

“Varanda de espera”: new positions of the family in the devices of the Psychiatric Reform***“Varanda de esperas”: novos posicionamentos da família nos dispositivos da Reforma Psiquiátrica****“Varanda de esperas”: nuevos posicionamientos de la familia en los dispositivos de Reforma Psiquiátrica****Received: 21/08/2019****Approved: 01/05/2020****Published: 11/08/2020**João Camilo de Souza Junior¹Anamaria Silva Neves²

This is an observational study carried out in a Child and Adolescent Psychosocial Care Center, and aimed to talk about the subjective positioning of the family in relation to services offered by the new Mental Health policy. Held in the first half of 2015, through 15 observations and interviews with employees and family members of users. Psychoanalysis guided the practice and analysis of the findings. Named “*Varanda de Esperas*” (“Balcony of Waits”), the observations showed that at different times there is a rivalry and distance between the team and family members, seen only as companions and not part of the therapeutic care. Medicalization and biologicist practice was seen as frequent. In this sense, there was a need for constant discussion and evaluation of the practices established by the Psychiatric Reform, especially in the psychosocial care that postulates inclusion of family members in the treatment of the user, especially children and adolescents.

Descriptors: Family; Mental Health; Psychoanalysis.

Este é um estudo observacional realizado num Centro de Atenção Psicossocial da Infância e Adolescência, e teve como objetivo dissertar sobre o posicionamento subjetivo da família em relação aos serviços oferecidos pela nova política de Saúde Mental. Realizado no primeiro semestre de 2015, através de 15 observações e entrevistas com funcionários e familiares de usuários. A *Psicanálise* orientou a prática e análise dos achados. Nomeando-se “*Varanda de Esperas*” as observações mostraram que em diversos momentos há uma rivalidade e distanciamento entre equipe e familiares, vistos apenas como acompanhantes e não fazendo parte do cuidado terapêutico. A medicalização e a prática biologicista foi vista como frequente. Nesse sentido, percebeu-se a necessidade de uma constante discussão e avaliação sobre as práticas estabelecidas pela Reforma Psiquiátrica, sobretudo na atenção psicossocial que postula a inclusão dos familiares no tratamento do usuário, especialmente crianças e adolescentes.

Descritores: Família; Saúde Mental; Psicanálise.

Este es un estudio de observación realizado en un Centro de Atención Psicossocial de Niños y Adolescentes, y tiene por objeto examinar la posición subjetiva de la familia en relación con los servicios que ofrece la nueva política de Salud Mental. Se llevó a cabo en el primer semestre de 2015, mediante 15 observaciones y entrevistas con empleados y familiares de los usuarios. El *Psicoanálisis* guio la práctica y el análisis de los hallazgos. Llamado “*Varanda de Esperas*” (“Balcony de Esperas”) las observaciones mostraron que en varios momentos hay una rivalidad y distancia entre el equipo y los miembros de la familia, vistos sólo como compañeros y no como parte de la atención terapéutica. La medicalización y la práctica biologicista fueron frecuentes. En este sentido, se percibió la necesidad de una constante discusión y evaluación acerca de las prácticas establecidas por la Reforma Psiquiátrica, especialmente en la atención psicossocial que postula la inclusión de los familiares en el tratamiento del usuario, especialmente los niños y adolescentes.

Descriptores: Familia; Salud Mental; Psicoanálisis.

* Study funded by the National Council for Scientific and Technological Development (*Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq*).

1. Psychologist. Mental Health Specialist. Master in Psychology. Professor at the Fundação Carmelita Mário Palmério, Monte Carmelo, MG, Brazil. ORCID: 0000-0003-0955-9620 E-mail: joao.camilo.s.j@gmail.com

2. Psychologist. Master, Doctor and Post-Doctor in Psychology. Associate Professor of the Graduate Program in Psychology at the Universidade Federal de Uberlândia, MG, Brazil. ORCID: 0000-0002-7722-8690 E-mail: anamaria.neves@ufu.br

INTRODUCTION

Currently, it is possible to perceive questioning on the part of professionals, especially those who deal with childhood, if families (especially those of low income) are able to support their children's psychological development, a question that is emphasized when they have some type of psychic suffering that can make care more complex¹.

