EXPLANATIONS OF FAMILY MEMBERS ABOUT PSYCHOLOGICAL DISTRESS: DIVERSITY AND COMPREHENSIVENESS IN QUESTION[1]

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ABSTRACT. This study presents the explanations of family members about psychological distress through the therapeutic itineraries of patients in mental health care from the perspective of the family. The Therapeutic Itinerary (T.I.) is understood as all movements raised by groups or individuals in order to safeguard or recover health, which can boost various resources, from religious practices and home care to the predominant biomedical devices. This study aimed to identify the explanations given by the family member regarding the mental health problem of the person in psychological distress. A qualitative study was carried out in which 10 interviews were conducted with family members of users of a Psychosocial Care Center (CAPS). According to the analysis of the interviews based on the Grounded Theory, it was possible to group the explanations into: (1) Spiritual, (2) Organic, (3) Family history, (4) Life events, (5) Diagnosis and (6) Others. The explanations given by family members involve a multiple look, which incorporates different causes and reasons, approaching the idea of integrality in health.

Keywords: Mental health; family; Psychosocial Care Center (CAPS).

EXPLICAÇÕES DE FAMILIARES SOBRE O SOFRIMENTO PSÍQUICO: DIVERSIDADE E INTEGRALIDADE EM QUESTÃO

RESUMO. Este estudo apresenta como tema as explicações de familiares sobre o sofrimento psíquico pelos itinerários terapêuticos de usuários na atenção em saúde mental a partir da ótica da família. O Itinerário Terapêutico (I.T.) é entendido como todos os movimentos suscitados por grupos ou indivíduos a fim de resguardar ou recuperar a saúde, que podem impulsionar diversos recursos, desde práticas religiosas e cuidados caseiros até os dispositivos biomédicos predominantes. O objetivo deste estudo foi identificar as explicações dadas pelo familiar a respeito do problema de saúde mental da pessoa em sofrimento psíquico. Efetuou-se um estudo qualitativo em que foram realizadas dez entrevistas com familiares de usuários de um Centro de Atenção Psicossocial (CAPS). De acordo com a análise das entrevistas com base na Teoria Fundamentada em Dados foi possível o agrupamento das explicações dadas em: (1) espirituais, (2) orgânicas, (3) histórico familiar, (4) eventos de vida, (5) diagnóstico e (6) outros. As explicações dadas pelos familiares envolvem um olhar múltiplo, que incorpora diferentes causas e motivos, aproximando-se da ideia de integralidade em saúde.

Palavras-chave: Saúde mental; família; Centro de Atenção Psicossocial (CAPS).

EXPLICACIONES DE FAMILIARES SOBRE EL SUFRIMIENTO PSÍQUICO: INTEGRALIDAD E INTEGRALIDAD EN CUESTIÓN

RESUMEN. En este estudio se presenta como tema las explicaciones de familiares sobre el sufrimiento psíquico por intermedio de los itinerarios terapéuticos de usuarios en la atención en salud mental a partir de la óptica de la familia. El Itinerario Terapéutico (I.T.) es entendido como todos los movimientos suscitados por grupos o individuos a fin de resguardar o recuperar la salud, que pueden impulsar diversos recursos, desde prácticas religiosas y cuidados caseros hasta los dispositivos biomédicos predominantes. El objetivo de este estudio fue identificar las explicaciones dadas por el familiar acerca del origen del problema de salud mental de la persona en sufrimiento psíquico. Se efectuó un estudio cualitativo en el que se realizaron 10 entrevistas con familiares de usuarios de un Centro de Atención Psicosocial (CAPS). De acuerdo con el análisis de las entrevistas con base en la Teoría Fundamentada en Datos fue posible la agrupación de las explicaciones dadas en: (1) Espiritual, (2) Orgánico, (3) Historia familiar, (4) Eventos de la vida (5) Diagnóstico y (6) Otros. Las explicaciones, dadas por los familiares, involucra una mirada múltiple, que incorpora diferentes causas y motivos, aproximándose a la idea de integralidad en salud.

