

The conceptualizations of adolescence constructed by professionals within the Family Health Strategy (FHS)*

As concepções de adolescência construídas por profissionais da Estratégia de Saúde da Família (ESF)

Los conceptos de la adolescencia construidos por profesionales de la Estrategia de Salud de la Familia (ESF)

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ABSTRACT

This paper examines the meanings constructed around adolescence, with their implications for the practices of physicians and nurses working within the Family Health Strategy (FHS) in a municipality in the interior of the State of São Paulo. The analysis was based on interviews and showed that immobility regarding collective actions was reinforced by predominance of a natural, universal and pathological view that positioned adolescence at a place not within the work routine of family health teams. For this reason, there is a need to rethink the conceptualizations, starting from the position that these professionals occupy in the labor market.

Keywords: Adolescence. Family Health. Sociohistorical psychology. Human resources formation.

RESUMO

Este trabalho examina os sentidos construídos sobre adolescência, com suas implicações na prática de médicos e enfermeiros, integrantes da Estratégia de Saúde da Família (ESF) de um município do interior paulista. A análise, com base em entrevistas, constata que o imobilismo para ações conjuntas é reforçado pelo predomínio da visão natural, universal e patológica, que coloca a adolescência no não lugar do cotidiano das equipes de saúde da família. Por isso, a necessidade de se repensar concepções a partir do lugar que tais profissionais ocupam no mundo do trabalho.

Palavras-chave: Adolescência. Saúde da Família. Psicologia sócio-histórica. Formação profissional de recursos humanos.

RESUMEN

Este trabajo examina los sentidos construidos sobre adolescencia con sus implicaciones en la práctica de médicos y enfermeros integrantes de la Estrategia de Salud de la Familia (ESF) de un municipio del estado brasileño de São Paulo. El análisis, con base en entrevistas, constata que el inmovilismo para acciones conjuntas se refuerza por el predominio de la visión natural, universal y patológica que coloca a la adolescencia fuera del lugar del cotidiano de los equipos de salud de la familia. Por ello surge la necesidad de pensar nuevamente las concepciones a partir del lugar que tales profesionales ocupan en el mundo del trabajo.

Palabras clave: Adolescencia. Salud de la Familia. Psicología sócio-histórica. Formación de recursos humanos.

INTRODUCTION

In Brazil, there are laws that guarantee adolescents the prerogative of being treated as subjects with rights, with corresponding public policies that enable adolescents' full development and, within the field of healthcare, give them the right to equality and universality of attendance of their needs.

With the legal guarantees and, most recently, with the approval of the National Policy for Adolescents' and Young Adults' Healthcare (Brazil, 2007), responsibility for comprehensive healthcare actions directed towards this population has been placed on primary care and, more specifically, on the Family Health Strategy (FHS). In this respect, we consider that it is important to deepen the field of knowledge relating to subjects who act routinely within the FHS and the way in which they understand adolescence and show this in the context of healthcare. Such actions, particularly within the fields of healthcare and education, are not perceived to have been effective, according to data produced by several bodies and institutes (IBGE, IPEA, Juvenile Development Report 2007, Map of Violence 2006 and others).

Taking the presupposition that any conception or meaning does not come separately from a historical context, but is produced in relation to people, and mediated by the objective living conditions of these subjects, along with their histories and symbolization, from the perspective point out by Vigotski (1983), Bock and Aguiar (2003) and Aguiar and Ozella (2006), we sought to gather the meanings constructed by such professionals without fragmenting their thinking and their process of developing awareness. For this, we sought to socially and historically contextualize these processes, firstly in a macro form and then with linkage to these subjects' experiences and existence.

From the point of view of knowledge produced about adolescents and young adults, hegemony of conceptions can be shown. In a theory review study on the conceptions of adolescents and adolescence¹ in public health discourse, Peres and Rosenberg (1998) showed how the biomedical model predominates. This has important implications for practice, such as universalization and naturalization of adolescence, with regard to concrete subjects, following an adolescent pattern characterized by a condition of vulnerability, and defined by epidemiology. This means that in this model or paradigm, the experiences and significances of the processes of subject construction in general are ignored. In the specific case of adolescents, the questions involving given groups of individuals are dealt with homogeneously.

