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Opening Pandora's Box: The politics of the psychological clinic

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Abstract
This paper aims to discuss the policies within the psychological clinical device in Brazil. We performed a bibliographic cartography in the Brazilian academic literature regarding the key words "clinic" and "politics". The research resulted in the identification of psychopolitical characteristics of the clinic, which were categorized into four axes. In analogy to Pandora's box myth, these axes represent the evils released, as well as hope at the bottom: (a) colonizing practices, which move towards the maintenance of a hegemonic subjectivity colonized by European standards; (b) psychotechnocracy, practices that promote a universal truth about human beings and their behavior; (c) capitalization of care, a practice impregnated and guided by neoliberal logic; and (d) hope, proposition about a politicized and transformative clinical practice.

Keywords
clinic, politics, device, psychology

Introduction

What is produced through a traditional clinical practice, usually non-critical, that does not observe its origins and hegemonic tendencies? Being involved with the forces within our own professional performance requires a critical analysis concerning the discourses and practices that we may propagate. Psychology is not immune to or above these forces, it is not outside of power relations, or politics. In addition to being considered (or masquerading as) a practice of care and health, it can be a source of violence, exclusion and oppression. Since instituted as a field of knowledge, psychology is part of the massive network of social forces and configurations that entangle relations of power and domination. It is imperative that we, psychologists, are committed to analyze our theoretical and technical tools. It is a deception produced by liberal ideology to assume that our devices have a neutral positioning, apparently detached from political issues. Psychology acts intrinsically in the production of professed truths, traversed by several power relations, whose intention can be the maintenance of the *status*

quo, social control, silencing and obliterating the differences (Coimbra, 1995; Hur, 2013a). Therefore, we should be aware of the forces that intertwine our daily clinical practice and the resulting political positions.

The clinic itself originates from the medical practice, in which the practitioner observes and examines the patient to formulate the diagnosis and consequent possible treatment. Foucault (2014a) makes a critical analysis, pointing out the power relations present in this act, permeated by social, political and economic issues, in which the psychological knowledge exerts a direct power over bodies and population, in a government through biopower and biopolitics (Foucault, 2008).

In this framework, some produced norms transcend the individual. The norm and its deviation, namely disease, become entities themselves, characterized by a series of traits produced by these knowledge and techniques. Health, as a set of norms that are produced, is defined by the adequacy to what is instituted, that is, by the absence of deviations, "diseases" and "symptoms".

Psychology, in this scenario, is inserted in its articulation with medicine, as well as other normalizing knowledge. Psychological practice also presupposes, in principle, a range of normality as a reference. Deriving from the tests, evaluations and scales, the standard is established, and the deviations pursued. Between labs and analysis, the individual is leveled by one's average mediocrity. The focus is on the standard and on its deviation, the disease, to the detriment of the patient and his observations about oneself.

At the end of the nineteenth century, psychoanalysis seems to establish something new, inaugurating a clinic that focuses on the patient's discourse about one's own suffering, moving from the paradigm of observation of symptoms to listening. Through an individual, intimate and confidential clinic, the patient exposes the issues to an analytical intervention, which forms the classic image that represents psychology: a patient lying on the couch, the psychologist next to him/her listening with a notepad in the hand (Kahhale, Costa & Montreozol, 2020; Moreira, Romagnoli & Neves, 2007). However, it keeps reproducing the disciplinary, phallocentric and heteronormative logic (Hur, 2022).

In Brazil, Psychology, which was regulated by Law as a profession in 1962, maintains the same disciplinary logic. For example, one of its private attributions, standardized in Law 4119/1962, is to "solve adjustment problems", that is, to adapt people to norms (Hur, 2007). Following the intensification of neoliberalism, there was a significant increase in the number of courses and graduates in Psychology at the end of the 1990s, from which, in 2012, about 80% came from private institutions (Guzzo, 2018). Psychology formation focus mostly on the individual clinic in Brazil (Moreira, Romagnoli & Neves, 2007), despite the variety of professional activity possibilities. In spite of the increasing participation of psychologists in the public health system, companies, and several other sectors, their prevailing performance (Moreira, Romagnoli & Neves, 2007) still falls on the individual private clinic, corroborating the social imaginary that associates the image of the psychologist to the intimate clinical setting.

That said, this research seeks to analyze the private individual clinical device, understood here as "traditional clinic". Although nowadays the clinic can

assume several configurations, whether enlarged, group, or any other territory, we still find a large number of psychologists in the private individual clinic. According to the census carried out by Federal Council of Psychology (CFP) in 2022, the majority (73%) of these professionals is autonomous. What are the forces in this reserved space, and how to shed light on these problematizations and raise psychologists' personal implication? Is this practice necessarily individualizing and neutral? Does saying neutral necessarily mean producing a non-political practice? How do we observe the presence of politics in the clinic? From what practices does politics manifest itself?

As a knowledge that is supposedly neutral and detached from its social context, it's created the illusion that psychology and politics do not mix. This point of view reiterates a depoliticized practice, which deals with individuals alienated from their context, based on aprioristic universal maxims (Barros, 2005). It is appropriate, however, to problematize how much this supposed depoliticization is not a political positioning in itself. When considered neutral, psychology can support the silencing of suffering generated by social, race, gender and sexuality inequalities, emphasizing a decontextualized and individualized subject (Carneiro, 2020).

