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Psychology of Health

Building Bonds in Mental Health Care within Primary Health Care

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Abstract: Building bonds is a strategic relational technology for mental health care in Primary Health Care, which remains a challenge when dealing with severe psychological distress patients. We analyzed how bonds are and how they are formed between users with severe mental suffering, their families, and Family Health Teams in Belo Horizonte, Minas Gerais. Through qualitative research, thirteen open interviews with Primary Health Care workers, users with severe psychological distress, and their families were conducted and analyzed inductively by dialectical hermeneutic method. We identified some elements that permeate these bonds, such as precarious resources in the health network, the preponderance of the use of psychotropic drugs, the primacy of biomedical logic, and the stigma related to madness. Strengthening bonds between patients, their family members, and Primary Health Care workers can advance Psychiatric Reform. As a limitation of this research, there is a need to expand dialogue with patients and family members on this topic.

Keywords: primary health care, expanded clinic approach, family health strategy, mental health services

Produção de Vínculos no Cuidado em Saúde Mental na Atenção Primária

Resumo: A produção de vínculo, tecnologia relacional estratégica para o cuidado em saúde mental na Atenção Primária, permanece um desafio em se tratando de usuários com sofrimento psíquico grave. Objetivamos analisar como são e como se produzem vínculos entre esses usuários, familiares e equipes de Saúde da Família no município de Belo Horizonte, Minas Gerais. Em pesquisa qualitativa, realizamos treze entrevistas abertas com trabalhadores da Atenção Primária, usuários com sofrimento psíquico grave e familiares, que foram analisadas indutivamente pelo método hermenêutico dialético. Foram identificados elementos que atravessam a produção desses vínculos, como recursos precários da rede de saúde, a preponderância do uso de psicofármacos, a primazia da lógica biomédica e o estigma relacionado à loucura. O fortalecimento de vínculos entre usuários, familiares e trabalhadores potencializa a Atenção Primária para o avanço da Reforma Psiquiátrica. Como limite da pesquisa, há necessidade de ampliar o diálogo com usuários e familiares sobre a temática.

Palavras-chave: atenção primária à saúde, clínica ampliada, estratégia de saúde da família, serviços de saúde mental

Producción de Vínculos en la Atención de Salud Mental en Atención Primaria

Resumen: La producción de vínculos, tecnología relacional estratégica para la atención de salud mental en Atención Primaria, és un desafío para los pacientes con enfermedades mentales graves. Analizamos cómo son y cómo se producen los vínculos entre usuarios con sufrimiento mental severo, sus familias y los equipos de Salud de la Familia en Belo Horizonte, Minas Gerais. En una investigación cualitativa, se realizaron trece entrevistas abiertas a trabajadores de Atención Primaria, usuarios con sufrimiento mental severo y sus familiares, analizadas mediante el método hermenéutico dialéctico. Se identificaron elementos que permean la producción de estos enlaces: la precariedad de los recursos en la red de salud, la preponderancia del uso de psicofármacos, la primacía de la lógica biomédica y el estigma con la locura. Fortalecer los vínculos entre pacientes, familiares y personal permite a Atención Primaria impulsar la Reforma Psiquiátrica. Como limitación, es necesario ampliar el diálogo con pacientes y familiares.

Palabras clave: atención primaria de salud, clínica ampliada, estrategia de salud familiar, servicios de salud mental

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Primary Health Care and the Rede de Atenção Psicossocial (RAPS) [Psychosocial Care Network] are strategies historically developed by the brazilian Sistema Único de Saúde (SUS) [Unified Health System] to provide comprehensive care in a free and accessible manner. The Family Health Strategy enables care for users with psychological distress in Primary Health Care to be provided in the same territory where they live, without disrupting their social ties and with the construction of new ways of life daily (Souza et al., 2019).