From this viewpoint, the biomedical paradigm accentuates the sense of adolescence from a developmental perspective, taking it to be a transitional stage between childhood and adulthood, and taking this change to be natural and universal, independent of the concrete conditions of the subject's existence. This perspective, and the notion of crisis marked by torments and disturbances

¹ An important discussion on the use of the words adolescent and adolescence as synonyms can be found in the study by Peres and Rosenberg (1998). This is of great importance in comprehending healthcare practices, but no distinction will be made in the use of these terms at this moment.

(which has been defined by some authors as “Normal Adolescence Syndrome”, is shown in constructs produced within the field of healthcare (Marcelli and Braconnier, 2007; Heidemann, 2006; Taquet et al., 2005; Ávila, 1999; Cano et al., 1998; Oliveira and Egry, 1998; Silva and Pinotti, 1987). Thus, this comprehension backs a viewpoint of adolescence from a perspective of what is normal or abnormal over a certain chronological period of life and biopsychological development.

Thus, professionals’ training and practice are guided by parameters of time and expected behavior, and thus, processes of change are diagnosed as “illness” during adolescence. We have taken such stances to be naturalizing, universal and pathological, since they conceive adolescence to be a developmental phase, during which the crises or conflicts inherent to this age are inevitably experienced.

Different stances can be found, albeit still at an incipient stage, pointing towards breaking away from the hegemonic model, in studies by Ferrari, Thomson and Melchior, 2006; Ventura, 2006; Leão, 2005; Assis et al., 2003; Bastos, 2003; Catharino, 2002; Mendonça, 2002; Ayres and França, 2000; Calazans, 2000; Formigli, Costa and Porto, 2000; and others.

The theoretical reference point backing our reflections on adolescence and the meanings constructed by healthcare professionals is sociohistorical psychology, in which the epistemological basis comes from dialectical historical materialism. The conception of man and the world that we share goes through negation of human nature and is understood historically and socially as constructs under the concrete conditions of existence. In the present study, we have taken the main analysis category to be comprehension of meaning, within the dialectal movement between thinking and language, from the perspective discussed by authors such as Vigotski (2001, 1984, 1983), Lúria (2001), Leontiev (1978) and Aguiar and Ozella (2008, 2006).

Thus, adolescence is understood as a time within a process and, as such, a state of construction, which may differ in nature between the perceptions of adolescents themselves and those of society. Adolescence is understood to be natural and universal, but is a product of individuals’ life histories, considering that they belong to social groups and cultures that influence them and towards which they act dialectically. This is not developmental, since individuals experience it in their own separate manners, depending on their social interactions, the development of their interests and needs and the significance that the biological changes may or may not have. It is non-pathological in the sense that one adolescent does not experience the same things as another adolescent, such as the so-called crisis of adolescence, and may be healthy in that each individual can be the subject of his own history, capable of making choices within the objective and subjective possibilities, thereby developing self-awareness and autonomy within the context. This understanding does not negate the biological changes, but means that they are also taken as historically and socially significant (Aguiar and Ozella, 2008; Ozella, 2003; Vigotski, 1984).

Within this context, we have sought to reflect on what this (new) attribution means for the daily routine of the Family Healthcare teams, not only in relation to demand but also and especially in the way in which these professionals view the adolescent and young adult population and its healthcare needs.

Methodology

The field investigation was carried out in a municipality in the state of São Paulo with a population of 213,000 inhabitants that is accredited by the Ministry of Health to provide full management. The municipality has a public healthcare attendance network at primary care level composed of 12 primary healthcare units (PHUs) in the urban zone and one in the rural zone, and 11 Family Healthcare Units, with 12 teams. It occupies 17th place in the ranking of municipalities in the state of São Paulo, with an HDI of 0.84 (2000) and GDP of R\$ 3,137.11 in the year 2006 (Seade Foundation, 2009), and is considered to be a center for scientific and technological development (with two public universities and three private universities).