What do we call politics? We think politics not only from the state or partisan perspective. According to Hur and Lacerda (2017), politics happens in different spaces, in the exercise of the relations of forces that results in the management of life and in the processes of subjectivation. Thus, politics is exercised in all social spaces, whether in its macropolitical or micropolitical aspects (Guattari, 1981; Hur, 2009).

The psychological clinic, that is, the relationship that is established between the psychologist and the patient, is also a political relationship. By thoroughly analyzing it, we can observe the forces it comprises, the individuals positioning, the practices of power/knowledge, as well as the discourses reproduced and reassured, the investments of desire that are modulated and the produced subjectivity. Although the clinic is individual, it is still imbricated in the great social web that surrounds it, through which the person must be seen in one's plurality, as a historical, psychopolitical subject. This configuration of forces produces subjectivities, and affects the way we see and experience life. Forces that may evoke desiring production processes, which produce life and emancipation, or forces that activate limiting processes and block life (Hur & Lacerda, 2017).

This paper aims at discussing the politics within the psychological clinical device in Brazil. Thus, we conducted research to find out the discourses and practices that characterize the psychological clinic. How can the clinic conform or not to the broader political conjuncture? In this sense, we discuss the relation between the psychological clinic and politics, that is, the politics of the clinic.

To carry out this work, we used bibliographic cartography as method (Hur, 2016; Quadros, Moraes & Bonamigo, 2019). Cartography emerges as a possibility to follow the nomadic composition of heterogeneous elements. The researcher, being one of these elements, does not claim to be impartial (Passos & Eirado, 2009). The research, from this perspective, is not the representation,

interpretation, or discovery of fixed data about the object. It instead follows the processes that constitute the object and the subject, which "define each other, one in function of the other" (Barros & Barros, 2013, p. 374). Cartography is accomplished by deconstructing certainties and raising non-universal possibilities (Rolnik, 2006). The reality is denaturalized, which makes other perspectives possible concerning the same reality being experienced, while contemplating the coemergence of subject/world. By destabilizing what is already naturalized, enabling openings to be analyzed, we access and follow the composition of the reality in which we are also inserted as researchers (Passos & Eirado, 2009).

Cartography in bibliographic research, therefore, is not limited to data collection and subsequent interpretation. "Nothing to be interpreted, nothing to be represented. In cartography, writing is the intensity in transit. It is connected to the outside, it comes from the outside, it forms a rhizome" (Quadros, Moraes & Bonamigo, 2019, p. 88). It is intended to map not what arises as frequency, but irruption of intensities (Hur, 2021). It is, therefore, a process of experimentation and affectation by heterogeneous forces that transgresses individual and intentional limits, questioning norms and rules, problematizing and denaturalizing what is instituted. Junctions, disjunctions, connections and decompositions in the common plane of intensities that include the researcher and that connect as a rhizome in an infinite way, using criticism as an affirmation of difference.

> This proposal of interventional and participatory bibliographic research makes speaking, seeing and writing, it makes evident investments of desire that are being operated, and copulates with the sociopolitical field through agency with other practices and knowledge in a movement of concatenation. If the bibliographic research produces records, these records will be consumed by other researches, which in turn will produce new effects, implying an ethical-political commitment that is at the same time an ethical-political-aesthetic investment. (Quadros, Moraes & Bonamigo, 2019, p. 101)

We researched the Brazilian academic literature productions on clinical and politics in order to identify the forces in the psychological device and how they act. Two important databases containing academic journals of Brazilian psychology were chosen, namely Scielo and Pepsic, from March to May 2022. We paired the following descriptors for the research: "clinic" and "politics", without specifying a time frame. We found a total of 257 papers. We excluded from our sample the papers focused on education, law, dentistry, medicine and public health, as well as the duplicated ones. Thus, 96 papers remained. From these, we performed a general analysis of the papers, excluding those that did not specifically address the politics in the psychological clinic device. So, we selected 54 papers, being the oldest from 2001. It is noteworthy that the analyzed papers address the discussion of the in-between aspects of the psychological clinic and politics, therefore, they talk through the facets of this device in a critical way.

In these remaining 54 papers, we map out the various clinical practices that point out the configuration of the forces in the psychological device, discussing

them from a critical perspective, referenced mainly by Gilles Deleuze, Félix Guattari and Michel Foucault. We have divided these characteristics into four axes. We used the myth of Pandora as a metaphor to our attempt to understand this configuration of forces. Pandora (the one who has all the gifts) is the first woman created on earth, at the behest of Zeus, punishing Prometheus for stealing the fire of the gods and giving it to men. She arrives on earth with a box that should not be opened. Moved by curiosity, Pandora opens the box, from which flew out over the earth all manner of misery and evil. Pandora's box represents the psychological clinic, from which we expect health and mental care, but may release several evils instead. The first three axes are considered the evils that flew out from Pandora's box, namely: colonizing practices, psychotechnocracy and capitalization of care. These axes act on the individual producing effects that reaffirm, reproduce and/or sustain power relations with different configurations of governing life. Pandora, realizing her mistake, tries to close the box, managing to keep the only positive gift in there: hope. Thus, the fourth axis maps out practices that can represent hope at the bottom of Pandora's box: hope, being the proposal for a critical political clinic.

