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RESEARCH

Discontent and Collectivity: Free Psychoanalytic Clinics as Spaces of Sanitary Emancipation

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Abstract
This article examines Brazil's free psychoanalytic clinics as radical experiments in what I call *sanitary emancipation*—a mode of mental health care production that links wellbeing to liberation from colonial oppression. Based on ethnographic research with clinical collectives in São Paulo, Rio de Janeiro, and beyond, I argue that these grassroots initiatives mobilise a "corruptive" form of emancipation: an imperfect, materially entangled refusal of purity that emerges from a discipline (psychoanalysis) marked by elitist and patriarchal histories. Through practices of *territorial listening*—offering sessions in breadlines, public squares and sites of racist police violence—these clinics reimagine care in ways that directly challenge the coloniality of power, knowledge and being embedded in Global Mental Health paradigms. Situated within Brazil's post-Psychiatric Reform landscape, clinics like Coletivo Pontes da Psicanálise (with its Afro-Brazilian *escuta de gira* approach) and Margens Clínicas (working in territories scarred by state violence) and several others confront DSM-driven diagnostic logic as a neo-colonising discourse under financial capitalism. Their work critically fulfils the promise of the medical humanities by, first, politicising care as a *commons* rather than a commodified service; second, fostering situated knowledges grounded in relational and territorial forms of alienation; and third, resisting the de-politicised metrics of global health epidemiology. These unfinished, situated experiments in street psychoanalysis and anti-racist care ethics reveal both radical potential and inevitable capitalist contamination. Ultimately, they offer a compelling model for rethinking mental health through insurgent, place-based and decolonial frameworks.

Keywords Decolonial psychoanalysis · Critical medical humanities · Territorial care · Sanitary emancipation · Global mental health critique

Introduction: Setting the scene

The field of psychological care has been, historically, enmeshed within the pillars of Modern medical scientific discourses and their related scope of possibilities when it comes to bodies, minds, subjectivity, relationality and, above all, what is normal and

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what is pathological. The psychologies, psychiatries, psychotherapies and psychoanalyses—as plural fields—have grappled with difficulties in quantifying, categorising and naming forms of suffering that more often than not have found limited, if not little, epidemiological certainty or evidence. Ultimately, fundamental challenges in mental health, spanning both diagnosis and treatment, arise from the difficulty of establishing robust evidence to guide system planning and service delivery. More recently, efforts in what has been named *Global Mental Health* have followed suit, often measuring access to a particular kind of psychiatric provision as a sign of collective wellbeing in what is understood to be the peripheral corners of the world—making interventions from the field of critical medical humanities even more urgent. It is under this prism that I develop this article, addressing matters of suffering, psychopathology and coloniality as well as possible dialogues with a Latin-American critical thought in public and collective health, psychosocial studies and modes of decolonising and thinking health systems in the contemporary. In particular, this article addresses the current phenomenon of psychoanalytic free clinics in Brazil as spaces of sanitary emancipation. This somewhat unlikely pairing of psychoanalysis, a European discipline of the late-nineteenth century, known for its eliteness and patriarchal traces (see Frosh et al. 2024), and autonomous collectives proposing a modality of "territorial listening" evidences a "corruptive" form of emancipation, as I wish to argue in what follows, drawing on my psychosocial ethnographic and archival research.

More precisely, what this article maps are possible orientations towards sanitary emancipation within the post/colonial condition, specifically, in terms of mental health care. Here, I am radically aligned with proponents that *mental health* relies on emancipation from colonising forms of oppression which generate subjective, relational and territorial alienation—from Martinican Psychiatrist Franz Fanon (1963, 1986) since the 1950 s to Lebanese Psychologist and analyst Lara Sheehi (2026), Cypriot Psychoanalyst Avgi Saketopoulou (2026), and Palestinian analyst and Psychiatrist Samah Jabr (2024), for example, in our times, to name but a few. The implications of these interventions in care are profound, arguing for a shift away from the paradigms of functional epidemiology, the structures of globalised financial capitalism and universalising political and onto-epistemic foundations guiding the hegemony of health and humanitarian NGOs, as well Third and Public Sector implementation of evidence-based and economics-grounded strategies of care. Instead, as laboratories of sanitary emancipation, in free clinics we find further grounds for community care that addresses the situatedness of singular individuals in their webs of relationality and life, accounting for both experiences of oppression and autonomy-affirming potentialities within each territory.

In sum, this text is a gesture in the direction of answering to the question of what would Global Health become in light of an alternative mode of care ethics. By doing so, it also invites us to take seriously the politics of mental health care and the fundamental links between emancipation, alienation and wellbeing. In what follows, I first delineate suffering, psychopathology and coloniality as pillars of a mental health biopolitics. I then set the scene of free psychoanalytic clinics: introducing my research methods, offering a contextual overview and mapping their inventions and idiosyncrasies. In the final part of the article, I critically situate hegemonic systems of diagnosis and care in relation to these clinics, before opening an engagement with a landscape of sanitary emancipation—as I name it—practised *otherwise*. Throughout, we zoom out, in, out and in again: thinking with our field and engaging it dynamically as we move along.

Listening on the street: Field-note, scribble

An elderly man is sitting at the left corner of the table; he is creating intricate landscapes and mandalas with colourful marking pens. This man is recovering from a shoulder surgery that left him unable to draw for a couple of months. He is joyful for being back and is joyfully welcomed by the clinical team. The clinicians have a folder with several of his drawings and he also carried some in his backpack. As I sit next to him, he tells me a bit about his life story. He is from sertão and arrived downtown age 2 with his mother and brothers, all running away from a violent alcoholic man, his father. Downtown São Paulo is his town. His mother was not just brave but smart too, he tells me, as she arranged school, home and work all nearby so it was possible for her to raise him and his siblings on her own. That man was not really his father, he shares. He only saw him at his funeral, some years ago. He took a coach up to the Northeast and paid some protocol respects. In his memories, he explained, that man would leave the house in the morning before going to work telling his mother he wanted pasta for dinner, but would get home drunk after stopping at the bar and demand feijoada at midnight. The impossibility of the task could only amount to violent beatings. She had enough. He loves drawing. The clinic on the street, where he grew up, is the space where he can draw and where his drawings find space. No doctors, no state, no police, no bureaucracy, just ears, eyes, gestures and space. The clinic is outside or inside a community theatre if it rains. No money involved. Listening to knit and recompose the world-in-common imperialism ruptures every day. Listening as space for imagination and memories.

Mental health, otherwise; psychoanalysis, otherwise

What does sanitary emancipation mean, really, in the field of mental health and under post/coloniality? What my psychosocial ethnography of free clinics points to, resonating a long-lineage of radical psy practitioners, is that it means active dis-alienation (Robcis 2021; Fanon 1963; 1986). Let us engage this question further.

