


Deinstitutionalization and the new possibilities in the daily lives of family members of graduates of a psychiatric hospital

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Objective: to understand the process of deinstitutionalization and the new possibilities in the daily lives of family members of graduates of a psychiatric hospital. **Method:** qualitative study of exploratory and descriptive character, developed with five relatives of graduates of a Psychiatric Hospital in the interior of Bahia. For data collection, the Free Word Association Technique (TALP) and the semi-structured interview were used and for analysis, Content Analysis. **Results:** the process of deinstitutionalization of users caused family fears, apprehension and attitudes of non-acceptance. The work of the deinstitutionalization team allowed the (re) approximation and (re) construction of affective bonds. **Conclusion:** the deinstitutionalization process is complex, it should involve professionals and managers to raise awareness and encourage reflections and actions that strengthen the care of graduates and family members.

Descriptors: Family Relations; Deinstitutionalization; Psychiatric Hospitals; Mental Health.

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How to cite this article

Silva INC, Batista CPS. Deinstitutionalization and the new possibilities in the daily lives of family members of graduates of a psychiatric hospital. SMAD, Rev Eletrônica Saúde Mental Álcool Drog. 2022 Jan.-Mar.; 18(1):47-56. doi: <https://dx.doi.org/10.11606/issn.1806-6976.smad.2022.175842>

Desinstitucionalização e as novas possibilidades no cotidiano dos familiares de egressos (as) de um hospital psiquiátrico

Objetivo: compreender o processo de desinstitucionalização e as novas possibilidades no cotidiano dos familiares de egressos (as) de um hospital psiquiátrico. **Método:** estudo qualitativo de caráter exploratório e descritivo, desenvolvido com cinco familiares de egressos (as) de um Hospital Psiquiátrico no interior da Bahia. Para coleta de dados utilizou-se a Técnica de Associação Livre de Palavras (TALP) e a entrevista semiestruturada e para análise, a Análise de Conteúdo. **Resultados:** o processo de desinstitucionalização dos (as) usuários (as) ocasionou nos familiares medos, apreensão e atitudes de não aceitação. O trabalho da equipe de desinstitucionalização permitiu a (re)aproximação e (re)construção dos vínculos afetivos. **Conclusão:** o processo de desinstitucionalização é complexo, deve envolver profissionais e gestores a sensibilizar e estimular reflexões e ações que fortaleçam o cuidado aos (as) egressos (as) e familiares.

Descritores: Relações Familiares; Desinstitucionalização; Hospitais Psiquiátricos; Saúde Mental.

Desinstitucionalización y nuevas posibilidades en la vida cotidiana de familiares de egresados de un hospital psiquiátrico

Objetivo: comprender el proceso de desinstitucionalización y las nuevas posibilidades en la vida cotidiana de los familiares de egresados de un hospital psiquiátrico. **Método:** estudio cualitativo de carácter exploratorio y descriptivo, desarrollado con cinco familiares de egresados de un Hospital Psiquiátrico del interior de Bahía. Para la recolección de datos se utilizó la Técnica de Asociación de Palabras Libres (TALP) y la entrevista semiestruturada y para el análisis, Análisis de Contenido. **Resultados:** el proceso de desinstitucionalización de los usuarios generó miedos familiares, aprehensión y actitudes de no aceptación. El trabajo del equipo de desinstitucionalización permitió la (re) aproximación y (re) construcción de vínculos afectivos. **Conclusión:** el proceso de desinstitucionalización es complejo, debe involucrar a profesionales y gerentes para generar conciencia y fomentar reflexiones y acciones que fortalezcan la atención a los egresados y familiares.

Descriptor: Relaciones Familiares; Desinstitucionalización; Hospitales Psiquiátricos; Salud Mental.

Introduction

In the twentieth century, political transformations and advances in knowledge such as psychoanalysis and the mental hygiene movement enabled changes when looking at the family of mental health users. Until then, the family was seen in a negative way, being blamed for the onset of the mental disorder⁽¹⁾. Sustained by psychiatric medical knowledge, the person with a mental disorder was distanced from the family environment, and their isolation was justified by the need to protect the family in the face of madness and prevent possible contamination from other members.

In recent decades, the way of conceptualizing the family has undergone changes in view of the new family trends and configurations discussed in modern times. Despite this, the family continues to be primary support for its members and essential in the process of caring for users with mental disorders, as it enhances comprehensive and humanized care and makes it possible to intensify affective bonds, with care focused on the perspective of psychosocial care⁽²⁾.