Evils: Colonizing practices

From the perspective of the analyzed papers, we encountered some practices that reproduce a colonizing logic. Practices in which the movements are directed towards the maintenance of a hegemonic subjectivity colonized by eurocentric patterns. To colonize is to inhabit another space and impose habits and behaviors, in an imperialist way. It is not restricted to territorial domination, but rather in the transmission of values and production of a way of thinking, being and living, in which there is an indoctrination concerning the hegemonic morality perspective (Hur, 2013b). The colonized subjectivity sees itself from the perspective of the colonial domination and prejudice, thus nullifying its own potentialities and singularities.

Psychology in Brazil is structured from epistemological views that are based on the reproduction of models imported from Europe and the United States. Much of our academic output is directed to the understanding and reproduction of foreign thinkers (Hur, 2013a; Lanza, 2021). Colonized and colonizing psychology is based on a standard identity (Deleuze & Guattari, 1996), which is based on white and European production on mental health and psychic suffering, disregarding the reality of a large part of the Brazilian population, which is composed of an ethnic-racial variety (Veiga, 2019; Benedito & Fernandes, 2020; Oliveira, 2017; Rodrigues, Véras & Teixeira, 2017; Tokuda, Peres & Andreo, 2016; Barros, 2005; Carneiro, 2020; Alves & Delmondez, 2015).

From eurocentric perspective of seeing the world, history and humanity, the clinical device creates a discourse that naturalizes the hierarchy between differences, organizing them into relations of power and oppression that are daily reproduced and reinforced, everywhere. It takes the colonial matrix as a

reference, covering up other narratives, which are made invisible to maintain patterns of power and subjection of individuals in society. History told from European perspective:

> has taught all of us that there was a Classical Greece that originated Rome, that decayed and originated Middle Ages, that at some point became more flexible and originated Renaissance, opening the doors to Modernity. All this in Europe as a scenery, the radiating center of rationality and democracy to the world. We are so familiar with this discourse that we take it for granted, because Eurocentrism has established itself, throughout a series of historical processes, as the dominant paradigm in several spheres of human life and in the most diverse points of the globe (Alves & Delmondez, 2015, p. 654).

The naturalization of this belief also produced a standard representation of human being. The, white christian heterosexual property-owner educated civilized european man determines as another everything that is different from himself, enunciating what must be civilized, catechized and domesticated. This other is considered in the logic of the negative (Deleuze, 1997), being contemplated as inferior, marginal, and often criminal.

However, these discriminations are not always explicit and evident. They can occur in a subtler way, permeating actions of apparent care and protection, often silencing the suffering that these naturalizations may cause. Psychology can reinforce this in a number of ways. We identified in the analyzed texts some themes that refer to colonizing practices, among which we highlight eugenics, racism and patriarchy. Through an apparently neutral protective-controlling discourse, one can reinforce eugenic, racist and patriarchal beliefs, with controlling postures and silencing. By claiming to be neutral and scientific, psychological assumptions may be politically in favor of the colonial hegemonic discourse.

In this review, we come across a critical stand that the psychological device naturalizes biological and social traits, favoring the economic elites, but also white people and large cities, that is, who live in the urban space and not in the rural. It operates as an apparatus belt called by Foucault (2008) as the racist state.

Socially, the suffering produced by inequality, exploitation and lack of access is disqualified and minimized. The structural racism we see present in everyday institutions and relationships is ignored. In the clinic, the topic is often individually treated, emphasizing individual spheres of resilience and adaptation. It is suggested that the individual should be strengthened, learn to live with these situations, suppressing the social and political aspects involved. In this way, the therapeutic relationship can, and in fact is, another oppressive device on these lives. Races play roles of value defined by a hierarchy established by years of slavery and colonization, justifying the existence of the privileges of the dominating class, the white (Benedito & Fernandes, 2020). The naturalization of these privileges, the lack of opportunities and marginalization of black people is a great source of suffering. The clinic performing a colonizing practice can make invisible the suffering of the black body in the face of the inequalities generated by this perspective that places the white race as a standard and holder of

privileges. White is a standard of beauty, of superiority, it has access to opportunities and facilities. The black is considered as another, seen in the same negativity logic mentioned above, always in inferiority and deviation. "Eurocentrism and whiteness not only refuse that black people think about their own history, but also do not see themselves as part of it" (Benedito & Fernandes, 2020, p. 9).

The defined standards stratify social places to be occupied by individuals, as discussed by Benedito and Fernandes (2020). The memorization and reproduction of these patterns is assigned to individuals, who cannot even access the possibility of producing other ways of living. In the individualization of social issues, people are led to disregard the structural facet, personalizing racist behaviors. The discourse of resilience is used as a tool so the person can learn to "be strong", ignore these offenses and behaviors, suggesting greater personal effort and dedication to overcome the obstacles imposed by the lack of opportunities. This perspective silences the denunciation of structural racism, individualizing the issue and weakening collective agendas and resistance. It perpetuates the place of white people as superior, the one who will civilize the others. Thus, the race exercises

> symbolic, evaluative and stratifying roles in multiracial and racist societies such as Brazil. The adoption of this concept allows the division between classes, in which the ideal status belongs to the white ruling class. These divisions and their consequences, racism, are not only the result of the historical process experienced in slavery, but are also the result of capitalist interests and, therefore, are maintained. (Benedito & Fernandes, 2020, p. 3)

Therefore, the clinical practice in this conjuncture must perform an analysis of its implication (Lourau, 1975) and the struggles it generates. The white psychologist must be aware of one’s whiteness, recognizing how race may affect the therapeutic relationship.

