Original Article

A Psychosocial Care Center Team's work from a family perspective*

O TRABALHO DA EQUIPE DE UM CENTRO DE ATENÇÃO PSICOSSOCIAL NA PERSPECTIVA DA FAMÍLIA

EL TRABAJO DEL EQUIPO EN UN CENTRO DE ATENCIÓN PSICOSOCIAL EN LA PERSPECTIVA DE LA FAMILIA

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ABSTRACT

The objective of this study was to understand the experiences of family members of patients seen at a Psychosocial Care Center (PSCC) in terms of the work performed by the mental health team. The theoretical-philosophical framework used was phenomenological sociology. Data collection took place by means of an interview performed with 13 family members in October and November, 2006 at a PSCC in the city of Porto Alegre, Brazil. The comprehensive analysis yielded three categories. This article focuses on one of those categories: work as a project, action, and act. The analysis permitted to consider that the PSCC team's work has concrete results in mental health care; the team's actions are user-centered; and that the team's work should increase family-service integration. These considerations could serve as support for mental health teams to reflect about their practice regarding involving the patient's family in their work.

KEY WORDS

Mental health.
Mental health services.
Family.
Philosophy.

RESUMO

O objetivo deste estudo foi compreender as vivências de familiares de usuários de um Centro de Atenção Psicossocial (CAPS) em relação ao trabalho da equipe de saúde mental. Como referencial teórico-filosófico utilizou-se a sociologia fenomenológica. Os dados foram coletados por meio de entrevista realizada com 13 familiares em outubro e novembro de 2006, em um CAPS de Porto Alegre. Três categorias emergiram da análise compreensiva. Este artigo está focado em uma dessas categorias: o trabalho como projeto, ação e ato. A análise realizada permitiu considerar que o trabalho da equipe do CAPS tem resultados concretos na assistência em saúde mental; as ações da equipe estão focadas no usuário; e que o trabalho da equipe deveria integrar mais a família ao serviço. Estas considerações podem servir de subsídios para que as equipes de saúde mental reflitam sobre suas práticas a respeito do envolvimento da família no seu trabalho.

DESCRITORES

Saúde mental.
Serviços de saúde mental.
Família.
Filosofia.

RESUMEN

El objetivo de este estudio fue comprender las vivencias de los familiares de los usuarios de un Centro de Atención Psicosocial (CAPS) en relación al trabajo de un equipo de salud mental. Como marco teórico y filosófico se utilizó la sociología fenomenológica. Los datos fueron recolectados por medio de entrevistas realizadas con 13 familiares, entre octubre y noviembre de 2.006, en un CAPS de Porto Alegre. Del análisis comprensivo, emergieron tres categorías. Este artículo está enfocado en una de esas categorías: el trabajo como proyecto, acción y acto. El análisis realizado permitió considerar que el trabajo del equipo del CAPS obtuvo resultados concretos en la asistencia de la salud mental; las acciones del equipo están enfocadas en el usuario; el trabajo del equipo debería integrar más a la familia al servicio. Estas consideraciones pueden servir de subsidio para que los equipos de salud mental reflexionen sobre sus prácticas en lo que se refiere a la participación de la familia en su trabajo.

DESCRIPTORES

Salud mental.
Servicios de salud mental.
Familia.
Filosofía.

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INTRODUCTION

Since the beginning of Psychiatry in the 18th century, the concept of the Western world about madness as something eminently mystic and divine has been replaced with the scientism that emerged in that period, transforming it into an area of Medicine. In this area, madness was understood as the lack of reason (*unreason)* which plagued the individual and required his social isolation[1].

Setting individuals apart from their social and family environments became one of the premises of the treatment proposed at the time, since the alienists saw the family as the entity that caused the disease, which reinforced the need for isolation as a therapeutic measure[2]. The history of Psychiatry has also been the history of the attitudes of Psychiatry regarding the patient's family, since the relationship of the family with the asylum was seen as a veiled partnership, translated as the relatives' gratitude for being relieved of their problem[3].

Both of these attitudes are attributed to the family – the veiled partnership expressed in the promises of cure and responsibility for the suffering of a relative – clouded a perspective of its possible role as a resource in the therapeutic process focused on the person undergoing mental suffering.