Palabras clave: Salud mental; familia; Centro de Atención Psicosocial (CAPS).

Introduction

In Brazil, the number of studies that have investigated the explanations given by family members about mental disorder is limited, according to searches carried out in the SciELO, Lilacs and BVS-Psi databases. Only six articles, published between 2004 and 2013, chose this theme for research. Some studies (Budini & Cardoso, 2012; Moraski & Hildebrandt, 2005; Villares, Redko, & Mari, 1999) separated the explanations that family members of users give for the origin of the mental disorder into categories. Examples are: the innate tendency for mental illness to emerge, spiritual reasons, and life events considered traumatic, such as deaths and job losses.

The theme of this research was the explanations of family members about psychological distress[4] from the therapeutic itinerary of people in psychological distress. The Therapeutic Itinerary (TI) is understood as all movements taken by groups or individuals in order to safeguard or recover health, using different resources for this purpose, from religious practices and home care to the predominant biomedical devices (Cabral, Martinez-Hemáez, Andrade, & Cherchiglia, 2011). The definition of TI allows to realize that this concept is not restricted to the identification and availability of local health services, as it also encompasses the different individual searches for health care and the socio-cultural possibilities of each patient, because it considers the complexity of the choice process (Martins & Iriart, 2014). In Health Anthropology, the concept of TI came up with the main objective of interpreting the processes by which individuals or social groups choose, evaluate and adhere (or not) to the different forms of treatment (Alves & Souza, 1999).

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[4] In this article, the expressions 'mental disorder', 'psychological distress', 'mental suffering' and 'mental illness' are used as synonyms.

When dealing with the disease, the patient and people close to him/her (such as family, friends, therapists) formulate, (re) produce and disseminate a set of ways and paths to be followed according to the socio-cultural universe of which they are part (Moreira & Bosi, 2014). The participation of other individuals in the construction of the TI takes place, primarily and predominantly, by family members. This participation of others in the construction of the itinerary is quite frequent in the case of people in psychological distress, in view of the family's involvement in the care of the individual, whether in times of crisis or not.

In the case of Brazil, with regard to services that can integrate the TI of people in psychological distress, there is currently a network of hospital and community services spread across different states and the Federal District. Today, we find the coexistence of Psychosocial Care Centers (CAPS), beds in general and specialized hospitals, devices for deinstitutionalization (such as therapeutic residences), mental health care within the scope of primary care (in the Basic Health Unit or Family Health Basic Units), among others, according to Ordinance nº 3.088 (2011). In all these equipments, the family is present, either as an informant of the condition of the person being treated, as co-responsible for the care of the individual, or as a target for the care of the teams.

The presence of the disease can cause the user of mental health services to become dependent on his/her family members, and with this the burden, which can be characterized by material, subjective, organizational and social wear can affect the family (Covelo & Badaró-Moreira, 2015). Therefore, it is important to emphasize that the family subsystem is one that most influences the choice of TI by the individual. The choice of forms of care depends on the contents that have been associated with the experience of psychological suffering, which are cultural elaborations shared between individuals and mobilized in situations of distress and directly submit to a shared world of practices, beliefs and values (Moreira & Bosi, 2014). Therefore, explanations about psychological distress can influence the choices for forms of treatment, types of services or therapeutic resources.

In view of the above, the general goal of this research was to identify the explanations given by the family member regarding the mental health problem of the person in psychological distress from the investigation of the therapeutic itineraries.

Method

The research participants were ten family members of people who were undergoing treatment at a Psychosocial Care Center (CAPS) located in the Triângulo Mineiro. These users were over 18 years old and had at least a history of psychiatric hospitalization. The family members had no previous psychiatric hospitalization or treatment carried out/underway in Psychosocial Care Centers (CAPS).

