
MULTIPLE COMPLAINTS USERS: SOCIAL REPRESENTATIONS BUILT BY THE PRIMARY HEALTH CARE DOCTORS¹

Renata Goltara Liboni Vescovi²

Universidade Federal do Espírito Santo, Vitória-ES, Brasil

Luiz Gustavo Silva Souza

Universidade Federal Fluminense, Campos dos Goytacazes-RJ, Brasil, e

Universidade Federal do Espírito Santo, Vitória-ES, Brasil

Luziane Zacché Avellar

Universidade Federal do Espírito Santo, Vitória-ES, Brasil

ABSTRACT. The phenomenon of the vague and diffuse symptoms (VDS) relates to nonspecific pain without clear organic cause. It is important to take into account these symptoms for the context of the Primary Health Care (PHC), once they are very prevalent in PHC users in many countries. The research reported here aimed at understanding the social representations constructed by the PHC doctors about the vague and diffuse symptoms. We conducted semi structured interviews including a vignette case with five doctors of the Family Health Center (FHC). We analyzed the data through the thematic content analysis. The interviews revealed aspects of the representational field related to the VDS users that included ideas and images associated with other communication objects at the FHC: the boring patient, the sick person and the lower social class population. The doctors mentioned the idea and the image of a multi problematic patient who attended to the FHC without real need, as objectification elements. The analysis highlighted the hegemony of the traditional clinical practice, based on centered-doctors rather than in centered-patient interactions. It is suggested the revision of normative relations between health workers and the VDS users which must be transformed including the later as active managers of their treatment.

Keywords: Somatization; social representation; clinic practice.

USUÁRIOS POLIQUEIXOSOS: REPRESENTAÇÕES SOCIAIS CONSTRUÍDAS POR MÉDICOS DA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO. O fenômeno dos sintomas vagos e difusos (SVD) diz respeito a dores inespecíficas que não encontram associação direta com causa orgânica. Destaca-se a relevância da consideração desses sintomas para o contexto da atenção primária à saúde (APS), uma vez que as queixas com tais características aparecem em grande número como demanda de usuários ao chegarem para o atendimento nesse contexto, em muitos países. A pesquisa desenvolvida teve o objetivo de compreender representações sociais construídas por médicos da APS sobre o fenômeno dos sintomas vagos e difusos. Foram realizadas entrevistas semiestruturadas com uma vinheta, das quais participaram os cinco médicos atuantes na unidade de saúde da família pesquisada. Os dados obtidos foram tratados a partir de análise de conteúdo temática. As entrevistas revelaram aspectos do campo representacional relacionado aos usuários SVD, que incluíram ideias e imagens associadas a outros objetos de comunicação na USF: usuário chato, pessoa doente e população de classe social menos abastada. Destacaram-se como elementos de objetivação figuras construídas sobre usuários SVD relativas à ideia de que esses usuários frequentavam o serviço como poliqueixosos, sem precisarem dele. Destacou-se a hegemonia da clínica tradicional calcada em relações mais médico-centradas do que usuário-centradas. Sugere-se a revisão de

¹ *Support:* Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES).

² *E-mail:* renatagliboni@hotmail.com

relações normativas entre trabalhadores de saúde e usuários SVD e de abertura para a cogestão destes na decisão sobre a condução de seu tratamento.

Palavras-chave: somatização; representação social; prática clínica.

USUARIOS POLISINTOMÁTICOS: REPRESENTACIONES SOCIALES CONSTRUIDAS POR MÉDICOS DE ATENCIÓN PRIMARIA A LA SALUD

RESUMEN. El fenómeno de los síntomas vagos y difusos (SVD) está relacionado a los dolores inespecíficos que no tienen ninguna asociación directa con causa orgánica. Se destaca la importancia en considerar estos síntomas en el contexto de la Atención Primaria a la Salud (APS), una vez que las quejas con tales características surgen, en muchos países, en gran número como demanda de usuarios al llegar para la atención en este contexto. La encuesta desarrollada tuvo el objetivo de comprender las representaciones sociales construidas por médicos de APS sobre el fenómeno de los síntomas vagos y difusos. Se realizaron entrevistas semiestructuradas con una viñeta, de las que participaron los cinco médicos que actúan en la Unidad de Salud de la Familia (USF) investigada. Los datos obtenidos fueron tratados a partir del análisis de contenido temático. Las entrevistas revelaron aspectos en el campo de la representación relacionada a los usuarios SVD que incluyó ideas e imágenes asociadas a otros objetos de comunicación en la USF: usuario aburrido, persona enferma y población de clase social más baja. Se destacaron como elementos de objetivación figuras construidas sobre usuarios SVD relacionadas con la idea de que esos usuarios frecuentaban el servicio como polisintomáticos sin tener necesidad del mismo. Se destacó la hegemonía de la clínica tradicional enfocada más en las relaciones médico-centradas que en usuario-centradas. Se sugiere la revisión de las relaciones normativas entre trabajadores de la salud y usuarios SVD y abrir la posibilidad de una gestión compartida entre ellos en la decisión sobre la conducción de su tratamiento.

Palabras clave: Somatización; representación social; práctica clínica.