The 20th century was characterized by new perspectives on mental healthcare, which triggered a process of new ways of providing mental care. Several proposals involving psychiatric reforms were discussed during this period, including Institutional Psychotherapy, Therapeutic Community, Sector-based Psychiatry, Community Psychiatry, Antipsychiatry and the Italian Democratic Psychiatry. The latter, also known as the de-institutionalization movement, inspired the Brazilian Psychiatric Reform in the 1970s.

The characteristic of de-institutionalization is not *de-hospitalization* or *un-care*, but epistemological criticism on the medical knowledge in Psychiatry, in an attempt to retrieve the rights of the citizens[1]. Therefore, this movement questions the traditional institutions, knowledge and psychiatric practices.

The traditional psychiatric practices can be understood as those concerning the asylum model[4], with the psychiatric hospital as the main site for treatment, among other characteristics, and sees the individual as a person who is sick instead of one who takes part in his own treatment, which requires isolation from family and social life. However, since the psychiatric reform movement started in the 1990s, mental healthcare policies in Brazil have been based on the psychosocial model[4], which, among other characteristics, considers the individual as a person undergoing mental suffering, becoming a main part of the treatment along with his relatives and the social environment where he lives. Moreover, the places of treatment are many and function within the community, as a part of it.

These services are essential for the constitution of a mental healthcare network focused on providing care for both the person in mental suffering and his family, such as day-hospitals, psychiatric emergency wards in general hospitals, Psychosocial Care Centers – *Centros de Atenção Psicossocial (CAPS)* –, basic healthcare units and family healthcare units[5].

The family is the main *locus* for treating their relative undergoing psychic suffering. However, living with the patient becomes a challenge for the family, due to the resulting stress, tensions and conflicts[6].

Mental healthcare professionals are increasingly concerned with the responsibilities placed on the relatives, in the context of the psychiatric reform, due to the lack of institutional support[7]. The family is not well prepared to maintain the relative in mental suffering de-institutionalized[8].

> The history of Psychiatry has also been the history of the attitudes of Psychiatry regarding the patient's family, since the relationship of the family with the asylum was seen as a veiled partnership, translated as the relatives' gratitude for being relieved of their problem.

The therapeutic interventions of the healthcare professionals should be implemented with this reality in mind. When a person seeks a mental healthcare professional to treat a patient, there is the possibility for acknowledgement and welcoming of the suffering of both people in this encounter[9]. This acknowledgment should consider the improvement of the family and social network of the subjects in mental suffering in quantitative (support services and qualified professionals) and qualitative (support, information and research) terms[10].

With the proposal of de-institutionalization, the family was transformed from a partner/victim situation into the protagonist of the therapy [3]. Therefore, it is indispensable to have the healthcare staff commit to and become responsible for building a space of negotiation where the family can feel part of a project[11].

With the new service proposals, such as the CAPS, the mental healthcare staff should abandon the traditional approach of the family – blaming, victimization, seeing them as accomplices or mere informants – and move towards a new attitude: protagonists of a process of mental healthcare reforms.

The proposal of this article is to comprehend how the relatives of users of a CAPS experience the work of mental healthcare staff working for this service.

This study is relevant because it gave voice to the relatives who experience the work of a mental healthcare staff. Furthermore, it allowed for a closer approximation and comprehension about the experiences of the family in this context, which may result in better reflections of mental healthcare teams about their daily professional routine.

OBJECTIVE

To understand the family experiences of users of a Psychosocial Care Center regarding the work developed by the healthcare staff, according to Alfred Schutz's phenomenological sociology.

THEORETICAL-PHILOSOPHICAL REFERENCE

Since this study is focused on the comprehension of family members' experiences, we chose to use Alfred Schutz's phenomenological Sociology as the theoretical-philosophical reference framework. This sociologist based his work on Edmund Husserl's phenomenology and Max Weber's comprehensive sociology to conceptualize the phenomenological sociology, thus contributing to knowledge construction in human and social sciences.

This reference furthers the knowledge of social reality as a social world, which is experienced by social actors and their peers, who can also attribute meanings to their experiences and actions.

In this perspective, work is defined as an action in the outer world, which is based on a project that is based on the intentions of the social actor to be executed[12]. In other words, work is an action performed by a social actor, based on a project (s)he has previously established.

The world of these social actions occurs in a reality seen as the social world, which is shared, experienced and interpreted by the actor and his peers. Therefore, it is possible to understand the world with the others in its intersubjective meaning, i.e. based on the social relationships[13].

