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# Autonomy of people with psychological suffering from the perspective of work: Perceptions of users and their families

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## ABSTRACT

**Objective:** To present the results of a study with a psychosocial approach that aimed to examine the autonomy of people with mental suffering cared for at psychosocial care centres from the perspective of work, based on the perceptions of the users and their families, and using the psychosocial rehabilitation framework and Agnes Heller's theory of everyday life.

**Methods:** Four psychosocial care centres were selected, and 40 people collaborated with the research through semi-structured interviews analysed with the Collective Subject Discourse technique.

**Results:** Although the users wanted to have a job, they showed no initiative, as there are impediments to carrying out work activities due to the side effects of the medication and the obstacles posed by third parties concerned about the loss of social benefits. Prejudice was seen as a mechanism that negatively interferes with social relations and empowerment for autonomy. Expectations of resuming studies and participation in voluntary activities, especially religious ones, were frequent in the users' discourse.

**Conclusions:** There is an urgent need to expand territorial spaces so that the users of mental health services can be protagonists of their own autonomy and carry out their occupations in the area of productivity with greater ownership.

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## Autonomía de las personas con sufrimiento psíquico desde la perspectiva del trabajo: percepciones de los usuarios y sus familias

### R E S U M E N

#### Palabras clave:

Autonomía  
Terapia ocupacional  
Trabajo  
Rehabilitación

**Objetivo:** Se presentan los resultados de un estudio con enfoque psicosocial cuyo objetivo es investigar la autonomía de las personas con sufrimiento psíquico atendidas en centros de atención psicosocial desde la perspectiva del trabajo, a partir de las percepciones de los usuarios y sus familias, usando el marco de rehabilitación psicosocial y la teoría de la vida cotidiana de Agnes Heller.

**Métodos:** Se seleccionaron 4 centros de atención psicosocial y colaboraron con la investigación 40 personas mediante entrevistas semiestructuradas, analizadas con la técnica del discurso del sujeto colectivo.

**Resultados:** Aunque los usuarios deseaban tener un trabajo, no esbozaban iniciativa, ya que existen impedimentos para llevar a cabo actividades laborales por los efectos secundarios de la medicación y los impedimentos planteados por terceros ante la preocupación por la pérdida de beneficios sociales. El prejuicio fue visto como un mecanismo que interfiere negativamente con las relaciones sociales y el empoderamiento para la autonomía. Las expectativas de reanudar los estudios y la participación en actividades voluntarias, especialmente religiosas, fueron frecuentes en el discurso de los usuarios.

**Conclusiones:** Existe una necesidad urgente de expandir los espacios territoriales para que los usuarios de los servicios de salud mental puedan ser protagonistas de su propia autonomía y, así, realizar sus ocupaciones en el área de la productividad con mayor apropiación.

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## Introduction

The use of work to treat people with mental disorders was known as moral treatment and was put forward by Philippe Pinel in Europe towards the end of the 18th century. It marked the start of an ideological conception of the topic, when it was implemented as a therapeutic intervention model practised by psychiatry in France and England, and identified work as an object of intervention to standardise and control the irrational behaviours of madness<sup>1</sup> under the name of ergotherapy, praxis therapy or laboratory therapy,<sup>2</sup> to name but a few.

It was the use of work as a therapeutic medium in Europe that had an impact on the major psychiatric hospitals of Latin America, including hospitals in Brazil where this research was conducted. As a result, the Occupational Therapy (OT) Department in “Engenho de Dentro” in the city of Recife is one of the first work activity-based rehabilitation initiatives focused on training that is promoting productive behaviours to incorporate people with functional diseases or difficulties and losses into the workforce.<sup>3</sup>

When the biomedical model was hegemonic in the field of psychiatry,<sup>1</sup> madness was then seen as a form of alienation, annulling the right of those deemed to be insane to freedom and citizenship.<sup>4</sup> It is important to mention that all activities performed from the perspective of the hospital-focused model, including work activities, were extremely institutionalised, with the sole objective of occupying periods of inactivity without necessarily having any purpose for individuals. These activities were understood to be an occupation lacking in human exchanges, production and creativity; activ-

ities with objectives of dominion and subjection, which forces users into social exclusion.<sup>5</sup>

Towards the end of the 1970s, asylum institutions were criticised and sought alternatives to their usual therapeutic practices. Consequently, OT grew in importance in the field of mental health when professionals from this area started to question possibilities of action and their therapeutic potential by seeing social law from the psychosocial perspective as their goal.<sup>3</sup> They redesigned their professional profile based on emerging demands to move away from a merely disciplinary practice towards a practice that would rescue human rights and an individual's emancipation,<sup>2</sup> and work was understood as a form of social inclusion.