Data were gathered by means of semi-structured interviews, which were conducted individually with all the medical and nursing professionals who made up the 12 teams (22 professionals, considering that two of the teams were incomplete) that existed in this municipality at

that time. Through knowledge of the subjects, we then defined which of them would undergo qualitative analysis, with the aim of deepening the understanding of them. The criteria used were 1) Interview content that was as complete as possible in terms of information, i.e. detailed responses obtained regarding the main points, in accordance with the study objectives; and 2) Interviews that represented the two main groups of professionals present, i.e. firstly, professionals with traditional training and longer experience who had recently become members of the FHS; and secondly, professionals with recent training directed towards the FHS after graduation, and professional experience focused on the FHS.

For the deepened analysis, we set up four interviews: the subjects were two doctors (M5 and M6) and two nurses (Nurses C and J). Considering that in qualitative research, the main reference point is not the number of subjects analyzed but the elements that enable deepening of comprehension, we took the view that these four professionals would be sufficient for the aims of the study. They worked in PHUs in peripheral areas, attending a poor population. Among the four, two had already had experiences of working with groups of adolescents, although at the time of the study they were only occasionally seeing such patients.

The transcript of each interview was read attentively, with the aim of gathering pre-indicators that consisted of significant expressions of discourse, which could consist of content, repetition or intonation, or other possible ways in which significance for the subject was shown. Following this, the material was grouped according to what it indicated, so as to organize it as indicative of meanings. We then began the analysis in its true sense, by grouping the indicators according to centers of meaning. We organized these in such a way that it became possible to comprehend the meanings constructed by the subjects while not fragmenting the construction of the thinking. This methodology is better described by Aguiar and Ozella (2006) and Fonseca (2008).

In the present paper, we retained the centers of meaning dealing with comprehension of adolescence and the place of this population within the field of healthcare, in the context of the FHS. The analysis on the other centers, along with their relationships and connections, can be found in Fonseca (2008).

Analysis and discussion

The meanings constructed by the subjects were singular, even though it was possible to point out similar features in the discourse and construction of meanings. We then compiled comments about the four healthcare professionals, from the perspective of picking up elements of the discourse and the construction of meanings relating to adolescence and the FHS that could aid in comprehending how their conceptions might influence the daily routine of services at the PHU.

Conceptions of adolescence

In the words of the professionals, adolescence was understood as a phase of bewilderment, difficulties, dissent, confusion and vulnerability. This corresponded to the socially and culturally predominant model of adolescence, which we named the universalized view, given that at no time did these professionals indicate any comprehension that adolescence might be different for each subject, in each culture. They universalized it as a phase of “conflict”, as the passages below illustrate.

“My understanding of adolescence, and I’ve always experienced this here, is that it’s a terrible phase of absolute bewilderment both for the family and for the adolescent”.
(M6)

“Look, adolescence is something that’s very... it’s a bit of a knot, a bit of an attraction today [...] I see adolescence as a period of transformation of the body and biology, which causes changes in terms of hormones, body shape, breasts, pubic hair. But it’s also a period of psychological transformation for people: the time when they want to acquire responsibility, while at the same time they don’t want it because they want to

enjoy life and still be a child. It's a period that's difficult because it's a long time since I was there". (Nurse C)

They attributed certain characteristics to adolescents, thus indicating an understanding that they are natural and responsible for the conflict experienced, such as insecurity, lack of understanding of themselves, imbalance and vulnerability.

"[...] you're no longer a child, but at the same time, you [...] are not an adult yet to be able to look after your own affairs! So, it's a transition phase in which you lose some things and are unable to acquire other things in replacement". (M5)

"What I would comment about adolescents is that, maybe even because of the organic vitality of that age, they are less vulnerable to traditional diseases. They've already passed through the childhood generation, so they've won in the most critical phase. If they reach adolescence, they've proven that their natural selection was good and that they must have taken care in relation to childhood illness and so on. But I think that for them, it's mental health and their emotional side that's often not good". (M6)

The idea that this is a phase characterized as one of conflict, transition and loss of childhood privileges was clear. This discourse indicates that the professionals seemed to have constructed a meaning of adolescence with reference to cycles of life. This conception was marked by an idea of natural development, within growing acquisition of physical, cognitive and emotional resources that equip them to enter other phases of life. This way of characterizing adolescence is taken to be the time at which formation of the personality is finalized. Certain characteristics are attributed as inherent to adolescence, thus coming close to the definitions of Aberastury and Knobel (1989), with indication of symptoms such that a certain degree of pathological condition is considered normal at this age.

