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Articles

Structural and functional analysis of the social network of users of the Psychosocial Care Center: the pathways of Psychosocial Care

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Análisis estructural y funcional de la red social de usuarios del Centro de Atención Psicosocial: caminos hacia la Rehabilitación Psicosocials (resumen: p. 17)

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Abstract

The objective was to analyze the structural characteristics, functions and attributes of bonds in the social networks of users of a Psychosocial Care Center. For this purpose, a qualitative study was developed in which 16 users of a Psychosocial Care Center participated. In-depth and semi-structured interviews were carried out based on the Network Map diagram. Extensive social networks were identified, with a concentration of intimate relationships, limited to family members and health services. After the illness, the participants reported fragile family relationships. The appropriation of spaces in the community and in friendship relationships favored the structuring of networks. The analysis of the network map comprises an analysis tool indicating the pathways for psychosocial care to reach the production of mental health care.

Keywords: Psychosocial care. Mental health. Community mental health services. Social networking. Social network analysis.

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Introduction

Beginning in the 1970s, mental health professionals, users, and family members of people with mental disorders developed an intense mobilization in Brazil, leading to the production of a series of anti-manicomial movements. As a complex and contemporary social process, the Psychiatric Reform (PR) has produced a break from the asylum model in mental health care and can be analyzed under four dimensions - theoretical-conceptual, technical-assistance, legal-political, and sociocultural, which are evidently intertwined and interdependent[1].

Mental health care is based on Law no. 10,216/2001, which defends the deconstruction of psychiatric hospitals, the creation of community mental health services, and the guarantee of rights for people with mental health problems. Its operationalization is articulated to Ordinance no. 3088/2011, which establishes the Psychosocial Care Network (RAPS in the Portuguese acronym), proposing a horizontal and articulated organizational arrangement between the equipment and health actions so that the coordinated production of care meets the comprehensiveness, access, and linkages[2,3].

Through its aim to reverse the asylum and asylum-like model, mental health care in Brazil is based on the theoretical and methodological assumptions of the Psychosocial Rehabilitation in Italy[4], understood as a set of fundamental strategies for people to have guaranteed spaces for negotiation and exchange in the community where they live. It consists of the full exercise of citizenship through the expansion of contractual power organized in three major axes: housing, social network, and work with social value, which are incorporated into the RAPS from a micro-to-macro dimension, respectively, encompassing from the level of affectivity to the organization of services[5,6].

It is argued that, in consideration of Psychosocial Rehabilitation, the production of care in mental health started to operate a clinic that integrates in an expanded and articulated manner the three axes, making it possible to take the complexity and uniqueness of the experience of mental suffering as changing processes inserted collectively[4].

Given the experiences of transformation and conformation of a care field consequent to the Psychiatric Reform process in Brazil, the theoretical-methodological contributions in Psychosocial Rehabilitation have been incorporated and metabolized, resulting in a new paradigm: Psychosocial Care (PC) that can be characterized by theoretical-practical, political-ideological, and ethical actions that seek to replace the asylum model and the psychiatric paradigm[7,8].

The significant social network[9,10], the object of study of this research, is concomitantly related to PC and to the three axes of Psychosocial Rehabilitation, especially the second axis that is also called social network and discusses the assumption of the quantitative and qualitative narrowing of relationships in the social network negatively impacting community insertion and affective and material exchanges[5,6].

In this direction, the significant social network of users in psychological distress has central importance in the production of care in territorial and community-based

services that constitute the RAPS. The Psychosocial Care Center (CAPS in the Portuguese acronym) emerges as one of the strategic equipment for users in psychic suffering and their families with the normative horizon of PC[1,6-8].

The expansion of the significant social network involves "professionals and all stakeholders in the health-disease process, that is, all users and the entire community"[5]. Thus, it is understood that the alignment of mental health care to the PC requires the partnership among the professional team, the family, and the community in the assistance to people in psychological distress, since the subjects spends most of their time outside the services, in the company of people who are part of their social networks. It has been discussed, however, that services aligned to the asylum model, such as psychiatric hospital and its updates, such as therapeutic communities, still occupy the center of the care network[11].