Such questioning has vast historical roots, given the blaming of families in relation to the "behavior deviations" of children and adolescents, blaming carried out by scientific and social knowledge dating from the beginning of the 18th century². Still, the State systematically resorted to closed institutions for the education and pedagogization of children and adolescents, and it was believed that there was offered some type of protection that the family was unable to provide².

Institutions, especially therapeutic, predominant until the early 1990s, valued *therapeutic isolation*, that is, the separation between patient and family³. This treatment strategy was based on the way in which the family was conceived by the medical hygienist field, that is, as an alienating family and responsible for making the patient's treatment difficult. Thus, the family group was perceived as a "pathogenic agent" and should therefore be isolated.

The promise of a cure was only possible due to treatment capacity and techniques of the care institutions³. Thus, in view of therapeutic isolation, the care addressed to families was relegated to a second level, in which the family passively expected improvement of their relative, so that, "the implicit message was that care for the patient was exclusive assignment of mental health workers and assistance services"³.

A similar situation also occurred with the subjects who historically were considered "crazy". The calamitous situation experienced by these people in closed institutions persisted in Brazil until the end of the 1970s⁴. When Franco Basaglia, an important Italian psychiatrist, visiting Brazil, summoned the press to denounce the atrocities of the asylum in Barbacena, this fact helped to intensify the movement to fight for Psychiatric Reform, providing a reinforcement to the insurgent Mental Health Workers Movement (*Movimento dos Trabalhadores de Saúde Mental - MTSM*) and expanding the movement and political discussion for this cause nationwide⁵.

Institutional changes were being promoted since the mid-1980s; however, only after several years of struggle for legislative changes that had the nickname of ending long hospitalizations and enabling the creation of new Mental Health devices, laws were instituted in Brazil for a new model of psychosocial care dating from the early years 2000, namely Law 10.216⁶.

In the new model of psychosocial care, the Psychosocial Care Center - CAPS (*Centro de Atenção Psicossocial*) device was inserted as a tool in the proposal to replace the hospital-centered view of the work once done with "madness", a tool based on interdisciplinarity, aiming to conceive the service user in its multifaceted dimension⁴. In this sense, the CAPS service was established based on a series of actions aimed at reconstructing the subject's lost or broken ties with their environment, with themselves and/or with family members, providing conditions for such individuals to experience affective exchanges and the development of new skills in dealing with social life.

Therefore, if the Psychiatric Reform established institutional movements, with different practices and devices, in the midst of these changes the family resurfaces, surrounded by new facets. With the implantation of CAPS, it was possible to treat users in psychosocial care services and to return them daily to their homes⁴.

The subjects who were formerly hospitalized for long periods in segregationist institutions, or used the also recent Therapeutic Residences service (homes for people in psychological distress who remained in long psychiatric hospitalizations and were unable to return to their families of origin), or returned to their families, start to constitute a new reality in the family scope and in the social aspect of madness⁷.

It can be seen that, in a way, the relationship between users' relatives and Mental Health services is presented as unprecedented. With the daily return of users to their homes, the family started to demand a new approach from the service, since daily contact with the distant relative implied and still implies new relational perspectives; thus, in this sense, the family group has become a strategic subject in therapeutic care, also starting to live with the possible difficulties resulting from psychological suffering⁸. In addition, the family bond was evident in institutions, given that such bonds, made ill by relationships that are often restricted by violence and ruptures, started to demand attention from the CAPS teams, because, when attending the institutions together with the users, in numerous times they revealed tragedies experienced in their daily lives.

