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THE MEDICATION THAT APPEASES AND THE FAMILY THAT CARES: SOCIAL REPRESENTATIONS OF PROFESSIONALS ABOUT USERS WITH SCHIZOPHRENIA

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ABSTRACT
The Psychosocial Care Network is made up of a group of services created within the scope of the Unified Health System with a view to producing care in freedom for people who are in psychological suffering. This study sought to understand the social representations of the professionals of the Psychosocial Care Network about users with schizophrenia. This is a qualitative field research developed in the north of the state of Minas Gerais, Brazil, guided by the theoretical-methodological framework of the Theory of Social Representations of the Social Psychologist Serge Moscovici, based on the structural approach of Jean-Claude Abric. The results directed to two important themes in the context of mental health: medication as an ally in expanded care and the family as a center of care. Thus, from the relationships established in the production of mental health care, the need for policies that favor the strengthening of care artifices emerges, including the sharing of care between professionals and family members.

Keywords: Social Representation. Psychosocial Care Network. Medication. Family. Schizophrenia.

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INTRODUCTION

The Psychosocial Care Network (RAPS) is a group of services that were created in the Unified Health System (SUS) with a view to caring for people in psychological suffering (Brasil, 2011). RAPS assists users with various psychiatric demands . In this context, patients with mild to more severe mental disorders are welcomed. RAPS offers care to users with schizophrenia, among other psychopathologies, whose practice is guided by historically constructed representations, which give meaning to the established relationships.

Schizophrenia is a serious mental disorder and synonymous with stigma and prejudice over time. Originating from the Greek term *skhizô,* which means to separate, to divide, the disorder brings the idea of disaggregation, of a personality in rupture with the world (Priberam, 2022). It can be characterized by the absence of contact with reality (Tamminga, 2022). It is "a serious and disabling mental illness that affects subjects of all social classes and races, in all parts of the world" (Queirós *et al*, 2019). Subjects with schizophrenia and/or other mental disorders have been, throughout history, considered insane.

A brief look at the history of madness allows us to observe a diversity of representations that society has constructed about these subjects. Sometimes associated with religious influence, sometimes with the alienist-insane-mental complex (Barboza, 2019) in the name of order and morality, subjects who were in mental suffering were hospitalized withthe victims of disorder and social disorganization.

Over time, and after many barbarities committed, the conditions of treatment in the various institutions/asylums were seen and imputed as inhumane. These were precarious spaces where people's humanity was confiscated, spaces such as the place of deposit of the "misfits" (Arbex, 2013).

In this context, a study of great relevance is carried out by Social Psychologist Denise Jodelet in a psychiatric institution in France, in the 1980s, which brings important considerations about the construction of social representations about madness. This research unveils a set of beliefs about the relationships established between the actors in that context and makes explicit a dismaying aspect: the conviction of mental illness as contagious. (Jodelet, 2015, p. 290).

The Psychiatric Reform allied to the anti-asylum movement, initiated from complaints from professionals and family members who were dissatisfied with the drastic

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and inhospitable situation of asylums, provided the restructuring of psychiatric care. This is a criticism of the hospital-centered model previously in force and an attempt to overcome the asylum model that governed health policy. Thus, the psychiatric reform, provoked from the 1970s in Brazil, was constituted in the search for better treatment conditions for subjects in mental suffering, aiming at humanized care (Sousa; Costa, 2019).

The proposal to deinstitutionalize the Psychiatric Reform and the search for mechanisms that would guarantee the production of care in freedom led to the emergence of the so-called Psychosocial Care Network (RAPS). Established by Ordinance MS/GM No. 3,088, of December 23, 2011, the RAPS aims to "create, expand and articulate health care points for people with suffering or mental disorders and with needs resulting from the use of crack, alcohol and other drugs, within the scope of the SUS" (Brasil, 2011).

