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(Dis)trust in the care of work related mental health problems in Brazil: Between multiple systems and shared lifeworlds

Fernanda Sousa-Duarte^{a,b,*} , Patrick Brown^a 

^a Department of Sociology, University of Amsterdam, Nieuwe Achtergracht 166, 1018, WV, Amsterdam, the Netherlands

^b Department of Social and Work Psychology, University of Brasília, Campus Darcy Ribeiro, ICC Sul, AT-013/12, 70910900, Brasília, Brazil

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ABSTRACT

Sociologists have understood trust in healthcare contexts chiefly in terms of how the patient relates understandings of the system and the professional, amid unfolding interactions and relations. This theoretical framing, where trust is usually considered in relation to a relatively coherent healthcare system, tends to neglect the multiplicity of organisations, systems and institutions shaping patients' (dis)trust. Embedded within this 'system' is often a global-north-western typification of the benevolent, well-paid healthcare professional in stable employment. In this article we adopt a phenomenological approach to partially build upon these conceptual bases as a way of extending our understandings of (dis)trust amid healthcare constellations. We draw upon a study of (dis)trust in Brazilian contexts of work-related mental health problems (WRMHPs), within a highly fragmented network of multiple systems, where the mental health professionals themselves worked in low paid and often precarious work situations. Drawing on 14 in-depth interviews with patients with WRMHPs, and their psychological-therapists, we found the fragmentation of systems and distance between them was fundamental to analysing emerging relations of (dis)trust. In turn, these multiple system dynamics configured lifeworld structures of shared assumptions, shared critiques of biomedical models, shared precarity and negative experiences in the Brazilian labour market. These lifeworld structures formed the basis of professionals' trust in their patients and facilitated the listening and deeper communicative action which slowly built patients' trust. The Brazilian case of WRMHPs is useful in rendering more explicit the multiple abstract systems, epistemic traditions and organisational structures pertinent to understanding (dis)trust amid healthcare contexts, and the role of increasingly precarious professionals within these.

1. Introduction

For decades, trust relations in healthcare contexts have been explored in terms of individual patients' understandings of 'the system', 'the professional' and how these relate to one another (Calnan and Sanford, 2004). Parsonian themes are often implicit in such approaches, with an individualised notion of patient-doctor relations. Studies that have problematised these approaches are rare and tend to draw on empirical studies in the majority world, whereby north European or American assumptions become destabilised (e.g. Rodrigues, 2016). Studies from beyond global-north-western contexts are more likely to acknowledge that 'trust in individuals (e.g. a doctor) is highly contingent on trust in a variety of social systems' (Meyer et al., 2008, p.180), yet they have tended not to systematically map out trust pertaining to multiple systems or to explore this multiplicity further in empirical

analyses.

Influential trust theories have characterised professionals as working at 'access points' to abstract systems (Giddens, 1990), whereby patients see professionals as embedded within envisaged systems, as a way of navigating unfamiliarity and uncertainty (Luhmann, 1988) as characteristic of modern healthcare. Key theoretical works refer to or imply systems in plural - Giddens (1990) usually refers to 'abstract systems', while Luhmann (1979: 100) writes about networks of 'system nestings of many sorts', thereby suggesting complexity and multiplicity. Yet there are also ambiguities in these key texts: Luhmann attempted to harness phenomenology in his writings on trust (Frederiksen, 2016) which therefore emphasised how people conceptualise a symbolic 'system'; Giddens's (1990: 34) key definition of trust refers to 'the reliability of a person or system'. Amid such ambiguities, very few empirical or conceptual studies have systematically conceptualised and addressed

* Corresponding author. Department of Sociology, University of Amsterdam, Nieuwe Achtergracht 166, 1018, WV, Amsterdam, the Netherlands.

E-mail addresses: f.sousaduarte@uva.nl (F. Sousa-Duarte), p.r.brown@uva.nl (P. Brown).

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multiple systems in health care and their consequences for (dis)trust. The application of trust theory in healthcare research via survey studies has often tended to measure perceptions towards an individual system/institution (e.g. [Aboueid et al., 2023](#)), while important qualitative studies have also tended to refer to an individual system (e.g. [Skirrbekk et al., 2011](#)) or to different components/layers of the same system ([Brownlie and Howson, 2006](#); [Gilson et al., 2005](#)).

In this study of (dis)trust in the care for work-related mental health problems (WRMHPs) in Brazil, we examine how the mental health professionals and patients in our case study negotiated relations of (dis)trust amid a complex systemic context. We explore the interplay between multiple (fragmented) systems – organisational systems (work-, social security and healthcare-related), abstract knowledge- systems, professional practice systems –and their related configuring of lifeworlds ([Habermas, 1987](#)). To do so, we build upon Luhmann’s and Giddens’s works on system trust from a Habermasian perspective as we seek to render explicit the way lifeworld-based understandings of multiple systems are fundamental for patient-professional (dis)trust.

Work-related mental health problems are located at the intersection of healthcare-, social security and work-related contexts and the Brazilian case is particularly interesting due to its unique historical,

professional and regulatory background regarding workers’ mental health. While multiple systems are often implicit within a lifeworld imagination of a ‘healthcare system’, studying (dis)trust in care contexts which straddle multiple systems, beyond the global north-western contexts where trust and systems have typically been conceptualised, helps render explicit the inherently complex, contextually-contingent and fragmented systems and lifeworlds which are integral to processes of (dis)trust.

Unlike most European countries, Brazilian labour market regulations have included recognition and compensation of mental health problems as forms of occupational disease since 2000 ([Ministério da Saúde, 2001](#)). Links between mental health problems and work-related factors can be demonstrated through evaluations done by medical doctors of the Instituto Nacional de Seguridade Social - INSS (social security system) or inferred, based on a list of common risk factors for occupational diseases (Technical Epidemiological Nexus – NTEP). Both pathways require bureaucratic checking, including input from medical doctors in the public or private healthcare systems, in social-security/INSS and in occupational health companies. Workers are thus highly dependent on these professionals for accessing welfare benefits. [Fig. 1](#) illustrates these pathways:

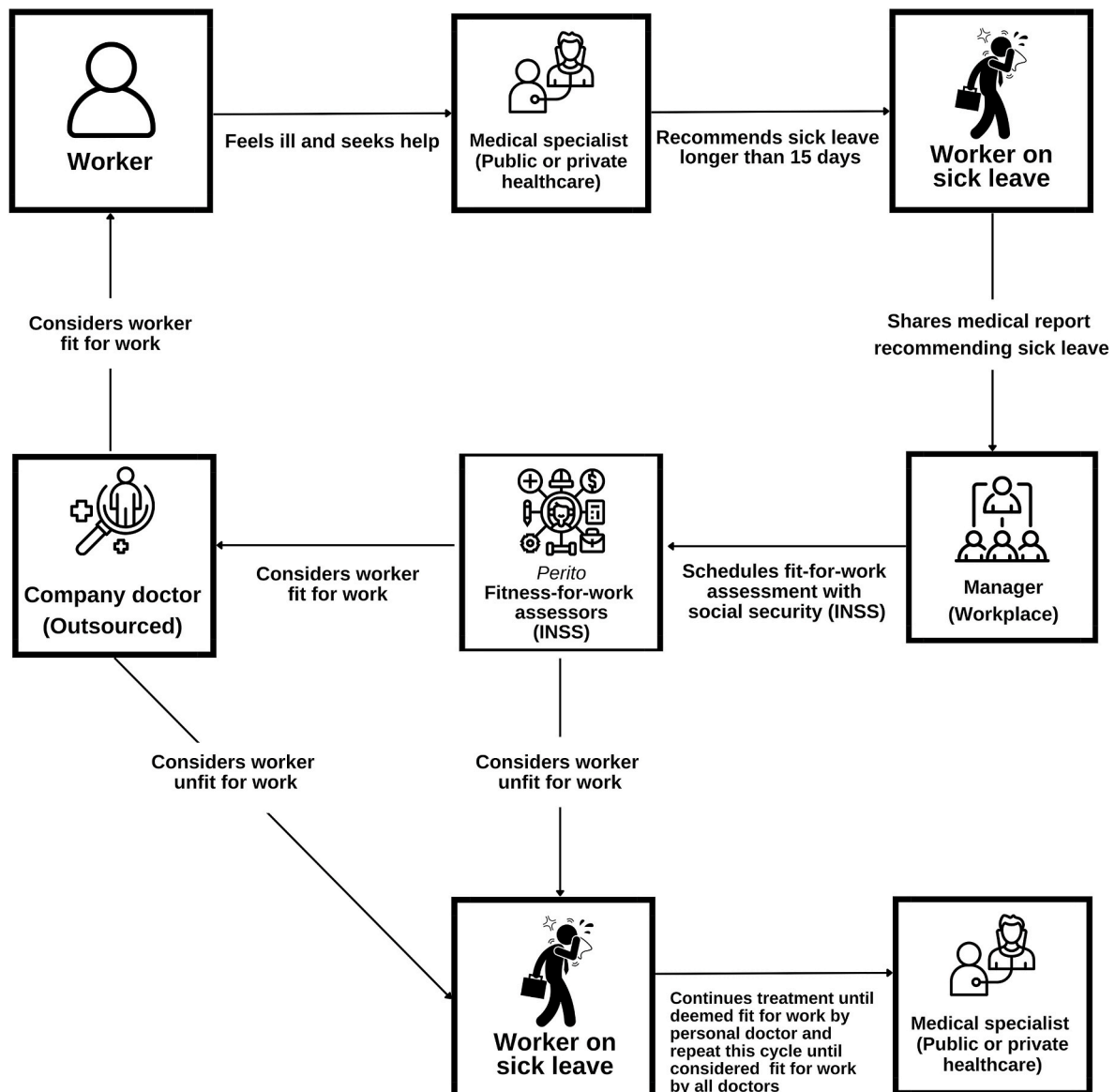


Fig. 1. Pathways for paid sick leave in Brazil.

Despite regulations considered to be favourable to occupational health, as rooted in a broader universal right to health (dating from the 1988 constitutional reforms), investigations of links between work and illness tend to be neglected or contested in both healthcare and social security medical practices (Jacques, 2007). Due to the additional benefits (financial included) provided by INSS (social security) in cases of occupational disease or accidents at work, those claiming that their illnesses are work-related, especially if suffering from “invisible illnesses” such as mental health problems, tend to be stigmatised and discriminated against by medical professionals in general, including INSS’s doctors working as fitness-for-work assessors (*peritos*), the main actors behind recognition of and compensation of occupational diseases (Zavarizzi and Alencar, 2018).

Amid this medico-centric bureaucratic approach to recognising links between work and illness, our study focuses on interactions between psychological-therapists and patients regarding WRMHPs. Brazilian psychology is the predominant discipline behind WRMHP research and psychological-therapy in Brazil (Sousa-Duarte et al., 2022), the latter often being perceived as a legitimate and effective treatment for WRMHP (Schaufeli, 2017). However, despite this legitimacy, research points to psychologists’ difficulties in recognising links between work and mental health (Pires, 2008; Souza, 2013; Keppler and Yamamoto, 2020). These difficulties have been attributed to the deep theoretical, methodological, and technical fragmentation within Brazilian Psychology, where biopsychosocial and biomedical approaches to mental health are in constant tension and negotiation when it comes to handling cases of WRMHPs.

Far from one abstract system, therefore, ‘Psychology’ in Brazil reveals a multiplicity and interplay of systems, highlighting the diversity of abstract knowledge systems (e.g. diverse epistemic approaches) and professional-practice systems (e.g. organisational and work psychology, psychological-therapy). This fragmentation is by no means unique to Brazilian Psychology, but we emphasise it here as it is neglected within much trust research around healthcare ‘systems’.

Additionally, patients’ healthcare-seeking practices and their claiming that their mental health problems are work-based rely on their own interpretations of work as a determinant of mental health, implying their construction of an aetiology of mental health problems that is not necessarily fully aligned with epistemic and normative assumptions of various forms of expert knowledge and practice. In this way different abstract systems (as psycho-therapeutic epistemes, or traditions of knowing) will shape the respective structures and overlaps of, or divergences between, professional and patient lifeworlds, in turn rendering the worker-patient more or less vulnerable (c.f. Bury, 1982; Flick, 2016).

Located at the intersection of healthcare- and work-related systems, exploring trust within this case enables us to understand the multiplicity of systems, and the interplay between interpersonal- and (multiple) systems (dis)trust for both parties. The low paid and precarious working arrangements of the mental healthcare professional study participants represent a further contrast to the Parsonian or northern European norms assumed within sociology of professions and healthcare organisation literatures. The insights emerging from this ‘southern’ systems-context may also be prescient for the conditions increasingly facing health and social care professionals in a number of ‘northern’ contexts (c.f. Saks and Zagrodny, 2020). Engaging with existing work on trust in relation to phenomenology, lifeworlds and systems (following Habermas, 1987) helps us develop these conceptualisations.

