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ORIGINAL ARTICLE

THE FAMILY IN THE PSYCHOSOCIAL REHABILITATION OF PEOPLE WITH MENTAL SUFFERING

A FAMÍLIA NA REABILITAÇÃO PSICOSSOCIAL DE PESSOAS COM SOFRIMENTO MENTAL LA FAMILIA EN LA REHABILITACIÓN PSICOSOCIAL DE PERSONAS CON SUFRIMIENTO MENTAL

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ABSTRACT

Objective: to describe the contributions of families in the psychosocial rehabilitation of users of a Psychosocial Care Center Type II (CAPS II). **Method:** qualitative study conducted with eight relatives of users of CAPS II in August 2013, in a municipality of Jequié/BA, Brazil. Information was produced by non-directive, semi-structured and group interviews. The analysis was carried out through content analysis technique in the modality of thematic categorization. **Results:** the categories presented were: << The family in the mental health care context >>; << Social exclusion as a limiting factor for psychosocial rehabilitation >>; and << Caring for Rehabilitating.>>. **Conclusion:** it is necessary the family not only to recognize the devices for psychosocial rehabilitation, but also to benefit from care instruments, that serve for both, the person with mental suffering and its family members. **Descriptors:** Rehabilitation Centers; Family Relationships; Mental Health.

RESUMO

Objetivo: descrever as contribuições das famílias na reabilitação psicossocial de usuários de um Centro de Atenção Psicossocial do tipo II (CAPS II). **Método:** estudo de abordagem qualitativa, realizado com oito familiares de usuários do CAPS II, no mês de agosto de 2013, no município de Jequié/BA, Brasil. As informações foram produzidas por meio da entrevista não diretiva, semiestruturada e em grupo. A análise ocorreu por meio da técnica de análise de conteúdo na modalidade categorização temática. **Resultados:** foram apresentadas as categorias: << A família no contexto do cuidado em saúde mental >>; << Exclusão social como fator limitante à reabilitação psicossocial >>; e << Cuidar para reabilitar >>. **Conclusão:** é necessário que a família não apenas reconheça os dispositivos para a reabilitação psicossocial, mas também que se beneficie deles como instrumentos de cuidado, que servem tanto para a pessoa com sofrimento mental quanto para todos os membros de sua família. **Descritores:** Centros de Reabilitação; Relações Familiares; Saúde Mental.

RESUMEN

Objetivo: describir las contribuciones de las familias en la rehabilitación psicosocial de usuarios de un Centro de Atención Psicosocial del tipo II (CAPS II). **Método:** estudio de enfoque cualitativo, realizado con ocho familiares de usuarios del CAPS II, en el mes de agosto de 2013, en el municipio de Jequié/BA, Brasil. Las informaciones fueron producidas por medio de la entrevista no directiva, semi-estructurada y en grupo. El análisis fue por medio de la técnica de análisis de contenido en la modalidad categorización temática. **Resultados:** fueron presentadas las categorías: << La familia en el contexto del cuidado en salud mental >>; << Exclusión social como factor limitante a la rehabilitación psicosocial >>; y << Cuidar para rehabilitar >>. **Conclusión:** es necesario que la familia no apenas reconozca los dispositivos para la rehabilitación psicosocial, pero también que se beneficie de ellos como instrumentos de cuidado, que sirven tanto para la persona con sufrimiento mental como para todos los miembros de su familia. **Descriptores:** Centros de Rehabilitación; Relaciones Familiares; Salud Mental.

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INTRODUCTION

Psychosocial paradigm recommends that treatment should be guided by the deinstitutionalization. Thus, this indicates that treatment must not be focused on curing the disease, in the readaptation of individuals or the normalization of subjects, but rather on the existence of human suffering as a real object of intervention directed to rehabilitation.¹⁻² Thus, the psychosocial rehabilitation can be seen as a strategy, political will and comprehensive modality that assume complex and delicate care actions "towards persons who are vulnerable to the usual modes of sociability."^{3:21}

The psychosocial model also proposes the involvement of various social actors in mental health care and encourages the participation of users of mental health services such as family, health professionals, in short, the whole society in a constant process of care. In this context, the family plays a key role in the constitution of subjectivity and in issues concerning mental health.⁴

Family involvement in the care of people undergoing mental distress is fairly recent, as until the end of the 1970s, this treatment was basically restricted to asylums, what used to cause a distance between the person and his or her family.⁵

