Insertion and care for the family in the psychosocial care center

Inserção e cuidado à família no centro de atenção psicossocial
Inserción y atención a la familia en el centro de atención psicosocial

RESUMO
Objetivo: analisar a inserção da família no cuidado às pessoas com transtornos mentais, acompanhadas pelo Centro de Atenção Psicossocial (CAPS) de um município localizado no interior do estado do Rio Grande do Sul. Método: trata-se de uma pesquisa exploratória, descritiva, com abordagem qualitativa, realizada pela equipe multiprofissional que presta atividades assistenciais no CAPS. A coleta de informações ocorreu por meio de entrevista semi-estruturada no período de janeiro a março de 2022, sendo utilizada a análise temática de Minayo. Resultados: emergiram duas categorias: "ações de cuidado realizadas pela equipe à família" e "dificuldades da equipe para inserir os familiares no cuidado". Conclusão: percebeu-se que existem dificuldades para inserir a família no processo de reabilitação do portador de transtorno mental no CAPS. Cabe ressaltar que, os profissionais devem implementar estratégias para inclusão dos familiares dos pacientes portadores de transtorno mental no processo de cuidado.
DESCRITORES: Família; saúde mental; atenção à saúde; serviços de saúde mental.

ABSTRACT
Objective: to analyze the insertion of the family in the care of people with mental disorders, accompanied by the Psychosocial Care Center (CAPS) of a municipality located in the interior of the state of Rio Grande do Sul. Method: this is an exploratory, descriptive research, with a qualitative approach, carried out by the multidisciplinary team that provides care activities at the CAPS. Information was collected through semi-structured interviews from January to March 2022, using Minayo's thematic analysis. Results: two categories emerged: "care actions performed by the team to the family" and "difficulties of the team to include family members in care". Conclusion: it was noticed that there are difficulties to insert the family in the process of rehabilitation of the person with mental disorder in the CAPS. It should be noted that professionals must implement strategies to include family members of patients with mental disorders in the care process.
DESCRIPTORS: Family; Mental Health; Health Care; Mental Health Services.

RESUMEN
Objetivo: analizar la inserción de la familia en el cuidado de personas con trastornos mentales, acompañada por el Centro de Atención Psicosocial (CAPS) de un municipio ubicado en el interior del estado de Rio Grande do Sul. Método: se trata de una investigación exploratoria, descriptiva, con abordaje cualitativo, realizada por el equipo multidisciplinario que brinda actividades asistenciales en el CAPS. La información se recolectó a través de entrevistas semiestructuradas de enero a marzo de 2022, utilizando el análisis temático de Minayo. Resultados: surgieron dos categorías: "acciones de cuidado realizadas por el equipo a la familia" y "dificultades del equipo para incluir a los familiares en el cuidado". Conclusión: se percibió que existen dificultades para insertar a la familia en el proceso de rehabilitación de la persona con trastorno mental en los CAPS. Cabe señalar que los profesionales deben implementar estrategias para incluir a los familiares de pacientes con trastornos mentales en el proceso de atención.
DESCRIPTORES: Familia; Salud Mental; Atención de Salud; Servicios de Salud Mental.

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INTRODUCTION

The way of inserting the family has changed throughout the historical construction of mental health care with the implementation of the Brazilian Psychiatric Reform. Family members need to develop adaptive resources to ensure the balance of their family structure. Therefore, they need support, which can be provided by a professional and social care network to help them in this process. However, they often do not have professional help, feeling unassisted due to the barriers and difficulties encountered when accessing mental health services[1].

Accordingly, conceptions regarding "madness" underwent several changes, as well as conceptions regarding the family. Historically, the treatment of people with mental disorders was through isolation, being excluded from the family and social context. The family, on the other hand, away from the treatment, was considered one of the factors for the origin of the mental illness, blamed for the subject's illness. Now, considering the Psychiatric Reform and the current mode of treatment, the family is seen as the one who cares, but also the one who needs to be cared for. It is not possible to delimit what is the specific place that the family should assume in the care of the individual, but it is possible to allow it to be in different positions during the course of the treatment and to be integrated into the user support networks. [1-3]

