Editorial

The perennially transient in mental health

When the writer Guimarães Rosa claimed to be love an antidote to fight the disease[1], or rather, raising love as a feeling capable of promoting health, it certainly did not refer only to romantic and bourgeois love that often insists on being acclaimed as a cure for those who suffer. Before that, this love would be related to a feeling of compassion for the other, of respect, of interest for the other, of the possibility of dialogue in search of understanding. Whoever understood could then be empathic, put himself in the place of the other and, with that, allow the madness of living to rest, to give a truce, leaving the feeling of health. This health, almost a synonym of rest, of interstitial, would be interrupted by our contemporary way of life, accelerated, in disharmony, seeking achievements that often do not refer to their own desires, but to social expectations that often promote suffering when they cannot be met.

We live in times of an almost perennial malaise that crosses relationships, ways of being, existing and also caring for the other[2]. This so-called contemporary malaise has been discussed by different interlocutors, sometimes by philosophers, psychologists, psychiatrists and other specialists, sometimes by popular knowledge, as in social networks. In a discursive arena in which these knowledges sometimes clash, sometimes align, it is urgent that we can take a closer and more careful look at the phenomenon that is widespread in our society: mental health. In times of excess, including terminological, expressions gain the discursive space and emerge as triggers of internal and also social processes that must be debated by all: psychic illness, psychic suffering, mental suffering, madness, emotional balance, emotional conditions... mental health, just to name a few more recurrent ones.

Why, almost at the beginning of the third decade of the 21st century, is the term mental health increasingly evoked, both in formal and informal circles? Although some studies systematically portray the construction of the history of mental health[3,4] it should be signaled, in contemporary times, that the term mental health has ceased to be a typical expression of the old psychiatric hospitals and began to live with lay people and not lay people on wheels of conversations, heated debates on the Internet, sewing any and all training courses in the field of health. Thus, it becomes a ubiquitous term, but that is not even consumed as something that is saturated, on the contrary: about this concept has still been thought and produced and, in the present times, transmitted[3]. Mental health is not exactly a term "of fashion", but emerges as something necessary, and the task of our society is pressing to assume the importance and complexity around this expression that has marked our last decades so well. We therefore live in a historical moment in which this expression has been embodyed in the way we relate, how we produce, how we get sick and how we exist.

The mental health construct has undergone some reformulations since its classic definition that assumed a stable model of return to homeostasis, characterizing the bio-psycho-social "complete well-being"[5]. The heritage present in this standard of care is the biomedical model, predominant in the beginning of professions involving human health, which intoned the Cartesian molds of replicability and adequate measures of physical health[6]. The needs of care have sought to broaden boundaries and looks in the face of the transience that characterizes living and its human way with unique health measures to each living. Clinical research converges in this paradigm shift and also applies seeking to break mental health prejudices and historical stereotypes. The crisis in health and the change of knowledge are constant in the contemporary way of caring.

The paradigm shift in health care, with the advent of the psychosocial model, has been increasing variables at the apexes of public health, implying questions about human stability and its health prescriptions, in view of high rates of ineffective and often iatrogenic treatments that make up about half of the entries in health screenings and their demands in primary care[7]. Data from the World Health Organization included depression and anxiety, such as the disorders with the highest incidence in the general population, a context in which 4.4% of the world population suffers from depression, while 3.6% suffer from anxiety disorders, and depression alone is

capable of more dysfunctional outcomes and suicide deaths[7]. Focused on the elimination of the symptom and the reestablishment of the emerging symptoms, for the extinction of the problem, each new symptom is unbalanced the Existence. The movement that follows with the increased flow of demands is that of the patient "pain-carrier" of acute syndromes that become chronic, commonly treated as morbidities or comorbidities in mental health, and who suffer the medicalization offered and available in the health system.

The practices in different health sciences sought to question the curative model, which does not effectively respond to repeat offenders in different medical specialties, circulating their complaints and making the health system extended into demands without resolution in their cases, and also, increasing circulation in specialist professionals to accommodate conditions of "mental health", which culminate in reinforcing the Cartesian model and protocoling control and remission of the psychopathology established.

Psychopathology, in different therapeutic approaches, reflects the know-how with populations and the life cycle, in the reception of the existence of their "pain-carriers" of the health-disease axis, in a continuous flow of understanding of the ways of describing painful experiences, restrictions and also the way of establishing their existential measure in the present day, in a descriptive way about their ways of being and being in the world , characterizing a psychodiagnosis that avoids static classifications[8].

But every "pain-carrier" carries the stigma of falling ill, psychic pathology, cognitive and social limitations when entering the mental health scenario. At this point, Psychology establishes a redundant place of specialist, because it also can not enter the whole of each pathology alone, needing to make use of the collaboration of knowledge of the multidisciplinary team, either to exclude organic causes of mental involvement and even to verify drug interactions. We ask, then: What is the place of mental health?