Substitutive services to replace the psychiatric hospital, specifically a network of mental health care, came with the proposal of deinstitutionalization. This network is formed by the primary health care services as well as by specialized services including mental health clinics, Psychosocial Care Centers (CAPS), day-hospitals, psychiatric emergency services and emergency bed or unit in a general hospital as well as residential care.⁶⁻⁷

The CAPS are services of daily care to mental health, with a substitutionary character in relation to the psychiatric hospital. These centers work with a multidisciplinary team and the activities developed therein are quite diverse, offering calls on groups and also to individuals; therapeutic and creative workshops; physical activities; recreational activities; art therapy, among others, in addition to medication, which was previously considered the main form of treatment.⁸ The dynamics of work at CAPS, seen as a collective and dynamic, is constituted and transformed to meet the needs of the different actors.⁹ Among these actors, the family should be considered as an essential element of treatment, including specific care and free access to the service.¹⁰

The inclusion of family members in the care and the actions proposed by the psychosocial model reveals that the family should be seen not only as an object of sociopolitical pressure or of subjugation to the requirements of professional services, but as an adjunct in the treatment, which should benefit not only the person with mental suffering, but all his or her social network. The family, staff and territory, as well as users of health services are areas of life, feelings, opening the possibility for the implementation of partnership in mental health care and, consequently, psychosocial rehabilitation of the person with mental suffering.⁹

The interest in the families of persons with mental distress arose while developing teaching, research and outreach activities by the Group of Studies and Research in Mental Health: Crazy for citizenship, from the State University of Southwest Bahia (UESB), both in CAPS type II as well as in the homes of users of the health service.

During home visits to a user of the CAPS II, we noticed that the participation of the family in the care gained prominence as far as effort was made in order to include it in the decisions and construction of its independence was allowed, for example, in regard to child rearing and the realization of home activities.

In this case, the above mentioned user ran her daily activities with the support of her family who, in turn, was not doing it for her, but with her, whenever requested. On the other hand, when we shared this experience in the study group, we realized that other families that were visited had trouble in dealing with this situation, reinforcing feelings of dependence, fear, indifference or distance from the care.

In this context, there were some concerns that led us to the main question of this study: what are the family's contributions to the psychosocial rehabilitation of users of a Psychosocial Care Center Type II? With a view to answering this question, we draw the following objective:

- describe the contributions of families in the psychosocial rehabilitation of users of a Psychosocial Care Center Type II (CAPS II).

METHOD

Study with qualitative approach, a method used to study the history, relationships, perceptions, beliefs and opinions, product of the interpretations that people make about how they live, feel and think.¹¹ The survey allowed the identification of devices for

psychosocial rehabilitation used by relatives of people experiencing mental distress that can contribute to the care given by mental health professionals, and the difficulties faced in this process.

The survey was conducted in the CAPS II of a municipality in the countryside of the state of Bahia, which has a network of health services that consists of 28 Family Health Units, four Basic Health Units (BHU), one general hospital, among others. There are two CAPS to serve the mental health field, one for alcohol and other drugs and the other a Type II, four mental health clinics in the BHUs and one inpatient unit, attached to the General Hospital.

The CAPS II was chosen as field for the research due to prior contact of researchers with the professionals, the users of the service and their families in the practical lessons of the course Nursing in Mental Health Care and the Mutual Aid Group and Intersubjectivity of Caring (GAM) in space of the center, both linked to the undergraduate and outreach dean's offices of the UESB, respectively.

The GAM is made up of users, families and the occupational therapist of the CAPS II. The GAM meetings take place twice a month, and in the first half of the month happens a meeting in CAPS II or in the UESB and in the second half of the month, the members of the group go out for a walk for a sightseeing in the city or elsewhere chosen democratically by vote. Generally, 20 to 30 people participate in each meeting. The presence is not mandatory at all moments.

The proposal of the study was presented to GAM members at the end of a meeting and some relatives were willing to voluntarily participate in the research. Inclusion criteria for participants were: age over 18 years; be familiar and responsible for at least one user of CAPS II; and have available time to participate in the interview.

