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# FROM TRANSVERSALITY TO TRANSDISCIPLINARITY: CARE AND HEALTH WORK

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**ABSTRACT.** This article develops the notion of transversality and debates its importance for the formulation of an ethical and politically centered action for psychology and public health. In the first moment, we problematized the production of health between the individual and society, clinic and politics with the concept of transversality as a guide for the formulation of the care plan and the health work plan. This problematization aims to reconnect knowledge and experience by increasing the communication between the different actors in the social practices of assistance and care in opposition to the microfascisms of the daily lives of health institutions. Then, considering the inseparability of the production of subjectivities and the production of health inherent in any care action, we unfolded the aspects of lateralization, analysis, and management of conflicts and the inclusion of the collective necessary for the composition of heterogeneity in the National Humanization Policy of the Brazilian Unified Public Health System as a transversal policy based on the translation of health as a value of use. Finally, we proposed citizenship and the invention of life forms as founding values for care practices and services to characterize and explore the benefits of a transdisciplinary approach in the field of health work.

**Keywords**: Transversality; transdisciplinarity; health work.

# DA TRANSVERSALIDADE À TRANSDISCIPLINARIDADE: CUIDADO E TRABALHO EM SAÚDE

**RESUMO.** O presente artigo visa discutir o sentido da noção de transversalidade e sua importância para formulação de uma atuação ética e politicamente composta entre a psicologia e a saúde coletiva. No primeiro momento, problematizamos a produção de saúde entre indivíduo e sociedade, clínica e política com o conceito de transversalidade servindo de guia para a fundamentação do plano do cuidado e para o plano do trabalho em saúde. Tal entendimento parte da indissociabilidade entre conhecimento e experiência propiciando aumento da comunicação entre os diferentes atores das práticas sociais de assistência e cuidado em contraposição aos microfascismos que ruminam nas frestas do cotidiano das instituições de saúde. Em seguida, atrelamos a produção de subjetividades e à produção de saúde inerente ao cuidado para retomar aspectos da lateralização, da análise e gestão dos conflitos e da inclusão do coletivo para a composição da heterogeneidade na Política Nacional de Humanização do SUS como política transversal fundamentada na tradução da saúde como valor de uso. Com isso, trazemos como direcionamento para as práticas e serviços de cuidado a cidadania e a invenção de modos de vida a fim de caracterizar a potência de uma abordagem transdisciplinar para o campo do trabalho em saúde.

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**Palavras-chave:** Transversalidade; transdisciplinaridade; trabalho em saúde.

## DE LA TRANSVERSALIDAD A LA TRANSDISCIPLINARIEDAD: TRABAJO ASISTENCIAL Y SANITARIO

**RESUMEN.** Este artículo tiene como objetivo debater el sentido de la noción de transversalidad y su importancia para la formulación de una acción ética y política capaz de articular psicología y salud pública. Así, problematizamos la producción de salud entre el individuo y la sociedad, la clínica y la política con el concepto de transversalidad, que sirve como guía para la construcción del plan de cuidado y del plan de trabajo de salud. Con eso, proponemos una reconexión del conocimiento con la experiencia aumentando el grado de comunicación entre los diferentes actores de las prácticas sociales de asistencia y cuidado, abordaje que contrapone a los microfascismos del cotidiano de las instituciones de salud. Luego, indicamos la inseparabilidad entre la producción de subjetividades y la producción salud inherente a las prácticas de atención y cuidado para retomar los aspectos de lateralización, de análisis y gestión de conflictos y la da inclusión del colectivo para la composición de la heterogeneidad presentes en la Política Nacional de Humanización del Sistema Único de Salud brasileño como una política transversal basada en traducción de la salud como valor de uso. Finalmente, proponemos la ciudadanía y la invención de formas de vida como valores de conducción para las prácticas y servicios de atención y cuidado para explorar las potencias de un enfoque transdisciplinario en el campo del trabajo sanitario.