The logic of protecting the citizenship of the individual using the CAPS was expanded with Ordinance 251, of 2002, for the protection of family citizenship³. This Ordinance established an approach specifically aimed at the family group in the therapeutic project of every user of the new Mental Health devices. Thus, in this approach, the family should be clarified, guiding them on: diagnosis, treatment program, hospital discharge, among other information related to the service.

The family has become, initially, the main “*caregiver*” of the subject in psychological distress, be it an adult, adolescent or child, and this burden has brought new circumstances to the family environment⁹. At first, after the Psychiatric Reform, the responsibility for care was relegated to the family, without any help from health services¹⁰. However, even after structuring the new devices of the mental health service, many families still say they are overloaded, and report physical and emotional fatigue, partly generated, according to family members, by the helplessness caused by the lack of support from services.

Bearing in mind the history of the condition of therapeutic isolation instituted by the institutionalization of treatment relegated to childhood and “*madness*”, as well as the constitution of the Psychiatric Reform and the emergence of the family group as an important strategic subject, this article presents an excerpt that aimed to analyze, within a Center for Psychosocial Care for Children and Adolescents - CAPSi (*Centro de Atenção Psicossocial da Infância e Adolescência*), the approach of such institution towards the families of users served by it, as well as the subjective field that the family group occupied in relation to the care of children and adolescents, as well as their influence on institutional daily life.

Thus, it was possible to realize, with the research, how the relationship between institution and family was managed, a relationship articulated around the treatment. The present cut is then based on what was called in the study “*Balcony of Waits*”, a marginalized position occupied by families in CAPSi, which seems to subsist given the tacit and confused agreement between the institution and the family group. Thus, this study aims to talk about the subjective positioning of the family in relation to the services offered by the new Mental Health policy

METHOD

This is an observational study carried out at the CAPSi institution, in the first semester of 2015. Such observations occurred on alternate days and times in order to expand knowledge about the institutional routine. Each of the observations lasted an average of about six hours, seeking to observe/capture/apprehend the practices and bonds created and sustained in CAPSi.

With this practice, we sought to know the public served and the different families. Prior to the observations, the research project was submitted to the Research Ethics Committee under CAAE No. 36949714.0.0000.5152/2014, allocated on the website managed by Plataforma Brasil and the project was also submitted to the Health Department of the municipality where the research took place. After approval of both administrations, practical research began.

In the present study, the psychoanalytic method guided apprehension and analysis of the findings. In Psychoanalysis there is a distinction between *technique* and *method*¹¹. The psychoanalytic technique developed by Freud refers to the technical apparatus used in the clinic, consisting, for example, of fluctuating attention, transference interpretation, neutrality and others. The interpretive method goes beyond the technique and can be used outside the office, in places where the classic technique is not feasible. The idea of an *extensive clinic* consists of using the psychoanalytic method outside the office, creating variations of the technique for this purpose, using *interpretive listening* of discourses that circulate in the research field¹¹.

Entering the field of research and being implicated by it, the transference field was established, indispensable for the production of practice. And, "you can only do research in psychoanalysis *under transfer*"¹². In this sense, transference means that there is a subject beyond conscious discourse and that transmission goes beyond what is superficially observed. To be in transference, then, is to be available for the unconscious production of both parties, analyst and analysand.

CAPSi also interviewed family members of users and employees of the institution. In such conversations, we sought to analyze the different points of view and the way these subjects related, that is, how the family perceived the welcoming of the institution, as well as the employees perceived the family's involvement with the treatment. In this sense, a greater amount of information was needed, which is necessary to understand the research questions.

We also analyzed the institution's medical records and some procedures that could be followed, such as, for example, the reception of families that sought the care of their children at CAPSi. Analytical listening in an institution takes into account from the speeches of the people who make up the institutional group, through medical records and technical documents, even reflecting on the meaning shared by the institution and its users about furniture and walls¹³. The position of the researcher who uses the psychoanalytic method in the institution is not interested in forming alliances or creating oppositions, but starting from a place of not knowing, being prepared at every moment to produce new readings not yet imagined.