The instrument, used in a larger study, was a semi-structured interview script that investigated, in addition to the sociodemographic data of the interviewee, the explanations given by the family member about the disease or mental disorder; the search for support after identifying the problem; treatments already performed by the user; and family feelings about their inclusion in mental health services. For this study, excerpts from the interviews were used, which dealt with explanations given by family members about the psychological distress. In addition to the interview, a questionnaire was also applied to collect sociodemographic data and the clinical history of the user (diagnosis, number of

hospitalizations, medication in use) from the medical records at CAPS, adapted from Schein and Boeckel (2009) with authorization from the authors.

Family members who came to CAPS to accompany the user in medical consultations and/or group activities/family meetings were invited to participate in the research. Verbal information about the research was provided and, if the family member accepted to participate, an interview was scheduled at a date, time and place of their choice (their residence or in an appropriate university room). On the day of the interview, the Free and Informed Consent Term was delivered, in two copies, for signature, according to the model approved by the Research Ethics Committee (Opinion 1.007.528). All interviews were recorded, only in audio and, to guarantee confidentiality regarding the identity of the participant, the interviews were numbered from 1 to 10, using the name E1 for the first interview, E2 for the second, and so on.

The number of interviews was determined by the data saturation procedure (Fontanella et al., 2011) and after literal transcription, the analysis took place based on the steps delimited by the 'Grounded Theory', namely: open, axial and selective coding for data summarization, identification of the properties of the analysis categories and establishment of relationships between categories (Straus & Corbin, 2008 apud Biaggio & Erdmann, 2011). As support for the construction of categories, the 'Trees of Association of Ideas' was used, according to Spink and Lima (1999). The elaboration of a tree for each interview, with emphasis on the speeches that met the objective of this research, allowed the open coding of the material. Then, the keywords were highlighted in each idea tree of association, enabling axial coding. Another step was to identify the common content of the interviews, in the selective coding stage. And, finally, the last step was related to grouping the results into thematic categories: 1) spiritual, 2) organic, 3) family history, 4) life events, 5) diagnosis, 6) others.

Results and discussion

Most family members were female, without a partner, with low education, with direct relationship with the user, aged over 45 years. The users, according to the data in the medical records, were mostly female, with a minimum age of 19 years and a maximum age of 55 years, without a partner, education was not reported in the medical records or was restricted to complete or incomplete elementary school, the majority were away from the job market or were retired, the number of hospitalizations ranged from a minimum of 1 and a maximum of 6, and the main diagnosis found was schizophrenia. The predominant gender among caregivers has also been highlighted in other studies (Pegoraro & Caldana, 2008). According to Follador (2009), historically, the role that society expects and wants women to play is that of care: of the house, children, husband and submission to the laws of men. And, although the entry into the labor market and the conquest of civil rights have changed the way women exist, resulting in the construction of a new female subjectivity (Boris & Cesídio, 2007), this heritage of care still persists, mainly in the cases of family members with mental disorders who are more dependent, and who in most cases, as shown in the results of this study, are the children, husbands and/or siblings of these women.

The family members did not have a single and uniform understanding about the psychological distress, but several hypotheses and assumptions, which pointed out multiple explanations given by them, showing how complex it is to understand a psychological distress. Only in the second and third interviews there is only one type of explanation for the

problem. For the other interviewees (Table 1), there is no single cause or explanation for psychological distress.

Table 1. Type of explanations given in each interview about psychological distress

Explanations	Interview
Spiritual	1, 4, 5, 8
Organic	1, 2, 3, 5, 8
Family history	5, 7, 10
Life events	4, 5, 6, 7, 8, 9
Diagnosis	4, 6, 7, 9, 10
Others	4, 5, 7

Source: The authors.

According to Budini and Cardoso (2012) and in line with the findings of this research, this multiple knowledge is built between the family and the person with psychological distress in direct relationship with time and with the behaviors that person presents, that is, the explanations may change and/or evolve over time and/or in accordance with the behavioral changes presented. As presented by Villares et al. (1999), the multidimensional approach is very important, as it encompasses, in the study of psychological suffering, the different areas of life: biological, social, psychological, environmental, economic and cultural, which are of paramount importance for thinking about interventions in the area of promotion of mental health, including care for everyday family relationships.