2. Trust, systems and lifeworlds: their fragmentation, multiplicity and interplay

In contrast to many conceptualisations of trust as involving a stably-employed professional embedded within one healthcare system context (and sometimes depicted with multiple components), we have devoted space above to sketching the circumstances surrounding Brazilian

WRMHPs to emphasise what is a fragmented, dynamic and contested complex (May, 2007) of multiple systems pertaining to policy, knowledge and practices around ‘workers’ health’ and ‘psychology’ across different contexts. Fig. 2 illustrates this complexity where, amid work, healthcare and social security contexts, different healthcare professionals – represented by ‘open’ dots – are positioned at the overlap of multiple abstract systems (knowledge, professional practice, legal, economic) as indicated by the coloured areas interpenetrating each other:

While previous trust studies have tended to frame mental healthcare systems as being constituted of largely aligned knowledges and practices amid one wider organisational context such as *the NHS*, in this study we draw attention to the fragmentation of the ‘psy’ expert knowledge systems and practices (Pilgrim et al., 2011), not least around WRMHPs (see Fig. 2). We also acknowledge the tensions that may emerge between diverse traditions of knowing within abstract knowledge systems, the experiential knowledge and related practices of professionals and patients, and the way these combine to form multiple layers of shared or divergent assumptions (i.e. lifeworlds). Where lifeworlds of knowledge and assumptions overlap, this forms an important basis upon which communication and, potentially, mutual understanding and trust, can be built.

In the analysis presented later, we will also see further abstract systems – legal and economic – which become relevant to understandings, assumptions, practices and (dis)trust of WRMHP professionals and patients. To explore how relational and communicative dynamics of (dis)trust are embedded in the interplay of these multiple and fragmented knowledge, organisational and practice systems, we build on studies of trust in mental health services that suggest that (dis) trust between patients and professionals are often influenced by other trust relations; for example within the healthcare professionals’ workplace and organisation (Gilson et al., 2005, p.1427). These wider organisational dynamics are, in turn, influenced by policies of the state (Doblytė, 2022; Brown and Calnan, 2016).

Empirical studies of trust from the majority world seem to be more likely to recognise more multiplicity (Gilson et al., 2005) because of less individualised narratives of ‘the patient’ and a much more diffuse configuration of healthcare provision, much beyond the auspices of the state. Rodrigues (2016), moreover, developed a phenomenologically-grounded approach - which involves an attentiveness to multiple layers of assumptions and social relations in which everyday processes of knowing, practices and (dis)trust are rooted. Phenomenology is especially important in peering beneath the simplicity of everyday more superficial or ‘pseudo’ logics of social actions (Schutz, 1967), such as trusting, and digging deeper into the layers of far more complex, yet usually taken-for-granted, assumptions; things which we often ‘know’ without knowing we know them.

Phenomenological theory also helps inspire Luhmann’s (1979) classic work on the roles of familiarity and assumptions towards ‘systems’ for everyday practices of trust. However, Luhmann struggled to reconcile the lived experiences and understandings of individuals with a Parsonian-inspired analysis of systems and ultimately the taken-for-granted features of trust were ‘abandoned’ in favour of a more risk-oriented, systems-driven analysis (Frederiksen, 2016, p. 52). Habermas (1987), meanwhile, develops a far more effective synthesis of phenomenological insights and systems-related theory, with this work on lifeworlds and systems offering a more effective basis for distinguishing, while connecting, the socio-cultural processes pertaining to individual and shared meaning-making, assumptions and knowledge about people and systems (lifeworlds), and the scientific-bureaucratic functioning of organisations and abstract systems of expertise and practice (systems). From this perspective (dis)trust between patients and professionals is rooted in underlying lifeworld processes involving the assumptions which underpin: thinking about and performing the self (identity); the legitimation of particular ways of being, thinking and acting by those around us (society); and meaning-making regarding the

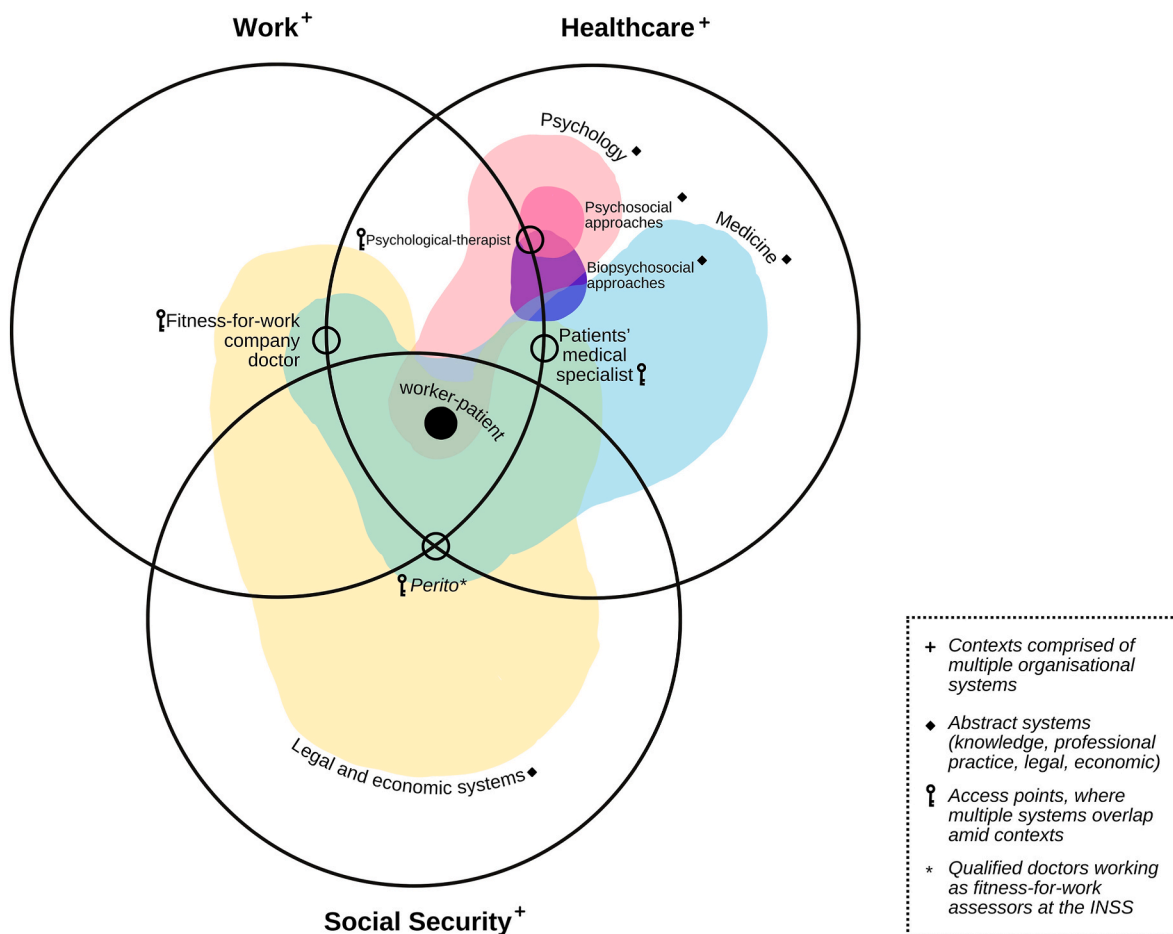


Fig. 2. Conceptualising multiple system dynamics of (dis)trust across different contexts.

world around us (culture), including our work, our health care, and the science that underpins the latter.