In the context of health care, we have identified different instruments that enable the analysis of the relationships between individuals and families with the social environment. The genogram and the ecomap comprise two instruments that help identify the functioning, interaction, and organizational patterns of the family system[12]. The social network analysis comprises a differential approach by focusing on the subject and on the establishment of his or her social relations with other subjects and institutions, returning as a practical and theoretical-methodological reference for therapeutic interventions[9,10,13].

The significant social network is an open system that gathers together all the relationships; individual, family, community, and institutional, that influence a person's recognition as a subject. They function as a social buffer by providing real and lasting help and support at the intermediary level of the social structure that deals with social integration and identity development in dynamic processes. When inserted into a diagram, it configures a network map and serves as an intervention instrument, showing the degree of closeness and commitments available to the subject in a given context and situation[9,10,14].

There is a strong relationship between social network and health, its positive aspects affirming the potentiality of large and solid significant social networks. Investigations indicate that the lack of support can be one of the factors that contribute to the development or worsening of psychological distress[13-15]. Several studies have used the Network Map to assess the social network of subjects in various care settings, especially among those dealing with psychological distress[16-21].

Therefore, the analysis of significant social networks makes it possible to understand the relationships established by the subjects and their conditions, informing the health services workers about the processes of psychosocial integration[13] and subsidizing elements for the conformation of psychotherapeutic interventions[10]. Moreover, it potentially acts as an analyzer of the work processes in relation to the PC proposal. In this sense, we aimed to analyze the structural characteristics, functions, and attributes of the bonds in the social networks of users of a Psychosocial Care Center.

Method

This was a descriptive and exploratory study of a qualitative nature. By considering the objective and the object of study, qualitative research; by referring to people's lives and their lived experiences, favors the description, understanding, and interpretation of social phenomena perceived by the subjects[22]. The items of the Consolidated Criteria for Reporting Qualitative Research were followed as criteria for organizing the data[23].

The research was developed in a Psychosocial Care Center, type III, located in a city in the interior of São Paulo, which belongs to a care complex administered by the state. This particularity gives the service a regional character, acting as a reference of specialized care for municipalities located in the Center-West of São Paulo, belonging to the VI Regional Health Department of Bauru.

We used convenience sampling[24] to select the participants, considering as inclusion criteria: age of majority, being under follow-up for more than six months, living in the same municipality as the service. Cognitive deficit that impacted data collection was the only exclusion criterion. Thus, 24 users were invited to participate in the research, of which eight refused due to incompatibility of schedules for data collection or unwillingness to report on their experience and their networks. Thus, the sample of participants consisted of 16 users.

Data collection was conducted between the months of November and December 2019. The technique used was the individual semi-structured in-depth interview guided by a script divided into two parts: the first with closed questions in order to raise sociodemographic information of the participants, and the second with open questions, prepared by the authors and based on the theoretical framework, guiding the completion of the Network Map diagram[10].

The interviews were scheduled, prioritizing times and dates that users would be at the service for their therapeutic activities. They were carried out in a private room in the service itself, audio-recorded, and later transcribed in full. The duration of the interviews varied between 40 and 50 minutes. In case there were any gaps in the users' network composition, the institutional records were consulted as complementary collection instruments.

The network map is organized by a diagram with three concentric circles (internal, intermediate, external) divided into four quadrants: the first is focused on family relations, the second on health services relations, the third on community relations, and the fourth on friendship relations. Regarding the organization of the circles, the inner circle symbolizes the relationships that the individual has the best bonds (intimate relationships); the intermediate circle indicates the relationships with a lower degree of relational commitment, such as social and/or professional relationships and even family ones (contact relationships); the outer circle represents occasional relationships, such as acquaintances from the community in general (occasional relationships)[9,10].

We analyzed the structural characteristics of the networks in terms of their size, density, composition, and homogeneity/heterogeneity, observing the functions of network ties, taking into account social companionship and emotional support[9,10].

