ISSN: 2318-8413 DOI: 10.18554/refacs.v8i0.4671

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# Perception of Psychology professionals about the assistance offered to Psychosovial Care Centers users

# Percepção de profissionais de Psicologia sobre a assistência oferecida aos usuários de Centros de Atenção Psicossocial

# Percepción de los profesionales de Psicología sobre la asistencia ofrecida a los usuarios de los Centros de Atención Psicosocial

**Received: 28/10/2019**
**Approved: 15/04/2020**
**Published: 01/08/2020**

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This study aimed to examine the perception of Psychology professionals about the assistance offered to users of alcohol and other drugs. This is a descriptive, exploratory research with a qualitative approach, carried out in four municipalities in the Northwest region of the state of São Paulo, Brazil, in the first semester of 2018. Data were collected through semi-structured interviews conducted with seven professionals linked to four Psychosocial Care Centers of Alcohol and Other Drugs. The participants were mostly female, aged between 29 and 56 years old, married, and had graduated between five and 35 years prior. The reports were submitted to content analysis, with three thematic categories being highlighted: *family participation in treatment*: the family is perceived as a source of support, when present effectively in the treatment space; difficulty in adhering to treatment: the high incidence of users giving up treatment is highlighted; *addiction to the drug as a symptom of sick bond*: the physical and psychological damage identified are understood to result from the psychopathology of bond configurations. The strengthening of bonds and personal support network of users is highlighted as a fundamental strategy in the context of health care.
**Descriptors:** Substance-related disorders; Health services; Drug users; Comprehensive health care.

Este estudo teve por objetivo examinar a percepção de profissionais de Psicologia sobre a assistência oferecida aos usuários de álcool e outras drogas. Trata-se de uma pesquisa descritiva, exploratória, de abordagem qualitativa, realizada em quatro municípios da região noroeste de São Paulo, no primeiro semestre de 2018. Os dados foram coletados por meio de entrevista semiestruturada realizada com sete profissionais vinculados a quatro Centros de Atenção Psicossocial Álcool e Outras Drogas. Os participantes eram majoritariamente do sexo feminino, com idades entre 29 e 56 anos, casados, e haviam se graduado entre cinco e 35 anos. Os relatos foram submetidos à análise de conteúdo, sendo destacadas três categorias temáticas: *participação familiar no tratamento*: a família é percebida como fonte de apoio, quando presente de maneira efetiva no espaço de tratamento; *dificuldade de adesão ao tratamento*: é ressaltada a elevada incidência de desistência do tratamento por parte dos usuários; *adicção à droga como sintoma do vínculo adoecido*: os prejuízos físicos e psíquicos identificados são compreendidos como resultantes da psicopatologia das configurações vinculares. O fortalecimento dos vínculos e da rede pessoal de apoio dos usuários é apontado como estratégia fundamental no contexto do cuidado em saúde.
**Descritores:** Transtornos relacionados ao uso de substâncias; Serviços de saúde; Usuários de drogas; Assistência integral à saúde.

Este estudio tuvo por objeto examinar la percepción de los profesionales de la Psicología sobre la asistencia que se ofrece a los usuarios de alcohol y otras drogas. Se trata de una investigación descriptiva, exploratoria y de enfoque cualitativo, realizada en cuatro municipios de la región noroeste de São Paulo, Brasil, en el primer semestre de 2018. Los datos se recogieron mediante una entrevista semiestructurada con siete profesionales vinculados a cuatro Centros de Atención Psicosocial de Alcohol y Otras Drogas. Los participantes eran en su mayoría mujeres, con edades comprendidas entre 29 y 56 años, casadas y que se habían graduado entre cinco y 35 años atrás. Los informes se sometieron a un análisis de contenido y se destacaron tres categorías temáticas: *participación de la familia en el tratamiento:* la familia se percibe como una fuente de apoyo, cuando está efectivamente presente en el espacio de tratamiento; *dificultad de adherencia al tratamiento*: se destaca la alta incidencia de abandono del tratamiento por parte de los usuarios; *drogadicción como síntoma del vínculo enfermo:* los daños físicos y psíquicos identificados se entienden como resultado de la psicopatología de las configuraciones de los vínculos. El fortalecimiento de los vínculos y la red de apoyo personal de los usuarios se señala como una estrategia fundamental en el contexto de la atención en la salud.
**Descriptores:** Trastornos relacionados con sustancias; Servicios de salud; Consumidores de drogas; Atención integral de salud.

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## INTRODUCTION

In Brazil, assistance to drug users is currently organized through a public care network. This network is constituted from an effort of integrated organization of sectors, services and articulated professionals with a view to offering continuous care, in response to the specific needs of this population[1]. Thus, care for drug users is organized around an assistance network of services[2].

Central and articulating part of this network, the Psychosocial Care Centers (*Centros de Atenção Psicossocial - CAPS*) are health equipment made up of a multiprofessional team that provides public health services for the reception and integral assistance of people with mental disorders[3], and among the types of services there are the Psychosocial Care Centers of Alcohol and Other Drugs (*Centros de Atenção Psicossocial Álcool e Outras Drogas - CAPSad*).