Colonial psychiatry, as Stefania Pandolfo (2018) dissects so well in her book *Knots of the Soul* which is situated in her ethnographic research in Morocco, actively eradicated indigenous knowledge and practices of care. French Ethnopsychiatry, following colonial psychiatric paradigms inherited from the Algiers School, remains, as per Didier Fassin's (2011) caught in a colonial aesthetics of either universalising phenomena or culturally differentiating subjects by binding them to their origins.[1] In psychoanalysis, in particular, several colleagues have been attuned to the colonial tropes embedded in canonical texts as well as to the potencies of practising otherwise (see El Shakry 2024). When it comes to considering Global Health and mental wellbeing, it is important to acknowledge that onto-epistemological compasses carry a decisive material weight once structures of care and of relationality are formulated upon the age-old questions of what is "normal" and what is "not". In other words, "conceptions of mental life become sites of moral and political reckoning and ethical speculation and reconfiguration, birthing novel experiments in justice, rights, survival, personhood and the good life" (Béhague and MacLeish 2020). At the end of the day, we are talking about elementary historical ways of producing and reproducing otherness, and not without consequence (Chamberlin 2020). In this prism, situatedness or territorial embeddedness are fundamental aspects of dis-alienating efforts (Beneduce 2019).

Following this logic, matters of scaling, replicating, and universalising, therefore, are political aspects of the very infrastructure of care. If we zoom into the vast, heterogeneous and complex territory of Brazil, there is an infrastructural context for the emergence of a vibrancy of free clinics—out of the current 250 free clinics, 250 mapped around the world, around 36% of them are located in Brazil.[2] Some answers lay in the dis-alienating character of the health and care system, even if these are still sites of ideological battle and precarity. The movement known as "Brazilian Psychiatric Reform", whose main articulators were the Movement of Workers in Mental Health (Movimento dos Trabalhadores em Saúde Mental, or MTSM), accompanied the foundation of the Sistema Único de Saúde, SUS, in the same wave of processes of redemocratisation and writing of the 1988 Constitution after the years of Dictatorship. As widely argued, such Sanitary Reform had an impactful effect in the field of psy, challenging an uncritical psychiatric hegemony in the country (Amarante 1994; 1995). The further establishment of a national system of psychosocial care embedded in the territory and drawing on multidisciplinary approaches with the articulations of RAPS (Rede de Atenção Psicossocial) and an impressive presence of almost 3.000 CAPS (Centros de Atenção Psicossocial) nationally in SUS, after the 2000 s, are direct legacies of the Brazilian Psychiatric Reform and its radical understanding of collective health.[3] [4]Yet, despite the progressive and critical approaches alive in day-to-day CAPS activities, a movement known as a "counter-reform", or the movement backwards from the advances of the Psychiatric Reform, started gaining strength in the recent years that culminated with the far-right presidency of Bolsonaro in 2018. As a subtle yet telling example of such conservative and damaging movement, we can situate the prioritising of psychiatric medications as the central form of care during the recent COVID-19 pandemic. Apart from the various tragedies in managing populational health and wellbeing, which resulted in mass deaths and extreme precarity, psychological distress was addressed with the liberation of around 650 million Brazilian Real in September 2020 by the then Health Ministry and just under a fourth of this amount to fund the RAPS (Garcia et al. 2022).

In such a complex landscape, the current phenomenon of psychoanalytic free clinics in Brazil emerges, offering, thus, spaces of sanitary—and collective—emancipation. As we hear in the field time and again, it was in the wake of such threats to care in the 2017–2021 period that a majority of actors of free clinics decided to collectivise. At times, as I heard in the field, combining going to the streets to talk about the elections in the "*vira voto*" (vote switch) campaign, to joining a collective practising psychoanalysis on the public square. Sanitary emancipation, thus, speaks to collective efforts of producing health otherwise, at times against the grain of public health.

The connections of psychoanalytic thinking and practice in Brazilian collective health are vast and were made stronger during the Brazilian Psychiatric Reform—an interesting chapter in the history of psy in itself, little researched or accounted for outside of the country. However, we are not talking about "any" kind of applied psychoanalysis, but of one that "can help us to endure a invested "we" and to tolerate ourselves in our differences" (Campos 2012, 13), be it in the clinic or even in organisational clinical workers' matters. In this interchange, seemingly, stakes are high for both public health and the field of psy. In the twenty-first century, psychoanalysis has not vanished as some predicted; instead, it continues to shape various practices, inform values and guide ethical stances in many contexts. It offers both "a theoretical framework and practical tools" for health professionals who engage with it not just academically, but through the transformative "experience of personal analysis", often emerging with a desire to help others live lives "less alienated from their own desires". Yet, as Campos (2012) notes, certain "exclusionary polarisations" must

be challenged to better understand the relationship between psychoanalysis and collective health. One such division arises when a "certain" version of psychoanalysis—mistakenly treated as the definitive form—is seen as dealing only with the "individual" and "pure singularity", while collective health is relegated to addressing what concerns "society" or "many". In other words, it is an "alive" psychoanalysis—psicanálise viva (Broide 2023).

Historically, figures such as the Hungarian analyst Michael Balint, or the Argentinean analyst Enrique Pinchon-Riviere, or even the French children's analyst Françoise Dolto, to name but a few, have offered important interventions on the matter of therapeutic relationality, forms of listening and processes of treatment and illness beyond 1-1 private care settings. That is to say that this dialogue is not new, particular to Brazil, nor outdated. Franco and Merhy (2011) stress that there is a subjective production in health care, which unfolds in the very act of care. The authors propose that "care practices are mediated by the singularity of each person" (Franco and Merhy 2011,10) all across primary and family health care and, as such, "the mode of production of care would be effectively revealed in the scope of its micropolitics, its subjective production in action, which produces health care" (Franco and Merhy 2011,10). In this manner, the "flows of intensities in connection" will then "produce social reality" (Franco and Merhy 2011, 11).

With similar ideas in mind, another Latin-American critical epidemiologist, Gastão Sousa Campos, draws on psychoanalytic ideas of an inventive clinical *dispositif* to propose a model of "local reference teams and specialized matrix support". He reminds us that Freud designed his well-known therapeutic setting—including the use of the couch and an emphasis on the "free flow of speech"—as a protected space to foster the dynamics of "transference and countertransference" between analyst and patient, generating material the subject could use to construct meaning and insight (Sousa Campos 1999). Sousa Campos thus suggests that health care environments—such as hospitals and clinics, and we can add now, in light of free clinics, streets, squares and community centres—should also be understood as kinds of "settings". This raises important questions about the kinds of "bonds" these environments promote: do they lead to "alienation and inappropriate interactions", or do they instead cultivate "productive, powerful and necessary bonds" that support meaningful treatment and healing?

In this manner, a break with the "supposed to know" of doctors and their vertical and functionalist address of knowledge in the therapeutic process is established, stimulating, instead, novel forms of relationality which, as acts, generate modifications in the micropolitical sphere. Suely Rolnik astutely reminds us, tracing this back to Freud, that "the psychoanalytic *dispositif* constitutes, in principle, a ritual-territory of relational experimentation that enables an unobstructed access of the spirit to affections, to exercise itself as an affect that evaluates collective affections, producing adequate ideas about their cause. In this movement, a place less subjected to the captivity of neurosis is constructed in the subject" (2022, 318). What some free clinics have been articulating, however, as we will see next, is not just a possibility to access one's desire in a less symptomatic manner, as traditionally seen on couches across the world, not challenging patterns of re-production of sociopolitical alienations, in a sense just scratching the surface. Rather, as one interviewee puts it, succinctly, when taking the clinic to the street "the issue is not just about the location, the matter for us is the ability to compose in difference. This has to do with a theoretical perspective of making common-in-difference". In this manner, such exercises of territorial listening (Broide and Broide 2025) demand a reinvention of its own means as "effects of the collective assemblages of enunciation that emerge in the encounter" (Rolnik 2022, 327). This reinvention starts with the elementary understanding that the clinical is political and

moves onto reinventing the *dispositif* itself, negotiating practices of listening within a collective rather than with an institution "top-down". Situatedness and emancipation, therefore, connect theory and practice, working in the tension of difference without succumbing to the age-old traps of othering entrenched in the field of psy and its alienating colonial legacies.