Among the contributions that this work brings is the exposure of the mental health care offered in the territory, since social representations allow access to the way of thinking of a certain group when reflecting reality (Leal et al., 2010). In addition to reflecting reality, they function as an organizing entity of this reality, governing and defining the relationships established. (Giacomozzi, Camargo, 2004).

We agree with Leal et al, (2010) that representations denote change and transformation, since our actions are determined by the way we conceive the world and that such a phenomenon can constitute health promotion, since it allows the identification of the perceptions of the interviewees in their narratives, beliefs and cultural processes. Thus, in the area of collective health, this exposure can instigate the need to build new care practices that ensure the strengthening of arrangements that cooperate for the construction of RAPS, among them, continuous training of its agents.

Therefore, considering the potential of the Theory of Social Representations to enable the unveiling of the perceptions of groups about various phenomena, as well as to treat the meanings, beliefs and values attributed by the subjects as tools for apprehending the world and guiding daily practices and attitudes, this research was carried out with the aim of understanding the social representations of RAPS professionals about users with schizophrenia.

METHODOLOGY

This is a field research carried out in the RAPS of four municipalities in the northern region of the state of Minas Gerais/Brazil. In the municipalities visited, there are two

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Psychosocial Care Centers (CAPS), thirty-nine Family Health Strategies (ESF), two Specialty Centers and a Multiprofessional Mental Health Team, with an average of 99 professionals in the categories surveyed. Of these, 50 higher education professionals included in the National Registry of Health Establishments (CNES) were interviewed: psychologists, nurses and doctors with at least 6 months of experience. Professionals who were away from work due to vacation and other leaves at the time of data collection were not included.

This is a qualitative study guided theoretically and methodologically by the Theory of Social Representations through the Structural Approach of the Central Core Theory (Moscovici, 2007; Abric, 1998).

Data collection took place between March and July 2023 and included the application of a sociodemographic questionnaire with 10 questions, use of the Free Word Evocation Technique (TALP) and application of an open question in depth. TALP was induced from the expression "patient with schizophrenia". The data generated by TALP were analyzed through the structural approach with the help of the Software *Ensemble de Programmes Permettant l'Analyse des Evocations* (EVOC)® through the four-house table by Pierre Vergés (2005). And those generated through the open question were analyzed by Laurence Bardin's content analysis (Bardin, 2016).

The research project was approved by the Research Ethics Committee of the State University of Montes Claros (UNIMONTES) under opinion number 5.836.113, with its own funding. All the professionals interviewed agreed to participate in the research and signed the Informed Consent Form (ICF) in two copies. The interviews were identified with the vowel "E" (numbered from 1 to 50).

Mental images, common sense, beliefs, words, ideas, senses, memory, cognition, language and communication are expressions used by Moscovici to refer to social representations, which are the result of a continuity of elaborations and changes that take place over time and are the outcome of a sequence of generations (Moscovici, 2007). Therefore, in the context of the disease, the representations are also crystallized by the successful presence of the interpretative discourse, which is an element triggered by the threats and modifications that the illness causes in the individual and social life of the subjects (Herzlich, 2005).

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RESULTS AND DISCUSSION

The sociodemographic variables of the interviewees are described in Table 01.

Table 01 – Sociodemographic Variables of Health Professionals About Users with Schizophrenia. North of Minas Gerais, 2023.

Variable	Category	Number	%
Sex	Female Male	29 21	58 42
Age	25 to 40 years old 41 to 69 years old	37 13	74 26
Income*	1 to 2 MW	6	12
	2 to 5 MW	19	38
	5 to 10 MW	11	22
	>10 MW	14	28
Schooling	Higher education	23	46
	Specialization or Residency		
	Incomplete	2	4
	Specialization or Residency		
	Complete	25	50
Specific Course in Health	Yes	18	36
Mental	No	32	64
Working Time at RAPS	06 months to 5 years	27	54
	06 to 10 years	11	22
	11 to 15 years	06	12
	15 to 20 years	04	8
	> 20 years	02	4
Frequency that serves	Rarely	07	14
Patients with schizophrenia	Occasionally	11	22
	Frequently	24	48
	Very often	08	16

Source: Survey data, 2024.
*During the period of the interviews, the value of the minimum wage varied between R$ 1,302.00 and 1,320.00.