**Palabras clave:** Transversalidad; transdisciplinariedad; trabajo en la salud.

### Introduction

Modernity and democracy have been axes that operate a cross-section in psychology, the first since its genesis, the second from the problematization of the ways of constructing knowledge and the social practice of psychologists. From the intersection between psychology and history, psychological practice transforms into successive revolutions that occur amid events capable of destabilizing, generating crises, and ruptures so that, finally, something new emerges from the encounter between the two (Coimbra & Abreu, 2018).

Starting from this allocation of psychology as a social practice, this article addresses a diagonal section that complicates and poses challenges for psychology: the field of collective health. A section from which the theme of knowledge in modernity breaks down into the problem of complexity and that of democracy is expanded by being problematized at the level of micropolitical relations of care. With this, we start from a problem in psychology – that of the relationships between clinical and political, between individual and social – to the construction of health care, based on light technologies of relationship and transversal communication between different actors, levels, fields, and processes of care (Prado, Lima, & Xavier, 2019).

Therefore, this study aimed to discuss the meaning of the notion of transversality and its importance for the formulation of an ethical-political action between psychology and collective health.

To begin with, in order to draw some lines that permeate and disturb the dichotomy between clinical and political for the field of psychology through the notion of transversality,

we make a digression to position the transformations and becomings of a transdisciplinary approach to health care, taking relational technologies as its focal point.

## A repositioning of issues between the subject and Society

With the disruptive events of May 1968, political and philosophical thought, aware of the collapse of post-war life models and the boiling modes of subjectivation, could not avoid collapsing and drifting.

On the one hand, some feared the event, confusing it with barbarism, like Theodor Adorno (1997); on the other, in the same vein as those who claim to be defenders of order, there are the military executioners who interrogated Caetano Veloso in his prison next to Gilberto Gil under the accusation of fragmenting customs and moral values, as highlighted by Passos and Mizoguchi (2019). A weird pairing that places the Frankfurt school philosopher alongside and in the same category as the military of the Brazilian dictatorial regime. Strategically, the confusion in placing one of the pillars of Freudo-Marxist critical theory alongside authoritarian interrogators brings a transversal political analysis.

The theme of fascism can no longer be restricted to a vertical cut that separates the great names in political history into two sides. It must be interrogated in the intimacy and lightness of everyday life, including the day-to-day life of progressives. Small fascisms take by storm a wide range not only of officials of truth, those who position themselves as owners of political legitimacy but also of bureaucrats of the revolution (Foucault, 1996).

Concerning the production of knowledge and the politics inherent to social practices, we highlight two points with such considerations. One, when we make cracks in such aseptic categories, it is the very separation between disciplines and the underpinning objective-subjective dichotomy that is called into question. Therefore, we observe an intellectual morality of petty fascism that deals with the great binary divisions of reality (such as civilization and barbarism); only these capable of legitimately enunciating the truth about its time, men, and history in order to keep politics far from a desire to fulfill it behind closed doors.

Thus, faced with the collapse of given models of life, there were, on the other hand, those who assumed not just slogans but a certain attitude of uncodable contestation. They assumed decoding as a new ethical-aesthetic-political principle. A position perhaps only rehearsed by Marcuse – who writes a letter reprimanding and breaking with Adorno –, the tropicalists themselves, and, alongside them and many others, a philosopher dedicated to the production of difference, Gilles Deleuze, and the psychoanalyst and activist of several political movements, Felix Guattari.

In Deleuze's correspondence (2018), we see the importance and details of this meeting marked, crossed, by the radicality of transversality. The philosopher promptly identifies the importance of this notion to overcome the dichotomy between the individual unconscious and the collective unconscious to advance in the construction of a framework capable of articulating Marxism and psychoanalysis. A key question agitates this meeting: how does the socioeconomic sphere interfere with the psyche, the formations of desire, the unconscious, and vice versa? The militant Guattari (2004) asks whether social revolution – if not feasible, at least plannable – should or can crush desire? Both, along with Foucault (1996), ask themselves what connects social exploitation and psychic repression so closely (Lopes & Romagnoli, 2018).

