

CARE FOR MENTAL HEALTH IN PSYCHIATRIC HOSPITALIZATION: THE PERCEPTION OF THE FAMILY MEMBERS

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ABSTRACT: This study seeks to analyze the perceptions of family members regarding the mental health care provided during psychiatric inpatient treatment. This is a qualitative study, undertaken in a psychiatric inpatient center in a university hospital, with five family members who participated in the Family Group. The framework of thematic analysis was adopted for critical appreciation of the results, with the category The care in mental health emerging. The care is perceived by the family members through Embrace, Access to Information, Improvement in Self-care, the Taking of Medication, and through the family groups offered by the center. It is concluded that the mental health care indicates the family as a partner in the most effective comprehensive health actions, this attendance requiring greater closeness and availability of the nurse.

DESCRIPTORS: Mental health; Family; Mental health care; Mental health services.

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INTRODUCTION

Mental health care has passed through various transformations since the advent of the Brazilian Psychiatric Reform, initiated at the end of the 1970s. These changes are centered on the mode of psychosocial care, in which the person with psychiatric problems must be viewed as a complex and unique subject, with the care for them directed to the territory. Thus, the care in this area has de-institutionalization, psychosocial rehabilitation and social reinsertion as the guiding element for its assistential practice.

In this regard, the mental health actions seek the return to coexistence in society, based on broad care, in which the health team takes responsibility for the service user, recognizing the limits of knowledge and technologies, and concerning itself with the production of a life beyond the purely biological questions⁽¹⁾.

It is understood that the care should transcend the medical diagnosis, centered on the production of signs and symptoms, for a care which allows the production of new technologies, such as bonds, embracement, co-responsibilization and autonomy. In this way, it requires the valorization of the light, or relational, technologies as components of the practice in the mental health services, allied with the emancipatory perspective of operating the care in line with the requirements of the Psychiatric Reform and of psychosocial care⁽²⁾.

This stance does not entail the rejection of the mental disorder in its organic, psychological and/or cultural expressions, but their existence does not mean that the phenomenon, in its totality and exclusivity, is physical, psychological or social. Hence, the mental health care cannot be centered only on drug treatment of the symptoms and the illness, forgetting about the person, their previous history, and, mainly, their family⁽³⁾.

The care must be organized through the embracement of the person who suffers. Caring is an interactive attitude which includes involvement and relating between parties, covering embracement, listening to the subject, and respect for her suffering and for her life history⁽⁴⁾.

Thus, these attitudes must pervade professionals' actions in various services stipulated based on the Psychiatric Reform, such as, for example, the Psychosocial Care Centers, the Therapeutic Residential Services, the Return Home Program, the care provided by the Primary Care health teams and the psychiatric beds in general hospitals⁽¹⁾. In this scenario, psychiatric inpatient treatment in general hospitals is a therapeutic resource for the acute cases,

when the symptoms interfere in the individual's social functioning, requiring continuous actions for a limited period of time. In this way, it is understood that the care in these services regarding the proposal for psychosocial care increased its complexity, in which actions directed only at the diagnosing of the disease are characterized as impersonal and as having little resolute capacity, pointing to a mismatch with the promotion of mental health.

Hence the importance of bringing the family closer to the treatment, aiming for their participation, placing them in a position of responsibility and as transformative agents in the various care actions⁽⁵⁾. Thus, the family must be integrated into the mental health care, taking on a facilitative and caring position.

It stands out that the role of the nurses in the setting of the services which substitute the psychiatric hospitals is extremely important in the production of health and in offering the humanized care proposed by the Psychiatric Reform⁽³⁾. Hence, this professional is strategic in the family's inclusion in the treatment, offering it spaces of protagonism and of participation throughout the process of rehabilitation of the person with a mental disorder who has been hospitalized.

The interest in developing this theme arose from the experience of nurses in the psychiatric inpatient unit of a general hospital in Rio Grande do Sul. In this space, they experienced daily contact with family members and their beliefs and cultures, and the feelings and emotions aroused by the illness of their family member.

No other studies were identified working with the family members' perceptions regarding the care in a psychiatric inpatient unit, which shows the present study's relevancy in supporting humanized and comprehensive care in services which are similar to that studied.

It is understood that allowing family members' views to be heard is fundamental for the construction and consolidation of mental health care in the perspective of psychosocial care. In this way, the study contributes to the insertion of the family in the health services, making it possible to integrate and strengthen the relationship between the team, the patient, and his family members, in this way qualifying health promotion in a broad practice, guided by the psychosocial care. In addition to this, the intention is to make possible new forms of care in the area, offering support for the construction of knowledge on this issue.