This was inspired by experiences from the Italian psychiatric reform and, in the 1990s, a transformation in mental healthcare began in Brazil. From that time onwards, the Brazilian mental healthcare model was based on concepts of care from the perspective of psychosocial rehabilitation.<sup>4</sup> Such discussions triggered a social process that resulted in the restructuring of the mental health sector with more humanised care, based on the ideas of psychosocial rehabilitation.<sup>6</sup>

The experiences of social cooperatives implemented during the 1990s were significant examples that also grew in popularity in 2004 by supporting employment through cooperative work and self-management, the fruit of the articulation between the psychiatric reform movement and solidarity economy practices. Within this scope, work initiatives and the generation of income for people treated by outpatient mental health departments were promoted. As a result, OT combined with the psychosocial perspective used the framework of solidarity economy and began to gain national importance as a

mechanism for social inclusion through work by stimulating the key role of users in the processes, with the offer of self-management and the exercise of democracy, which promote the search for social rights and the right to work itself.<sup>7</sup>

OT makes essential care for people possible through various types of everyday occupations, which cover occupational areas: activities of daily living, instrumental activities of daily living, sleep and rest, education, work, play, leisure, free time and social participation, to name but a few.<sup>8</sup> This research focused on work by relating it to the employment of users of mental health services and analysing their autonomy in this occupation.

Occupational work areas are understood to be economic, domestic and family organisation, volunteering, paid and unpaid activities aimed at helping the community and/or personal development.<sup>9</sup> Work is therefore understood to be making an effort to be able to do or make something specific; to organise, plan or evaluate services; and occupations with or without financial reward. These occupations may be protected or voluntary.<sup>10</sup>

Research has been conducted suggesting that mental health service users have difficulties in several occupational areas, without any one area in particular predominating.<sup>11</sup> Nevertheless, it has also been reported<sup>12</sup> that users of community-based mental health services may have more difficulties in the occupational area of work, followed by a lesser impact on the occupational area of leisure and finally on the occupational area of self-care. Another study reported that psychiatric patients living in Taiwan had more difficulties in the occupational area of self-care, followed by the occupational area of work and finally the occupational area of leisure and socialisation.<sup>13</sup> However, research conducted in Brazil shows that outpatient service users have problems in all occupational areas, i.e. self-care, work and leisure.<sup>14</sup>

Mental suffering is understood from experience to be any suffering resulting from changes and/or transformations to an individual's daily repertoire that may weaken the individual in view of his/her own limitations and disabilities. Whenever such changes or transformations, which may be psychological, emotional or mental, occur,<sup>15</sup> there is an increased need for better support and specific interventions targeting these occupational areas, especially work, when mental health service users are in community spaces, at home or in the outpatient social context.

With these concepts and from the psychosocial rehabilitation perspective, the question is: have outpatient mental health services been able to increase user autonomy in the occupational area of work? With this perspective and considering the psychosocial approach, the aim of this study was to investigate the autonomy of people with mental suffering, with an emphasis on the occupational area of work from the perceptions of users and their families.

## Methods

Exploratory-descriptive qualitative research was conducted to study the autonomy of people with mental suffering who were

treated at type II Psychosocial Care Centres (CAPS II in Spanish), with a focus on the occupational area work, from the perceptions of users and their families.

CAPS are considered strategic points of the Psychosocial Care Network in Brazil. They are regulated by the State and are open, community-based healthcare services that replace asylums as a strategy for mental healthcare. There are 5 types of CAPS. Type I provides low-complexity population groups with healthcare and offers basic services; CAPS II are open for longer hours and treat people with medium-complexity problems; and CAPS III have a larger team of employees and offer 24-h intensive care services. They all have a territorial logic, with CAPS II being located in areas with 70,000–200,000 inhabitants. Each centre has a multidisciplinary team specialising in the treatment of people with mental suffering under an intensive care, semi-intensive care or non-intensive care regimen.<sup>16,17</sup>

In particular, CAPS II offer psychosocial services that primarily treat people in situations of severe mental distress, resulting in severe and persistent mental suffering, including services related to substance abuse and other medical conditions that make it difficult or impossible to establish social ties or pursue lifelong goals.<sup>17</sup>

A total of 40 people participated in the research: 20 users and 1 family member of each user, who was their regular chaplaine to the CAPS II centre. Ten people were consequently selected from each department in the four towns in the state of São Paulo (Araras, Capivari, Limeira and Piracicaba). Professional participants from each of the centres were selected based on the following inclusion criteria: residence in the town and having received follow-up and/or treatment at a CAPS II centre for at least 1 year; organised speech; no psychotic activity; awake, alert and oriented to place and time; ability to understand and answer questions; and interested in participating in the interview. For family members, the inclusion criteria were: residence in the city; organised speech; awake, alert and oriented to place and time; ability to understand and answer questions; and interested in participating in the interview.

