

## PSYCHOSOCIAL REHABILITATION IN MENTAL HEALTH CARE: STRATEGIES UNDER CONSTRUCTION<sup>1</sup>

Maria Alice Ornellas Pereira<sup>2</sup>

Pereira MAO. Psychosocial rehabilitation in mental health care: strategies under construction. Rev Latino-am Enfermagem 2007 julho-agosto; 15(4):658-64.

*This study aims to identify the representations about Psychosocial Rehabilitation by Mental Health professionals working in open services, and also the difficulties they have met in the process of turning the care effective for the population. The study uses a qualitative methodology, collecting data by means of semistructured interviews with 15 subjects. The professionals identify the rehabilitation process as complex, meeting several obstacles and requiring their dedication and a flexible attitude to achieve the expected results.*

**DESCRIPTORS:** social support; mental health; concept formation

## REHABILITACIÓN PSICOSOCIAL EN SALUD MENTAL: CONSTRUCCIÓN DE ESTRATEGIAS

*La finalidad de este estudio es identificar las representaciones sobre la rehabilitación psicosocial por los profesionales de Salud Mental que trabajan en servicios abiertos, y también las dificultades que han encontrado en el proceso de hacer la atención eficaz para la población. El estudio utiliza una metodología cualitativa, recogiendo datos por medio de las entrevistas semi-estructuradas hechas con 15 personas. Los profesionales identifican el proceso de la rehabilitación como complejo, con varios obstáculos, a requerir su esmero y una actitud flexible para alcanzar los resultados previstos.*

**DESCRIPTORES:** apoyo social; salud mental; formación de concepto

## A REABILITAÇÃO PSICOSSOCIAL NO ATENDIMENTO EM SAÚDE MENTAL: ESTRATÉGIAS EM CONSTRUÇÃO

*Este estudo teve como objetivos identificar as representações elaboradas por profissionais de serviços substitutivos acerca da reabilitação psicossocial, e as dificuldades por eles encontradas na efetivação da assistência em Saúde Mental. Adotando abordagem qualitativa, a pesquisa teve a participação de quinze sujeitos, que foram ouvidos através da entrevista semi-estruturada. Identificou-se que a reabilitação é vista como processo complexo que enfrenta obstáculos diversos para a concretização de seus objetivos, e que as mudanças ocorridas na assistência solicitam, de cada profissional, disponibilidade e flexibilidade.*

**DESCRIPTORES:** apoio social; saúde mental; formação de conceito

<sup>1</sup> Paper extracted from Free Lectureship Thesis; <sup>2</sup> Adjunct Professor, Botucatu Medical School, Paulista State University "Júlio de Mesquita Filho", Brazil, e-mail: malice@fmb.unesp.br

## INTRODUCTION

The transformation process psychiatric care has been going through in Brazil has led to complex structural changes, raising discussions about the need to reorganize the practice of professionals from the multidisciplinary Mental Health team, in view of the new forms of care that are adopted. The creation of new services affiliated with municipal and state networks did not only mean an alternative to hospitalization, but also the opening of possibilities for community work towards reintegration into the social context, capable of giving a new individual and social meaning to people affected by mental disorders, as well as to their families.

Current care practice tends to follow recommendations by the World Health Organization by granting an increasingly smaller amount of resources to psychiatric hospitals, dislocating them towards more elastic and contextualized community structures. Although the roles of each structure under construction, there is no doubt about the need to redirect the care models, in view of the importance of returning respect to people with mental disorders and reestablishing their social bonds. This transformation movement entails conflicts and challenges, leading to another knowledge that demands flexibility in the different team professionals' actions and roles.

In this perspective, psychosocial rehabilitation is configured as a set of strategies to increase the possibilities of exchanges, the valuation of subjectivities, and to provide for contractuality and solidarity, thus moving beyond the mere implantation of service networks.

As a strategy, rehabilitation allows for the recovery of the capacity to create meaning, which is capable of reestablishing the exercise of citizenship, creating bonds between the person needing care and the care service. Hence, "the mental health service's task is to help the person who at some moment in his/her life lost the ability to create meaning, accompanying him/her in the recovery of non protected but socially open spaces to produce new meanings"<sup>(1)</sup>. This evidences the change from tutelage to contract relations, giving rise to new practices at institutions that adopt the psychiatric care transformation process. Current projects directed at the psychosocial rehabilitation model have focused on four aspects: housing, work, family and creativity (recreational/artistic).