The technique used for gathering information was non-directive, semi-structured and group interview guided by a script containing open questions, in order to meet the goal.¹² The script was composed of the following questions: how do you see the reinsertion of the subject who experiences mental distress into different social spaces? In your understanding, which is the family's contribution to the psychosocial rehabilitation of people with mental suffering? What strategies of Psychosocial rehabilitation can be used by the family in the care of a family member with mental suffering? What are the

limits and possibilities of family activities in the context of psychosocial rehabilitation?

Information was collected on the third day of September 2013, in a classroom of the UESB, through a group interview that lasted 2 hours. Eight family members of users of CAPS II with the following profile participated in the study: two male and six female, aged between 50 and 82 years, three domestic workers, one seamstress, one woman working in general services, one community health worker, one merchant and a street vendor; the degree of kinship, there were four uncles and aunts, two mothers and one brother and one sister.

The research was initiated after approval by the Research Ethics Committee of UESB under the protocol nº 301.120/2013, and the participation of the family only occurred after signing the Informed Consent - IC, through which privacy and integrity of informants was guaranteed, as directed by Resolution nº 466/2012 of the National Health Council.¹³ By signing the IC, participants also authorized the recording of the statements through a digital recorder in order to ensure reliability in the transcription of the information. In order to maintain anonymity, participants chose names of birds and selected the following codenames: Guriatã, True thrush, Parrot, Bem-te-vi, Hummingbird, Eagle, Sparrow and Belgian Canary.

For treatment of information, the thematic content analysis technique was used¹⁴ as follows: listening and transcription of the conversations; exhaustive reading of transcriptions and organization of the material according to the representativeness, homogeneity and relevance in order to select elements endowed with meaning, such as words, phrases and sentences, that are considered important variables in the process of evaluation of the meaning of opinions, which are called units of analysis; selective reading, which resulted in an inventory containing the units of meaning that were coded according to the analogy of meanings; and, finally, abstraction of categories.¹⁴

RESULTS AND DISCUSSION

The interpretation of the content of the speeches led to the definition of the themes analyzed in this article, which were defined as: The family in the mental health care context; Social exclusion as a limiting factor for psychosocial rehabilitation; and Caring for Rehabilitating.

◆ CATEGORY 1: The family in the mental health care context

The family - "forgotten in the hospital-centered model" - became co-participant in the process of rehabilitation and care to people with mental distress after the incorporation of the psychosocial model in community mental health services.^{13:42-13} Thus, family members who participated in the survey recognize that they need to actively participate in the care provided to the family member with mental suffering, as noted in the following speech:

[...] Family care is needed, because today there is no longer a long-lasting psychiatry (prolonged hospitalization). [...] The family has to be prepared, just as if you were in a hospital, in a clinic [...]. (Guriatã).

While recognizing that the family needs to be inserted in the process, the family does not feel prepared to assume this care, indicating a need for support from managers and professionals of mental health services, as noticed in the units of analysis:

[...] So, you have to have the Union, the state, the municipality to give some support, structure, and that the family take that structure and turn it into reality in order to care. [...] The family alone does not solve the problem, then, it is a group to interact in the health of the CAPS user [...]. (Guriatã).

The speech of Guriatã demonstrates the need for an interaction between the family, the multidisciplinary team of CAPS and managers. These results corroborate the findings of other studies that show the need for professionals to provide care and support to families, actions seen as important tools for the user's reinsertion in the community and for them to resume their daily activities.^{9,15}

Guriatã emphasized also that, though the responsibility to prepare the family for care is of the multi-professional team, the greatest support is found in nursing, as was emphasized in the speech:

[...] The psychiatrist himself, he realizes, but the support he will find is on the nurse, who will give the medication in the mouth, who will apply the 'little injection' in him, gently, then he will start to like the nurse, he will start to feel affection, then this will already help. (Guriatã).

The nurse was highlighted as the one who provides the greatest support to the family in treatment, reinforcing the results of studies showing that the nursing professional search the relationship reciprocity with the user and the family, and this way redeems affective and social ties^{16,17} essential for the identification of devices that enable the construction and invention of new perspectives of life and subjectivity, based

not only in diagnosis and prognosis of mental illness, but rather, in the complexity that involves the individual in his psychic dimension and in his relations with the environment that he lives.⁹

In this perspective, the speech of Sparrow emphasized that there must be a collective effort to improve care to CAPS users and proposed a kind of entanglement from which different social actors can share knowledge in order to empower everyone, as shown by the following units of analysis:

[...] Health has also many professionals who have ability, but many that have yet to be trained, because it is a fan, is a bridge. It is the Federal, the State, the County, Health, Family, Institution [...] So, everybody has to work in that outline, intertwined. (Sparrow)

The thought of Sparrow confirms the perspective of the work of the multiprofessional CAPS team, as this is oriented according to interdisciplinarity, decentralization of knowledge and power by the division of responsibilities, according to the peculiarity of each profession that makes up the team. In addition, the teamwork will be done along with the family, what requires sharing responsibility and commitment to the achievement of a comprehensive assistance to the user.⁹

The following units show that there continues to be a transference of responsibility of the care to the person with mental suffering from the part of many relatives who despise, forsake, leave the garbage, dump or isolates in the house of the family member who is more willing to host the ailing:

[...] Everyone despised. [...] The mother left at the dump in Sao Paulo, abandoned! [...] There is not a single person among my brothers to stay with her. [...] The family is no longer coming to my house, they left me because of her, no one goes in my house, they are affraid of her. [...] If (I) go to top level, who will take care of her? (Eagle)

For the survey participants, there is still no co-responsibility by all family members, team managers and professionals to care for the CAPS II user. This reinforces the idea that one family member tends to take the whole responsibility, the caring dimension of the relative who is suffering, and this ends up feeling abandoned, while others omit care, and this, therefore, suggest the need for the family to receive social and welfare support.

¹⁸

♦ CATEGORY 2: Social Exclusion as a limiting factor for psychosocial rehabilitation

In this category, we present the relationship between social exclusion, prejudice and discrimination still extant in our society, as ascertained in units:

[...] I find it very important that he participates, that he may not be discriminated, isolated, the more he participates in something the more he will be able to develop. (Guriatã)

[...] No one wants to know about her, people seem to have disgust to touch her hand [...] they passby her and shake their hand [...]. (Eagle)

Through these lines, it is clear that, despite the changes proposed by the psychosocial paradigm, the social stigma towards people with mental distress remains very strong in our society. For the study participants, this type of exclusion can be reproduced by the family when this relates mental suffering to violence, as noted in the units of analysis:

[...] he would get very violent [...] I wanted to beat everybody [...] I'm not going out with him to places because his violent temper was too much [...] he was angry, really angry [...] He would throw a lot of stones, really, stones, not now, now he is normal [...]. (True thrush)

Regarding violence, Guriatã argues that the exclusion and/or isolation by the family itself can also trigger such a situation, what it is identified as a negative development, as noted in the following units:

[...] If the family picks up and throws him out, he'll cause trouble out there, then he will throw a stone in the neighbor's car, he will throw a stone in any person. [...] (When violent) he has entered into another development, a negative development [...]. (Guriatã)

This conception reinforces the idea that links the person undergoing mental distress to violent and aggressive behavior and stereotypes of dangerousness and incomprehensibility of the mentally ill. This conceals or prevents the suffering situation to be overcome, in addition to strengthening the belief that one needs to be away from society and be prevented from exercising their ability to self-care and citizenship.¹⁹ In contrast, family members emphasized the need to humanize the care when relating it to the humanization and social interaction, as shown by the units of analysis:

[...] All those who have mental problems need to have a humanizing treatment, they

need to be seen by the Federation, the State, the municipality and also by the family because it has to cover, to interact, in order that the patient may see himself and feel humanized, feel cared [...]. (Guriatã)

In this sense, it is essential to ensure the person who experiences mental suffering "the right to come and go, to be heard, to express their opinions, to be treated with dignity and respect".^{20:151} With the proposal of extinction of psychiatric hospitals, still under process of deconstruction, the movement of change of the health care model has difficulties to propose strategies for dealing with the invisible walls of exclusion. However, the need to humanize the care through social inclusion and actions of psychosocial rehabilitation, beginning with the family context, constitutes a consensus among family members and scholars in the field.

♦ CATEGORY 3: Caring for Rehabilitating

In the category Caring for Rehabilitating, family members who participated in the study showed several devices capable of promoting care and psychosocial rehabilitation, including: leisure areas, interpersonal relationships, church, CAPS and the Group of Mutual Aid (GAM).