All interviews were conducted at the CAPS II, recorded to audio format and transcribed for corpus training.<sup>18</sup> The Collective Subject Discourse (CSD) technique was used to analyse the interviews, which allows the opinion of a collective to be presented as a single discourse, emphasising each statement analysed.<sup>19</sup> As a strategic tool, it makes it possible to consolidate what is common in the discourse of a specific group in order to give a significant representation of participants who share a particular experience.<sup>19</sup> Each interview was subjected to exhaustive reading, which generated 2 key expressions (KEs), from which 26 central ideas (CIs) emerged. These stood out due to the representativeness of the respective interviews.<sup>19</sup> For each KE, there were CIs from both users and family members: for KE 1, "Impediments and difficulties for performing work activities", the users' discourse suggested 9 CIs, while the family members' discourse also suggested 9 CIs. For KE 2, "Expectations and attainment of skills in work activities", the users' discourse presented 5 CIs, while the family members' discourse presented 3 CIs.

## Results

### KE 1. Impediments and difficulties for performing work activities

In the users' and family members' discourses, the following CIs were suggested: effects of medications, and physical and memory difficulties. Specifically in the users' discourse, the following CIs were also suggested: voluntary work, auditory hallucinations, insecurity, initiative, stigma and prejudice. In the family members' discourse, the following CIs were also suggested: lack of control and behaviour changes, visual hallucinations, aggression against others (hetero-aggression), desire to work, lack of initiative and/or lack of continuity of activities (Table 1).

The users reported a desire to have work, but they showed no initiative for carrying out simple activities such as watering a garden, checking on the garden and/or finishing a specific activity. This situation could be related to despondency caused by the actual mental suffering: "[...] he wants to work but has not yet looked for a job. [...] He doesn't have the ability to pick up a hoe and gets tired [...]. He says he wants to do it but does not have the ability to do so. [...] I have done everything I could. He doesn't go".

This extract highlights the social surroundings of the subject with mental suffering, who responds more to a feeling of exclusion from the world of work due to intrinsic characteristics of their illness, leaving a reflection on the existence of social determinants that prevent or facilitate inclusion in employment and recovery of their autonomy to one side, a fact that may indicate that psychosocial rehabilitation assumptions are not addressed by mental health departments to the extent that such assumptions are not necessarily based on skills experience.

In addition to these difficulties, the users' discourse also revealed some impediments for performing work-related activities. The users mentioned that they did not perform any volunteer work due to side effects of the medication and impediments posed by other people, together with worries about the possible loss of disability pension. This is reinforced in the family members' discourse as a certain degree of conformity with this economic income. This seems to generate not only an obstacle but also possibly discredits these users' potential to perform any type of work activity.

In addition to disability pension benefits, another factor that limits their performance of work-related activities is the use of medications, since users who report having been looking for work indicated that they experienced despondency, physical and/or motor, concentration and memory difficulties due to the side effects of the medications. On this matter, family members reported insecurities: "[...] I used to ask him to wash the dishes but now I don't even ask him to do that. Since the day I caught him with the skin scrubbed off his nose with the scouring pad, I am afraid to ask him to wash the dishes!".

The users themselves reported that they did not perform any type of work due to physical difficulties and despondency, emphasising memory problems, auditory hallucinations, insecurity and borderline personality. In this sense, it is clear from the users' discourse that unpredictable

behaviour linked to a volatile personality causes fears and insecurities, triggers specific communication and socialisation difficulties, impairs interaction and causes a lack of initiative: "[...] I am afraid to go to work and not be able to do it. People don't understand my illness. Insecurity!".

For family members, the symptoms impede basic activities of daily living. In this sense, they think that users are aware of their limitations and difficulties but are unable to control them. Work histories from before the users became ill but after they were given their psychiatric diagnosis, and especially after getting their disability pension and starting treatment at the CAPS, were reported. These show that work-related activities became increasingly scarce.

The users' discourses also show how they themselves are aware that their performance, especially in relation to work, is lower than it was prior to becoming ill. This allows us to understand that these difficulties converge in distancing from their social relationships, (re)discovery of potentialities, acquisition of rights as citizens and empowerment of their own autonomy.