Family is understood as a dynamic system that plays important roles in society, be it affection, education, socialization. The family is a system and each member is what they are for themselves and for the relationships they establish with the others⁽³⁾.

The family is the social institution that most lives with the person with mental disorder, in everyday life, they are the ones who feel and experience the phenomenon of mental illness⁽⁴⁾. This relationship was often built through the fear and social stigma of madness culminating in abandonment, by the families, of many users in asylum institutions in unhealthy conditions in dwelling places, for long periods of time.

During and after World War II, societies began to question living conditions within hospices, culminating in experiences that boosted the Psychiatric Reform process around the world, such as Sector Psychiatry in France, Antipsychiatry in England, Preventive Psychiatry or Community in the United States and the Basaglia experience in the Italian Democratic Psychiatry Movement that proposed a radical break with traditional psychiatric knowledge and a deinstitutionalization project⁽⁵⁾.

Deinstitutionalization goes beyond dehospitalization and withdrawal of users from psychiatric institutions, as it is a dynamic and complex process of building new concepts, care spaces, new ways of dealing with madness that relate to social and cultural contexts, pointing to the deconstruction of knowledge and practices, and to the transformation of the social place of madness⁽⁵⁾.

In Brazil, the Psychiatric Reform has as its legal framework Law No. 10,216/2001, which aims to prevent the expansion of the number of psychiatric beds, the

construction of a new care model with new care structures, and to break the asylum paradigm⁽⁶⁾.

Thus, some mechanisms were instituted to ensure this reform process, such as: The National Program for the Evaluation of the Hospital System/Psychiatry (*Programa Nacional de Avaliação do Sistema Hospitalar/Psiquiatria, PNASH/Psiquiatria*) - Ordinance No. 251/GM; the Annual Psychiatric Hospital Care Restructuring Program in the SUS - GM Ordinances No. 52 and 53/2004; the guidelines that establish the functioning of the Psychosocial Care Centers - Ordinance/GM No. 336/2002; the Residential Therapeutic Services - Ordinance/GM No. 106/2000; and the Homecoming Program - Law 10,708/2003⁽⁷⁾.

The "Back to Home" (*De Volta para Casa, PVC*) was created by the Ministry of Health and aims at the social integration of people with mental disorders, discharged from long hospital stays, with the payment of psychosocial rehabilitation assistance as an integral component. The program is a deinstitutionalization strategy to the extent that it assists in dehospitalization in encouraging the transformation of the isolated-subject into an autonomous-subject⁽⁸⁾.

These strategies of the Brazilian Psychiatric Reform constituted as much criticism of the mistreatment and violence that occurred in psychiatric institutions as they sought political and social changes about the concept of madness and how to coexist with it in freedom⁽⁹⁾.

This redirection in the mental health care model enabled the redefinition of care in freedom, the rescue of the uniqueness and individuality of people, the transformation of the relationships with the social environment, especially with the family that has become a strategy and link for social reintegration in everyday life⁽¹⁰⁾. The walls of the hospitals started to give way to houses, streets, avenues, with new possibilities for social reintegration and reconstruction of the individuals' subjectivity in the face of this "new" reality.

The family, until then understood as an institution that contributed to the emergence of mental disorders or that should be protected from it, with the advent of the Psychiatric Reform and the process of deinstitutionalization, gained different outlines in the care, protection and social insertion of the users in psychological distress⁽¹¹⁾.

These new relationships are also marked by the experiences of graduates from long periods of reclusion in a psychiatric hospital, which are permeated by the reproduction of the disease, stigma, care with impersonal and massified routines, deprivation of freedom and annihilation of citizenship resulting from the asylum practices. Thus, leaving these institutions and returning to a living space creates possibilities for resuming the life stories of the users, their daily routine, citizenship and care with the family⁽¹²⁻¹³⁾.

In view of the considerations raised above, this study points to the following guiding question: What are the new possibilities in the daily lives of family members of graduates of a psychiatric hospital in the process of deinstitutionalization? And as objective: To understand the deinstitutionalization process and the new possibilities in the daily lives of family members of graduates of a psychiatric hospital.

Method

This is a qualitative study of an exploratory and descriptive nature, developed with family members of graduates of a Psychiatric Hospital in the inland of Bahia.