In this article, we used some concepts of phenomenological sociology to understand the social reality of the relatives of users of a CAPS regarding their experience with the work of a mental healthcare staff. Such concepts were made explicit during the presentation of the results.

METHOD

This is a phenomenological qualitative study, according to Alfred Schutz's phenomenological sociology. This modality aims to describe the experiences and meanings attributed to them by the subjects who experience this phenomenon[14].

The study field was a CAPS II in Porto Alegre, the capital of Rio Grande do Sul, Brazil. CAPS II are mental healthcare services focused on providing care to people with serious and persistent mental disorders who live in the area of coverage, with a population between 70,000 and 200,000 thousand inhabitants[5]. This CAPS was chosen intentionally, as the researchers were involved in educational activities, such as teaching, extension and research in this area.

The mental healthcare staff includes three psychiatrists, two nurses, four nursing auxiliaries, three occupational therapists, three psychologists, one social worker, one physical educator and one nutritionist. It is worth noting that there are interns and residents from different areas, such as psychology, psychiatry, nursing and physical education, who took part in most activities provided by the service.

The study subjects were 13 relatives of service users who were more involved with the treatment of the user-relative, which were identified through informal conversations with the users, relatives and the healthcare staff itself. Therefore, we selected the relatives the users considered as participants in their treatment; those who drove or picked up their user-relative, as well as those who were rated as too demanding by the staff. In addition, the people who were selected should be willing to participate in the study.

Interviews were held to collect the testimonies in October and November 2006, according to the following guiding question: *Talk about the work of the CAPS staff*. The interviews were finished when we detected exhaustive repetition of the same statements.

This study was approved by the Ethics Committee of Nursing School at Federal University of Rio Grande do Sul and the Porto Alegre Municipal Health Secretariat, file #001.042261.06.6, in 2006.

We focused on the convergences of the units of meaning that emerged from the testimonies, according to Alfred Schutz's phenomenological sociology. The following steps were followed in order to reveal the essence of the phenomenon [15]: Each testimony was read; Each testimony was then re-read, highlighting the units of meaning; Description of what was implied in these statements, using a reflective attitude; when the convergence of the units of meaning was established, the concrete categories were built; a vague, average comprehension of the testimonies was performed, based on the concrete categories; and, finally, the comprehensive interpretation was used to reveal the essence of the phenomenon.

The analysis of the testimonies made it possible to organize the results of the experiences of these relatives in three concrete categories, with their denominations being inspired in concepts of the phenomenological sociology framework. We consider that the work of the CAPS staff is experienced by the relatives according to the following concrete categories: work as a project, action and act; work is based on the interest at hand; and work permeated by interactive relationships.

In this article, we present the comprehensive interpretation of the testimonies of the first concrete category – the work of the staff as a project, action and act. The comprehensive interpretation, according to phenomenological sociology, allowed us to *go back to the same things*, unveiling aspects of the knowledge held by the relatives.

In the presentation of the testimonies, the relatives are represented with the letter F, followed by the number that corresponds to the order of the interview (from F1 to F12). We used the letter W for the professionals and fictitious names for the users in order to preserve their anonymity.

RESULTS

The delimitation of this category occurred according to the unique descriptions of each relative interviewed. Therefore, in the phenomenological sociology framework, the actors of the social world are considered biographically, i.e., constituted by history, culture and social relationships[13]. As a social group, the relatives expressed their experiences about the work of the CAPS staff according to their own place in the social world.

In this reference, the biographic situation of the researcher also interferes in the comprehension of the phenomenon. Although our perspective is guided by the rules of phenomenology, we do it according to the place we occupy in the social world, i.e. as nurses and researchers who have already had the experience of working with families. As such, the construction of the category – work as project, action and act – was mediated by the biographical situation of both the research subjects and the researchers.

Work as an action, based on a project, integrates present, past and future dimensions[13]. As such, this concept evokes other concepts: *project*, *action* and *act*. The *project* is the anticipated fantasy of the *act*, with the intention to develop it; the *action* is related to a conduct based on a previous project; and the *act* designates the result of this previously-executed action[13].

In this category, these elements could be identified in the testimonies of the relatives when they described their experiences about the work of the staff. The work as a *project* is unveiled by the relatives when they refer to the work of the staff as something that was planned and organized in staff meetings.

> […] I believe that what they want to do and what they are doing is very good (F1).

> These staff meetings that are held once a week [...] in order to provide better care to this patient (F8).

