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UFSM
Rev. Enferm. UFSM - REUFSM
Santa Maria, RS, v. 11, e14, p. 1-20, 2021
DOI: 10.5902/2179769243181
ISSN 2179-7692

Original Article Submission: 03/28/2020 Acceptance: 09/03/2020 Publication: 02/12/2021

Mental health care notions and practices from the perspective of peasant women

Noções e práticas de cuidado em saúde mental na perspectiva de mulheres camponesas

Nociones y prácticas de atención a la salud mental desde la perspectiva de mujeres campesinas

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Abstract: Objective: to know the mental health care notions and practices from the perspective of peasant women. **Method:** exploratory-descriptive study, with a qualitative approach. The study had the participation of 18 peasant women. Data were produced through a semi-structured interview, from March to April 2017, and subjected to thematic analysis. **Results:** the mental health notions are still influenced by the religiosity and the conception of madness of the classical age. Socialization, participation in groups, leisure and religiosity stood out as care practices. Conflicting family relationships, idleness, nervousness, suffering, stress, work overload and economic difficulties were factors producing mental illness. **Conclusion:** the mental health care of the peasants should be considered by public policies, thus requiring actions from health professionals in order to promote this care.
Descriptors: Women's Health; Mental Health; Rural Health; Primary Health Care; Nursing

Resumo: Objetivo: conhecer as noções e práticas de cuidado em saúde mental na perspectiva de mulheres camponesas. **Método:** estudo exploratório-descritivo, de abordagem qualitativa. Participaram do estudo 18 camponesas. Os dados foram produzidos mediante entrevista semiestruturada, no período de março a abril de 2017, e submetidos à análise temática. **Resultados:** as noções de saúde mental ainda são influenciadas pela religiosidade e concepção de loucura da idade clássica. A socialização, a participação em grupos, o lazer e a religiosidade destacaram-se como práticas de cuidado. Relações familiares conflituosas, ociosidade, nervosismo, sofrimento, estresse, sobrecarga laboral e dificuldades econômicas foram produtores de adoecimento mental. **Conclusão:** a atenção à saúde mental das camponesas necessita ser considerada pelas políticas públicas e requer ações dos profissionais de saúde com vistas à promoção desta.
Descritores: Saúde da Mulher; Saúde Mental; Saúde da População Rural; Atenção Primária à Saúde; Enfermagem

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Resumen: **Objetivo:** conocer las nociones y prácticas de la atención a la salud mental desde la perspectiva de mujeres campesinas. **Método:** estudio exploratorio-descriptivo, con enfoque cualitativo. Participaron del estudio 18 mujeres campesinas. Los datos se produjeron mediante entrevista semiestructurada, de marzo a abril de 2017, y se sometieron al análisis temático. **Resultados:** las nociones de salud mental aún están influenciadas por la religiosidad y la concepción de la locura de la época clásica. La socialización, la participación en grupos, el ocio y la religiosidad se destacaron como prácticas de atención. Las relaciones familiares conflictivas, la inactividad, el nerviosismo, el sufrimiento, el estrés, la sobrecarga de trabajo y las dificultades económicas fueron productores de enfermedades mentales. **Conclusión:** la atención a la salud mental de las mujeres campesinas debe ser considerada por las políticas públicas y requiere acciones de los profesionales de la salud para promoverla.
Descriptores: Salud de la Mujer; Salud Mental; Salud Rural; Atención Primaria de Salud; Enfermería

Introduction

In this study, it is understood by rural or peasant population the diversity of people living in the rural area and identify themselves as belonging to this population stratum, regardless of whether or not they perform paid activities in rural or urban areas. Another notion that underpins this investigation refers to the vulnerability that encompasses people's possibilities of illness "as a result of a set of aspects that are not only individual, but also collective and contextual" and the resources available for their protection.[1:123]

Mental health can be understood as a state of well-being where the individual experiences his/her skills and is able to deal with stressful everyday situations, being able to work productively and contribute to the community where he/she takes part. Mental health is not restricted to the absence of mental suffering and can be affected by individual and/or socioeconomic factors.[2]