To evaluate the network in its structural characteristics, we measure its size, which is linked to the number of people included in the participant's network. The networks that have more effectiveness are those of medium size, since the networks characterized as small are less effective in times of overload or periods of long tension, and the larger ones have the idea that the "other" family member is taking care of the problem[9,10].

Density indicates the quality of the relationship, demonstrating the influence that person can exert on the individual. In relation to the composition, pointing out the place that each member occupies in the quadrants; analyzing the dispersion refers to the geographical distance between the members of the network, and finally, there is an analysis about the homogeneity/heterogeneity that relate to gender, age, culture, and the socioeconomic level[9,10].

In order to know the functions of the bonds exercised by the network, we analyzed some items such as: social companionship, which will indicate the performance of activities in the social environment, and the emotional support that involves the individual[9,10].

The network map analysis used Sluzki's[9] method, which proposes that from the layout and characteristics of the network it is possible to identify structure, functions, and attributes of the ties of significant social networks. This construction of the network map represents an graphic view of the significant social network, from which one can understand its structure, its composition, the functions performed by the network members, and the attributes of the existing ties[10].

The analysis of qualitative data from semi-structured interviews that guided the construction of the network maps took as methodological reference the content analysis in its thematic representational aspect[25]. This research applied the network map as the main instrument to achieve the proposed objectives, thus, the nomination process of categories and subcategories of analysis respected, respectively, the quadrants of the network map and the characteristics, functions and attributes of each quadrant[9,10].

This study was cleared by the Ethics Committee on Research with Human Beings of the Botucatu Medical School - Universidade Estadual Paulista "Júlio de Mesquita Filho", under opinion no. 057382/2019, complying with Resolution no. 466/12[26]. To guarantee the anonymity of the participants, the speeches were identified with the letter 'E' for Interviewee, followed by numerical numerals, according to the increasing order of the interviews.

Results and discussion

Regarding the participants, ten were men and six were women. Age ranged from 25 to 59 years, with an average age of 44 years. Regarding marital status, the majority declared themselves unmarried and of the remaining three, two were married and one was in a stable union. The majority declared themselves white, two declared themselves brown, and one black. Ten reported living with a family member, five reported living alone, and one resided in a nursing home. All participants said they professed some religion, Christianity was the one that stood out the most, and one participant declared

his religion was Jehovah's Witness. The totality is in treatment in the service for more than two years and 15 participants reported using psychotropic drugs daily.

As general aspects, the participants' network map showed that the quadrants with the largest number of people and institutions were related to family relations and work/health services relations. Consequently, the quadrants pertaining to community relations and friendship had the fewest people and institutions. Regardless of the quadrant, most of the relationships considered in the 16 network maps were considered intimate, that is, they were located in the inner circle. Compared to networks built by users of CAPS Alcohol and Other Drugs[27,28], we noticed more structurally diverse network maps.

The extent of the networks can be visualized through Figure 1 - Collective Network Map, which illustrates the composition built by each participant. In this map are inserted the people and institutions that were considered as elements of the participants' networks, whether family relationships, community relationships, friendship relationships, or relationships with health services.