The created spaces also contain concerns and doubts about how to deliver daily care, how to advance in order to actually deliver rehabilitating and meaning-producing care. It represents a challenge to the professionals, in their ability to establish bonds and be receptive to the other. It becomes essential for the actors in psychiatric care transformation to be more ethically committed to the care and to their own desire, and to continuously ask themselves: "What am I doing here?", reconstructing their answer each day and thus configuring a dynamic coming and going of represented practices<sup>(2)</sup>. This makes us reflect that the exchange of experiences and sharing of knowledge can lead to a broader understanding, facilitating rehabilitating interventions.

In view of the Mental Health care transformation process, this study aimed to identify the representations professionals from substitutive services elaborate about psychosocial rehabilitation, and the difficulties they face to apply new practices.

## METHODOLOGY

This research fits into the premises of the qualitative research method, where we work with the meaning an individual or a certain group attributes to relevant phenomena. Qualitative research uses the natural environment as a direct source of data, and the researcher as its main instrument<sup>(3)</sup>.

We developed the study at two open services in the region of Ribeirão Preto - SP: the Day Hospital of the University of São Paulo at Ribeirão Preto Medical School *Hospital das Clínicas*, and the Ribeirão Preto Psychosocial Care Nucleus (NAPS/RP).

The participants were professionals from the NAPS and HD's technical teams: nurses, psychologists, physicians, social workers and occupational therapists. No previous criteria were established for the selection. The professionals were invited and received information about the research's ethical procedures, according to the project approved by the Institutional Review Board of EERP/USP (Process Number 0292/2002). All professionals who were working during the period the interviews were held accepted the invitation. The interviews were recorded and had an average duration of 30 minutes. Semistructured interviews were used for data collection. The following questions were asked to the subjects: a) How do you understand psychosocial rehabilitation? b) What do

you consider important for psychosocial rehabilitation to occur? c) What are the difficulties faced in this process?

Based on "floating attention"<sup>(4)</sup>, the transcribed texts were read several times to have contact with the collected material. The next phase consisted of *Thematic Analysis*, which is part of the first phase of the *Discourse Analysis*<sup>(5)</sup> process. Five themes were obtained from this phase. In this article, which is part of the research, we will present the themes *Autonomy* and *Social Insertion*.

## RESULTS AND DISCUSSION

In the narratives, psychosocial rehabilitation appears associated with the idea of autonomy, and refers to the conception of the patient as a person to be considered in his/her individuality, valuing the occurred changes as conquests:

*... before he came and went back home, he was there inside the room, isolated, without taking care of himself, he didn't leave the room for anything, and now, the mere fact that he's active, that he comes to the H.D. and goes back, I think that's rehabilitation.*

Considering the person in his/her individuality, associated with the changes occurred in the professional him-/herself who performs this reflection, values the progress towards autonomy, addressing aspects of daily life.

*... I used to imagine that rehabilitation would be to put the person in a college (...) today, I understand that rehabilitation are small things which we have to value (...) like taking a bath, self-care, cutting one's hair, shaving, cutting one's nails.*

We observe from the report that autonomy is a concept the professional should elaborate:

*Sometimes the professionals themselves help to turn people chronically ill. I think that what is missing is the actual therapeutic project, aimed at autonomy.*

Autonomy is also related with the idea of independence:

*... it is when he manages to be more independent, I think it varies according to this person's degree of dependence, degree of illness.*

A more elaborate conception of autonomy refers to the patient's engagement in a self-organization process:

*... it means the person having control over things and being able to actually do something for his own life.*

*... I think that the individual's comprehension of the*

*cure mechanism is not limited to the physician, psychologist or nurse, but allows him to have other possibilities within his ability.*

Another simpler conception only focuses on social insertion:

*... our goal is to gradually bring him back to social life or as closely as possible to the basic condition he had before.*

The diversification of the professional's look and the dislocation of his/her attention from the focus on the disease stimulate important discoveries in care, allowing broader perspectives to the patient and facilitating his/her readiness for daily life.

Autonomy is a condition for people to create standards, orders for life itself, according to the situations that have to be coped with. Occasionally, there is a wrong understanding of the relations among autonomy, self-sufficiency and independence. We are all dependent to some extent, but people with mental disorders excessively depend on few relations/things, and this limited situation can decrease their autonomy<sup>(6)</sup>.