The multidimensionality of the elements involved in the mental health processes of peasant women is related to physiological, psycho-emotional, ethical-political, behavioral, socio-cultural, economic, racial and gender aspects, as well as technological and organizational issues related to the production and consumption profile. In addition, there is an influence of physical, chemical, biological, mechanical and ergonomic risk factors present in the work processes in the countryside.[3-4]

In rural areas, the contexts of vulnerability lack greater social visibility, whose the aforementioned elements affect the ways of life of peasant women, with the potential to produce or not mental health, or even in the determination of other vulnerabilities that mark these territories.[4] Peasants also face difficulties in accessing goods and services essential to life, such as health, education, income generation, housing, basic sanitation, transportation, leisure, labor rights and social recognition of their status as rural working women, which are factors decisive for the access to services and better quality of life.[4-6]

A study points out that "despite the prevalence of rural residents in the most vulnerable health conditions, such as the elderly and low-income people, the demand for health services is lower in these areas for all social groups".[6:9] There are difficulties of access in the search for care due to the lower offer of rural health services, which implies higher travel costs for people, as they need to go to the city, interrupted therapeutic itineraries, lack of bonds with health teams/services, which can be transposed to the mental health area.[3-6]

International surveys conducted in India and the United States in urban and rural areas have shown a prevalence of Common Mental Disorder (CMD), characterized as a combination of somatic, depressive and anxious symptoms in women.[7-8] In the national scenario, the prevalence of CMD in a rural area corresponds to 23.3% in a municipality in São Paulo (SP) and 35.7% in a municipality in Rio Grande do Norte (RN).[9-10]

Another survey conducted with 2,012 residents of rural settlements in RN found that 15.6% of them manifested symptoms that indicated CMD and 39 participants had two conditions simultaneously, CMD and alcohol abuse.[11] Studies indicate that old age, female gender, being married and widowed/separated, low education level, non-white color/ethnicity, less hours of work per week, self-reference to pesticide poisoning at work and complaints of health problems are associated with a greater chance of developing CMD among rural residents.[8-9]

The absence of mental health promotion services in the countryside or in small cities raises questions, also highlighted by the National Policy for Integral Attention to Women's Health (PNAISM, as per its Portuguese acronym), which states that the rural population has difficulties in accessing health services, thus constituting challenges for the Brazilian Unified Health System (SUS, as per its Portuguese acronym). PNAISM, when relating gender and mental health issues, affirms that women suffer twice the consequences of mental disorders due to gender inequalities and their interface with social, economic and cultural conditions.[12]

It is understood that this study is relevant in terms of strengthening discussions on the mental health care of rural women, since some documents, such as the IV National Conference on Mental Health, which superficially addressed issues related to the rural population, and the National Policy on Integral Health of Populations of the Field, Forest and Waters (PNSIPCFA, as per its Portuguese acronym), which, although concerned with this population, sinned in the superficial approach of issues related to mental health.[3,13] Conversely, PNAISM advances by considering issues related to rural women's health.[12]

Despite the guideline of integral health care, one of the pillars of SUS, this theme is still separated, perhaps because of its specificities or because of the emphasis on fragmentation of health care. Besides not problematizing the understanding of what mental health is for the rural population, especially peasant women. In view of these considerations, the study has a research question: what are the mental health care notions and practices from the perspective of peasant women? Therefore, the objective of this research is to know the mental health care notions and practices from the perspective of peasant women.

Method

Exploratory and descriptive study, with a qualitative approach,[14] developed in the rural area of a municipality in the north region of the state of Rio Grande do Sul. The municipality

has an estimated population of 7,409 inhabitants, of which 52% live in the urban area and 48% in the rural area, where the main economic activity is stone extraction.[15] In the health area, the municipality has three Family Health Strategies (FHS), a Support Center for Primary Care (NAAB, as per its Portuguese acronym), a Regional Unit Specialized in Occupational Health (UREST, as per its Portuguese acronym) and a small-sized hospital. In the social assistance area, there is the Service of Coexistence and Strengthening of Bonds. Of these, none are found in the rural areas of the municipality.