Phenomena such as health and disease are in the biomedical paradigm as settings that support the health professionals in their practices, theories that claim as truth and as higher than the knowledge of the common sense. How this paradigm, which overlaps the others, explains phenomena that escape from their fields, such as pain without injury or without correspondence with an organic dysfunction? How these phenomena are understood in the public health context? An example of phenomenon that fits in such specifications is the vague and diffuse symptoms.

Silveira (2000) analyzes the vague and diffuse symptoms on the nerve phenomenon perspective, rescuing a term popularly used for such manifestations. Other authors (Lazzaro & Ávila, 2004; Fonseca, Guimarães, & Vasconcelos, 2008; Maragno, Goldbaum, Gianini, Novaes, & César, 2006) used names proposed in diagnostic manuals as Common Mental Disorders, Somatization, Somatoform Disorders, or even in other categories that are correlated with the former as neurovegetative dystonia, conversion, hypochondria and psychosomatic.

The symptoms referred to these different names concern the diffuse pains that are not directly associated with organic cause. Complaints, such as headaches, abdominal pain, body aches, insomnia, among others, appear in large number as users demand for the health care (Lazzaro & Ávila, 2004). The diagnosis is not often established accurately, which directly influences the therapeutic approaches often misleading and limited to psychotropic prescriptions, requests for unnecessary laboratory tests, hospitalizations and even surgical interventions (Guedes, Nogueira, & Camargo Jr., 2008).

Too often, as they are characterized as refractory tables to the medical therapy and to the palliative measures undertaken, the trend is the intensification of the abandon condition of these people by the professionals and the impression that they over use the medical services (Bombana, 2006). To those whom show such symptoms it is an enterprise towards the legitimacy of them (Zorzaneli, 2011). At the PHC in many countries, the prevalence of somatization (physical symptoms without organic cause) can reach large percentage, ranging from 16% to 52% of the care provided. Researches (Fonseca et al., 2008; Maragno et al., 2006) point to the substantial occurrence of users with the so-called Common Mental Disorders whose manifestations are related to the vague and diffuse symptoms in PHC queries.

The nonspecific somatic symptoms are more frequent in the female population, who are low income and education, housewives or those who show difficulties in the work activities outside home (Strengths, Villano, & Lopes, 2008; Tófoli, Andrade, & Fortes, 2011). To those whom usually seek a Health Unit, the main service of the Brazilian PHC, which is one of the entry door to the Sistema Único de Saúde (SUS) - Unified Health System, in order to minimize their pain, which are manifested by vague and diffuse symptoms they are labeled as multiple complaints or pithiatic users (Fonseca et al., 2008). This multiple complaints users "label" falls more often on females, an aspect that meets the indicated prevalence studies (Machin et al, 2011). Guedes (2007) states that the established causality relationship between cause-injury, which guides the conduct linked to the biomedicine, is broken before the somatic suffering. Other resources must be developed in an attempt to deal more effectively with such cases.

Based on the psychosocial conception, we recommend the adoption of a psychotherapeutic attitude and the staff involvement both in the social life and in the user interface (Saraceno, Asioli, & Tognoni, 2001). The meeting between the health professionals and the users who constitutes the territory of the so-called "soft technologies" makes up this orientation (Franco, Bueno, & Merhy, 2003, p. 38), as it involves relations technologies opposed to a "centered-procedure" (Franco & Merhy, 2003, p. 71), based on procedures and laboratory tests.

If there was not the opening process from the medical knowledge to other knowledge, the professional takes the risk of exerting a ritualized practice for recurrence and little resolute (Fernandes, 1993). The need to consider the subject and his context beyond the illness is pointed out. As a result, it is going to pave the way for the construction of medical devices exceeding the standardized technical procedures which constitutes a resistance expression to the hegemony of the biomedical paradigm, such as the Extended Clinic (Campos, 2003, 2011). The effect of asymmetrical power relations often is to delete the user, removing his voice on his own suffering, situation that leads him not to feel welcomed and that reaffirms his place of knowledge devoid (Sampaio, 2010).

The biomedical and the psychosocial paradigms (Costa-Rosa, 2012) are sets of pregnant ideas in the context of the public health, but they are far from exhausting the social cognitive tangle featuring the daily life of the field. The analysis of the common sense theories built by the PHC doctors about the vague and diffuse symptoms should lead to a broader understanding of the user stigmatization conditions with this type of symptom.

The consultations are the emergence place of these common sense elements that permeate the management of the VDS cases by the PHC doctor. In this space in which it develops a relationship between the doctor and the user regarded as complex interpersonal dynamics, there is a meeting of different cultures, different social groups, which requires the contribution of other areas of knowledge for its discussion, such as the Social Psychology. The analysis of these psychosocial processes can be made from the perspective of the Social Representations Theory, developed by Moscovici (1961/2012).

The social representations are a set of theories and explanations on the reality around us, forming the common sense knowledge. The common sense is produced in the consensual universe understood as thought and practice systems, formed through the appropriation of the reified universe (universe of the official knowledge, the scientific one), along with other elements, other rationalities and theories which serve to the management of the everyday life that promotes the elaboration of the social realities and the phenomena interpretation (Moscovici, 2003).

