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PROPOSAL FOR GROUP INTERVENTION WITH FAMILY OF USERS IN A MENTAL HEALTH DAY-HOSPITAL THROUGH PSYCHO-EDUCATION

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ABSTRACT

Objective: present a proposal for psychological intervention, through a therapeutic group, with the family members of users of a Reference Mental Health Service aiming at strengthening the institution / family bond. Methodology: The Arco de Maguerez was used, an instrument developed in the 70s and the basis for the application of the Problem-solving Methodology. In this methodology, the study takes place from a certain aspect of social reality and consists of five stages: the observation of reality, the key points, the theorization, the hypotheses of solution and application to reality. Results and discussion: It is proposed that the group be divided into three modules. Module I, Crisis in Mental Health, is designed to address issues related to the crisis (concepts and definitions, alerts and signs, creative possibilities of the crisis, among others). Module II, Family member as caregiver, aims to explore the role and responsibilities assumed by family members of reference in the context of the service user's illness. Finally, module III, Caregiver Self-Care, aims to stimulate reflections and provide a moment of self-care. Final considerations: During the meetings, it is expected to create a space where family members can share experiences, aiming at strengthening the group to deal with the difficulties and complexities of daily life, as well as enabling a discussion on mental health and the search for strategies that ease the burden of care and the family's suffering.

Keywords: family, psychoeducation, group, mental health, CAPS

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INTRODUCTION

PSYCHIATRIC REFORM IN BRAZIL

Psychiatric treatment, for many years, was based on the hospital-centered model that aimed to intern people in psychological distress indefinitely in asylums[1]. However, this asylum model was inhumane and inefficient and, therefore, received numerous criticisms, especially in Europe. In the 1950s, the psychiatric deinstitutionalization movement emerged that aimed at humanizing treatment and defending the human rights of individuals[2]. This movement aimed at the humanization of care and sought to defend the civil and human rights of people with psychiatric disorders[3]. Based on complaints, members of the movement showed that hospitalization caused the disease to become chronic and segregation was an obstacle to family and community integration.

The Psychiatric Reform process in Brazil was influenced by Italian Democratic Psychiatry. However, the Brazilian process started in the late 1970s, about two decades after European countries. In Brazil, as in other countries, there were complaints about the precarious conditions in asylums, abuses against patients and insufficient treatment[4]. In 1964, at the beginning of the dictatorship, the Brazilian government created the Ação Plan, an agreement with private psychiatric hospitals. After this agreement, more than 90% of mental health funds were allocated to the private sector. Mental health professionals spoke out against privatization, denouncing inhuman treatment within private institutions[5].

At the end of the 1970s, the first manifestations of redemocratization appeared in Brazil. However, due to the economic recession, there was a need to cut expenses for private asylums. In addition, the Mental Health Workers Movement, started in 1978, also denounced the precarious working conditions of mental health professionals, contributing to the struggle for the adoption of community psychiatric care in Brazil[6].

Thus, the economic crisis and social pressure to improve assistance to the population were decisive for the reformulation of health policy. In the 1980s, the government presented a proposal for mental health, which proposed replacing the hospital model with broader care, including different forms of care, decentralization of services, extra-hospital treatment and a short hospital stay. In 1985, with the end of the dictatorship, Brazil again had a democratic regime. This made society appreciate the right to citizenship.

In 1986, the 8th National Health Conference took place, which aimed to raise proposals for Brazilian psychiatric care. During this conference, it was proposed to create a comprehensive and multiprofessional psychiatric care. In addition, treatment should be carried out in health centers, specialized outpatient clinics and in Psychosocial Care Centers - CAPS[7]. Psychiatric emergency care should be carried out in general hospitals. Thus, the treatment would not be permanent and exclusive. However, the psychiatric deinstitutionalization movement only gained prominence at the 1st National Conference on Mental Health and the 2nd National Congress of Mental Health Workers, in 1987.

As before, it was proposed to replace the hospital-centered model with the community model8. From these events, the movement gained greater visibility and participation of family members and people undergoing treatment. From the creation of the motto "For a Society without Asylums", a strong campaign for adherence to psychiatric reform[9] began. In 1989, deputy Paulo Delgado's bill was presented, which proposed the closure of asylums. At the same time, the implementation of substitute services began, aiming to serve people without the need for hospitalization[8]. However, there were many obstacles in the psychiatric reform process, as the institutions of private psychiatry

pressed for the maintenance of the health insurance and were against closing the asylums.