We can reformulate this question in this text based on the productions and itineraries of collective health in Brazil to interrogate the relationships between clinics and politics. This concern serves as a guide to follow the itinerary that leads from transversality to

transdisciplinarity. For if it is between individual psychology and social relations that the microfascism that affects everyday life is, together with the concept of transversality, formulated as an ethical issue and as a conceptual-instrumental bridge between the care activity and its political effects on the society where the different subjects live.

## The transversal between the care plan and the work plan

In the scope addressed here, we consider the real social problem that emerges between the production of health and the production of subjectivities. More than the disciplinary fields of health sciences and psychology, we are interested in the spaces and moments where one deterritorializes the other, leading it to re-territorialize in other fields that link clinical and political studies.

Starting from Institutional Analysis (Guattari, 1981), we glimpse the value of transdisciplinarity as an original inquiry and appreciation of empirical research in the human sciences that made Deleuze and Guattari avoid dogmatism because by "[…] advocating a deviation through social and institutional practices [...] this criticism paves the way for a reconnection between research, knowledge, and the terrain of experience, lived experience, representations of actors and their words" (Dosse, 2010, p. 73).

Inspired by the theoretical-practical conception of institutional analysis, Lancetti (2000) points to the usefulness of a varied set of tools for work in collective mental health that expands its object and means of intervention. Health care should not have as its center the pathology, the nosographic entity of the disease, nor be restricted to the individual afflicted by it, but the family group; family is understood as people who, for whatever reasons or ties, share a roof, daily life or share a home.

Health care is therefore characterized as a group activity in at least two aspects, on two problematic planes: what we can call the care plane, which configures the care produced with the groups and collectives assisted, and the work plane, which includes tasks and duties carried out in groups in, by, through or with the mediation, support or aid of multidisciplinary teams. Both plans unfold at different levels.

Under the care plan, the vertical level is related to the socio-historical formation of each individual, to the roles they exercise, assume, or may occupy according to the social context in which they are– in the current formulation, the inscriptions of race, gender, and class would fall into this stratum (Ceccon & Meneghel, 2019). Furthermore, the vertical level is where your personal history and the differentiation of the self unfold in terms of identification with possible figures of the ideal self, hierarchical figures of model or leadership, in operations that often lead to relations of oppression, exploitation, and suffering evidenced in works such as those by Angela Davis (2016) and Djamila Ribeiro (2017).

Next to it, a horizontal level is configured as a common denominator between group members and their relationships with each other. The intersection between individuals or groups that form an as-one[4], a homogeneity, based on the identification and lateral recognition capable of unifying, even if occasionally or provisionally, elements or traits shared between the members, in the process or at the time in which the group takes place (Freud, 2011; Pichón-Rivière, 2000). In other words, according to this operationalization, the group – the collective or the family – cannot be reduced to a scenario for the individual (Hur & Viana, 2016), taking effect in the articulation between the verticality of what affects personal history and the horizontality of current processes.

[4]In Portuguese, common is *comum*, hence the association with the expression *como-um*, which we translate as as-one, and means 'as if it were one', as if what we have in common was capable of being brought together under aspects or a set of homogeneous elements.

At the work level, such relationships are updated in stereotypical forms of reproduction of communication codes and circulating exchanges through verticality and horizontality (Guattari, 2004). On the hierarchical vertical axis, the institution updates the closed pyramidal structure of the objectivist organizational chart in which the fixity of roles embodied in leadership, sub-management, and subordination positions mark the micropolitical field of everyday relationships. Therefore, it is not uncommon for health institutions to replicate a model of physician-centered relations in which other professionals are reduced to paramedics, and their duties are subject to the allocation of assistants, being at most complementary or alternatives to primarily medicalized treatment as in the Medical Act's proposal, recently debated in Brazil.