In this way, the family must be included in the substitutive services of the Psychosocial Care Network, having as references the Psychosocial Care Centers (CAPS), to enhance mental health care through actions aimed at reintegrating the individual with a mental disorder into society and the family environment and, at the family level, promoting the acceptance of individuals who have had their social processes disrupted by institutionalization. [3]

It is understood that the family is a link of great importance for the care of the individual with a psychic disorder, being an ally in the therapeutic process and autonomy of the same, through the various difficulties that affect them significantly. Thus, the general objective of this study is to understand how the family is inserted in the care of people with mental disorders accompanied by the Psychosocial Care Center (CAPS), in a municipality located in the interior of the state of Rio Grande do Sul.

METHOD

This is a qualitative exploratory and descriptive research, carried out in a Psychosocial Care Center (CAPS - Centro de Atenção Psicossocial), type II, located in a municipality in Vale do Rio Pardo, in the interior of the state of Rio Grande do Sul.

The study included nine professionals from the team who work directly in the care of patients and their families at the referred service, contemplating the eligibility criteria: working at least six months in the CAPS II, perform therapeutic activities with patients and not be on vacation or leave. Participants signed the consent form and signed the Free and Informed Consent Form (FICF) before the interview.

For data collection, a questionnaire prepared by the researcher was applied, consisting of two parts. In the first part, questions related to the characterization of the participants were asked. The second part consisted of semi-open ques-

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tions.

The interviews were carried out individually in a reserved place in the service, at a previously scheduled time and lasting approximately thirty minutes. Data collection took place during the months of January to March 2022.

In order to guarantee the confidentiality of the participants, "En" was used, with "n" being the number of interviews. The interviews were recorded and later transcribed in full and will be kept for five years, after which they will be destroyed. The collected information was analyzed using the Thematic Analysis Technique proposed by Minayo. [4]

The research was approved by the Ethics and Research Committee of the University of Vale do Taquari- Univates (COEP), under opinion nº 5,185,370. Because it involved human beings, the research was conducted in accordance with the ethical standards required by resolution nº. 466 of December 12, 20125 of the National Health Council, which regulates this type of study.

RESULTS

In this chapter, the main results will be presented, responding to the research objectives, thus, the care actions aimed at family members, carried out by the care team of the CAPS II under study, will be addressed. According to the professionals, these aim to include family members in the therapeutic system both individually and collectively, being concerned not only with the patient, but, above all, with the understanding that family members have about the mental illness, their anxieties, difficulties and anxieties experienced in daily living with the disease in the family.

Category 1: Team care actions to include the family in care

It was identified that when welcoming the patient, the team requests the presence of a family member, being able to visualize and manage possible conflict situations in different contexts. In addition, the presence of the family member is also requested by the team to support the patient when he does not have the psychological conditions for self-care and, included in the Singular Therapeutic Project:

> *"[...] I call family members when the patient does not understand or does not have the psychological conditions to care for their own health [...] then we call family members to provide support" [E2].*

Sometimes, the team's professionals understand that the user's responsibility is part of the care process in the adult CAPS, and thus the assistance ends up being more individualized with the patient, leaving the call of the family member for a second moment. Thus, when there is evidence of a need, it is offered that the family members attend together with the consultations, for a better understanding of the events and to translate the possible risks that the patient may be experiencing, as we can analyze in fragments taken from the interviews:

> *"[...] we care for the individual a lot, right, but there comes a time when sometimes you are in care and [...] they are adults, right, so the adult is already in his process of responsibility for his life, [...] he already comes to take care of his life, right, so this practice, it ends up being a little less common, of me calling someone in charge [...] but I offer it, you know? [...] Sometimes they want it, but often when you offer it, they don't, so I think it has this peculiarity, you know, because they are people who are responsible for their life choices too" [E3].*
> *"Sometimes we deal with a situation, and we understand that it is necessary to call the family member to talk, clarify about the treatment [...]" [E7].*

In addition, the group of family members is also a welcoming space, characterized by the team as an important device of the service aimed at the patients' families. Mediated by a professional from the care team, it aims to guide and inform family members about psychiatric disorders, as well as to clarify the management of the patient's behavior. The same serves for family members to exchange experiences and express their anxieties, thus constituting a place to demystify the idea that they are alone in this process and helpless in the face of experienced stigmas and prejudices:

> *"[...] the most important thing, the most concrete space in the CAPS is the group of family members, you know... which is like this support space, you know, which I think is very important for family members to understand, right? The reason for the disease, how the disease works, understanding the symptoms, understanding the behaviors [...]" [E3].*

Team meetings and case discussions are also indispensable actions to include the family in the therapeutic process, seen as spaces for professionals to exchange knowledge and discuss the best way to intervene in conflicts and family situations. Depending on the complexity of each case, the team plans the need for referrals, interdisciplinary and multidisciplinary care, seeking to make the team responsible, and not just a professional for a given demand:

> *"[...] in team meetings, we discuss the cases and the best way to approach the family in different situations. And we also refer to CREAS when there are situations of mistreatment or violence" [E2].*
> *"[...] sometimes we even share care, one professional stays with the service user and the other with the family member, then we do care together and, the multidisciplinary [...]" [E7].*

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In this way, interdisciplinarity is perceived between the CAPS team and other units and professionals in the health network, where they end up requesting support between services to monitor the context between patient and family, mainly through home visits, aiming to analyze the territory they are inserted in and their relationships, in order to help these families in their difficulties:

> *"We have home visits, where we can also monitor the family structure of this patient a little bit, [...] we go to them, and within what we can do, seek a little answers, why the patient is here, why he does not get better, what is happening. So, the home visits that we do are requested both by the multidisciplinary colleagues or psychiatrists themselves, as well as by the UBS, the FHS, the health agents, who even go with us if we request it" [E5].*

Category 2: Difficulties of the team to include family members in care

In this category, the difficulties encountered by the team that interfere with the adherence and insertion of family members in the CAPS therapeutic process will be presented. Difficulties are observed, such as lack of understanding and acceptance by family members in relation to mental illness, stigma, prejudice, social issues, reconciling schedules, exhaustion, fragile family network and lack of accountability.

In agreement with the authors, CAPS team professionals report that the lack of comprehension and understanding of family members about mental disorders, as well as non-acceptance, interfere considerably with their adherence to the service, especially when they are resistant to changes:

> *"Look, the main difficulty, I think, is for the family member to understand disorder as a disease, without judgment, without criticism. This is very difficult, mainly because the mental disorder does not show up in exams" [E1].*

> *"[...] I think that sometimes it's a lack of understanding of the disease, a lack of understanding, it's... there's still some prejudice, right, so I think that sometimes the difficulty is when you run into that, right, the person, the family member not understanding and not accepting, right [...]" [E9].*

This misunderstanding of mental disorders by family members and also by society generates criticism, stigma and prejudice, which is also one of the obstacles cited by the team:

> *"There is the stigma, the prejudice, people are very ashamed, you know, I get that, a lot in relation to the population that we serve, you know, and that ends up making it difficult for people to improve, sometimes adherence to treatment" [E4] .*

Consequently, these social processes end up reducing the access of subjects and their families to the service. They resist accessing the CAPS because they are afraid, because they are also considered crazy, or because they mess with their own emotions, even though they are disorganized and need help:

> *"Of the difficulties, it's that people don't get involved in that problem, that's a little bit, what I told you about. It's you who has the problem, it's not me, or else you go to that place over there that's for crazy people. But that, those who have this resistance don't realize that they don't want to touch their issues either, you know [...] so you don't want to make yourself responsible too, for listening to some things, you know, for talking about the problem [...]" [E3].*

The exhaustion of the family also affects the commitment to the family member with mental illness. The team emphasizes that, when the patient enters the service, the family members end up identifying the CAPS as an escape valve for the fatigue of coexistence and management difficulties. Sometimes, they move away from the circumstance they are experiencing and do not insist on engaging in the therapeutic process, and they are often involved in that symptom, or even are sick as much as the patients themselves:

> *"Also, many family members are tired, you know, sometimes they are already so exhausted from the situation of that family member who is already sick, right... Sometimes it's like, "I'll take you to the CAPS, right, go to the CAPS, you're in treatment and now I... " then you move away from the situation a little because you can't take it anymore, right? [...]" [E7].*