In Primary Health Care, there is a quest to decentralize the doctor-patient relationship into a user-team relationship, aiming to promote bonding, a relational technology essential for effective healthcare according to the National Primary Health Care Policy (Ministry of Health, 2017). This bond is mediated by the health network (Ministry of Health, 2010) and is based, on the part of the team, on a commitment to the health of those who demand it and, on the part of the user, on the trust placed in the team as those who can contribute to the defense of their health (Campos, 1999). This process depends on a multiprofessional practice, which typically involves a prior training path that is predominantly uniprofessional, making it necessary for teams to develop new perspectives in care practices (Giacomini & Rizzotto, 2022).

Belo Horizonte, a city with a population of 2,315,560, where this research was conducted, has a robust RAPS, in line with the guidelines of the Ministry of Health (MH). It consists of 8 Centros de Referência em Saúde Mental (CERSAM) [Mental Health Reference Centers] – the name given to the city's Psychosocial Care Centers, 5 CERSAM for Alcohol and Other Drugs (CERSAM-AD), 3 CERSAM for child and adolescent (CERSAMI), 9 Community Centers, and 33 Residential Therapeutic Services. Its Primary Health Care has 153 Health Centers, each with at least one mental health professional who holds monthly Matrix Support meetings with the Equipe de Saúde da Família (eSF) [Family Health Team], with occasional attendance by CERSAM professionals. These teams cover 88.8% of the population and work with medium, high, and very high-risk groups. Low-risk users are served by professionals such as general practitioners, pediatricians, and gynecologists, who complement the work of the eSF in the Health Centers.

Despite the power of these links in providing mental health care within Primary Health Care, there are difficulties in establishing them. A significant obstacle is the maintenance of a health logic based on specialties, which focuses on the disease rather than the individual experiencing it and, in the case of mental health, assigns psychiatrists and psychologists the responsibility for caring for users with psychological distress (Amarante, 2024). In this case, the logic of referring these users to other mental health care facilities prevails, which fosters a dichotomous view between health and mental health, fragmenting individuals and violating the principle of comprehensiveness (Cardoso et al., 2022). Added to this logic is the stigma (Goffman, 2021) assigned to people with mental suffering, based on which these subjects are labeled as "dangerous" and "unpredictable," which can be reproduced by health professionals (Moro & Rocha, 2022; Nascimento & Leão, 2019).

Considering the importance of strengthening Primary Health Care as a strategic locus of RAPS and the central nature of bond formation at this level of care, this study aims to analyze how bonds are formed between patients with severe psychological distress, their families, and Family Health Teams in the city of Belo Horizonte, Minas Gerais, with an emphasis on the elements that influence their formation.

Method

This study is characterized as exploratory qualitative social research in health (Minayo, 2014).

Participants

The research was conducted in Belo Horizonte, Minas Gerais, which has 9 regional health departments, comprising 153 Health Centers with a total of 597 eSF, as well as Expanded Family Health Centers and Mental Health Teams (Belo Horizonte City Hall, 2024). For these Mental Health Teams, which provide matrix support to the eSF, there is usually one psychologist for each Health Center, who may be accompanied by a psychiatrist, a professional who supports more than one Health Center.

Participants in this study included workers from the municipality's eSF, users with severe psychological distress treated by these teams, and family members of users linked to any of the regional directorates in Belo Horizonte, as indicated by key informants. Professionals from different categories within the eSF were included, with preference given to those with longer periods of service in the network. 8 workers from 3 different regional health directorates were interviewed, with work experience in Primary Health Care ranging from 5 to 26 years, including 2 Agentes Comunitários de Saúde (ACS) [Community Health Workers], 2 doctors, 2 nursing technicians, and 2 nurses. Regarding users, those recognized by workers as people with severe psychological distress, aged over 18, with a history of care at other RAPS locations but who, at the time of the interview, had Primary Health Care as their main reference for mental health care were included. As an exclusion criterion, users could not be experiencing exacerbated productive symptoms. 3 users from 2 different regional offices were interviewed. To select the family members interviewed—who were not necessarily related to the users interviewed—we sought individuals who were the most important support figure for a user with severe psychological distress, for whom Primary Health Care was the main reference for mental health care. 2 interviews were conducted with family members from different regional offices.