Each CAPS should have a broad therapeutic project that considers the technical skills of the professionals, the initiatives of the relatives and the users, and the potentials of the territory it is inserted in, respecting its cultural identity[5].

For the relatives, the work of the staff is planned by the professionals in the quest for a goal regarding the users of the service. These plans guide the actions of the staff and are considered relevant to qualify the work developed, resulting in better care provided to the users.

However, the therapeutic project of the CAPS should support the production of the Individual Therapeutic Project – *Projeto Terapêutico Individual (PTI)* – for the individual undergoing mental suffering. The project should be designed with the participation of a professional from the service staff, along with the family and the user, according to his necessities[5].

A study carried out among the staff in this service showed that the PTI is one of the main guiding instruments in the search for the psychosocial rehabilitation of users[16]. However, in our research, in the perspective of the relatives, the PTI was not seen to be an instrument of staff activities. The contrast between these findings entailed some unrest on the CAPS production of the PTI.

Thus, we ask ourselves: are the relatives invited to take part in the construction of the PTI? If they acknowledge their participation, are they aware of the importance of this instrument? If they are not, how would it be possible to become aware of their potential protagonism in the mental care process (de-institutionalization)?

According to the Ministry of Health, the PTI is an essential instrument for work at the CAPS, being an important mechanism to guide staff actions and to assess the mental healthcare provided to the users and their families[5]. We understand that the construction of the PTI should focus on the relationship between the involved subjects – professionals, users and family – and on the mutual acknowledgment of their unique biographical situations, especially regarding psychic suffering.

For the relatives, the CAPS planning of mental healthcare is designed exclusively by the staff in private meetings. We believe that the non-participation of the relatives in the construction of the PTI, or even their lack of awareness about the meaning of this project could negatively affect the involvement of the family with the treatment for their user-relative, which would interfere in their insertion in the service, consequently weakening their commitment in the assignment of responsibilities among those involved.

On the other hand, although the relatives recognize that staff planning is important to qualify their work, it was also shown to be an obstacle for relatives and users' service access.

> [...] the older girl, who is retarded, goes on without treatment due to the bureaucracy (F11).

> It was scheduled by the hospital […] I know that there is a door, but see if you can do it. This friend of mine came here directly, and I say, no, please, you're not going to lose it (F1).

In these testimonies, it is evident that, when they mention the *door* that leads to the service they imply that there is an organization for people to receive the care provided by the CAPS staff. However, they have difficulties to understand the logic of the CAPS access flow orientation.

The organization of this flow was shown to be an obstacle for the access of these people. The testimonies make

it clear that those who can access the service have feelings of achievement and relief, as they managed to overcome the bureaucracy. This shows that the organization of service access reflects in the experiences of the relatives about the work of the staff, since, to receive care, the family members should have been sent there by a healthcare service, which is not a guarantee that the patient is going to be admitted at the service.

For the community to access the CAPS, it is indispensable for the staff to believe in the possibility of welcoming as an organizational strategy[12]. Welcoming, as well as carefully listening to the suffering of those who seek the CAPS, represent the first contact of these subjects with the team, with whom they intend to establish a trustful therapeutic bond[5].

We understand that the mental healthcare staff act of welcoming involves listening to the needs that emerge from the biography and the existential situation of those who seek the service – the subjects in mental suffering, their relatives, or both. Therefore, welcoming includes listening attentively to any and everyone seeking out the service, the mutual creation of bonds, commitment and credibility among those involved.

The mental healthcare teams should understand that welcoming occurs in the contact among professionals, users and relatives. Therefore, a discussion should occur within the scope of these services about the use of this resource as an important tool.

To move from what is planned to what is executed, the CAPS professionals use several strategies with therapeutic goals, in order to transform the planned action into a concrete act. For the relatives, these strategies are configured as home visits, clinical appointments and several therapeutic workshops.

> There was a time when he was not well, we'd call the service, and the nurse or the social worker, whoever was on duty at the time, would come to our house (F1).

> She took part in the workshops that they offered here at the CAPS […] Then, when she felt more secure, she came to the scheduled appointments more often (F8).

Therefore, work as *action* is seen when the staff implements these strategies by providing mental healthcare to the users, and, in part, to the relatives, since they are seen by the staff when required. However, the participation and insertion of these relatives in the CAPS still seem to be superficial, as team actions are predominantly focused on the user-relative.

