos relativos às mulheres.*

PALAVRAS-CHAVE *Gênero. Saúde mental. Mulheres. Sistema Único de Saúde.*

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Introduction

The history of women in mental health was and is marked by social, political and cultural issues, which produced and continue to produce different views on what it means to be a woman, what is feminine and what social roles such bodies should play[1,2].

For decades, asylums operated as instruments of gender oppression, placing women in situations of violence, isolation and invisibility. Silenced and described from the male perspective of prejudice, they were hospitalized for any sign classified as 'deviation'[1-3].

The Anti-Asylum Movement invested in breaking the violent logic of hospitalizations, bringing together workers, users and family members[3-5]. With the implementation of psychiatric reform and the creation of the Psychosocial Care Network (RAPS), the Unified Health System (SUS) committed to territorialized care and the development of unique therapeutic projects, prioritizing autonomy, individuality and integrality[3-5].

In RAPS, women are included as users, family members and workers, being a majority presence. For family members and network workers, the role of care is naturalized as something of the 'feminine' order, with important repercussions on their quality of life[2]. On women, pressure persists to exercise the socially determined role of what it means 'to be a woman' and, at the same time, it causes the invisibilization, devaluation and silencing of their 'care functions', generating effects of suffering[2]. This process mainly affects black women, marked by structural racism and the updating of colonialist rationality[6,7].

In mental health services, it is common for women to be present with their children in psychological distress without the presence of a father, women who have returned from decades of psychiatric hospitalization, women living on the streets, women victims of different types of violence and/or in other conditions of social vulnerability[7].

In Brazilian society, gender issues continue to be fraught with prejudice and violence, perpetuating mechanisms of oppression and/or exclusion of bodies outside hegemonic standards[2,8]. Research on feminist movements and the anti-asylum struggle highlights the importance of investing in reflections between gender and mental health, analyzing their implications in care processes[2,8]. Similarly, they emphasize the need to consider social context, life trajectory and comprehensiveness when building strategies, taking into account gender relations and their implications for the mental health of men and women[8].

In line with such concerns, an extract from the research 'Mental health, where do gender issues arise? Cisgender Woman in Mental Health' is presented, which aims to understand how RAPS workers and members of the anti-asylum struggle see gender hierarchies and their implications for comprehensive mental health care for cisgender women in their cultural, age, racial and sexual orientation diversity.

Women and mental health

The social production of gender discrimination uses biological characteristics and differences, naturalizes them and, simultaneously, attributes characteristics to the bodies of men and women, delimiting their social spaces of action, affections, weaknesses and strengths. This process naturalizes inequalities, maintains privileges and determines silencing[1,6].

'Modern science' produced the image of man who dominates nature, to which the feminine was symbolically associated. Thus, analogies were created between intellect, reason and 'masculine', which guaranteed men the place of scientificity[8]. Such scientificity, when operated by medicine, linked the 'feminine' to a nervous nature and the woman's body to the imperfect version of the man's body, taken as a normative standard. Scientific discourse constituted, under alleged neutrality, a fundamental force for gender hierarchization[8].

Using anatomy, physiology and biochemistry as support, it defined permitted and prohibited roles and spaces for men and women, as well as justified the enslavement of bodies that differed from those of white European men[8].

Based on medical studies on female bodies, in which the uterus was given centrality as responsible for mood changes, sexual behavior and women's illnesses, the idea of fragility and 'distemper' was reinforced. In this way, the menstrual period and the postpartum period would be moments that facilitate women's illness, in which morally 'inappropriate' female attitudes could cause uterine pathologies. A fragile woman was responsible for the domestic sphere, fulfilling her role as mother and wife, whose sexuality was linked only to procreation[8].

In Brazil, psychiatry participated intensively in the social control policy. 'Madness' transformed into illness and having the asylum as a suitable place contributed to silencing and dominating female bodies and subjectivities[9]. Medicine transformed behaviors classified as deviant and dangerous to the social order into pathologies, and, *pari passu*, psychiatry established an ideal of women and 'feminine madness'[9].

Research carried out in records from the first Brazilian psychiatric hospitals outlined the profile of women hospitalized there[10-12]. Although they were a minority among those hospitalized, they had the longest length of stay and ended up dying institutionalized. Most of them were described as brown, black and poor, who arrived at the asylums involuntarily and were taken by the police[10-12].