The result of the association of words brought by EVOC is found in the table of four boxes (figure 01). The evocations brought by the 50 professionals interviewed totaled 251 expressions, as follows: 113 different words, considering an average of 5.2 words per participant. A *range* of 2.90 was recorded, and as for the constitution of the frequencies: the minimum at 5, and the intermediate at 9.

Distributed in the quadrants that indicate the central nucleus and the peripheral system, there are 11 words evoked: agitation, hallucination, care, medication, aggressiveness, specialized care, family, difficulty, misunderstanding, isolation and welcoming.

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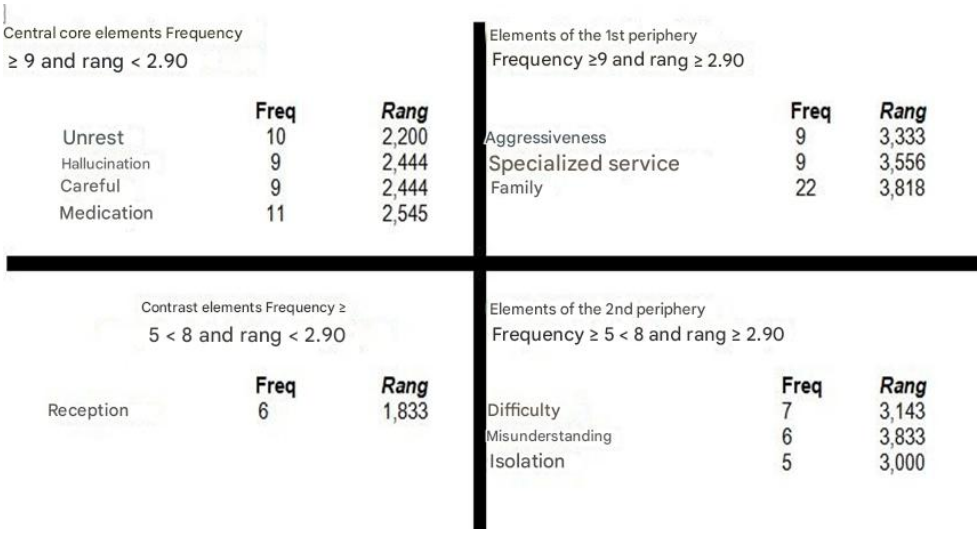
Figure 01 - Table of four places: frequency classification and average order of position generated by the Rangfrado Software EVOC).® Social Representations of Health Professionals About Users with Schizophrenia. North of Minas Gerais, 2023.



Source: Prepared by the authors themselves, 2024

It is essential to contextualize the meaning of the representations located in each quadrant. The expressions shown in the first quadrant (agitation, hallucination, care, medication) signify the presumed elements of the central nucleus, where the structure of the representations presented by the professionals is concentrated. According to Abric (1998), this system contains information that is related to historical, sociological and ideological circumstances, so it refers to a more consistent, stable collective memory, resistant to change. This can be seen in the words "agitation and hallucination" where the signs and symptoms are images that occupy the place of the subject, being objectification of the constituted representation.

Among the words that appear in the quadrant, medication is the one with the most frequency, seeming to emphasize medication care as a product of a historical conjuncture that valued (or still values) mental health care based on a biomedical logic.

Despite this, it cannot be affirmed that there is a marginalization of comprehensive care for the subjects, because the word "care" that also appears in the central nucleus is mentioned in the discourses with the meaning of expanded care.