Some professionals also point out that the fragile family network is a frequent problem for including family members in the service, where they are unable to summon one of the members to provide support or monitor the patient:

> *"And then comes the difficulty of when there is no such person for us to contact. These are the most difficult cases that we have to deal with, when you don't have anyone like that, you know, you pull from here, pull from there, but a neighbor, a friend,*
> *and sometimes it's not the family itself, sometimes it's another reference person, right? [...]" [E3].*

Labor issues, lack of transportation, CAPS availability and opening hours also make it difficult for family members to join the service:

> *"What we have difficulty with,*

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> *when we call a family member, is, or work, that they cannot miss work, even if we give proof [...] but the biggest difficulty I see is this: "I can't", "I don't have time", "because I also have my family", "I have my problems ", "I have a contract" [E5].*

DISCUSSION

The Psychosocial Care model, which has the CAPS as the main service for treating people with mental illnesses, brings the importance of including the family in care, often resulting in an enormous burden on the family member. In this sense, it is necessary that, in addition to assisting in care, she is also welcomed and cared for individually, being included in the care network, through qualified listening. Professional team work is necessary that goes beyond superficial care, involving the production of actions for the family, fundamental for the continuity of the subject's treatment. [6]

It appears that in addition to individual embracement, embracement in the group for family members becomes a facilitator in the constitution of networks of experiences and affections, enabling them to have a new vision about madness through interaction with other participants and professionals, learning new ways of dealing with certain contexts. [7]

This interaction is extremely beneficial so that family members do not feel helpless. Group members can bring a new meaning of perception by identifying similar problems and experiences lived with the person with psychological distress, offering support, understanding, encouragement and advice. In this way, the group collaborates in changes in behavior that strengthen the relationship and reduce conflicts. [8]

Regarding team meetings, it is believed that they are privileged spaces for the discussion of team professionals, both in small groups, and with all of the team, enabling a breadth of recognition between the needs of family members and their affected members, through exchanges of experiences and knowledge, discarding the idea of resolving only emergency situations. [9]

In addition, the interdisciplinarity in team meetings allows professionals from different backgrounds to express different opinions on the topic in question, in order to share responsibilities. This will enhance the relationship between professionals, based on support to overcome the difficulties encountered, essential for not working in isolation, where the participation of all team members is necessary to forward important decisions. [9]

Home visits are actions that provide better knowledge of the subjectivity of the user's relatives, including and involving them in the therapeutic project. This makes the home a place to carry out therapeutic actions, where the team can intervene in a more humane way. [10]

Home care requires actions capable of meeting the multiple dimensions of individuals in their complexity. With the implementation of the CAPS territorialized care, the ideas of segregation are extinguished, seeking to understand the territory, its demographic coverage and the social relations incorporated in that place, that is,

the territory creates a space for the production of care among people, so that their ways of living are considered. The home visit has a great ability to articulate the CAPS, users, family members, territory and home, inducing interaction between subjects, forming bonds, understanding how certain family dynamics and their reality are established, addressing issues that do not only refer to physical issues, but also of an emotional nature. [11]

Thus, the idea of Morais et al. [11] goes according to the statements cited by the team, where it is perceived that the consolidation of the home visit enables the CAPS to interact with different spaces in which the user lives, especially the family member, with the family being important in the therapeutic process, sharing responsibilities and also, being seen as an object of care.

According to Ferreira et al. [2], the deinstitutionalization logic recognizes that the family also needs to be taken care of, however, the family approach in the service is still a great challenge in daily practices, because, the family must be summoned both to care for the subject, but also to be part of the actions and help in the therapeutic project of the subject.