In the horizontal section, the replication of lateral identification and mutual recognition of the same is observed. This is a cut usually marked by corporatism, where different professional categories – but also service users or family members – recognize each other in their vocabulary and demands, their institutionalized positions, and their desires and life projects (Barros & Passos, 2005).

At the thresholds and interstices of both strata, vertical and horizontal, of the planes of care and work, transversality causes ruptures based on fissures in the socio-historical formations of the social context and the homogeneity of identification and lateral recognition as it operates from the fissures in hierarchical pyramids and corporatism. With the diagonal drawn by transversalization, the boundaries between the planes of care and work become obsolete and both touch and mix. This does not mean a simple horizontalization that connects only strictly related and similar areas, nor does it mean that there is no distinction whatsoever between the professionals who provide care and the subjects to be cared for (Romagnoli, 2019).

Thus, the issue of transversalization operates with an inherent question: how does such a process of subjectivation work? Through the determination of which factors - since there is no privileged factor capable of reading all reality or all relationships always, inexorably, and infallibly (Prado et al., 2019) - do such processes take place?

Transversalization serves to decipher modeling systems: what determines us and our relationship with the world, the social condition of class, race, and gender?

What matters is the existential circumscription that unfolds intrinsic references, processes of self-organization, or singularization in each subjectivity. A cut that calls into question the organization of a subject – with its resistances and subjections – as subjectivation corresponds to the different processes of production of referents. Therefore, becoming a subject means producing references for oneself, references capable of acquiring consistency in the subject's encounters and relationships with the world (Uno, 2016).

Guattari (2004) proposes the concept of transversality especially based on two articles in 1964, entitled 'Transference' and 'Transversality', gathered in a collection published as *Psicanálise e transversalidade*. Therefore, the concept of transversality aims to respond to the insufficiency and limitation of the notion of transfer to clinical management in the institutional context, which is crossed by a multiplicity of vectors.

The notion of transversality is deeply marked by the Frenchman's experience at the La Borde clinic. There, under the inspiration of Tosquelles' ideas of heterogeneous, polycentric, and transdisciplinarity, the aim was to build a social space for exchange based on three principles: a) the democratic centralism of the management group, b) the deliberate precariousness of statutes that favors the movement of everyone between manual work, and c) intellectual work gives the mark of communist utopia to the project and collectivization

of responsibilities and salaries as an anti-bureaucratic community organization (Dosse, 2010).

Given this, with transversality, the present poignancy of social and political impasses is assumed, irreducible to the ritual repetition of the past accessible to the analysis of the transferential repetition of the Oedipus complex, which would be capable of explaining not only the psyche but the entire social life, which would be modeled from him.

Taking this criticism further, we immediately have two consequences. First, that politics invades the clinic (Guattari, 2004). With this, the analysis requires and involves a conception of multiple subjectivities, irreducible to the intrapsychic, to the family dynamics updated in the current phantasmatic, as the processes of subjectivation and subjectivity itself are irreducible to the unconscious or even to the individual psyche. In short, by problematizing individual healing and including the institutional dimension in the analysis, it moves from the field of technocratic specialty to that of social experimentation.

For this reason, several collective instances are installed, from general assemblies to secretariats and workshops, which, by questioning hierarchical bureaucratic routines and their serial repetition, aim at the collective and permanent construction of devices for the reappropriation of meaning, valuing the singularization of relationships with work and the world. With such devices thematizing what is produced in the institution, the analysis becomes politicized as it takes as its objective not correction through remodeling but the modes of production of subjectivity and deviations, the creation of new meanings and expression in alterity.

Finally, it is useful to return to the considerations of Barros and Passos (2000) in proposing the concept of the plan instead of the field for health care work when considering the instability of the elements and relationships that make up a plan as a heterogeneous plan. Therefore, the plan of care work is irreducible and does not stabilize in the homogeneity of any scientific subject or field since it is composed of processes and encounters, which incessantly produce deviation and mutation.