"I think that stabilization of the personality is not achieved without going through a certain degree of pathological behavior, which according to my criteria should be considered inherent to the normal evolution of this stage of life (Aberastury and Knobel,1989, p.27).

Vigotski (1984) criticized this understanding and considered it to be biologizing. According to this author, what marks adolescence is not a natural development process but, rather, radical changes in interests, in a dialectical movement of crisis and synthesis triggered by the subjects' concrete experiences and also by organic biological changes. This is when new needs emerge, and self-awareness and consequently autonomy develop as a result of the revolution in the psychological processes.

It seems to us that, in constructing the meaning of adolescence, the professionals who we investigated brought out some socially shared values that, in a general manner, universalized and naturalized adolescence. They treated adolescence as a phase: like something natural within the cycle of life that, therefore, everyone experiences, without differences in its essential aspects, as can be observed in the context of the following words.

"We get into conflicts: 'Hey, you lot, at the same time that I want to do this, I don't want to do that. I like my mother but I feel angry about her' It's... 'I like my sister, but at the same time I'm jealous' [...] I had to accept that I had big boobs in relation to others and was a big girl in relation to the others. An inferiority complex, if you like, in making comparisons with the others". (Nurse C)

It seems clear to us that the sense of adolescence that they constructed is riddled with contradictions stemming from internalization of assumed values in adolescents' lives, learning and experiences in professional training and the symbolism of adolescence itself. Thus, they naturalized and universalized adolescence, taking the view that conflicts and emotions specific to that age exist, while at the same time, they contextualized and attributed to families a certain responsibility for the difficulties that adolescents experience. This was expressed by Friedman (1995, p.137): "Personal meanings relate to ties or relationships attributed to words in comparisons between the prevailing social significances and personal experiences".

This hegemonic view is questioned by authors who take the view that human constitution and development are the product of social factors, and that adolescence is a significant time in all cultures, and may not even have the meanings constructed in capitalist societies. According to Vigotski (1984), what marks this age is the qualitative leap in psychological functions and personal characteristics that psychological acts acquire, and not a form of predetermination inherent to human nature. The sense of adolescence is much broader than the meaning expressed in the word "conflict", such that it reflects these individuals' life histories and links the psychological events that are produced, in the light of reality (Aguiar and Ozella, 2006).

We can take the view that these professionals, in their constructed meanings, demonstrated an understanding of human nature divided into cycles of life (phases) that everyone goes through, independent of the culture or social group that people belong to. However, learning is a process and not a fixed point in these concepts, in indicating collective actions, while still very focused on problems, considered socially to be the so-called "adolescent phase".

The contradictory senses of adolescence picked up from the discourse show that these professionals were seeking freedom of thinking, in the sense pointed out by Vigotski (1983), in which it was indicated that free choice does not consist of being free from reasons, but of being aware of the situation and of the need for choices that the motives impose. Thus: "Human freedom consists precisely in thinking" (Vigotski, 1983, p.288).

Adolescence, health and the FHS

The meanings constructed by the professional who participated in this study on adolescence and working with this population within the FHS always brought out the element of change: an understanding that the healthcare sector should be held responsible for care, from a viewpoint of comprehensiveness. In moving towards constructing their awareness and thinking, they perceived adolescents' "lack of place" in the healthcare services and in professional training. The meanings are necessities that have not yet been fulfilled, but which mobilize the subjects into action (Aguiar and Ozella, 2006, p.227), as can be seen in the following.

With regard to these professionals' constructed meanings relating to the FHS, we can point out that this is under construction, thus leading the subjects to rediscover ideals and motivations for creative attitudes and change. In other words, the FHS is full of meanings that have been constructed and linked to the subjects' personal histories and to professional training and experiences, along with the possibility of recovering lost and neglected principles that had mostly been constructed within family relationships. One example is in the words of M6, who stated that in the FHS it was possible to go back to the medicine that he learned with his own father and grandfather.