Dis-alienating practices: Methods of fieldwork

In early 2023, I joined a collective research project at the University of Essex in the UK, that focuses on the history and legacies of free psychoanalytic clinics in the public sphere in the Americas and Europe. As part of this multidisciplinary psychosocial research conducted by a team of nine scholars and support researchers, I have been researching clinical collectives in São Paulo and Rio de Janeiro, in Brazil, as well as in Buenos Aires, Argentina, that we call, broadly speaking, "free psychoanalytic clinics" in their heterogeneity and plurality. In the field, we have been conducting several interviews, participant observation and archival research and the project is ongoing until 2027. What I bring in this article are partial findings of this work, which does not aim to map horizons completely, nor categorise these collectives; rather, it wishes to enter a critical and productive dialogue that accounts for the "unfinishedness" of this very exercise of research (Biehl and Locke 2017). In doing so, these collective efforts are presented as laboratories of emancipation where mental health is brought into the realm of the commons, politicising community mental health care.

Adding more practical precision to the methods employed in this piece and others, here is an example of psychosocial ethnography that openly draws on over 40 interviews (most of them individual and around a dozen group interviews of at least an hour and a half each; mostly also in person and a handful conducted online); on archival research of public archives (such as the Helio Pellegrino archive in Rio de Janeiro, or semi-public archives such as the library of Circulo Psicanalítico as well as on ongoing collaborative archives (such as self-published zine collection). The work involved participant observation in several administrative meetings, day-to-day clinical practice, skill-exchange events, clinical supervision sessions, academic events and parties, conferences and that which Geertz (1998) names, plainly, "deep hanging out".[5] Anthropology, ethnography and medical anthropology have moved miles away from the idea that research only happens with delineated informants, during scheduled meetings and, worse, that academic ethics forms and bureaucracy grant more scientific probity to what is encountered in the field and later articulated in scholarly texts—see, for instance, the work of Tim Ingold (2014), Elisabeth Povinelli (2011; 2017) and Jeanne Favret-Saada (2012), to name but a few.

As a psychoanalyst born in Latin America but trained and practising in the UK, this encounter with clinical infrastructures involved, at times, being summoned as a foreign observing researcher, at others as a Latin-American colleague charged with the task of telling "gringos" "how we do it here", as well as working as a psychoanalyst and participating as a patient in clinical groups. Of this wealth of "alive" and "live" material, I have paid attention to repetitions, paradoxes and inventions, similarly to the psychoanalytic mode of listening employed in the clinic. These rescued curiosities are, by no means, empirically neutral; rather, they are constructions of a collaboration of the lively listening of the researcher and the field. This mode of listening, applied to events, sound and streets as well as to texts opened up a cartographic exploration of contextual conditions of possibility for the observed phenomena. In feminist epistemology, this approach to research, writing

and producing knowledge can be named "situated" and this is my political disposition to ethnography in this piece (Haraway 1988; Povinelli 2011; Tsing 2015). I suggest and hold on to the view that a feminist and decolonial positionality needs to work with such imprecisions, excesses and unfinishedness. This nuance is important and germinative in the field of medical humanities, transdisciplinary in its essence and, hopefully, un-disciplined too.

Free psychoanalytic clinics: Laboratories of sanitary emancipation

In the last decade or so, a vibrant movement of such autonomous free psychoanalytic clinics has emerged in several corners of the world, including London, UK; New York, USA; or Santiago, Chile, but especially in Brazil, across various urban centres from North to South.[6] Experienced analysts are often joined by a new generation in offering psychoanalytic treatment or a psychoanalytic form of listening not just to those who cannot pay for this oftentimes expensive or even typically "luxurious" appointment, but to anyone attuned, consciously or not, to the effects of Patriarchal, Racist and Capitalist State violence in one's sense of wellbeing—and, in various cases, to contingent passers-by. On the streets or in unorthodox community centres, our colleagues challenge established hegemonic notions of care, mental health and diagnosis by de-medicalising, de-individualising and re-politicising experiences of suffering within the social bond. Exiting the closed quarters of medicalised clinical settings, these encounters introduce the city, the streets and another texture of aliveness to care.

In the city of São Paulo alone, the *Territórios Clínicos* (clinical territories) map gathered, in 2021–2022, a total of 96 independent clinical initiatives not connected to the national public health care system—*Sistema Unico de Saúde* (SUS) network—which offer psychological listening and support under a psychoanalytic scope. Out of these almost one hundred groups, 53, or more than half, are autonomous collectives not linked to clinical training institutions or universities.[7] [8] In October 2023, a group of psychoanalysts created an interactive open Google Maps resource listing these collectives around the country, counting with over 25 entries across 14 cities just a month after launching the map *Psicanálise Popular*.[9] In addition, a collection of 22 self-published zines entitled *Clínicas de Borda* (border clinics) has been published in partnership with n-1 publishers over the second semester of 2023, gathering autonomous free psychoanalytic clinics to speak in their own words.[10] As part of our own research project, an international network of free clinics was also composed.[11] We counted around 250 international free clinics, around 90 of which are located in Brazil, as mentioned above. Another important element to notice here is that young researchers are arriving at the university to conduct scholarly work on the effects of these free clinics in psychoanalysis, mental health, public health and politics. Some of these young researchers, such as Paula Camarão (2024), are mapping this moment she named a "boom" of free clinics; others, as Augusto Coaracy (Coaracy et al. 2022), are thinking of this phenomenon as a social movement, and still, several others are drawing on their experiences as part of these collectives in new ethnographic attempts to think about psychoanalysis, care and health care (Marino 2024; Lima and Guerra 2024).[12]

In sharp contrast with privatised images of psychoanalytic spaces, which often involve a couch, quiet privacy and an artificial type of relationship and setting understood as the frame, in technical jargon, the work of these free clinics usually happens on the street.[13] Beach chairs or makeshift furniture are regular features, very little or no money is involved, and sessions happen frequently with different analysts at different times.

Challenging not just form, but means and the very possibility of clinical listening, the work in such free clinics veers away from a problematic ideological belief in neutrality, which has guided the psychoanalytic field for the last century; instead, openly politicising the process, the context and the clinical *dispositif* itself from the get-go, naming violences such as poverty or racism in promotional material and group manifestos (Soreanu and Minozzo 2024).