Regarding 'spiritual explanations', in two interviews (E1 and E8), family members associated the origin of the psychological distress with the domination of the user's body by an evil spirit, which made him/her hear and see things, causing him/her to have more aggressive attitudes. Seeking help from religious institutions so that users were no longer hospitalized was the solution found by these family members, who stated an improvement in the situation: "It is then, I think it is more [...] these voices are not good [sic] [...] I think it's not [...] it's the enemy's voice, who takes advantage of her illness and then comes in and stays because she only speaks negative things, just to make her nervous" (E8).

Some spiritual explanations presented by family members in this study relate to the idea of psychological suffering to the supernatural, such as spirits, black magic and spells, going in the same direction as other studies in the area (Cirilo & Oliveira Filho, 2008; Iglesias, Quintanilha, & Avellar,2016; Villares et al., 1999). For Villares et al. (1999), these explanations generate a feeling of acceptance in the face of the difficulties experienced, bringing comfort and not blaming the family for the disease. However, for Iglesias et al. (2016), this feeling of acceptance can lead to the conformation and/or lack of responsibility

of families for the care of their family members, since there is nothing more to do than wait for divine action. Nevertheless, the other spiritual explanations given are associated with the depletion of resources already sought, leaving, then, the religious institutions for the search for care and 'cure' that medicine was unable to provide.

In two other interviews (E4 and E5), family members turned to religious institutions due to the depletion of resources already sought, which had no effect; and in one of the interviews, the initiative was taken through advice given by a close friend of the family. Once again, family members say they have improved their condition after taking this initiative. "We even think like that, we think it's a spiritual type [...] Just today, yesterday, I was advised to try to take him to that doctor X clinic, right? Because we think of several possibilities to solve, to help [...]" (E4). According to the literature, religious institutions and religions can be an important support for these families, because they offer social support through the church community, in addition to understanding the suffering that legitimizes the lived experience (Budini & Cardoso, 2012). However, Iglesias et al. (2016) alert the health services to treat this issue very gently, so that the individual does not blame him/herself if his/her symptoms do not disappear from faith. Moreover, our data also point out that the search for help and access to health services was driven by the search for the improvement of symptoms perceived by the family, which became unbearable for the family, as also pointed out by the studies by Budini and Cardoso (2012), Iglesias et al. (2016) and the classic work by Tsu (1993).

The 'organic explanations' were found in five interviews. In four of them (E1, E2, E3 and E5), family members used expressions such as "[…] weak personality" (E1), "[…] problem in the head" (E3; E5), "[…] disorder in the brain" (E2), as the excerpt illustrates: "To this day I think I don't know what X really is [...] I know one thing, it was [...] it's a head disorder, only this [laughter], that's all" (E3). Another interviewee explains why her brother has a 'brain problem' through observations of his behavior: "Sit, lie down, put his head on my lap, right, then I put a cloth, wet, cold, on the forehead that remains too hot. So it seems that it is a disorder that is there, in his brain, right?" (E2). It is, therefore, a physical location of the problem, even though the cause is not clearly known by the participants.

Two family members (E2 and E8) identified the beginning of the psychological distress during early childhood, reporting developmental difficulties when compared to other children, such as: motor, cognitive, language delay, among others. "His development was not the same as that of the children or other children that Mom had already had. He was slow to walk, he was slow to talk, he was slow to crawl. He was slow to develop like a normal child" (E2).

Moreover, interviewees 3 and 8 identified that, from a certain event, there was a change in the users' behavior, such as delirium followed by fainting, making the wife no longer "[…] normal" (E3) or after an intense headache, it was no longer possible for the daughter to perform tasks with the previous ease: "I asked ' what is this problem, is it depression?', then he said that it is not, that the brain does not operates normal, and that these drugs are to go back to what, to go back at least as it was before" (E8, emphasis added).