In the medical records, one sees the moral judgment about women's sexuality, bodies and behaviors, always compared to what would be an adequate feminine standard[10,11]. In this sense, they were the majority among those who underwent lobotomy, which was justified because they 'suspended their dress', 'spoke obscene words', 'did not accept giving themselves to their husband', 'very forward with boys', 'difficult to deal with'[11,12].

Although the trajectory of women was marked by machismo and misogyny, resulting in psychological suffering and/or being considered crazy when they broke with social norms[1,6], it is worth highlighting that the ideal of a woman – fragile, maternal and tied to private space – was not universal insofar as gender hierarchies were linked to those related to skin color and social class[1,2]. Thus, black women and those from lower classes occupied the streets, worked hard and experienced violence that was different from that which affected white women from other social strata[1,6].

In women's history, there was also struggle and resistance, which intensified from the 1950s onwards[1,2], a period in which social movements eager for political and social changes emerged and strengthened. The sexual revolution, feminism and the black movement marked this process, presenting important proposals regarding public policies and academic productions that meant the expansion of research articulating psychiatry and women's rights[1,2].

Also seeking social transformations, the Brazilian psychiatric reform invested in shifting the understanding of meanings and practices regarding psychological suffering with a focus on respect for human rights, embracing singularities and territorialized care[2,5]. This process consolidated RAPS in the SUS, which represents a huge advance[2,13]. However, it must be remembered that the anti-asylum struggle is a movement that is always inconclusive[2,13]. Understanding that the asylum logic can occur in any space, affecting the bodies and subjectivities of women users, caregivers and RAPS workers, this research is undertaken.

Material and methods

The research adopted a qualitative approach, working on the epistemological, theoretical, morphological and technical poles in their dialectical articulation[14]. In this direction, it was linked to hermeneutics-dialectics,

seeking to understand, establish relationships and build conclusions while considering the conditions in which texts are produced. It is about understanding that subjects transform reality, which acts on themselves, marking their production of thought. Testimonials, speeches and texts need to be interpreted as social processes with specific meaning, resulting from multiple determinations[14].

When considering this objective, the RAPS worker who was linked to the anti-asylum struggle movements was chosen as the research subject. It was assumed that workers involved in the anti-asylum struggle would be more sensitive to issues linked to gender hierarchies and the diversity of sexual orientation of cisgender women, as the movement's ethical commitment is to guarantee human rights and citizenship[2-5].

Carried out under the effects of the pandemic, the research took place using digital platforms. Thus, an invitation flier was created for the research, which was published on the social networks of anti-asylum movements with a link that led to a form created in the Google Forms application, which was available for 15 days.

The consolidated spreadsheet with information from the forms was analyzed, excluding respondents who: did not complete the form; were linked to private health and/or education institutions; worked exclusively with teaching and research; were RAPS users or family members of RAPS users. This resulted in a total of nine research subjects available to carry out the semi-structured interview[14], who were from the states of Rio de Janeiro, Pernambuco and Mato Grosso do Sul.

The individual interviews took place via the Zoom platform, on a day and time convenient to the research subject, and lasted an average of one hour. Before the start of the interview, the text of the Free and Informed Consent Form was reviewed for the participant's agreement to continue the process and for the recording to begin. To guarantee confidentiality and anonymity, participants were identified by the letter E (from the portuguese word for interviewee – Entrevistado) and numbers from one to nine were added. The research was approved by the Research Ethics Committee of the Sergio Arouca National School of Public Health, through Plataforma Brasil, under Certificate of Presentation of Ethical Appreciation – CAAE nº 56479222.1.0000.5240 and opinion nº 5.371.655.

Table 1. Profile of research subjects

Interviewee	Gender	Profession	Education	Time working at RAPS
E1	Feminine	Social Worker	Postgraduate	13 years
E2	Feminine	Nutritionist	Postgraduate	11 years
E3	Feminine	Social Worker	Postgraduate	15 years
E4	Feminine	Psychologist	Postgraduate	2 years
E5	Feminine	Social Worker	Higher education	20 years
E6	Feminine	Social Worker	Higher education	16 years
E7	Masculine	Psychologist	Postgraduate	6 years
E8	Feminine	Psychologist	Postgraduate	2 years
E9	Masculine	Psychiatrist	Postgraduate	6 years

Source: Own elaboration.