The insertion of the family in the CAPS can occur through several strategies, such as individual attention, family groups, active search, home visits and therapeutic workshops. These contacts and partnerships create bonds between the staff and the family for the construction of pathways that are more forgiving and less stigmatized in the experience of mental suffering[17].

By using these simple strategies with the relatives, it would be possible to listen to their needs and difficulties in a qualified way. At the same time, the staff would be able to handle certain situations mental healthcare services face on a daily basis[18].

The actions of the CAPS staff have been developed in a context named *social world*, i.e. where the daily life occurs, where people communicate and act[12]. Through acts of work, the professionals communicate and can organize different spatial perspectives in this social world.

The social world in which the CAPS team has been acting and communicating, among themselves and with the users and families, transcends the physical space of the service. As such, for the relatives, the space of the home is also a dimension of the social world where the staff develops their work.

The acknowledgment of the home as a space for mental healthcare points to the community as a social space to be explored. However, their actions should be guided towards the social world, breaking away from the spatial limits of the service and the home, covering other social spaces.

The community represents an inexhaustible source of material and human resources for a mental healthcare service[3], and the utilization of all the possible social spaces for the work of the CAPS staff with the family is necessary for the promotion of integral care[17].

The creation and diversification of strategies for working with the families, as well as the occupation of different social spaces (the setting for the actions of the staff) could facilitate the effective insertion of the family in the CAPS. Then, team actions would occur in a broader setting, full of possibilities for mental care promotion.

In the phenomenological sociology framework, the concretization of the planned action is seen as an *act*, as this action has already been concluded. As such, the result of the actions of the staff could serve as the relative's object of reflection about the work developed, which would attribute meanings to it.

The work of the staff as an *act* is described by the relatives as the concrete results of the treatment offered by the service. For the relatives, these results are contrasting, as they compared the situations before and now, being able to detect important changes in the mental condition of their relative since he was admitted into the CAPS.

> As I see it, the work brings lots of results. I say this because of my wife, her situation when she started coming here, the way she used to be, and the way she is now (F13).

> […] the person receives treatment to see if he can be healed, or controlled. He has to control it (F3).

The meaning the relatives attribute to staff results is characterized by the stabilization of their user-relative's mental symptoms, even when they use the terms *healed* and *controlled* to describe this stability.

Although these terms refer to the stabilization of the users' mental suffering when used by the relatives in the CAPS context – a service that replaces the psychiatric hospital – they reflect a ubiquitous conception of Psychiatry's traditional promises: healing madness from the life of people. This shows how attractive these promises are and is still present in the collective imaginary of people when they speak about psychiatric and mental healthcare.

It is worth noting that this mentality of control and cure could also be a part of the conception of the professionals working in this type of service, which would lead them to adopt a work logic that is incoherent with the precepts of the psychosocial model. Therefore, differently from control and cure, the professionals should seek the promotion of health and quality of life for the people in mental suffering, the promotion of their citizenship, their social reinsertion and psychosocial rehabilitation.

According to the framework of phenomenological sociology, the comprehension of human actions may be possible through the indirect interpretation of the motivations of the actors of a given action in its subjective dimensions – *reasons why*[12]. As such, when the relatives resort to this possibility of comprehension, consider that the *reasons why*, i.e. which propelled the actions of the CAPS professionals in their routine, were fundamentally directed towards the stabilization of the user's clinical situation.

Therefore, relatives consider that the definition of staff goals of the staff remains restricted to the biological perspective, centered in the suppression of a symptomatic condition related to a mental problem, or a *disease*.

Although the team has been stabilizing the mental condition of the users, one relative alerts that her user-relative has episodes of relapse (crises). However, she recognizes that these relapses are less frequent if compared to other moments in her life, attributing this situation to the treatment offered in the service. On the other hand, another relative states that the treatment offered by the CAPS staff could have prevented several psychiatric hospitalizations her user-relative was submitted to if she had received care such as the care she receives nowadays in previous occasions.

> […] I believed she got better in here. I mean, not really getting better, but she stabilized. Of course, sometimes she has a relapse, but they are few and far between (F12).

> Over the years, if my mother had received care here, she would surely not have undergone all the hospitalizations she's been through (F7).

Many healthcare professionals are exclusively concerned with the care provided to the user in mental suffering, forgetting the frequent insecurity of his relatives when they have to cope with crises[8].