The care through participation in leisure activities, entertainment and distraction was evidenced in the units of analysis in which participants talked about the strategies that can promote psychosocial rehabilitation of people with mental distress, as noted below:

[...] To go to a party, go to several places that have some distraction, fun. And those who look for it, to receive it, receive with humanization, [...] he can walk, he can go to the movies, as far as he has a follow-up that does not destabilize him, but cheer him up to a rehab [...]. (Guriatã)

Such statements reinforced the thought that is independent is the person who does what likes to do, the increase of autonomy as desirable attribute and resulting from the process of rehabilitation.²¹ However, Sparrow pointed out the difficulty of providing leisure to the member under mental distress, as the territory is very poor with respect to the offering of leisure facilities, like squares and other social facilities, as demonstrated by the analysis unit: "[...] We do not have squares. We don't have leisure [...]".

With respect to interpersonal relationships, the study participants reported that family conviviality and good interpersonal relationships make the person feel loved and understood, cared, as noted in the units below:

[...] Everybody takes care of him, everybody likes him. It's a very good boy, [...] with love and affection to him, that's good. That's lovely. [...] The people like him, like him [...] (True thrush).

[...] (making reference to CAPS) he is participating in everything very well because it depends on the way they deal with him there too, [...] the moment he's in there they have to deal with him with more love and try to understand [...] love and understanding, [...] only love builds [...]. (Parrot)

At this moment of coexistence and adaptation, people who experience mental distress, as well as their families, need to open up the relationships. Families need to seek to know the person in his uniqueness and evaluate the daily life in the relationship, emphasizing important aspects of life, as for example, sports, dating, family, study, work and leisure,²². However, Guriatã recalls that due to the complexity of mental health care, it is necessary to comprehend, host, accept and understand the changes that can happen, as we see in the following units:

[...] Because deal with the patient who has psychological problems is not easy (referring to the complexity) [...] because one day the patient is well, but another moment he presents another frame, so, this is kind metamorphosis, he changes the picture, the psychological changes [...]. (Guriatã)

The family highlighted also the church as a possibility for the person with mental suffering to practice exchanges in the territory and integrate activities that other family members participate, as we can see in the units: "[...] It is very good to go to church [...]" (Guriatã) ". "[...] He does not give me trouble, because he goes out, goes to church with me [...]" (Parrot)

Such statements corroborated the finding of a study that says that the church is a place to share collective feelings with peers.²³ However, family members pointed out that this site can also produce carelessness if it promotes prejudice and social exclusion, as identified in the following units of analysis:

[...] When he was healthy, he used to come with me to the church [...] he was very violent in the church, he wanted to beat everyone, so I had to remove him from the church [...]. (True thrush).

[...] She goes to church, sees people hugging, and from far she does like this (embrace, negative gesture) she comes back home in tears, crying. Then she was not going anywhere, no longer [...]. (Eagle)

The Speech of Eagle demonstrates how some actions that could be therapeutic, constructive or libertarian, "can activate

solvent aspects of the subjectivity and hard lines, paranoid and of intensification of death."²¹ In this case, the members of the church reproduced the same prejudice and stigma experienced in other environments, closing possibilities for establishing new relationships with the relative of eagle, even in other social settings.

The speeches of True thrush and Eagle reveal that while the family wants the participation of the person with mental distress in different social spaces, violent behavior and social prejudice contribute to the social exclusion. This confirms a study that shows certain weariness of the family in the coexistence and even hopelessness regarding the inclusion of the person with mental disorder in social life.²⁰

The CAPS was also highlighted as a care device by the participants, as for them, the activities in the service improve the health, especially the relationship of the user with other people, as we see in the units of analysis:

[...] (After enrolling in the CAPS) does not curse anymore, does not say dirty words, does not respond me badly, to anyone, does not throw stones. It's a blessing now [...]. (Hummingbird)

[...] After the CAPS, today, he is another person [...]. (Eagle)

In this sense, CAPS has been identified as a place of meeting, dialogue between people with needs, desires and stories, where the user's family is perceived as an essential part for the satisfactory progress of the user in the psychosocial paradigm of mental health care.²⁴ Nonetheless, the speech "[...] I am no longer responsible for him, he's from the CAPS [...]", said by Bem-te-vi, shows the risk of the family transfer the responsibility of the care to CAPS professionals and identify the service as the most important instrument for the care of the family itself.²⁴

The testimonies also showed the importance of the Mutual Aid Group (GAM) of CAPS II to carry out actions to support family care to the user and to their families, as identified in the following units:

[...] If I learn with each one, then I'll treat my patient differently, my family differently [...]. (Sparrow).