The interview script included the following aspects: the work developed at RAPS; the importance of the anti-asylum movement; the perception of the relationship between mental health and women, the way men and women experience psychological suffering and the effects of psychological suffering on women's lives; how women arrive at RAPS and whether there is a specific approach for them; the way in which women with psychological distress are seen by society; the existence or not of situations experienced by women in society that affect their mental health and if those appear in RAPS services; and the presence of women as RAPS workers and in the service in which they carry out their activities.

The content of the interviews was transcribed and systematized, deriving from their analysis the elements that, according to the participants, marked the relationship between cisgender women and mental health. They are: psychiatric reform, the sexual division of labor, the exercise of motherhood, gender violence and self-inflicted violence. Such elements were reorganized in the in-depth analysis of each interview in dialogue with the theoretical categories arising from the bibliographic review. In this article, we will work with two analytical axes: motherhood and violence.

Results and discussion

Who has the right to be a mother? Women with psychological distress and the exercise of motherhood

Psychiatry contributed to the production of motherhood as an experience to which women's bodies were predestined in view of their reproductive function, making the denial of this a behavioral deviation. However, this perspective brings with it a tension that persists: how to deal with the desire for motherhood among so-called crazy women?

If motherhood remains understood as what 'naturally' characterizes a woman, at the same time thought, it remains neither 'advisable' nor 'allowed' for poor women who use alcohol and other drugs and those with psychological distress.

According to those interviewed, women who arrive at the Psychosocial Care Centers for Alcohol and other Drugs (CAPS AD) are often referred by the Guardianship Council or the judiciary in processes involving the custody and care of their children. It is common for women who use alcohol and other drugs to be evaluated by the child and adolescent protection services on suspicion of neglect in caring for their children and, in many of these cases, they have the family power removed.

> *We see people suffering situations, loss of family power by the woman because she uses a substance in a way that is not even a problematic use [...] as if she had to be the perfect person in the family. The prejudice of protection services, for example. We notice several women who have lost their children, the child is in a shelter and sometimes they take care of the child, they show affection, but they lose the child because they are drug users.* (E3).

Sometimes, institutional care measures for the baby take place shortly after birth, as there are few protection and economic support services aimed at maintaining the mother-baby binomial together. Thus, these women do not find protection for motherhood.

> *A user here who was homeless and pregnant, several meetings were held asking for her to be welcomed and we were unable to do so, because she was pregnant, in a vulnerable situation and using drugs, we were unable to welcome her. And then she went to have the baby and the hospital forwarded the request to the Guardianship Council and requested a place in foster care for her and the child. And there was no such place. The child will go to the shelter and she will not have the right to take care of her daughter.* (E3).

All women who give birth in that maternity hospital and who have any history, whether recent or 20 years ago, of drug use, the courts need to be notified and that is an immense sadness [...] because we have a situation of women who give birth and do not take the child home. (E2).

Institutional care services are only aimed at children after 'removal'. Professionals find it difficult to carry out actions that contribute to the promotion of the family in the absence of public policies to protect and support motherhood that consider the material difficulties, stigmas and all the fragility experienced by these families.

What is this mother's role? There is the Child and Adolescent Statute related to this. But how much this affects women in a different way compared to what happens to men. Also at CAPS AD where I work, we try to do work that includes trying to minimally deconstruct and say that these women... try to have some dialogue with the courts to say that these women, even though they are users, they can be mothers if they want. (E2).

Such women are judged based on ideal models of mother, family and housing based on the perspective of the nuclear patriarchal family produced in the articulation of the models of the European bourgeoisie and hygienist movement. The social construction of Brazilian families and how family dynamics are an effect of social and economic reality are ignored, as well as the possibility of bonding and exercising care, dehumanizing and protecting such bodies.

However, it is clear that women are looking for ways to resist the loss of custody of their children and support their desire for motherhood, even if this represents a greater risk to their health and safety.

