Mental health professionals and family members of people with mental distress: encounter or disagreement?[1]

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Abstract: This study examines the dilemmas faced by mental health professionals in the inclusion of the family in the projects of therapeutic care to the person with psychological distress. Semi-structured interviews with mental health professionals from two psychosocial care centers in the Southeastern region of Brazil were conducted. The content analysis pointed out discursive regularities that delineated four categories: serving the families: insecurity and rivalry; taking responsibility; primary focus: diagnosis or necessity?; trust, bonding and difference. Having the ethical philosophy of Spinoza and the politics of mental health care in Brazil as reference, the following are identified as issues to be evaluated and included in the reflections of the professionals on the assumptions that guide their practices in serving the families: the ideal of family, blaming the family and accountability for the care of patients with mental distress.

Keywords: mental health, family, psychosocial care, Psychosocial Care Center.

Introduction

Historically, since the 19th century, mental hospitals have been the only resource for treating mentally ill patients. In this model of treatment, caring for the "mentally ill" was directly related to seclusion. Treating these persons suffering mental distress meant separating them from their family and social coexistence. On the one hand, the family was considered to be threatened by the individual's insanity, and thus needed to be protected. On the other hand, seclusion was necessary because the family would provide mental alienation, due to their finding it difficult to exert control and discipline. In this model, the family was excluded from the treatment, which reinforced their feelings of guilt and associated them as being the cause behind the mental illness (Navarini & Hirdes, 2008).

From World War II on, psychiatric hospitals and the ways of dealing with mentally ill patients begin to be questioned, when complaints regarding the model of exclusion become prominent and culminate in discussions that evolve into these institutions being transformed. In this context, movements that seek to put an end to the care-exclusion relationship emerged that proposed psychiatric institutions being opened. In Brazil, the first signs of the possibility of psychiatric care being transformed occurred in the late 1970s, which was when the so-called movement of the "Brazilian psychiatric reform" began. However, it was only in 2001 that the "Law of the Psychiatric Reform" – Law nº 10.216 – was signed, which was also when the National Commission was formed, which was designed to address issues concerning the changes in the care to people with mental distress.

The main consequences of this law included the creation of new services to replace the asylum model – Psychosocial Care Center (CAPS), partial hospitalization, Therapeutic Community Houses – that are characterized by the intensive use of a broad and complex set of therapeutic psychosocial practices and technologies aimed at keeping the person with mental distress besides their family and within the community. Recently, reiterated by Ordinance GM nº 3.088, from December 23rd of 2011, which establishes the network of psychosocial care (RAPS), ensuring the citizenship of the person in mental distress, promoting the return or permanence of the person in mental distress in their territory and promoting the acceptance of people who have been disrupted by the process of institutionalization in the family plan, are tasks for the mental health care services.

These transformations have certainly resulted in the family being more involved regarding care for their relatives in mental distress. The organization of the services in the health care network with territorial basis is provided by Ministry of Health Ordinance 3.088/2011. The network of attention and care in mental health, through intersectoral actions, enhances the conviviality of the person in mental distress with their family and community. Thus, it is necessary that all care services have a family-group focused approach.

Some studies suggest that the family is accountable in relation to the etiology of the mental illness, which may

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cause the feelings of guilt, frustration and impotence in family members (Silva & Santos, 2009). Authors basing their work on Psychoanalysis, for example, reiterate the theory that characterizes the mother of the person with schizophrenia as authoritarian, overprotective, but at the same time as anxious and guilty of emotional coldness, and as the person who is an abject of total reliance by her child (Bergeret, 1998; Coutinho, 2005).

Similarly, for authors related to anti-psychiatry (Cooper, 1986; Szasz, 1979), the family would be the backdrop of such schizophrenic behavior in that it sets out roles for its members, defining their place in the world.

More recent studies propose an analysis for how the behavior of the family determines a significant influence on the likelihood of patient relapses. Among them we highlight the "expressed emotions" (EE) studies, which concern the relatives of schizophrenic patients. The EE studies are related to a high level of involvement, comments, criticism and hostility that would be predictive factors for relapses, favoring or harming the patient regarding crises (Reis et al., 2014).