Instruments

Open interview. It allows for a detailed description of the beliefs, values, and motivations related to the actions

of subjects in a given space of interaction (Gaskell, 2015) and is suitable for exploratory research. The trigger question for workers was: "Would it be interesting for you to talk about challenging situations, but also situations considered positive that can illustrate bond formation in the daily care of users with severe psychological distress and their families in Primary Health Care?". For users and family members, it was: "It would be interesting if you could tell us about what it was like when (at this point there was an addition, in the case of family members: "your family member") started receiving care from this Health Center and the situations, both positive and negative, that tell us a little about your relationship with these workers".

Procedures

Data collection. In total, 13 individual open interviews were conducted, 12 in person and 1 remotely via Google Meet. It was decided to conduct the interviews with users and family members after those with workers, considering the possibility that the latter could become key informants for referring users and family members. However, the participating workers, and even the key informants who recommended them, had difficulty referring users and family members, which partly explained their lower number compared to workers. The conduct of the research was also affected by the pandemic, which prevented extending attempts to recruit key informants. The interviews lasted an average of 1 hour, with the shortest lasting 42 minutes and the longest 1 hour and 43 minutes. They consisted of an initial rapport followed by the trigger question.

Data analysis. The analysis was inductive in nature and was inspired by the dialectical hermeneutic method proposed by Minayo (2014), in 3 stages: (1) Data ordering; (2) Data classification; (3) Final analysis. In the first stage, the audio recordings of the interviews were transcribed in full, followed by organization and exhaustive reading of the material. In the second stage, descriptions were produced for each of the participant segments in the study based on their perspectives, and then specific categories were developed based on the identification of points relevant to the analysis of bond formation, grouping different pieces of information that were similar in theme. This process involved triangulation among researchers in the group. In the last stage, we established links between the data and the theoretical references, identifying complementarities and differences.

Ethical considerations

The research complied with all ethical procedures recommended by resolutions 466/12, 510/16, and 580/18 of the National Health Council, and all current legislation in our country. The research was approved by the Research Ethics Committee of the Universidade Federal de Minas Gerais, CAAE 52763321.0.0000.5149, and by the Research Ethics Committee of the Municipal Health Secretariat - MHS/Belo Horizonte, CAAE 52763321.0.3001.5140.

Results

The results will be presented in two distinct movements: description and categorization. In the first movement, descriptions of the subjects involved in the bond formation will be presented from the perspective of the users, family members, and workers interviewed. These descriptions seek to map the roles assigned and adjudicated in bond formation, as suggested by Pichon-Rivière (1982/2007). In the second movement, the elements that stood out in the interviews as those that can traverse the bond formation process will be categorized.

Subjects in bond formation

Users. The subjects suffering from severe psychological distress who attend Primary Health Care were identified by workers as users who may require more time and attention than others, and it is common for them to visit the Health Center daily. One of the users indicated that waiting is somewhat difficult, considering that "everything is too much for us". This same user, however, recognizes that there is an "order" in the reception and that it would be a mistake to want to change it. Another user explains that after understanding this flow at the Health Center, he was no longer nervous and even offered to explain to other "stressed" users what he had learned on his own, since the managers do not have the time available to provide explanations.

One worker shared that a user in her micro-area goes to the Health Center almost every day to talk about his problems, such as marital separation and difficulties with his children. According to her, the patient needs to talk, and the place he finds, as the closest point of access, is the Health Center, with one consultation per month not being sufficient.

On the other hand, other workers point out that there are users with severe psychological distress who come to the Health Center only for appointments to renew prescriptions for psychotropic drugs, appointments with the psychologist, and more specific health care appointments. In these cases, the user's absence from appointments is a warning sign that they may be in crisis, which is usually responded to with an active search carried out by the ACS.

Family members. Generally, participants viewed families as essential to caring for individuals with psychological distress. Both professionals and family members acknowledge that caring for and living with someone experiencing severe psychological distress is difficult and demands emotional availability and time. It is also common for families to be perceived as unwell themselves, which the eSF should consider. One family member interviewed emphasized the importance of eSF support for families, believing that workers help them develop ways to care for their loved ones and understand that certain behaviors are caused by mental illness, not the person's whims.