> the creation of the bond. Although this goal should be achieved in any therapeutic relationship, we highlight that among the repercussions of racism are the difficulty of establishing bonds and the representation of oneself as inferior, unpleasant, inadequate and a continuous sense of non-belonging, as well as the perception of the world as potentially violent (especially in the interracial relationship), which can influence the establishment of a bond with the therapist. (Tavares & Kuratani, 2019, p. 5)

Disregarding these aspects means perpetuating the reproduction of colonialism and the silencing of this suffering, which prevents the manifestation of the difference. The cynicism of the analyst and his whiteness can naturalize inequalities and ignore the privileges obtained through race, relegating to the fallacious discourse of meritocracy the social abysses that exist. "Whiteness operates as a device of power regulating the limits of analyzability. Therefore, a mechanism of colonialist power that gains materiality through institutional racism" (Apolonio & Verzrman, 2022, p. 43). On many occasions the white

person does not recognize him/herself as racialized, seeing the white as a reference, turning the perception into the black body, which becomes the object of study and intervention.

The analysis of one's whiteness (Bento, 2002) is an essential step towards the deconstruction of a colonizing practice. Not only, though. The colonial bias of patriarchy is also reproduced in clinical practices, generating oppression as effect. Equally sustained by neutrality, the universality of androcentric thought is reproduced. Men is placed in a position of superiority, and women are subjugated in a place of submission and subservience. The gender hierarchy is often neglected by the clinical practice, where violence is reduced to dichotomies such as good/bad (Timm, Pereira & Gontijo, 2011). Without the psychologist ethical and critical commitment concerning the issue, in which said neutrality is sustained, clinical practice is reduced and:

> based on individual subjective experience, privatizing people's pain and suffering. The history of this hegemonic practice atomizes, dissociates, fragments and *pathologizes* the subjective experience as if it was not related to its social context, as if everything was a matter of 'intimate forum'. [...] The critical analysis of patriarchy demands to rethink the impact of culture on the process of gender identities constitution and the consequences, such as individual subjectivities. [...] Women in this western patriarchal culture are constituted by men's perspective, feeling deeply helpless when they are not noticed and often conforming to a violent family or marital scene in order to prevent loneliness'. (Timm, Pereira & Gontijo, 2011, pp. 253-254)

Clinical device as a reproduction of patriarchy, therefore, repeats oppression thus disregarding subjectivation processes that break the cycle of submission and inferiority. It keeps women tutored and fragile, so they can be controlled. Such practice may be masqueraded as care and prudence. A male psychologist may listen to a woman performing the role of the protector, discouraging her from ruptures that may be necessary and urgent. A nuance easily perceived as care, which hides, however, the reproduction of social roles in which the man acts as the protector, and the woman is fragile and incapable, requiring a tutor.

> both in the theories listed and in the reports by the women listened, the concept of family is still imprisoned in patriarchal, phallocentric and heteronormative structures and is reduced to the traditional model of the bourgeois nuclear reproductive family. [...] In this sense, Psychology itself (as well as other fields of knowledge – nursing, medicine, social work, etc.) needs to review its practices and concepts, considering its tendencies, often reductionist. (Tokuda, Peres & Andreo, 2016, p. 928)

Acknowledge colonizing practices is to remain in constant self-analysis, seeking other perspectives, questioning and problematizing the interpretations, observing the role we play in the therapeutic relationship, and its implications.

Evils: Psychotechnocracy

Technocracy is a term used to designate the use of scientific knowledge in the resolution of everyday problems and issues, that is, an administration made by specialists, a management of life carried out from fields of knowledge and technologies. Accordingly, we name as psychotechnocracy the attempt to manage life through psychology scientific and technical knowledge, that is, psychological expertise and techniques. These practices seek to promote a universal truth about human being and behavior. These regimes of statements, taken as truth, are guided, as Michel Foucault (1979) teaches us, by normalization, classification and pathologization. Consequently, psi practices can erase differences by adapting to socially accepted norms and standards.

Psychotechnocracy derives from disciplinary power, proposed by Foucault (1979). The french philosopher studies a new governmentality that emerge from knowledge regimes of techniques that articulate power relations that focus on life. Disciplinary power:

> adopt new procedures, such as examination, surveillance, confinement in a space and time management. They describe traits of individuals, as well as they produce measures, molds, codes and statements in order to appropriate life, thus making it more effective and productive. Standardizing sanctions are used as interventions, which regulate behavior and correct deviations: body domestication. This utopia falls upon diagnose and correct, discipline and punish. The truth produced by these procedures is called 'norms' (Hur, 2018, p. 80).

Based on this, psychotechnocracy is the adaptationist and normalizing practices of psychological clinic, in which the psychologist is a kind of social orthopedist (Bicalho et al., 2009). For example, when we break a bone, we look for an orthopedist, who will put the bone back in place, plaster until it calcifies in the correct position. The orthopedic psychologist plays the same role: based on a norm, he identifies which bones are “out of place", that is, individuals with inappropriate, deviant behaviors, which must be put back in the correct position and plastered until they calcify. Norms that justify and update *status quo* values, that sustain logics in order to maintain domination and exploitation, reducing the production of individual differences, of multiplicity. Disciplinarization directly updates the forces diagram of discipline (Foucault, 2014b), in which knowledge and practices instituted by *psychology* create anatomopolitical and biopolitical norms to manage life (Hur, 2018).