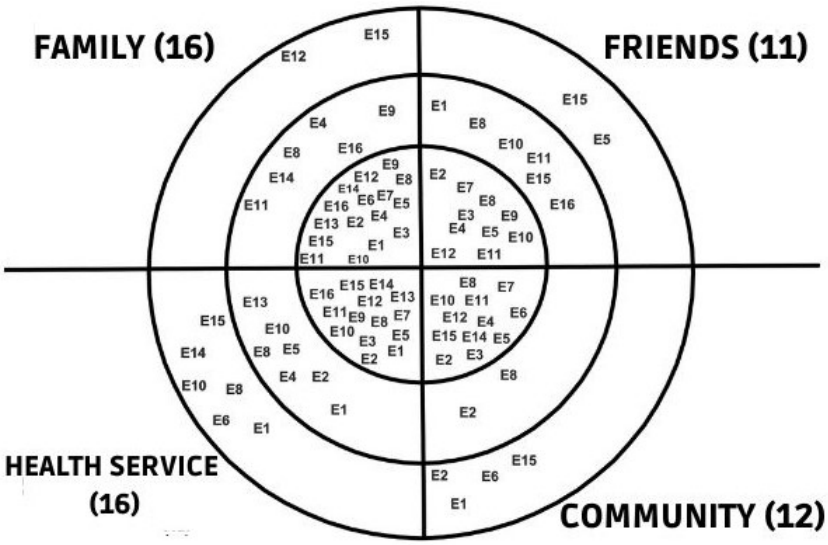

Figure 1. Collective Network Map. Botucatu/SP. 2019.

We started the analysis of the structural characteristics of the maps, considering the size of the networks and their homogeneity. The former is related to the number of people who make up the network map, and the latter, to the similarities between the socioeconomic, demographic, and cultural characteristics of the people inserted in the map[9].

In regards to the size, we noticed more often extensive social networks (E3, E7, E8, E9, E10, E11, E12, and E15), followed by intermediate networks (E1, E2, E4, E5, E6, E14) and small networks (E13 and E16). As for the homogeneity of the network maps, in general, the majority are adults. Children were exceptions among maps, and when highlighting the feelings aroused in the participants when mentioned, we found that they produce positive affections:

> my nephews, they live in my heart, my joy. If I'm sad, I go there to recover my joy. (E6)

We identified that the functions of the bond was the most used criterion for the insertion of individuals in the network map. Among the functions, emotional support was the most cited, and participants attributed reciprocity and degree of commitment. In general, the relationships that offer emotional support were expressed through key words and experiences related to care, help, support, availability, and commitment established in these relationships, and these are the people participants seek out when they need them.

In the quadrant that refers to family relationships, excerpts allow us to affirm the presence of people with whom the density of relationships was considered strong and significant, and the function of these bonds exercised social companionship, emotional support, and material help:

> my mother, she is the center of everything, she never arrived to diminish, she always arrived to add, because she is the great pillar, my life. (E2)

> my aunt Cida, she talks to me, asks what is happening to me, I go to her house, she makes lunch for me, a very good person, with a very good heart, she has even given me money when I was without money. (E8)

Family relationships exert, positively or negatively, a strong influence on the mental health of individuals. The conviviality, satisfaction, and connection of effective relationships decrease the expression of psychological suffering, while distant or abusive relationship styles lead to worse psychological outcomes[29]. The fragility of family bonds reveals another extreme of the density and function of these relationships in the participants' network map. We noticed that the geographical territory, proposed in the referential as dispersion, was considered adjunct to density and that the follow-up in the service influenced the quality of the relationship[9,10]:

> my family is from here, but I don't even need to count on my family, they don't give a damn about me no, I have ties with some, but if I have to count on them, I don't even need to. (E12)

> I consider as family my children, my husband, close family that is with me directly and two brothers. The rest, we hardly see each other, so I don't consider it family anymore. (E11)

> I consider outsiders my family, after I started going to *Cantídio* [Center for Integral Health Care] and came here they all moved away from me, nobody wants to know about me anymore, I live alone in this world. (E1)

The density was characterized by a larger number of people and institutions in the inner circle, evidencing the weakness in the participants' networks (Figure 1) [9,10]. Family relationships represent one of the first contexts that are interfered with by the psychic illness and go through intense and diverse dynamics, reconfiguring

the conviviality of the members in the family context. From symbolic mourning to overloads, the coexistence among family members experiences conflicting situations that can lead to atrophy in this quadrant, as was characterized in the composition of the participants' network map[30,31].

Regarding the frequency of contacts, we perceived that the geographical distance led to a greater need to maintain contact in order to sustain the intensity of the relationship. In another case, the perception was of an occasional relationship, of little commitment[9,10].