The social reality is built in the relationship of reciprocal influence between individual and environment (Sá, 1993). The social representations are historically rooted and allow making the strange, the unusual, something familiar and viable as well as they guide and justify behaviors, the practices (Moscovici, 2003). The representations operate in everyday life through cognitive and social processes: the objectification and the anchoring. The objectification means a simplification, organization and generalization process that naturalizes ideas and images in order to build a tangible picture of an abstract and odd phenomenon. On the other hand, the anchoring is the search for elements, in an existing semantic field, which may support the new object to be classified and resubmitted (Moscovici, 1961/2012).

The research reported here aimed at understanding the social representations built by doctors from the Family Health Unit about users who express vague and diffuse symptoms (VDS). The relevance of

the theoretical framework is the fact that most works found on users with vague and diffuse symptoms (hereinafter, VDS users) in the PHC context refer to prevalence researches. One of the studies that support this claim is by Souza, Menandro, Couto, Schimith, & Lima (2012), who in developing a review of the Brazilian literature on Mental Health in the Family Health; they find no production focused in the social representations of doctors regarding the VDS users. This fact increases the interest to undertake an investigation of this object based on the psychosocial focus.

Method

Participants

The survey was conducted in a Family Health Unit (FHU) located in Vitória-ES/Brazil, with five family health doctors, who attended users with vague and diffuse symptoms manifestations. We interviewed all those who were on duty respecting their availability and the functioning of their service. The profile of the participating doctors was relatively homogeneous by not vary in the social category aspect. All belonged to the upper middle class, taking into account the income criteria above 11 minimum wages and housing neighborhood. Four were female and only one male. Regarding aging they were among 32 and 50 years old. The length of professional experience ranged from 8 to 24 years. Two of them worked in the unit for a considerable time (nine and 13 years) and the others have been in the service for about three years.

Instruments and data collection procedures

Individual semi-structured interviews with the five doctors in local and agreed time before were performed. Each one lasted approximately 45 minutes. The script issues focused the following aspects: the doctor-patient relationship in general and doctor-VDS user; perceptions about boring users; representations of users in general and the VDS user; practices with regard to the VDS user; explanations built on the behavior and on the symptoms presented by the VDS user. The script contained a case vignette that described the case of a woman, possible VDS user. The focus of the interviews and of this article on the VDS users is justified by the prevalence of the aforementioned studies, which indicate a higher incidence of VDS in women. The interviews were recorded and transcribed for analysis. The entries were voluntary and authorized by signing the Free and Informed Term of Consent, according to the Resolution 466/12 of the Conselho Nacional de Saúde (National Health Council), with the guarantee of anonymity. To that end, fictitious names were adopted to the professionals: Amanda (40 years old, 13 years at the FHC), Bruna (32 years old, 8 years at the FHC), Clemir (39 years old, 10 years at the FHC), Daniela (50 years old, 11 years at the FHC) and Elvira (49 years old, 12 years at the FHC). Any references that could link them directly to the study place have been hidden.

Analysis procedure data

The interviews were subjected to the thematic content analysis proposed by Bardin (1977/2011). The procedure was established by exhaustive reading of the reports to the identification of the meaning units (Themes) built by the professionals about the investigated phenomenon. The themes were grouped into the following categories, built *a priori*: Perceptions about the boring users and the VDS users; perceptions about the behavior of the VDS users; practices that the professionals intended to the VDS users.

Results and Discussion

Were the boring users and the VDS users perceived similarly by the professionals?

Regarding the users who were considered boring by the professionals and the VDS users, the following topics were identified: the boring users were tiring, uncompromising, difficult to handle and negligent as to health care; the VDS users were tiring, boring, intransigent and insistent; the VDS users behaved in an unwanted way into the doctor's office; the VDS users were always in the Unit; the VDS user group was objectified as multiple complainer, "*My health clinic, my life*", "*little guava*", "*Unit chronics*", "*Unit member*" (These terms will be explained below); the doctors found themselves facing a limitation when they met the VDS users.

When reporting the characteristics of the users considered boring, the professionals said: "*These are people who want everything at that hour. These are people who got me tired. They want to order everything at their time, you know?*" (Amanda, 40). Or, they also reported: "*He says what he wants, he is uncompromising, and then he is the patient who is difficult to deal with The person is closed and there happens to be boring because you're proposing something; so, nothing works*" (Bruna, 32).

It is observed that, in the perception of the professionals, the boring users were tiring when they did not follow the medical guidelines; intransigent, for seeking the doctor with a specific goal and not accept the assistance and the set out diagnoses; difficult to deal with as they resisted to accept what the doctor said and still insisted in a particular symptom and they were also negligent in the health care. This insistence on a particular symptom was understood as stiffness and could lead to confrontations with the doctor.