As a result, the question was asked: What is the perception of the family members regarding the mental health care undertaken in a psychiatric inpatient unit?

Thus, the present study aims to analyze the perceptions of the family members regarding the mental health care undertaken during hospitalization in a psychiatric inpatient unit.

METHOD

This study has an exploratory-descriptive character, with a qualitative approach⁽⁶⁾, and was undertaken in a psychiatric inpatient unit in a university hospital in Rio Grande do Sul. This unit has 36 beds, 26 of which are for the use of the Unified Health System and 10 of which are private beds, attending persons with mental disorders in acute phases, aiming to re-establish mental conditions, through encouragement for self-care and bringing the family members and multidisciplinary team closer together.

The participants were five family members who were in this psychiatric inpatient unit's Family Group, which meets weekly, and who agreed to participate in the study. They were chosen intentionally, the inclusion criteria being: to attend the Family Group during the data collection period and to have a family member due to be discharged from hospital, because these people could discourse more concerning the experience of hospitalization and mental health care. The exclusion criteria was difficulty in communicating.

Data collection occurred in the period July – August 2008, through individual semi-structured interviews, with the following guiding question: How do you see the mental health care which your family member has received? During the months when the data was collected, only five families had members due to be discharged. Nobody refused to participate in the study.

A complete reading of the interviews was undertaken, adopting the framework of thematic analysis for critical appreciation of the content, seeking to find the significant passages for constituting the issues addressed in the works researched, in relation to the study object⁽⁶⁾. By following the steps of pre-analysis and exploration of the material, the organization and repeated reading of the corpus of the research were possible. Next, the researchers proceeded to the treatment and interpretation of the results obtained, described in recording units and context units, which allowed the grouping of relevant ideas in a category titled "The mental health care".

The study participants were numbered from 1 to 5 according to the chronological order of the interviews. The research was approved by the

above-mentioned hospital's Ethics Committee, under Protocol number 08-068, the ethical aspects involving human beings being considered, in accordance with the requirements of Resolution 196/96 of the National Health Council⁽⁷⁾. The participants signed the Terms of Free and Informed Consent after being informed about the research's objectives.

RESULTS

The mental health care

The mental health care in the inpatient unit studied was perceived by the family members interviewed as: 1) Embracement; 2) Access to Information; 3) Self-care; 4) Medication; 5) Family Group.

Deciding on hospitalization in the psychiatric unit was a difficult experience, permeated by suffering, as at many times the ill family member does not accept this conduct, not being able to evaluate the need for treatment due to the acute symptoms. As a result, the hospitalization represents relief for the suffering of the family which coexists with a person in crisis and as yet not receiving care. Thus, in the psychiatric inpatient treatment unit in question, the embracement must occur continuously, requiring the professionals to have a stance of listening, care, responsabilization, communication and ability to resolve the questions made by the family. The embracement was valorized, as in the statement:

Since we entered here, I think we have been embraced very well. (F3)

Another characteristic of the mental health care in the psychiatric inpatient treatment unit mentioned was the confidence that the service user was receiving qualified assistance, unlike what was happening at home, as the family does not feel qualified to provide the care. This security, verbalized by the family member, gave him more stability, enabling him to continue working:

The fact of her being here, with her being cared for, makes her safer than she was at home. In addition, I feel more secure, I am managing to work now, much more. (F3)

It is understood that when the family members feel embraced at the time of the crisis, they are able to have a more positive attitude regarding the mental health care, which will cause a feeling of safety.

The mental health care is complex and fairly broad. The interviewees understood the access to information on the service user's state of health as a form of assistance, in the inpatient unit studied. Thus, the information on the state of health was considered important and extremely necessary, when requested by the family members, either personally or over the telephone:

When I ring here, nobody denies anything, whereas with the other places, it was either wait, or he's okay, or he's not. Sometimes, he was not okay when I got there and they said he was okay. Here, no; here it is an open thing, I think it is wonderful! (F5)

The health team must be sensitive and perceive that this time creates anxiety in the family, which must be embraced in relation to their questions and their requests for information regarding the ill family member's state of health and care in general. It may be noted that information on hospitalization routines, visiting hours and activities undertaken in the unit generally assuage the family members' anxiety, giving a feeling of safety and comfort at a very difficult time in their lives.