The disciplinary clinical device reproduces psychotechnocratic practices. According to the papers studied in the literature review, psychotechnocracy is performed by vertical knowledge-power relations, permeated by neutrality, disciplinarization, adaptationism, medicalization, classifying and diagnostic homogenization, among other practices in which norm is preponderant (Barboza & Andrade, 2022; Safatle, 2017; Smith, 2005; Canavêz, 2017; Martins, 2008; Dettmann, Aragon & Margotto, 2016; Borba, 2014; Decotelli, Bohre & Bicalho, 2013).

Under the aegis of neutrality, brazilian psychology went through the years of civil-military dictatorship (1964-1985) without being persecuted. Disregarding its political and social characteristics, separating politics and psychology (Hur, 2007), clinic is assumed as neutral, thus being disconnected from the reality that surrounds it, immersed in the inner world of the patient's self. Neutrality, objectivity and scientificity (characteristics of the positivist paradigm) describe the individual as a natural object that is not historically produced (Coimbra, 2004). This subject is seen as a center in conjunction with the dichotomy society x individual. These two realities are considered apart and separately analyzed, although they are intrinsically articulated (Barros, 2005).

During the dictatorship, taken as neutral, psychology penetrated the social sphere through a hygienist perspective of mental health (Oliveira, 2017). Assuming the discourse of neutrality implies decontextualizing and naturalizing power relations that have been historically built, taking them as given universal truths and individualizing issues. Hence, neutrality reinforces, often by omission, relations of oppression, depoliticizing and weakening people, whether at the individual or collective level. When a perspective is considered a universal truth, "it comprises a variety of blind spots, which will necessarily violate the perspective others" (Martins, 2019, p. 57). In other words, we consider that no truth is universal, it is always a point of view contemplating a specific reality, be it historical, cultural, social or economic. Therefore, neutrality as it is put does not exist. It must always be questioned, because it is permeated by the reality that surrounds it and produces it.

Neutral discourse, on that account, may corroborate situations of oppression, such as racism and sexism. In an unequal class society, it is necessary to analyze the roles we as well as our patients play in society. Psychology as a "neutral" discipline has already been used as a tool to pathologize physical differences (Benedito & Fernandes, 2020), justifying social domination. Currently, it can still be seen in the criminalization of black poor people, which associates social class and race with violence and drug addiction (Coimbra, 2006).

Psychotechnocratic practice widely contributes to body disciplinarization, where a norm to be achieved and maintained is established (Silva, 2005). By reinforcing norms concerning ways of living, classification and diagnosis are effective tools, as they standardize and quantify therapeutic relationships that should be unique. With respect to standardization, universal truths about humans are produced. The norm establishes the limits within which the individual must remain. In this sense, the clinical setting mingles with the hegemonic discourse that disregards multiplicity (Canavêz, 2017), which diagnoses, disciplines and regulates. Psychological techniques are used as a way of diagnosing, defining and limiting ways of being and living.

Another practice that characterizes psychotechnocracy is the production of diagnoses, which operate as a production of specific subjectivity: the discipline of subjectivity. As an effect, patients reproduce a limited discourse about themselves, embracing a high content of (self)codification, restricted by the identity affirmation of "this is me". This perspective limits the possibilities of

change, thus generating fatalism (Martín-Baró, 1998). Sadness to depressives. Lack of control to anxious ones. It consolidates normative stereotypes that are difficult to break through.

Along these lines, the creation and improvement of mental health diagnoses (International Classification of Diseases – ICD; *Diagnostical Statistical Manual* - DSM) imply the production of static norms and "a physicalist view of mental disorder. [...] As a consequence, the dialogue with the patients about their suffering loses importance, as well as the concern with their psychosocial context" (Martins, 2008, p. 332). These forces appear in the clinic from a social idealization of repairing what is not working: the pain, the symptom, the deviation. These forces appear in the attitudes of the patients themselves. There is a standard that rules and prioritizes certain ways of life. These norms establish an ideal pursued by individuals, who want to achieve them at any cost. Or yet, these forces may be part of the psychologist behavior, who may define the success of psychotherapy as the absence of anguish and symptoms, in search of immediate solutions and social adaptations to the patient's struggles.

Given what has been said, psychotechnocracy combines the diagnostic perspective with an intervention that aims to identify the symptoms to be erased and silenced through protocol techniques used to train and discipline people. Ultimately, the anesthesia of the insurgency, the suppression of anguish and the management of sensations are sought. These products are widely offered by psychology and psychiatry, in which behavior is standardized. It is a psychosocial hygienism whose purpose is analgesia as subjectivity (Martins, 2008).

Pain (symptom) or the lack of it as a reference for health (physical and mental) turns clinical practice into a protocol to accommodate and format certain models (Decotelli, Bohre & Bicalho, 2013). There is a multiplication of sickness roles, in which diverse behaviors are pathologized, resulting in the medicalization of health. Abnormality is attributed to what escapes the rules and norms set by work, school, church, family, discourses, etc. Deviations are recognized as pathological, they are medicalized and "corrected" (Martins, 2008).