The VDS users, in turn, "*appeared too much*" in the Unit. This statement referred to the case vignette that described a prototypical VDS user; from this feature the professionals' perceptions about the phenomenon were issued. Amanda (40), said: "*They appear. Too much. Especially in demand [Without scheduling], you know*", while Elvira (49) agreed to say "*It is exactly the user profile who demand the unit as you asked first.*"

In describing this type of user, doctor Amanda (40) said: "*That's the tiresome*". Doctor Clemir (39) stated: "*Yes, she is the 'boring', she is the 'boring' that is always here.*" Daniela (50 years) said: "*Well, they are patients ... they are Unit chronics.*" To arise the terms such as the aforementioned, it can be inferred that the VDS users gather attributes similar to those of the users considered boring. The VDS users were tiring, boring, intransigent and insistent. They manifested intransigence when resisting to the medical recommendations. They refused taking the drug, using the justification that it did not suit them. They were also identified as those who behaved in an unwanted way into the doctor's office, demanding that the doctor did everything for them at the time they find it convenient. About this group of users, Clemir (39) said: "*They want that the doctor does everything for them, does everything for them, at the moment they want. This is boring for me.*"

The VDS users were always in the Unit and their attendance to the service, linked to the way they manifested their complaints, it also corroborated to strengthen the designation above (boring). According to the professionals, it happened to the VDS user move through the spaces of the Unit without complaining of a problem of biological order: "*There are often people here who come to sit in front, sometimes to sing*" (Bruna, 32). Such behavior provoked ironic comments from the professionals: "*They come to the shopping, you see. Regardless of rain or any time. It's like the only thing they have to do*", reported Amanda (40).

The two boring and tedious descriptions can ally with the other which are very emphatic in the doctors speeches, related to the fact that the VDS users are often in the Unity. The VDS user group was objectified as multiple complainer, "*My health clinic, my life*", "*and little guava*", "*Unit chronics*", "*Unit member*". The utterances followed accordingly. Amanda (40) said: "*There is even a patient from the area of [Name of a community health agent] that is so 'multiple complainer'*". The professional Bruna (32) stated: "*Some people are 'little guava' in everything!*". Then, Daniela (50) said: "*Well, they are...well... Unit chronics, you know.... Don't we have that social program 'My home, my life' to the*

lower classes? Well, I say: - "My health clinic, my life". While the professional Elvira (49) reported: "They generally become Unit 'member'. [Laughs]."

We can observe that the professionals use terms and images from the common sense to object (Moscovici, 1961/2012) the VDS users, such as "*little guava*". For the professional, it concerns a Brazilian popular phrase attributed to that person who always has problem, such as a guava he often presents worms (larvae). The term multiple complaints presents a peculiarity, although it is considered a pejorative one in the literature of the area (Fonseca et al., 2008), It is fairly shared among the group of doctors, like a technical term to describe the somatic suffering.

The verbalization "*My health clinic, my life*" is a kind of burlesque association with the housing program of the Brazilian Federal Government entitled "Minha Casa, Minha Vida" – My home, my life - whose focus is to serve the poor. It is assumed that to object the VDS users as those who make the Unity their reason for living is to locate them in the representational field (Moscovici, 1961/2012) which is produced about users from the popular class, in this sense there was a generalization. That is because they, as well as all other users, belong to the category of the low income, which are considered needy and external assistance dependent for obtaining something substantial in life. Such ideas reinforce the image that they are the people who take account of the system in order to take advantage unduly, having no initiative and settling down themselves to their condition. The VDS users anchoring is evidenced (Moscovici, 1961/2012) in the given images to people of popular class.

The doctors sought the definition of a phenomenon that crossed their daily practice as professionals in common sense images (Moscovici, 2003). This may indicate that they could not find enough grounding in the scientific universe, consisting of elements of his education, discursive resources for delegation of meaning about a phenomenon still difficult to understand - vague and diffuse symptoms.

This idea was reinforced by the Theme of the doctors when facing a limitation at the moment they met VDS users. As the VDS user do not enable the construction of a diagnosis, that is, he keeps the doctor in the insecurity of not knowing, led him to contact a limitation. Elvira (49) stated: "*The 'multiple complainer' is so much complicated, you know? It's a never-ending process.*" It could be suggested that the presence of this type of user caused discomfort and shook the professionals' references for the exercise of the medical clinic. Fernandes (1993) and Zorzanelli (2011) argue that doctors are issuing a negative look to this service because they feel unable to cope with the various complaints, since many of them cannot be solved from the theoretical and technical instruments which they take hold in their daily practice.

Before the VDS user, it was up to the doctor to redefine his practices and to access various resources to deal with the situation. As seen, the resonance for this was not present in his formation contents; so, other references on the doctor's personal experience were recruited in the process. This search may be the explanation for the use of many terms of the consensual universe (Moscovici, 2003) for the definition of such users.

Explanations developed by the doctors on the VDS patients' behavior

The explanations adopted by the professional when referring to behaviors presented by the VDS users could be organized according to the following themes: The vocal complaints was perceived as different from the real problem; Presence of psychological disorders; Emotional source demanding; Relational source demanding; The presence of negative emotions such as boredom and restlessness and doubt as to the veracity of the reported symptoms.

The professionals perceived the VDS user problem as something that was not immediately clear. It seemed that the manifested complaints were different from the real problem: "*Related to the 'multiple complainer', we already know he has something behind what he's not talking about We cannot see what is really the right problem, you know?*". Amanda (40) states. Another doctor issues her perception indicating not having yet formulated a specific name: "*There's something there behind, there is stuff*", concluded Bruna (32). The demanding showed by the VDS user was considered difficult to grasp. It was as if he were to hide what really bothered him. In saying that the real source of showed symptoms

is hidden, there is ratification on as that user is an element who is difficult to grasp for the professionals.