It is the function of CAPSad, as well as the other CAPS, to stimulate social and family integration of people in severe and persistent mental suffering, in addition to supporting users to acquire autonomy and restore new possibilities to live life fully, maximizing their general well-being. Among the services offered at CAPSad, group activities stand out.

At CAPSad, group activities, implemented within the scope of individual therapeutic projects, are prepared in accordance with the guidelines that guide the operation of the service, taking into account demands and expectations of the participants. In this sense, two types of group activities stand out: the therapeutic groups themselves and the operative groups.

Therapeutic groups seek to treat people with indication for psychotherapy, that is, who can benefit from strategies that presuppose the search for means of self-knowledge and personal development, or that aim at the removal and/or relief of symptoms related to psychological problems[4]. Operative groups, on the other hand, are devices formed from the establishment of common objectives among their members, having the group task as a structuring axis. The activities of the operative group must favor learning that favors the progress of the members, whether at the individual or collective level, through the exercise of alternating (rotation) roles that emerge during the performance of the group task[4].

One of the theoretical assumptions that support working in an operative group is the recognition of the central importance of bonds for the psychic constitution. And, in the case of groups in the context of mental health, it is important that their members interact with each other and with the group coordinator. In order for this interaction to be strengthened and to foster conditions that favor transformation and appropriation of knowledge by all, it is necessary to encourage the examination of the bonds that the participants establish between themselves and with the coordinator.

From the perspective of Pichon-Rivière's Social Psychology, the link is structured within interpersonal dynamics, being capable of handling and improving through learning from experience. For this reason, the bond is considered an instrument for understanding the relationship that the individual establishes with themself and/or with other people, which can be repeated in the different link configurations that they establish throughout life[5].

The quality of the bonds affects the person's relationship with themself, which in turn interferes with their ability to withstand frustrations and face adversity when coming into contact with reality. It also interferes with the ability to learn, to be creative and to feel fulfilled with their relationships and the repercussions of their actions developed in the world, which is reflected in the way the individual feels as an active participant in the community to which they belong. The consistency of the bond makes a difference in terms of whether or not the person feels happy and adjusted in their community, family and with themself, even when they are under a certain burden of stress, limitations and deprivation, which are otherwise inevitable because they are inherent phenomena in living[6].

The several significant bonds that the individual builds along the various stages of the life cycle result in the formation of their significant social network. Due to the intersection and porosity of the existing border between the various members of this network with other

networks, individuals can both influence and be influenced by them. In this context, the network can be understood as a structure without borders, an open and permeable system formed by links and support points, a set of autonomous people who add resources and share ideas about common interests and values to live[1,6].

In this sense, social support networks constitute sets of bonds established by the individual with people emotionally significant to him, that is, those with whom regular interaction takes place, such as conversations and exchanges that lead the subject to feel real and prone to seek an *active adaptation to reality*[5]. The networks are verticalized in concrete groups, which can be personified in family, friends, co-workers, neighbors, people who belong to the same religious and community circle, health professionals, teachers, among others. These networks serve as a potential source of resources, emotional support and information, and are characterized by encouraging frequent interactions, significant support and positive affection[7].

Understanding how groups and networks of social support are formed, as well as the importance that these sources of support have for the constitution of subjectivity, it is evident the need to work under a group approach when adopting a perspective of promotion and prevention in mental health. In this perspective, the subject can be seen in its dialectical totality as one who is not only influenced but is themself an influencer and transformator of their environment.

In a group, what a person says, thinks or feels also communicates something from the group of members. When someone gets sick, somehow they are communicating something about the groups in which they participate and the weaknesses of the bonds that connect them to the other members. In this perspective, mental illness can be understood as a phenomenon that emerges from the intersubjective dynamics of a family group and, therefore, communicates something that could not yet be formalized in words, because it has not yet reached the symbolization in the space of the linked family configurations.

The patient can be seen as a messenger who, in a way, gives voice to an emotional problem that involves their family group. Thus, they become a spokesperson, one who denounces, through their suffering, another type of discomfort that has not yet managed to be represented and named, and that found outlet and achieved some type of relief in a symptomatic expression vectorized by the member of the family that gets sick[8]. Seen by this theoretical framework, the sick person carries the pathology linked to the group to which they belongs.

In this context, the person who manifests the disease is not always the weakest and most vulnerable member of the group. Sometimes it is just the one who personified a drama that belongs to the family group and its unconscious link. Pichon-Rivière argues that the patient is precisely the strongest member of the family organization, elected precisely because they became the depository for most of the group's unresolved conflicts, assuming for themself a responsibility that should be equally recognized by all. The individual affected by the mental disorder thus becomes the scapegoat for their family group. It is recognized that this is a key concept for understanding the roots of severe and persistent psychological suffering. When they no longer supports massive group deposition, the most sensitive family member succumbs to the disease[8,9], with which, paradoxically, they denounce unrecognized family malaise, which makes them a martyr and sacrificial victim of the family[8].