One example is the *O Cool das Clínica* project in São Paulo, at Praça Marechal Deodoro, an area of downtown São Paulo near what is called "Cracolândia", or the perimeter where people living with addiction to crack-cocaine and in extreme poverty live. The collective offers breakfast and optional listening to those living in a situation of homelessness in the area since 2021. Another example is the work of *Coletivo Margens Clínicas*, which has promoted group sessions in regions where recent racist police violence has taken place. Their work, especially the project *Aquilombamento nas Margens* (2019–2021) unfolded into a variety of racial relations–focused self-organised further collectives of health and care workers as well as a municipality-funded training in psychoanalysis, mental health and race convened by Kwame Yonatan in 2024 in the School of Public Health of São Paulo (Dos Santos 2024).

Other groups, some already discontinued such as the *Projeto Digaí-Maré*, in Rio de Janeiro, or *Favela de Psicanálise*, in São Paulo, as well as the current and potent *Perifanálise* São Mateus, bring psychoanalysis to peripheric communities and, as the latter, promote the encounter of clinicians from the territory itself with patients/groups of the same region. Examples are, as seen, abundant and compelling. The territory is at centre-stage and collective articulations are generated and opened up in relation to contextual events, in clinical devices named 'escuta territorial', or 'territorial listening'—as proposed by Broide and Broide (2013).

My ethnographic incursion and the series of interviews conducted over the past years evidence a type of active listening, there named psychoanalytic too, in which other discourses and disciplines of care, social sciences and humanities are interweaved. A recent interviewee, who trained first as a psychologist but had, all across his formation, psychoanalysts as mentors, managers or teachers, emphasises the impact of the landscape of psychoanalysis he came into in a context post-Brazilian Psychiatric Reform, with Centres for Psychosocial Care (CAPS) already well established in the early 2000s.[14] He tells us

> With the reasoning of collective health,[15] public health, psychology together with psychoanalysis; psychoanalysis composed thinking along with other spheres of health. This was very important for my training and for the way I propose and practice psychoanalysis. I think Psychoanalysis came to and at me, as 1-more. Psychoanalysis as one more. And this was very important, psychoanalysis in an interdisciplinary proposal, as yet another aspect, as yet another field of knowledge that comprises both the professional, the practice, and the mode of care… It wasn't a psychoanalytic care at all, it was and it never stopped being a form of care, but it wasn't strictly or only psychoanalytic, so it was psychoanalytic care, amalgamated with many other forms of care, collective health, health, psychology, mental health care above all, right? It was a toolbox where psychoanalysis was one-more of those tools.

This articulation of psychoanalysis with other practices speaks, in its own way, of an effort of making alliances, of assembling together that anchors the kind of listening being performed or allowed in clinical encounters (Guattari 2009; Santos 2025). "Listening with the eyes" as our colleague Dos Santos (2023), part of *Margens Clínicas* free clinic collective, proposes in his anti-racist clinic, which allows difference, racial differences, to be

accounted for, to be heard, to be worked with and through in the clinical encounter. In this sense, there is a tradition being rescued by the actors of these free clinics of addressing *that which does not fit*, that *which does not feel right*, sufferings that are singular and yet grounded in lived experiences within the world from an assemblage of knowledges of care and clinical practices (Santos 2025; Santos et al. 2025; Broide et al. 2022). One group in fact publicises their activity with the following message:

> What do you do when you're feeling bad, without really knowing what's going on? Who do you turn to when you're upset with yourself, with relationships, with family, with work (or the lack of it), with everything!—when life feels so uncertain and you have no one to truly talk to?[16]

In interviews but also across the rich intellectual production of colleagues working in such autonomous free clinics, it is evident too that without a spark of disobedience and a disposition to work in alliance with other knowledges—be them from within mental health or social care broadly speaking but also therapeutics and cures from diverse cosmogonies—clinical praxis risks a short-sightedness of the order of the "Transparent I". This position would be, as defined by Denise Ferreira da Silva (2007; 2016), the point of reference of the Modern Eurocentric subject which is still the point of departure of much of the foundational epistemologies guiding mental health care. As an example, we can mention the collective *Coletivo Pontes da Psicanálise*, which meets at a public square in the North-eastern capital city of Recife since 2022. Creating a space where passers-by can join for a free session and colleagues or members of the community can come together to read, study and discuss, this collective has found in the vocabulary of Afro-Brazilian cosmologies a model for their infrastructural operation they name "escuta de gira". In their manifesto, they explicate

> The proposal is to offer psychoanalytic listening in a public space to any subject who seeks it. Having a decolonial proposal as its central pillar, the collective will insist on promoting what we call "gira listening", that is, that the listening of psychoanalysts has a character of continuous connection, in order to promote bridges between spiritual dimensions, class, gender, race, among others, which in turn produces an intersectional device and that the analyst's own fragments of experience can be used in the listening process. (Coletivo Pontes da Psicanálise n.d.)

Gira, which alludes to turning, to movement in a more literal translation of the Portuguese word, is a *dispositif* from Afro-Brazilian spiritual practice. Departing from a space of blackness and movement, thus, is a radical, disobedient shift away from a Eurocentric, universalist and static canon, re-politicising clinical relationality. In their state of Pernambuco, one of the first sites of the colonial encounter in the region, where Whiteness, Indigeneity and Blackness converge into the social fabric, this choice is, therefore, strategical to the clinical-political proposition of this collective. Gathering in a circle, in a *gira*, that turns, in this same manifesto, they elaborate

> Thinking about public listening in psychoanalysis means making yourself available to listen the effects of the social on the lives of people from Pernambuco, promoting cracks in the false binarism: individuality x collectivity. This crack could point to us new possibilities of political emancipation for our people[…]. (Coletivo Pontes da Psicanálise n.d.)

Conversely, another interviewee, in the South-East of Brazil, with an active clinical and research practice recalls a past conversation with one of their university colleagues:

> I have colleagues who are very implicated in this type of [free clinic] work, but who still come up with some sentences that I get really curious about. Such as 'oh I went to this indigenous community to spend some time there and spoke to such and such person and they explained to me how things worked over there'. And this is someone wanting to listen to the other. Then this colleague said 'this person told me all these things and I thought, oh wow, this is profoundly Freudian'. And I was like this, oh, you went there to listen to this other and all you could hear was Freud? You only heard Freud, right? I think that these kinds of things are impressive, they represent a certain psychoanalytic posture that I see a lot around of 'let's listen to the other' and then they come back and want to fit it into whatever Freud or Lacan said. To me this seems a little colonising.

Positionality, therefore, is never neutral; more so when it aims at a certain neutrality which ends up reproducing a colonial mode of listening and caring, often left unquestioned in a functional epidemiological understanding mental health. The very mix of psychoanalysis as the organising principle of these free clinics already speaks to a certain contradiction. As we can grasp in the above examples, the free clinics landscape is heterogeneous, plural, maintaining what feminist Silvia Federici comprehends as the "contamination" of efforts to produce a *common*, or forms of emancipating togetherness. In her words, "we should not presume that in a world governed by capitalist relations commons can escape all contamination. But they remind us that commons exist in a field of antagonistic social relations and can easily become means of accommodation to the status quo" (Federici 2019, 7). In other words, there is potency in trying to formulate 'other ways' of listening and in not necessarily expecting perfection, completeness nor purism on the way.