In 1992, the Dehospitalization Support Program (PAD) was implemented, which aimed to deactivate psychiatric beds[8]. From the money that would be withdrawn from the deactivation of psychiatric beds, hospitalized patients could return to their families of origin or other families, receiving a minimum wage. However, this program has not been implemented.

After 12 years of processing and political and social mobilization, on April 6, 2001, Federal Law 10.216, known as the Paulo Delgado Law, was enacted, being the law that made community psychiatric care official in Brazil. The law provides for humanized treatment, protection for psychiatric patients, the implantation of substitute services throughout the national territory, the bases of operation of the services and the regulation of compulsory hospitalizations. Thus, in addition to the CAPS, the establishment of mental health clinics, NAPS, therapeutic residences, day hospitals and psychiatric units in general hospitals was planned[10]. In addition, it advocates the creation of preparation units for social reintegration and services for the care of families[5].

In this perspective, health care is associated with the promotion of spaces for dialogical construction, in which the subjects actively participate in its process. According to the authors Leal and De Antoni[11], in this period, the National Mental Health Policy originates, which aims to guarantee mental health care in substitute services to psychiatric hospitals, overcoming the logic of long-term hospitalizations and isolation from living together familiar and social. As a result of these movements, the CAPs (Psychosocial Care Center) were created, configuring themselves as open and daily care services, working in a multidisciplinary team[12]. They act in a logic of territorial care and the assistance is given individually, in groups, assistance to families, community actions, home visits,

The services carry out actions aimed at psychosocial rehabilitation through insertion by culture, leisure, art and work, thus favoring the autonomy of the service user[12]. Therefore, these services seek to reinsert the subject in the world, contributing to deinstitutionalization. It is about emphasizing the community dimension of the human being.

THE FAMILY IN THE CONTEXT OF MENTAL HEALTH

For many years, the treatment of people affected with some psychological distress was carried out within psychiatric hospitals, being excluded from society. Asylums were characterized as spaces of segregation that removed the individual from his family and social spaces. However, this scenario changed because of the Brazilian Psychiatric Reform, as this movement criticized the hegemony of biomedical knowledge in care and denounced the inhuman treatment, promoted by the asylum model[14]. In this perspective, there was emphasis on the importance of the family in the care of the individual[7]. Thus, according to Serapioni[15], it is necessary to reposition the family within public policies, create support networks for them and the community and integrate the family within the services.

The family is the first social group in which we are inserted; for some, it is a protective factor; for others, at risk. In any case, it is necessary to admit the importance of involving close people, family members or not, in cases of mental illness. Studies show that family relationships change with the illness of one of its members, whether for clinical or psychological reasons. Cases of alcoholism, anorexia nervosa, depression, anxiety, among others, affect not only the person affected, but also those who are close to them[16]. The family's participation in the treatment of psychiatric patients is also shown to be an important factor in patient adherence and improvement, also influencing the relationships established between their own members.

However, the family's approach to mental health institutions is, in general, recent. Until then,

individuals considered to have mental disorders were removed from their family (sometimes even by a decision of the same). They were thus excluded and included in the hospital-centric paradigm, in which all care and responsibilities fell on the institutions[17].

Thus, according to the authors mentioned above, if the family was previously removed, because it was understood that she was also responsible for the illness and made it difficult for the individual to be treated; today it is understood that the family has a fundamental role in the recovery and dignified treatment of the sick person[18].

PSYCHOEDUCATION AS A CARE STRATEGY

Nowadays, the family is perceived as the main responsible for the care of the mentally ill, providing the "supply of their physical needs, financial support, keeps them safe from the environment, teach new skills, organize social and recreational activities, monitor medication and medical consultations and help patients repeatedly in crisis situations "[19].

The authors state, however, that there is a shortage in the provision of basic information to the family regarding mental health and the management of individuals with mental disorders. Thus, their participation in treatment should be encouraged at the same time that, when they assume reference roles in care, they also need a space for self-care and exchange of experiences.

In this context, psychoeducation is shown to be a favorable tool to offer support to caregivers and family members, as they often deal with issues related to "decreased personal care, aggressiveness, inappropriate behaviors, lack of adherence to treatment, pronounced isolation. social risk, suicide risk, mood swings, pervasive anxiety and depression, substance abuse, manic behaviors, delusional and hallucinatory behaviors ", which most often occur unexpectedly[19].