The field stage of the research was developed in a rural community, assigned to an FHS that serves the urban and rural population. Regarding its characteristics, the place has rugged relief, and unpaved roads, where the public transportation is held by the school bus, which only works on school days and once a week during school holidays. The community has electricity, access to water is via an artesian well, there is no sewage system and garbage is collected every two weeks.

The 18 study participants were selected by lot, from the list of 40 rural residents provided by the Community Health Worker (CHW), and among those selected, there was no refusal to integrate the research. The inclusion criteria were: to be over 18, identify as a woman and live in the countryside; and as an exclusion criterion: to show some cognitive condition capable of interfering with data collection. Data collection took place from March to April 2017 through semi-structured interviews, previously scheduled, via telephone call, with an average duration of 30 minutes each. The interviews were conducted at the homes of the peasants, observing issues of ambience and privacy, and addressed socio-demographic and health information, issues related to work routine, family and social life and the understanding of factors producing mental health. These interviews were recorded and later transcribed by the researcher. In order to preserve the identity of the participants, at the end of their statements, they were identified by the letter 'E', which is initial letter of the word *entrevistada* (interviewee in Portuguese), followed by Arabic numbers from 1 to 18.

The empirical data were submitted to the thematic analysis technique, which allows the identification of manifest contents of the participants' speech, operationalized through the following steps: pre-analysis; exploration of the material; treatment of the obtained results; and interpretation. In the pre-analysis, the produced material was organized to be analyzed with the systematization of the initial ideas. Subsequently, the produced empirical data were classified, categorized and interpreted.[14] The research was approved by the Research Ethics Committee of the Federal University of Santa Maria on 02/16/2017, under opinion nº 1.929.232, Certificate of Presentation of Ethical Appreciation nº 63283116.2.0000.5346, and the participants signed the Free and Informed Consent Form according to Resolution nº 466 of the National Health Council.

Results and discussion

With regard to sociodemographic and health characteristics, the average age of the participants was 48.2 years, with a minimum age of 29 years and a maximum of 69 years. Of the 10 peasant women who were in reproductive age (between 10 and 49 years old), they had 1 to 4 children, with an average of 2.2 children. Those over 49 had 1 to 6 children, above the fertility rate of Brazilian women, which in 2013 was 1.7 children.[12] As for education, the average was 5 years of study, ranging from 1 to 10 years. Regarding marital status, 14 were married, 3 in a stable relationship and 1 widow. Regarding religion, 14 were Catholics and 4 Protestants. Regarding occupation, 8 reported being farmers, 3 housewives, 1 seamstress and 1 cleaning lady. Of the 5 retirees, 2 still worked in agriculture and 1 worked as an craftswoman.

What follows are the two thematic categories discussing notions of mental health and mental illness from the perspective of peasant women and their care practices.

Notions of mental health and mental illness from the perspective of peasant women

For the peasant women, the notions of mental health ranged from good interpersonal relationships, tranquility, moments of rest, absence of worry and stress, feeling of well-being and self-care. Such notions influence the way in which these women perceive the world around them and conduct their ways of life.

When asked about what promotes mental health, one of the highlighted aspects was the repeated mention of the word peace. The fact of living in a peaceful environment can be understood as a factor promoting mental health for these women:

> *I think the tranquility of people in a home, in the family context, in society. We're living well, without conflict, and things are going well. It's very good for health, good for everything, because we're at peace.* (E2)
>
> *That's all I pray to God, health and peace. If you have peace, you have everything. If you live in tittle-tattle, in trouble, you can't have peace.* (E12)

The fact that the word peace is brought by the participants may be linked to the situation of being a woman and being in the countryside, circumstances that may produce fear and insecurity, with negative effects on mental health. Violence in the countryside increases other vulnerabilities for those who live in this territory, since it highlights social contexts of tension and dispute, marked by living with difficult situations, such as land conflicts, the exploitation of labor and slave labor, the violation of citizenship rights and land occupation and possession.[16]

Despite being constant, the issue of violence in rural areas is little disseminated.[16-17] In 2016, Brazil recorded 1,536 conflicts in the countryside, an average of 4.2 conflicts per day. Among the 61 murders that happened, the victims were 16 young people aged between 15 and 29 years old, 1 teenager and 6 women.[16] Another issue involved in this setting is violence against women. In Brazil, in the first half of 2016, *Ligue 180* (a Brazilian phone service) received 67,962 calls with reports of violence against women, of which about 10% were from rural areas and, in recent years, this percentage has been growing.[18]