In this context, the exchange relations, with broad dimensions, constitute a link that outlines the rehabilitation process, continuing the different levels of contractuality, whether affective, material or symbolic. To the extent that people increase their exchange power, their contractual power grows proportionally and can extend to autonomy as a condition the patient acquires through his participation in the rehabilitating process itself.

It is evident that the professional's involvement, commitment and participation are very valuable and also facilitating aspects for people in mental suffering to be able to reconstruct and take up again their own road. However, this road without a predetermined destiny will follow the course the walker can/wants to walk, with the professional acting as a catalyzing element and as an important reference in subjective courses.

The statements quoted above also suggest the consideration of possibilities that personal self-reorganization will occur, originating from the patient's dynamic participation as the main actor on the scene of probabilities. After the "crumbling" brought about by the experience of living with the questions characteristic of mental disorder, the period of reconstruction can start, whether of the mental apparatus or of the personality, meanings and affections. This diversity demands projects that consider the subjectivity and maintain the idea of the whole, with broad interconnections.

The narratives presented rehabilitation in the sense of social insertion in combination with the idea of belonging, and of movement that brings something that was sleeping. In the authority of the asylum apparatus, imbued with the subject-object relation, procedures are standardized, depersonalizing people, in a silent cycle that leads to chronified states for the patient, institution and professionals. The idea of recovery appears connected with insertion:

*... it means reconstructing something that was lost inside the hospital (...) we can try to promote spaces for the person to take up his things again, including the ability to participate.*

*The bond with companies is good, we don't have that partnership here and it's very difficult for more severe cases of patients to go back to work.*

Hence, the notion of restituting lost parts appears connected with the possibility that the patient can recover for himself; "only what emerges from each being's core can be experienced as real. An apparently normal life can be maintained on the basis of the *false self*, while the individual is still absent from himself, excluded from life itself. It is interesting to observe that the *false self* is actually a dissociative defense that protects the true self, while the latter remains hidden"<sup>(7)</sup>. What is hidden inside the hospital and configured by the symptoms of psychosis can lead to the retreat process of existence itself. The reconstruction of what seemed lost directly depends on the bonds created around the person, as well as on the professionals' sensitivity to unknown codes.

Although the subjects seem to have brought rehabilitation, insertion and context as interdependent factors, disbelief appears in the possibility that a set of procedures or strategies exist which are interconnected with the expansion of interactive networks that promote real exchanges:

*... it means being able to insert the person in his context, I work more with the term insertion than with rehabilitation, because rehabilitation departs from the premise of integrating all aspects of the person, and that is often not possible.*

The subject's narrative contrasts with the theoretical premises of human conduct, with respect to the meaning of conduct in a specific situation that is experienced<sup>(8)</sup>. The object's quality is relational and derives from the relations and conditions each object is in at every moment.

A frequent conception of psychosocial rehabilitation identifies it as a *complex process*:

*... it involves many factors, within a transformative mental health policy and it aims to lead the person back to life.*

The complexity of psychosocial rehabilitation suggests the existence of contradictions, indeterminations, probabilities, difficulties and connections that contrast with the simplifying thinking:

*I see it as quite a broad, complex process, quite difficult to define its range, where it starts, because there are so many and big variables we see that are interconnected with the illness process.*

*... it is complex... it covers a look, attention for the review of social roles. The relatives and the patient's place in society is a place that favors disease or health.*

The complexity indicated in the subjects' narratives reminds us of the range of interactions between the parts, which interfere and construct the dynamic whole, which is never exhausted nor reduced to the sum of the elements. The specificity of each part, in contact with others, is modified, and the whole is also modified:

*... there are many different factors, but I see rehabilitation as a net, each one depending on the other to construct something.*

The existence itself of this "net" brought by the subject suggests life and this implies dependences, contradictions and ambiguities that lead to a new understanding of and interweaving between phenomena.

Variables and contradictions brought by the subjects, families and the patient's position in society were mentioned as factors that influence the health/disease process. Thus, significant reference borders are extended to the larger social group. They are not limited to the family, but include the set of interpersonal bonds, considering culture, work, friends, and understanding the importance of professionals metabolizing this social view as well.