Also seeking to understand the listening of the family-group in a psychoanalytical research¹⁴ it was postulated that the analytical listening in this aspect is attentive to the discourses that represent the desires shared by primary psychisms of each one of the family group, however, also does not rule out in their listening share of autonomy of each family member. The analyst who proposes to listen to families in a research that has Psychoanalysis Link as the guiding theoretical current, is attentive to the symptoms shared by the family as a group, sometimes having a subject as spokesperson fulfilling a certain role, sometimes having another family member as a spokesperson. symptom voice¹⁵.

There were also interactions with children and adolescents assisted by CAPSi at various times. Through games and help in daily life, several children and adolescents were accompanied by the institution. The reports known in the research were extremely important, and it is necessary to highlight the diversity of experiences, pointing to the uniqueness of the psychic experience that demands a diversified care from the institution. We also analyzed the institution's medical records and also some procedures that could be followed, such as, for example, welcoming two families who sought care for their children at CAPSi.

Every day, after the observations, field diaries were used, recording the dialogues that remained, memories and affects awakened in the experience. The field diary is an important research tool, in which the researcher rediscovers himself when they deepen in their analysis¹⁶. The description of the analysis took place in a narrative form.

RESULTS

The researched CAPSi institution has an old residential house in a region close to the city center, with 15 observation activities for an average of 6 hours.

The institution's architecture featured several aspects of a residence: kitchen, living room, pool, bedrooms, soccer field and balcony. Each room in the house has its role in the institutional routine. However, in one room its particular function drew more attention.

Such a room that drew so much attention is the porch of the house, where family members sometimes wait for one, two, three or even more hours; they wait for several things there: care with the psychiatrist, care for children that takes place inside the residence/institution, they also wait for the receipt of a document or for conversations with a CAPSi employee.

In conversations with both the team and family members, it was noticed that both refer to the balcony as “*outside*” and the house as “*inside*”. This distinction marks the understanding that there is a separation, from which it can be apprehended that the child and/or adolescent, cared for inside the house, are the users and the family, who await care or the activities that occur at the residence, are companions.

In the process of writing this study, when referring to the balcony, the balcony was named in a flawed act as the “*Balcony of Waits*”. When reflecting on such an appointment, it was possible to perceive the amount of meanings that this flawed act held.

CAPSi operates in shifts; in the morning, the activity routine occurs from 8 am to 10 am and in the afternoon, from 2 pm to 4 pm. At the beginning of the routine, mothers, fathers, uncles and grandparents arrive with the children and adolescents. The little ones go inside the house, while their companions sit on the chairs reserved for them on the balcony. At the end of the routine, children and teenagers leave and, again on the balcony, meet their relatives.

In this day-to-day service, crossed by some conversations with family members, some calls in some room or reports about the routine, a group of family members takes place on the balcony, once a week, usually conducted by the social worker or psychologist of CAPSi, and may also have the participation of professionals from other places, such as educators and nutritionists. This group was accompanied on some occasions. There was always a pre-established theme that guided the conduct of the group, themes such as feeding the child, the best way to educate or “correct” certain behaviors. The speech of the family members was polarized in some participants who complained about the day-to-day, sought to clarify any doubts or were worried about any anguish or complaint.

When accompanied, the employees followed the reception protocols. Such reception was done in a synthetic and directive way, collecting from cards, the main points of the child's or adolescent's history or trying to unfold and better understand the complaint that led him to CAPSi.

Specifically, in an observed reception, it was possible to perceive that the given direction left something to be desired in the sense that important issues were not brought up, that is, prioritizing the protocol, the breadth and depth that the reception demands for the carrying out the *Singular Therapeutic Project*, as well as the anxieties of family members and users were neglected. It was also noticed that the conversations between family members and professionals were carried out most often in a hurry, thus apprehending an attempt to summarize or speed up the meeting with family members.