> ... the oldest one is called L., she doesn't live here, only she calls me every day, she is a loving daughter and when she always can she comes to see me. (E11)

> my father, because I don't live with him, we don't talk much. (E4)

It may be affirmed that the emotional and material support offered by family relationships had positive repercussions for health promotion, specifically in solidarity and co-responsibility[17,18]. In this sense, the material help was attributed only in the family quadrant in the participants' network map, was characterized by financial help and was independent of the affective characteristic of the relationship. Owing to the absence or insufficiency of social security benefits for the maintenance of expenses and survival, in several moments, material help was the justification for the inclusion of some relative in the network map:

> my sister, she transferred money to me for four years. But she helped with this money, but it is very difficult to live with her, because she is very explosive. [...] it's not every problem I have that I can take to my sister if it's not going to give an argument. (E15)

> my brother, because he pays half of my nursing home, he who committed to pay, took me in Pardinho to eat street food. A person I consider, I know he loves me, he talks to me about everything, he never condemned me for being like that. (E8)

Building the network map together with the participants made it possible to understand the conditions of a certain lived context that influenced them. The material help, represented in the speeches, illustrates such a result. It is warned that economic difficulties generated by insufficient income, currently considered factors in the social determination in mental health, are associated with worse health outcomes in young people and adults[29,32,33].

The composition of the second quadrant of the network map, health services, was concentrated between Basic Health Units (BHU) and CAPS, which were distributed among the three circles of the participants' maps (Figure 1). We observed that the intermediate quadrant had a greater number of relationships when compared to the familiar one. The following excerpts characterize these qualities:

> [...] the M. from CAPS, I like it. V. always helps me when I need it, attends to me. They are all good, they have empathy for the patients, they treat us with love. (E10)

> Dr. M., from the health center, because she makes things work. (E9)

The fact that two services of the RAPS, CAPS and BHU, evidence a small quadrant, considering the structural characteristic of the social networks[9,10,27,28]. We emphasize this positive aspect, because they are community mental health services that, besides having strategies to deal with the mental illness, include in their actions the collaboration and the active participation of family members and other members of the social network of the user, with the objective of instrumentalizing the management in the welcoming and care of the various difficulties that may occur. These services have the ethical, technical, and political commitment to produce emancipation and autonomy for users, building spaces for dialogue to deconstruct stigmas and prejudices[28,34].

In the view of the study participants, the functions performed by health services are similar to those performed by families, being points of comparison for the participants. In this exercise, different densities can be observed, as well as, multidimensionality is identified as an attribute of these bonds[9,10]:

> The CAPS, but not so close because I think the family helps more. Family is family, that's where it helps us. (E4)

> A. and S. are closer, they help me a lot, they try to do their best, so they are close. It's not family, but it gives a good help. (E13)

When the health services and their professionals were approached, we noticed the concentration of statements related to emotional support due to the quality of the bonds established with the participants. We visualized these results when participants referred to seek services when they do not feel well, emphasizing that the service is the place where they find support and care, a characteristic that concretizes the variables of the micro-dimension that determine rehabilitative results[6]:

> M., from CAPS, because when I was at my worst without... I was at my worst she helped me. (E3)

> Dr. V., I find her a very intelligent person, she I can tell my whole life without fear, I can even cry... (E8)

> A.L., R. and M., because they help me get out of the bottom of the pit. When I was like a beggar, I came with the bag on my back here and stayed... (E12)

In the quadrant that discusses the insertion of the community in the network map, we observed the circulation of participants through various spaces in the territory. Most people and institutions were inserted in the closest relationships that were linked to religious issues and citizenship:

> I am a Jehovah's Witness, my friends are all there, there I learn, I am a person who goes, who is religious, I go for me, because I like it. (E10)

> In the MTC [religious movement], I was well received and they give a basis to show that the social security reform, for example, was not such a good thing, the labor reform will lead to loss of rights and... of people, of the worker, so that's why I put the MTC [religious movement] (I15)

In the community, emotional support was characterized by participants pointedly when referring to how they are welcomed, how they perceive the affection and consideration received in religious institutions:

> The church, because I always go to the Sunday masses and I'm welcomed. (E5)