The organic explanations for the psychological distress given by family members in this study indicated that they believe that there is a problem in the constitution and/or in the functioning of the head or of a specific organ - in this case, the brain -, corroborating studies by Moraski and Hildebrandt (2005), Spadini and Souza (2004), Azevedo and Gaudêncio (2007). This happens, according to Tsu (1991, p. 49, authors emphasis), because family members believe "[…] that mental illness is something that occurs 'within' the body space.

The subjectivity of the individual is discarded, making a reduction that transforms it into a damaged object […]", discarding the psychosocial dimension. Another reason for this type of explanation to be the most cited (along with life events), according to Moreno (2000), is that the family members have little understanding about the psychological distress, therefore, they seek to understand through medical examinations areas in the brain that may have been affected, thus explaining the patient's behavioral changes.

Other explanations found in this study relate to 'family history' as a cause of psychological distress. In these explanations, three interviewees pointed out that users behave very similarly to other close relatives, such as mothers and uncles. One interviewee (E5) reported four cases of psychological distress in her family, recalling that a doctor suggested that the problem could be hereditary. To this explanation, the interviewee also added the organic perspective: "P: Do you think that in her case [...] E1: It is puerperium. Whoever sees it is really hereditary. It's from the head. P: Do you think it is [...] that it is hereditary. E1: It is hereditary and really head disorder" (E5). A second interviewee (E7) highlighted the family history as a cause of the psychological distress, as the relatives related the current problem of the sister-in-law to that of her mother, stating that the two had a 'crazy' problem: "   And considering her condition, they say she is just like her mother. The same problem she has is what her mother had. Her mother died, it seems that in her early thirties, they say she was crazy, and her condition, when she is [...]" (E7).

In the last interview (E10), the family member says that the user had a brother and sister with the same diagnosis as hers, and the sister committed suicide by setting the house on fire and from this event that the family worried about the case of the CAPS patient: "The woman had the problems that my mother has [...] when [the husband] came home the woman set the house on fire and burned to death with her cell phone on the side, with her legs crossed, died the way she was. So that's where we were concerned [...]" (E10).

Several studies (Iglesias et al., 2016; Pereira, 2003; Spadini & Souza, 2004; Tsu & Tofolo, 1990) bring family history as a cause cited by family members and point out that the heredity factor comforts the family because it does not imply responsibility by getting sick directly, but at the same time, it brings despair, because the family does not see change or improvement in something hereditary. Furthermore, a fact that caught our attention in the interviews, which goes against the findings of the aforementioned research, refers to the fact that, in most cases, even with family history present, the family members did not relate this family history with the explanation of origin of the mental disorder.

Explanations for 'life events' were found in six interviews. In two interviews (E4 and E8), family members pointed out that the onset of psychological distress was due to parental fights and divorce. "So there is a long time, right?! This ehh [...] these very different behaviors started more or less when my parents separated right?! They separated [...]" (E4). Still exemplifies:

> [...] then [...] then in fact she [...] we don't know if this is it, it's because I and her father, we didn't work out [...] then we fought sometimes and she didn't liked it [...] she asked like that, when I argued with her father she talked, she fought with her father too, it was not to fight with me [speaks in a low voice], then she got nervous [...] but I don't know if that's it [...] (E8).

In four opportunities (E4, E5, E6 and E7), family members related the origin of the users' psychological distress to the birth of their children (E4 and E5): "P: And tell me, it's [...] how, how did this problem appear? E5: Puerperium! [responds emphatically] P: Was it during the puerperium? E5: Yes" (E5). Likewise, another interviewee points out: "My sister, the eldest, after she lost her son, she was a little upset, taking a lot of medicine. I forgot the

medication she takes [...]. Psychologist medication [sic] [...] She is being followed up with a psychologist and there at the CAPS [...]" (E6).