The lack of knowledge about rights and legislation, such as the Maria Penha Law, difficulties in accessing protective measures and the specialized network for assisting women in situations of violence in the countryside, underreporting and problems with the flow of referrals after identifying cases are barriers when they are looking for support, which affects the scope and shows the little effectiveness of these measures. In order to overcome these limits, there is an urgent need to bring together professionals from different health and social assistance services, in such a way as to strengthen the network to confront violence against rural women and expand the welcoming process, in association with intersectoral policies.[19]

For one participant, the concept of mental health was linked to the fact of having a good relationship with people. Still, tranquility, having moments of rest and break, absence of worry and stress, the feeling of being and feeling good and taking care of oneself were aspects linked to this understanding, as reported by this peasant:

> *Getting along well with people, being friend with everyone, having the joy of living. Mental health is important. Take that time to leave your head without problems, without stress, resting. Having at least half an hour a day for us to be well mentally.* (E16)

The social relationships that peasants have with close people are producers of mental health, that is, the presence and quality of these relationships were recognized as important protective factors to prevent mental suffering. For the study participants, the fact of living in a community with a calmer pace can be favorable to mental health.

Life conditions associated with poverty, reduced opportunities for paid employment, limited social contacts and impaired access to health services are stressors and have the potential to produce and/or exacerbate contexts of vulnerability. The pertinent literature points out that these aspects tend to affect more strongly the mental health of rural women compared to women in the urban area.[6,11]

The peasants' notions about mental health and mental illness are strongly associated with those historically constructed, and their testimonies underline that mental illness is the fruit of God's designs and that to be mentally healthy is not to do wrong things:

> *I think this is the God's desire. We can't get in the way. We've to accept the illness.* (E11)
>
> *For mental health, when the person doesn't do something wrong, things we shouldn't do, such as mistreating people, fighting.* (E14)

As for the silences involving the issue of mental health, it is common for families to hide the individual who experiences some mental illness. In general, the fact of living in a rural community not only limits access to health services but tends to stigmatize the issue of mental health, within a socio-cultural context.[20]

The conception that the onset of mental illness happens by divine influence is a historical-social construction. In the Classical Age, madmen were removed from the city and excluded from the social environment, because madness was considered a penalty of God and that, even marginalized, He would not abandon them. In the same period, the insane were seen as dangerous, unproductive and, therefore, segregated, excluded from society and isolated in psychiatric hospitals, built far from urban centers.[21] The stigma in relation to mental illness still permeates society, despite the Brazilian Psychiatric Reform advocate the rescue of citizenship and the inclusion of people with mental illness.[22]

As for what affects mental health, some peasant women mentioned feelings such as nervousness, negativity, concerns, stress, anxiety, suffering and not being happy. Another participant said that issues that affect mental health are generated by a set of elements:

> *I think it's suffering. People who are suffering, mistreated, starving, despised* [...] *(E2).*
>
> *I think it's not being happy with what you do, being nervous about a problem, stress, it's a lot of things, it's an entire set.* (E15)

For the study participants, there are also external influences that compromise mental health, such as economic issues, family conflicts and idleness:

> *What can affect everyday problems are complications with the children, with the husband, lack of money, sometimes even lack of activity.* (E10)
>
> *I think it's stress, worry. The crisis of a while ago, is worrying people, and it causes all this, I think.* (E16)

Several factors contribute to situations of physical and mental illness of the peasant population, including environmental degradation, use and exposure to pesticides, triple working hours, conflicting family relationships, low level of social support, idleness, lack of cultural life, social isolation, low schooling, lack of perspective in terms of personal fulfillment and social ascension and lack of the very sense of existing.[4-5] Such factors are associated with the increase in chronic-degenerative diseases, as well as the presence of psychiatric morbidities and alcohol consumption among men and women at worrying levels.[5]