Two scenes described by our interviewees illustrate Federici's point well, linking this matter of contamination, or of contradictions, which not only relates to the epistemological frames of listening but to its very materiality. In the first scene, the collective goes to an impoverished neighbourhood in the South of São Paulo as a working group. There, they chat with locals, visit shops and hairdressers, and check out the school run. In this immersion, the group of psychoanalysts notices a number of keywords, or signifiers, which seem to carry more weight in that community and reflect their needs as well as their strengths as a community. In a group discussion they then agree that the best place to listen to what is going on in this particular community and to offer a space for elaboration is by being stationed at the *fila do pão*, the breadline, or queue for bread, where locals meet weekly. For example, in one case shared by our colleagues, the word "kids" and "trouble" were repeated often, leading the group to create a space for children to play and, whilst deciding on how to play and use the makeshift play space granted by a local business, also elaborate on their forms of relating to one another and of belonging, as kids, to their community. This modus operandi is an act of "territorial listening" [*escuta territorial*], as proposed by Jorge Broide and Emilia Broide (2013) and their group Rede SUR. It speaks to materiality and situatedness—turning universalist mental health care upside down. The second scene sees a young, white and middle-class psychoanalyst arriving home at an affluent neighbourhood of a mid-sized city where her collective is active. Her iPhone was stolen by a pickpocket, a too-familiar phenomenon in a region of intense social inequality. Upon tracking her stolen phone, she discovers, to her dismay, that her phone, stolen close

to her house, was now being handled very close to the site where her collective offered free psychoanalytic sessions during the weekend, a bustling downtown abandoned train station. She listens to this scene, thinks about it and shares it with me. Again, the position of the one who listens or cares is, in no way, neutral in a context of patriarchal coloniality. This analyst, in particular, was attuned to her territorial positionality—the white, middle class with "goods stolen"—in relation to the dwellers of the city and, in particular of the park where her group practised psychoanalysis for free on weekends—her patients, mostly poor, mostly non-white, would often be confronted with suspicion by privileged citizens and, importantly, by the police.[17] In these two examples, there was awareness of the power relations structuring the social fabric of Brazil and an active disposition to working with difference.

In relation to the position of the listener, in the field, we see the emergence of a grassroots network of clinicians. In my ethnography, I heard from colleagues from different regions offering peer supervision to one another regularly, noticed the rise of joint publications and, remarkably, saw the structuring of open clinical formations which invite actors from several different free clinics alongside political and intellectual actors. Examples of such open formations are the open lectures of *Margem Psicanálise*, from Fortaleza; feminist reading groups of *Rede Divan*, in São Paulo; or the more structured programmes of *REM* (*Rede de Escuta Marginal* or the web for marginal listening); and of *Psicanálise Periférica* formation called *Trans-formação para uma escuta Territorial* (or trans-formation for a territorial listening).These offerings also privilege access to poorer, black or indigenous, trans or gender non-conforming and peripheric colleagues, again, disobeying any canonical neutrality.[18]

Yet, for all this radical shift in the power relations that structure the positions of the one who cares and the cared for, capitalist contamination, again, echoing Federici (2019), is still pervasive. Since 2019, a philanthropic foundation, Fundação Tide Setubal, already mentioned, led by a banking heiress has not only sponsored a mapping of each autonomous free clinic (defined by psychoanalysis outside the national public health system, which is universal and completely free of charge, albeit precarious and facing fracturing privatisation) in the city of São Paulo, but opened a grant scheme of up to R$150,000.00 (around £21,000.00) for collectives to receive this money.[19] These grassroots groups needed not only to justify their activities and imagine what they would do with (so much) money, but they also had to register as taxable companies upon receiving this philanthropic grant, as several interviewees mentioned. In my fieldwork research, still ongoing, it has been the case that various collectives went into crisis either by considering applying for this grant or after receiving it and changing their internal dynamics. To this point I would like to quote, again, *Coletivo Pontes*, as above, when they propose that a crack "could point to us new possibilities of political emancipation for our people". In this sense, a political act towards emancipation is foundational to their but also to many other free clinics. In other words, what is behind this movement of free clinics is a political drive where listening to the discontents, impasses, symptoms, troubles and life-lines of people is an "act of citizenship", as named by the Chilean feminist Carolina Besoain (2024). What happens to such acts of citizenship and emancipatory wishes when there is a contamination coming specifically from financial capitalism and, worse, from funds accrued by the logic of debt (banking)?—debt which affects women and feminised/racialised bodies more dramatically so (Cavallero and Gago 2021).[20]

These observations can, therefore, speak to how the potent phenomenon of free psychoanalytic clinics reflects the riddles and contradictions of psychoanalysis itself, embedded, mainly in its relation to coloniality. Psychoanalysis, whilst marginal to the biomedical

spheres, then and still now, and as Edward Said (2003) proposed "non-European" in its own way, arrives in Latin America under the rubric of a European clinical discourse, nonetheless. Yet, it was soon incorporated into local intellectual and political activity, transformed into a tool for thinking about coloniality, racism, patriarchy and inequalities at times ahead of similar productions in the Global North (Hollander 1997; Facchinetti 2001; Marsilli-Vargas 2022). Several scholars have been researching the gory connections of psychoanalytic institutions, coloniality and the dictatorships across the Southern Cone (seeLima 2021; Plotkin 2001), mostly under the excuse of political neutrality which ended up in censorship and direct violence. Yet, psychoanalysis, as the current free clinics make evident, is polyvocal and multiple, echoing the complexities of Brazil's post-colonial condition, in constant "co/rruption". By corruption, what is meant is the "impairment of purity" (Moten and Harney 2021). What Fred Moten and Stefano Harney elaborate upon is the double-edge of corruption, which is, to one end, a force of repetition and, to the other, of difference-making. They write "The paradox of political corruption is that it is the modality through which brutal institutionality is maintained. The paradox of biosocial corruption is that it constitutes the militant preservation of a general, generative capacity to differ and diffuse" (Moten and Harney 2021,160). In the case of free psychoanalytic clinics, their ins-and-outs of institutional life, or their porosity, open a crack to forms of collectivity, of being a group, that is able to generate something new (Besoain 2023). This generative version of corruption, for Denise Ferreira da Silva, is "the becoming implicated in the constitution of everything" (Ferreira da Silva 2021, 7). Complexity, porosity and situatedness are characteristics of such diverse free clinics, miles away from epidemiological flatness, total quantification and universalism—as we will see next, questioning, thus, the tensions between approaches to Global Mental Health and radical, emancipating modes of care as discussed in this section.

Suffering, psychopathology and coloniality: Maps of alienation

Putting the phenomenon of free clinics globally and in Brazil, specifically, into context asks that we look at the bigger picture of how suffering, psychopathology and coloniality are enmeshed both systematically and epistemologically. The manner in which mainstream psy-disciplines dealt with psychic suffering through the twentieth century can be characterised as a "descriptive psychopathology" (Berrios 1996). As such, biology and individual causality are at the heart of the efforts of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA). More so after the late-1970s with the DSM-III, IV and V, where the body and psychological suffering are divided, listed and pathologised accordingly, producing a modality of psychopathological discursivity that fancies itself universal (Wright 2021; Scull 2019; Rose 2018; Shorter 2005). This debate involves complex philosophical, political and ideological assumptions that permeate wider discourses in psychiatry, psychologies and psychoanalysis that meet precisely at the complicated, yet often oversimplified, definition of what is normal distress and what is pathological in affective life and according to which compass of "world-system" we are situated, evidencing a condition and process of *coloniality* of power, knowledge and being (Quijano 1999; Grosfoguel 2006).