The notion of a plan works with constitutions and emergencies, from which different levels of reality are constructed. This means that instead of starting from the fundamental separation between the subject, object, or theoretical or conceptual system that supports the practice, we take them as emerging effects of the plan of the constitution of care.

Considering this procedural-constitutive dimension of the plan in which all reality is connected inevitably disrupts the elementary subject-object binary system. Disarrangement that appears as an effect of the transversalization of technical activities by the collective dimension of the plan of heteroclite forces that cross and constitute reality. Consequently, health care work assumes the function of accessing, interfering, and producing such a collective plan of forces, a plan of the impersonal, the constitution of subjects, the objectivities of knowledge, and also of the common.

With these notes, we move forward in proposing the ‘in-situation analysis’ method of transversalization. Moving beyond relativistic egalitarianism and simple dissent, the strategy of transversalizing focuses on opening channels of communication between different fields, knowledge, and groups. Therefore, every creative or instituting intervention must be capable of reaching, producing, or transforming the transversality coefficients corresponding to the place of real power, place of influence, and mutual disturbance between the psyche and society (Guattari, 1981).

Such openness in terms of communication channels and the disturbances intrinsic to it face the blindness of closed groups in their current condition (Guattari, 2004). Not infrequently, dealing with finitude and one’s own destiny can become a difficult, tense,

chaotic, and distressing activity for a group, which is more comfortable maintaining its established configuration, whatever it may be.

In this context, we understand that the group functions as an intermediary in the interface between psyche and society, between clinic and politics. It is a simulacrum, an unstable process since its constitution and exercise are not based on similarities but on dissimilitude and deviation from the group and model-individuals. Therefore, the group is considered the terrain of borders, passages, and selectivity (Barros, 2004).

There is a resonance between the modes of operation of a team of caregivers and the subjects of care from the perspective of transversality. Transversalization takes place in communication between different levels and, above all, in different directions. Schematically, transversality has a mobilization function based on the recognition of the production of multiplicity. With this, it is stated that it signals transit, movement, and passage between concepts, practices, and approaches from different disciplines or knowledge.

Because of this transit characteristic transversality and groupality appear strategically in the transversal policy of humanization and improvement of care offered in the public health system to indicate the inseparability between management and health care and operationalize transversalizing exchanges between both (Brasil, 2008).

## From transversality to transdisciplinarity: health production and subjectivation

The National Humanization Policy (Política Nacional de Humanização, PNH, in Portuguese) of the Brazilian Unified Health System (Sistema Único de Saúde, SUS, in Portuguese) emerges from the reiteration that the management of health work processes is irreducible to the administrative task and is necessarily linked to care practices and the invention of subjects who inhabit and exercise them (Brasil, 2008). In the development of SUS, several meanings are attributed to humanization in different instances. In this way, the compartmentalization and isolation of actions can result in contradictory, if not conflicting, practices, as humanization is sought and stratified by procedures, levels, or assigned clientele.

In this aspect, humanization is restricted to the field of welfarism, under the binomial lack-supply, the voluntarism of the virtuous and paternalism, close to clientelism and the equipment of health as a hanger for political bargains, or even to the field of administrative rationality management or technicism of the so-called ‘total quality’ (Barros & Passos, 2005).

In the context in which transversality indicates how to do the relational technologies that make up the PNH, it aims to draw diagonals whose objective is to increase communicability between management and care. This desire is based on the understanding that although the legal part of the SUS, its legal text, is established in the Federal Constitution, there is a concrete instituting experience, which takes place as a constituent process, of reinvention and tensioning in the de facto exercise of the public within the scope of the concrete daily functioning of the SUS (Barros & Passos, 2005).