One of the most prominent contemporary ways in which the pathology of the family bond can manifest itself is drug addiction. In a society that is exclusive and governed by consumerism and extreme individualism, the abusive use of psychoactive substances can be considered as a way of obtaining immediate pleasure that favors the avoidance of suffering. Although this promise never really comes true, the temptation to find a magic solution to the complications of living is considerable.

In addition to giving way to a type of omnipotent and wish-fulfilling thinking, which is eminently governed by the primary process, the use of drugs can also acquire an additional meaning of representing a form of subversion, contestation and transgression of the current

rules. This behavior has a negative impact on the physical, psychological and social health of the user, which makes it essential to outline an analysis of the family and sociocultural context underlying the appearance of symptoms of drug addiction, free from moral judgments and salvationist intentions.

The recovery of the drug user is favored by interventions aimed at building a support network that includes family, community groups and friends. The strengthening of social support networks is directly related to recovery of physical and mental health of the individual who is most vulnerable in the face of a crisis situation[7].

The application of groups to cope with disorders related to substance use already has a considerable established tradition. Today's society is characterized by individualism and the weakening of social ties, which imposes modes of subjectivation that bring people closer to experiences of extreme helplessness and loneliness[9]. This individualism is based on the search for immediate pleasure, with maximum avoidance of pain through incorporation of objects whose consumption illusively saturates human desire, by plugging the lack, giving the individual a false sense of narcissistic fullness. Physical incorporation replaces the requirement for symbolic elaboration work. It is as if having it deceptively guaranteed the passage to being[9].

The promises linked to the possession of certain brands, cars and electronic devices, such as laptops and mobile phones, are governed by the same logic that regulates drug use. This dynamics of functioning promises that the pain of existing can be remedied when the individual incorporates objects endowed with materiality, especially in the case of substances that promise to maximize the enjoyment of jouissance[9]. The use of the drug guarantees the subject a quick way to avoid painful and distressing situations, that is, it offers an escape, a biochemical shortcut in the face of a reality that is discouraging and unbearable, which induces suffering and amplifies the feeling of helplessness.

On the other hand, the possession of the drug object prevents the individual from becoming involved in the search for their own satisfaction, that is, it avoids contact with structural lack and needs of being, producing profound emotional isolation and social alienation. The drug universe is characterized by a strong presence and imprisonment in an eternal present, with a lack of recognition of the past and a remarkable indifference towards the future. It is relevant to remember that, in these circumstances, the irreplaceable bond is not with the other, but with the substance, which usurps the place of the missing object and thus obliterates the pain of structural incompleteness that is proper to human beings.

The formation of a bond is necessary in all forms of communication, but it requires time to be structured in a stable way in cases of people undergoing outpatient treatment. It should be added that, in most cases, over time the person seeks help for being frustrated in the relationship with the chemical artifact, which does not always guarantee that they have an understanding of the damage that addiction promotes. In these cases, there is an experience of breaking the *honeymoon* with the drug[10].

When the subject who makes chronic use of substances finds a place where they feel understood instead of criticized, and where they can be perceived by others without having to be the same, their feeling of threat can be mitigated and their sense of freedom is increased. Society is sick and with this, it promotes certain binding arrangements that have been contributing massively to the worsening of emotional illness. For this reason, the group device has been greatly appreciated and valued as a possibility of building healthier bonds, favoring the setting up of a support network that verticalizes healthy bonding configurations. The bond is the main tool of therapeutic work, and is therefore the best ally of treatment. Without a special attention to the linking plot, it is not possible to talk about lasting results for problems that are eminently human and, therefore, linked[11].

In a therapeutic group offered in the CAPSad scenario, participants can recognize the link space as a help resource, in which everyone can participate with suggestions, actions and affections that stimulate shared conflict management and resolution[11]. In the operative group,

in its aspect of intervention technique, there is a device that is in tune with the current paradigms in health and education, by establishing the subject at the center of their learning process, as an active subject and protagonist in the production of their health, through the collective construction of knowledge and senses that give meaning to the human experience[12].

CAPSad can be understood as a differentiated and more appropriate place than the psychiatric hospital for the treatment of addiction, but patients may still have difficulties in feeling safe and belonging to spaces other than those that are traditionally associated with their disease, due to the influence of the asylum model prior to the establishment of Psychosocial Care[13].

To the extent that they feel welcomed and belong to the group, individuals understand that they have a place in CAPS, in their family and in society. They also realize that their participation in the group is not something given and fixed, nor is it forever, since the group is a dynamic and temporal organism, subject to constant metamorphoses that can change its composition continuously. Group members can also experience changes when they come into contact with new feelings and emotions, which allows access to new ways of being and being in the world.

Chemical dependency must be treated as a chronic condition that goes beyond the contours of a medical problem. It is a health phenomenon and, simultaneously, a social problem, characterized by a mental and physical state that results from the user's distorted interaction with the object of their compulsion. This object can materialize in the form of alcohol and/or other substances with a psychoactive effect[14].