In addition to feeling guilty, the family may also feel overwhelmed for having to spend longer periods of time with the relative in mental distress, since they no longer live at the mental hospital. When faced with the demands to care for this person, the family members have to consider new dimensions in terms of their expectations regarding the future of their relative in mental distress, as well as concerning their own future, as there may be negative consequences to their social, emotional and professional lives (Constantinidis & Andrade, 2015).

The impact that involves the economic, practical and emotional aspects, to which the family is subjected, as they are responsible for the care of the person in mental distress, is called the "family burden". Soares and Munari (2008) point out that family burden is a phenomenon that persists even when the patient responds positively to innovative and effective treatments.

When faced with this situation, the family members often feel let down by the mental health services and, with the process of introducing new therapeutic technologies and complex psychosocial practices, there is a tendency for the family to think that the State is responsible to care for the person in mental distress (Gonçalves & Sena, 2001). Machado and Santos (2013) point out that, as a result of family burden, hospitalization appears as an idealized solution for many families and may represent an attempt to maintain the family structure for their benefit.

In regard to what concerns the professionals, despite the changes which came about following the "Brazilian psychiatric reform", Pegoraro and Caldana (2006) state that dealing with family members has been a difficult task for the team. Often the professionals assign stereotypes to the families and hold them accountable for the mental illness of a family member. These attitudes would be marks that withstand time and the modern ways of providing care for people in mental distress. If hospitalization minimized the responsibility of families and professionals, with deinstitutionalization, the relationship between technicians and family members may be intensified for sharing the everyday care for those in mental distress.

However, despite health planners and professionals being in agreement regarding the importance of providing services to the families of people in mental distress, several factors still hamper the deployment and effective execution of proposals. Some studies corroborate with this fact, showing the noncompliance of the relatives with the care offered to them (Colvero, Ide, & Rolim, 2004; Dimenstein, Sales, Galvão, & Severo, 2010; Waidman & Elsen, 2005). Some authors (Campos, 2001; Romagnoli, 2004) assign the lack of training of professionals when dealing with family members to this lack of compliance.

For Franco and Magalhães Júnior (2003), it is necessary for the team to include interdisciplinary and intersectoral work in the organizational models that avoid the bureaucratic forms of care. The workers need to be able to go beyond protocols and ordinances.

In countries like Italy, France, England and the United States, the consolidation of the deinstitutionalization process has made the representation of the family to be reviewed by territorial and community health services. These opinions seem to be more balanced and the family is re-situated in the user-family-service trinity, in which each pole tends to assume the position of subject and neither detrimentally devalues the other (Petersen et al., 2005).

Studies performed in these countries (Dell'Acqua, Vidoni, & Zanus, 1998; Miermont, 2001; Bortolussi, Bianca, & Fontana, 2005) show the classifications of modalities of care for family members of people in mental distress, based on the deinstitutionalization process. Miermont (2001) categorizes these into two types of model: the first considers the family as an unit that is susceptible to changes as a result of the direct involvement of family members; the second considers the active participation of the family, going beyond family therapy.

In Brazil, there are still no studies with surveys on and/or systematic classifications of the different models that substantiate the care for families of people in mental distress, as there are in other countries. We believe that, based on the aforementioned, the difficulty of executing these forms of care emerges in this field as a result.

In light of the situation described above, we questioned the dilemmas faced by the mental health professionals regarding the inclusion of the family in the care process for the person in mental distress. We also questioned the impasses in regards to those that prevent or hinder the encounter between mental health professionals and families.

Conciliation according to the ethics of Spinoza

We understand an encounter based on the ethics of Spinoza (1677/2007), that is, as the ability to affect and be affected by other beings. For this philosopher, a good encounter takes place when there is an increase in the power for each of the actors to affect the relationship, resulting in joy – which is the affect of the increase in power – and a joining of forces may thus occur, which increases the possibilities for action by these subjects.

In his *Political Treatise*, Spinoza (1670/1994) states: "If two people agree with each other and unite their forces, together they will have greater power and, consequently, a right over Nature that each lacks by themselves" (p. 35, our translation).