This Hospital, aiming to enhance the residents' exit, implemented a deinstitutionalization team in 2012, composed of 03 (three) psychologists, 01 (one) nurse, 03 (three) occupational therapists, 02 (two) social workers and 01 (one) psychiatric doctor. From 2012 to 2017, 87 (eighty-seven) residents were dehospitalized, 32 (thirty-two) returned to their families and 55 (fifty-five) to therapeutic residences, distributed in several cities in the state of Bahia. In the municipality where the research was conducted and where the Hospital is located, up to the time of this study, 05 (five) residents had returned to their families.

This research was approved by the Ethics and Research Committee under protocol No. 1,884,678, and all recommendations involving research with human beings were respected, according to Resolution 466/2012 of the National Health Council⁽¹⁴⁾.

The address and telephone data were searched in the medical records of the users who were discharged, and the information that was not found was made available by the hospital's deinstitutionalization team. Once this was done, contact with the family members was initiated through phone calls, to invite them to participate in the research. After agreement, the interviews were scheduled according to availability and better comfort in relation to place, date and time.

The interviews were conducted at the family members' own residence and in public places, respecting the family member's wishes and maintaining the privacy and confidentiality of the information. Before the interview, the family members were provided with information about the research, its objectives, and the data was only collected after the participant had been clarified on the research and signed the Free and Informed Consent Form (FICF). There was no refusal by the interviewees to participate in the research. The interviews had audio recordings and were transcribed in full.

Five family members of graduates participated in this study, who met the following inclusion criteria: being a family member of a graduate from the hospital under

study; being over 18 years old; being a resident of the municipality where the hospital is located; and having participated in the deinstitutionalization process of the graduate's family member. The exclusion criteria were the following: the family member being under 18 years old; not having participated in the deinstitutionalization process of the graduate; not accepting to participate in the research. Data was collected from April to June 2017.

For data collection, due to the researcher's familiarity in previous research studies and training, and because of its projective nature, the Free Word Association Technique (FWAT) was used, in which the participants were presented with inducing stimuli that permeated life and the vocabulary of the family member and of the graduate, despite the stigma surrounding some terms, so that they could make associations with daily life. The inducing stimuli were the following: family; day-to-day with the mentally ill person, and change.

For the interview, a semi-structured script was used, divided into two parts: the first, composed of closed questions for the sociodemographic characterization of the individual and the second, composed of open questions that explored the perceptions of these family members' daily lives.

The interviews were transcribed in full respecting the order in which the recordings were made and, for their analysis, the Content Analysis method was used⁽¹⁵⁾. This method is configured as a set of techniques for analyzing communications in order to obtain, by systematic and objective procedures for describing the content of messages, the inference of knowledge related to the conditions of production/reception of these messages. The Free Word Association Technique supported the semi-structured interview in the construction of the analysis categories (I and II) and subcategories: I - Deinstitutionalization and the construction of the bond (subcategories: First impact with the possibility of dehospitalization; Experiences in family (re)approximation; New paths in the (re)construction of the bond; II - Marks of institutionalization and new possibilities in the face of coexistence.

To identify the participants, in order to maintain anonymity, the term "family member" associated with the order of the interviews was used.

Results

As for the relationship with the graduate, there were two children, a sister, a son-in-law, and a niece. Regarding the length of stay in the Psychiatric Hospital, the family members reported 22 to 28 years. Thus, two categories of analysis emerged: Deinstitutionalization and construction of the bond and Marks of institutionalization and new possibilities in the face of coexistence.

Deinstitutionalization and construction of the bond

The dehospitalization process of users who had been in the Psychiatric Hospital for a long time provoked feelings of fear, apprehension and non-acceptance in the face of dehospitalization in the family members. However, with the work of the hospital's deinstitutionalization team and with the progress of the process, the users and families were looking for ways to (re)approach and (re)construct the affective bonds. These apprehended experiences, identified in the statements, gave rise to three subcategories: First impact with the possibility of dehospitalization; Experiences in family (re)approximation; and New paths in the (re)construction of the bond.

First impact with the possibility of dehospitalization

The users admitted to the hospital experienced a long period away from their relatives, of nearly 22 (twenty-two) to 28 (twenty-eight) years. During this hospitalization time, some users received visits from family and friends; however, many remained for years without contact with the family. They did not expect that the idea of returning home could exist, which generated non-acceptance and feelings of unease in the lives of the family members.

Then the first contact was that they went there and said that they were going to deliver him. [...] The first moment is that you don't want to accept it. (Family Member 04); [...] Very troubled. First, because we didn't imagine that the State would take this attitude, for us, we were in a comfortable area, which was precisely the fact that she was there. [...] (Family Member 05)

Experiences in family (re)approximation

The process of returning home of the user's family member, according to the family members' report, demanded time and continuous work by the deinstitutionalization team, with scheduling visits by the team with the family, the latter with the user, as well as with professionals from the Psychosocial Care network of the municipality of origin.