When the family members were questioned regarding their understanding of the care in the place studied, they brought their lay knowledge, based in their culture. Thus, their response depended on how this care had been experienced in their family unit. The encouragement given in the psychiatric inpatient treatment unit for self-care, for leisure activities and activities of daily living – such as taking a bath, changing clothes and watching television – was understood by the family members as a means of caring, based on their experiences of other episodes of hospitalization in institutions with asylum-like characteristics.

Here they encourage him to take a bath, at least he is having a bath, he didn't even used to wash. You couldn't even look at his hands, and better not to talk about his hair! He has changed in this respect, there has been improvement, he didn't use to change his clothes. In the other hospital he stayed doing nothing, without having a bath, nothing. He spent nearly two months there and I didn't see any improvement in him [...]. Now, here, less than one month, and I can already see improvement. (F2)

Yes, it is helping. He has even managed to watch cartoons on the television. (F2)

The interviewees identified that the care was linked to the self-care of the service user, through managing to undertake daily activities such as eating, having a bath, that is, being able to interact with normal life. They believed that in this way their family member was returning to being in contact with reality, that is, returning to socializing and taking back the autonomy which had been compromised during the crisis. As a result, the mental health care was expressed in the service user's appearance, which calmed the family when they met.

Another care measure during the hospitalization, noticed by the interviewees, was the administration of the medication by the team. The interviewee even emphasized that in a different place, the hospitalized family member had not taken his medication, because the professionals had not checked if it had been swallowed.

[...] with the medications, for example. Here, I know that he takes all the medications, everything goes correctly, but there in the other place he didn't take them. Sometimes there was no time for them to stand there waiting for the person to take the medications. (F1)

The family members made a direct relationship between the medicine and the cure. Often, the health professional nourishes this idea through believing that only the medication can control and stabilize the symptoms, spreading this concept to the family. The medication is one of the important mental health care actions, given that it acts on the psychiatric symptoms, as a result of which it is valorized in the care in this area.

The Family Group was emphasized by the family members, as presented in the account below, as a form of mental health care provided by the psychiatric inpatient treatment unit. This space offers care through information which assists the family members at times of crisis, as well as providing listening, dialog, and the exchanging of experiences. It is important to provide spaces for the family members to bring up their doubts and difficulties, as it makes integration and participation viable between the team and the family, allowing the team to become familiar with their doubts and how they coexist with the mental disorder.

I felt good, I also felt I was in a conversation, [...]. I never had anybody who came up to me so that I could talk like that. I don't have anybody to talk to, nobody. I am alone at home and my children don't believe me. So, it was wonderful. I wish I could always have some support. (F5)

I think that yes, these morning meetings, I think that they are to support how we are going to handle her later. (F4)

DISCUSSION

The mental health care in an inpatient unit must support the principles of the Psychiatric Reform, overcoming the exclusive, asylum model of treatment of madness. In overcoming the asylum model and its forms of negative experience – long confinement, mental and institutional suffering, oppression by the methods of social control, and discrimination – the care in psychosocial care requires technologies which include valorizing people's subjectivity, their life experiences, and the meanings they have for leading their actual existence⁽⁸⁾.

As a result, caring in the psychosocial perspective is more than an act; it is an attitude of the professionals, permeated by feelings of concern, responsabilization, and of affective involvement with the other⁽⁹⁾. The important role of the nurse as a professional qualified to offer humanized care dedicated to the psychosocial mode in the perspective of the services which substitute the psychiatric hospitals is inserted in this scenario.

Thus, in the context of the inpatient unit, the family undergoes the experience of separation, which creates feelings of ambivalence regarding the decision to hospitalize, in a place far from its care. Added to this, there is a fantasy which permeates the social imaginary related to the psychiatric hospital and the entire phenomenon which surrounds madness. In this scenario, the role of the health team, in particular that of the nurse, is extremely important, as it is the nurse who has the first contact with the service user and his family, meeting the needs of both, adopting an embracing stance, of listening and of giving answers to the requests of each subject of this process⁽¹⁰⁾.

Embrace and forming a bond are decisive in the relationship of care between the mental health worker and the service user, affording shared responsibility⁽²⁾, expressed through the ability to respond to a specific situation on one's own. It is a stance of involvement, which, in the case of the health services, is evidenced through the strengthening of the bonds between the person who seeks attendance, the service and the territory⁽¹¹⁾.

It is believed that integrating the family in the service users' care is not just allowing them to come and visit them, but is, rather, allowing times for inte-

raction, meeting and exchanging knowledge. One of this process's aims is to establish a relationship of confidence, links and responsabilization for people's health and life, in which all, together, can think of a better way of assisting the person with a mental disorder in the existing context, rather than an imaginary context, as often happens.