Interactions between patients and professionals are fundamentally rooted in these lifeworld processes, with the communication amid these encounters potentially building trust, but where differences in underlying assumptions between patients and professionals can hinder effective communication and, consequently, trust (Doblytė, 2022). Trust-building communication can also be helped or hindered by the manifestations of different systems, as their functioning in terms of bureaucracy, time, or power differentials, for example, can mean that communicative action – aimed at mutual understanding and refining a common lifeworld – is warped and replaced by more strategic forms of interaction (Kihlström and Israel, 2002, p. 212) aimed more instrumentally at accomplishing tasks (Brown and Calnan, 2016, p. 300).

3. Methods

The data presented below are drawn from the first author’s doctoral research that explored Brazilian psychological-therapists’ handling of cases involving work-related complaints from a social and work psychology perspective. A re-analysis of these data as part of post-doctoral research and a reflexive dialogue with the second author are fundamental to understanding why, in this study, we engage with these data focusing on relations of trust and distrust and the fragmented systems in which participants were embedded.

As a Brazilian social and work psychologist, the first author’s positionality was that of an insider-outsider (Bukamal, 2022) in relation to psychological-therapists, where a seemingly insider position due to her educational and professional background was contested. As much as the

researcher had the same educational background as the psychological-therapist participants, whenever they identified the researcher as a work psychologist and not ‘psicóloga clínica’ (clinical psychologist and psychotherapist are used interchangeably in Brazil), they would distance themselves by reaffirming their position as ‘psicóloga clínica’ (clinical psychologist), emphasising their identification with clinical psychology, the practice-oriented abstract system related to psychological practice in Brazil (Passos and Barros, 2000). These interactions highlighted the fragmentation of professional and expert abstract knowledge systems and, at the same time, as will be seen in the analysis, how shared lifeworlds bridged professionals’ (lack of) expert knowledge in WRMHPs and patients’ accounts of work-related problems. In the remainder of this article we refer to these professional participants as psychological-therapists.

The first author undertook 14 in-depth individual interviews – seven with psychological-therapists and seven with patients, between May and August 2018 in Brasília, Brazil. She started by inviting psychologists who had at least 1 year of experience with psychological-therapy and had identified work-related complaints among their patients. She also invited people who were undergoing psychological-therapy because of work-related complaints. Invitations were shared on the website and social media of the Regional Council of Psychology, in mailing lists of alumni of undergraduate Psychology courses, and through posters placed in public spaces of the city where the research was carried out.

Ethical approval for this study was granted by the first author’s regional research ethics committee, and all participants signed informed consent forms that explained the nature, aims and procedures of the study. Due to the sensitive nature of the topic, anonymity, the right not to answer any particular question and/or to withdraw from the study at

any moment were emphasised. In the first round of data collection, seven psychological-therapists and two patients volunteered to participate in the study. During the interviews, the psychological-therapists were asked to pass on details of the study to patients that could be potential participants, and a second round of interviews involved five more patients. Interview settings varied according to participants' preferences. Among psychological-therapists, locations of choice included their own office (n = 2), their homes (n = 2) and cafes (n = 3). Patients preferred public locations (cafes, n = 3; libraries, n = 1; the researcher's office, n = 2) to their homes (n = 1). Talking to strangers about one's health may be experienced as less risky than sharing it with close ones, as it presents an alternative to sharing problems while also keeping emotional distance (Colineau and Paris, 2010).

The interviews were conducted in Portuguese, lasted approximately 1.5 h each, and explored three dimensions with both psychological-therapists and patients: experiences of work; understandings of relations between work, mental health and illness; and understandings of psychological-therapists' practices, whereby trust emerged as an important theme. Interviews with psychological-therapists also included questions about their educational background. The participants of this study were all providing or receiving care in the private sector, reflecting a wider tendency that most psychological-therapy in Brazil is offered in the private sector (Bastos et al., 2022), where insurance plans are financed by employers or individuals, and services are also provided for those willing to pay out-of-pocket (Montekio et al., 2011).

All participants were highly educated women, aged between 27 and 41. The inclusion of only women psychological-therapists may be linked to the gender imbalance of the profession in Brazil, predominantly practiced by women (n = 79,2% according to Bastos et al., 2022). Among patients this sample composition may have been impacted by Brazilian men's lower healthcare seeking practices in general, as shaped by a common, gendered stigmatising stance towards seeking health and psychological care (Gomes et al., 2007). While the inclusion of men could illuminate other aspects related to trust building in regards to experiences of work-related problems and psychological-therapy, our participants' experiences echo more general issues regarding the medical and social security handling of their cases, as reported in other studies regarding work-related illnesses (e.g. Siqueira and Couto, 2013; Zavarizzi and Alencar, 2018).

Patient participants had an average of eight years of work experience in the fields of healthcare, social care, education, and administration in the private and public sectors. Five of them were still undergoing treatment when the interviews took place. Some of them had previous psychological therapy experiences with cognitive-behavioural and/or gestalt psychological-therapists. Their initial motives for seeking psychological therapy usually fell into two main categories: personal or work-related issues; with the first group also experiencing workplace problems that they eventually decided to share with their psychological-therapists later in their treatment.

Most of the psychological-therapists referred to having a psychoanalytical approach to psychological therapy, with an average of five years of experience as psychological-therapists in situations of self-employment or *quasi* self-employment. The first type of work as a psychological-therapist in Brazil refers to offering psychotherapy in one's own private practice, whereby patients come without an official medical referral and usually pay out-of-pocket, outside of health insurance coverage. Monetarily, this implies psychological-therapists receive full payment for the sessions. The second type of experience is when psychological-therapists work at a private clinic where health insurance can partially or fully cover the costs of psychological therapy for patients. We named this *quasi* self-employment because these professionals worked at these clinics on a specific type of informal agreement, without any salaried contracts.