Although the eSF creates strategies to support families caring for users with severe psychological distress, this is not always possible. According to one of the workers, some

family members take on excessive responsibility for care and are reluctant to accept the participation of other actors, rejecting offers of care from the eSF. On the other hand, some families do not participate in care. Some users interviewed say that their family members do not recognize mental suffering as an illness and therefore do not go to the Health Center in situations where the user is in crisis and unable to seek this service themselves, nor do they go to the Health Center when called by the eSF. Finally, situations were described in which families refuse the strategies proposed by the eSF, not participating in caring for the user and hindering attempts to assist, such as using the user's social benefits for purposes other than their treatment, disagreeing with the community-based care model, and refusing proposals that do not involve hospitalization.

Teams/workers. In interviews, users and family members described the workers on their referral teams as people who go "beyond the professional", referring to the respect, affection, and genuine concern shown by these workers. As a result, they believe that a kind of intimacy is created, leading the workers to be perceived "as if they were part of the family".

This familiarity, mentioned by users and family members, takes on different nuances when it comes to ACS professionals. For them, since these workers live in the community and are frequently present in their homes, the sense of familiarity is even stronger. In the workers' accounts, this group is also distinguished in daily professional practice, which does not take place only within the Health Center.

One of the workers interviewed emphasizes that his team is not doctor-centered, but at the same time, it was common in the reports to indicate that when a team is without a doctor, the resolution rate decreases significantly, which overloads and stresses the other workers on the team.

It is possible to observe negotiations between professionals and management to deal with everyday care issues related to the challenges of caring for users with severe psychological distress. One of the reports shared by a worker illustrates how the team negotiated the conditions for continuing to monitor a user. In this situation, the user went to the Health Center manager to complain that the doctor was prescribing medications to kill her. The manager, based on the relationship of trust demonstrated by the user, accepted the complaint and became more involved in the care process. For example, the user had shared consultations between the doctor and the manager, who was trained as a nurse. For the aforementioned professional, their knowledge overlaps, resulting in a partnership for building and managing the case.

Elements that may impact bond formation

Precarious working conditions and resources in the Health Care Network. Many challenges arise in the daily routine of health services. In the interviews, work overload, high professional turnover—especially among physicians—and limited resources such as cars, physical space, and low pay were pointed out as issues that undermine the capacity of eSF to form bonds.

One worker reported a situation in which he requested transportation to make a home visit to a user to administer intramuscular Haldol, as she did not accept the medication orally. The family had been going to the Health Center to request this support for four days, and the car had not yet been made available, resulting in a lack of care for the user. For the interviewee, this type of situation "breaks" the bond between the team and the family, even if the worker explains that he is trying his best. According to him: "It's like this: the family is trying to get help, you are trying to help, but you still need one more step, one more ladder, more people to help you. That's difficult!".

Nevertheless, in interviews with users and family members, it became clear that if they recognize that limitations in care are imposed despite and independently of the willingness/disposition of workers, as in the case above, these shortcomings do not necessarily break the bonds formed with the teams.

The prevalence of psychotropic drugs. For participants, mental health treatment is still largely or exclusively linked to psychotropic drugs. A common perception was noted among some workers, revealing the central role attributed to psychotropic drugs in care, based on the overvaluation of a certain "normalizing" effect they produce. In this sense, they appear to be one of the main responses in crisis management. Thus, users who take their medication as prescribed, at the correct frequency and dose, manage to "appear normal" most of the time, which contributes to bond formation. For one worker interviewed, the bond with the family breaks down when the family does not comply with what has been determined by the team regarding the administration of psychotropic drugs.

Following this logic, Primary Health Care was not recognized as an appropriate place for crisis management, as this was considered a psychiatric emergency. For one family member interviewed, mechanical and/or drug restraint would be the appropriate response, which the Health Center cannot offer, leading to resistance in taking their children to the service for other health demands, not trusting that eSF workers will be able to intervene in case of crisis.