We try to develop relationships, or seek encounters, which provide an increase of our power to act and avoid those aspects that reduce such power. We have verified that encounters between families and professionals are usually characterized with disagreement (Gonçalves & Sena, 2001; Colvero et al., 2004; Waidman & Elsen, 2005; Pegoraro & Caldana, 2006; Dimenstein et al., 2010; Machado & Santos, 2013). We can infer, based on the views from Spinoza, that this relationship is marked by the decrease of power, leading to the mobilization of affects resulting from sadness in both subjects of this relationship. The proposals of this mental health policy, in a broader manner, are also involved in this relationship, and make up the context in which this encounter occurs.

In light of the issues presented here, we hypothesize that there are obstacles that prevent a good encounter between mental health professionals and family members of people in mental distress. The aim of this study is to understand these obstacles regarding this relationship in family care and reflect on the factors which could increase or decrease the possibility of a good encounter, resulting in an increase in the power to act among professionals and family members.

Methodology

Working within the universe of meanings, motives, aspirations, beliefs, values, attitudes, in addition to dealing with the level of the non-visible reality, which needs to be exposed and interpreted, are characteristics of qualitative research (Minayo, 2007) and the proposal of this study.

This research project, in accordance with the National Health Council Resolution No. 466 of 12 December 2012, for involving human beings, was approved by a Research Ethics Committee.

Locus of the research

The study was conducted at two Psychosocial Care Centers (CAPS) located in a city from the Southeast region of Brazil. One Center operates according to CAPS mode III and another according to CAPS mode i. The two CAPS were the only ones in operation at the time of the research (2011). This field of study was chosen for being a strategic device that, by carrying out the clinical monitoring and the social reintegration of people in severe mental distress, seeks to ensure a support network in their territory and, to that end, making sure that the actions directed to the families occupy a prominent position.

The Mental Health Program of the aforementioned city has as proposal offering comprehensive and territorialized care to residents in mental distress of all ages. The priority of this program is to provide care to people, including children and adolescents who suffer from serious mental disorders, and to abusers of alcohol and other drugs. These actions are developed using the Matrix Support, through the joint efforts of the mental health network and Primary Care Units (UBS), which facilitates the directing of the network's flow. The staff of the health units try to become acquainted with the demand of the territory, the families and the general context of each situation so that, together with family members, the community and the professionals, they may develop care and treatment strategies. While discussing the cases with the mental health teams, which include professionals from CAPS, the need to direct the case to complexity services like CAPS was analyzed.

CAPS III offers daily care treatment to people in severe mental distress aged 18 years or older, five days a week, in two shifts: morning and evening. The team is made up of the following professionals: four psychologists, three social workers (one of whom is responsible for coordinating the CAPS), six occupational therapists, two psychiatrists, a physical educator, four nursing technicians, two nurses, a music therapist and an art therapist. This team may be considered young, since most of these individuals have worked at the CAPS for a short time (less than two years). Some of these professionals have not had previous experience working with serious mental disorder. Each professional is responsible for the health of a micro-region of the municipality, which corresponds to a territory that has its own units and health teams. The professional is responsible for participating in the matrix support of the cases of this territory.

The team meets to discuss clinical cases and issues related to the work in the CAPS on a weekly basis. The team also relies on an institutional analysis that is performed on a monthly basis. The therapeutic intervention plan is formulated individually for each user. People in mental distress are referred to other services, and their admittance is performed by technicians of the CAPS. The user, when admitted to the institution, is assigned a reference technician who will be responsible for their treatment, their contact with the family and the matrix support with the network. After the case is discussed within the team, an individual therapeutic plan is designed and, together with the user, the frequency, the consultations and the activities that they will participate in are determined. The CAPS offers groups and therapeutic workshops and individual consultations as therapeutic devices.