The (re)approximation process was long, seeking to respect each other's time and space, approximately one year or more, according to the reports. In this construction, the deinstitutionalization team used some strategies, such as visits to the hospital; licenses for users to spend a period at the family member's home, initially on weekends, continuing for fifteen days to a month; in addition to the support for organizing and restructuring the physical environment to receive the graduate in the house. Evidenced in the statements of the family members.

Adaptation was what? Visits constantly weekends, fifteen days, a month for him to gradually adapt there. And he reacted normally, at first it was difficult, then he changed. It was almost a year just

him adapting and to build, buy the materials, see a bricklayer, buy everything and then he goes back home. (Family member 03); They gradually made this approach. She came, staying with me for a few days and coming back. It was a whole process, it took a long time. (Family member 01); [...] we took care of buying him some clothes. And we would pick him up once or twice a month, take him for a walk in the lagoon and take a walk around the mountain. And when it was time to leave, he would take him. (Family Member 04)

New paths in the (re)construction of the bond

The return home enabled new paths in the (re) construction of the affective bonds that were broken by the long period of hospitalization and the institutionalization process. With the return home, these families began to welcome the graduates and started to express affective feelings that were (re)constructed with the coexistence and daily care of the family members.

After her approach, she came here and created a link. It was creating that link, that feeling. Understand? But before I didn't have it until then, it was normal for me. (Family member 01); Many things changed (crying). And it's like a person who has come to the family, who is embraced by the family. (Family Member 03)

Marks of institutionalization and new possibilities in the face of coexistence

With the long period of hospitalization and the conditions of institutionalization in an asylum and madhouse model, the users acquired life habits different from those socially accepted. Upon returning home, the families reported that the beginning was a difficult period, as the behaviors acquired in the hospital bothered the family members, which required patience to teach new habits and behaviors, through commitment to change.

When she came here [...], she was still adapting, then she screamed a lot, pissed everything, pissed the whole house. I already woke up with her pissing standing, on my head, almost peeing on my face (laughter). So it was a very difficult moment, very difficult indeed. Her business was just going back to the hospital, she thought about running away, she just wanted to go out and drink, she smoked a lot too. (Family member 02); Here it comes full of things for us. Then we have to go polishing, removing [...] and for people who have no experience with this, it's very difficult. Very difficult. (Family member 01); It won't change! If you work, it changes. But if you don't work...; Still the same thing (Family Member 03).

The return home made them know other ways and create new references, with other possibilities arising in the face of living with the family, these graduates took on new ways of being in society. The naturalization of the asylum and madhouse routine, with the incorporation of habits permeated by the loss of privacy and of identity, and the

knowledge of this as the only possibility, initially caused strangeness and difficulties in the users but, with the daily living with the family, new daily habits were incorporated.

He masturbated and the neighbors were nervous seeing him do that. But, that was not his thing. Not today, he doesn't do it at home anymore, when I get it, if I see him do something I say "Uncle, what did I teach you? Inside the bathroom" Everything he has already learned. He doesn't do what he did anymore. It makes the person cheerful, content and happy, right? (Family member 03); She doesn't speak well, but she's more lucid, clearer than before, understand? Many things changed, she came out here and pissed, today she doesn't do that anymore, she does it in the toilet. Today she doesn't give so much trouble. (Family member 01); We worked, it was all worked on, we taught him that he has to wash his hands to eat, because he doesn't have any teeth anymore, but he knows that he has to brush his teeth, all of that (Family member 04).

The family members also reported that they perceived the difference in the relationships established by the graduate within the family environment, when compared to the period they lived in the hospital and perceived the change as a consequence of living with the family.

[...] my uncle living at home is great, it's excellent. It's not the conviviality of going to the hospital "I want to smoke" "What did you bring me?" and not even say goodbye and leave. Everything about him changed, it really did. (Family member 03).

In this new relationship of the family with the graduates, the organization of the family routine and their social and cultural habits also became part of the graduates' lives. The environments frequented by the family members have become opportunities for social (re)insertion.

But then, whenever she's here at home, she goes out with me, every environment I go to, she's with us [...]. (Family member 05); We do activities, take him for a walk, he's not left out of the family activities of our house. We take them to places, family parties we do not leave him out of parties in any way (Family member 04).