The peripheral elements are distributed in the first, second periphery and contrast zone. They unveil the renewal and conjuncture of social representations, they say of the contextual communication processes. For Abric (1998), this is a space of greater flexibility, which is also essential for the understanding and explanation of phenomena, characterized by the integration of individual experiences and histories. As observed, in the first periphery

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of our study, there are: aggressiveness, specialized care and an emphasis on the expression "family". In this context, we can think of the redimensioning of the space occupied by the "family" institution in the treatment of mental suffering. As for the second periphery, there are: difficulty, misunderstanding and isolation, which are elements that also characterize the daily care routine.

The contrast zone also brings important elements, however they are the ones that appear with the lowest frequency, which here is the word "welcoming". Considering the principles of the Psychiatric Reform, its meaning in this quadrant can be explained by the fact that, although user embracement exists in the territory, there is a need to occupy an essential place in the production of this care.

After comparing the highlights brought by the four-box table with the analysis of the content, two main categories were reached, distributed as follows:

Chart 01: Delineation of the Categories and Subcategories resulting from the content analysis.

Category I **The medication how Allied in Extended care**	**Category II** **The Family as a Center of Care**
Subcategory I: Medication as a way to appease the patient with schizophrenia. **Subcategory II:** Expanded Mental Health Care	**Subcategory I** Family as a pillar in the stabilization of patients with schizophrenia; **Subcategory II:** Burnout and family illness in the care process.

Source: Prepared by the authors themselves, 2024

MEDICATION AS A WAY TO "APPEASE" THE USER WITH SCHIZOPHRENIA

Medication is an essential element in the treatment of users with schizophrenia. This support cannot be dispensed with, since the absence of psychotropic drugs in adequate doses in the body of these users is capable of precipitating crises, in addition to enhancing characteristics common to schizophrenic conditions, such as delusions, hallucinations, as well as aggressive and violent behaviors.

In his renowned study on social representations of madness, Jodelet brings findings that characterize medications as those that camouflage the symptoms and drain the risk of the crisis. However, the process of attenuating the crisis provided by medicines also produces other meanings to it. They are synonymous with safety, tranquillity and express the incurable character of mental illness. (Jodelet, 2015, p.291).

Despite the advances in psychiatry, which works in coexistence with a multidisciplinary team, some professionals still overestimate the value of medication in the

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care of patients with schizophrenia: "usually when the patient is in an outbreak (it is) the only way we have to appease". (E1)

The medication is presented in the E1 interview as the first choice to reassure the user in acute psychiatric crisis. This attitude may point to a model of care present in networks that are still fragmented with regard to the proposal of intra- and intersectoral articulation propagated by the Ministry of Health in recent decades. The networks thus characterized denote a biomedical care model, mechanistic, centered on pharmacological treatment, sometimes marginalizing comprehensive care for the subjects and underestimating basic principles of the biopsychosocial model by neglecting a holistic approach. (Papadimitriou, 2017).

From this perspective, medication as a mechanism to appease mental health crises is the product of a series of meanings that instrumentalized professional knowledge and managed the operational environment of care processes, over time, as a mode of social incorporation of representations (Jodelet, 2011).

Thus, the emphasis given to the medicinal element can be explained as resulting from anchoring. Anchoring as a synonym for classifying, for naming something, but also as a process that comes from an operation that is not only intellectual, therefore, associated with a social attitude (Moscovici, 2007).

According to Lima and Guimarães (2019), the aspects brought express the scenario of a Network that is still being designed and consolidated through metaphors about RAPS, as a territory where threads are aligned, embroidered and reconnected. In this sense, the territory is a place where an entanglement of threads is established: whether they are subjectivities, consistencies, memories, or even structural conditions for care. The fact is that the entanglement of all of them engenders a design of the care offered, which is often not the desired design, but is the product of arrangements that are made, undone and that illustrate the "knots" that interconnect the Network, which are essential for its implementation.

The centralized presence of the drug element may represent traces of fragmented care, still crossed by traditional remnants of treatment. Or as "islands of resistance", as the aforementioned authors point out. On the other hand, the identification with non-drug therapies, the social approach and better care for users and family members denote the search for expanded dimensions of care, of enunciations inaugurated by the Psychiatric Reform, of an "embroidery" that is under construction, even if stitched together.