As a way of anchoring (Moscovici, 1961/2012), many of the doctors used scientific concepts that facilitated a user rating. In many speeches the presence of psychological disorders was considered. Here are some reports: "*She's somatizing a problem she has and could not explain, she could not talk about it*", reported Daniela (50); and "*They will somatize everything, you know?... The person feels insomnia, gets a headache which can lead to insomnia, then leads to depression, the person becomes moody, it can give pain in the body you know?*", Elvira stated (49).

It is seen that either the term somatization was used to assign an effect whose cause provoked doubt, in this case with apparent oscillation between an organic and psychic origin, or to designate a relative process to a psychological and relational source. As studies (Guedes et al., 2008), the medical professional, when faced with patients with diffuse somatic manifestations, tends to frame them in a psychological context of demand.

When the assumption came up that these users might have a disorder of psychological origin, the corresponding utterances were as follows: "*It gives the impression that she has some other disorder that needed some attention*" (Bruna, 32); "*Not only from an organic disease but from the very same psyche. I think there is a disorder, something that does not let her live well due to all of this*" (Clemir, 39); "*In fact they are in need of a more psychological support, you know?*" (Elvira, 49).

It is highlighted the evocation of several elements that were mingled in an attempt to explain the phenomenon. The doctor could draw different explanations for behaviors in the same discursive construction as: the presence of psychological disorder (refers to the psychogenesis), issues of organic order as symptoms triggers (refers to an organic etiology) and insertion in an unfavorable social context (association with the social context). Assign a cause to a phenomenon where subjective aspects (symptoms reporting) predominate on the goals (illness signs) results in some uncertainty. Relating the phenomenon to disorder, that is, to something that appears out of a pattern, and the disorder, characterizes the attempt to frame it to a nosography recognized by the medical rationality, facts upon which the medical practice was anchored (Moscovici, 1961 / 2012). Thus, the object can be considered treatment focus to the traditional molds, read up appropriate medication to the dysfunction, lab tests and directive guidelines.

Other ways to understand the phenomenon were also raised. The consideration of the demand for these users as an emotional factor was very relevant. The emotional aspect, difficult to measure and to detect, appeared either as cause or as effect of a demand for relational source. See the following reports: "*We often see ... family conflicts due to lack of conversation, lack of family structure*" (Clemir, 39); "*I imagine she is a patient who has many problems at home*" (Daniela, 50).

The VDS users were seen as those who experienced conflicts with family and experienced violence in their daily lives. For these reasons, they had the diffuse symptoms. Although the origin of the symptoms such as emotional order had emerged in the reports, the explanation for the behavior was related to problems experienced by the users in their context. The approach to the problem from the context of life is closer to the psychosocial model (Costa-Rosa, 2012). The users were described as persons within the environment surrounding them and, therefore, they were influenced by the multiple relations that were established in it.

Although the doctors share, to a large extent, the symptoms explanation and the origin that lead the VDS users to the status of users to be served like any other, the discourse about them carried ambiguities and a gap. Gaps which may be responsible for launching them in the marginal dimension where one "*do not need medical attention.*" This is when the theme "Doubt as to the veracity of the reported symptoms" is analyzed.

The professionals made it clear that the VDS users elaborated strategies to entry into their offices. Among these strategies, would be the invention or symptoms simulation. According to them, when the VDS users sought appointment service without prior, the mention of complaints were frequent and "*the complaints were not according to what comes here because she invents there to get into here*" Amanda (40) said. Others still questioned the diversity of the manifest symptoms: "*And we think that people cannot have everything*", Bruna (32) stated.

The emotional and relational issues raised as an explanation for the symptoms could be taken as illegitimate. In the study by Guedes (2007), the doctors in contact with somatic suffering suggested with emphases that the manifest symptoms should not be considered, since they were not "serious" or "true". With these utterances, the author concludes, the doctors further delimit the scope of their activities. The suffering from users is then destined to a marginal extent, taken as excuses, as a device to escape from the problems or even as exaggeration (Zorzanelli, 2011). If so, what credit to assign to their suffering? Although the professionals seem to realize the need that users had on welcoming and care, no real importance was attributed to their wide state of malaise.

What did the professionals say on the practices which were intended to the VDS users?

When speaking of welcoming and care, you enter in the intricacies of the social practices. You need to understand that they were got by reporting, product of a cognitive commitment which suffers context interference, from the interlocutor, from the politically correct discourse, among others. Anyway, words and contradictions can help in the apprehension of what the professionals thought on the practices which were intended to the VDS users. In their relationship, the doctors said that: They invested in the bond formation; They adopted technical investigation procedures; They advance in the research of the users experiential aspects; They adopted attitudes such as listening and welcoming and they prescribed psychiatric drugs.

By considering the VDS users hard to deal with, especially on a first visit, they said that the strategy used in order to understand the reported problem was the investment in the bond formation. It was a relationship built over the time between doctor and user that should define the presence of the medical intervention: "*With the creation of the bond, they end up at some point, reaching the main very complaints*" (Amanda, 40). It seems that the bond was intended to make the VDS users to talk about the real cause of their search for the service. Having this goal, the link is not as an implication of the doctor with the assisted person, but with the idea that the latter intentionally omitted the cause of his discomfort.