Discussion

Due to the social representation about mental disorders and that their treatment must be based on the biomedical, hospital-centric conception, the families of users who had a long period of hospitalization learned this conception, in addition to the stigma, prejudice and discrimination that exerted an influence on the impact felt by the family with the possibility of the return⁽¹⁶⁾. The deinstitutionalization process (re)invented new ways of welcoming and treating these people and their family members, turning the deconstruction of all representations and practices into a complex and continuous process.

When a family member is affected by a mental disorder, it transforms family relationships, with the possibility of developing attitudes of non-acceptance and denial. The expressions, the voices of the family members, their complaints and difficulties, must be welcomed as a subsidy in the unveiling of their dilemmas and vicissitudes so that the professional team can create care strategies with families and users to cope with the mental disorder⁽¹⁷⁾.

In another study⁽¹⁸⁾, resistance from the family members was also observed when the first conversations about the closing process of the psychiatric hospital began. This resistance expressed by the family members can be justified by the contexts of social vulnerability, the absence of public mental health policies during the hospitalization period, lack of knowledge about the existing psychosocial care network, as well as past dynamics and conflicting family ties.

Many families⁽¹⁹⁾ also found it difficult to receive the family members with mental disorders at their homes, especially due to the way in which the health services led these users to leave hospitals for homes, not building an exit plan with the family, with guidelines, adaptations and the construction of affective bonds. This context is not understood in the statements of the family members in this research, as the results point out.

The loss of the family bond with this user due to the long period of hospitalization can be an important analysis factor for the resistance of the family members expressed in the reports of this study. Allied to this, other issues can also be relevant in this analysis, also found in another study, such as considering families with a past history of conflicting bonds, structural weaknesses of the family and the difficulty of bonding during the coexistence period⁽¹⁸⁾.

In a study carried out in a Psychiatric Hospital in the region of Sorocaba⁽¹⁸⁾, the return of the users to the family was configured as a broad process, focused on clarifying the situation the hospital was undergoing and an attempt to build with the families possibilities for the resident to leave, and visits to the hospital and licenses for users are also used as strategies to strengthen the bonds, thus corroborating the strategies identified in this research.

For the user, deinstitutionalization is a new production of life, meaning, sociability and forms of relational interactions, and the participation of family members is precisely the help for these institutionalized people to see other ways of living and desires to experience a new life. Deinstitutionalization is a therapeutic work that involves establishing welcoming and bonding relationships, reinventing experiences, expanding social exchanges and finding possibilities to deal with psychological distress both in the user and in the family⁽²⁰⁾.

Among family members, this possibility of new experiences is an important process of recognition of the urban space for users and family members; it is also a transition that allows for the approximation with the social space, in an attempt to resignify the individuals' subjective position, exposing them to new ways of living and seeing life within the free and multiple spaces of the city⁽²¹⁾.

Living in a family involves sharing emotions and experiences that determine how people's interactions are processed. These interactions can be positive or negative, depending on the quality of the time shared, the level of people's commitment to the activity developed, and the way in which communication takes place between them⁽²¹⁾.

Sharing moments among family members can promote a sensation of well-being and reduce the emotional burden of the difficulties experienced in daily life. It is these moments together that favor approximation, creating a relational space for building trust and bonding among the family members, thus contributing to the family and social reinsertion of the person with a mental disorder⁽²¹⁾.

The implication of the family in the care of the graduate from a psychiatric hospital and the range of feelings experienced, requires the family to be recognized not only as a co-participant in the therapeutic process that influences the user's autonomy and the quality of treatment, but also as a focus of care⁽²²⁾.

In addition, this adaptation process of the graduate to the new home is complex and subjective because it involves family ties, relationship with the community and with the psychosocial care network, in addition to therapeutic projects for (re)insertion in public spaces, circulation in the territory and strengthening of affective bonds. For this social inclusion to be effective, it is necessary to prepare and monitor the graduate, the family members and the territory⁽²³⁾.

The return home through deinstitutionalization brings the users back to the territory from which they were previously removed by long years of hospitalization. This territory constitutes a fundamental part of the return home and to the city, as well as in the reconstruction of the autonomy and citizenship lost over the years. The territory produces and reconstructs the life previously made dormant by the institution⁽²⁴⁾.

This return home requires changes in the family members' daily lives, which are produced by direct participation in the care of the users after a long period of hospitalization. Such changes are permeated by the lack of preparation for living with the new situation, by the need to understand how to deal with unconventional behaviors, and by daily living with stigma and social discrimination, which can contribute to the psychological distress of the family members, also requiring support and care^(10,20).