The rural population has a life marked by violations of basic social and citizenship rights and precarious life and working conditions.[4-6] Problems in the production and decline of the agricultural economy, use of pesticides, precarious transportation, socioeconomic difficulties, issues related to rural succession, family conflicts, as well as barriers to access health, social security and agricultural credit policies, tend to aggravate these contexts of vulnerability affecting the mental health of these people.[5,23]

Still regarding life in the countryside, the participants reported that their work routine is difficult, heavy and tiring. In the same direction, the peasant women reported physical and mental health problems, such as breast cancer, panic syndrome, depression, osteoarticular diseases, psoriasis, besides the fact of having family members with mental disorders:

> *I had a lump in the breast, they sent me to remove it, I was afraid of losing my breast. I got depressed [...] I cried, I won't be able to wear a blouse, nothing. The mastologist said: a breast is lost, but not life. It was there I*

> *thought: It's better to lose a breast than my life, and I'll continue living, it was there I gained strength.* (E12)
>
> *I have depression, I take medication, but I'm fine now.* (E6)
>
> *The mother had a depression problem, [...] she can't sleep without taking remedies.* (E1)
> *My brother was a little bewildered, he was having a mental problem, so he was admitted to a nursing home. He attempted suicide, but he's fine now.* (E2)
>
> *I had OCD* [Obsessive Compulsive Disorder] *and panic syndrome. I treated myself until recently, but it's something very terrible.* (E14)
>
> *Look at the way I'm looking like a girl* [showing her arms]*. Look at my psoriasis as it is, everything is attacked. I have psoriasis and it's from the nervous system, it's really complicated.* (E17).
>
> *I have a lot of pain in my body, but they're health problems. I'm not healthy, I did physical therapy on my arms and hands, the result of a lot of work. Now, I have to do it on the shoulder, my pain is chronic. We worked too hard. All my life working with heavy things.* (E8)

In addition to the diversity of occupations of the peasants, what appears as something common to the participants is the manual labor and the illness generated from it. In this sense, a study points out that the work process, in force in the capitalist production mode, can compromise the person's subjectivity and produce mental suffering and illnesses, in addition to physical wear and tear.[24] Moreover, according to PNSIPCFA, pain in the arms or hands are among the morbidities that most affect the rural population in relation to the urban.[3]

It is noticed that the notions of mental health encompass good interpersonal relationships, tranquility, moments of rest, absence of worry and stress, feeling of well-being and self-care. Those that deal with factors affecting the participants' mental health include nervousness, worries, stress, anxiety, suffering and not being happy. Other understandings added economic issues, mistreatment, interpersonal problems, family conflicts and idleness as

situations that affect mental health. In addition to the historically constructed conceptions that consider mental illness as the fruit of divine designs.

Mental health care practices

The activities related to the mental health care practices performed by the peasant women included socialization, participation in groups in the community, leisure and religiosity. Regarding participation in group meetings, the peasants reported that they attend activities linked to the Catholic Church: liturgy, catechesis, family and prayer teams:

> *Here, in the Community, there is a group of women, I also give catechesis, and so on.* (E5)
>
> *I take part in the family group, where we talk about religion.* (E7)

Leisure constitutes an important dimension of life in terms of social interactions and, in rural areas, this issue takes on peculiar shapes, since entertainment practices are usually linked to religious, community and political spheres. In general, the path of people's lives is crossed by a transcendental dimension that does not necessarily have to do with religion or spirituality, but generates, in the individual, a feeling of belonging to something greater, timeless, unlimited and that produces an existential sense. The emphasis on the religious nature in leisure and sociability practices has also been identified in other studies.[4,23]

With regard to participation in group meetings, the peasants mentioned it as positive. They also pointed out work overload as a limiting factor for socialization and leisure moments:

> *In the past, we visited a lot and, today, very little. It seems to have more service, before, it seemed that there was less.* (E8)
>
> *We're only at home, there's no leisure. He's at home working.* (E15)
>
> *My day starts early, I milk the cows, work with the cows, in agriculture, in the vineyards, I make cheese, take care of the house, children, husband, that is, the whole family.* (E14)

> *I also read in the fields; and, when I get home, the tasks remain. I have lunch, clothes, the house, this is all women's work.* (E18)

The participants also expressed difficulties in managing their duties as peasants and for the traditional gender role that is assigned to women, the responsibility for the care of the house, children and other charges linked to marriage. This work overload tends to make it impossible for women to have 'certain time' for leisure and socialization activities.