They also mentioned that they adopted technical and scientific investigation procedures translated by identifying the symptoms and attempt to unravel them and to group them in forming a diagnosis. Amanda (40) said: "*We try to solve the complaints by parts*". In this investigation of each symptom, the professional prescribed various lab examinations. They favored, in this case, the "centered-procedure" (Franco & Merhy, 2003, p. 71) relating to the tools apparatus for testing used to reveal an organic dysfunction. It seemed to be the corresponding role and expected from a member of that profession.

Daniela (50) highlighted the main foundations of the medical practice in the identification of the problems relating to the VDS users, approaching herself to the reified universe, as a set of concepts themselves to the scientific knowledge (Moscovici, 2003). According to her: "*The diagnosis in the conversation, in the anamnesis, you do at that time. Because we examine, we make the clinical examination*". She also stressed the power of the clinical practice when she used the additional resource, the dialogue, with the assisted person, i.e., a characteristic humanized interview of a shared practice in which the user has the possibility to manage together with the doctor the diagnosis, the intervention and the treatment options (Campos, 2011).

The doctors stated the importance of the research on the experiential aspects of the users. Elvira (49) set out: "*You'll see that person's life, you know ... you do not see a brain stopped in front of you, a breast..., you're seeing the patient as a whole and his family.*"

The participants noted the importance of knowing the family and the life situation of the users in order to get more information about what could influence the onset of the symptoms presented. They indicated that they started the exploitation of the experiential aspects only after the scientific proof that the symptoms were not related to a disease. This means that the taken approach was more restricted, based on the procedure valuation (Franco & Merhy, 2003) and in a second stage, they started listening to the user in order to relate the symptoms to the context elements.

This last idea points to the fact that the doctor safety would take him to favor tangible proof of the presence of a disease at the expense of possible aspects that emerge in the encounter with the person

assisted. The adoption of the psychosocial model in conducting the consultations could aid the doctor in the conclusions made about the health of the assisted person and in the performance of a more resolute clinic, as the Extended Clinic, as proposed by Campos (2003).

By following this approach, some professionals said adopting attitudes such as listening and the welcoming during the sessions: "*This person deserves to be heard, be nurtured, and be reassured*" (Elvira, 49); "*I appreciate too much the part that is not strategically drug She will speak and she will feel better*" (Daniela, 50). However, as some conceived the VDS phenomenon as the result of a psychological or emotional disorder, such practices were associated with the prescription of psychotropic drugs: "*I first talk enough listen to the patient enough of all forms and I try, if appropriate, to prescribe a drug. An antidepressant, as the anxiety arises because of depression, you know.*" (Clemir, 39).

Still on the prescription of psychotropic drugs, as we observed with the analysis of the reports on practices designed to the VDS users, the doctors barely mentioned the medication. They pointed out that the approach came back to the prescription of lab examinations, to the care, to the reception and to the listening. However, when specifically asked about the medication use other elements surfaced. For the doctors the medication was effective in part.

The participants stated to resort to medications, whether in the form of symptomatic or psychotropic drugs, in order to placate directly or indirectly the symptoms. According to the reports: "*I already forward both to the care or to the psychologist along with the homeopathy, then if he got a good return from sleeplessness or the anxiety, I started to prescribe the very Promethazine and Amitriptyline if it is the case*" (Amanda, 40); "*I like the anxiolytic, according to the person it is not a mental disorder, it is an anxiety*" (Bruna, 32); "*I start with Fluoxetine and Citalopran*" (Clemir, 39); "*Sometimes I prescribe a symptomatic*" (Elvira, 49). They agreed that the medication was effective in part for helping in the treatment, saying: "*Not alone. Because as we have seen that the emotional part weighs heavily in every sense*" (Amanda, 40); "*In more extreme cases like this, it solves. Now to sleep, Promethazine, and others not fully solve this problem.*" (Clemir, 39).

It was necessary that other features were added to the drug prescription to obtain a good result. It is pointed out that there are two positions regarding the medication effectiveness. One that approaches to the highlight of symptomatic therapy effectiveness, because its use is carried out in order to control or appease the manifestation of the user problem that is too uncomfortable or impeditive to him. The other relates to the curative therapy efficacy as it is believed that the drug potential in eliminating the causing agents of a problem and thus remedy it (Saraceno et al., 2001).

This second position raises two hypotheses: firstly, that the doctors attributed to themselves and their technology the power to solve almost everything, so only when there was persistence of the symptoms they referred to other professionals whose competence would be to identify a source of an installed specific disorder and treat it; and secondly, that the doctors put the focus to medication (for the referral) both to attempt a resoluteness in the primary care and not to overload the experts - including the psychologist. On the use of psychotropic drugs, Saraceno et al. (2001) teaches us as it is useful to consider on pharmacological interventions. It is important to assign them a place of auxiliary resource of limited action.