The families are offered a partnership with the CAPS so that they can commit themselves to the process treating the person in mental distress. The CAPS offers families: family therapy, which consists of therapy for the close relatives of the user, multifamily therapy, which consists of an opportunity for reflection regarding issues raised by the family and the user and, finally, family groups, during which topics brought up by the relatives can be discussed. In addition to these devices, the family is invited to participate, along with users and employees, in the General Meeting of the CAPS, which has a deliberative character, during which topics that concern issues related to the institution, the daily lives of people and relationships in general, are dealt with.

CAPSi offers daily care to children and adolescents with serious mental disorders, which are provided five days a week over two periods: morning and evening. The team comprises four psychologists, one of whom is responsible for coordinating the CAPS, two occupational therapists, a pediatrician, a psychiatrist, two art therapists, a music therapist, a physical educator, a social worker, two nurses and four nursing technicians. This team has three years experience of providing care to children, adolescents and their families.

The child or adolescent is referred here by the health units or by the APAE. An initial welcoming session is performed by a professional from the team for the child/adolescent and his/her family. The therapeutic plan is individualized, beginning from the child's admission, based on the discussion with the team from the CAPS and/or with the staff of the units and the family members, with the frequency and therapeutic activities that shall compose the treatment having already been determined. The CAPS offers groups and therapeutic workshops and individual care in different modalities. As is true for CAPS III, which is the locus of this study, beginning from admission, the user is assigned a reference technician who is responsible for the treatment, the contact with the family and the matrix support with the network. Similarly, each professional is responsible for the health of a micro-region of the municipality, being responsible for participation in the matrix support of the cases within the territory of reference.

The family members are included in the process, which involves sharing the responsibility for the treatment and receiving care when necessary. Family care includes close relatives only, and is most often psychotherapeutic or pertaining to family counseling. Group care for family members, such as family groups and groups of women (restricted to female relatives), have been discontinued.

Meetings with family members, professionals and users occur without predetermined intervals being scheduled according to the demands of the CAPSi community.

The team gathers daily for meetings in which the daily events and care provided are discussed, and weekly, to discuss clinical cases and administrative issues. Institutional supervision happens on a monthly basis.

Instrument

During an international study, interviews were the instrument used for data collection, with the method for their execution being classified in accordance with semi-structured types of open questions (Turato, 2003). The topics that served as general guidance concerned treatment view, relationship with the relative of the user, obstacles and motivations in this type of study. The meetings were held at the CAPS and lasted an average of 60 minutes. Digital recordings with subsequent audio transcriptions were used.

Participants

The participants were professionals, with a higher level of education, who were responsible for family care at the CAPS. The selection was made based on these professionals' experience in providing care to families and also on their availability and willingness to participate in the interview. Twelve professionals were interviewed, among these were: two social workers, two doctors, five psychologists, an occupational therapist, an art therapist and a nurse. Professionals who do not participate in family care were excluded, which only included the nursing technicians in this case. The participating professionals dedicate themselves entirely to work at the CAPS, with the exception of the doctors and of the psychologist who also work in private practice.

In view of the objectives of the study and of the theoretical approach, the saturation sampling technique was adopted in order to define the number of participants. This criterion involves defining the number of participants during the data collection process, i.e., when the sample gave conditions of improvement and proposed theoretical reflection and information began being repeated, the interviews were ended (Fontanella et al., 2011).

Data analysis

The treatment of the material, namely its coding, was conducted through content analysis. Bardin (2011) defines content analysis as a "wide and heterogeneous set of manual or computer-assisted techniques for contextualized interpretations of documents produced by communication processes in the strict sense of that phrase (any kind of text, written, iconic, multimedia, etc.) or signification processes (traces and artifacts), having as ultimate goal the production of valid and trustworthy inferences" (p. 42).

This research was developed using the thematic analysis mode which "seeks verbal or textual expressions based on the general recurrent themes that appear within several more concrete contents" (Turato, 2003, p. 442, our translation). Considering that this study did not presuppose a quantitative analysis, the categories were not necessarily delineated through the repetition of lines, but also through the relevance of the reports from the execution of the discussions.

Presentation and discussion of the results

The assessed data, in accordance with the process detailed above, pointed out discursive regularities which outlined four categories: (1) Serving the families: insecurity and rivalry; (2) Taking responsibility; (3) Primary focus: diagnosis or necessity?; (4) Trust, bonding and difference.