There are, also, many direct links between the hegemonic model of diagnosis and the operative global financial capitalist system, once a manual such as the DSM comes to operate as a neo-colonising discourse through the imposition of its frameworks of categorisation of psychic experience (Minozzo 2019; 2021; 2024). This relation is clearer

if we look into the DSM's presence around the world. Despite being a North American psychiatric manual, the DSM has its scope and influence more globally. If at the start of the DSM project and with the DSM-II in particular, in the 1950 s and 1960 s, there was a preoccupation in matching the "international" standards of the International Classification of Diseases (ICD), published by the World Health Organization (WHO), after the third edition of the DSM, the discursive "power" shifts hands. With the publication of the DSM-III, in 1980, things move in the opposite direction and the ICD goes on to follow the trends in diagnosis already present in the DSM. In the following version of the international manual, the first post-DSM-III, the ICD-10, from 1992, a longer list of very specific and detailed types of disorders appears, reflecting the categories' checklist system that came to dominate not just care but a wider understanding of what is pathological and its individualised aetiology across various contexts. An imported and exported grammar of suffering that is at the core of the project of the ICD for public health whilst crossed by the logic of the DSM also represents a colonising liberal globalisation of the manners of suffering that accompanied the globalisation of financial capital within a neoliberal and neocolonial ideology. It is worth mentioning that along the terminology of "Global Health" and several private-public and philanthropic capitalist efforts, the USA has been the largest donor to the WHO yearly budgets for years in a row (Birn 2014).[21] The subject of neoliberal capitalism becomes, through such diagnostic systems and multinational pharmaceutical corporations, a global paradigm, and the potentiality of affects and experiences such as anxiety, grief or melancholy, for instance, or the possibilities involved in experiencing psychic distress in the (at times, sickening or maddening) social bond is erased systematically by the hegemonic practices in the field of psy, serving the powers of globalised financialisation of human capital virtually directly (Birn 2011).

In more recent years, the field of psy has welcomed yet another force to reckon with under the seemingly benevolent banner of "Global Mental Health". As per an ominous special issue of *The Lancet*, from 2007, edited by British experts, GMH aims at addressing a gap in access to treatment, with a focus on low and middle-income countries.[22] Following this line, the World Health Organization in fact estimates that 1 in 8 people globally live with what is called by hegemonic psychiatry a "mental disorder" (including anxiety, depression, PTSD as well as psychosis), and access to psychiatric provisions is thus enmeshed in notions of "development".[23] In 2008, the WHO kickstarted what was called "Mental Health GAP Action Programs" (mhGAP), which, by its very title definition aimed at "scaling up care for mental, neurological, and substance use disorders". Most of its vocabulary reflects the language of development, focusing on what they called a mental health "burden" of low and middle-income countries in relation to the provisions offered in higher income countries. The objectives of these Global Health actions are, in the published document to

> reinforce the commitment of governments, international organizations, and other stakeholders to increase the allocation of financial and human resources for care of MNS disorders. To achieve much higher coverage with key interventions in the countries with low and lower middle incomes that have a large proportion of the global burden of MNS disorders. (WHO 2008, 10)

The proposed interventions start by mapping epidemiological realities by disorder (e.g. depression, schizophrenia, addiction) and proposing frontline interventions of medications (e.g. antidepressant medication and anti-psychotic medication), leaving what they understand as a psychosocial intervention solely to be an offer of Cognitive Behavioral Therapy (CBT) (WHO 2008, 11). To achieve this, the programme proposed working with national leaders as well as what they call "donors" and with NGOs—again scaling a type

of financial capitalist solutions-model. Such WHO's effort is clearly aligned with a "Functional Epidemiology" that ignores "ways of living" and multiple and complex knowledges, by finding economic grounds to support the need of furthering a very specific type of care deemed "evidence-based" (Basile and Iñiguez 2023). Under principles of quantification, isolation and universalisation, as well as the focus on scale and development, such pillars of a GMH impose themselves in a dependency-like power relation across territories which, when reaching subjective and local collective experiences, has devastating effects once it impedes the politicisation of suffering and psychopathologies, locking these experiences in a dynamic of coloniality—or, simply put, in alienation, to think in Fanonian terms.

In this context, what Basile and Istúriz—Latin-American Critical Epidemiology scholars—name "sistemas-Frankenstein" of health and care appear as patched up apparatuses in Latin America, or, in their words: "Weberian bureaucratic health apparatuses, biomedicalised, curative-assistance and commodified, which are perceived as external to societies and that were accumulating languages, mandates, logics, theses, at the same time that they crystallized dehumanization, racism, inequities, violence" (2022,1). The epidemiological ground of health systems in the region, therefore, reproduces modes of coloniality that attempt to adapt and respond, in their own way, in each particular country, to both Global North paradigms and health and to local necessities. According to the authors, one key aspect of an effort to decolonise health systems in the twenty-first century is to revise the role of the State as central guarantor and anchor of health systems, and being so, opening up to the potencies of the "and [of] the territorialities of collective ways of life" (Basile and Istúriz 2022, 3). An alternative critical paradigm is that of "cuidado integral de la salud (CIS)" [integral health care] in territorial webs, which "puts at the center the territory where life develops and collective health is socially produced, it resizes the required morphologies and the possible forms that health systems acquire in each country, territory, contextuality, without unique and canned recipes" (Basile and Istúriz 2022, 4). When it comes to psychological distress, a focus on the territory, on forms of social bond and a bio-psycho-social understanding of forms of subjective and collective responses to circumstances take us away from de-politicised, individualised and colonised modes of pathologising experiences. Here, thus, we can find potent resonance with the work of free clinics in Brazil, as discussed above, with their focus on the territory and direct engagement with subjective positionalities with a matrix of power that generates suffering (e.g. racism, police violence or capitalist expropriation). By doing so, these collectives twist the hegemonic epidemiological function of psychopathology, connecting it to lived experiences in collectivity rather than with biologised and individualised issues.

Efforts that resonate a critical approach to mental health have a long trajectory within the fields of (anti)psychiatry, psychology and psychoanalysis. As early as 1961, the Martinican psychiatrist Franz Fanon listed a number of mental illnesses that he observed as resulting from the internalized reverberations of colonial violences. In a chapter called "Colonial War and Mental Disorders" of *The Wretched of the Earth*, Fanon gives us a good example of what he calls "sociogenesis"; in other words, how power matrices affect a person's lived experiences in ways that are not ahistorical or universal, but situated (Fanon 1986; Wynter 2001). What becomes clear when we examine Fanon's book is that a significant part of each patient's suffering was directly intertwined with contextual colonial conditions that also affected poverty, sexual violence, relationships and a general sense of purpose.[24] Without a political ear, we could argue, mental suffering could not really be heard. Since then, a large number of critical *psys*, as well as feminists and anti-colonial thinkers, have offered insights into the effects of oppression and inequalities on wellbeing and their implications in terms of psychic suffering—from black feminists such as Audre Lorde (1988) to Lélia Gonzalez (1984), for example, to Italian critical ethnopsychiatrists

Simona Taliani and Roberto Beneduce (Beneduce 2015; 2019 and Beneduce and Taliani 2021). However, as noted above, despite such interventions, what we call, in general terms, the "psy field", in its hegemonic form, has brought to the fore the very antithesis of such critical models of understanding the experiences of suffering, by privileging a biomedical approach to mental health that responds to the parameters of the DSM, ICD and, more recently, efforts in GMH, resulting, for instance, in high rates of medicalisation (Moncrieff and Horowitz 2022).