In two cases, what did they do? These mothers lost their children, two, three children, and then in the next pregnancy they left the city, to have a child somewhere else to be able to keep the child that was born later. There was a patient who, in order not to lose her son, handed her son over to a family member who was involved in drug trafficking, and then no one went in there to get it, not even the counselor was able to get in there to get it. The way she had access to this child and protection was within trafficking. (E3).

Territorialized care implies understanding the singularities of women, their possibilities of existence and that of their families in the face of the absence of fundamental rights in spaces marked by social inequality and violence. Without public policies guaranteeing the right to motherhood, the 'parallel power' mediates and 'intercedes' for these women and their motherhood.

In another direction, the right to motherhood is negotiated in relation to adherence to what is offered by RAPS. If treatment makes it possible to regain custody of the child and invest in a less vulnerable life project, then women approach health teams – which creates impasses and frustrations, and "*when they are unable to recover their children, they abandon this care*" (E3).

Despite the militancy in the anti-asylum struggle, the link between madness and the idea of incapacity persists, which, in the case of women, extends to the exercise of motherhood. Referring to the pregnancy of women with psychological distress considered 'severe', interviewees speak of concerns regarding medications and damage to mother-baby health, financial sustainability and emotional overload.

One of the interviewees says that when a patient talks about pregnancy, in general, "*she is already pregnant*" (E9), and that if she had known beforehand that the patient wanted to get pregnant, she would have invested in changing her mind.

If a patient says she wants to get pregnant, we will have to think about how she will be able to... Sometimes there are patients who are curated. How are you going to take care of her and the

child? But sometimes it never really happened. I tell you knowing that it is a difficult issue. [...] I think I would try to talk to her so we can think about other projects or think very carefully, because that's how it is, it won't be easy. (E9).

A pregnancy could and should be part of the life project of women attended at RAPS. However, no information was mentioned in the interviews about the carrying out of work related to family planning in the services, nor was there any reference to referral and/or intersectoral action to address pregnancy and motherhood of people undergoing mental health monitoring.

Certainly, motherhood represents challenges for women with psychological distress given the stigma of the 'disease', the difficulties in relation to their autonomy and the use of psychotropic drugs. However, many of them lose custody of their children because they are considered, a priori, incapable of care. It is essential to question this idea of 'incapacity' and the right to motherhood of women undergoing mental health care.

The construction of the feminine from violence

Violence was described by interviewees as a very present phenomenon in the lives of women treated at RAPS. According to them, almost all of them reported episodes of violence suffered at some point in their lives, especially sexual violence in childhood and/or youth and psychological violence. Workers realize that stories of violence appear more frequently in women's speeches when compared to men's speeches.

The suffering of these women was greatly affected by gender violence. So the use of substances was something insignificant compared to the suffering they experienced, which was most of the time also triggered by violence, structural violence, physical violence, psychological violence, especially all of them in the group experienced psychological violence. So it's a very different suffering, it's a suffering that has a causality in the way we organize ourselves, build ourselves and live as women in the world and in Brazil. (E4).

Some of the suffering that we see at Caps is very much influenced by this issue of sexual violence. We see this a lot from women who are in this moment of crisis, they arrive with depression, they arrive at a critical point in their lives. That catches your eye. And we will discuss the cases at the clinical meeting and there is always, there is always a history of abuse in some way, how this woman was raped. And then it depends on whether it was in childhood, whether it was in youth or whether it was recently. Usually in youth. And the cases are much higher than the cases in which men suffer violence. This thing about violence seems like something that constitutes women and obviously constitutes their suffering. (E1).

In the interviews, female subjectivity emerges as constituted by suffering and violence, stating that all women are subject to suffering violence in the spaces they occupy inside or outside the home, as well as establishing the idea that violence is a possible cause of psychological suffering. However, it is noteworthy that the observation of violence and suffering as basic elements in the construction of being a woman in Brazilian society is not accompanied by critical reflections or attitudes to transform the situation, being, in most reports, absolutely naturalized.

It is also noteworthy that, despite the recognition of the presence of violence in women's lives, when situations of violence appear in the reports of those responsible for monitoring at RAPS, they are sometimes disregarded. The reports are classified as delusional so that the idea of violence as a cause of suffering is relativized or denied when it comes to RAPS users. Often, such users are discredited, and their narratives are attributed to personality and diagnosis.