This constituent dimension expresses the commitment of assistance to the agreement of the different instances of the SUS, making the PNH assume more than the right to health and health as a value of use, carried out in the social dynamics of bonds and exchanges between the subjects in the system. To this end, it encourages the protagonism of the population at a collective level of social control and co-management, guiding the exchange of knowledge and teamwork based on the needs and desires that circulate in the decentralized care network aimed at co-responsibility of the different actors that compose it.

The production of subjects and health is concomitant with the invention of models of care and management of humanized work processes. This means that humanization seeks

to create means of qualifying social care practices in a double aspect: focused on citizenship, where it acts to equalize differences with a negative effect on the production of health, and towards the defense of life, in the sense of openness to the production of deviations inherent to living (Prado, 2017). With this, we realize that producing health means inventing new subjects and a new society; we realize that the construction and exercise of humanized care implies establishing new values for public life.

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Therefore, the PNH guides the translation of health not as an external adaptation to the inner rules placed vertically nor to a horizontal axis that dispenses with professional performance and technical rationality based on the spontaneity of 'all is fair'. As a public policy, PNH comprises the inseparability between the production of health and care in a transversal approach based on multivector communication and the intersection between the vertical and horizontal axes (Barros & Passos, 2005).

In the intersection between the different actors, the service user's knowledge and practices shade and reorganize the professional's practices and knowledge, just as technical knowledge re-signifies everyday social practices. Eventually, such two-way exchanges act by reactivating disused customs about food and ways of living of each local sociability, with their own existential repertoires, among other practices that are difficult to allocate in any disciplinary field (Passos & Carvalho, 2015).

Strategically, the PNH is organized according to principles of transversality, the inseparability between care and management, and the implementation of protagonism, co-responsibility, and autonomy of subjects and collectives. Its conceptual and methodological challenges (Barros & Passos, 2005) are schematically answered by six concepts stated in its normative formulation (Brasil, 2008).

The Expanded and Shared Clinic, together with embracement, implies the qualification of listening and dialogue in recognizing the legitimacy and uniqueness of health needs to sustain relationships of trust, commitment, and bond between service and population. Participatory management and co-management through spaces and devices of groupality and collectivization. Added to these concepts is the ambience, capable of favoring the institution as a meeting place, in addition to valuing workers and defending users' rights.

In this context, PNH seeks organic and sustainable practices able to promote the inclusion of different actors in the inseparable processes of management and technical care to favor co-management arrangements and spaces. At the same time, the transversalization between social and institutional practices contributes to the invention of different ways of life and professional activity aimed at investing in the negotiation capacity of service users.

In terms of the articulation between management, care, and health evaluation, the triple inclusion method is proposed to update the principles of the PNH through lateralization, analysis, management of conflicts, and transversalization. First, it organizes itself to sustain an inclusive attitude, a composition of different people on the same plan. It is included through lateralization in an arrangement that produces crises and deterritorializations necessary for change.

Such tension is not necessarily problematic in the sense of configuring antagonisms that would make it a point to be demonized or avoided at all costs. On the contrary, when placed as a conflict of coexisting forces, the tension takes on an agonistic character, functioning not as an indication of war but as an institutional analyzer. The question that follows is, 'What are the implications at stake; what are the different positions (posed) in question?'

Subsequently, the second inclusion is characterized by the positivity of destabilizations, institutional crises, and critical points as a potential for change caused by lateralization. Inclusion of institutional analyzers through the analysis and management of conflicts.

These two inclusions provide conditions for the third, the inclusion of the collective, of the as-one not as an identifiable and localizable element of what is homogeneous at an intersection but as a regime of composition of heterogeneity, of dissonant communication that potentially alters and complexifies the communication patterns in health institutions.

The technological question that arises from this third inclusion, that of the collective, is 'How to compose a transversal?.' Certainly, there is a need to destabilize the organizational culture in favor of an increase in openness to communication – or an increase in communication quanta (Guattari, 2004).