In order to discipline bodies, childhood is also normalized through various diagnoses of learning and attention neurological disorders. Standardization of childhood establishes health and regular cognitive abilities. Those who don't fit are contained by medicalization. Life is regulated through the definition of an ideal behavior, learning and attention, which, in fact, sustains biopolitics, regulation and control of lives. In short, "monitoring of both efficiency and [...] existence in all their extension" (Decotelli, Bohre & Bicalho, 2013, p. 448).

We observe how psychotechnocracy permeates clinical practice. Supported by *psy* knowledge-power (whether from psychology, psychoanalysis or psychiatry), universal truths are established through classifying practices and normalization of behaviors, so certain ways of being in the world are reinforced. It is such a vigorous force that permeates daily practices. Even professionals self-acknowledged as critical end up being crossed by these forces, thus being psychotechnocratic.

Evils: Capitalization of Care

The bibliographic cartography revealed other characteristics present in the psychotherapeutic space, in the private practice, which we categorized as the capitalization of care. This category embraces neoliberal capitalist argumentation in mental health care practices and actions. Deleuze and Guattari (2010) affirm that capitalism must be seen as a semiotic machine that is updated in the most distinct instances, so they choose to call it as axiomatic of capital. Thus, from the intensification of neoliberalism, peculiar features of clinical device foster the production of a hegemonic subjectivity, whose manufacturing is serialized and international, encompassing the way the world is perceived and how it is articulated in society: capitalistic subjectivity (Guattari & Rolnik, 2006). In this category we observe the following characteristics: relationship between economy and subjective production, individualism, identity fixation, homogenization and massification of suffering, medicalization of health, psychology as a tool used to cover, naturalize and reproduce the exploitation guided by class inequality (Ceccim & Merhy, 2009; Cruz & Ferrari, 2011; Batista, 2013; Indursky & Conte, 2017; Moraes & Perrone, 2017; Sato, Martins, Guedes & Rosa, 2017; Kahhale & Montreozol, 2019; Kahhale, Costa & Montreozol, 2020).

Coimbra and Leitão (2003) highlight the direct relationship between economic relations and the productions of subjectivity; these are constituted by different social apparatuses, but they are articulated, since psychology is crossed by knowledge-power relations. The authors point out how much this capitalist territory produces, among other things, the "way-of-being-individual", a model that defines specific ways of being in the world to the detriment of others. This perspective is convergent with Guattari's statements that capitalism is primarily a factory of subjectivities (Lazzarato, 2014).

This way, individuality is exaggeratedly considered, taking precedence over collectivity. Self-identity is also emphasized, incited and modulated precisely in favor of the market imperative. The more categorizable, the more predictable, the more controllable and manipulable for the purposes of capital. There is the passage of a "technique of masses into [...] a machinery whose principle is no longer moving or motionless mass, but a geometry of divisible segments" (Foucault, 2014b, p. 160). In other words, the subject comes to be seen as a singular element to be articulated in a set that seeks greater efficiency and productivity.

In psychological clinic, one of the effects of this belief is the individualization of experienced vicissitudes. Care is instrumentalized to depoliticize and dismantle the political and social dimension of suffering, thus privatizing damage (Indursky & Conte, 2017). In other words, clinical intervention does not consider or associate collective facets of given suffering. It instead turns everything into internal and subjective scope. It displaces social issues to the individual sphere, that is, it discredits the social context as a way of blaming the person.

Considering capitalization of care, intervention proposals are fast and superficial. They follow a protocol as if they were a cake recipe, which promises

to solve anxiety attacks, panic disorders and *burnout* from individual perspectives that disconnect the person from immediate social reality. It ignores the entire cultural historical context, as well as the effects it engenders at the origin of certain suffering (Ceccim & Mehry, 2009; Cruz & Ferrari, 2011).

"Clinic is reduced to the imperatives of therapeutic efficacy and guarantee of short-term results" (Cruz & Ferrari, 2011, p. 162). The power of psychotherapy is reduced to symptom eradication by standard protocols, so the duration of the process is minimized as per the capitalist logic. One should also bring to this discussion the fee received by the psychologist, which is often disguised, not openly discussed, a "black box", however it is totally linked to the capitalization of care. As Baremblitt (1992) teaches us, it is an important analyzer of the process. In this context, psychology is another apparatus of neoliberal network, as a field of knowledge and practice that dictates truths about humans, based on its supposedly neutral expertise, but which continues with the bureaucratization of technical procedures in favor of productivism.

Poor classes cannot access therapy in many situations. Therapy is restricted to those who can afford it, considering that what is offered by the public health system is still insufficient for the demand. Social care offered by private professionals slightly mitigate this situation, although this practice is often guided by assistentialism and individualism (Silva & Bonatti, 2020). It is very common that clinical psychologists find their limit in the anguish arising from social inequality, which seems like a dead-end street, taking into account that some intervention devices do not problematizes these social and political issues.