Final Thoughts

We observed a number of meanings shared by the professionals regarding as they conceived the VDS users and how they perceived the practices compiled for them. It was observed that the representational field (Moscovici, 1961/2012) related to the VDS users included ideas and images related to other big and salient objects at the FHC: boring users, sick person and lower social class population. It was noted that for doctors, the Unit was reaffirmed as a space in which the presence of this type of user persisted. The VDS users were reaffirmed as tiring, difficult and boring cases (objectification elements), so they could be identified by the figures (terms that bring objectification elements): "*My health clinic, my life*", "*little guava*", "*Unit chronics*", "*Unit member*".

From the time that the object nomination to be known occurs it is possible to attribute qualities and the expectations development relate to the expression of their behavior. When this process was triggered by the contact with the VDS users there was an evidence of them in relation to the other people who attended the Unit, and finally, they became the object of a shared agreement among the professionals. These results obtained, as Moscovici (2003), through the appointment of a not yet familiar object.

The practices stated by the professionals on the VDS users related to the different ways of dealing with them. However, it was observed that they showed no significant differences from those practices identified in the literature review: prescriptions and procedures privilege in the medical clinic. The usual pattern was the adoption of a biologist rationality that consisted of applying technical and scientific investigation procedures under the symptom-diagnosis logic.

Fonseca et al. (2008) located the difficulty of the professionals in dealing with this type of user in not understanding the codes used in the suffering expression in the absence of adequate capacity, on the fact that the services and the professionals have rooted a care model that focuses on addressing the immediate somatic complaints, the direction of the mental health policies for cases considered serious, as well as the absence of care and welcoming procedures for the VDS users. Many of these aspects in speeches were identified. By the listed reasons, to appropriate of the humanization concepts that define the practice of an Extended Clinic (Campos, 2003), is not always a guarantee of its presence in everyday life.

The issues raised during the exposition of the results of this study showed that the studied phenomenon - vague and diffuse symptoms - is perceived as an element which is difficult to be grasped and to be handled by the PHC professionals. The complaints brought by the VDS users were often related to a subjective dimension which tended to interfere in the formulation of the clinical picture by the professionals. The imprecision in the diagnostic delimitation led the professional to be insecure and to take hold in familiar conceptual systems for the biomedical paradigm.

Behaviors like the ones outlined led to the intensification of the state of abandonment of the VDS users, since they were not welcomed in their suffering. For not having a conventional behavior, normal to a sick user, they were labeled and stigmatized in the service that they were contacting. It is considered that this type of user requires closer therapeutic resources to those covered by the psychosocial paradigm, by extrapolating the objectivism of a paradigm that is still prevalent in the health field.

The public health services, although they are community-based and governed by the psychosocial paradigm, for different reasons, are shown not able to make such effective guidelines for the demanding population. Thus, the practice of the traditional clinic predominates, in which the welcoming, the listening and the encouraging to the users' autonomy are placed in the background. The VDS users are the ones who suffer more the effects from this operational structure because they are strongly driven to a subject of medicalization framework that does not facilitate the construction of ways to deal with their discomfort. They always return and, unfortunately, they will continue returning until they can direct someone their pain and, at the same time, they receive the care they need.

In conclusion, it is expected that this article has contributed to the debate and to the appreciation of this phenomenon as a research focus in the field of the social representations. It aimed to enable the questioning of the difficulty encountered by the professionals in dealing with this kind of people as well as to broad the understanding of the suffering associated with the vague and diffuse symptoms development to those that express them. It is possible because we identify the perceptions, the images and the conceptions of the health professionals on the somatic suffering. It is worth mentioning that the study has some limitations and if they are worked they can generate interesting developments on the subject and encourage the construction of more resolute forms of care in relation to the VDS users. It is suggested a survey along to the somatic sufferings to investigate which social representations they built on their sick, the medical care directed to them and investigations around the mapping on the difference of manifestations related to the gender.