[...] The GAM group, the Mutual Aid Group, is about one helping the other [...] GAM group becoming a reality, it becomes an association. [...] association will help us, that is, help the country itself, the state itself, the city itself and the Family. (Guriatã)

Such lines ratified the results of a study that ensures that, in addition to the specific objectives that are proposed, these groups provide an opportunity for the exchange of knowledge and cooperation among its participants.^{9,22}

Thus, the family showed that spaces of hosting and sharing experiences favor the facing of daily difficulties inherent to the health-disease process, as well as increase self-esteem, improve quality of life, motivate and empower users of CAPS II and their families to the achievement of empowerment for the exercise of citizenship.

FINAL CONSIDERATIONS

The family should be involved in the care of the person with mental suffering and, despite recognizing the importance of other social actors to be "intertwined", the family needs to overcome the dependence on CAPS professionals, managers, on the community in general and even other family members who seem unprepared and against the family participation in the care. In addition, it is necessary to deconstruct the notion that care should happen in the CAPS at the expense of the family and of the territory, as orients the mental health paradigm.

Ignorance and fear of the family regarding the care need to be overcome, as these feelings can lead some families to abstain from the process, making them isolate not only the person undergoing mental suffering, but also family members who are co-responsible for the care.

This study showed the tendency of many families to reproduce practices of the asylum in the family context, as they want to treat the person under mental suffering as if "she/he were in a hospital, in a clinic", emphasizing the supply of medicines and control of aggression and violence as forms of treatment.

Instead, the family needs to see the CAPS as well as society in general as partners in psychosocial rehabilitation, as a space for hosting and sharing knowledge. Anyway, it is necessary to advance in relation to the ownership of devices that can assist in psychosocial rehabilitation of people under mental distress, such as leisure facilities, interpersonal relationships, the church, the CAPS and the GAM, to not only recognize them, but use them and benefit from them, such as disease prevention tools and promoting the health of the entire family unit.

REFERENCES

1. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, organizador. Ensaios: subjetividade, saúde mental, sociedade. Rio de Janeiro: Fiocruz; 2000.
2. Dimenstein M, Sales AL, Galvão E, Severo AK. Estratégia da Atenção Psicossocial e participação da família no cuidado em saúde mental. *Physis* [Internet]. 2010 [cited 2015 June 15];20 (4):1209-26. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-73312010000400008
3. Pitta AMF. O que é reabilitação psicossocial no Brasil, hoje? In: PITTA, Ana (Org.). Reabilitação Psicossocial no Brasil. 3rd ed. São Paulo: Hucitec; 2010. p. 19-26.
4. Brito ES de, Badagnan HF, Ventura CAA. The care integrated to family and community in the view of professionals from a psychiatric hospital. *J Nurs UFPE on line* [Internet]. 2015 [cited 2015 June 30];9(suppl. 4): 8088-96. Available from: <http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/6456/pdf/7923>
5. Ribeiro MBS, Martins STF, Oliveira LR. Familiares de usuários vivenciando a transformação do modelo assistencial psiquiátrico. *Estud psicol* [Internet]. 2009 [cited 2015 June 15];14(2):133-40. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-294X2009000200006
6. Brasil MS. Lei nº 10.216, de 6 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. *Diário Oficial da República Federativa do Brasil* [Internet]. Brasília [cited 2015 June 15]. Available from: http://www.planalto.gov.br/ccivil_03/leis/leis_2001/l10216.htm
7. Brasil MS. Portaria nº 3.088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental e com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde. *Diário Oficial da República Federativa do Brasil* [Internet]. Brasília [cited 2015 June 15]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html
8. Brasil MS. Portaria GM nº 336, de 19 de fevereiro de 2002. Define e estabelece diretrizes para o funcionamento dos Centros de Atenção Psicossocial. *Diário Oficial da República Federativa do Brasil* [Internet].