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Processualities that show the transformation of the unfamiliar to the familiar, from the reified universe into consensual to the assimilation of the uncommon (Moscovici 2007).

In view of the complexity of mental health care, it is necessary, in addition to "appeasement", to continue strengthening this expanded view in the construction of care focused on integrative practices, which overcome the fragmentation of the network, which restructure the organization of shared actions and which consider the subjects in their subjectivities, recovering their histories and resignifying their realities.

EXPANDED MENTAL HEALTH CARE

The stabilization of the user with schizophrenia, as well as of all subjects in mental suffering, is the main objective of the treatment offered to them. However, it is important to say that the stable condition is achieved not only with drug therapy, but also by resorting to other artifices, already proven effective, such as psychotherapy, the practice of physical activity in groups, the use of artistic expressions, the adoption of adequate nutrition and healthy lifestyle habits, with a view to not only achieving, but to maintain the much-desired stabilization.

> (...)The patient with schizophrenia requires differentiated attention , that all the mental suffering, and, whatever the diagnosis, it requires more attention from the team, responsible [for] taking care of this patient, but schizophrenia, I see it as something, [that] requires differentiated care, better care for the person, for the family. (...) So, follow-up, with medication, non-drug therapies is extremely important and a social approach as well, for these families. (E27).

This statement portrays a scenario in which, even with the medication element, there are other important components involved in the care relationship between professionals and users, such as: differentiated care, better care for subjects and families, follow-up with non-drug therapies and a social approach to the family group.

Other aspects associated with care are part of the interviewees' statements: welcoming, psychotherapy, food, the need for understanding, family support and a quality of life, consistent with "providing well-being for the patient, a better quality of life, not so much for the patient, but also for the family, because through our care, through our attention, As a health professional, we provide this well-being for him". (E38).

The evidence pointed out above highlights that non-pharmacological care occupies an important place in the treatment of users, in line with studies that show the efficacy of

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psychotherapy and other non-pharmacological interventions. (Russel, 2012; Nimmons, 2024).

This presence of components involved in the care relationship beyond medication points to what Moscovici (2007) brings as the unfamiliar, that is, the presence of something real that was once absent, the mark of the reified universe, which presents itself as the strange, the new.

The definition of health in recent decades is associated with the overcoming of traditional approaches to thinking and doing health, which advocated the objective character to the detriment of the subjective. From the Health Reform, new meanings are stimulated in this conception, among them, the establishment of a proposal, an interdisciplinary articulation, a shared view on the part of the health disciplines, as well as Social Psychology for issues related to health promotion, causing a proposal to break the fragmented conception between subject and object, of a positivist nature. This is a broader definition that points to the involvement of professionals and subjects who reflect these practices of renewal of the concept henceforth the assumption of health as a "common good" (Oliveira, 2000).

Health as a "common good" is inserted in the context that considers that the health-disease relationship is accompanied by the understanding of health as a result of the concrete conditions experienced by the subjects, therefore defined in the historical context of a society (Amarante, 1998).

It is from this perspective that expanded mental health care emerges, as a mechanism for the suppression of the asylum apparatus combated by the psychiatric reform, which is not restricted purely to the psychiatric hospital, but in the association of various factors, such as gestures, looks and attitudes that are responsible for the propagation of intolerance and differences substantiated in the daily life of social relations (Giovanella; Amarante, 1994).

Expanded care in this sense is articulated with the expanded clinic, through which the care offered to the subjects overcomes the individual and egocentric perception of the professionals, as a way of undoing the idea that reason is found purely in them, suppressing the knowledge and desire of its agents (Arruda, 2018).