Serving the families: insecurity and rivalry

Insecurity, fear, facing difficulties arising from experiencing a lack of professional knowledge can be enough reasons for discontinuing the service to families: "*Many give up [serving family members] because it really is very hard and makes the professional question him/herself, to the effect that, 'am I doing this right?'. So it makes us question lots of things*" (P11).

The difficulty of the process of serving is assigned to families:

> *There are families that are challenging, namely family members, mothers and fathers who are very difficult to deal with, I would even say that they are unbearable, we cannot have the decency of telling them that, but we can't see them as rivals, someone who hinders the treatment (P8).*

Having family members as rivals, as mentioned by P8, is an attitude that is reinforced by other professionals who admit to opposing sides in the relationship and seem mindful of the difficult task of not allowing friction with the family while moreover not judging them:

> *Thus, in this sense, this job is very difficult. You have to be very careful, self-assessing yourself as a professional to see to what extent you're not defending the patient and putting that relative against the wall. Sometimes we judge them without even knowing it (P11).*

What causes opposite sides to emerge in this relationship? The moral judgment of the professionals – based on their ideal of a good family –, theories on the relatives' guilt in the etiology of the mental disorder, in addition to the fact that they offer their services to the family, but are faced with non-attendance to care, with the lack of participation in the treatment and with the lack of accountability of the family in relation to the users, may contribute to it.

Some professionals believe that the attitude of the family in relation to family care is due to the frustration of their relative not recovering, meaning that they have expectations that are higher than what the professional/service can offer.

> *I believe expectation is one of these things. For a mother who has a child with some kind of disorder, talking about treatment is the same thing as talking about healing. So when two, three, four months go by without any sign of the change they had hoped for, they become discouraged (P7).*

Expectations are part of the process of encounters between professionals and families. At first, the family member either tries to or agrees to have an encounter with the professional, as they believe that their knowledge will help solve the problem. It can be said that this relationship begins with this premise and that the professional has a valued role, experiencing a feeling of increased power, which is as a result of the good image of themselves reflected by the family who believes in them and their ability.

However, the results show that, in this relationship, disappointment prevails. On one side is the professional who cannot meet the needs of the family and feels powerless, and on the other is the family, who feels frustrated and equally powerless. What results from this is rivalry, that is, opposing sides that do not generate a commonality, an encounter in which the investment in power happens as a result of the repelling effect of these bodies, on both sides, thereby decreasing the power of these individuals' actions.

Taking responsibility

When it comes to accountability, the data indicate that the doubt regarding who is responsible for whom seems to be a constant factor: "*There is no active participation and then, when the situation is very serious, they come along and hand it to us. "There, you solve it!*" (P8).

The reports from the professionals show that some families have difficulties assuming responsibility for their relative in mental distress. We infer that this is due to the protection and asylum culture of segregation that is still present and also to the fact that assigning accountability to these families is something relatively new. We believe that this is one of the impasses of psychosocial care that, in trying to keep the person with mental distress within a community, and thereby building the autonomy and citizenship that is possible for them, must share responsibility with their families and the community. As previously discussed, the family has its share of responsibility for their relative when it comes to everyday life, as it is up to the professional and the State – with policies focused on mental health care – to ensure this, so to avoid the user being abandoned.

Sometimes the professionals summon these family members using the courts: "*Many times we have to summon the family, which can even involve legal procedures. There are families who distance themselves so, so much... And sometimes, they distance themselves so much, that they need to seek justice... Instead of seeking care, they seek justice...*" (P3).

The judicial determination brings back the traditional way of treating the person with mental disorder, which is through hospitalization in psychiatric hospitals.

The proposal of mental health care, guided by the provisions of Law 10.216/2001, is being threatened. Beyond the adversarial mood between justice and healthcare professionals, with each judging themselves correct and just in their positions – on the one hand, the judge believing that they are protecting the family, and on the other, the healthcare professionals wanting to be respected for their technical knowledge and protecting the right of the user to be included in life outside the hospital – there is also aggravation in the relationship between the professionals and the families. These families feel helpless, on the one hand, and, on the other, the professionals blame them for the abandonment and hospitalization of the users.