The accumulation of tensions produced in interpersonal relationships, excessive work, social isolation and few socialization activities and leisure spaces may produce problems in the psycho-emotional field, thus resulting in the occurrence of female mental illness in rural areas.[4] The fact of coexisting with acquaintances and having social participation in the rural community produce feelings of territorial belonging and well-being, with positive effects on health.[25]

The organization of events in the community as a form of group participation was highlighted by the peasants. In addition, mention was made of participation in a group of women promoted by the Technical Assistance and Rural Extension Company (EMATER, as per its Portuguese acronym), which was interrupted and, as a result, two peasants sought group meetings in other communities, as indicated by one of them:

> *I liked it when I had a group, since when it took place in EMATER. There was a course on candies, crochet, embroidery, then it didn't work out very well. I think these things are missing, since we, women, could get together, meet each other. We talked, participated. Now, it's over, there's no more.* (E10)

The production of mental health through group activities associated with artisanal and food production favors the socialization process and the sharing of experiences, which happens in groups coordinated by EMATER. Moreover, the linking of participants to EMATER groups is associated with the fact that they foster the peasant identity.

For these women, the fact of living in a rural community means being part of a group of people linked by geographical proximity and a strong sense of community, belonging and solidarity, which strengthens the social relationships and allows the establishment and maintenance of social support networks.[23] When considering the vulnerability contexts of these women, "support networks can express themselves as mechanisms to cope with adverse life and working conditions, as well as social protection," aspects that can be understood as producers of mental health.[26:471]

In the mental health field, the main community devices of citizenship are operative groups, social groups, handicrafts or income generation groups, among others, with the potential to produce, in and to the territory, new supports, which articulate health, culture, leisure, work, income, autonomy and citizenship. It is a matter of betting on the strength of the community, the co-responsibility and the competence of the subjects in permanent production of themselves and the world. The group is characterized by a group of people, with common objectives, who propose to carry out a certain task, with the intention of mobilizing stereotyped structures and promoting learning.[27]

Some peasant women who participated in group activities, such as the mothers' club and community parties, stopped doing them. Another interviewee said that she was not part of any group and also reported a lack of encouragement from her partner to participate in health actions promoted by NAAB:

> *It's fun to go out, meet friends. I love to dance on a matinee. Wow, it looks like you get renewed. We haven't been out for about five years, just at home, I intend to change that.* (E12)
>
> *We've been leaving little, more due to home tasks. Because leisure, if we see it, is to take it off to rest.* (E18)
>
> *I made an appointment with the psychologist and went to the NAAB meeting. I stopped because I had no encouragement from my husband, 'what are you going to do there? If it's to talk, talk at home'. I was discouraged. I thought, I'm not going anymore. And, my conversations with the psychologist were very important.* (E17)

The exercise of narrating her sufferings and taking her own life in her hands while listening to herself while explaining, in addition to being listened to by an attentive health professional, has creative potential, as it expands possibilities for peasant women to perceive and resignify their sufferings, from their choices, in the way in which they move in life. It is up to the health professional, from the care-related meeting mediated by the bond, by careful and sensitive listening and dialogue, to build and/or recognize, together with these women, care practices to deal with the delicate issues of life that generate suffering and/or some type of illness.

It is worth underlining that qualified listening has therapeutic potential and allows people to express their stories. This allows health professionals to identify needs and demands, with a view to building resolutive intervention behaviors, through a dialogical relationship with the assisted person, considering their life context. Nevertheless, there is still little recognition of listening as a therapeutic resource by health professionals.[28]

Through praxis centered on the individuals and their experiences, singular interventions are needed to direct the production of emancipatory mental health care. Resources of this nature should be based on expanding the gradients of autonomy so that life-health is taken on its creative powers in the management of delicate life issues.[28]

In addition, the E17's testimony brings elements related to machismo, which gives the woman the role of staying in a private/domestic space and that leaving home, even if seeking health care, tend to be secondary. This lack of encouragement from the husband for her socialization reveals asymmetries in the exercise of power in the marital relationship, sometimes naturalized. When complying with the husband's decision, female submission, seen as something natural and socially acceptable, is reproduced and conflicts are avoided, making gender vulnerabilities to which they are subjected invisible, which may interfere with mental health.