Capitalization of care is performed through a productivist logic. Both by the financial bias, as by the results obtained. Patients are seen as "defective machines", so they must be "cured", "repaired", so that in the shortest period of time they resume their place in the great social productive gear. In short, we observe the therapeutic massification via the description of symptoms that silences violence in favor of the capital. This means that symptoms are homogenized and massified, encompassing increasingly large portions of people, and protocols are created and followed to managed life in a productive way. Thus, social violence resulting from exploitation and oppression is camouflaged with alleged care practices.

Some authors discuss the use of diagnosis-prescription procedures in behalf of longevity as the stagnation of singularity production (Ceccim & Merhy, 2009). With reference to consumption and capital, whose aim is maximum productivity, the symptoms are identified, the person is categorized, diagnosed and prescribed. Symptoms are silenced and, moreover, singularities are erased. What is unpredictable, and therefore uncontrollable, is nullified. This perspective occurs in conjunction with neoliberal individualist argumentation discussed above, which manages life via market-productivist viewpoint.

Another aspect that deserves to be highlighted is how psychological device becomes a drive belt of what has been constituted as health market. According to critical researchers, this market is basically focused on "medicalization of life" (Decotelli, Bohre & Bicalho, 2013). For such, the pharmaceutical industry of psychotropics, which moves immense profits, offers quick solutions in pills for

profuse emotional issues. In that regard, body and psyche are seen only in their mechanical dimension, in which certain medications would solve their adaptation problems, returning them to work. Ritalin is an emblematic example of what has been used for children, so they control their focus, attention, and increase production in schools. In other countries, such as the United States, amphetamines such as Adderal are prescribed to make workers and students increase production, thus corroborating hypertrophy of production. Health plans, permeated by this same logic, increasingly define and delimit the performance of professionals. "It is the criticism of the work captured by its management, by protocols, by its corporatization or by the rationalities in which it is inscribed or from where it unfolds" (Ceccim & Merhy, 2009, p. 532). Consequently, ways of acting, seeing, thinking and living are fostered, they are already outlined and standardized as per adaptation to capitalism and its demands. As Nikolas Rose (2013) criticizes, psychological devices are no longer concerned only with normalizing and encoding (psychotechnocracy) people, but rather with motivating the highest possible productivity of individuals taken as body-machines.

The papers reviewed show us how easily the clinic can be modulated by the hegemonic logic of capital. Practices that, by responding to capitalist demands, incite people into ways of living reduced and regulated by productivity and profit.

Hope: Proposition about a politicized clinical practice

Pandora's box was not all about evil. Hope was left at the bottom. Something that humans could turn to in order to survive chaos. Likewise, our bibliographic cartography indicates clinical practices that are capable of opposing the identified evils, politics of oppression, standardization and hyperproductivity. Among the evils, and in spite of them, there is hope. According to Paulo Freire, hope as a mobilizer of change, hope as a verb (2014). In opposition to immobility and fatalism, useful to groups of domination, hope incites action. It is a way of overcoming paralysis in face of difficult situations. The authors highlight how art, clinical friendship and autonomy can be an ally in this confrontation (Prandoni & Padilha, 2006; Martins & Peixoto Junior, 2013; Silveira, 2016; Cruz & Teixeira Filho, 2017; Safatle, 2017; Walter & Pine, 2017; Benedito & Fernandes, 2020).

Art helps producing differences in psycotherapy. In its interface, clinic and art activate other subjectivation processes, as per existential aesthetics. Art-clinical relationship may occur in two distinct ways: 1st in an instrumental dimension, in which art operates as an intervention device and 2nd the subjectivation process itself as an aesthetic experience.

Therapeutic and artistic processes are transversalized "through devices that enhance the aesthetic experience and its interferences in subjectivity and corporeality" (Santos et al., 2020, p. 69). That is, art is used as a way to reach oneself and a way of being in the world. Art in photography, painting, literature,

music, dance, etc., can foster life production. Art about everyday life may, for instance, help expressing beyond naturalized words and situations, promoting ruptures and movements that may guide someone into new possibilities to given situation. It can be a way of overflowing repressed and suffocated affections.

As an example of experiment, someone tries to access immediate reality through the lens of a camera, or by brushes, or by musical notes. It is possible that this produces displacements previously inaccessible by the automatism of everyday life. Reading poetry and short stories, or even their creation, can make room for the expression of affections previously repressed by socially predefined norms. There is no prefabricated recipe concerning our relation with art. Thus, psychological expertise is denaturalized, which enables attentive connection with the patient as well as space to new experiences.

As an illustration, Ernesto Neto believes on interactive art. This way of making art refuses contemplation, in which we only observe what was produced. It invites us instead to directly interact with the pieces of work, thus producing singular experiences. Cruz and Teixeira Filho (2017), when analyzing this artist, point out that

> The signs that the artist creates by providing a differentiated atmosphere of interaction provokes the public's thinking and disorganizes it for a moment until thought recomposes it, however, not by reasoning, but by sensation, which transforms the spectators into artists themselves as they create ways of relating to the pieces of work. "Truth" becomes implied rather than absolute (p. 138).

On the other hand, some clinical practices visualize that subjectivation process itself is an aesthetic production, a self-reinvention. From the body composed of flow of affections and encounters, intensive states can emerge, which require the creation of something new. It is life that "takes place in the production of differences and their affirmation in new forms of existence" (Rolnik, 2015, p. 104). The author states art as a means of expressing the intensive differences that vibrate in people, or that make people vibrate. Not art in its formal dimension, permeated by rules and forms, commercially recognized. But intensive art instead: a venture against the deactivation of an experimental creation of existence process. The existence itself comprising non-predefined ways of expressing affections through experimentation, rejecting interpretation or reproduction. By experimenting, through aesthetic production, our relationship with the world and with others can activate creative processes and produce new forms of existence.