In several conversations with family members, there was a significant suffering that lasted for generations. The stories converged to an emotional, cultural and financial fragility. The helplessness and violence transmitted by such stories generated in the *observer* the desire to also get rid of such intense and arduous content; in this sense, analyzing that, linked to the tiredness of the service routine, dealing with families can become something that over time becomes preferable to be avoided, taking into account the affections that this can generate in the professional. On some occasions, it was also observed that some family members already

arrived at the institution with more aggressive behavior, shouting or talking harshly. The violence experienced by the family member was sometimes directed at the institution.

The psychological suffering of children and adolescents was something that affected both professionals and family members. Thus, it was apprehended that the persistence or worsening of symptoms distressed both the family and the CAPSi, generating wear and tear in relationships and hopelessness. However, instead of generating empathy or the possibility of walking together, such a situation created a rivalry, placing greater emphasis on distance. Gradually, isolation made treatment difficult, and, in this sense, medication was used to deal with the suffering brought by the child or adolescent, given that this was observed at various times, when the psychiatrist became the only one to attend the CAPSi and, users arrived practically "doped".

In addition, the family's *poverty* and violence, reflected in the various illnesses of children and adolescents, demanded attention and care that the institution was no longer able to maintain. Thus, in order to protect itself from such aspects, a device was created that here was called "*Balcony of Waits*", in which families are gathered in a place that is considered as possible to keep them, that is, where it does not "interfere" in the daily practice of professionals. In that same *balcony*, when there were no professionals around, family members talked about their day-to-day anxieties, about the fears of the fate of their children and grandchildren, about the ways the family adapted the prescribed medication and the scares when the closest pharmacy I didn't have the necessary medication.

DISCUSSION

In writing this work in one of the field diaries, a precious flawed act occurred. When reporting on the balcony of the house where the CAPSi works, it was called "*Balcony of Waits*", with the word "*wait*" in the plural. Reflecting together with the supervisor on such a flawed act, a variety of things were apprehended.

The various waits that took place on the balcony, "*outside*", calls for thinking about different meanings: from the complete paralysis and stagnation of these mothers, fathers and/or grandparents waiting passively for the service to be done inside the house; or, on the other hand, it means "*waits*" in the sense of "*hope*", since the Portuguese words for "wait" and "hope" - *esperar* and *esperança*, respectively - originate from the Latin word *spes*, which means "*to trust something positive*"¹⁷.

Families expect that something that occurs within the institution, improves the situation of the children and grandchildren attended, although these family members do not seem to participate actively in the routine of the institution, they wait outside and, for sometimes alienated, to what is promoted inside the house.

Such separation also reproduces the split present in *psychosis*, and when approaching it, the institution ends up (re)producing it, together with the family. Limiting the family to occupy a pre-established and delimited place in the institution ends up ambiguously establishing and denying the dimension of the family's role/function as a fundamental, responsible and indispensable subject in the lives of children and adolescents, their children, grandchildren and nephews.

Gradually, family and institution seem to contribute to each other so that the distance relationship is maintained. Psychotic functioning, the governing principle between family and institution at different times, contributes to a hermetic functioning, closed to dialogue, trying to distance and immobilize the authors who could move affections that could cause anguish, but could also bring about an improvement in the situations received there.

However, this agreement returns with violence, family members and institutions attack each other, both distant from the demand of children and adolescents, building, instead, another new symptom to be considered in care. A game of forces is established between family and institution and, as discussed, the forces of the State and its institutions stand out from

family norms, modifying and treating them so that they adapt to dominant desires, thus revealing a unidirectionality of forces.

It is possible to evoke negative disguising pacts of representations and affections that try to be denied, but insists on being brought up - and, in this case, these contents were mirrored between family and institution¹⁸. It is alluded to, the attempt to occupy in relation to the child the position of those who have knowledge, or also, of those who know what is best for them.

In relation to the game of forces between family and CAPSi, which can refer, historically, to a time before the Psychiatric Reform, the relationship between State (laws and institutions) and family has been mediated, since the 18th century, by medical knowledge and attended to ideological and political aspects². The State used medical rules for the manipulation of the family group, with a view to controlling citizens through the threat of health and moral "dangers" experienced by families that did not follow the binding rules indicated to them.