In people with psychic ailments, especially those diagnosed with severe and persistent mental disorders, crises are expected in the course of the treatment. The relatives have acknowledged the importance of the treatment offered by the CAPS staff as a mental healthcare device as it meets the needs of the subjects undergoing psychic suffering, reflecting in the reduction of crises and psychiatric rehospitalizations.

However, it is essential for the staff to recognize that these users are not isolated and exempt from social relationships, or that these are restricted to the CAPS space. On the contrary – it should be acknowledged that these subjects are participants of family and community groups, and that they frequently interact with those around them.

As such, acknowledging this social dimension of the subject undergoing mental suffering, which the family is part of, and participating in this territorial dimension is very important for the CAPS staff, along with the families, to build strategies to cope with the suffering of relatives who have to live with situations of madness.

In view of the concrete results obtained by the staff, configured in acts like the stabilization of the psychiatric condition and the reduction of the number of new psychiatric hospitalizations, the relatives give credit to the activities developed by the staff. This credibility is also shown in the following testimonies, where the relatives are observed to be satisfied and grateful with the work of the staff.

> I think it is great. Wonderful. I really like it. We think that we're getting good service in everything we needed and everything we still need (F3).

> I like their service, both for me, as a relative, and for my mother, who is a patient (F12).

The relatives' feelings of satisfaction and gratitude are expressed due to the results achieved by the staff working with their users-relatives in mental suffering. However, some of them complemented such statements saying that they also feel supported by the staff.

We believe that, according to these relatives, certain necessities and expectations on the treatment of their user-relative are being met by the staff, but the statements contained herein do not permit measuring to what extent these necessities have been met. However, we observed that the actions of the staff, previously described by the relatives, are focused on meeting user needs, leaving the family at the margin of those actions.

Therefore, it was observed that not all the acts of the CAPS staff were satisfactory for the relatives, since the achieved results were different from those expected, in some situations.

> […] I was really disappointed, I wanted to leave this place at any cost, because my son was getting worse […] They struggled, but even then […] (F5).

> […] they sent us here. It was really, really hard, like, they took him in here, but they failed (F11).

Although not all family expectations about the treatment were met, the testimonies pointed to the need for greater involvement of the CAPS staff with the users' families. Establishing a more intimate relationship between the staff and the relatives could yield a higher chance of acknowledging the necessities of these relatives. Frequently, such necessities are distinct from those conjured by the mental healthcare team.

Building spaces for exchanging and establishing contracts will expand the field of possibilities where individual and collective interests blossom, making it possible to build a truly therapeutic relationship[18]. In these meetings – intense, continuous or even recurrent – between the CAPS staff and the family, it will be possible to continuously reflect, outline, acknowledge and (re)build the needs of the relatives to be addressed by the staff. We understand that the staff will effectively act with the family through the dialogic perspective and the encounters.

In spite of the dissatisfactions voiced before, the credibility of staff work, along with the feelings of satisfaction and gratitude expressed by the relatives, made them note that the work developed by the CAPS staff is better than the care provided by other mental healthcare services, according to previous experiences.

> [...] I thought it was much better than all the other places she's been in (F3).

> The treatment here is much better than the one she was receiving at the hospital (F12).

These testimonies show the social relevance the relatives attributed to the CAPS and the work of the mental care staff, when they acknowledged the distinct way in which this team deals with mental suffering. In the research context, the CAPS was shown to be an important mental healthcare device, which has gradually contributed to the transformation of the healthcare model.

FINAL CONSIDERATIONS

The utilization of Alfred Schutz's phenomenological sociology framework was relevant to conduct studies in the mental healthcare area, since it allowed us to better comprehend the social world of the relatives of users at a CAPS service, especially regarding the work developed by its staff.

The work of the CAPS staff, characterized as project, action and act, considers the past, present and future dimensions to outline the actions of the social actors. As such, we find ourselves in a process of knowledge reformulation and invention of new practices and new devices in mental healthcare, opposed to the past, marked by care centered on Psychiatry, and in line with a future that is open to constant transformations and reinventions.

The challenge presented in this study is to allow the families to assume their roles as protagonists, along with the subjects in mental suffering and the mental healthcare professionals, to consolidate a new way of providing mental healthcare – the psychosocial model.

With a therapeutic proposal based on the psychosocial healthcare model, the work of the CAPS staff has achieved concrete results, reducing the crises of the subjects and the psychiatric hospitalizations. However, the actions of the team are focused eminently on the user, with the family often being left at the margin of this care.