When the family experiences the disease, it creates a new functioning and a new physical and emotional structure to maintain functionality and adapt to reality. It is important that the multi-professional team of the psychosocial care network is attentive to the family structure and dynamics and to the bonds between members, in order to design assistance capable of meeting and strengthening these bonds, which are essential to maintain the balance and health of the family and of the mental health user⁽²⁵⁾.

In relation to the second category, it is important to notice how institutionalization and its disciplinary and imposing devices massacre the individuality and uniqueness of the subject, limiting the possibilities of experiences and new ways of reinventing themselves. Thus, the space of psychiatric hospitals is not a housing reference for residents, as it prevents them from walking around the city and establishing relationships outside the walls, in addition to not contributing to a psychological support capable of providing a return to living in society. In addition to that, the norms of daily life within these spaces prevent the subject from taking responsibility for self-care⁽²¹⁾.

Therefore, the behaviors that the family members found strange about these graduates find justification in the hospitalization/institutionalization process, as a long period of hospitalization transforms the subjects, causing relational difficulties in their social, family and affective context. By having freedom, by inhabiting other spaces, forming new connections with the family, and collectivity, they start to elaborate other ways of existing in society⁽²⁶⁾.

The perception by the family members of changes in the graduates adopting new behaviors can be related to the ways of perceiving and appropriating the new living space, which occurs through an individual and subjective construction, building their ways of signifying and experiencing the new home. With the subjective constructions of daily life, the residents recover their social identity deteriorated by years of confinement in the asylum and the home takes on the role of shelter but, at the same time, it acts as the space where the subjects rescue their citizenship and become active subjects in the reconstruction of their identity⁽²¹⁾.

These new existential territories are formed when these graduates start to inhabit the city. The experience of everyday situations in the community by these "new" residents enables social exchanges that transform the way in which the relationship between city and madness is being shaped⁽²⁷⁾.

We must consider that deinstitutionalization does not end with leaving the psychiatric hospital and returning to the family. Deinstitutionalization involves deconstructing our own institutionalization in the social fabric, building new forms of life that are not subjected to the logic of control and exclusion and is associated

with the deconstruction of ways of living that impoverish existence⁽²⁸⁾.

Criticisms of the asylum model not only face the existence of the psychiatric hospital but also, in the case of deinstitutionalization, the care structures. Deinstitutionalization is sustained through the practical action of transforming knowledge, institutions and actions. It is in the reality of the substitute services that make up the psychosocial care network and in the relationship between these services and the territory that it is possible to sustain the production of care and build citizenship in the real life contexts and scenarios⁽²⁹⁾.

As a limitation, this study included only family members of graduates who lived in a municipality, involved in the deinstitutionalization process of the Psychiatric Hospital, not having coverage for the various municipalities in the state of Bahia where the graduates returned home.

Conclusion

The study made it possible to understand the deinstitutionalization process and the new possibilities in the daily lives of family members of graduates of a psychiatric hospital in the inland of Bahia. As main results, we highlight that the family members experienced feelings of fear, apprehension and attitudes of non-acceptance in the face of dehospitalization, the work of the hospital's deinstitutionalization team and the strategies adopted being essential, as they allowed for the (re)approximation of the users to their families, as well as the (re)construction and strengthening of affective bonds.

The habits and behaviors of the graduates, acquired through the long period of hospitalization and the conditions of institutionalization in an asylum and madhouse model, represented a great challenge for the family members, which required involvement and co-responsibility in the care management of the user with (re)learning and reframing of the activities of daily living, such as bathing, using the toilet and wearing clothes, among others. As the graduates took on new forms of being in society, (re)acquiring socially accepted habits, family resistance decreased.

The daily life of family members of long-term hospitalization graduates is complex, permeated with subjectivity, possibilities and potential, despite the relational and everyday difficulties. This study reiterates the need for other forms of care that transpose the asylum and madhouse logic, that deinstitutionalize practices of violation of rights, that reassert the deinstitutionalization process, and that give voice and place to the family members both in management and as a focus of care.

The results and considerations of this research were taken to the management and the deinstitutionalization team of the referred psychiatric hospital, aiming to

stimulate reflections and actions that further strengthen the process of deinstitutionalization, dehospitalization and care for users and their family members, also pointing out the need to strengthen the Psychosocial Care Network in the state of Bahia.

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All authors approved the final version of the text.

Conflict of interest: the authors have declared that there is no conflict of interest.


Received: Oct 16th 2020

Accepted: Feb 4th 2021

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