Meanwhile, the relational strategy was highlighted in many cases as effective for crisis management, an intervention made possible by the bonds previously established between workers and users. In one user's account, the "shaking crisis" was treated with coffee, as the worker already knew her and knew that she liked this drink.

Primary Health Care has also been recognized as the place where longitudinal monitoring, including the effects produced by psychotropic drugs, influences the evaluation and renegotiation of therapies used in mental health care. Therefore, it is important to remember that even the preponderance of the use of psychotropic drugs for the care of users suffering from psychological distress in Primary Health Care is only sustained in a manner mediated by the bond between users and workers.

The primacy of biomedical logic. The biomedical logic in Primary Health Care appeared in several situations described in the interviews, mainly with the central role of

the doctor and the value of specialization in mental health care. This logic was shared by both workers and users. The prestige that users give to medical professionals seems to help build trust in the relationship, even though it does not guarantee it.

Regarding users with severe psychological distress, knowledge about the territory and daily lives of users is particularly valuable for care. In this sense, and in contrast to biomedical logic, the ACS professional, due to her hybrid position—as both a health worker and a user who lives in the area—is the one who is closest to the reality of the territory. For this reason, in the workers' statements, the ACS appears as an agent of the bond between the team and the community.

In BH's Primary Health Care, due to the way the service is organized in the municipality, the mental health matrix support team assists the eSF in monitoring users with severe psychological distress. In the interviews, however, some users and family members still associate these specialists with what qualifies or would qualify mental health care within Primary Health Care. Interviews with workers also indicated that the understanding of care for users with severe psychological distress as the responsibility of the eSF, in addition to the Mental Health Teams, still needs to advance.

Despite the influence of biomedical logic in the composition of relationships, one of the workers pointed to a more dialectical possibility for the relationship with mental health specialists in Primary Health Care, which moves toward shared responsibility for the care of users with severe psychological distress: "So, we learn from the case, bring it up, discuss it again, and with that we actually grow with the case".

The stigma of madness. In interviews with users and family members, the generalist nature of the Health Center appeared as a point that was sometimes considered inadequate for the care of users with severe psychological distress, and sometimes recognized as a feature that brings advantages to the care of these users. In the case of one family member interviewed, for example, the fact that the Health Center has children makes her avoid taking her children with severe psychological distress there. For her, CERSAM is considered a safer environment for her children than the Health Center. For an interviewee from another family, however, the experience of accompanying his brother to the Health Center has been considered better than that experienced at CERSAM.

One of the users, when describing his preference for Primary Health Care, curiously reproduces the stigma of dangerousness and unpredictability attributed to madness, with which he usually lives more at CERSAM, where he has already been assaulted. He understands that this results from the condition of people with varying degrees of "compromise" being "loose." In this sense, he identifies CERSAM as a dangerous place, in contrast to the Health Center, where he believes there would be no risk of encountering "people on drugs" or wearing "electronic ankle bracelets", which is not confirmed in the daily routine of the services.

It is interesting how the Primary Health Care environment seems to allow users themselves to feel distant from these negative attributes related to madness. In the interviews, it becomes clear that, even with advances, there is still a reproduction of stigmas inherent to the asylum logic by users, family members, and eSF, which can serve both to favor bond formation with the eSF and the opposite.

Discussion

Primary Health Care can be powerful in building bonds, with its model of reference teams, longitudinal care, proximity to the territory, and the fact that it is an open-door service (Ministry of Health, 2017; Souza et al., 2019). However, the results pointed to some challenges, such as those related to working conditions and resources in the Health Care Network, in line with the literature on bonds in Primary Health Care (Baratieri et al., 2012; Cunha et al., 2017).

The limitations imposed by working conditions reduce the possibilities for Primary Health Care to resolve issues, which is an important point for the population to trust this level of care as being capable of responding to their health needs (Ministry of Health, 2017). At the same time, when the team, users, and family members devise coping strategies, there is a tendency to strengthen the bond between them. This analysis is in line with the National Humanization Policy, which believes that just as problems can arise, they can also be analyzed and addressed, enabling shared care agreements, which favor bond formation capable of producing increasing degrees of autonomy and co-responsibility (Ministry of Health, 2010).