I often see professionals minimizing the suffering of these women based on the argument and crystallization of the diagnosis, they are hysterical, they are borderline, they are histrionic, so they are somatizing, they are theatricalizing, this has an important effect when reading the suffering, thus in the way the care is offered. (E7).

This for me is one of the most difficult things to deal with, because many times the woman comes and says that she was beaten by her husband or father. And then you see that person who is totally welcoming and sometimes the whole family says that she is crazy. Then what? [...] And I tell you that its difficult the situations in which we do like this. Sometimes we don't because the family suffering is too much already, there is no notification necessarily. Sometimes is hard. I start thinking, did he really hit her? Didn't he really? and sometimes there is the mother, father, children saying that she isn't ok. And then it's difficult, it's difficult even to know what to do in those situations. To know in what to believe. (E5).

Faced with doubts about the veracity of the information presented by the woman, notifications, complaints or referrals to support services for victims of violence are generally not made. This has implications for the care offered to these women, ensuring their safety and underreporting situations of violence against women.

When the topic is self-inflicted violence, those interviewed observed an increase in the number of suicide attempts. Considering the people who arrive at psychiatric emergency services as a result of attempted suicide situations, participants said that the majority are women and, normally, young people. Among the situations that lead young women to attempt suicide are intergenerational tensions; prejudice, sexual repression and conflicts with family members who 'do not accept' their sexual orientation and the social pressure for them to correspond to the feminine ideal established by the patriarchal perspective.

According to the Ministry of Health[15], the majority of victims of death by suicide in Brazil are men, but women represent the largest group with suicide ideations and attempts. In 2019, 124,709 cases of self-inflicted injuries were recorded in the country, an increase of 39.8% compared to 2018. In 71.3% of the records made, the victims were women, in most cases (46.3%), in the age group from 20 to 39 years old, followed by those from 15 to 19 years old (23.3%). Such differences can be explained by the fact that men use more lethal methods and are more resistant to seeking care at RAPS.

For a man to arrive and say that he needs this support, he has already been on this journey for a long time, suffering or looking for other ways to respond to his need. (E5).

Another central aspect in the production of intense suffering is linked, according to those interviewed, to the impacts of social inequality. Women are extremely socially vulnerable to unemployment, loneliness, homelessness and hunger. One of the interviews mentions that many professionals believe that medication will remove all suffering from women's lives, but argues that "*mental health is not only done within the service*" (E4), highlighting that, during home visits, they perceive the precarious conditions in which many RAPS users live.

The case I was monitoring, which was a user with three children, one of whom was already up for adoption at the shelter and the children ended up on the street with her. And she said that she didn't have anything left to feed her children, that she went to ask for money and managed to buy beans, she cooked the beans and put rat poison in them and was going to give it to them. She had already planned to give the beans with poison for her children to eat and she was going to eat, she said it was unbearable to see her children starving. (E2).

Although territorialized care is recommended, that is, linked to the physical and social space in which life is built in all its

complexity, it is clear that an exclusively sectoral approach to health needs persists and, often, only a pharmacologic approach to psychological suffering.

Research shows that women consume the most legal substances, such as antidepressant and anxiolytic drugs[16]. One of the interviewees says that, in the service where she works, it is common for women who use these medications to arrive:

> *This mental health group in my unit aims to work on this, to create an opportunity for weaning. Many women take medication for anxiety and are dependent on these medications. When we propose a change the reaction is very negative, because there is an attachment, the medicine will cure, 'the medicine heals, saves and frees' and we seek to work on well-being and self-esteem in a different way.* (E6).

Based on the idea that women suffer greater social pressure, those interviewed believe that those with psychological distress, in addition to the stigma of madness, suffer prejudice simply because they are women. In other words, in their experience, misogyny and oppression due to 'unreason' are associated.

However, when asked about how workers deal with issues related to gender inequality in services, they said that there are times when certain gender stereotypes are reproduced. One of the interviewees stated that "*this thing about the stereotype that we have about women's hysteria is always an added tone*" (E5). Women are considered more 'viscous, loud and critical'. Another interviewee says that she has heard from RAPS health professionals that users are to blame for experiencing situations of sexual violence and harassment.

> *When a woman says that she has felt violated or harassed, there is always a 'but she also laughed a little', 'but she also keeps offering herself'. But I think it has improved a lot because the women who work at the CAPS where I work make a point of constantly pointing this out. I think that in a way we feel a little affected when this happens.* (E2).