In the family ideology, the State undermined functions for each entity, so that these functions helped to control the citizen and manage biopower. The family starts to live proposed guidelines and, to adjust to what medical knowledge, considered as superior, indicated or not to do.

At the CAPSi institution, the so-called game of forces takes effect, and the family accepts the place reserved for them, as seen in the passivity/alienation of the family in the face of institutional strength, such as the long stay on the "Balcony of Waits" and also the silence of some family members. At other times, apparently, the family tries to change the logic of forces by criticizing the service, limiting itself and insisting on monitoring only with the psychiatrist, among other ways. It is questioned, how much such acts have changed such a game of forces, or are adapted to circumstances, being absorbed by the reality experienced by the family and institution.

The understanding of the family path on the part of the CAPSi team, from the recognition of psychological suffering, the maintenance of this to provide answers to their own anxieties, as to the search for care, often falls short of what would be necessary to conduct the care.

The family, when faced with the psychiatric environment, is often terrified by the impression made on the facilities and users³, and so resists accepting that their relative shares the same condition as other users. In the moment immediately after the diagnosis of the mental disorder, using several strategies, the family invests massively in the possibility of the patient's cure, believing that the condition is temporary and that the "right" decision-making will lead to the complete remission of the psychopathological condition.

With the stagnation or dragging of the symptomatic picture, the family group becomes disoriented, feeling guilty for the production of the problem and for the feeling of inability to resolve the situation³. On the other hand, seeking to alleviate the feeling of guilt, the family sometimes looks for a biologicist explanation of the psychiatric disorder, in order to remove its implication in causing the problem.

Thus, the family demands from the health teams more tests, even when the psychiatrist sees no need. The search for the organicity of the symptomatic condition aims to remove the weight of the family drama on the child's diagnosis; then, the diagnosis of an organic problem eases the feeling of family guilt¹⁹.

Dealing with such guilt, as well as possible changes in the family in conceiving the issues that involve their loved ones, permeate the team's performance, promoting the role of family members in the care performance, considering the limits that the family has in relation to the improvement of the suffering individual psychic²⁰.

However, when this is not possible, the biologicist and distanced view of the problem is again used. The attribution of childhood care to medical psychiatry - which produces rapid and overwhelming diagnoses - does not require the family to listen to the relationship with the child and the family significance of the problem²¹. The common and ritualistic measure taken here is that of medicalization.

In other attempts, on the part of the families, to “*normalize*” the symptoms of the mental disorder integrates them to the routine experienced before the outbreak of the psychiatric condition³. Thus, the mobilized efforts are focused on behavioral control, seeking to transform the peculiarities of the condition of the psychotic subject into behaviors that do not differ from what is considered *normal*. Medical explanations are meant by the family to alleviate the problem, producing, themselves, meanings and explanations that do not greatly affect the family.

There is a responsibility of the mental health professional not to repeat the social exclusion practiced around “*madness*”²². The mental health team should not act in order to educate or discipline those who seek the service, but it is also not a matter of acting with permissiveness, action should promote the responsibility of both parties, user and institution²².

The family should not be positioned as a mere victim in its relationship with psychosis and with its social circle; such a perspective does not consider the complexity and depth of the issue, while creating a Manichean and also unproductive relationship. Caring only for the inclusion of the family in the treatment, without making it responsible for its production, does not guarantee a change in the subjective position of the family.

CONCLUSION

Since it is a work in a single institution, the scope of its findings in different cultural regions of the country has probably been limited, considering the Brazilian cultural wealth. In this sense, it is necessary studies that establish an articulation of different realities that can be found in the national scenario. The short term that remained in the institution can also be a limiting aspect of the present study.