Thus, situations involving resource constraints are both powerful and challenging for building bonds. Challenging because they reveal a lack, and powerful because they bring together and create elements of identification between the user and the worker, both of whom may be neglected by the government. Therefore, when we deal with bond formation between users with severe mental illness, their families, and eSF, the way in which deficiencies are handled daily seems to have an effect, as do the deficiencies themselves.

Another aspect that permeates bond formation in Primary Health Care between users with severe psychological distress and workers is the primacy of biomedical logic, evidenced, for example, in the overvaluation of medical professionals, whose word is often taken as truth. According to Pichon-Rivière (1982/2007), the professional categories of workers can differentiate the conditions for building bonds with users, due to the different roles and prestige attributed to them. While this perspective may favor bond formation between users and physicians, it also weakens the process of user autonomy, which could be strengthened with patient-centered care through shared and supported decision-making strategies (Hormazábal-Salgado et al., 2024). In other words, in addition to identifying what contributes or does not contribute to building bonds, it is important to assess the type of bond in question, whether it produces relationships based on subordination or empowerment, despite recent research in Primary Health Care in Belo Horizonte having observed an association between bonds and elements of autonomy on the part of workers (Franco & Penido, 2025).

In the case of physicians, it should be added that their exclusive role in prescribing medications adds importance to their place in the team and for users. Garcia et al. (2020) also identified the superiority of medical knowledge and drug therapy over other types of knowledge and services. The authors emphasize that the provision of medication and consultations can also be considered a potential strength of Primary Health Care, provided that they are not the only and main resources. In the specific context of our study, we observed that the medication, due to its "normalizing" effect, also seems to fulfill the function of preventing Primary Health Care professionals from having to deal with manifestations of the user's psychological distress, which they are not prepared to face.

Furthermore, regarding the relationship between users and workers, we recognize ACS as a strategic professional category for the advancement of Psychiatric Reform, considering their proximity to the community and their creative capacity to promote care and co-responsibility in mental health issues, with "the bond created between the ACS and the user indicated as an adjunct to this process" (Soares et al., 2021, p. 11771). At the same time, we consider that the idea circulating among the professionals interviewed that "the ACS is our link" is problematic, because building bonds with users is the responsibility of all team members and must be done daily. If, based on the hybrid position of ACS, it is assumed that the bond between the user and the team is already established, this may have the effect of transferring responsibility for building this bond solely to this professional.

Therefore, it would not be interesting if the bond in Primary Health Care were only between users and physicians – because they occupy a prestigious social position and are the ones who prescribe psychotropic drugs – or between users and ACS – because they are identified as belonging more to the territory or being more "familiar." The power of Primary Health Care lies in the possibility of the co-creation of plural bonds. In this sense, it is worth questioning another incidence of biomedical logic: the assignment of care for users with severe psychological distress to specialist professionals, such as psychologists or psychiatrists. The assumptions of Psychiatric Reform bet that breaking the logic of specialists makes it possible to build collective care (Amarante, 2024), which in turn favors the intended deinstitutionalization. It is important to emphasize that confronting the logic of specialists does not mean excluding specialists from direct care for users with severe psychological distress, when necessary, nor does it mean banning specialized mental health centers, such as CERSAM in Belo Horizonte, when necessary. First and foremost, it means a distancing from the institutionalized view that psychological suffering can only be treated by specialists or in specialized services. None of these considerations, however, disregards the fact that the eSF is the coordinator of care and must therefore assume its role in this context.

In this context, Matrix Support appears as a lightweight technology that contributes to the expansion and sharing of clinical practice among different professional categories, through its care dimension and, above all, its technical-pedagogical dimension, as well as to the joint construction of Singular Therapeutic Projects in more complex cases (Campos, 1999; Ministry of Health, 2017; Santos et al., 2021). Although there are challenges to its implementation in the field of mental health, as it is based on principles that run counter to the fragmented logic of thinking about health (Costa et al., 2023), the bet is that strengthening the support function can contribute to advancing accountability for the care of users with severe psychological distress in Primary Health Care and, consequently, to building these bonds. In the same sense, the logic inherent in Matrix Support can help break with fragmented biomedical practices by encouraging integrated care (Treichel et al., 2021). As summarized by Queiroz et al. (2021), implementing other modes of action in healthcare guided by relational technologies and expanded and shared clinical practice strengthens interpersonal bonds and reorganizes the provision of comprehensive care based on co-responsibility in Primary Health Care.