Interviewees say that there are workers who 'respect' and 'understand' the suffering of women as part of the 'mental illness', the 'disorder'. However, due to the moral judgment of part of the teams, the psychological suffering of women is also associated with 'whining', with 'excessive sensitivity'. According to those interviewed, it is common for women with anxiety and depression, even those who have attempted suicide, to be 'classified' as 'sensitive', and their reports are understood as 'whining'.

> *There are those who respect, who are careful and who are attentive. And they understand that this is a crisis movement, that it is a time of illness that needs to be taken care of. Some may think it's whining. And this often happens, not with psychotic patients, it happens mainly with female patients who attempt suicide. Which is a very significant number, much more significant, I have observed this in the emergence of women who attempt suicide, young women, really very young.* (E5).

Some workers state that, when they witness moral judgments or prejudiced comments from other team professionals about women, they make a point of intervening and taking a stand, using their place of speech in an attempt to encourage debate about the use and trivialization of certain terms and attitudes in handling cases.

Part of the interviewees consider that it is important to shed light and debate issues related to gender inequality and its effects on women's mental health. However, it is possible to perceive that a moral and religious judgment persists that permeates the production of mental health care to the extent that it is present in professional listening and in the perception of women's suffering. Furthermore, the sexist and prejudiced view of women disregards important aspects of their reality, reproducing patriarchal and asylum logics, which contribute to the psychological suffering and silencing of women.

Final considerations

This work sought to reflect on gender relations and mental health from the perspective of cisgender women as RAPS users and workers and the meanings attributed to them by public mental health service professionals and members of anti-asylum movements.

The relationship between cisgender women and mental health was represented by the interviewees through the exercise of motherhood, which is seen with suspicion when it comes to RAPS users, and violence, which works as triggers of psychological suffering in women and, at the same time, can be made invisible when stated by users.

If motherhood and care summarize what 'naturally' characterizes the experience of being a woman, then a place of exception is created for women in psychological distress since they are given the label of being incapable of both. The desire for motherhood tends not to be welcomed by teams and is even discouraged. In most cases, mental health and justice are responsible for removing their offspring in order to protect children from their unreason and/or the use of alcohol and other drugs.

The same process of delegitimization occurs when it comes to violence that is minimized, questioned and/or made invisible when it emerges from 'diagnosed' bodies, despite being recognized as producing psychological suffering and its worsening. Such mechanisms expose cisgender women who use RAPS to increasing situations of vulnerability, taking away their protection rights guaranteed by legislation. At the same time, the underreporting of cases of violence in this population makes invisible the need for more effective public policies to protect and guarantee rights.

In this sense, it was noticed that the proposal of intersectoral strategies to protect women in psychological distress who experience situations of violence and/or motherhood are few and, in most cases, insufficient as they operate based on the ideas of 'incapacity, mentally ill, delirium, whining'.

Respect for autonomy, singularity and integrality of care cannot be limited to personal values and ethical commitments of professionals as they are guidelines for public health policies. Even considering the majority presence of women among RAPS workers, the persistence of elements linked to machismo, patriarchy and the tutelary logic of those who in psychological suffering emerged in the statements of the research subjects. From this perspective, the workers interviewed stated that movements to tighten gender hierarchies reproduced in services are timid and that, hegemonically, the naturalization of discourses and practices marked by machismo and sexism persists, including in the organization and management of work processes.

It seems essential, therefore, to point out that there is a need for continuing education strategies for more qualified actions in mental health care and for the organization of RAPS services that include the discussion of gender hierarchies and their effects.

It is understood that the discussion on gender, women and mental health is vast and that it is not limited to the considerations and contributions made in this work. The focus is on the possibility of mobilizing workers, users and family members to guarantee comprehensive mental health care that is more attentive to the social construction of gender hierarchies, in order to engage them in processes of transformation of society and of existing stigmatizing practices.

Collaborators

Rangel SPA (0000-0002-1161-7052)* contributed to conception, planning, analysis and interpretation of data, preparation of the draft and critical review of the manuscript. Castro AM (0000-0003-1190-5828)* contributed to the conception, drafting and final review of the manuscript. ■

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