If we return to some scenes of the free psychoanalytic clinics around Brazil, as detailed earlier in this text, we find a completely different scenario and horizon for thinking and working with mental distress. The unfinished nature of these collective actions, or their refusal of closing-in and scaling-up, replicating universalising models, gives room for staying with the "trouble", to paraphrase, Donna Haraway (2016). By being curious to listen to the politics of suffering and by forging unorthodox settings and inventing territorially inscribed *dispositifs* and techniques, these clinics operate as micropolitical laboratories. What we see is not a set of definite answers to the riddles of suffering, psychopathology and coloniality, rather, a disposition to engaging with dis-alienating practices. This resonates that which anthropologists Biehl and Locke qualify as a disposition to work and notice precisely such "unfinishedness" that grants humanity its irreducibility, plasticity, complexity and creativity. They write "To attend to the unfinished, we need a conscientious empiricism wedded to a radical analytical openness to complexity and wonder" (Biehl and Locke 2017, xi). In other words, we can also grapple the stakes of such unfinished-style of not just anthropological work but for a medical humanities-informed entrance onto scenes of health emancipation.

Conclusion: Evidences or pieces of the world

In this piece, I have shared elements of my current psychosocial ethnography in free psychoanalytic clinics in Brazil, contextualising this phenomenon in light of dialogues within medical humanities, critical epidemiological Latin-American thought and psychosocial studies. My aim has been to imagine possible answers to the question of what would Global Health become in light of alternative modes of care. In this effort, I have offered various threads, some weaved in and some still loose, on the implications of sanitary emancipation, alienation and wellbeing departing from what I have been encountering in the field.

Medical humanities, as an interdisciplinary area of inquiry, offers space for thinking of mental health in more creative and, as I hope to have demonstrated, also more radical ways. Here, I have incorporated the ethnographic disposition of paying attention and listening to how people theorise their own experiences, which, to paraphrase Annemarie Mol (2002), leads to the possibility of a "body multiple". In the case of mental distress, a situated multiplicity, or a turning of hegemonic universalism upside down. The psychoanalytic approach, attuned to excesses and unconscious processes, also grants signifiers an important position: it is a careful elaboration of how people's words make their worlds. In sharp contrast with a lot of scholarship in Global Health that works with more traditional Social Sciences methods, I bring psychoanalysis not just as the object but as lenses of enquiry. By that I mean that I have approached free clinics not after the "evidence-based" markers, rather from and as a form of listening that supports a form of enunciation, sustained by an encounter.

There is a lot to this transdisciplinary disposition, once planning systems of care is a task that escapes one-dimensional answers constantly, favouring complexity and, we could argue, a certain plasticity that responds to health as integral to the web of life (Breilh 2010). Such approach proves crucial when thinking and working with psychosocial and psychological forms of distress. The critiques of universal health systems from a Latin-American critical epidemiological perspective (that is also feminist and decolonial in its foundations) propose the social determination in health (*determinación social de la salud*) as an anchor of a Global South perspective on health and care systems. As such, a shift away from a biomedical approach that universalises and also surveils vertically—or one that aims at "eradicate", "eliminate", "monitor", "combat" diseases in populations and people" (Basile 2020, 4)—into an interdependent, integral universalisation of webs of health and care that de-commodify illness, suffering, distress and the therapeutic effort (Basile 2020).

In the field of psy, the riddle of "evidence-based" treatments dominates scientific, funding and public planning discourses (one of such examples is the important attempts to disprove the serotonin/chemical imbalance hypothesis of depression by researchers critical of Big Pharma, see Moncrieff et al. 2023). Meanwhile, if we take efforts of epistemological and clinical decolonising seriously, another way around it would be to address the very epidemiological grounds that sustain such clinical efforts understood as hegemonic and reproduced by Global Mental Health advocates; for instance, taking seriously the bioethical implications of such epidemiological frames when it comes to health, care, relationality and, chiefly, modes of being and living in their plurality. As autonomous collective initiatives that centre on the territory and produce a novel "*saber-hacer*" [know-how] beyond universalising truths or one-size-fits-all solutions to psychosocial and psychological distress, free psychoanalytic clinics, as my current and ongoing research demonstrates, also propose an alternative to the options of "reform" or "substitution" in public health systems, being a creative, hybrid movement of situated solutions to collective distress. In summary, there is a possibility of stretching our imagination towards action in the mental health landscape when learning with these forms of situated-care.

We go back to the clinic on the street: a table set outside, downtown, where the conditions for the possibilities of speaking and listening are invented, forged, sustained collectively. Listening is a form of care in which what does not have space is granted space. The technology is minimal, bureaucracy, money and quantification too. It is another vocabulary, another logic of care. In one person's suffering, instead of their individualised issues, we find patriarchal violence, internal xenophobia, class exploitation, urbanist prejudices, the organisation of time, family and food. Symptoms are pieces of the world.

To take seriously our gestures towards alternative forms of Global Mental Health care, thus, means that we treat each clinical encounter as having the potential of speaking for a piece of the world. In free clinics, as in decolonial practices of mental health care, the fundamental links between emancipation, alienation and collectivity are integrally weaved within a politics of wellbeing and strategies of care. When Denise Ferreira da Silva (2021; 2016) names implication as an antithesis or remedy for the catastrophic tunnel vision of the "Transparent I" of scientific discourse, praxes of dis-alienation via sanitary emancipation as seen in my fieldwork populate a new imagination of what care may look like when practised otherwise. In this effort, as I take with me from these encounters, there are attempts and a disposition towards listening to the world in the symptom, at the same time one is open to listening to the symptoms in and of the world.

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Data availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

Endnotes

[1] Didier Fassin's 2011 text is very critical of this approach and the work conducted in public hospitals to this day in France. If he was critical to Georges Devereux's initial work in ethnopsychiatry, which inaugurated the field in the twentieth century, he is even more critical to Tobie Nathan's anthropological assumptions that ground the practice he developed at the Centre Georges Deveraux in Paris for its cultural determinism in treating migrants. Indeed, Didier Fassin's text brings us a polemic clinical vignette in which aspects of spirituality, local cultural symbolisms and language are mixed into the interpretation of the group of clinicians specialising in treating migrants and or racialised patients in France. Fassin's overall criticism lays over the fact that migrants and or racialised patients are treated differently as if they would be necessarily bound to their "original" system of references in their symptomatic presentation. It is a nuanced case, since Fassin does not defend a "western" and hegemonic approach to some sort of scientific neutrality in the taxonomy of mental suffering, rather, he is critical of the colonial reverberations both in making migrants "same" and "different".