Destabilization of vertical organizational charts and lateral arrangements and identifications implies making the multidisciplinary team more than a multidisciplinary composition or interprofessional intersection but rather crossing the borders, the increase in traffic between different fields, and the complexity of relationships between users, technicians, and managers as analyzed by Passos (2013), and which translates into the implementation of the transdisciplinary approach, distinct from both multidisciplinarity and interdisciplinarity.

Schematically, the multidisciplinary approach adopts the scientific framework of the geometrization of reality (Bachelard, 2005) and thus understands the complex nature of the health object as something that has several faces to be referred to as its respective professional competence. Here, the relational aspect of care does not alter the relationship between knowledge, its meaning, or its object. Consequently, the understanding of relational technologies is restricted to the scope of spontaneism or limited to their characterization in the field of soft-hard technologies based on cores of already consolidated practices and knowledge (Passos, 2013).

On the other hand, we have interdisciplinarity, which multiplies the boxes of expertise and the frameworks of reality with the approximation and intersection between disciplinary professional fields. Based on the idea of producing the common as as-one through the establishment of zones, objects, and/or methods of homogeneity, it opposes transversality as common production.

Assuming that soft technologies permeate all instances and levels of care (Merhy & Franco, 2003), we conclude that there must be an approach through distance, from which a common plan is formed not based on the homogeneity of the intersection but from a heterogeneous composition, of intercession, of an intercessory disturbance generated in and by difference (Deleuze, 1992).

With this, Passos (2013, p. 227, emphasis added) concludes that instead of hierarchy and corporatism that mark the institutional culture in the field of health in the (alternated) defense of different units and homogeneities (old or new), transversality reconfigures "[…] the common with the meaning of 'like anyone else'. It is the idea of common as a practice of, for, with, through anyone".

In this way, health care is formulated as a 'clinic of the common', characterized by the transversal deterritorialization of lines of hierarchy and corporatism that support the exclusivity of knowledge, practices, or settings that claim to hold truth and competence for care in health and mental health. The meaning of care work is assumed, therefore, by transdisciplinarity, the disturbance of the intercessions between the different disciplines that authorizes and legitimizes a transdisciplinary approach of transversalization of practices and knowledge focused on ways of life and the production of health.

Following the same line of complexity, we link this definition of a common clinic from a transdisciplinary perspective to the formulation by Merhy and Franco (2003) that light relational technologies operate between, with, and alongside all care activities. Therefore, when caring, one must make a constant commitment to the embracement, bonding, accountability, autonomy, and transference games inherent in the production of care.

For both perspectives, transdisciplinary and light technologies, relational dynamics are not restricted to the field of psychology (or even fields close to it, social work, occupational therapy, etc.); they are not exclusive to it. On the contrary, from this perspective, psychology, like any other area and field of knowledge, does not explain anything alone; as a social practice, it must explain itself. Therefore, the question arises: what does it do, what can it do, and how does psychology act at the specific core level and the level of composition with and among other disciplines?

In this context, a variety of nationally coordinated documents and research have been produced by the Technical Reference Center for Psychology and Public Policies (Centro de Referência Técnica em Psicologia e Políticas Públicas, CREPOP, in Portuguese) of the Federal Psychology Council, aiming to qualify and provide technical reference for the work of psychologists in public policies – not only relating to the health field – greatly contributing to reflection on practices in the psychology and care field in Brazil. Health care and invention occur contiguously, in intercessions, through the disturbance of other knowledge, of elements and principles outside psychology. Therefore, it is essential to overcome the individual and social dichotomies, divided into psychological interiority and political-economic class, in clinic and collective health to articulate the care for each individual's health with the care for the health of populations.

With the transversalization of social and institutional practices, we realize that the action of care is clinical-political and must be formulated according to a transdisciplinary approach. In this sense, the Charter of Transdisciplinarity starts from the confrontation between disciplines to take on a complementary approach to them in favor of the emergence of the new – co-extensive with the agreement on a new vision of nature and reality – focused on articulation and openness to that which crosses and exceeds them (Nicolescu, 1999).