"What it means to me, today; I can say to you that what it means is professional fulfillment. I've never been so happy in all my life, in my almost 50 years, as I am today, because of self-fulfillment. Look, here, like in all the units, the work is intensive and dense. But it is potent in the sense of gratifying every professional [...]. So [...],if I were to leave today, I'd leave happy because I finally managed to do Medicine in the way that my father and grandfather there in [...] recommended. They were old-school doctors who said: 'You're a doctor from earlier times', like I hear some colleagues today saying very depreciatively in referring to Family Healthcare, that we are

throwbacks: that we want to bring Medicine from the past. But, in my view, this is fulfillment”. (M6)

This shows one of the central theories of historical-dialectical materialism, consisting of unity of contradictions and inability to dissociate thinking and affection, or symbolism and emotion. According to Aguiar and Ozella (2006), all human expressions are cognitive and affective. This sense of the FHS is permeated with emotions and affection.

“My view is that I love family healthcare. I don’t think that it’s the solution for all of SUS: it would need various changes, but it is... [...] a strategy for attempting to reorganize a public healthcare system that on paper is very beautiful, with comprehensiveness of care. In my opinion, family healthcare provides a possibility of implementing comprehensive care: looking at individuals in a broader and more singular manner, and looking at families in a more singular manner; seeking... It’s a facilitator in the sense of generating equity”. (Nurse C)

“Well, I see that the FHS has made use of everything good from the initial project and has expanded this greatly. This is a question of care, because today we no longer regard health as an issue of “I’m going to treat you”. No, no, I’m not a witchdoctor, I’m not just a scientist, I’m not just a... I’m a carer! [...] It took me some time to understand this a little, “but I treat my patients so well; I’m kind, I’m attentive, I try to keep myself informed and I think I’m competent, you know”, but it’s not just this. Care is much more than this”. (M6)

From a sociohistorical viewpoint, it is understood that subjects are affected by the world and that such experiences have many possible meanings. Their psychological world is constructed at the same time as they are influencing the world through activities and the mediation of language. According to Vigotski (2001), affectations are body states that increase or decrease the body’s capacity for action. In this process of affectation, the meanings of the FHS become constructed through the various elements experienced by the subjects. The relationship between thinking and language makes it possible to construct critical awareness, as can be seen in the following passage:

“But I think, without any doubt, that more than 90% don’t have any preparation for dealing with things: they only know how to deal with diseases. When they go there and see people with nonspecific complaints [...] they don’t know how to deal with this. Why? They go there, ask for electrocardiograms, hemograms, lots of blood tests and whatever else, and everything comes back normal. ‘There’s nothing there’, they say to patients [...] In fact, there’s no doctor! There are a lot of technicians in medicine! Technicians in medicine, who went there to study to be carpenters, toolmakers or metalworkers: there are lots of them. But there are very few doctors who have the ability to get into patients and see what they need, play along with them, live with them a little and try to help them”. (M5)

Here too, it can be seen that the criticism is founded in experiences of life. Development of critical awareness, constituted and mediated by language and activities, is presented. Leontiev (1978) provides a reminder that awareness is not immutable and should be considered in the development process. It depends on the subject’s concrete conditions of existence (lifestyle and social relationships), which consist of qualitative transformations of thinking that Vigotski (1983) named superior psychological functions.

In moving towards constructing critical awareness, the discourse of M5 shows his convictions regarding the abovementioned difference, with the understanding that doctors are the ones who are really concerned with people’s necessities. He considered the others to be medical technicians. The

same was shown when the professionals analyzed adolescents' situation in the context of the FHS. The following passages make this perception clear:

“I think it's not just in Family Healthcare, but in the healthcare system. I think that we still don't have – with a few honorable exceptions – work that really goes towards rescuing this population of adolescents that most needs this: the ones in peripheral areas. Also, the ones in mansions: we think that because they are there, they are well-served, surrounded by care, but in reality it's not like that: in most cases, it's not much like that. I think that we still need a lot”. (M6)

“There is no work in Family Healthcare for adolescents [...] They are not regarded as a priority because we have bigger problems, such as chronic diseases ordiabetic hypertension [...], which cause impairments, sequelae and death. [...] So, Family Healthcare ends up acting where the biggest problems are. Well, where are they? They are among people with chronic diseases and women, especially focusing on prenatal care and precisely on children. We work on children a lot up to the age of two years! After that, this work no longer exists”. (M5)