> The church, the people like me, I became a worker, there I bring the word, I pray for the people. (E7)

We identified the appropriation of territory by the participants when they reported the places they frequent as leisure options such as the square, the snack bar, and the mall:

> The square in the occasional relationships, it is where I am me, I am not afraid of anyone, freedom of expression above all, resistance, joy. The Boss in the square with his guitar, you start to philosophize, there is this good energy... For those who were crazy in the past, today be I., the joyful singer. (E2)

> At the mall, I feel very comfortable. I feel that there are a lot of understood people there, [...] I met many there, they talk to me without prejudice. [...] shopping, I love shopping, me and my niece go there Saturday and Sunday. I go there to make friends. (E8)

We noticed in the community network, an institution that performs several functions in the lives of the subjects, the most cited was an association of mental health users with a focus on work, as reported below:

> the Arte e Convívio [Non-Governmental Organization], I don't know how to explain, they help me look for a job, I like them. (E4)

> the Arte e Convívio [Non-Governmental Organization], there you have contact with other people's madness. (E12)

> the Arte e Convívio [Non-Governmental Organization], in the first [quadrant], because I work, I earn income. I like to work, it does me good. (E8)

Associations of users of mental health services showed to have a fundamental role in the defense of rights, are focused on work, sociability and empowerment of users and

their families. It can have five profiles, being them: of mutual help; of mutual support; of defense of rights; of transformation of stigma and dependence in the relationship with madness and the crazy in society; and of participation in the health/mental health system and wider social militancy[35,36].

Psychic illness resonated negatively in the community quadrant of the network for some participants:

> I can't with too much noise, I don't like to go out, before everything happened, I used to attend... (E9)

> now I don't leave the house much, I don't like tumult, talking in my head, I like to stay more at home. (E10)

We observed, when analyzing the third quadrant, its power in the production of care in spaces beyond the health services, bringing together principles and guidelines that make interlocutions with the social network axis of psychosocial rehabilitation and with the sociocultural dimension of the psychiatric reform. The circulation through the different spaces of the territory favors the expansion of the *pari-passu* contractuality with the deconstruction of the social imaginary that sustains the stigma of madness[37].

In the last quadrant, friendship relations, there was again the insertion of professionals and other users in the CAPS that were related to the experiences and the welcoming performed by professionals. This finding corroborates data from research conducted with users of CAPS-Alcohol and other Drugs[27]:

> The CAPS patients, D., G., I consider them a family here, right? Because we go through the same things, so, one understands the other. R. [professional] I like her very much here [CAPS] (E10)

> V., she helped me a lot, the strong friendships I have are here. (E1)

Similar to the community, in the quadrant referring to friendship the participants included people linked to religion and were related to critical episodes of the illness:

> The friars E. and J., because when I was very bad from obsessive thinking, I would go to look for them and they would help me, listen to me, give advice, [...] I have friendship with them. (E15)

The relationship between intensity and dispersion of the people inserted in the participants' network maps also appeared illustrated in the quadrant referring to friendship. It is characterized that there is a relationship between geographical distance and intensity of the relationship:

> M., lives in Itaberá, this is a friend of many years, I consider her a true friend because the two of us are like this: one helps the other. When she is not well, I

> help her and when I am not well, she helps me. Until today we are like this, one keeps sending messages to the other, talking if she needs to get something off her chest. (E11)

Even though the inner circle in the friendship quadrant (Figure 1) has a greater density of relationships, it can be noticed that in comparison with the community and health services quadrants, there was a greater distribution among the outer circles of the network map. The participants, however, presented some difficulty in expressing the reason for insertion or stated that they did not have friends, these relationships being linked to illness and treatment:

> I would like to have friends, sit down, talk. I had them in the past, then they disappeared. (E1)

> I don't have friends. (E6)

> ... even the friendships I had before, I abandoned. (E7)

> Friendship is God, no one comes by the house for coffee, to go anywhere, so my friends have all died. (E14)

Isolation from friendship relationships in an elderly population was associated with worse outcomes for stress and depression symptoms[38], also functioning as protective factors for the population with severe and persistent mental disorders[29]. With this characteristic, it dialogues with the perception of loneliness as a social network factor that most negatively influenced health in the population of three European countries[39].