The interviews were transcribed and then managed with the software Atlas.ti, where they were coded and analysed in Portuguese by the first author, following the steps of thematic category analysis, which treats

data in three consecutive steps: pre-analysis, exploration of the material, and treatment of the findings (Bardin, 1977). By employing an inductive and theoretically driven approach, we opted for establishing semantic categories oriented by phenomenological approaches to (dis)trust and systems in the experiences of work and of the psychological-therapy of work-related problems. Therefore, identifying vulnerabilities and uncertainties was fundamental to locating processes of trust and distrust (Brown and Calnan, 2016).

During the pre-analysis, after the first author did the first readings of the transcripts, we decided that the data would be organised in two different *corpi* - interviews transcripts of patients, and of psychological-therapists. Then, the first author did a first round of coding, in Portuguese, for each corpus, focusing on potential themes and sub-themes around participants' accounts of health and work-related uncertainties, vulnerabilities and (dis)trust. This was followed by a second round of coding that refined the initial one, in which the dynamic and changing character of these uncertainties, vulnerabilities and (dis)trust in workplace actors, work- and health-related systems were identified. In the third and final step, relations of complementarity between the coded themes of the two *corpi* were identified – thus identifying how patients' and psychologists' lifeworlds and systems were intertwined in shaping relations of (dis)trust.

4. Findings

The data presented below shed light on the processual nature of (dis) trust and of WRMHPs and their treatment. We pay particular attention to the complex web of mutual interactions between people (patients, patients' managers and colleagues, psychological-therapists, medical specialists, fitness-for-work medical experts), the multiple systems in which they are embedded, various features of their lifeworlds, and the way these lifeworlds overlapped in some cases, while not in others, by which we identify the making and breaking of processes of (dis)trust in cases of WRMHPs. The first section denotes the negative experiences within the work and social security organisational-systems, which first brought workers into contact with psychological-therapy. The second section then explores the social, legal and epistemic distance of psychological-therapy as a professional-practice system which is important for understanding participants' accounts of trust, as are the overlapping lifeworlds (shaped by similar experiences of systems) between psychological therapists and patients, which form the focus of the third findings section.

4.1. *The downward spiral of vulnerabilities and uncertainties in the workplace: work-related-system distrust leading to initial contact with psychological-therapists*

Changes to patients' workplace organisational dynamics were often perceived as antecedents of WRMHPs by both patients and psychological-therapists. These changes were described as happening in patients' relationships with their colleagues, direct managers, or in organisational management styles and policies more broadly. All seven patient narratives described monitoring practices in the workplace. The resulting changes to workplace (dis)trust involved patients becoming both the distrusters and the distrustees in these workplace relationships. These changes that resulted in harmful workplace practices could also involve discriminatory behaviours based on gender and/or sexuality:

“He started using certain mechanisms to intimidate, manipulate. To mistreat us in the workplace, but not directly. Of course, he was not naive. And in these meetings where most participants were women, there were sexist jokes about how a meeting with so many women could only mean they were there to talk nonsense.” (Patient 5, administrative assistant in the public sector)

Both patients and psychological-therapists commonly described WRMHPs as stemming from being victimised amid these situations of

violence in the workplace. Those affected by such problems felt uncertain and vulnerable in their workplaces, with the impact extending to their personal lives. At first, because the symptoms were experienced as unfamiliar and diffuse (bodily aches, headaches, gastrointestinal problems, recurrent infections), patients shared that they struggled to understand the embodied nature of their malaise:

“I didn’t know where that was coming from, I didn’t. But then, little by little, symptom by symptom, you start realising [a connection to work], slowly but steadily.” (Patient 2, administrative assistant in the public sector)

In such instances patients described the state of their health as uncertain. But even when they sought medical help, medical diagnosis could also be uncertain and hard to define:

“I fainted, went to the Emergency Room, when I woke up my dad was there. Then a neurologist examined me and told me I was fatigued and I needed to stop [...]. But I didn’t accept it.” (Patient 6, bank worker)

Most of the participants reported that they had to see multiple different medical specialists before they were either diagnosed with a mental health disorder or syndrome by a psychiatrist, or were referred to seek psychotherapy. In that sense, not only was the malaise itself uncertain, but also its diagnosis, causal attribution, and treatment. Even when the connection between malaise and the workplace was suggested by a professional, patients usually struggled initially to acknowledge the negative impacts of work on their health due to an unwillingness to accept further work and health related uncertainties, fear of being stigmatised and willingness to avoid the bureaucratised process of paid sick leave through the INSS, the Brazilian institute for social security. As Patient 6 continued to elaborate:

“We live in a society where complaining about your work looks bad. I didn’t have space to do that in my life.” (Patient 6, bank worker)

With increasing uncertainties in the workplace and, consequently, around their health and well-being, patients said they felt like they could no longer take their productivity, role, or status in the workplace, or outside of it, for granted. Still, they often initially resisted modifying their work practices (e.g. by taking sick-leave), as Patient 6’s refusal of the doctor’s offer (above) shows. The increasing uncertainties in the workplace and around their poor health evoked possible further changes in their relationships in the workplace and also in their financial situation, which justified their resistance to take sick-leave:

“I didn’t even want to hear the word INSS (social security). In my mind, there was this relationship, even if unconscious, that ‘well, if I take a leave with the INSS, when I’m back to work they will fire me’. But they fired me anyway.” (Patient 3, administrative assistant in the private sector)

As apparent above, sick leave itself involved a risky choice and notions of (dis)trust in the employing organisation. The once distant and abstract relationship with the social security institution became more concrete, closer and more personal. In the face of changes to their experiences of vulnerability, patients’ ‘choices’ to stay in the detrimental workplace, even when entitled to sick leave, were also related to distrust in broader systems in which they and their workplaces were embedded, such as occupational health and social security. In that sense, accepting or refusing to take sick leave was, in some cases, also based on direct or second-hand (through acquaintances) negative earlier experiences within their workplace, with employers’ occupational health services, or with the INSS, where practices were perceived as more instrumental-bureaucratic and, typically, distrusted. As Patient 1 explained:

“But if I do [take leave from the public school job], I will be with the INSS, and it is that horrible bureaucratic process”. (Patient 1, school teacher)