In accordance with Deleuze (1997, p. 139), "the conditions of a true critique and a true creation are the same: the destruction of an image of thought which presupposes itself and the genesis of the act of thinking in thought itself." So the interrelation between art and clinic provides us with the chance to leave the presumed representation of ourselves and the world to enable a rupture that can lead to creation comprising the body with its intensive affections.

In addition to art as a transmutation power, friendship was also pointed out as a clinical facet that increases one’s potentia. Silveira (2016) believes that intervention in complex contexts comprises several resources and produces

different effects, among them the desire to create new networks of social relations, which may interrupt automatic processes in social life.

> Alleging the psychotherapy political facet involves the understanding that dual or group relationships, in office or in the community, must comprise the whole complexity of contemporary subjectivity. The notions of individual and group need to be denaturalized, being understood as a particular effect of always collective subjectivation processes. (Silveira, 2016, p. 339)

For this author, the rupture of power relations enables different experiences, which allow singularities and new different ways of relating to others. The production of new social connections, as opposed to neoliberal individualism, is a possible clinical effect that refuses hierarchical privatizing normalizing practices. Thus, the affections that arise from a horizontal therapeutic relationship can promote the movements required to produce authentic ways of being in the world, in which the search for connections, new allies and friendship affections produce softness.

Another way of disrupting colonizing disciplinary pharmacological neoliberal psychology is autonomy. Autonomy refers to self-government, self-management, the opposite of heteronomy, which is a vertical, asymmetrical government (Castoriadis, 1982). So, the clinical device may foment processes to regain life regaining and potentia. To achieve this goal, Prandoni and Padilha (2006) believe in the importance of considering the uniqueness and history of each individual, refusing adaptationism, pursuing autonomy through self-care practices together with social and political changes. Working with singular subjectivities means operating transformations in one's life considering the specific history, affections and displacements. Using control as care or psychotechnocratic approaches only provides stagnation and immobilization when facing an identity that is assumed as deficient regarding an average. The production of autonomy encompasses creating new possibilities of life, as well as the recognition of basic rights and the possibility of managing your own life.

It is worth emphasizing how connected it is to intrinsically political and critical facets of the clinic. The individual cannot be analyzed apart from society. Relational dimensions of human being cannot be ignored, along with the forces that transversalize these relations (Coimbra & Monteiro de Abreu, 2005). So we believe in hope as an active clinical approach concerning the production and creation of different subjectivation, one that is not subjected, adapted nor disciplined, but instead categorically implicated in the production of desire. As Jô Gondar (2004) affirms: an insurgent desire., the act of creating inseparable from the experimentation of unprecedented ways of affecting and being affected.

> The challenge of facilitating the emergence of creative processes in subjectivities crystallized in symptoms and excessive suffering now requires the constitution of an intermediate space of experimentation, in which the psychotherapist's body and affections is also claimed, so that transformation can take place in this aesthetic encounter. (Maciel Júnior & Kupermann, 2005, p. 8)

Hence, hope in psychotherapy is a rupture in politics of subjection, orthopedics and market logic identified earlier. It implies an ethical aesthetic political posture of the psychologist, which enables the emergence of inventive and desiring processes capable of displacing the individual from fixed identity. An invention process of other selves. Experimentation of other ways of occupying the world and the relationship with oneself, others and nature. Crystallized subjectivities die so that it is possible to become something else.

Conclusion

This paper, as unveiled by the bibliographic cartography, outlines the politics in psychological clinical device. An implication analysis is required so psychologists may ethically offer professional support, since clinics may produce or reproduce oppressive and excluding discourses. However, we believe how powerful psychotherapy could be if used as a way of promoting autonomy and transformation towards free and authentic ways of life.

The papers investigated cartographs four categories that psychopolitically characterize the clinic: colonizing practices, psychotechnocracy, capitalization of care and hope. The first refers to oppression, the colonization of subjectivities and the maintenance of a dominating hierarchy, whose target is the conservation of the privileges of part of society based on Eurocentric standards. The second is based on discipline, which frames life in norms and manages it based on universal truths about humanity and their behavior. The third is grounded in neoliberal logic, the axiomatic of capital, controlled by economic and production relations, massifying and serializing the ways of living and relating to others, acting in favor of the market and capital, reinforcing individualism, identity fixation and medicalization of life, instrumentalizing psychology in order to accelerate productivity in any instance. The fourth, which is the approach we believe in, unveils politicized practices, those implicated in singularities and production of differences. Hope is a way of opposing forms of oppression, domination and hierarchization identified in the previous axes. A way of fomenting changes by collectively strengthening resistance, as opposed to fatalism and immobility.

In conclusion, we believe in an ethical approach, which approximates individual and collective political forces. It works through an experimental and creative attitude towards the production of life, enabling processes of subjectivation that produce reality by denaturalizing what is stated by the hegemonic and dominant social order. A clinic based on deviation, which destabilizes the order taken as natural and dares to invent new ways of being, thinking and feeling life.

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