Some studies (Campos & Soares, 2005; Pegoraro & Caldana, 2006) confirm this tendency of family members to assign responsibility of care to the person in mental distress to the State, and the fact is that the families feel helpless due to the difficulties in providing care, without a base of support or assistance from society.

Thus, due to the difficulty of sharing this responsibility, accountability is avoided and transferred. Therefore, what could unite the families and professionals, by way of sharing the duty of caring for those in mental distress, is actually what separates them, with both sides accusing the other of neglect and abandonment of this care.

Primary focus: diagnosis or necessity?

The interviewed professionals – as seen in the previous reports – find working with family members to be a difficult task. However, they do not assign this to a lack of training, but rather to the weariness caused by dealing with conflicts which are inherent to this relationship.

> *I think that working at the CAPS, with patients with serious mental disorders, is generally exhausting on a whole as the family is included. I think that the hardest thing for me is not even the contact, it's the way the family keeps resisting, it's having to deal with this resistance. This I find exhausting (P9).*

P12 speaks of the trajectory, experience, involvement and structure as necessary elements for the professional in the service of family members:

> *You're not going to give them everything. I'm talking about professionally giving. I think it's each one's individual trajectory. . . . And whoever has a trajectory and involvement... because I think the family is far beyond these. Because to serve the family you have to have structure, experience, lots of knowledge, lots of time to treat the primary focus. I find it more difficult to deal with a family than the child (P12).*

The excerpt from the report: "the family is far beyond these" indicates something that should be achieved by the professional. When advancing this discussion, we can analyze the term "primary focus" in two ways. On the one hand, if the focus is a situational diagnosis of the family, made by the professional, and one that will guide their conduct, training and professional experience, then these should be the prerequisites for serving the family. In this case, the supposed knowledge of the professional is what governs the process of treatment. To "professionally give", as suggested by the participant, the professional needs to have scientific and technical knowledge regarding what destabilizes the family. The professional, with their knowledge on the "primary focus", has such power. The result of this analysis corroborates the conclusion of some authors (Campos, 2001; Romagnoli, 2004) who assign this to the difficulty that professionals have working with families of people in mental distress, there is a lack of training for these professionals to deal with family members.

On the other hand, the "main focus" may be knowing what the family needs. For Teixeira (2005) this need is not always explicit or defined and constitutes itself in a debate, i.e., in an experimental scenario. In this sense, the author points out that this need is not always evident in the affects of this encounter, and it is necessary to elaborate it together with the user. According to this proposal, nobody holds the power, nobody knows more than the other, but together they provide ways to meet the needs that emerge.

From this, we infer that universal truths regarding the family and the relatives are not attainable from the affects originated from this relationship, but rather discussed/redone/drafted/negotiated during the encounter. The meaning produced during these encounters is built in the sum of knowledge between professionals and families.

Trust, bonding and difference

What maintains this relationship? At various moments, according to the reports of the professionals, it is the "lack of adherence" of the family members with respect to the professionals that is evidenced by the constant absences; it is the abandonment of consultations, showing a non-advancing relationship, which is interrupted. Would there be enough support for it to survive the previously evidenced differences? The advancing relationship is sustained by the bond, which in turn ensures its continuity: "*It is also a process, we must firstly welcome this family, invest in this bond..., but those with whom we bond provide a very good experience, the number of hospitalizations really does decrease. But it's not all of them...*" (P6).

For P6, the bond would be something to be invested in, to be built in a process of welcoming that would give power to the family that would in turn face the difficult situations with their relative, without resorting to hospitalization. According to the professional, not all families form this bond. In accordance with Spinoza's theory, the latter would be families who have not had good encounters with professionals, but rather most likely encounters in which sadness and impotence prevailed, providing no progress in the relationship.

> *Thus, the family opts for hospitalization without talking about it first. Then soon after hospitalization we sit down with the family and introduce the subject: 'what happened? During this period, if you noticed these things, if you felt these things, why didn't you talk about them with us? Usually these families are* the most difficult *to sit down and talk with, they are the least likely to seek the service...* (P7).