Thus, the care in the psychiatric inpatient treatment unit provides the families with security, both in relation to the fact that the patient is in a protected environment, and the fact that this care unit feels safe to work in. The family's questions need to be heard, and its needs need to be met, it falling to the professionals to offer support and help for coping with the distance between family members and service users, qualifying the mental health care. The meeting between the family and team leads to exchanges and clarifications, and helps to demystify madness and establish partnerships, qualifying the care and leading to greater adherence and continuity in the treatment. A family which is linked participates in the healthcare and becomes more present in the process of rehabilitation⁽¹²⁾.

The mental health care must be related to encouragement for the individual's autonomy, so that he may undertake his tasks, encouraging the finding of solutions to day-to-day questions together with his carers. He must be an active subject in the process of his rehabilitation. In this way, rehabilitating means helping the service users to overcome their limitations and disabilities and promote self-care, with the aim of raising their self-esteem, giving rise to the restitution of their autonomy and personal and social identity⁽¹³⁾.

The degree of autonomy is measured by the capacity for self-management, for understanding regarding the health/illness process, for using the power, and for establishing commitment and contract with others⁽¹⁴⁾. It is noted that the care during the psychiatric crisis is seen in terms of care for personal hygiene, taking into account that at this time the person experiences difficulties in caring for himself and also is disadvantaged in social interactions.

The family identifies improvement when it observes that the ill family member is beginning to re-establish his appearance, once more taking an interest in daily activities and communication, the family visualizing in this way that the result is being effective⁽¹⁵⁾. Comprehensive care proposes continuous investments in all the spheres of a person's life, including help with practical issues which the person cannot undertake alone, so that she may exercise citizenship in all its fullness⁽¹⁶⁾.

One must, however, exercise precautions so that the care should not return only to the suppression of the signs and symptoms through medication, considering that this practice is an inheritance of the type of treatment that the majority of the service users knew in the psychiatric hospitals – and also of the training of the professionals in the biomedical model⁽¹⁷⁾.

In this regard, the guidance provided to the family members on the use of the medication, its effects, duration of action, administration and maintenance appears fundamental in mental health care, it being interesting to allow times for meeting and space for dialog regarding this issue. Thus, listening to what the family has to say regarding its difficulties related to the administration of medication and, jointly, to plan individualized care, which meets their doubts and facilitates the partnership in the care, is a care strategy which helps in the mental health actions.

The family members recognize this group as a therapeutic space, which helps at difficult times, where they can exchange experiences, and which strengthens them; that is to say, a space which cares for those who care. Hence, it is necessary to guide them in terms of practical strategies for managing the illness, to provide them with clarification regarding the therapies proposed, to share information, and train them regarding what to do in crisis situations, among other aspects⁽¹⁷⁾.

A group of family members can function as a space for embracement of the life experiences of its participants. Encouragement to exchange experiences has been shown to be an important tool for increasing the ability to deal with the problems⁽¹²⁾. Thus, the experience makes a sense of inclusion, valorization and identification possible in the collective experiences of the health problems. The care produced is the result of a collective strength, whose coordinator must be attent to the uniqueness of each subject, and personalized care⁽⁵⁾.

FINAL CONSIDERATIONS

During this study, the perceptions of the family members, regarding the mental health care in the psychiatric inpatient treatment unit, were analyzed. These perceptions support the requirements of the psychosocial care which entail the comprehensiveness of the care and the embracement through the attitudes of the professionals, through qualified listening and dialog.

The family members brought the understanding that the care in the hospitalization translates into security, both for the family members and for the service

users attended in this space. This understanding leads us to see that the physical and emotional overload reduces during hospitalization. In addition to this, the ease of accessing information, the improvement in self-care, and the verification of the taking of the medications on the part of the service users also provides a sense of security for the family members.

The family groups appear as strategie for mental health care, as the family feels cared for, supported and more empowered for the care in the home. Offering attention to this care center means giving guidance, clarification, information, support and security.

Finally, we understand that mental health care, at the present time, indicates the family as a partner for more effective comprehensive health actions. This requires the nurse to become closer to the family members, seeking to assist, provide guidance, and discuss interventions; and in this way to invest in therapeutic contracts which take into account the complexity of the experience of mental illness. It is necessary, therefore, for these professionals to establish bonds and relationships of trust and responsibility with the life of these people, making it possible for these family members to actively participate in the mental health care.

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