The CAPS staff recognizes that the object of their work is human subjectivity. In order to deal with this subjectivity, it is necessary to build denser social relationships and use different therapeutic devices in the daily routine. However, thinking about de-institutionalization involves considering all the available resources in a community in order to make it effective.

The utilization of the social spaces of the community can facilitate the effective insertion of the family into the CAPS, promoting better co-responsibility of the team and the family in order to de-institutionalize the person in mental suffering. On the other hand, although the family is assisted by the team in some dimension, working with the relatives implies in a better performance of the team regarding the life history of this particular group, especially regarding the acknowledgment of its necessities and demands that come from its experience with the respective users-relatives and the acknowledgment of their values, beliefs and culture.

The inclusion of the family in the work of the staff may increase its potential results, striving to improve the quality of life of the subjects undergoing mental suffering and their families, as it would allow for the construction of unique mental healthcare services.

The conscious involvement of the family in the production of the Individual Therapeutic Project and the utilization of the service's organizational welcoming strategies may be important tools for the work of the staff, with effective possibilities for the mental healthcare staff to act with the families.

In spite of the problems faced by the CAPS, the relatives acknowledge that the work developed in this service is beneficial regarding mental healthcare. However, the property of reinventing and recreating itself should become an inherent characteristic of staff in these services, so that they can keep on promoting the life and health of the subjects in mental suffering and their relatives.

REFERENCES

1. Amarante P. O homem e a serpente: outras histórias para a loucura e a psiquiatria. Rio de Janeiro: FIOCRUZ; 1996.

2. Moreno V, Alencastre MB. A trajetória da família do portador de sofrimento psíquico. Rev Esc Enferm USP. 2003;37(2):43-50.

3. Saraceno B. Libertando identidades: da reabilitação psicossocial à cidadania possível. 2ª ed. Rio de Janeiro: Instituto Franco Basaglia; 2001.

4. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, editor. Ensaios: subjetividade, saúde mental, sociedade. Rio de Janeiro: FIOCRUZ; 2000. p. 141-68.

5. Brasil. Ministério da Saúde. Departamento de Ações Programáticas Estratégicas. Saúde mental no SUS: os centos de atenção psicossocial. Brasília; 2004.

6. Oliveira MMB, Jorge MSB. Doente mental e sua relação com a família. In: Labate RC, editor. Caminhando para a assistência integral. Ribeirão Preto: Scala; 1999. p. 379-88.

7. Randemark NFR, Jorge MSB, Queiroz MVO. A reforma psiquiátrica no olhar das famílias. Texto Contexto Enferm. 2004;13(4):543-50.

8. Waidman MAP, Gusmão R. Família e cronicidade da doença mental: dúvidas, curiosidade e relacionamento familiar. Fam Saúde Desenvolv. 2001;3(2):154-62.

9. Melman J. Família e doença mental: repensando a relação entre profissionais de saúde e família. São Paulo: Escrituras; 2001.

10. Reinaldo AMS, Saeki T. Ouvindo outras vozes: relato de familiares sobre o convívio com o paciente psiquiátrico. Rev Esc Enferm USP. 2004;38(4):396-405.

11. Wetzel C. Avaliação de serviço em saúde mental: a construção de um processo participativo [tese]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2005.

12. Schutz A. Fenomenologia e relações sociais: textos escolhidos de Alfred Schütz. Rio de Janeiro: Zahar; 1979.

13. Schutz A. El problema de la realidad social. Buenos Aires: Amorrortu; 2003.

14. Schneider JF. O método fenomenológico na pesquisa em enfermagem psiquiátrica. Rev Gaúcha Enferm. 1996;17(2):100-8.

15. Schneider JF. Ser-família de esquizofrênico: o que é isto? Cascavel: Ed.Unioeste; 2001.

16. Schneider JF, Camatta MW, Nasi C. O trabalho em um Centro de Atenção Psicossocial: uma análise em Alfred Schütz. Rev Gaúcha Enferm. 2007;28(4):520-6.

17. Schrank G, Olschowsky A. O Centro de Atenção Psicossocial e as estratégias para a inserção da família. Rev Esc Enferm USP. 2008;42(1):127-34.

18. Kantorski LF, Wetzel C, Reinaldo A. A inserção da família na assistência em saúde mental. Saúde Debate. 2005;29(69):5-16.

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