For many women, not submitting to the will of their husband is an issue that goes beyond personal desire and follows a gender logic that is amalgamated in the patriarchal culture,

perpetrating hierarchies and inequalities historically constructed.[4,11,19] Studies identify that bad relationship/coexistence with the partner is a risk factor for CMD among rural women, with negative effects on their mental health.[10,20]

A peasant woman mentioned the practice of sports as a group activity and talked about its benefits. The women's soccer game is an activity that takes place weekly, on Wednesdays, in a court in the community:

> *It's good, it distracts me, makes me laugh. If you stay alone at home, you won't see that. It's a sign that you have to live forward. It doesn't stay in that world 'tomorrow I don't know what to do', it makes me want to die. So, you talk, we'll play on Wednesday, have a dinner, that makes you live forward.* (E15)

Mental health care practices should promote new possibilities for modifying and qualifying the ways of life for peasant women. For them, life can have several ways of being perceived and experienced, which is why these practices should not be restricted only to the healing of diseases, but guided by the production of life-health in an expanded perspective. For health professionals, this shift from looking at the disease to care, from the resignification of suffering, favors the activation of therapeutic resources that solve everyday problems and enhances other individual and group ways of managing life, converging to more positive notions of mental health.

In this logic of integral care, the groups are potent care practices that produce mental health, which favor the dialogue, the exchange of experiences and the subjective transformations that impact people's health and autonomy, which are not always achievable in individualized care. Thus, the group as a space for self-care and production of mental health is anchored in the development of autonomy, choices and group commitment, gradual and spontaneous.

Mental Health and Primary Health Care are fields converging to a common object (the subjectivity of the care-related meeting and the production of health-life), which require ethical, socio-political and economic challenges in order to create new horizons for the production of

mental health care is made possible in rural areas. In this sense, the breakthrough in these challenges must be a common ground for health professionals.

Moreover, the procedural dimension of this other mode of care production anchors, but, at the same time, projects the construction of integrality in mental health from the perspective of longitudinal care in the contexts of the peasants' lives, that is, beyond the fences of the territory assigned to the health service. It is up to health professionals to create/invent plural practices of mental health care, which add light technologies, such as listening, bonding and welcoming, as well as interventions that contemplate other possibilities of subjectivity and sociability, for example, encouraging participation in community groups.[28]

As a limitation of the study, it should be highlighted the fact that it was carried out with women from a rural Community; accordingly, it cannot be generalized. The need for further studies of this nature in other rural realities should be also highlighted.

Conclusion

Of the different identified notions about mental health, the relationship established between this and mental illness processes as a punishment and/or divine design draws attention. The factors producing mental health listed by the peasants go through peaceful domestic and social environments, exchange of visits, socialization and religiosity, while work overload, economic issues, family conflicts, stress, anxiety and not being happy were mentioned as those non-producers.

Regarding the mental health care practices adopted by the participants, leisure, sports, participation in community events and group activities were the most prominent. It should be noted that socialization is an important element in mental health care for rural women, in view of the specificities of life in rural areas.

The study contributes to the promotion of mental health to the rural population and to the formulation of public policies that guarantee dignity, expansion of access to quality public health and social security, as well as consider the specificities of those who live and work in the countryside. It is worth mentioning that the discussions on this topic are relevant for the production of knowledge and reinforce the importance of the multiprofessional health team's performance in the rural setting, so that it contemplates mental health care to the rural population.

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Chief Scientific Editor: Cristiane Cardoso de Paula
Associate editor: Daiana Siqueira.

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How to cite this article

Sganzerla J, Cabral FB, Hildebrandt LM, Trezzi I. Mental health care notions and practices from the perspective of peasant women. Rev. Enferm. UFSM. 2021 [Accessed in: Year/Month/Day]; vol.11 e14: 1-20. DOI:https://doi.org/10.5902/2179769243181