[2] You can access the Free Clinics Network on <https://freepsyproject.com/the-free-clinics-network-directory/>.

[3] For detailed context and statistics, see the Ministry of Health Virtual Health Library resources on <https://bvsms.saude.gov.br/20-anos-da-reforma-psiquiatrica-no-brasil-18-5-dia-nacional-da-luta-antimanicomial/> and <https://bvsms.saude.gov.br/bvs/publicacoes/Relatorio15_anos_Caracas.pdf >.

[4] The Brazilian CAPS model of community mental health care features in a somewhat recent report on Global Mental Health issued by the World Health Organization in June 2021 that is the result of an effort to promote person-centred and rights-based approaches in the heavily over-medicalised and still violent field of mental health care (WHO 2021). This model, albeit precarious in reality, is anchored in co-production, active participation of service users in all decision-making, the right to choose and negotiate a treatment alongside a multidisciplinary team and a strong local community support system of networks of care.

[5] The anthropologist Renato Rosaldo has been credited for first using this term in a conference presentation on ethnographic methods. However, the precise authorship is nebulous, around Rosaldo, as well as Clifford and Geertz and their works: James Clifford, Anthropology and/as Travel. Etnofoor 9, no. 2 (1996): 5–15; and Clifford Geertz, Deep Hanging Out. *The New York Review of Books* 45, no. 16 (1998): 69–72.

[6] The list of collectives and autonomous clinics is vast, but it is worth citing at least a few such as the Psychosis Therapy Project, in London; the Greene Clinic in New York; Colectivo Trenza in Santiago, Chile; and Colectiva Silvia Bleichmar, in Buenos Aires, Argentina. Collectives are, as this article will go on to articulate, a realm of epistemological intervention in the field of psychoanalysis.

[7] The "Territórios Clínicos" project was funded by Fundação Tide Setúbal, a philanthropic foundation linked to Banco Itaú, one of Latin America's largest banks. The digital map is available at https://fundacaotidesetubal.org.br/territoriosclinicos-mapeamento/.

[8] SUS is the Sistema Único de Saúde, Brazil's public healthcare system, in some ways similar to the British National Health Service, for examples.

9 The interactive map of psychoanalytic clinics can be accessed at https://www.google.com/maps/d/u/0/viewer?mid=1R2hvKr8Lh5GMd1VIUl5pvU4jzzo9Nm4&hl=en_US&ll=-17.369553726240834%2C-46.5964762&z=5.

[10] You can access Clínicas de Borda information on <https://www.instagram.com/clinicasdeborda/>.

[11] As mentioned previously, you can access the Free Clinics Network on <https://freepsyproject.com/the-free-clinics-networkdirectory/>.

[12] It is not too bold to say that there is a transnational interest in community psychoanalysis permeating the field in the recent years and one can access a special issue of the British journal Psychoanalysis and History on the subject named "Psychoanalysis for The People: Free Clinics and the Social Mission of Psychoanalysis"

(Volume 24, Issue 3, December 2022) or the North American Division 39's journal Division Review Volume 28, from 2022 with a large section on commentaries on community psychoanalysis initiatives.

[13] It is worth mentioning the digital component of several clinics too, which, even after the COVID-19 pandemic, carried on offering online sessions, which expand access to spaces of listening outside central urban areas.

[14] The Brazilian Centres for Psychosocial Care (CAPS) are a unique public health dispositifs that replaced the previous asylumbased care with community-integrated treatment long term and emergency treatment. Its core strength, besides being completely free of charge, is the radical interdisciplinarity that compose each centre. CAPS may be managed and ran by teams of psychiatrists, social workers, therapeutic companions (Ats), psychologists, artists (*oficineiros*), psychoanalysts and nurses. Several psychology students start their clinical work as interns in CAPS and experience, first hand, a psychoanalytic practice outside orthodox frames.

[15] Saúde Coletiva, of Collective Health, is a particularly Brazilian strand of Public Health thought, it emerged from Brazil's sanitary reform movement, emphasizing social determinants over biomedical models.

[16] The therapeutic group at the culture and arts centre, JAMAC, in the South periphery of São Paulo can be found here: https://www.instagram.com/p/DBRJP9XuRU_/?igsh=MWl6MDI4dnAxd2xxeg%3D%3D.

[17] Our colleague Emilia Broide coined the term "sujeito-suposto-suspeito" or "subject-supposed-suspicious", playing with the Lacanian phrase "subject-supposed-to-know" to address some of the complexities of the relations of transference in the Global South. You can read this in more detail in Broide (2022).

[18] Something about the unregulated position of psychoanalytic listening also permits a certain porosity here, in this collectivising of the praxis itself. Psychoanalytic practice is not regulated by law in most countries, rather, clinicians selforganise via professional associations' codes of ethics. In Brazil, particularly, differently from the UK, for instance, a majority of my interviewees were also clinical psychologists (a regulated profession virtually everywhere). However, with the boom of free clinics, many colleagues, from various backgrounds, including that of social work or political activism, are being formed as analysts within these collectives, as I observed in the field.

[19] See more at https://fundacaotidesetubal.org.br/editais-para-as-perif20erias/territorios-clinicos/territorios-clinicos-2023/.

[20] Fundação Tide Setúbal's wealth derives from Itaú's financial operations, which include predatory lending practices in urban peripheries. Notably, the bank's founder, Olavo Setúbal, was a right-wing politician appointed as mayor of São Paulo during Brazil's military dictatorship (1964–1985). His daughter, Neca Setúbal, previously directed the foundation, now commanded by her daughter Tide—a banking heiress turned psychoanalyst. There is an interesting podcast episode from 2024 named "Neca Setubal e a culpa de ser rica superada com terapia" [Neca Setubal got over the guilt of being rich in therapy]. You can listen to it fully here: https://open.spotify.com/episode/4yrK8zc8PZW4LFyaOHbGuq.

[21] On 20 January 2025, Donald Trump announced the US withdrawal from the World Health Organization (WHO) during his inauguration, citing its handling of COVID-19 and China's alleged evasion of accountability. That same week, China declared it would expand its WHO participation, positioning itself as a leader in global health governance—a stark contrast to the US retreat. Argentina's far-right president Javier Milei soon followed Trump's example, exiting the WHO in early 2025 as part of his anti-globalist agenda. While this piece scrutinises the WHO's medicalised, top-down approaches to health crises, it does not reject international cooperation outright. Rather, it critiques the coloniality embedded in global health hierarchies—an ethical disease often masked by neo-nationalist theatrics like these withdrawals. See more at https://www.reuters.com/business/healthcare-pharmaceuticals/china-give-500-million-who-next-5-years-official-says-2025-05-20/; https://www.bbc.co.uk/news/articles/c8975qp1n4qo.

[22] See the full The Lancet report on <https://www.thelancet.com/series/global-mental-health>.

[23] See the full WHO report on <https://www.who.int/news-room/fact-sheets/detail/mental-disorders>.

[24] Stephanie Hsu (2019) has offered a detailed reading of a possible Fanonian critique towards trans-affirmative care in this journal. This is a valuable exercise at the same time that a feminist critique of Fanon is still a relevant project.

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