In this report it is clear that the encounter with these families, in which there is no advancing, no bonding, is marked by a difficulty that is not only the family's, but also the professional's, as can be seen in the excerpt: "[the families] *are the most difficult to sit down and talk with*". Relationships are dialogical, they depend on both actors to happen. Trust in the professional would result from the support to cope with difficult situations (Teixeira, 2004). Trust is the foundation of the relationship's bond, it is the power capable of supporting both the confrontation of difficulties in regards to everyday predicaments, which mental illness imposes on these families, and the difficulties of the relationship between family and professional, which makes it possible for each actor to show themselves without being threatened by difference.

The encounter did not have enough power to support the family's difference with respect to the professional and vice versa. The lack of attendance, the devaluation of what is offered and the rivalry, which sometimes arises clearly in the relationship between these professionals and families, may be examples of reactions to this moment of facing differences.

And how can confidence, the foundation of such a bond, be sustained, if indisposition, the lack of inclination to remain close to the other, prevails in the relationship?

For some professionals, it may be necessary to overcome resistance so that the bond can be established: "*So if it got to a point that the family abandoned it, that is because on this side there was also resistance, a difficulty in welcoming them, listening to them, knowing when to bring up certain things*" (P8).

P8's report, through the use of the term "transfer", adopts a psychoanalytic referential. Figueiredo (2007) points out that for psychoanalysis, the resistance present in the professional-user/family relationship can come from both sides and it is necessary to know how to handle it so that the relationship may move forward. Thus, resistance, when well handled, could actually bring people closer together.

Getting close to the families, according to P9, is no easy task, as it requires investment in the bond and generating trust between the people involved. This bond, once established, generates spontaneous demands from the family members:

> *Some families members now, after three years, after a while, after having established a bond, ask me: 'I want to talk with you' and they come to me for counseling. I find it interesting because they really do come and ask: 'can I talk to you?', and sometimes they say: 'I'm not alright, I need counseling'* (P9).

Unlike the previously mentioned situations, in which the professional insists on offering care and tries to convince the family to attend the meetings, we are faced with a situation in which, with the bond having been established, it is the family member who seeks the service in a time of need. Whether such a service becomes a reality is not only up to the professional, but also to the family member. In wanting to trust the professional with their uneasiness ("*I'm not alright*"), the family member is actively seeking the service, probably desiring to be supported by it.

And what would be involved in supporting this family member? We are dealing with someone who is asking for help - the family member - and someone who offers protection, the professional. "One supporting the other represents a trust in this power, it is a desire for it to manifest. This confidence strengthens the courage of surrendering, in the other and in yourself" (Rolnik, 1995, p. 72).

Final considerations

The contribution of this research was based on the proposal of studying the encounter, the successes and the frustrations in the relationship between people who have availability and reason to encounter each other, knowing what prevents them from doing so and what favors this relationship, all of which are based on the experiences and affects generated in it. We emphasize the importance of assessing the situations, which are not infrequent, in which family care is made unviable by the neglect or refusal to participate by the family members, with institutional or even legal interventions. Although our focus has been the increasingly common fact that family members ally themselves to justice with a view to hospitalize their relatives, it shows the radicalism of the actions that can be generated in this field. We believe that a deepening of this issue is relevant for research in this field.

The data from this study indicate that the dilemmas faced when including the family in the therapeutic projects of caring for individuals in mental disorder are permeated by the insecurity of these professionals, who consider the family members to be difficult to deal with, far from their ideal of family, and rivals in this relationship. When failing to cater to the needs of the families, which are scarred by the burdens of everyday living with the person in mental distress, the professionals feel helpless and stand against this feeling, resisting the possibilities of holding an encounter.

Thus, professionals and families are in a relationship in which tension predominates. Helpless mental health professionals stand on one side while the family feels guilty and no less powerless on the other.