The functions of attachment in the fourth quadrant, social companionship is evidenced:

> A., there's V., T., T., they also go to the salon, they are the ones I consider, who are together, always talk, always take pictures together, that's why I say they are closer, there's P. (E10)

> M., because he is a person like that, when we arrange something, if I go to his house or he goes to my house, we arrange it and he goes..., we like to have a tubaína, to talk a little, so that's why I put him there. (E15)

During the configuration of the participants' network map, it was identified that the psychological illness triggered a process of reduction of the social network, a phenomenon called vicious circle[9]. This fact, operating under the aegis of PC[4,7,8], creates different opportunities for intervention for the equipment and professionals working in the RAPS. Interpreted in a complex way, the network calls for a set of actions from promotion to care production to support the user in weaving networks based on circles that expand and are, in their territories, at their disposal[5].

Final considerations

It was possible to understand the structure of the social network of CAPS III users, how the relationships are established, and their functions. In general, we affirm that the networks were characterized as large, with distinct densities and better-quality prevailing in family relationships and among health services, specifically in CAPS. Regarding the composition, in all areas intimate relationships prevailed, highlighting the family quadrant. Regarding the dispersion of the network, it was mostly made up of people geographically close, influencing the frequency of contact. There was no high heterogeneity in the composition of the networks. The most evident functions of the bonds were social companionship, emotional support, and material help, and the functions of cognitive guidance, social regulation, and stimulation of new contacts were not observed.

We noticed that users have appropriated the spaces in the community and seek friendships beyond the health services, most of them related to religion. Some family relationships, especially after the illness of the subject, have become fragile, indicating the need for health professionals, especially from CAPS, to support and work with family members during the process of psychosocial rehabilitation of users.

Through these data, the health services can reflect the paths they are following, when the horizon of psychosocial care is taken as a reference, since the expansion of significant social networks moves the rehabilitation triad and advances the project of building an anti-manicomial institution and democratic society.

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Resumo

Objetivou-se analisar as características estruturais, as funções e os atributos dos vínculos, nas redes sociais, de usuários de um Centro de Atenção Psicossocial (Caps). Para isso, desenvolveu-se um estudo qualitativo em que participaram 16 usuários de um Caps. Foram realizadas entrevistas em profundidade e semiestruturadas com base no diagrama do Mapa de Redes. Identificaram-se redes sociais extensas e com concentração de relações íntimas, circunscritas aos familiares e aos serviços de saúde. Após o adoecimento, os participantes relataram relações familiares fragilizadas. A apropriação dos espaços na comunidade e nas relações de amizade favoreceu a estruturação das redes. A análise do Mapa de Redes compreende uma ferramenta analisadora indicando, à produção do cuidado em Saúde Mental, os rumos para a Atenção Psicossocial.

Palavras-chave: Atenção psicossocial. Saúde mental. Serviços comunitários de saúde mental. Rede social. Análise de rede social.

Resumen

El objetivo fue analizar las características estructurales, las funciones y los atributos de los vínculos en las redes sociales de usuarios de un Centro de Atención Psicosocial. Para ello, se desarrolló un estudio cualitativo en el que participaron 16 usuarios de un Centro de Atención Psicosocial. Se realizaron entrevistas en profundidad y semiestructuradas con base en el diagrama del mapa de Red. Se identificaron redes sociales extensas y con concentración de relaciones íntimas, circunscritas a los familiares y a los servicios de salud. Después de la enfermedad, los participantes relataron relaciones familiares fragilizadas. La apropiación de los espacios en la comunidad y en las redes incluye una herramienta de análisis, indicando a la producción del cuidado de salud mental los rumbos para la atención psicosocial.

Palabras clave: Atención psicosocial. Salud mental. Servicios comunitarios de salud. Red social. Análisis de red social.