However, from what could be analyzed, the new health devices are still beginning in their guidelines and are crossing a new political and therapeutic field, which must be constantly addressed to release the hardships of asylums. For this, it is necessary to ask about the real participation of the family and the user in the institutional management and if their uniqueness is respected by the decisions taken, talking about a constant reform.

Working with families who take their children and adolescents to the institution is difficult work, given the violence and the illness of such bonds. However, as it was proposed by the therapeutic changes resulting from the Psychiatric Reform, it is necessary to give the subject a voice so that he perceives his condition and is the *master* of his change. Treating it passively, with medicines and unidirectional care, or reserving them a *Balcony*, consists of the institutionalization of psychological suffering.

The family is an important protagonist to be considered in current therapeutic and political processes, with an unprecedented proximity to the relationship between Mental Health devices and family. Theories and studies that change this way of seeing the family are still recent, making it necessary to reflect and question the variables established in this situation.

Based on the *Psychoanalysis Vincular*, it is essential to accept the bonds built by the families, considering that their alliances act in the affective destinies, as well as try to remain impervious to the proposed changes.

Conceiving the position of families in Mental Health services is an embryonic question to be adjusted among the knowledge active in the post-reform devices. However, due to the findings of this work, the need to help families to go through their fantasies and ghosts and to deal with the burden of daily care is highlighted.

REFERENCES

1. Rizzini I, Leite ADS, Menezes CD. Cuidado familiar e saúde mental: a atenção das famílias a seus filhos na infância e na adolescência. Rio de Janeiro: Editora PUC; 2013.
2. Donzelot J. A polícia das famílias. Rio de Janeiro: Edições Graal; 1980.
3. Rosa LCS. A família como cuidadora. In: Rosa LCS. Transtorno mental e o cuidado na família. São Paulo: Cortez; 2011. p. 54-76.3.
4. Amarante P, Nunes MO. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. Ciên Saúde Colet. [Internet]. 2018 [cited in 26 Oct 2019]; 23(6):2067-74. DOI: <https://doi.org/10.1590/1413-81232018236.07082018>
5. Arbex D. A luta entre o velho e o novo. In: Arbex D. Holocausto brasileiro: vida, genocídio e 60 mil mortes no maior hospício do Brasil. São Paulo: Geração Editorial; 2013. p. 200-12.
6. Borges CF, Baptista TWF. O modelo assistencial em saúde mental no Brasil: a trajetória da construção política de 1990 a 2004. Cad Saúde Pública [Internet]. 2008 [cited in 26 Oct 2019]; 24(2):456-68. Available from: <http://www.scielo.org/pdf/csp/v24n2/24.pdf>
7. Santos GLG. Sobre discursos e práticas: a reabilitação psicossocial pelo “olhar” dos técnicos de referência de um CAPS da região metropolitana de Recife [Internet]. [dissertação]. Recife: Universidade Federal de Pernambuco; 2008 [cited in 26 Oct 2019]. 146p. Available from: https://repositorio.ufpe.br/bitstream/123456789/8261/1/arquivo3599_1.pdf
8. Rosa LCS, Silva EKB. Família na política brasileira de saúde mental, álcool e drogas. Ser Social [Internet]. 2019 [cited in 26 Oct 2019]; 21(44):199-222. DOI: https://doi.org/10.26512/ser_social.v21i44.23491
9. Schrank G, Olshowsky A. O Centro de Atenção Psicossocial e as estratégias para inserção da família. Rev Esc Enf USP [Internet]. 2018 [cited in 26 Oct 2019]; 42(1):127-34. Available from: <https://www.scielo.br/pdf/reeusp/v42n1/17.pdf>
10. Maciel SC, Barros DR, Silva AO, Camino L. Reforma psiquiátrica e inclusão social: um estudo com familiares de doentes mentais. Psicol Ciênc Prof. [Internet]. 2009 [cited in 26 out 2019]; 29(3):436-47. Available from: <http://www.scielo.br/pdf/pcp/v29n3/v29n3a02.pdf>
11. Herrmann F. O método da psicanálise. In: Herrmann F. Introdução a teoria dos campos. São Paulo: Casa do Psicólogo; 2004. p. 38-49.
12. Elia L. A transferência em psicanálise: lugar ou excesso? Psicol Reflex Crit. [Internet]. 1999 [cited in 26 Oct 2019]; 12(3):775-88. Available from: <http://www.redalyc.org/articulo.oa?id=18812315>
13. Neves AS. O psicólogo e o paciente-instituição: considerações teóricas acerca da intervenção. Psicol Ciênc Prof. [Internet]. 1999 [cited in 27 out 2019]; 19(2):44-9. Available from: http://www.scielo.br/scielo.php?pid=S1414-98931999000200006&script=sci_arttext
14. Gomes IC, Levy L. Psicanálise de família e casal: principais referenciais teóricos e perspectivas brasileiras. Aletheia [Internet]. 2009 [cited in 26 Oct 2019]; 29:151-60. Available from: <http://pepsic.bvsalud.org/pdf/aletheia/n29/n29a13.pdf>
15. Kaës R. O grupo como situação psicanalítica. In: Kaës R. Um singular plural: a psicanálise à prova do grupo. São Paulo: Loyola; 2010. p. 63-76.
16. Leal J. Diários de campo: modos de fazer, modos de usar. In: Almeida SVD, Cachado RA, organizadores. Os arquivos dos antropólogos. Lisboa: Palavrão; 2016. p. 143-54.
17. Rezende AM, Bianchet SB. Dicionário do latim essencial. Rio de Janeiro: Autêntica; 2014.
18. Kaës R. A negatividade: problemática geral. Psicol USP [Internet]. 2003 [cited in 27 Oct 2019]; 14(1):21-36. Available from: <http://www.revistas.usp.br/psicosp/article/view/42389/46060>
19. Mannoni M. A contratransferência. In: Mannoni M. A criança retardada e a mãe. 5ed. São Paulo: Martins Fontes; 1999. p. 31-6
20. Santos SS. Influência familiar no tratamento terapêutico de paciente portador de transtorno mental [Internet]. [monografia]. Florianópolis: Universidade Federal de Santa Catarina; 2016