In the case of drug addiction, the person suffers from their inability to be alone and, at the same time, from having difficulties in relating to others. For this reason, the psychoactive substance can seek satisfaction that it cannot obtain from a real and genuine relationship, but without paying the price of the supposed risks associated with intimacy, since the contact with reality in its otherness dimension is experienced as unbearable[15]. It is as if, when adding to an object, there is an attempt to defend oneself from dependence on another human being. The extreme of this addicted way of relating is represented by the passionate devotion to the drug object, justifying a fusional relationship with the other that, in this union in which the limits of self are dissolved, are no longer considered in their otherness and uniqueness[15].

The difference between chemical dependence and addiction lies in the fact that the dependency is focused on the individual's relationship with the psychoactive substance. Addiction, on the other hand, refers to the subjectivity of the individual and his or her own way of relating beyond the use of the substance itself.

Thus, understanding the phenomenon of addiction from the perspective of binding configurations is essential to conduct potent interventions with users of psychoactive substances, both in groups and in the individual mode, by providing a sensitive look that goes beyond common sense perceptions, which is why able to offer shelter to the suffering of these people and means to encourage them to develop their transformation resources.

Given the importance of working with groups to strengthen healthy bonds, a diverse range of group interventions make up the repertoire of practices conducted in the care provided at CAPSad. Part of these interventions is under the responsibility of psychology professionals. In this context, it is relevant to know the perception of these professionals about the work performed.

Professionals who operate in the logic of Psychosocial Care need to have a comprehensive view in their community activities, in accordance with the model recommended by the health policy, which recognizes CAPSad as the main articulating element in the care network for drug addicts within the Unified System of Health (*Sistema Único de Saúde - SUS*)[7]. Individuals involved in problems related to substance abuse are often excluded from a dignified social life, and for this reason they need interventions that also address their difficulties in establishing and maintaining healthy, stable and lasting bonds.

Considering the importance of fostering reflections on the importance of binding configurations in the range of therapeutic care aimed at CAPSad users, especially the links established with the health team, this study aimed to examine the perception of Psychology professionals about the assistance offered to alcohol and other drug users.

## METHOD

This is a descriptive-exploratory research, carried out in the first semester of 2018, in the context of CAPS Alcohol and other Drugs (CAPSad). Psychology professionals who worked with the interdisciplinary team in the particular CAPS of four municipalities in the northwest region of the State of São Paulo participated in the study, namely: Ribeirão Preto, Sertãozinho, Santa Rita do Passo Quatro and São Joaquim da Barra. The eligibility criteria of the participants were: to be a professional with formal employment relationship with the institution and to act as coordinator of groups with patients diagnosed with substance use disorders.

The approach chosen for conducting the research was qualitative, employing a semi-structured interview, applied individually in a reserved room of the service. As a data collection technique, the interview makes it possible to obtain data on the most diverse aspects of the individual's social and subjective life. In the case of semi-structured interviews, it is noted that they offer greater flexibility, allowing the interviewer to be able to clarify the meaning of the questions and adapt them to the interviewees and the specific circumstances in which the conversation takes place[16].

The script used to conduct the semi-structured interview was composed of questions that sought to know the participants' perceptions about the assistance offered, treatment route and binding configurations prevalent in alcohol and other drug users. The interviews were audio-recorded and the records were later transcribed in full and literally, constituting the corpus of the research.

Data analysis took place through the construction of thematic categories, based on literal transcriptions of the interviewees' statements. The reports were submitted to Thematic Analysis, which followed the model proposed by Bardin[17].

The research was approved by the Ethics and Research Committee (CAAE: 84147518.5.0000.5512; Number: 2,577,592). In conducting the study, all ethical precepts were respected, as determined by Resolution 466/12 of the National Health Council. The interviews were only completed after the consent of the CAPSad coordination and the signing of the Free and Informed Consent Form by the participants. Anonymity was ensured by replacing their real names with codes, which ranged from [P1] to [P7], with the letter P being the initial of the word “participant”, and the subsequent number associated with the time order in which the interview was conducted .

## RESULTS

Seven psychologists participated, mostly female, aged between 29 and 56 years, married and graduated between five and 35 years. From the analysis of the research corpus, three thematic categories were constructed, namely: *Participation of the family in treatment*, *Difficulty in adhering to treatment* and, *Addiction to the drug as a symptom of ill bond*, presented below.