Despite the broader understanding of health and disease, when the professionals in this study spoke about health and disease among adolescents, their discourse was permeated with the entire historical construction of comprehending adolescence, as shown in the first section of this analysis, i.e. a universal sense that led them to understand disease in adolescents as emotional: the product from conflicts, imbalance and natural circumstances of adolescence. Thus, it did not need to be prioritized in comparison with other population groups. Some of the constitutive elements of the construction of meaning were also permeated with biologizing notions resulting from their training. Hence, the subjects' entire histories and concrete conditions of life were neglected, which had a determining influence on planning the day-to-day actions of the healthcare services. The conflicts and emotional issues, which were seen as inherent to the adolescent phase, showed and reinforced the naturalization and pathologization of this time of life, with a concrete influence on healthcare actions, as can be seen from analyzing the professionals' words.

“[...] they may be physically healthy, but emotionally and psychologically speaking, they are completely vulnerable to illness, and that differentiates them”. (M6)

“Because adolescents are... they think they are, not they are, but they think they are all-powerful, their issues, when they crystallize into illnesses, are emotional issues”. (M5)

“Adolescents think that they don't get ill, isn't that right? (laughing) They are easily exposed to risks, aren't they? They have a lot of vitality and think they are the best. Their own training and age. Well, sometimes they end up getting ill with more serious things because of this situation. [...] In my view, adolescents are very healthy”. (Nurse J)

We consider that it is important to deal with emotional issues as a healthcare target for adolescents. However, the lack of linkage with other factors that produce health and disease ends up placing a pathological element on this group, to differentiate this from other times of life. Dealing with this as a separate element transforms adolescence into a “pathological phenomenon” in relation to a society in which becoming ill is a routine matter, given the concrete conditions of existence of the population, either because of socioeconomic issues or because of violence in all its forms. Taking this factor as a differential for health and disease may imply distortions in healthcare practices and, in some cases, dangers to medicalization.

If this is analyzed more specifically, it can be understood that the pathological view also predominates within this context, given that conflict and insecurity are understood as inherent to adolescence. Thus, we observed that, for these professionals, adolescence was a unique time, resulting from the development process: a phase through which everyone will go and within which conflicts will be experienced, which was understood as something that could lead to becoming emotionally ill.

Blasco (1997) provides a reminder that these concepts that naturalize adolescence and take it to be universal and pathological have influenced the day-to-day routine of work developed among and for adolescents. This author asked what the consequences of treating adolescence as a crisis or a phase of conflict would be. Within this perspective, we take the view that such an understanding paralyzes and adds difficulty to interventions among the adolescent population, especially with regard to the FHS professionals. They need to be attentive towards the various problems faced by adolescents that remain unnoticed generally because they are seen as or confounded with inherent or normal problems of this age. This is also reflected in not identifying adolescents with the healthcare service, which explains the low demand. Furthermore, it may cause difficulty in observing other relevant matters that it is important to deal with among adolescents: issues that are taken to be social, but which are directly related to the healthcare sector, such as violence).

Consequently, the participants in this study believed that the professionals in this field had difficulties in working on adolescents' healthcare because of a lack of theoretical grounding and because of the way in which the services were organized. Hence, the adolescents were left without attention and without any organized strategy that would meet their needs.

“And... today, I am not working much because right now I have a conflict, really, about how to work with adolescents, because I don't have this well-structured. And so I say: “How can I give to others what I don't have?” And so, the team is trying to restructure. We are trying... we are seeking to study, consult, see dynamically and do things dynamically, to see whether things are clear, and then study adolescents”. (Nurse C)

“On the other hand, I think that we, healthcare professionals, leave much to be desired. We still need capacitation, training and improvement in speaking the language of adolescents, so that we can get closer to them through special programs. Not a very closed matter, fitting into little boxes, but something that goes along with the nature of adolescents”. (M6)

Although the professionals' personal sense of adolescence was greatly permeated by the naturalized, universal and pathological conception, they also indicated that the educational institutions were responsible for deficiencies in training and exclusion of adolescents from healthcare services. Thus, we can consider that, setting aside the due differences in personal constructions, these professionals brought the presupposition of predetermined human nature, ingrained in their conception of adolescence, especially with regard to its developmental evolution. They considered it to be a phase of life consisting of conflict, in the way described by several authors who were cited earlier in this article. However, they understood that this condition could, to some extent, be changed, thereby holding society responsible for the work, especially the teaching and health institutions.