### KE 2. Expectations and attainment of skills in work activities

In this KE group, users' and family members' discourses converged in the CI of expectations. The following CIs were specifically suggested in the users' discourse: skill attainment, personal satisfaction, volunteering and informal work, while the CIs study and autonomy were suggested in the family members' discourse (Table 2).

The users' discourse shows that they acquired new skills and, consequently, feelings of usefulness and pleasure through attempts at certain work-related activities. They report that performing some activities is fulfilling and that when there is financial recognition, there is an even more significant improvement in their self-esteem. Expectations of resuming studies were also frequent in the users' and family members' discourses. Users showed a desire to continue with the activities that they had stopped at a particular time for a given reason (including illness).

The users' discourse highlights that participation in work-related activities has a strong influence on making these individuals feel useful. It is inferred that "feeling useful" is a healthy milestone for people. It allows them to build their identity in the occupational area of work, facilitates their process of social inclusion and paves the way for employability. A perception of autonomy in relation to work-related activities was also observed: "[...] I look for informal jobs, sometimes organising parties, promoting barbecues. I am crocheting! I have to work hard to earn our money".

The family members' perception is that the user is the one who should decide and choose to perform activities, without having to be reminded by others or receive help, which may be interpreted as an assessment of empowerment and autonomy. Therefore, CAPS II become a promoting and stimulating space for users to expand on these desires, since it is a place where they feel safe to take risks and start certain activities.

For users, participation in volunteer activities had a strong influence on making them feel useful and religious activities play a major role: "[...] I am a missionary. [...] I pray, teach the children catechism, give adults preparation classes for mar-

**Table 1 – Collective subject discourses of users and family members on impediments and difficulties for performing work activities (KE1).****CSD-Users**

I have never done volunteer work due to my medications. I start to shake! I take one [pill] every fifteen days. The problem is the medication. At church, I can't even go and get a broom to sweep because I will lose my benefits [disability pension]. And I can't carry anything heavy! I have some problems because my bones really hurt. The bone problem! I spent a long time standing with all of my body rigid! That causes muscle weakness; it seems that I don't have much dexterity. I don't have a good memory to store things, to remember. I have some trouble remembering. I hear [voices]. I find it difficult to write. I write exactly how I speak. My everyday behaviour is unpredictable, I have a personality that changes. I am insecure about doing certain things due to my problem. I am scared of making a mistake. I do not feel like doing anything. Schizophrenia does that. I am afraid to go to work and not be able to do it. People don't understand my illness. Insecurity! My body can no longer do what it used to. My eyesight is bad. I was born short-sighted. I can't see very well. When I am sewing, and threading the needle, sometimes I can't see the needle very well. Some days I don't come out of my shell! I have a calm personality. It seems like I can't stand it. My case is serious and there is no cure. I will have a better quality of life! I am scared of being rejected. People sometimes reject us; they think that people like us who are receiving treatment are mad. They think I am mad, crazy, just because I visit the CAPS! Prejudice! I think we are all equal. Nobody is better than anyone else!

**CSD-Family members**

He already has a salary [disability pension]. And he doesn't need to work. He can't work because he takes so many pills! I think the medications he takes make him feel down. His problem is purely mental. His body is healthy! But when it comes to the mind, this doesn't help. I think he forgets things. I used to ask him to wash the dishes but now I don't even ask him to do that. Since the day I caught him with the skin scrubbed off his nose with the scouring pad, I am afraid to ask him to wash the dishes! He is aware that he has no control over the problem, that he does things that he shouldn't do, but he has no control. He doesn't work [at the moment] because he says his body doesn't help. I think that a job wouldn't work out. I think he would have [problems] to work. Not in terms of his body, only in his head. He doesn't know how to lie. He says he is going to see the psychiatrist, that he is taking medication. His problem is mental; he is nervous. He sees things, he breaks things. There was a time when he used to get aggressive! He is not a fast person; he is very slow. He doesn't have the ability to scrub [to clean a shoe, for example]. His hand coordination is not good and he has a slow mind. In my opinion, he gets it into his head that, if he says he can't do it, then he won't be able to do it! He has problems working because he can't react. One day he's one way and the next day he's another. He gets nervous, agitated. He says he wants to work. He really wants to work; he dreams of having his own money. He wants to work but has not yet started looking. He says he wants to go back to work but that he can no longer cope with it because the medication has made him weak. He only knows how to give orders [laughter] but he doesn't have the ability to pick up a hoe and turn the ground. Do you understand? He simply shows that he is willing but doesn't have the ability to do it. He used to go to SESI [for a course] on cooking, on crafts. He always quit! I enrolled him in everything [activities and courses] I could. He won't go. I don't know if it is difficult or really discouraging!