In two cases (E6 and E7), the interviewees pointed out that the loss of a child or the disappointment caused on their parents were reasons for the mental disorder: "Heartbreak! Because the children, when she went into depression, was when her son died of an accident and then the children grew up, everything went the wrong way, you know? She has no good for her three children" (E6). Another example: "[...] her son [...] told everyone that he didn't like woman, that he liked man. Then he released, she passed out [the user]. Then she says that in this blackout that she had she hasn't returned good anymore" (E7).

In addition, in three interviews (E4, E7 and E9), family members were able to identify events that resulted in the worsening of the condition of patients, such as the loss of the father: "It can be, for example, a depression, especially his behavior after my father died, he got worse, he just wants to lie down, he doesn't leave the house, he often has to go there at the CAPS he doesn't go, he doesn't get up early [...]" (E4).

Other events reported and related to the worsening of the condition of the user were pregnancy and stress related to loss of job and income: "It seems that in her second pregnancy with E. it seems that she no longer stayed [...] the problem seems to have got worse. Because she says that she no longer wanted to look at the boy, she did not accept the boy, she was very aggressive, very nervous [...]" (E7). Another example: "[...] he can't live under pressure [...] When he has some difficulty, worried about something, he freaks out. He can't handle it! So [...] this time it was what triggered it" (E9).

The explanations for life events in the findings of this study related stressful events passed on to the onset of psychological distress in their family members, as if such an event were the divider between health and disease, as pointed out in the studies by Pimenta and Romagnoli (2008), Budini and Cardoso (2012), and Iglesias et al. (2016). According to Rodrigues (2007), these explanations manifest the social dimension contained in these speeches, as mental illness is represented as part of a person who integrates a social system that affects it and, when family members explain it from this perspective, they are also attributing external and less stigmatizing causes to the disease. In addition, Villares et al. (1999) state that attributing the emergence of mental disorder to specific causes, for families, is less embarrassing and painful than recognizing, discovering and thinking about other causes and/or naming them by their scientific name.

Explanations by 'diagnoses' appeared in five interviews. In three interviews of this category (E4, E9 and E10), the interviewed family members believed and agreed with the diagnosis given by physicians. "I would go for the option of the physician, the report, that he has progressive schizophrenia [sic][…]" (E4); "Similar to the physician in duty there [psychiatric office], psychiatrist, he was explaining the issue to me[…] He is bipolar and he also has schizophrenia […]" (E9) and "So, the medical report says bipolar disorder, but there is another thing […] another name, a kind of maniac, mania, such stuff, you know? At the same time she is well, she gets agitated, nervous [...]" (E10).

In the other interviews (E6 and E7), family members support their information in the medical diagnosis received, showing that sometimes they do not understand this diagnosis so well and at other times they do not believe in it: "We did not understand what depression was, right? We didn't know what she had [...]" (E6). "Oh [...] I know how to tell the fact that I know this way from her reports [...] that she tried to commit suicide three times [...] because she had a very strong depressive crisis. She tried to commit suicide, that's what I can tell you [...]" (E7).

In this research it was possible to observe that the psychiatric diagnosis according to the established criteria of the ICD and DSM can be meaningless for family members. Most of the interviewed family members are not familiar with the scientific nomenclatures and with the technical terms used by doctors, so, when listening to the interviews, we have the impression that these words are played at random among their explanations. Some family members, however, explain the emergence of psychological distress according to the diagnosis received, always reporting, together with the medical statements, the daily experiences lived, the patient's symptoms and behaviors, thus showing that the psychiatric diagnosis alone does not make sense, which is in agreement with Moraski and Hildebrandt (2005).

Three interviews presented 'other explanations' with different reasons about the origin of the psychological distress of users who did not fit into the previous categories. Interviewee 4 explains two of these explanations: the first related to not taking medication and the relationship between this refusal and the problem he had: "So [...] we imagined that he took it, he said that he took it and often not, he lied, so we still don't know if the problem is because he doesn't take his medication [...]" (E4). The second is related to the patient's trickery. According to the family member, the user behaves this way so as not to have to deal with life's difficulties: "But because we work, we go after him, he never liked to work. So, I think maybe he pretends to not face life, you know? Not to go after it [...]" (E4).