Brasília [cited 2015 June 15]. Available from: http://dtr2004.saude.gov.br/susdeaz/legislacao/arquivo/39_Portaria_336_de_19_02_2002.pdf

9. Schrank G, Olschowsky A. O centro de Atenção Psicossocial e as estratégias para inserção da família. Rev Esc Enferm USP [Internet]. 2008 [cited 2015 June 18];42(1):127-34. Available from: <http://www.scielo.br/pdf/reeusp/v42n1/17.pdf>

10. Mielke FB, Kantorski LP, Jardim VMR, Olschowsky A, Machado MS. O cuidado em saúde mental no CAPS no entendimento dos profissionais. Ciência e Saúde Coletiva [Internet]. 2009 [cited 2015 June 18];14(1):159-64. Available from: <http://www.scielo.br/pdf/csc/v14n1/a21v14n1.pdf>

11. Minayo MCS. O desafio de conhecimento: pesquisa qualitativa em saúde. 12th ed. São Paulo: Hucitec; 2010. 407 p.

12. Vilela ABA, Carvalho PAL, Araújo RT. Envelhecimento Bem-Sucedido: Representação de Idosos. Rev Saúde Com [Internet]. 2006 [cited 2015 June 15];2(2):101-14. Available from: <http://www.uesb.br/revista/rsc/v2/v2n2a2.pdf>

13. Conselho Nacional de Saúde (Brasil). Resolução Nº 466, de 12 de dezembro de 2012. Diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. Conselho Nacional de Saúde. [Internet]. 2012 [cited 2015 June 07]. Available from: <http://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf>

14. Bardin L. Análise de Conteúdo. Edição Revista e Atualizada. Lisboa: Edições 71; 2011.

15. Cantero AID, Rodríguez CM. Intervención junto con la familia en el centro de rehabilitación psicosocial de badajoz. Informaciones Psiquiátricas. 2010 [cited 2015 July 14];201(3):301-16. [Internet]. Available from: http://www.revistahospitalarias.org/info_2010_pdf/201_inf%20psiq.pdf

16. Moreno V. Enfermeiros e a família do portador de transtorno mental. Rev Bras Enferm [Internet]. 2010 [cited 2015 June 30];63(4):603-7. Available from: <http://www.scielo.br/pdf/reben/v63n4/16.pdf>

17. Almeida Filho AJ, Moraes AEC, Peres MAA. Atuação do enfermeiro nos centros de atenção psicossocial: implicações históricas da enfermagem psiquiátrica. Rev Rene [Internet]. 2009 [cited 2015 June 30];10(2):158-65. Available from:

<http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/19458/pdf/120>

18. Randemark NFR, Barros S. The family in therapeutic design of users of CAPS: representations of health professionals. J Nurs UFPE on line [Internet]. 2014 [cited 2015 June 30]. 2014 [cited 2015 Jul 14];8(7):1956-64. Available from:

<http://www.revista.ufpe.br/revistaenfermage/index.php/revista/article/viewArticle/4976>

19. Maciel SC, Maciel CMC, Barros DR, Sá RCN, Camino LF. Exclusão social do doente mental: discursos e representações no contexto da reforma psiquiátrica. Psico USF [Internet]. 2008 [cited 2015 June 30];13(1):115-24. Available from: <http://www.scielo.br/pdf/pusf/v13n1/v13n1a14.pdf>

20. Brischiliari A, Waidman MAP. O portador de transtorno mental e a vida em família. Esc Anna Nery [Internet]. 2012 [cited 2015 June 30];16(1):147-56. Available from: <http://www.scielo.br/pdf/ean/v16n1/v16n1a20.pdf>

21. Lancetti A. Clínica Peripatética. Hucitec Editora: São Paulo; 2014.

22. Santin G, Klafke TE. A família e o cuidado em saúde mental. Barbarói [Internet]. 2011 [cited 2015 June 30];34:146-60. Available from: [file:///C:/Users/CIEP/Downloads/1643-7198-1-PB%20\(1\).pdf](file:///C:/Users/CIEP/Downloads/1643-7198-1-PB%20(1).pdf)

23. Reinaldo AMS. Sofrimento mental e agências religiosas como rede social de apoio: subsídios para a enfermagem. Esc Anna Nery [Internet]. 2012 [cited 2015 June 30];16(3):536-43. Available from: http://www.scielo.br/scielo.php?pid=S1414-81452012000300016&script=sci_arttext

24. Wetzel C, Schwartz E, Lange C, Pinho LB, Zillmer JGV, Kantorski LP. A inserção da família no cuidado de um centro de atenção psicossocial. Cienc Cuid Saude [Internet]. 2009 [cited 2015 June 30];8(supl):40-46. Available from: <http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/9716/5529>

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