References

- Bardin, L. (2011). *Análise de conteúdo*. Lisboa: Edições 70. (Original publicado em 1977).
- Bedrikow, R., & Campos, G. W. de S. (2011). Clínica: a arte de equilibrar a doença e o sujeito. *Revista da Associação Médica Brasileira*, 57(6), 610-613.
- Bombana, J. A. (2006). Sintomas somáticos inexplicados clinicamente: um campo impreciso entre a psiquiatria e a clínica médica. *Jornal Brasileiro de Psiquiatria*, 55(4), 308-312.
- Campos, G. W. S. (2003). *Saúde Paidéia*. São Paulo: Hucitec.
- Campos, G. W. S. (2011). A mediação entre conhecimento e práticas sociais: a racionalidade da tecnologia leve, da práxis e da arte. *Ciência & Saúde Coletiva*, 16(7), 3033-3040.
- Costa-Rosa, A. da (2012). A instituição de saúde mental como dispositivo social de produção de subjetividade. *Estudos de Psicologia*, 29(1), 115-126.
- Fonseca, M. L. G., Guimarães, M. B. L., & Vasconcelos, E. M. (2008). Sofrimento difuso e transtornos mentais comuns: uma revisão bibliográfica. *Revista APS*, 11(3), 285-294.
- Fortes, S., Villano, L. A. B., & Lopes, C. S. (2008). Nosological profile and prevalence of common mental disorders of patients seen at the Family Health Program (FHP) units in Petrópolis, Rio de Janeiro. *Revista Brasileira de Psiquiatria*, 30(1), 32-37.
- Franco, T. B., Bueno, W. S., & Merhy, E. E. (2003). O acolhimento e os processos de trabalho em saúde: o caso de Betim-MG. In E. E. Merhy, H. M. Magalhães, J. Rinoli, T. Franco, & W. S. Bueno (Orgs.). *O trabalho em saúde: olhando e experienciando o SUS no cotidiano* (pp. 37-54). São Paulo: Hucitec.
- Franco, T. B., & Merhy, E. E. (2003). Programa de Saúde da Família (PSF): contradições de um programa destinado à mudança do modelo technoassistencial. In E. E. Merhy, H. M. Magalhães, J. Rinoli, T. Franco, & W. S. Bueno (Orgs.). *O trabalho em saúde: olhando e experienciando o SUS no cotidiano* (pp. 54-124). São Paulo: Hucitec.
- Guedes, C. R. (2007). *A subjetividade como anomalia: estratégias médicas para lidar com os sintomas vagos e difusos em biomedicina* (Tese de doutorado em Saúde Coletiva não publicada). Universidade do Estado do Rio de Janeiro, Rio de Janeiro.
- Guedes, C. R., Nogueira, M. I., & Camargo Jr., K. R. de (2008). Os sintomas vagos e difusos em biomedicina: uma revisão da literatura. *Ciência & Saúde Coletiva*, 13(1), 135-144.
- Lazzaro, C. D. S., Ávila, L. A. (2004). Somatização na prática médica. *Arquivos de Ciências da Saúde*, 11(2), 2-5.
- Machin, R., Couto, M. T., Silva, G. S. N., Schraiber, L. B., Gomes, R., Figueiredo, W. dos S., Valença, O. A., & Pinheiro, T. F. (2011). Concepções de gênero, masculinidade e cuidados em saúde: estudo com profissionais de saúde da atenção primária. *Revista Ciência & Saúde Coletiva*, 16(11), 4503-4512.
- Maragno, L., Goldbaum, M., Gianini, R. J., Novaes, H. M. D., & César, C. L. G. (2006). Prevalência de transtornos mentais comuns em populações atendidas pelo Programa Saúde da Família (QUALIS) no município de São Paulo, Brasil. *Cadernos de Saúde Pública*, 22(8), 1639-1648.
- Moscovici, S. (2003). O fenômeno das representações sociais. In S. Moscovici, *Investigação em Psicologia Social*, (pp. 29-109). Petrópolis: Vozes.
- Moscovici, S. (2012). *A psicanálise, sua imagem e seu público*. Petrópolis: Vozes. (Original publicado em 1961).
- Resolução nº 466, de 12 de dezembro de 2012. (2012, 12 de dezembro). *Diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos*. Brasília, DF: Ministério da Saúde, Conselho Nacional de Saúde.
- Sá, C. P. de (1993). Representações sociais: o conceito e o estado atual da teoria. In M. J. Spink, *O conhecimento no cotidiano: as representações sociais na perspectiva da psicologia social*, (pp. 19-45). São Paulo: Brasiliense.
- Sampaio, A. C., (2010). *Qualidade dos prontuários médicos como reflexo das relações médico-usuário em cinco hospitais do Recife/PE*. Tese de doutorado em Saúde Pública, Centro de Pesquisas Aggeu Magalhães, Fundação Oswaldo Cruz, Recife.
- Saraceno, B., Asioli, F., & Tognoni, G. (2001). *Manual de saúde mental*. (3ª ed). São Paulo: Hucitec.
- Silveira, M. L. da (2000). *O nervo cala, o nervo fala: a linguagem da doença*. Rio de Janeiro: FIOCRUZ.
- Souza, L. G. S., Menandro, M. C. S., Couto, L. L. M., Schimith, P. B., & Lima, R. P. (2012). Saúde mental na Estratégia Saúde da Família: revisão da literatura brasileira. *Saúde e Sociedade*, 21(4), 1022-1034.
- Tófoli, L. F., Andrade, L. H., & Fortes, S. (2011). Somatização na América Latina: uma revisão sobre a classificação de transtornos somatoformes, síndromes funcionais e sintomas sem explicação médica. *Revista Brasileira de Psiquiatria*, 33(1), 59-69.
- Zorzanelli, R. T. (2011). Sobre os diagnósticos das doenças sem explicação médica. *Psicologia em Estudo*, 16(1), 25-31.

Received: Oct. 29, 2014
Approved: Mar. 16, 2015

Renata Goltara Liboni Vescovi: Sociologist; Master in Psychology by the Post-Graduate Program in Psychology at the Federal University of Espírito Santo, Brazil.

Luiz Gustavo Silva Souza: PhD in Psychology by the Federal University of Espírito Santo, with doctoral internship at the Université of Provence (France); associate professor in the Department of Psychology at the Federal Fluminense University, Campos de Goytacazes campus; assistant professor of the Post-Graduate Program in Psychology at the Federal University of Espírito Santo, Brazil.

Luziane Zacché Avellar: PhD in Clinical Psychology by the Catholic University of São Paulo; associate professor at the Federal University of Espírito Santo, Brazil.