Still regarding medication, in an interview, the questioning about the possibility that a strong medicine administered in the past had triggered the current problem was identified:

> The case of [user] [...] is that in the past psychiatry was much torture, right? There wasn't this [...] this chemotherapy, right? [sic] She didn't have this [...] medical treatment, right? And she was abused, you know? Then there was [...] a very heavy trauma. And in the past, the medicines were very strong, so in the case of my mother what happened [...] she [...] did not return. She was supposed to be fine (E5).

Finally, interviewee 7 relates the appearance of her sister-in-law's psychological distress to madness, saying several times during the interview that the behaviors that she presents: "[…] the madnesses, things she does, belong to very crazy people […]" and because "There are times when she doesn't say anything, sometimes she hits, she hits her face, she pulls her face [...] Ah, it's very strange" (E7).

In the findings of this study, most of the interviewees expressed their knowledge about psychological distress through the symptoms and behaviors of their family members (being aggressive, not leaving home, being upset), which according to Budini and Cardoso (2012) is one of the ways that mental illness can be meant. From the above, the multiple views of these family members towards the sick person do not indicate conflict. On the contrary, different explanations constructed by the interviewees can add up, indicating how the family reflects on psychological suffering, and suggesting a more integral look in relation to the other. As Moraski and Hildebrandt (2005) point out, it is also understood in this study that psychological distress is not located in only one region of the brain, but that it encompasses a multiple being that has other areas that can interact and be affected, in addition to the exclusive biological body. Furthermore, an understanding of the multiplicity of explanations provided may be the strategy adopted by the family to deal with its morbid reality, which presents itself in different ways and evolves without a predictable pattern (Moraski & Hildebrandt, 2005).

From these explanations, the families legitimize their own care for the relative, showing that they are capable and that they can take care of their relative, combining attention with the health services; they also legitimize their knowledge vis-à-vis the family member, which is called informal by the science that calls lay the knowledge acquired in the

experience, however, these results have taught us that families are also experts in what they do and in the care they give, and that, sometimes, health professionals ('real' specialists) are unaware and take a long time to find out simply because of the lack of dialogue with the family, directly interfering with the treatment; and, finally, families legitimize informal care, showing that they help and that, together with formal care, they can even be decisive in their lives. The multiple views of family members to the person in psychological distress can bring families closer to the notion of comprehensiveness. The explanations given by family members legitimize the need to care for the person, highlight that resources in the therapeutic itinerary can be considered more or less resolving from the perspective of comprehensive health care. According to Venâncio de Siqueira, Hollanda and Jardim Motta (2017, p. 1399):

> Comprehensiveness in its dimension of health practices forces one to think of the other from the relation of production in health as the other different from what we are. A difference with potential for creativity and the exercise of alterity. Thus, relationships with others start to be mediated by the different looks that go through the relationship, which can interfere with access and quality of care provided.

Finally, an issue to reflect on is the fact that families of users, users and health services are important agents in the construction and direction of therapeutic itineraries, since they are the main responsible for these choices that determine the path that these users will follow. We believe that TI are a process, a social construction, that is, they were and are made, together, in a movement that never ceases, by the users themselves, their families and their social support network.

Final considerations

This article aimed to identify the explanations given by family members of people in psychological distress and with a history of psychiatric hospitalization regarding the mental health problem of users of a Psychosocial Care Center. When different explanations were identified and the possibility of multiple conceptions about psychological suffering, we assessed that the objective was met, presented and discussed throughout the article. As a contribution of this study, the more comprehensive conception of health/illness of the family stands out, when they direct a look capable of involving different explanations about the psychological suffering. As a limitation of the study, we point out that it was carried out from a single service that approached family members who were there waiting for care for themselves or the user. As a suggestion to the services, we point out the need for openness to know the explanations of family members about psychological suffering, considering that they can subsidize choices of forms and places of care for the user, they are multiple and complex, and cannot be limited to a single answer.

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