Since the production of health and ways of life go beyond and cross the disciplines of health and illness, these must be organized in a network based on transdisciplinary dialogue between the different levels of care. However, health and ways of life are not produced only in health devices, which is why they must seek contact and intercessions with the different public and private sectors, composing spaces and moments of active participation aiming at the social involvement of/in the territory capable of instrumentalizing transdisciplinary practices of promotion, prevention, monitoring, and construction of health (Brasil, 2008).

In this context, we affirm an attitude of composition through heterogeneity. 'Composing between' implies the aggregation of diverse propositions capable of reciprocally encouraging their terms and accompanying the understanding and development of strategies and tools for managing the complex situations that involve the production of health and subjectivation.

Such transdisciplinary strategies and tools include and support instruments such as the Singular Therapeutic Project, shared consultation, case discussion, interconsultation, and matrix support, in order to cover complex health needs and demands, irreducible to the technologies used by this or that specialty. Therefore, transdisciplinarity implies creative and joint transdisciplinary efforts, the mobilization of institutional and community, and material and subjective resources articulated for producing care co-extensive with the invention of subjects, the technician, the manager, the user, and their significant social network.

## Final considerations

By way of conclusion, the present study allowed us to debate and call into question the meaning of transversality as a cut that connects the individual and social, clinical, and political dimensions of the production of care. With it, we reached the formulation of the principle of transdisciplinarity for the level of collective health care practices that link the production of health to the production of subjectivity.

We point out how transversality serves as an ethical-political principle of complexification of the social practices of care work, combining theoretical and practical action as a way of knowing and intervening in the production of reality as it is understood through the prism of composition through difference. With this, it proposes a paradigm of creative intervention based on opening communication channels between different fields, knowledge, and groups.

Next, we resumed some points from the SUS National Humanization Policy to reposition the production of subjectivities with the production of health. Since the production of health takes place in the relationships between different actors, it is inseparable from the production of subjectivation that occurs in action and crosses it transversally. Therefore, the production of subjectivities in the care relationship is not restricted to the field of psychology but a transdisciplinary clinical activity.

Taking transversality and groupality as principles, the PNH takes on the conceptual and methodological challenge of co-producing management and health care in its instituting aspect, committed at the same time to the de facto exercise of the public and health as a value of use, expressed in the dynamics of social bonds and exchanges.

With this, by guiding the humanization of care based on the construction of values for public life, the PNH aims to re-signify social practices focused on health through multivector communication that places light relational technologies as articulators of all instances and levels of care. Therefore, the common production of transversality provides the meaning of the care work of a common clinic, which links the health of each and every one to the health of all as a clinical-political practice of, for, with, and through anyone.

In this aspect, health care does not fit into the explanatory grids of any knowledge and is not necessarily better carried out by one disciplinary field or another, and we finally return to some of Foucault's (1996) ethical propositions for healthcare practices of production of subjectivation and its relationship with politics. In fact, it is necessary to highlight the micropolitics of social relations in the construction of technical and knowledge activities, which are not neutral.

Thus, given the partiality and positioning of technical and knowledge activities within the scope of care, within these, it is necessary to pay attention to the transversal crossings with which they interfere with the processes of subjectivation and their functioning. That is, transversality takes place in the micropolitics of the production of referents, self-organization, and singularization in the subjects' institutional, political, and social daily lives.

In this sense, it is important to note how the fronts of combat and resistance have

moved and gained new areas – such as the recent revival of debates about gender and race, crossings that resonate in the interfaces, in the interstices of everyday life.

Therefore, the transdisciplinary approach is configured as a proposal for non-unitary and non-totalizing political realization and action, whose paradigm is to grow action and thought through proliferation and disjunction instead of the subdivisions that sustain the state of things in their customary stratifications. Finally, from transversality to transdisciplinarity, we focus on the moving, positive, and multiple characters of the difference that engenders reality to the units, uniformities of systems of reading, construction, and intervention in life.

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