It can be seen from the statements described that the process of caring for a subject with a mental disorder involves feelings intrinsic to the family, which is responsible and often dedicates itself exclusively to the subject, generating a great burden on the caregiver. The very social representation that family members have of madness is a product of their lack of understanding about the disease. This ends up interfering in the family context, as family members do not always know the characteristics of mental disorders. [12]

To Ahnerth et al., "the limitations of the caregiver's understanding of the family member's mental suffering may be associated with social, cultural, religious and economic factors that tend to make understanding difficult". [13:9]

The stigma and prejudice on the part of the mentioned family members is preceded by a historical context, where society determined concepts and definitions for madness and established the idea that the subject considered crazy was an irreparable evil, repressing his rights and excluding him from society, so that he was isolated from his social body. In this way, society, through discrimination, left impregnated marks on madness and the view that it is considered a social evil, which goes beyond the levels of physical illness. [14]

The reduction in access to the service is evident because family members postpone seeking treatment. Together with the first symptoms and the difficulty in dealing with the behaviors, they reflect embarrassment, guilt, shame and fear. It becomes easier for family members to think that the symptoms will pass than to admit that one of their members is disturbed, that is, this generates concern

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due to the fact that they are undergoing treatment for mental illness and are not able to solve the problem within the family. [13]

In this way, it is difficult to think about care for family members, when they act in a contradictory way to professional guidelines. These families can be considered antagonistic as they diverge from the team's care in relation to their user, often seeking only internal resources for care. [15]

Moreira et al.[16] understand that the overload can manifest itself in different ways in the caregiver, often showing symptoms of depression, anxiety, stress and musculoskeletal injuries, often forcing them to neglect their own self-care and abandon their professional and leisure activities. Consequently, it is clear that the greater the burden manifested by the caregiver, the worse their quality of life.

The fragility of bonds brought up in the professionals' speeches is associated with both stigma and prejudice, as well as lack of affection, conflicts generated by economic issues, disorganization and social tensions, progression of the illness, recurrence of hospitalizations and evolution of the disease. The frequent and long hospitalizations generate intolerances in the family members and triggers for the patient's rejection, in addition to the desire for them to remain permanently hospitalized. It is noticed that the old asylum model remains present in many situations and many families are not able to fully take ownership of the new model of mental health care and treatment. [17]

According to Silva and Lima [17], many family members are obliged to fulfill the role of caregivers and, due to the lack of support from the Psychosocial Care Network and the State to find adequate treatment for their family member with a mental disorder, can make them move away from their responsibilities and not commit to the treatment.

CONCLUSION

The present study aimed to understand how the insertion of the family in the care of people with mental disorders followed in a Psychosocial Care Center occurs, by carrying out a qualitative research with the professional team of the service.

It is understood that the family is a link of great importance for the care of the individual with a psychic disorder, being an ally in the therapeutic process and autonomy of the same, through the various difficulties that affect them significantly.

It was possible to identify that the professional team performs several care actions aimed at family members in the CAPS, both individual and collective, which they understand are part of the therapeutic process of the service. In addition to individual consultations, home visits, spaces for discussion in team meetings, interdisciplinary and multidisciplinary work is part of the care directed at the family. It is through these actions that they receive information about the diagnosis of their family member with a mental disorder and the rights granted to them. The actions also serve to ensure that the daily overload with the user and the prejudices experienced do not become an unbearable burden for family members, facilitating the acceptance, understanding and management of the disease.

When reporting the difficulties found to include family members in the CAPS, the team highlighted the lack of understanding about psychic disorders and their symptoms, non-acceptance of the disease and resistance to seeking the service. In addition, the difficulty of dealing with the patient, experiencing issues such as stigma, prejudice, fear, exhaustion and overload, in addition to the weakened family network, are difficulties perceived by the team in relation to family members. Labor issues and lack of availability also make it difficult for these family members to seek the service, which only works during business hours and does not have extended hours.

Through this study, it was noticed that there are still difficulties to insert the family in the process of rehabilitation of the person with mental disorder in the CAPS, but that the team does what it can to ensure that their insertion occurs. It should be noted that professionals must seek, offer and expand strategies to include family members through actions, both individual and collective, but mainly to emphasize the Family Group, which, according to the team's report, is the most effective action to meet the dimensions of families. For this, it is necessary that the actions occur spontaneously, without prejudice and stigma, so that professionals are aware of all their needs, so that they can express their anxieties and con-

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cerns. This will facilitate both the rehabilitation of the person with a mental disorder and the family members themselves, who are still getting used to the recent care process.

In this way, this study becomes essential for students and nursing professionals to broaden their vision in relation to the process of care for relatives of people with mental disorders, aiming to promote health in a broader context, which helps professionals in the area improve their care for families, who also need care.

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