In attributing some difficulties to their own training, and indicating failures relating to adolescence, they believed that what would change this situation would be preparation that led to posing the problem of adolescence and discussing it. In this process, they were able to look at their own training as a professional category, and consider some important issues that affected day-to-day practice in the healthcare services.

“I remember [...] that during the course, the professor called up me and a group of colleagues and said: ‘Look, I want to show you a liver, there in ward 5’. ‘Ah, OK’. Well, he gave the impression that we would go there and we’d find a liver on top of the table, considering how smashed up the patient in that ward was”. (M6)

“I think that our biggest difficulty is this... it’s to organize ourselves to do educational activities. [...] I think this is the difficulty: we aren’t tied to the issue of demand, yet we don’t have the strength to expand this work of educational activities. (Nurse J)

However, the professionals created a contradiction in presenting the characteristics of adolescence as a difficulty. The practice and experience of the FHS seemed to be a significant element in reformulation of their conceptions, thereby demonstrating openness towards reviewing and advancing in this process, as was indicated several times in their discourse, when they pointed out that lack of preparation and capacitation were obstacles for healthcare professionals that, for example, made it difficult to approach adolescents and create linkages.

The intermittent way in which adolescence has been focused on, within the context of healthcare and Family Health, was another point highlighted by the subjects. They assessed the provision as ineffective, thus indicated that the predominance of the doctor-centered model and drug treatment had not opened space for adolescents to seek healthcare services and thus perceive Healthcare Units as reference points, even though from a biological point of view, they do not easily become ill. The professionals in this study criticized the FHS, taking the view that in fact, there was no work in which adolescents were the focus. In reviewing the literature, we found some interesting experiences with adolescents within the field of healthcare, albeit still very scattered, limited and insignificant (Ventura,2006; Leão, 2005; Taquet et al., 2005; Mendonça, 2002; Formigli, Costa and Porto, 2000).

Thus, we found some professionals who had already internalized and constructed personal meanings relating to the FHS, but who still constructing the significance of practice and day-to-day work, such that it would become possible for this understanding of healthcare to cause changes prioritizing the human angle, reception, listening, context and subject, in the process and in the community. In this respect, Martins (2005) provides a reminder that users and healthcare team professionals carry their individual and social histories in their practices: conceptions and preconceptions that may make changes difficult, considering that it is “important to remember that the day-to-day routine is the space with greatest expression of alienation” (Martins, 2005, p.150).

In thinking of adolescents within the FHS, these professionals emphasized that there was no work for them. In their perceptions, they took the view that adolescents were not a priority, because there were problems that they considered to be greater, as exemplified in the words of M5. At the same time, they considered that there was a lack of space and opportunities for professionals to learn to work, which once again caused non-prioritization of adolescence.

In correlating the FHS, adolescence and medical practice, these contradictions were even more evident, since these professionals constructed a representation in which family doctors have a better vision of adolescents but generally have difficulties in dealing with nonspecific complaints by such subjects. They attributed this to lack of preparation among doctors and nurses for dealing with such questions.

Thus, the meanings seemed to be mediated by a biomedical comprehension of this age group, from the perspective indicated by Peres and Rosenberg (1998). It was evident that, in this construction, the idea of naturalized adolescence helped the professionals to justify their lack of work with adolescents. At the same time, comprehension of healthcare and the FGHS led them to assume a “mea culpa”: not as personal responsibility but, rather, because of their training, which had not prepared them adequately.

“Well, so today there is the issue within Family Healthcare of things not existing but noise being made:‘look, there has to be work with adolescents, family planning,

attendance for adolescents within your micro-area and group formation', but it doesn't exist yet. I don't know what other cities' experience of this is...". (Nurse C)

In the contradictions present within the meanings of adolescence developed by the professionals in this study, in the context of the FHS, there seemed to be an intention of mobilization towards a more committed form of practice that would cause transformation and be coherent with the precepts of SUS, but which had not yet come into effect for a variety of reasons. Among these were personal values and sentiments that persisted and deficient training, thus influencing the thinking regarding proposals aimed towards the adolescent population. As stated by Aguiar and Ozella (2006, p.228): "the needs are constituted and revealed through a process of configuration of social relationships. This process is unique, singular, subjective and historical at the same time".