Psychological-therapists shared these negative perspectives of the INSS and its medical experts’ practices, emphasising a distrusting stance towards INSS, and its biomedical approaches to mental health and medical professionalism. They highlighted how patients were typically distrusted in their encounters with *peritos* (fitness-for-work medical experts within the INSS):

“In my practice all I hear are bad things about the INSS. Those *peritos* are assholes. So much so that they have the nerve to tell the patient ‘why don’t you go back to work if you take so many pills? It must be because you are lazy’.” (Psychological-therapist 6, self-employed and quasi self-employed)

Here psychological-therapist 6 noted the stigmatisation of mental illness and psychiatric medication use by *peritos* as well as the interpreted incompatibility of interests of employees, employers, employers’ occupational health services, and the INSS around WRMHPs. Considering this incompatibility, she described controlling practices - rather than trusting ones - as emerging within the workplace, from employers and the INSS, and further fostering patients’ distrust in work-related actors (e.g. *peritos*) and systems. Related to these controlling practices were feelings of not feeling heard, or of having the legitimacy of WRMHPs questioned, indicating how a lack of communicative action could undermine trust. Caught in a downward spiral of distrusting relationships at the workplace and within the systems that should provide support for patients’ recovery, such as social security, patients described feeling unable to resolve the problems underlying their WRMHPs communicatively in these spaces and systems:

“I realised that they [manager and colleagues] didn’t trust me, and I realised that whatever I said wasn’t listened to very well. And at the same time, when I kept quiet, I received complaints that I kept quiet. If I spoke, there was a problem, if I didn’t speak, there was a problem too. And I started to feel bad. And then I got ill.” (Patient 4, hospital psychologist in the private sector).

Importantly, the patient-participants narrated their eventual transition from workers to patients as happening when the risks of not addressing workplace issues started to be perceived as more threatening than the risks of seeking help from, as several patients put it, ‘crazy people’s doctors’. Some participants sought out a psychological-therapist as an alternative to avoid both the pharmaceuticalisation of their mental health problems and, as seen in this sub-section, the instrumental-bureaucratic practices surrounding paid sick leave through the INSS. Others were referred by their GP, psychiatrist or orthopaedic specialist. Common across all patient-participants were negative experiences with work, occupational health and social security organisational systems. As we will see in the next section, the organisational distance of psychological-therapy from these other systems was important for the construction of trust.

4.2. A stairway made of ‘steps of faith’: gradual processes of trust building located between multiple systems and overlapping lifeworlds

While patient-participants described initially being wary of sick leave, due to the risks noted above, all seven reported having chosen to leave their jobs or changed sectors during or after psychotherapy. This was described as positively life-changing. However, these shifts did not happen immediately. The process was especially gradual among patients (Patients 1, 2, 5, and 6) who described having had previous negative experiences with psychotherapy but who were referred to psychotherapy by their GPs, orthopaedic doctors or psychiatrists. Amid work-related uncertainties and new-found vulnerabilities regarding their workplace relationships, financial situation and health condition, these patients described preferring to approach psychotherapy by taking smaller ‘steps of faith’ rather than big leaps:

"[Psychotherapy] goes like: I talk, she listens, she talks, I listen. It is like a conversation. It is not like, you talk and she takes notes and then you leave and that's it [as per an earlier experience]. I don't like that." (Patient 5, administrative assistant in the public sector)

Here, Patient 5 contrasted the specific approach and process of *her* psychological-therapist with a negative typification of psychotherapy as a general approach, based on negative experiences with a gestalt psychological-therapist 25 years earlier. The communicative action pursued by her current psychological-therapist was evaluated positively in light of this comparison, and formed of the basis of continuing with therapy and trust. As patient 5 continued:

"If I don't feel [that I can trust], I keep quiet. I keep things inside and they stay inside me. And I think [psychological-therapist] worked on that, but not just by allowing me to talk, but also by listening rather than talking, which made me more confident to talk." (Patient 5, administrative assistant in the public sector)

Such openness of communication in psychological-therapy was often contrasted with accounts of social security/INSS, mainstream healthcare and workplace systems, which were often described as dominated by logics of (bureaucratic) control. The location of psychological-therapy outside of systems of work, social security and medicine (knowledge and practice), was therefore seen by patients and psychological-therapists as granting a distance from – and far more time than – the bureaucratic encounters of the INSS or the organisational politics of the workplace ('system' mechanisms).

"Psychotherapy was my refuge. Without that support, I don't know if that [quitting my job] would be possible. Talking about myself was sometimes the only way I could feel understood." (Patient 6, bank worker)

This distance between systems meant that psychological-therapists felt freed up from the task of assessing the credibility of mental health problems and its causal attributions which, in turn, provided greater distance from various medical and diagnostic imperatives and their related systems:

"Because there's still a lot of this medical perspective in which the psychiatrist tells you what you have. But I always say [to the patients] that it's not like a broken bone ... It's not the doctor who speaks for you. (Psychological-therapist 6, self-employed and *quasi* self-employed)

Here the psychological-therapist adopted a more critical approach towards diagnostics which was grounded in epistemic assumptions, as common within psychotherapy, that legitimacy of diagnostic and illness narratives are highly (inter)subjective, and that the 'truth' around them is socially constructed and embedded in power dynamics. Also visible here was the common theme of psychological-therapists' distrust in psychiatry, both as an abstract knowledge system, and professional practice system, whereby psychological-therapist 7, for example, noted that 'I avoid referring my patients to psychiatrists at all costs'. Such a positioning of (dis)trust dynamics in relation to multiple systems of knowing, as adopted amid lifeworlds structured within these same systems, is also apparent below. Here psychological-therapist 5 explained how, in engaging with the social security/INSS system by writing an official letter supporting her patient changing sector within her workplace, she was confronted with a conundrum of trust in her own judgement and approach to knowledge:

"What if I issue the report suggesting she changes sector and then she gets in the new place and repeats the same problem? I didn't issue the report immediately. We [her and the patient] spent some time working it out, co-constructing a narrative and understanding what was happening." (Psychological-therapist 5, self-employed)

While instances such as this gradual move towards writing a formal

letter could draw psychological-therapists somewhere closer to the bureaucratic and medical structures of the social security system, our findings indicate a general distance and insulation from these medical and bureaucratic systems. Epistemically this distance was marked by a combination of system distrust in Psychiatry and system trust in other Psy-epistemes, such as Psychoanalysis. In turn, these epistemic considerations, created a space for what was often referred to as '*acolhimento*', a Portuguese noun-concept which encompasses different dimensions of the experience of a safe, trusting, protective relationship. *Acolher*, the related verb, combines meanings of 'to welcome', 'to host', 'to shelter', 'to offer refuge', 'to protect', and 'to give emotional or physical comfort'.