The expansion proposed in the clinic is related to the valorization of the subjects beyond the disease. Unlike traditional medicine that worshipped the treatment of diseases, the new clinic is directed to the subjects, conceiving them beyond the symptoms and

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diagnoses, since health problems are correlated with different factors (Campos; Amaral, 2007), in accordance with the highlight presented by interview E18: "remember that it is not only the medication acting! It has its emotions, so does the patient's family. So it's really comprehensive care, which I think is the main thing."

In another interview: "follow-up of this health and disease process, so that he can live better" (E27).

The search for expanded care is also evidenced in interview E16, which points out the accuracy of a care plan in the service, characterized by welcoming, support, guidance and teamwork.

> It is a multidisciplinary team (...) this teamwork, treating this patient in the best way starts with welcoming! I'm going to listen to him, I'm going to listen to what he has, in this reception he reports what he came for (...) outlining a care plan for him.

It is worth considering that, as an element located in the central nucleus and resulting from the consensually established collective memory, mental health "care" in the territory is present in the discourses of professionals as a synonym for inclusion, promotion of social life, care plan, welcoming, quality of life, and differentiated care, therefore of expanded care.

Such a proposition unveils a remnant of the care offered in the territory in question, since according to Jodelet (2011), the social representations, constituted from the interpretation of the subjects with the world in which they inhabit, are instruments for organizing their conduct.

FAMILY AS A PILLAR IN THE STABILIZATION OF THE USER WITH SCHIZOPHRENIA IN RAPS

In the picture of four houses, the family appears in the first periphery. Of the 50 professionals interviewed, 37 referred to the family in their statements. A total of 102 references were made to issues related to the family in the production of mental health care.

The participation of the family in care is brought by the professionals in a dynamic way. Sometimes it is the family that provides care, sometimes it is the family that needs assistance, that is, sometimes it is the family that is seen as a pillar in the stabilization of the sick member, sometimes it is the family that is overloaded. In this context, it is

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proposed to discuss the place of the family in the production of mental health care, the family as an extension of the support network.

Interview 8 shows that the family needs to be with this user and points out that it is the pillar for the treatment: "The family, it has to be very close to the treatment so that this patient keeps it stabilized, so I think that the family is the pillar, together with this psychiatric patient" (E8). Or the family as sustenance, as interview 17 states: "adequate treatment, it allows the subject to take care of many things, even more, there are some families that for the subject in suffering, the sustenance is the family".

For Rosa (2003), the contributions of the Italian Franco Basaglia in the field of psychiatry emphasized the role of the family as a partner in the structuring of mental health care, as pointed out by interviews 19 and 21: "the patient, he has to be treated with the family, no matter how much he presents suffering, he needs, together with the family, give him this suffering of his, he has to be inside the house, the family has to deal with this situation too" (E19). "Because it is within the family environment that I think the patient can develop better" (E21).

Rosa brings that the information found in the medical records of mental health services is often mostly about the users, leaving references from the family context to be desired (Rosa, 2017). Melman (2008) also states that the recognition of family members as an important therapeutic instrument is rarely encouraged in health services. However, there are indications that this reality has been changing. This author informs about the body of evidence that brings the benefits of family interventions in promoting the improvement of the user, minimizing relapses and the number of psychiatric hospitalizations.

Such a change can be observed in studies that bring the participation of the family in a multiple way in the recovery of patients in situations of mental illness (Waller *et al*., 2019) and those that sought to know strategies that favor the involvement of the family in the treatment offered in mental health services (Tham; Solomon, 2024). Thus, the inclusion of the family in mental health care proposals has been valued.

The importance of the family in the treatment also appears, in this research, as a need for support for the user, according to interviews 14 and 40.

> [...] because, usually, they are patients who need support family, both to look for a qualified professional, and to Help us Movements. (E14).
> It needs treatment, it needs control, it needs emotional support, it needs a family structure, a base. (E40).