### *Family participation in treatment*

Taking as a starting point the idea that the family is of vital importance in the constitution of the subject's subjective life, the participants of this study understand that the presence of family members and/or people close to users in the treatment space is a fundamental part of care in mental health. The relevance attributed to the participation of people from the user's family life in the groups held at CAPSad is evident in the interviewees' statements:

*[...] Comorbidity, mainly, psychotic conditions that we might need if the family member were present [...] [P6].*

*[...] The family issue is also very important ... Family support [...] is important to be able to make this bond with the family, you know, to raise the family's awareness. I think everyone has to be together [...] [P7].*

Despite agreeing that the inclusion of users' family members brings gains to treatment, some obstacles to the effectiveness of this participation were also mentioned by the interviewees:

*[...] families no longer ... They have tried various ways to help and there was no response from the patient, right? [P7]. Family members also bring many difficulties to the services, in the sense that they wanted things to be very fast. They put themselves in a position of wanting to save that son, that husband, right? So, it is a very big charge in relation to them, well, about that. That this also needs to be looked at, right? Because it is very tiring for family members, that is why it also needs to be looked at how they put themselves in this relationship with the substance, in short. [P6].*

*[...] people who are all the time with mood swings, right, and also family problems, right? [PS3]*

In most cases, the bonds maintained by the user with the nuclear family are broken in the process of installing dependence on the psychoactive substance, and those who manage to preserve family bonds generally maintain relationships permeated by stress and affective ambivalence. Thus, according to the interviewees' perception, families are often worn out and discredited regarding their effective possibility of adhering to the therapeutic plan and achieving positive transformations in the course of treatment, especially in the face of relapses that commonly accompany this trajectory. Dependence, like other chronic disorders, has an unstable and winding course, with ups and downs, which sometimes culminate with recurrences in the symptom, which is the most predictable in this scenario.

In the participants' perception, when an individual falls ill, the members of their family, directly or indirectly, fall ill as well. When this process becomes chronic and lasts for a long time, the climate of hopelessness and the lack of credibility in change tends to predominate. Skepticism sets in because family members are often exposed to conflicting and degrading chronic situations, and experience difficulties in finding the solutions they long to resolve conflicts and heal the fragility of bonds.

Respondents also point out that frustrations and persistent exhaustion enhance feelings of anguish, tiredness and discouragement. Thus, the annoyances experienced on a recurring basis end up leaving everyone in a situation of marked vulnerability. In order for the family environment to become healthy, with less toxic relationship patterns, it is necessary to have a support network that ensures reception and provision of instructions, which must be permanently available to users and family members. The improvement of the family environment happens when the family finally regains vitality of its restorative forces, being able to actively offer support and understanding to its most vulnerable members, serving as a positive inspiration for the addicted individual. By including the family context in comprehensive care for the user, it is intended to help the family recover its potential to promote the maturation of its members.

The interviewed professionals understand that CAPSad, in fulfilling its institutional role, functioning as a support network for both the individual and the family, can collaborate to strengthen family bonds. This also benefits the quality of the links established with the health team professionals, as well as with other users of the service. The potentiation of these benefits contributes to establishing more favorable conditions for adherence to treatment, as it favors awareness of the real magnitude of the difficulties faced and the sharing of responsibilities. This can be seen in the statements of the participants:

*[...] I think it is the awareness, right, of this whole issue that involves mental health, of being able to guide the patient well and being able to make a good bond with them, well structured and strengthened to the point that hthey actually adhere to treatment. So, I think the starting point is awareness. [P7].*

*As the group of dependents is recent, we are hoping to join the group so we can start a group of family members as well. [P1].*

### *Difficulty in adhering to treatment*

In the interviewees' statements, it can be noted that the lack of adherence is highlighted as a problem that can become a critical point for the effectiveness of the treatment:

*[...] those patients who are forced to come, it is very difficult to have adherence. So, I believe that adherence is our greatest difficulty [...] [P1].*

*The greatest difficulty for the patient, when they bring the comorbidity of dependency, is adherence to treatment [...] I believe that, when there is adherence, the prognosis is good [...] [P7]*
*[...] the biggest difficulty we face, mainly, not so much from comorbidity, but which are associated with the use of alcohol and drugs, is adherence. [...] Now, most do not have the support of the family. It is that family that has already given up on him [...] [P2]*

According to the perception of one interviewee, one of the factors that favor adherence to treatment is the maximization of the link between the CAPSad user and the multidisciplinary team:

*[...] It can be a place to make a social bond, and the idea is always this, that can be linked to others, the team, employees and other patients. It is to create conditions so that the subject can find his way. [PS5].*

When considering that the substance use disorder constitutes a chronic health problem, which implies prolonged and persistent suffering, the interviewees admit that the difficulties of adhering to the individual treatment plan constitute a critical aspect of care, however, they assert that the embarrassments and setbacks are part of each user's therapeutic path. The moments that signal recovery often alternate with setbacks in treatment, when the user reoccurs in habits that are harmful to health. It is necessary to understand the nature of these obstacles and to be clear when approaching them with users and family members, seeking to build shared solutions so that the barriers can be overcome.