**Table 2 – Collective subject discourses of users and family members on expectations and attainment of skills in work activities (KE2).****CSD 2-Users**

I thought I couldn't make the cushion. And another thing I also managed to do was to crochet it! I like [to work] because now I have my own money. I have my own money and I am not nervous. It is not a lot of money but it helps when I need something. I hope to start here at the CAPS with a computer class to see if I can give guidance, if I can increase this field of knowledge, offer my services. I want to do [the course] and see if I can get into the undergraduate journalism course. I have already been a volunteer! I worked for a while with pregnant women and in the soup kitchen [community cook]. I am a missionary, I am committed to working for the church's tithing ministry, meetings, retreats. We take courses! I pray, teach the children catechism, marriage classes for adults, communion for the sick. We have a meeting, a spiritual retreat. So I am making myself whole with these tasks; I have been doing these spiritual tasks for 3 years now. I look for informal jobs, sometimes organising parties, promoting barbecues. I am crocheting! I have to work hard to earn our money.

**CSD-Family members**

If he has to wash the clothes, he has to come, pick them up and start to wash them straight away. He has a technician qualification in Commercial Management. His life revolves around studying. He loves books, he loves studying. He wanted to finish a course he did on AUTOCAD.

riage, give communion for the sick. [...] I look for informal jobs, sometimes organising parties, promoting barbecues".

## Discussion

This research questions 2 basic concepts that allow us to answer the proposed objectives: psychosocial rehabilitation (PR), which aims to promote autonomy and social inclusion in the daily lives of people in their territories of life,<sup>20,21</sup> and the concept of the everyday, from which a person with any mental suffering can weave themselves a community-based social life without losing the sense of his or her individuality, taken from Agnes Heller's theory of everyday life.<sup>22,23</sup> This theory and its categories act as a philosophical support for PR, since this process occurs in the network of everyday relationships and activities.<sup>24</sup>

Based on these 2 basic concepts, it can be argued that the importance of everyday life is related to the assumptions of PR, which allow people with mental suffering to strive for autonomy, self-determination, social participation and citizenship.<sup>24</sup> It is important to note that everyday life is a "key" to mental healthcare so that people can live in society without losing their individuality.

Perceptions of helplessness in work-related activities prompt fears related to rejection and social stigma. Some reports mention ideas of prejudice and lack of knowledge and information in society, which hinder the inclusion of people with mental suffering in family, community and social contexts, resulting in deterioration in their everyday lives.<sup>25-27</sup> Users perceive prejudice from the people around them. This is consistent with the literature, which states that contemporary society discredits a person with mental suffering due to their illness, its incurable nature and chronicity by setting limits for this individual to be in the world and showing their potentialities.<sup>28</sup>

Prejudice and discrimination are still powerful impediments for constructing a social network in the everyday life of people with mental suffering, since it makes it difficult to access new contacts in the social sphere.<sup>29</sup> As a result, it is understood that prejudice against people with mental suffering has major implications for the construction of social ties and the isolation generated by the social surroundings in which these people find themselves; reinforces the idea that prejudice associated with a lack of participation in significant

activities in the social context is an important characteristic of the life of these users; and has a negative impact on the construction of their social network.<sup>6,29</sup>

It is important to consider that users themselves may take up a position that disqualifies them when they are immersed in a society that is prejudiced against mental suffering.<sup>29</sup> Nevertheless, it is evident that the life history of each user with mental suffering is part of a social history impregnated with exclusion and is criss-crossed by an everyday life of prejudice and discrimination.

In this regard, it is through shared experiences in the territory, involving healthcare and mental health workers, family members and users, that this prejudice can be minimised<sup>25</sup> and, as a result, work-related activities can become a gateway for the social articulation of people with mental suffering in a broader context of relationships and productions, where the perspective of PR must serve to (de)construct and (re)signify the current scenario of mental health, which is still impregnated with stigma and prejudice.

In this sense, the work space may also allow satisfactory experiences, especially for people with mental suffering, to the point of helping to restore their health, improving their quality of life and offering an opportunity to be more active and participative, given that it is a means that allows the construction of social networks from contact with others<sup>30,31</sup> that generates a feeling of social acceptance.