*... the complexity of rehabilitation work demands very high investments in the development of treatment professionals and in the development of treatment methodologies.*

For the subject, the difficulty is focused on the preparation and competence of professionals who attend people in complex situations, revealing remote personal expectations about the realization of the rehabilitation process, as if there were distancing from actual possibilities for this fact to occur. Among the conditions the professionals consider important for psychosocial rehabilitation to occur, we identify the need for a prepared and assisted team, as well as the need for further information to the patient and society, and also the need for care delivery that is dislocated from the "disease focus". One common point

that emerges in discourse is the importance of the contest among various activity lines in the construction of a new care, which does not allow the supremacy of one single knowledge:

*A good team, precisely because the factors are diversified, which will imply efforts by several professionals from different areas, working jointly.*

*Teamwork is important, it is fundamental for the team to be competent for a needs diagnosis.*

*... sometimes the professionals' sign marks different roles, on the packing label, but the content is not different, you open it and they all smell the same, appear the same so, then, the psychosocial rehabilitation process is already impaired because they have differentiated knowledge and competences, they are not capable of reaching differentiated diagnoses and even less of differentiated therapeutic planning.*

Although the narratives consider the team's importance, they demonstrate concerns about the product derived from its performance which, according to the subjects, may not be capable of apprehending people's actual needs. This suggests that the procedures carried out by the whole team cannot always offer the benefits of satisfied needs. In other words, the production of actions does not always contain the expected dynamics between identified needs and interventions that make life possible.

Delimiting roles is quite difficult in Mental Health, reminding that, specifically in this area, good team relations are essential<sup>(9)</sup>. However, the non strictness, the flexibilization of roles, respecting each member's professional training and the dynamic fluency of open services' daily care request competence, accountability and commitment to the presented demand. The type of service and the care team's organization are variables that determine the evolution of the disease process and the efficacy of the interventions, which are guided by the bonds established in welcoming and solidarity<sup>(1)</sup>.

The concern with developing improved devices that are capable of dealing with the range of each patient's requests is very present in the subjects' discourse:

*A good team is important, what happens is that, often, the service turns into a vacation colony, a thing like that, because it's a protected space, sometimes the patient gets better because protection does good, but the patient's actual needs are not at all perceived. This leads to a more superficial approach because there is some improvement, but that is followed by a rapid relapse.*

The professional's possibility of having a plural look increases his/her competence and responsibility

to deliver care that aims to create subjective meanings, rediscovering resources according to each person's time and limit. It also evidences the importance of the professional developing conditions to bear the mental suffering of the other person before him/her, and to organize his/her own experience.

Open services need to characterize themselves as places where people are welcomed, but not where they can remain<sup>(10)</sup>. This thinking is directly related with the conditions the professionals develop to understand the subjective experiences of suffering and, consequently, develop interventions that actually attend to the patient's real needs.

The subjects reveal the importance of knowledge diversity in care:

*... there is a need for distinct, specific technical competences, a specific work method to develop different Rehabilitation plans.*

In the context of classifying health care technologies, it is considered that those based on the existence of bonds, welcoming and the promotion of autonomy do not belong to any professional's specific or strict area, but constitute the base for everyone's actions, through the mediation of knowledge that constructs effective intervention strategies<sup>(11)</sup>. However, the proximity with mental suffering as a result of the mental disorder provokes the professional's search for devices or internal resources, which are often felt as difficult to live with.

*... the team has one of the most difficult tasks, which is to bring the patient close to the service, because one cannot treat from a distance. The treatment depends on the bond, you have to treat from nearby. This requires a lot of training and also help. In general, this is not part of the reality of people working in mental health.*

This narrative not only reveals a complaint about the lack of care for those who care, but also demonstrates the difficulty to deal with abstract questions, be consistent, establish bonds and adopt the person him-/herself as the main work instrument. If the object of care is the human being, the practice of this care is connected with reflections and revisions of the care deliverers' lives, which demands that professionals perceive their own feelings and continuously expand the possibilities to cope with them. This presupposes that the object's qualities are always relational; thus, the emergent is situational and derives from a field<sup>(8)</sup>. This thinking helps us to reflect on the importance of flexibility and the possibility of developing positive interpersonal relations.

## CONCLUSIONS

The professionals from the multidisciplinary Mental Health team represent psychosocial rehabilitation as *a complex process of developing the autonomy of patients with mental disorders, making possible their social insertion and the abandonment of a unilateral view of symptoms*. For psychosocial rehabilitation to occur, the professionals consider that it is important to elaborate therapeutic planning together with a competent team, which diagnoses the patients' needs, provides them with further information and a better treatment, taking into account each patient's potentialities instead of focusing on the limitations entailed by the mental illness.