In this context, accountability for the person in mental distress is not assumed by the mental health professionals nor is it by the family. This leads to this person not being properly care for, despite all the possibilities that an alliance between the professionals and family would bring. As a result, there are institutional summons and, in extreme cases, the judicial system is used as a form of intervention in this relationship, which determines solutions from the outside that could be resolved internally in the relational dynamics between the professionals and the family.

Some authors (Campos, 2001; Romagnoli, 2004) attribute the lack of training for serving the families to the dilemmas faced by the professionals. This study proposes that it goes beyond professional knowledge. It highlights the importance of the professional affirming the difference that the family member has in relation to them, so that the necessities are spelled out, so that they are negotiated and so that care may be offered in line with the subjects of this relationship. For this to happen, we highlight the importance of the support of the team to this professional as well as the support in intersectoral work, which is in agreement with the guidelines of the mental health policy.

Profissionais de saúde mental e familiares de pessoas com sofrimento psíquico: encontro ou desencontro?

Resumo: Este estudo analisa os impasses enfrentados pelos profissionais de saúde mental na inclusão da família nos projetos terapêuticos de atenção à pessoa com sofrimento psíquico. Foram realizadas entrevistas semiestruturadas com profissionais de saúde mental de dois Centros de Atenção Psicossocial da região Sudeste do país. A análise temática do conteúdo apontou regularidades discursivas que delinearam quatro categorias: atender a familiares: insegurança e rivalização; tomada de responsabilidade; foco principal: diagnóstico ou necessidade?; confiança, vínculo e diferença. Tendo como referência o conceito de encontro da ética na filosofia de Spinoza, são apontadas, como questões a ser avaliadas, discutidas e incluídas nas reflexões dos profissionais na orientação de suas práticas e nos atendimentos aos familiares: ideal de família, culpabilização do familiar e responsabilização pelo cuidado da pessoa com transtorno mental.

Palavras-chave: saúde mental, família, atenção psicossocial, Centro de Atenção Psicossocial.

Professionnels de la santé mentale et membres de la famille de personnes souffrant de détresse psychologique: rencontre ou décalage?

Résumé: Cette étude examine les dilemmes auxquels sont confrontés les professionnels de la santé mentale sur l'inclusion de la famille dans les projets thérapeutiques de l'attention à la personne avec la souffrance mentale. Les entretiens semi-structurés avec des professionnels de la santé mentale de deux centres de soins psychosociaux dans le Sud-Est du Brésil. L'analyse thématique du contenu a défini quatre catégories – rencontrer la famille: l'insécurité et de rivalité; prise de responsabilité; objectif principal: le diagnostic ou la nécessité?; la confiance, le lien et la différence. En référence à la notion de rencontre d'éthique dans la philosophie de Spinoza, on constate, comme questions qui doivent être évaluées, discutées et comprises dans des réflexions professionnelles sur l'orientation de ses pratiques, dans les appels aux membres de la famille: la famille idéale, la culpabilisation du familial et la responsabilisation pour les soins de la personne souffrant de troubles mentaux.

Mots-clés: santé mentale, famille, soins psychosociaux, Centre de Soins Psychosociaux.

Profesionales de salud mental y familiares de personas con trastorno mental: encuentro o desacuerdo?

Resumen: Este estudio examina los dilemas que enfrentan los profesionales de la salud mental en la inclusión de la familia en los proyectos de atención terapéutica a la persona con trastornos psicológicos. Se realizaron entrevistas semi-estructuradas con profesionales de la salud mental, dos centros de atención psicosocial en el sudeste de Brasil. El análisis temático de contenido señaló cuatro categorías – conocer a la familia: la inseguridad y rivalidad; asumiendo la responsabilidad; objetivo principal: el diagnóstico o necesidad; confianza, vínculo y diferencia. Al referirse a la filosofía ética de Spinoza y la política de atención de salud mental en Brasil, se identifican como temas a ser evaluados en las reflexiones de los profesionales en los supuestos que guían sus prácticas con la familia: la familia ideal, culpar a la familia y la responsabilidad por el cuidado de los enfermos mentales.

Palabras clave: salud mental, familia, atención psicosocial, Centro de Atención Psicosocial.

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