The interviewees also highlighted that, when working with the link configurations, it is essential to think about offering group strategies and workshops that favor socialization and active participation of the user in the service. The recognition of the need to implement work that privileges the group setting appears in the interviews as a facilitating factor for adherence to the therapeutic plan:

*[...] And even, if they had the workshops, they would adhere more to the psychologist, right. I would adhere more to the psychologist and improve the treatment, right [P4].*

Thus, the interviewees understand that the groups formed in the CAPSad contribute to potentiate mutative properties of the linking process, since relationships that are established between participants and professionals, when well managed, can strengthen group bonds, opening up possibilities for reaching the group, which is a “sine qua non” condition for overcoming stereotypy and emergence of change:

*[...] The patient themself, who is there in this group, in this therapy, also begins to internalize care, right [P4].*

### *Addiction to the drug as a symptom of sick bond*

The participants identified as a relevant dimension in the therapeutic work to investigate the beginnings of the bond that the addicted subject established with the psychoactive substance and how their bonding pattern with the environment and the service is structured:

*[...] sometimes this is a little complicated too, you know, making them see that the relationship they have with the substance is the problem, not the substance itself. It is this relationship with the substance that we need to change in the environment in which they are inserted, right? [P6].*

This knowledge makes it possible to find more effective ways to intervene therapeutically, according to the testimony of one of the professionals interviewed:

*[...] So, this is the process, listening to the subject. Do not be stuck with phenomena, behaviors, but be aware of their relationship with their own life, with their family, with other patients, with us. It is a process in which we learn to listen. [P5].*

Another aspect raised by the study participants was the objective social conditions in which the drug addict is inserted as a member of their community:

*[...] Then it mixes everything: prejudice, family difficulties, difficulty of keeping abstinent, difficulty of relating even to society itself. [P2].*
*[...] Sometimes it is this issue that I told you just now, about the social vulnerability that they have, that sometimes they are people who are even on the street. [P7].*

The interviewees mentioned that institutional barriers are also part of the sick bonds, since they act as barriers that compromise the quality and effectiveness of care, since they de-potentialize the bonds established with CAPSad's assisted population. The participants consider that it is part of their job to maintain the hope that they can help the user to find new

ways of relating, insofar as they can invest in creating healthier bonds capable of strengthening their support network, keeping them inserted in their family and community, so that they can be seen as an active subject and responsible for their development process, thus regaining their role as a transforming agent in their own history.

## DISCUSSION

The first category analyzed, called *Participation of the family in the treatment*, showed that the perception of psychologists interviewed in the present study about family support corroborates data reported in another study, which point out that "the family is fundamental for the treatment of chemical dependence, as far as in which it is the link that unites members to the different spheres of society and that is related to the healthy development or not of its members"[18]. Nevertheless, professionals identified barriers that restrict this participation, depriving the user of its potential benefits.

In this study, the interviewees' perception indicates that the user's family is often exhausted when they feel that their coping resources are depleted, which makes them skeptical about their own potential to positively influence the evolution of treatment. The attitude of disbelief in relation to the mutative power of treatment becomes more prominent in the face of crisis situations triggered by relapses, which, in truth, are expected throughout treatment[7].

This process, which tends to be prolonged, has often dragged on for years, draining the energies of the family system and draining the hopes of all members, making especially vulnerable those most involved in finding solutions to the problem. For this reason, psychologists understand that families need to receive support not only due to physical and psychological overload, but also so that they can strengthen their defenses and, from this empowerment, acquire objective conditions to modify the weakened link organization.

Thus, when reflecting on the challenges of including family members in treatment, participants consider that when individuals are able to make a more realistic assessment of the extent and depth of the challenges they face, there is a greater chance of not underestimating or overestimating the scope of this undertaking.

The family is considered by interviewees as the primary socialization group, responsible for ensuring the conditions for providing the individual's basic needs. The family also provides the first social contact that human beings establish, maintaining a space for socializing and learning rules, customs, values and concepts. This bonding space can be predominantly healthy or pathological, depending on the ways that people privilege to resolve conflicts aroused by living together.

It is in the dynamics of family life that the individual builds and permanently deconstructs and reconstructs his bonding plot. If the family offers a context of healthy relationships and interactions, the bonds established by its members tend to be genuine and positive, which strengthens the processes of constituting subjectivity. However, when the intrafamily bonding plot presents ruptures, discontinuities and conflicts that are difficult to cope with, the bonding process can fray and be structured in a fragile and sick way. In that case, relationships become toxic and dysfunctional.

For the members closest to the sick relative, the consequences of the experience of living with the addict can be manifested through physical and psychological symptoms. For this reason, in the interviewees' perception, the drug user's family is a vulnerable group, which also needs to receive specific attention and care[18].

The groups that the individual naturally integrates into daily life, such as the family and colleagues in the work environment, reach a privileged position to formulate an understanding of how the family's linked configurations are manifested in the user's psychological functioning. In this sense, an accurate knowledge of the link dynamics is essential for the treatment of individual difficulties[7,8]. However, as observed by the professionals interviewed in this study, it

is not always possible to count on the effective presence of family members in the context of treatment.

The second category analyzed was Difficulty in adhering to treatment. The factors related to the user's non-adherence to the therapeutic plan established by the health team constitute a critical element highlighted in the participants' statements. It can be noted that the lack of a collaborative posture of the user is seen as a chronic problem in the management of treatment, a recurring expression of resistance that, if not resolved, can become an insurmountable barrier to resolving the individual treatment plan.