Among the difficulties and challenges faced to put psychosocial rehabilitation in practice, the professionals' lack of appropriate preparation was mentioned, in combination with a mental health policy that induces the patient's dependence, and with the complexity of the work (involving the patients' families and partnerships with social agents), difficulties that are aggravated by prejudices, stigmas and patients' previous social exclusion processes.

The results of this study suggest that the transformation process of psychiatric care is ongoing, producing results at the services where it is being implanted. Despite difficulties in its implantation, it is observed that many of the professionals we listened to have created awareness of the new focus that is adopted. Through their discourse, some of them evidence a systemic conception of the human being with mental disorder and his/her social environment, thus approaching the proposal for a systemic understanding of health. Just like systemic factors influence the vulnerabilities that create and/or aggravate the disorder, through the team's action, they can also be redimensioned, providing service users with new rehabilitation alternatives.

The theoretical reference frameworks of psychosocial rehabilitation are based on concepts like

*autonomy, socialization, citizenship and contractuality*. The subjects' discourse demonstrates that these frameworks have been partially assimilated, which makes us question whether these theoretical determinations, although necessary, are sufficient to guide the transformation process? Would the *subjective aspects* not have to be considered as well, for example how the users assess the services in terms of improvements in quality of life they provide?

The context in which psychosocial rehabilitation occurs is polysemic, in view of the plurality of the subjects involved, which demands adequate forms of action. Finding unique possibilities for each person, in the different situations in their lives, constantly demands a look and listening that acknowledge these subjectivities. Thus, the proximity with the person suffering the experience of a mental disorder confronts several interpretative possibilities, questions competences, requires the professional's sensitivity and understanding that mental suffering cannot be seen as something to be eliminated or fought against, but can lead to the rediscovery of the real, of the understanding of the patient's emotional experience.

It is relevant for professionals to be aware of the historicity of madness, its whole evolution, as well as its transformation process that gradually determines the delivered care. This helps to understand the ruptures occurred throughout the evolution and in the acknowledgement of madness' social production, evidencing the challenges, contradictions and the importance of open services. Thus, each person is requested to take up his/her responsibility in the scenario of changes towards an unknown and not predetermined future. The professional, social, supportive, affective commitment, aimed at improving everything that surrounds us, is needed in the daily construction of bonds, transformations, hope and the continuous promotion of life. Perhaps that is how we can always maintain the creative light burning and the current desire for constant searches.

## REFERENCES

1. Saraceno B. Libertando identidades: da reabilitação psicossocial à cidadania possível. Rio de Janeiro (RJ): TeCorá; 1999.
2. Cavalcanti MT. Transformações na assistência psiquiátrica, ou uma assistência psiquiátrica em transformação. In: Russo J, Silva Filho JF, organizadores. Duzentos anos de Psiquiatria. Rio de Janeiro (RJ): Relume Dumará/Ed. UFRJ; 1993. p.145-55.
3. Triviños ANS. Introdução à pesquisa em Ciências Sociais: a pesquisa qualitativa em Educação. São Paulo (SP): Atlas; 1994.
4. Laplanche J, Pontalis JB. Vocabulário de psicanálise. São Paulo (SP): Martins Fontes; 1992.
5. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1994.
6. Kinoshita RT. Contratualidade e reabilitação psicossocial. In: Pitta AM, organizadora. Reabilitação psicossocial no Brasil. São Paulo (SP): Hucitec; 1996. p.55-9.

7. Vaisberg TMJ. Sofrimento humano e práticas clínicas diferenciadas. In: Vaisberg TMJ, Ambrósio F, organizadores. Trajetos do sofrimento: desenraizamento e exclusão. Anais do 1º Seminário Temático do Ser e Fazer; 2002 novembro; 12(3) São Paulo (SP): Instituto de Psicologia da USP; 2002.
8. Bleger J. Psicologia da conduta. 2ª ed. Porto Alegre (RS): Artes Médicas; 1989.
9. Minzoni MA. O relacionamento da enfermeira com a equipe e com os pacientes em um hospital diurno psiquiátrico. Rev Psiquiatr. Dinâmica 1967 maio; 7(2):38-43.
10. Pitta AM. Os centros de atenção psicossocial: espaços de reabilitação? J Bras Psiquiatr 1994 setembro; 43(12):647-54.
11. Merhy EE. A perda da dimensão cuidadora na produção da saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Reis AT, organizador. Sistema Único de Saúde em Belo Horizonte: reescrevendo o público. São Paulo (SP): Xamã; 1997. p.103-20.