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As can be seen, sometimes the family is cited as a pillar in the treatment of users, sometimes as a source of support. Even so, it is worth remembering the contrary character of this perspective that society had in relation to it. The cause of mental illness was related to family factors, which justified the segregation of the user. There is a significant change in this relationship from the cause of disorders to becoming a center of care, pillar and source of support (Moreno, 2005). A Chinese study points to family support as a necessary extension of individualized care, as a mechanism to prevent suicidal ideation in older adults living in permanent institutions (Mião, 2024).

This displacement of the place occupied by the family, over time, added to the complexities that cross mental health care, gives rise to the possibility of resignifying this place (Cavalcante; Carvalho, 2022).

This resignification seems to express the transformative and dynamic character of social representations. As mechanisms resulting from a constant construction, representations communicate with each other, combining, separating and being replaced by others (Moscovici, 2007; Guareschi, 2013).

Whereas the amendment of the Representations is linked to new events in the group, this transformation takes place gradually, while some representations are inserted, others disappear. Their consecutive appearance in the practices of the group depends on the degree of consonance or contradiction with the old representations (Guimelli, 2003).

Therefore, the emergence of the family as a pillar in mental health treatment constitutes the unveiling of a significant component, which is present in the care practices in the territory in question. It brings the reaffirmation of principles that are dear to the Psychiatric Reform, such as the proposal of care in freedom and the search for dignity in these relationships. On the other hand, the role of the family in this process exposes the weaknesses involved, as observed below.

BURNOUT AND FAMILY ILLNESS IN THE CARE PROCESS

The challenges that go through the production of mental health care for family members lead to fatigue, exhaustion and consequently illness of the family member. Interviews numbers 3 and 44 say:

> When I think about mental health, I don't think about the patient's mental health, I think about the mental health of the family as a whole, because it's a patient for whom he has no cure, he has to stabilize the condition, he has to have acceptance from the family that he has that disease, because it's a disease, it's polar, there are

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> times when he's stable, There are times when he is not stable, this leads to a very large family exhaustion, and if he does not have family support, the medication is not enough . (E3)

> Difficult situation, a situation of a disease, which I think sickens the whole family! And many people are not prepared. (E44)

In this sense, the relationships that are established between mental disorders and family care express the multiple determinations produced during this process.

Leopoldo and Rosa (2020) refer to the fact that there is a great responsibility for this care to the families, which can have repercussions on the overload pointed out by the interviews carried out. Shohel *et al* (2022), in an Asian study (Bangladesh), mentions depression and anxiety as diseases that are observed in family members who have a member with a mental disorder. And it adds a factor that causes an overweight for these families, which is society's depreciation of mental illness, which can delay the search for treatment.

Pegoraro and Caldana (2023) systematize overload into four types: practical, financial, emotional, and overload in times of crisis for the user. The first is related to the caregiver's direct care for the sick family member (directing hygiene and medication activities, monitoring health services and surveillance). The second mainly affects the most financially vulnerable families, on the one hand is the increase in spending on the sick family member and on the other hand is the difficulty in attending the job market, since they need to offer full-time care. Emotional overload, on the other hand, implies the state of tension caused by the life situation. And the overload after the crisis expresses a certain forgetfulness of the professionals in relation to the family nucleus, often the attention is focused only on the moment of the crisis.

Allied to this condition, Rosa (2017) presents the importance of spaces in health services for family members to talk about their needs, so that the action of health professionals has repercussions on their (the caregivers) protagonism. These spaces are still scarce, since there is a lack of emotional and cognitive support from mental health professionals for family members of people undergoing treatment, according to a Norwegian study. (Aass *et al.*, 2021).

In this sense, Moen *et al.* (2021) reveal the relevance of seeking the view of these professionals on family relationships in the mental health care process, since a gap is identified in the literature on this topic.

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In addition, Pereira (2010) emphasizes the importance of the intervention of mental health professionals in the relationship with these family members and the offer of support in the face of the difficulties faced. Concomitantly, Leopoldo and Rosa (2020) defend, among others, a network of intersectoral public services as an instrument for sharing this care and preventing family overload.