Thus, from the perspective of PR and from the accounts of those who participated in the research, it is understood that, for users who do not have a job, this is not because of their own decision or because the occupation is not meaningful to them, but because of the imposition of a social structure with psychosocial barriers for mental health service users. However, work is a private social right, especially when it is related to or aimed at people with mental suffering. In this respect, although difficult, this population's integration or even reintegration into work still plays an important role in the lives of these people due to providing a privileged social surrounding.<sup>6</sup>

It is worth remembering that the use of work from the perspective of moral treatment was extremely relevant for people with mental suffering, both in Brazil and around the world. The difference is that, in the international literature, work models and programmes were based on formal, competitive work, which may be an obstacle to the process of social integration through work. In Brazil, experiences focused on

integration into work are based on PR, Italian reform theories and practices, forging a pathway between mental health and solidarity economy as of 2004, which is still in the development process.<sup>6</sup>

Another important aspect is spiritual activities, which seem to facilitate the expansion of social relationships and are a powerful space for exchanges,<sup>31</sup> allow occupations with others, triggering a sense of belonging in society and has a positive impact on social inclusion. Moreover, the possibility of exchanges and activities based on a shared action allow social inclusion through work.

For this reason, work is introduced as one of the pillars of PR and should be explored in depth, proposing a reflection that removes work from a conception of therapeutic resource or merely a rehabilitation process, as was the stance assumed in moral treatment, towards a conception in which work becomes the purpose of the rehabilitation and that from the articulation between the needs and desires of the person with mental suffering, mediates for social inclusion through work.<sup>6,32</sup>

People living with mental suffering who manage to perform a specific activity experience a process whereby their identity and their life are (re)constructed. This process therefore reinforces and increases their self-confidence and may even contribute with other users to the expansion of new roles in social life by overriding or modifying their role as sick people.

## Conclusions

Illness causes fragmentation in people's everyday occupations and often triggers negative consequences, such as isolation, minimal social relationships and the ability to maintain or form emotional ties and friendship.<sup>31</sup> Given the configuration of the increasingly competitive contemporary world, work occupies a key place that becomes affected when people have weaknesses in their own interpersonal relationships, which may lead to an isolated and lonely living environment due to being devalued on a daily basis.<sup>33</sup>

The discourses of both the users and their family members show the importance of side effects caused by medication and obstacles to participation at work posed by third parties. This research allowed us to study the everyday life of people with mental suffering who receive healthcare at CAPS II and aims to bolster the expansion of psychiatric reform processes in Brazil from the perspective of psychosocial rehabilitation. Although users report a desire to have a job, there is no evidence of any initiative. They also indicate that they did not perform certain jobs because they had physical problems and despondency, with an emphasis on memory difficulties, auditory hallucinations, insecurity and borderline personality.

Prejudice was also considered an important mechanism since it is an obstacle to social inclusion, which negatively affects social relationships, (re)discovery of potentialities, acquisition of rights as citizens and empowerment of one's own autonomy.

Although aspects related to impediments and difficulties for performing work activities are evident, participants also report attempts to acquire new skills and, as a result of this, the acquisition of feelings of usefulness and pleasure with

a significant improvement in their self-esteem. Expectations of resuming studies and participating in volunteer activities, especially religious activities, were common in the users' discourses. From the family members' perspective, users show a desire to continue with the activities they stopped at a certain time for some reason, which leads us to conclude that there is a process for inclusion and the construction of their identity in the work-related occupational area.

Work should be understood in healthcare practices from the perspective of PR, which facilitates the recovery of autonomy by strengthening family and community ties so that people with mental suffering can exercise their rights and achieve social reintegration. Despite this statement, it is important to consider that mental health users still do not achieve full integration into work, due to either a lack of decision-making, comorbidities not directly linked to psychiatric problems, complications arising from the clinical course of the psychiatric illness itself and side effects of medications. All of these elements seem to prevent essential work skills and amplify an already unfair and prejudicial social structure that imposes psychosocial barriers for social inclusion.

We therefore advocate that the mental health system must be focused on people living with mental suffering so that they can exercise their autonomy in the construction of a life outside mental asylums, i.e. in society, building emotional ties and (re)signifying the achievement of their own autonomy by requiring less help (from the health department itself or from their social environment, such as family members, neighbours and friends) in a network of social relations that allow them to live in the community.

Although PR is based on the idea of allowing the social integration of people with mental suffering through extended treatment and community actions,<sup>5</sup> Agnes Heller's theory shows that everyday life occurs through social interactions and exchanges between people, emphasising that this integration of the individual forms a network of social relations in the different aspects and occupations of everyday life.<sup>23</sup>

Healthcare based on the paradigm of the psychosocial healthcare model allows us to understand madness in an unprecedented way, by overcoming the scientific, cultural and political premises that supported the biomedical paradigm. Within this historical context of changes and transformations in the field of mental health, it can be said that there is a desire to move past this paradigm in order to better achieve the premises of the psychosocial healthcare model. Although there has been an effort to move away from the hospital-centred model in Brazil, psychosocial healthcare has not yet been fully implemented.