Coherent with this comprehension, it can be seen, for example, that Nurse C pointed out that working with adolescents within the FHS was theoretically an important instrument for enabling actions for them. As a strategy, it created an opening for planning adequate care and assistance for adolescents, as well as planning for group work, which in her view was the basis for working with this public. However, in practice, it seems that there is still no effective work.

These professionals showed that they had a clear and broad view of this "non-place" of adolescents within the healthcare context and, in a critical manner, pointed out the factors that contributed towards maintaining this situation. The political view of the healthcare space seems to us to be an important reference point in constructing the meaning of work within this field, thereby enabling conjectural analysis on what does not exist. However, this view still seems not to have been able to go beyond the line of analyzing and discerning proposals that might transform the practices.

We perceived that there were coherent and contradictory points between how the professionals thought of the FHS and how they envisaged the work with adolescents. Thus, we picked up a dialectical movement in the relationship between thinking and language (Vigotski, 2001), thereby contributing towards day-to-day actions relating to adolescence, linked with the conception of adolescent subjects. This is therefore a dynamic, fluid and complex sense based on a conception of man and the world, which situates adolescents' healthcare needs as important and fundamental to the day-to-day work of Family Healthcare teams.

Final remarks

In a general manner, it seemed to us that there was a form of immobilization among the professionals investigated, towards joint actions aimed at this public. We take the view that a large portion of this non-event and the paralysis of the healthcare services may have resulted from the natural, universal and pathological viewpoint. This relationship deserves to be deepened, in a manner not possible in this study. We consider that this will be fundamental for advancing the knowledge of the healthcare sector and for developing practices that are more effective and liberating in comprehensive healthcare for adolescents.

However, based on this study, we can point out that if the viewpoint of adolescence were to be reconstructed from the perspective that the manner of being an adolescent is the resultant from the culture and group that each individual belongs to, such that adolescents' histories of life and symbolization would be responsible for new ways of behaving, the professionals would probably feel more capable of intervening in the process. Through taking adolescence to be a social construction that can be experienced and given meaning in different ways, such as the time at which revolutionary changes in interests occur and self-awareness is developed, educational processes would start to have a fundamental role in healthcare actions, and might in fact be thought of from the perspective of comprehensiveness of care, as proposed by Ayres (2007).

From the words and meanings picked up here, we have constructed an understanding that the FHS, in its present shape and methodology, is substantiating its proposals in a manner that is incoherent with its conception.

We have shown meanings of the FHS constructed from the perspective of comprehensiveness of care, but the discourse on the day-to-day work pointed towards fragmented practice, resulting from appropriation of the organizational model of the FHS.

From the viewpoint of the methodology implemented, adolescents seem to occupy a “non-place”, under the argument that they do not present **health problems and**, in the words of some of the professionals, **adolescents do not become ill**.

The “non-place” of adolescence ended up appearing more strongly when the professionals were questioned and, in a certain way, led to reflect about their practices. A conflict was established between their conceptions and meanings constructed in relation to the FHS and healthcare, the real working conditions and their personal senses that guided their comprehension of adolescence.

At the same time, it seems that there were great efforts to go beyond the model, albeit only cognitively, but without discerning paths towards other practices, especially with regard to organization of healthcare services and professional training, which had not supported construction of knowledge about adolescence and society as social constructs that therefore would be capable of modification.

Our assessment is that there is a need to create possibilities for healthcare professionals in the FHS to rethink their conceptions from the place that they occupy within the world of work, such that they might consider multiple variables in understanding adolescence. If no moments of reflection on the meaning of adolescence are provided, immobilization will continue or ineffective actions will be developed, and once again this population will be invisible, without a place in healthcare training and services.

COLLABORATORS

Débora Cristina Fonseca participated in compiling the article, discussing it and writing and reviewing the text. Sérgio Ozella participated in discussing and reviewing the manuscript.

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