> So, this is a collective work, it has to be done! It is a person who requires a lot of care, it is from the family and the health team (...) so there has to be a base of both the Health Unit, that family support to be able to make the patient fit into the society in which he lives. (E23)

Interview 19 transcends the need for collective care by saying that the substitute service exists to teach and help the family in the treatment of the user. When referring to the family, she says "that's where I think we have to treat, that's why we have the substitute service, to teach the family to deal with that situation and help treat the patient".

In this context, when writing about the family and mental health care, Santin and Klafke 2023) bring about the need to build a network that promotes shared care and mitigates family overload. For them, the burden on the person who has a mental disorder is concentrated in one or two family members.

This shared care can be evidenced by a valuable tool cited by Moen *et al.* (2021) called Family-Centered Support Conversation as an extension of the care offered to the patient by mental health professionals, whose relationship can benefit both: professionals and families. On the one hand, it facilitates the involvement of families and, on the other hand, favors the reconstruction of beliefs related to the health and disease process and the union of forces in search of the necessary resources for the implementation of improvements in services.

Included in this support offered to the family and associated with shared care is, therefore, the need to welcome family members. Interview 15 expresses her attention given to the suffering of family members, who are tired and ill. "So I welcome the family more , the family's suffering. Families who report being tired, so I see more sick family members."

The professionals recognize that the family's suffering marked by fatigue and illness requires acceptance and care. According to Jorge *et al*. (2011), user embracement is a device that restructures the relationships established between mental health professionals, service users and family members through dialogue, respect, listening and bonding. Care and reception need to be carried out in an individualized way and the care network needs

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to extend to the family group through knowledge of the family reality, considering their daily histories (Mohr; Lavall, 2023; Brook; Rosa, 2020).

Interview 2 emphasizes: "I have to welcome him so that he feels safe, so that he feels confident in that professional and welcomes not only him, but the family!"

Welcoming evidences the reciprocal character of representations, constituted from social structures, but also produced by the subjects who give rise to them (Moscovici, 2007). It is perceived that the family as a center of care for users with schizophrenia, brought by the professionals, represents the valorization of this participation in the process of deinstitutionalization proposed by the Psychiatric Reform and, necessarily, of a participation that is still being constituted.

CONCLUSION

Considering the complexity of the production of care in the Psychosocial Care Network, as well as the transformations caused by the Psychiatric Reform in the Brazilian mental health policy, it is recognized that although medication care is emphasized by professionals as a way to appease and stabilize users with schizophrenia, other essential resources express the search for strategies that signal the construction of comprehensive care. Among these resources is the appreciation of the family as an extension of the support network.

Due to this resizing of the space occupied by the family, other circumstances unfold, such as family exhaustion and illness caused by daily overload. However, it is understood that along with the insertion of the family, although marked by encounters and disagreements, new devices are being considered in this process, such as the proposal of welcoming it by the professionals.

The process of understanding the social representations of RAPS professionals about users with schizophrenia aroused the need to resume the theme from the family's point of view, as a way of apprehending the impacts of this redimensioning of the place occupied by them in this new conjuncture. A theme that can constitute a proposal for future works.

It is noteworthy that the social representations of the RAPS professionals, which constitute meanings that guide the practice of care in the territory in question about users with schizophrenia, reveal that the sharing of care between professionals and family members should be conceived from an active presence of the state in its structuring,

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through the implementation of public policies that favor the strengthening of care artifices, Among them: the continued training of its agents.

The limitation of this work lies in the fact that the RAPS, where the research was carried out, are all located in small municipalities, except for one that is located in a medium-sized municipality, bringing a cut of the reality in the north of Minas Gerais.

GCS collected field data, performed analysis, interpretation, and final version of the manuscript. JFDR performed analysis and contributed to the final version. SSC collaborated in the interpretation of the data. CAS guided the research, contributed to the analysis and final version of the manuscript.

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