- [cited in 27 Oct 2019]. Available from: <https://repositorio.ufsc.br/xmlui/handle/123456789/168583>
21. Kamers M. Da criança a matar à morte da criança: reflexões psicanalíticas sobre a medicalização na infância [Internet]. [tese]. São Paulo: Universidade de São Paulo; 2018 [cited in 27 Oct 2019]. Available from: https://teses.usp.br/teses/disponiveis/47/47131/tde-14112018-160943/publico/kamers_do.pdf
22. Elia L. Responsabilidade do sujeito e responsabilidade do cuidado no campo da saúde mental. Rev Cient Saúde [Internet]. 2016 [cited in 27 Oct 2019]; 3(4):[5p]. Available from: <https://smsrio.org/revista/index.php/revsa/article/viewFile/92/114>

CONTRIBUTIONS

João Camilo de Souza Junior collaborated in the conception, data collection and analysis, and writing. **Anamaria Silva Neves** contributed to data analysis, writing and revision.

How to cite this article (Vancouver)

Souza Junior JC, Neves AS. “Varanda de espera”: new positions of the family in the devices of the Psychiatric Reform. REFACS [Internet]. 2020 [cited in *insert day, month and year of access*]; 8(Suppl. 2):801-810. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)

SOUZA JUNIOR, J. C.; NEVES, A. S. “Varanda de espera”: new positions of the family in the devices of the Psychiatric Reform. REFACS, Uberaba, MG, v. 8, p. 801-810, 2020. Suppl. 2. Available from: *insert access link*. Access in: *insert day, month and year of access*. DOI: *insert DOI link*.

How to cite this article (APA)

Souza J.C. Jr., & Neves, A.S. (2020). “Varanda de espera”: new positions of the family in the devices of the Psychiatric Reform. REFACS, 8(Suppl. 2), 801-810. Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.