"So having that '*acolhimento*' from someone, even if it was from someone that I don't have a direct emotional bond with, was very important for me because I felt protected. Taken care of" (Patient 1, school teacher).

Patient and psychological-therapist participants both used *acolhimento* in accounting for the safe space which characterised their experience of psychotherapy and which, in turn, enabled new possibilities to trust in self and within new workplaces. From this system separation and distance, we now move to explore the proximity and overlap in patient and psychological-therapist lifeworlds.

4.3. Overlapping lifeworlds as a basis for patient-professional trust: psychological-therapists' and patients' shared uncertainties and vulnerabilities at work

Sociological studies of healthcare professionals have typically emphasised their power and assumed the stability and security of their jobs. The psychological-therapists in our study, however, typically worked other non-clinical jobs (this was often in education, government departments or consultancy) alongside their clinical work to support themselves and their households, at least in the early years of their career. Patients also reported holding multiple jobs at the same time, at least at some point in their working lives. This lack of job security among professionals, as with the strained working experiences of patients (see first data section above), were often described in terms of vulnerability:

"Last week I had a bit of a mini existential crisis thinking that I'm working 10 times more than I get paid and what do I do with my life?" (Psychological-therapist 6, quasi self-employed)

In this wider sociocultural context and in the systems and subsystems (organisational policies, cultures, human resource management) which underpinned this, both patients and professionals narrated negative experiences. Influences of class and gender were also commonly reported when participants shared their everyday workplace experiences. Gendered and non-gendered workplace violence were common experiences to most of the all-women group of patient and psychological-therapist participants. Most of these acts of violence were verbal (insults, jokes, gossip) or social (silent discrimination, exclusion from decision-making). Psychological-therapist 3 shared her clinical experience with (gender-based) workplace violence as one of the motives for women to seek therapy and how, therefore, her own negative professional experiences shaped her understanding of her women patients with WRMHPs:

"And then I noticed how the upper management, the owner and the partners ... how do I describe it? They seemed to want to take advantage of the workers (...) Certainly the fact that I have had that work experience [myself] makes me understand what the dynamics are [for women patients], [to] understand the pressures, [the] political games." (Psychological-therapist 3, self-employed)

Psychological-therapists' negative personal work experiences could shape negative understandings of different kinds of workplaces and of organisational cultures that did not support workers' best interests. These understandings cultivated an openness to patients' complaints

and causal attributions - an openness characterised by an apparent suspension of moral judgement and doubts, laying the basis for trusting patients:

“They give so much value to that [work environment] ... And that exerts great power over the person and I think that is fascinating. So who am I to judge them, if I've already been there?” (Psychological-therapist 1, previously self-employed and *quasi* self-employed)

Some psychological-therapists' accounts, as apparent for psychological therapist 1 above, implied notions of reciprocal perspectives, with psychological-therapists assuming they could 'know exactly what [patients] are talking about' (Psychological-therapist 2). These deeper forms of relating to another ('we-relationships' - Schutz, 1967, p.158) were, in turn, built upon taken-for-granted negative expectations about work organisations in general, which then formed the basis of psychological-therapists' distrust of the specific people (managers, human resources managers) and systems (organisational policies, 'the capitalist system') which they understood as adversely impacting the health of specific patients. Grounded in (shared) lifeworlds, these related formats of system distrust - psychological-therapists' and patients' shared distrust in their (past) employers' organisational culture and policies - enabled professionals to 'connect' with their patients and interpersonal trust (patient-psychotherapist, psychotherapist-patient) was seemingly facilitated as a result:

“The experience of having an asshole boss makes you understand. [Before having this experience] you ask yourself 'how come a boss calls an employee dumb?'. But after having a boss call you 'dumb', you know this is real. Not only that one boss I had but I know of many others. It really changed the way I view things [in cases of WRMHP].” (Psychological-therapist 2, self-employed)

This overlapping of lifeworlds, through social positioning and experience (of bullying and workplace pressures), can also be understood as intersectional in that, alongside gender, it also referred to a similar class identity in the form of class opposition - 'a perception of the capitalist and their agents as opponents' (Surridge, 2007, p.209).

Although patient participants did not refer to being aware of shared backgrounds of understanding (overlapping lifeworlds) in these terms we note above, they did describe "feeling" a mutual understanding by the way they experienced an accepting and safe space ['*espaço de acolhimento*', in the words of Patient 1, a school teacher] in psychological-therapy where they felt able to complain about the problems they faced in the workplace; something they did not feel they could do elsewhere. Psychological-therapists, meanwhile, acknowledged how these shared lifeworlds, as shaped by work-related and social security system structures, led them to seek to foster such 'safe spaces' in psychotherapy practice, preferring a lifeworld-led approach to psychotherapy over instrumental ones:

“It is a matter of having had experience in the working world, of having worked and having been humiliated, de-individualised, 'thing-ified'. You may have read all books about work psychology, work sociology. I know how to approach them, their suffering. I ask more about this and that, and it makes a difference in making them feel '*acolhimento*'. Then they will trust you because you are not just another person judging them, thinking that they are incompetent.” (Psychological-therapist 1, previously self-employed and *quasi* self-employed)

As psychological-therapist 1 noted here, similar experiences were considered valuable in establishing a connection with patients, but more important for psychological-therapists were their understandings of the systems' operations (work-related, legal-economic, social security) in which these alienating experiences were embedded. These system functions included controlling practices that could emerge in interactions around WRMHP. From this understanding, aiming at communicative practices (Habermas, 1987, p.192) was a way for

psychological-therapists to facilitate trust-building.

5. Discussion

The common empirical findings we have summarised above are of a group of patient participants who had faced negative experiences of their employer organisations and of the Brazilian social security system (INSS). The lack of support from within the workplace and beyond, and the lack of recognition of their WRMHPs, left these patients in rather precarious, vulnerable situation. These workers came to psychological-therapy through different routes but one common theme was how, in contrast to the workplace and INSS, they experienced acceptance and understanding which were all vital in the development of patient participants' trust in their psychological therapists. The emic concept of '*acolhimento*' thus provided one pertinent example of a space where communicative action - Habermas's (1987, p.192) concept of open, relatively unfettered speech aimed at holistic mutual understanding - could take place. In order for vulnerable patients, who had suffered in and from their workplace, to feel able to talk, to listen, to trust, they needed to feel they were in a place of refuge which, importantly, involved both distance - from their work-organisation and occupational health policy system - and proximity, through overlapping experiences and lifeworld understandings with their psychological-therapists.