The question is whether mental healthcare centres have provided initiatives for PR in order to rehabilitate subjects for employment, remembering that PR considers work to be one of its central pillars, including the integration of people into jobs with social value, i.e. jobs that allow subjects to enter the marketplace, exchange goods, buy and sell things, acquire goods, distance themselves from the concept of alienated work, and understand work as something that goes beyond training for people with mental suffering.

Access to work by people with mental suffering is not only a form of occupational justice but also a form of equity, which retroactively affects their mental health.<sup>34,35</sup> In the con-

text of mental health, numerous challenges are being tackled to change the social representation of the concept of mental illness, in order to revise traditional models of healthcare and interventions and programmes that allow new forms of healthcare within the community setting.<sup>33</sup>

Given that work plays a key role in people's social lives, there is still an urgent need to expand and position the work aspect as being relevant for programmes and initiatives operating within local territories, with the community's support, so that the users of mental healthcare services can play a leading role in their own autonomy and can perform their work-related occupations with greater empowerment and ownership.

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## REFERENCES

1. Fiorati RC. A organização dos serviços extra-hospitalares de saúde mental, o projeto terapêutico e a inserção da reabilitação psicossocial. [Tesis de Doctorado]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo; 2010.
2. Soares LBT. História da terapia ocupacional. In: Cavalcante A, Galvão C, editors. *Terapia ocupacional: fundamentação & prática*. Rio de Janeiro: Guanabara Koogan; 2007. p. 3-9.
3. Medeiros MHR. Terapia ocupacional: um enfoque epistemológico e social. São Carlos: Hucitec, EdUFSCar; 2003.
4. Vasconcelos EM. Abordagens psicossociais. História, teoria e trabalho no campo. 2.a ed. São Paulo: Hucitec; 2009.
5. Mângia EF, Nicácio F. Terapia ocupacional em saúde mental: tendências principais e desafios contemporâneos. In: De Carlo MMRP, Baratalotti CC, editors. *Terapia ocupacional no Brasil: fundamentos e perspectivas*. São Paulo: Plexus; 2001. p. 63-80.
6. Amarante P. Saúde mental e atenção psicossocial. Rio de Janeiro: Fiocruz; 2007.
7. Lussi IAO, Morato GG. Terapia ocupacional e trabalho: perspectivas históricas e possibilidades atuais no campo da saúde mental. In: Matsukura TS, Salles MM, editors. *Cotidiano, atividade humana e ocupação: perspectivas da terapia ocupacional no campo da saúde mental*. São Carlos: EdUFSCar; 2016. p. 77-90.
8. Associação Americana de Terapia Ocupacional. Estrutura da prática da terapia ocupacional: domínio & processo. 3.a ed. Rev Ter Ocup Univ São Paulo. 2015;26:1-49.
9. Law M. Medida Canadense de Desempenho Ocupacional – COPM. Belo Horizonte: UFMG; 2009.
10. Christiansen CH, Townsend EA. Introduction to occupation: the art and science of living. 2.a ed. Cranbury: Pearson Education; 2010.
11. Bastos SCA, Mancini MC, Pyló RM. O uso da medida canadense de desempenho ocupacional (COPM) em saúde mental. Rev Ter Ocup Univ São Paulo. 2010;21:104-10. Available from: <http://www.revistas.usp.br/rto/article/viewFile/14093/15911>. Accessed 14 January 2020.
12. Cresswell MK, Rugg SA. The Canadian performance occupational therapy measure: its use with clients with schizophrenia. Int J Ther Rehabil. 2003;10:544-53.
13. Pan A, Chung L, Hsin-Hwei G. Confiabilidade e validade da Medida Canadense de Desempenho Ocupacional para clientes com desordens psiquiátricas em Taiwan. Occup Ther Int. 2003;10:269-77.
14. Kebbe LM, Rose LBR, Fiorati RC, Carretta RYD. Cuidando do familiar com transtorno mental: desafios percebidos pelos cuidadores sobre as tarefas de cuidar. Saúde em Debate. 2014;38:494-505. Available from: <https://doi.org/10.5935/0103-1104.20140046>. Accessed 14 January 2020.
15. Cavalcanti AC, Silva RM. Experiências psíquicas de mulheres frequentadoras da rede pública de saúde em Teresina (PI, Brasil). Ciênc Saúde Coletiva. 2011;16:2211-20. Available from: <https://doi.org/10.1590/S1413-81232011000400020>. Accessed 14 January 2020.
16. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental, incluindo aquelas com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS). Brasil: Portaria GM/MS no 3.088, de 23 de dezembro de 2011, republicada em 21 de maio de 2013. Available from: [http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088\\_23\\_12\\_2011\\_rep.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html).
17. Ministério da Saúde. Portaria GM/MS n° 336, de 19 de fevereiro de 2002 - Define e estabelece diretrizes para o funcionamento dos Centros de Atenção Psicossocial. Brasília: Diário Oficial da União; 2002. Available from: [http://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt0336\\_19\\_02\\_2002.html](http://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt0336_19_02_2002.html).
18. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11.a ed. São Paulo: Hucitec; 2008.
19. Lefevre F, Lefevre AMC. Pesquisa de representação social: um enfoque quali-quantitativo. 2.a ed. Brasília: Liber Livro; 2012.
20. Almeida DT, Trevisan ER. Estratégias de intervenção da terapia ocupacional em consonância com as transformações da assistência em saúde mental no Brasil. Interface-Comunic Saúde Educ Botucatu. 2011;15:299-307. Available from: <https://doi.org/10.1590/S1414-32832010005000030>. Accessed 14 January 2020.
21. Wachholz SMS, Mariotti MC. A participação do terapeuta ocupacional na reforma psiquiátrica e nos novos serviços de saúde mental. Cad Ter Ocup. 2009;17:147-59. Available from: <http://www.cadernosdeterapiaocupacional.ufscar.br/index.php/cadernos/article/view/104/69>. Accessed 14 January 2020.
22. Salles MM. Internação em hospital psiquiátrico: o (des)caminho para a vivência do cotidiano e da inserção social. [Dissertação de Mestrado]. São Paulo: Escola de Enfermagem da Universidade de São Paulo, Universidade de São Paulo; 2005.
23. Heller AO. Cotidiano e a história. 6.a ed. São Paulo: Paz e Terra; 2008.
24. Salles MM. Vida cotidiana de usuários de CAPS: a (in)visibilidade no território. [Tese de Doutorado]. São Paulo: Escola de Enfermagem da Universidade de São Paulo, Universidade de São Paulo; 2011. <http://dx.doi.org/10.11606/T.7.2011.tde-17082011-105117>.
25. Barros MMMA, Jorge MSB, Vasconcelos MGF. Experiências de famílias com usuários atendidos em dispositivos de atenção psicossocial. Physis. 2013;23:821-41. Available from:

- <https://doi.org/10.1590/S0103-73312013000300009>. Accessed 14 January 2020.
26. Taborda Zapata E, Montoya Gonzalez LE, Gómez Sierrac N, Arteaga Morales LM, Correa Rico OA. Manejo integral del paciente con esquizofrenia: más allá de los psicofármacos. *Rev Colomb Psiquiatr.* 2016;45:118-23.
  27. Campo-Ariasa A, Oviedo H, Herazoc E. Estigma: barrera de acceso a servicios en salud mental. *Rev Colomb Psiquiatr.* 2014;43:162-7.
  28. Constantinidis TC, Cunha AC. Desinstitucionalizando conceitos: a terapia ocupacional em busca de um (novo) lugar no cenário da saúde mental. In: Matsukura TS, Salles MM, editors. *Cotidiano, atividade humana e ocupação: perspectivas da terapia ocupacional no campo da saúde mental*. São Carlos: EdUFSCar; 2016. p. 37-59.
  29. Salles MM, Barros S. Transformações na atenção em saúde mental e na vida cotidiana de usuários: do hospital psiquiátrico ao Centro de Atenção Psicossocial. *Saúde em Debate.* 2013;37:324-35.
  30. Ribas DL, Borenstein MS, Padilha MICS. Iluminando as vivências de indivíduos em sofrimento psíquico de um CAPS em Florianópolis. *Texto Contexto Enferm.* 2007;6:40-6.
  31. Salles MM, Matsukura TS. Do individual ao coletivo: perfil ocupacional de usuários de um Centro de Atenção Psicossocial. *Rev Ter Ocup Univ São Paulo.* 2015;26:58-65.
  32. Saraceno B. *Libertando identidades: da reabilitação psicossocial à cidadania*. Rio de Janeiro: TeCorá; 2001.
  33. Ishara S, Cardoso CL. Delineamento do grupo comunitário de saúde mental. In: Ishara S, Cardoso CL, Loureiro SR, editors. *Grupo comunitário de saúde mental: conceitos, delineamento metodológico e estudos*. Ribeirão Preto: Nova Enfim; 2013. p. 19-40.
  34. Starfield B. The hidden inequity in health care. *Int J Equity Health.* 2011;10:1-3.
  35. Fleury S. Brazil's health-care reform: social movements and civil society. *Lancet.* 2011;377:1724-5.