Adherence to treatment is understood as the degree to which the service user follows recommendations of health professionals and returns to the service maintaining principles of the indicated treatment, be it medication or behavioral[19]. When the individual presents a non-collaborative posture, which translates into difficulties in adhering to the individual treatment plan, it can harm their prognosis, either because they increase their chances of succumbing to new episodes of crisis and reappearance of symptoms, or because the relapse can weaken even more the bonds with the family and their social environment, worsening their situation of vulnerability.

The interviewees also referred to another recurrent phenomenon in their clinical practice, which is the alternation between movements that signal possible stabilization with setbacks, which can culminate in recurrence. This dynamic of ups and downs expresses resistance to the new. In order to get in touch with the new, there is a need to abandon and say goodbye to the old, which enables a renewed understanding, but at the same time generates anxiety. When this anxiety is intense and exceeds the subject's ability to control, it becomes paralyzing and reinforces resistance to change. For this reason, the user again relapses habits that are harmful to health.

This instability will probably accompany the therapeutic itinerary of all users, which makes the outcomes unpredictable, increasing the chances of disruptive disruptions of the therapeutic bond. The volatility of therapeutic gains is frequently observed in the treatment of substance abuse disorders, which does not mean that efforts made previously were all in vain. Persistence and tolerance to frustration are the greatest allies of the psychotherapist who deals with contexts of uncertainty and unpredictability. Hope is the most suitable compass to go through the processes of sustaining the treatment path.

In addition to these difficulties, the participants reported that it is not always possible to count on the collaboration of family members in treatment. This happens for different reasons, ranging from an indisposition or animosity with the sick member to the unavailability due to work reasons, incompatible schedules, accumulation of responsibilities and daily tasks, and also physical and/or psychological limitations of family caregivers, who they frequently present themselves to depotentialized service and exhausted in their physical and psychic energies[19,20].

In relation to the user, many people who face a condition of dependency may feel imprisoned in this form of being[10]. To address them, it is necessary to resort to systematic and planned intervention by the health team. Health professionals need to be available to be able to create and reinvent their approach strategies at each stage of treatment. It is also essential that, during the process, these strategies outlined at the beginning can be revised and reformulated, with the flexibility to create sustainable bonds, based on tolerance and understanding of the user's limits and possibilities. Thus, the controlled emergence of anguish is possible, which, when accepted and understood by professionals, can trigger the work of psychic elaboration.

The interviewees valued interventions, programs and workshops based on the group strategy. This perception corroborates another study, which indicates that there are several types and modalities of groups available, highlighting more strongly those who propose to improve symptoms presented by members, in interventions aimed at resolving conflicts that cause anxiety and other symptoms[21]. To achieve this goal, it is important that the therapist is

able to adequately exercise his leadership role in group coordination, strengthening his symbolic condition as guarantor and guardian of the hopes deposited by the members.

The third category analyzed was called *Addiction to drugs as a symptom of the sick bond*. In an expanded reading of the phenomenon, drug addiction can also be seen as a symptom of illness of contemporary society, which is characterized by encouragement of excessive individualism and is guided by the search for immediate pleasure, with marked intolerance to the minimum of discomfort. The avoidance of psychic pain is sought at all costs by the incorporation of objects that appease anguish[9]. The adoption of evasive maneuvers creates a pattern of conduct in which the discharge of the impulse is a priority, to the detriment of the reality principle and the capacity for reflection and elaboration of the experience.

In this way, recurrent use of substances follows the same logic that drives the gears of the consumer society - a socially learned response, according to a logic according to which all pain can be filled or anesthetized with the indiscriminate incorporation of objects and chemical softeners. In this scenario, each individual chooses their preferred *drug-object*, a place that may or may not be occupied by a psychoactive substance. The substances are noteworthy because they promise to facilitate the access to the greatest and fullest enjoyment, eliminating the discomfort caused by the symbolic castration to which all subjects should be subjected and which constitute the unavoidable mark in humans.

In the myth of absolute freedom of choice, it is advocated that a person is free to choose, but without ceasing to consume, because that would be the only possible way of satisfying their basic needs. This freedom, paradoxically enslaving, is paralyzed in the ambivalent expression of the dependent, who becomes captive to a toxic and self-destructive link pattern. For this reason, when outlining treatment guidelines, efforts should be directed to understand the way in which these individuals connect to life, people and drugs, because this understanding makes the type of bond established with the team more intelligible and treatment in general[12].

The breaking of ties with the world of work appears in the interviewees' statements, sometimes as a causal factor, sometimes as the main consequence of the pernicious escalation of the addiction process, which points to the question that the user gradually accumulates physical, psychological and social losses , as the drug acquires priority in their life and starts to assume a central position in their daily life[6]. The social stigma that the individual carries is another barrier that hinders the opportunity to be able to compete for a place in the job market or even guarantee their permanence in a better quality job. The low professional qualification and the chronic unemployment situation are recurrent components in the user's life trajectories, contributing to destabilize the family organization, being able to trigger crises that aggravate vulnerability and intensify psychological suffering.