We have seen that trusting relationships were described by participants as being facilitated by multiple overlapping lifeworlds within these system locations, which were configured in time and social space - in terms of specific (shared) histories and specific locations (proximities and distances) in socio-organisational space. In turn we have seen that this specific structuring of these lifeworlds was the consequence of system dynamics and related configurations of power and economics over time, as these pertained to multiple systems which were concretely embodied as tangible 'access points' of people and buildings: abstract knowledge systems (e.g. professional practice, scientific knowledge); abstract institutional systems (e.g. legal/policy, economics/market) as these coordinate patterns of transactions; and organisational systems (employer, occupational health, human resources, independent psychotherapy practices).

Although not unique, psychological-therapy, as a professional practice system in Brazil, holds a rather specific position within broader system configurations. Psychological-therapy has status as part of a wider abstract knowledge and professional practice systems of Psychology but, with regards to the broader configuration of systems around WRMHPs, it remains on the periphery; outside the official state-biomedical-legal systems and formal legitimisation processes of occupational health and sick leave. Yet psychological-therapy has sufficient informal legitimacy within wider Brazilian culture of the middle-classes to be respected by many domains of medicine, whereby GPs, psychiatrists and orthopaedic surgeons referred those with WRMHPs to psychological-therapists.

This combination of relative legitimacy, marginality and distance of psychological-therapy, alongside the precarity of psychological-therapists themselves, created the system-distance and lifeworld-proximity in which communicative action and, over time, trust could develop. Here, we follow Doblyté (2022), whose work reflects how the specificities of broader national, post-empire, sociohistorical contexts (of Lithuania) are vital to analysing social relations and processes involving mental healthcare, whereby clinical psychology and even psychology can mean very different things.

Our analysis has emphasised the gradual nature of developing trust relations and how vulnerabilities, again shaped by socio-cultural lifeworlds (e.g. pertaining to stigma of mental health problems) and systems (e.g. pertaining to financial instability and the lack of worker protections), could gradually develop into conditions where help-seeking became more necessary and where effective trust-building communication became more possible. We have explored how multiple layers of (lifeworld) assumptions about multiple systems were

influential upon how (dis)trust developed, such as where a psychological-therapist's trust in self, as a practitioner, and underlying epistemic assumptions regarding the (lack of) validity of different abstract knowledge systems, configured tendencies to trust their patients' accounts which then seemed to facilitate communication with patients. In these contexts, distrust in some systems was as much of a guiding principle of practice, communication and trust-building as trust in other systems (c.f. Lewis and Weigert, 1985, p. 969).

This iterative, complex, dynamic and multilayered process by which multiple systems and professionals relate to patients who, themselves, are engaged within multiple social systems and social relations pertaining to their health and to (dis)trust (as per Fig. 2 above), takes us quite some way beyond the classic medical sociological approach to trust in terms of *the system* and *a doctor* (as per the Parsonian tradition influential on Luhmann and Giddens). Our analysis of this multiplicity has been aided by looking at an illness context (WRMHPs) where various systems are more apparent, nested within a national context (Brazil) where, different abstract knowledge systems and their fragmented parts, alongside abstract institutional systems and their ordering of transactions and interactions, stood in tension with one another, from the perspective of some lifeworld positions, such as those of patients and psychological-therapists. While these multiplicities and tensions may be especially explicit in our WRMHP case, we encourage sociologists of (dis)trust to examine multiple systems when researching trust – especially the configurations, tensions, distances and proximities, and the fragmentations within these systems.

Existing work in medical sociology has problematised oversimplified assumptions about a monolithic healthcare (e.g. NHS) 'system' (May, 2007) yet such recognition of a multiplicity of (often fractured) abstract knowledge systems, organisational systems and related practices has not yet been applied within in depth analyses of (dis)trust processes. Where future research pursues this type of analysis, it is important to distinguish between a) multiple organisational, and abstract systems and their political-economic structures and logics; b) common symbolic representations and understandings of various systems, which may or may not acknowledge multiplicity and fragmentation; c) the way these representations and understandings are configured by different socio-cultural lifeworlds (individual and shared).

It is also important for sociologists to recognise that the healthcare professionals working amid these multiple systems, across many global contexts, exist within more precarious employment relations (contractually, and amid cost-of-living crises) than assumed by classic sociological models. These changing dynamics can open up possibilities for trust, as shared class- and gender-positions build common lifeworlds, but may also lead to growing social distance between different professional groups, and/or to defensive practices within precarious situations which can also undermine trust. These shifting professional dynamics also need to be understood within the specific class dynamics configured by economic-political systems, as well as the related structures of experience and meaning-making that exist around these (c.f. Klein et al., 2018).

6. Conclusion

In this study we examined data from in-depth interviews with patients with WRMHPs, alongside interviews with psychological-therapists commonly treating WRMHPs, to understand how (dis)trust develops within these encounters. Our findings highlighted the importance of considering multiple systems and related assumptions held by psychological-therapists and patients towards these. These structures of system (dis)trust configured possibilities of open communication and trust relationships, as we have understood through Habermasian concepts of systems and lifeworlds. The precarity of psychological-therapists' work, in terms of limited stability and often working other jobs alongside their clinical roles, enabled professionals to better understand patients' experiences (such as gendered discrimination in the

workplace) through shared lifeworlds. System structures and power dynamics could, in this way, configure lived experiences and the forming of lifeworlds in ways which gradually shaped trust over the long-term processes of psychological-therapeutic relationships. Our phenomenological approach sensitised us to the multi-layered lifeworld assumptions held by professionals and patients, regarding knowledge, interests and practices, upon which trust was based. Trust was often gradually developed amid, and rooted in, complex combinations of system trust and distrust. We argue that analyses of trust dynamics will be better informed by adopting analyses which are more sensitised to multiple systems and lifeworld dynamics, as well as related assumptions pertaining to trust and distrust.

CRedit authorship contribution statement

Fernanda Sousa-Duarte: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Patrick Brown:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization.

Ethics approval statement

This study was part of the ongoing broader project “Práticas em Clínica do Trabalho” (University of Brasília, Brazil), which protocol was reviewed and approved in 2015 by the Research Ethics Committee of the Brazilian National Health Council, Ministry of Health, Brazil (approval number: n° 49245615.9.0000.5540). All procedures were compliant with legal and institutional Brazilian regulations, observing the rights to privacy of the participants and their informed consent for inclusion, collection of data and publication of research reports and articles.

Declaration of competing interest

None declared.

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Data availability

The data that has been used is confidential.

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