Currently, we have a shift from the concept of health, influenced by the aesthetic searches of the population and the health services offered in the hope of maintaining another illusory human homeostasis: denying boredom and finitude itself, bringing a range of aesthetic procedures and restorative scans of the young and healthy image, bordering on a compulsion by hedonism to the body, with again the body and mind clipping. We ask, here: What is the nature and ideology of care of these services, institutions and professionals that make up the denial of temporality? As researchers and professionals in the field of mental health, how can we locate ourselves in this increasingly less dense contemporary territoriality?

With the advent of the so-called postmodernity, we notice an effusive search for time well lived, elongated and pleasurable, almost an eternization of the healthy body and exclusion of the common setbacks of existence and its uncontrollable ills. Thus, the question arises, still unanswered: What problems are shown to come from a prescriptive historical horizon of "more living" versus "better living"? And yet, what would explain such a compulsion for pleasure that it needs to be assertive for its success?

When thinking about contemporary existence from the perspective of mental health, we also ask: What professional or multiprofessional vertices predominate in the look? Would there be a second look at statistics? What are the predominant epochal diseases in the population and their incidence? What is the mental health metric today and its markers of normality indexes, which once had its parameters defined descriptively in the DSM-IV manual? What changes, what is lost and what is gained from each new normative standard we create in search of what we consider to be mental health?

We watch, on a daily basis, to the incessant search for perfection, medicalization and extinction of possible health misfits: acute, chronic or any other "de-order" that points to human suffering, marked by the time of haste in resolution and aesthetics as the mark of a postmodern time, a time that does not accept deviations, a prescriptive time of the norms of well-being and well-being, with positive recipes and advice and that rejects any announcement of failure. A time that does not allow the interstices or, using the famous phrase of Guimarães Rosa that opens this text, rest in madness[1]. If one cannot "rest in madness" in times of excessive and temporal crossings, it may not be possible to rest in healt

The media and virtual support groups, together with virtual care, bring professionals who can not waste time of consultation or involvement with the patient's history, and thus rush to meet the demands of the population that avoids focusing on the complaints of life suffered and sick, which point, above all, to the lack of meaning of this, which does not meet the prescriptors of modernity.

You can't waste time talking. You can't waste time listening. Prescribing and medicating are the most urgent actions that offer a false perception of efficiency, because we are not always accessing, in fact, the subject in suffering. And also modern communication and information technologies cease to function properly, to which they propose and contribute to the strengthening of a way of relating increasingly distanced, fast and committed to a scarce time. The technology that would allow us to better communicate becomes something that makes the transmission of information more agile, which is very important, but that does not embody in attitudes that, in fact, enable communication, contact, the real sharing of "with-living".

The sense of falling ill needs to be narrated and serve as a thermometer that accuses the need for care and not in quickly extinguishing the pain or symptom. It is necessary to listen genuinely, understand the narrative of this pain in the care itinerary of these patients in different health contexts that also point to a phenomenon that is revealed, to listen to their history with the symptoms and their nuances that affect the life of their human life, welcoming suffering already as the first symptom and the others as parts of this care process. It is not possible to understand the other, who cries out for help, without the patience that involves caring, supporting and accompanying in the mode of reception, the patient, the family, the team and the community itself.

This special issue comes in response to the current problems, situated as a counterpart to the Cartesian model offered, bringing a handmade model, built in several hands, various tissues of a sometimes clinical and sometimes institutional plot, in which they intertwine in the search to sustain dialectics by answers and questions in mental health, because it has a way of being unique and personalized to each population's need , respecting the life cycle and its different temporalities that call for care that is attentive to biopsychosocial and spiritual needs, typical of integrative health.

Research elevates science as an update on psychological practices. Knowledge and practice are constructed and undisputed in a dialectical movement in the face of emerging needs in a world so transitory about constructs and definitions about the concept of mental health, which we have left to situate it in the encounter with the other and also on the one who feels and cares for this health: the human and skilled professional himself, seeking a balance between his/her professional growth and contributing to the mental health care of the population itself , understanding that the sum of knowledge favors and does not limit the professional. The research fulfills the informative function, but mainly seeks to remove from the invisibility the populations on the margins, so-called "emotionally compromised", vulnerable and sometimes labeled as "deviant" to the norms of science.

The different developmental contexts and the different meanings about mental health narrated in the articles that make up this issue are not based on the strengthening of a world of excesses, but are presented as possibilities of readings that align with a discourse that cries out for complexity, plurality and, more than that, for a mental health that is committed to the search for what promotes well-being , in a fine listening to a society that also falls sick and needs to be cared for by us – health professionals, teachers, researchers, lay people, finally, people.

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Good reading!

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