The multiple disruptions experienced by the user amplify the sensation of discontinuity of their vital process, establishing a fracture in their psychosocial world, which contributes to perpetuating chronic difficulties in dealing in a mature and flexible way with the demands of reality. However, one cannot lose sight of the subject's ability to assume the role of their life, provided they receive the appropriate encouragement and support so that they can regain their personal power and control over the events of their life[21,22].

The psychologist's work in this scenario must be based on a careful listening to what the subject is communicating, understanding that they also emit messages in a ciphered way through their symptoms. In deciphering these latent messages, we seek to understand the patterns of communication and linkage by which their relations with the environment and their own subjectivity are configured[23,24].

Respondents recognized that institutional barriers contribute to weakening ties, functioning as barriers that compromise therapeutic effectiveness of care and the building of bonds of empathy with the CAPSad user. The identified barriers cover a wide range, among which we can highlight: professional training based on moralizing, naturalizing and stigmatizing concepts, still strongly inspired by the biomedical model[25,26]; dismantling the

network of available services; local problems that mainly involve a work dynamic marked by overload; the structural scarcity of health equipment and chronic deficiency of resources and lack of investments in the health sector[27-29].

## CONCLUSION

In this study, interviews were carried out with Psychology professionals who worked in four CAPSad, in order to get to know the perceptions about their performance with the population of substance users. The results obtained confirm the importance of working with groups in the CAPSad, since the patterns of linked configurations can be better highlighted and elaborated in the group setting.

Operative groups offer therapeutic results that favor the bonding process, thus being able to open new ways to elaborate conflicts and point out possibilities of reframing for service users. By prioritizing work in groups, seeking to contemplate principles that have guided CAPSad since its creation, the service fulfills its role of providing a space for comprehensive care and socialization, promoting family integration and encouraging the autonomy of its users.

For interviewees, the professionals' understanding of the needs of the assisted user who is undergoing treatment due to drug addiction must start from understanding of the peculiar relationship that they establish with the substance, that is, the way the subject must be prioritized is linked to their drug-use object. Understanding the unconscious aspects of the special relationship that is established between the user and the drug, understanding it as a model of a diseased bond, means considering addiction as a symptom that can be treated through psychotherapeutic management. Working on the bond instead of the symptom helps to prevent dysfunctional behaviors of the drug user from becoming the target of prejudiced judgments and moralizing attitudes. In this way, the bond between the user and the service that offers treatment can also be favored and, consequently, the opportunity to live a success story in coping with addiction can be considerably expanded.

In the interviewees' statements, participation of family members plays a fundamental role in directing the treatment of people with substance abuse problems. However, when such inclusion is not effective in practice, the proposed treatment plan to address the bonding problems found in drug addiction may be impaired and the established goals may not be achieved.

Another possible obstacle that was highlighted by interviewees concerns the difficulty of the user to adhere to treatment. An attempt at a resolution that can be promising to address these barriers identified by participants has been the strengthening of support and protection network created by CAPSad.

Thus, the service can place itself in the position of privileged articulator of available community resources, as it strategically prioritizes the work carried out in groups, in networks and in the territory, which aim to strengthen bonds established by the user with the service team. By displacing the user from the place of individual loneliness to the solidarity of collective coping, CAPSad contributes to building a new relationship with drugs, family and society.

This study has limitations, such as a small sample and a cross-sectional design, with no possibility of generalization. On the other hand, the results obtained contribute to the advancement of knowledge produced about psychological assistance within the scope of CAPSad, in addition to providing relevant clues to foster future investigations.

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**CONTRIBUIÇÕES**

**Isabel Cristina Carniel** was responsible for orientation, conception, outlining, analysis, interpretation of data and writing**. Tamys Duran** and **Ana Carolina da Silva Oliveira** collaborated with bibliographic survey, collection, analysis, interpretation of data and writing. **Sandra Cristina Pillon** worked on analysis and revision. **Manoel Antônio dos Santos** contributed with conception, outlining, analysis and interpretation of results, writing and revision.

**How to cite this article (Vancouver)**

Carniel IC, Duran T, Oliveira ACS, Pillon SC, Santos MA. Perception of Psychology professionals about the assistance offered to Psychosovial Care Centers users. REFACS [Internet]. 2020 [cited in *insert day, month and year of access*]; 8(Suppl. 1X):575-589. Available from: *insert access link*. DOI: *insert DOI link.*

**How to cite this article (ABNT)**

CARNIEL, I. C.; DURAN, T.; OLIVEIRA, A. C. S.; PILLON, S. C.; SANTOS, M. A. Perception of Psychology professionals about the assistance offered to Psychosovial Care Centers users. **REFACS**, Uberaba, MG, v. 8, p. 575-589, 2020. Suppl. 1. Available from: *insert access link*. Access in: *insert day, month and year of access*. DOI: *insert DOI link*.

**How to cite this article (APA)**

Carniel, I. C., Duran, T., Oliveira, A. C. S., Pillon, S. C. & Santos, M. A. (2020). Perception of Psychology professionals about the assistance offered to Psychosovial Care Centers users. *REFACS*, 8 (Suppl. 1), 575-589. Retrieved in: *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.