Another point to be discussed refers to the stigma of madness. In our study, we agree with Goffman's (2021) perspective that the attribution of normal and stigmatized depends on the social situation in question. In the interviews, it is clear that, even with advances, there is still a reproduction of the asylum logic by users, family members, and eSF. For example, this perspective, permeated by the stigma of madness, can serve as a justification for users to link themselves to the Health Center – because they consider specialized services to be dangerous, for example – or to CERSAM – because they consider the user to be dangerous for non-specialized services. Due to these and other misconceptions and stigmatizing views about people suffering from psychological distress (Moro & Rocha, 2022), the Psychiatric Reform project calls for a transformation of society's perception of madness, so that it is possible to "weave a network of solidarity capable of breaking down resistance to the inclusion of madness in the urban space" (Honorato et al., 2022, p. 2) and also non-specialized services, such as the Health Center.

It is important to mention that, from a public policy perspective, addressing the challenge of integrating madness into the urban space transcends the health sector and requires incentives for intersectoral actions. In Belo Horizonte, in the so-called Regional Intersectoral Centers, which aim to discuss serious cases of rights violations and coordinate care between different public policies, cases of people suffering from psychological distress are frequently discussed.

The stigma of madness can also affect the relationships between family members and users. It has been noted that the way families care for (or do not care for) their relatives who are users can be categorized into four groups. In two of these groups, some families do not participate in the care of the user. In such cases, the reasons might be a lack of understanding of psychological distress as an illness or a history of difficulties living with the user. These families may choose not to interfere in the care provided by the team or may oppose it by boycotting those who do not refer the user for hospitalization. On the other hand, some families actively

participate in the care of users and seek support from the team, whether there is an opportunity for involvement or not. In these situations, it is important to offer resources to family members, such as flexible visiting hours at health facilities, suggestions for participation in health promotion groups, and encouragement for family members to focus on their own physical and mental health.

So far, we have presented and discussed some aspects of the subjects involved in building bonds in mental health care within Primary Health Care, as well as problematized elements that may affect bond formation between these subjects. These results may contribute to the development of strategies that strengthen bonds between users suffering from severe psychological distress, family members, and workers, ultimately promoting the potential of Primary Health Care for the continuous advancement of Brazilian Psychiatric Reform. Furthermore, it can contribute to the conceptualization of bonds, a concept that is difficult to characterize, although often evoked in the field of public health, as already evidenced in a literature review by Barbosa and Bosi (2017).

Among this study's limitations is the absence of debate about ethnic-racial relations in building bonds in mental health care within Primary Health Care. David et al. (2024) denounce the distance between Brazilian Psychiatric Reform discussions and practices and anti-racist epistemologies, pointing out the inseparability between the anti-asylum struggle and the struggle to confront racism. Gonzaga (2022) argues that it is essential to consider structural systems of oppression such as race, class, and gender in public health policies, "using intersectionality as a theoretical and methodological tool" (p. 4). Thus, future research may analyze how such social markers (to which we add the level of education) of the difference between workers/teams and users may be one of the factors that impact bond formation. It is also considered that other studies may broaden the dialogue with users and family members, a limitation of this study previously mentioned in the section on data collection.

Finally, it is suggested that future studies examine the potential of Matrix Support for building bonds within Primary Health Care, given that the "support function" can foster collaborative practices and shared responsibility in mental health care, in contrast to dichotomous and fragmented perspectives inspired by the primacy of the biomedical logic.

Data Availability

The study dataset is not publicly available, as it contains information about services and processes that allow the identification of respondents, as well as the locations where the participants were located.

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