Psychoeducation presents itself as a means of providing information and support for families, enabling benefits for both patients and their families. According to Arantes, Picasso e Silva, psychoeducation provides the exchange of "new information, questions about myths and prejudices and the reflection of experience"[20].

Thus, the authors point out that the four main goals of family education are: 1) to legitimize psychiatric illness; 2) reduce the negative emotions of family members; 3) recruit the cooperation of family members with the treatment plan; and 4) improve family skills to monitor the disease.

Thus, it is considered that the present material in order to present a proposal for psychological intervention, through a therapeutic group, with the family members of users of a Reference Mental Health Service aiming at strengthening the Institution / family bond. Specific objectives are the provision of information and support for family members through psychoeducation; address and discuss issues related to mental health; offering speech space to exchange experiences among group participants; and favor better adherence to treatment.

METHODOLOGY

The Maguerez Arch was used, an instrument developed in the 70s and the basis for the application of the Problem-solving Methodology. Prado et al.[21], states that the study takes place from a certain aspect of social reality and consists of five stages: observation of reality, key points, theorization, hypotheses for solution and application to reality.

Thus, during the internship it was observed that, in some cases, the family members present a distance from the service and, in turn, from the treatment of the user in a comprehensive way. Sometimes there is a lack of knowledge, or even disregard, regarding the suffering of the relative who is being treated. Pinho, Hernández & Kantorski[22], criticize the way individuals who lived in asylums were returned to families. For the authors, this process was carried out in a

disjointed and unassisted manner, leaving families helpless and overwhelmed.

Thus, it is considered the importance of support from family members for user compliance and treatment, as well as the need to offer a space of care for this family member and necessary information for care. It is believed that family members are central elements in the psychosocial care of service users. With this, the present material proposes the creation of a therapeutic group for family members as a strategy to solve this problem, allowing a space for listening and information through psychoeducation.

The proposal is that it takes place in the format of an open therapeutic group, thus allowing members who leave the group to be replaced by new participants, with a predetermined duration of three meetings[23]. According to the authors, groups of the type "clinic for outpatients" of short duration (five or less meetings) have a dropout rate of 17%, a number below all the other types they mention.

RESULTS AND DISCUSSION

It is proposed that the group be divided into three modules. Module I, Crisis in Mental Health, is designed to address issues related to the crisis (concepts and definitions, alerts and signs, creative possibilities of the crisis, among others). Module II, Family member as caregiver, aims to explore the role and responsibilities assumed by family members of reference in the context of the illness of the service user. Finally, module III, Caregiver Self-Care, aims to stimulate reflections and provide a moment of self-care.

THERAPEUTIC GROUP PLANNING

The group will start with a short initial activity (meditation, dynamics), continue with the discussion on the topics proposed for each meeting and will end with an exchange between members about what has been experienced. As the duration is one hour, activities should be divided within this time. Ethically, the group will be able to expose the relative in question, as well as intimate intra-family situations.

Therefore, at the beginning of all meetings, the professionals involved will welcome the family members, explaining that the space is confidential and everything said within it should not be shared, bringing awareness of the group space as well as human care. In addition, time will be available for each family member to introduce themselves.

Module I: Mental Health Crisis

In this module, the concept of crisis will be worked on. The objective is to discuss the disorder (diagnosis, cause, treatment) and reflect on the approach in episodes of crises. It is noticed that some families do not have guidance on how to manage care in times of crisis. Therefore, offering these guidelines and / or information facilitates how the family can deal with a crisis situation. In addition, it places it as a co-participant in the care process through knowledge and commitment. Providing information and guidance on how to deal with the behaviors of individuals who suffer psychically can reduce family burden[24].

Module II: Family member as caregiver

During this module, the group will address issues of care in the context of mental health. There are two types of family charges: objective and subjective. The objectives are characterized by the time used for assistance, financial issues, the impact on social relationships and work. Subjective charges, on the other hand, include symptoms of anxiety and distress, psychosomatic effects, feelings of guilt and shame[25]. Therefore, it is important that the family understands these factors so that it is not overloaded and, consequently, offers adequate assistance to the individual.

Then, to talk about the importance of including the family in the user's therapeutic project, the team will explain the process of Psychiatric Reform and the proposals advocated by it, such as: the humanization of care and the rescue of users' autonomy and citizenship[26]. It is important that, during the group, family members feel

welcomed so that they can understand its importance as a caregiver for the service user.

Module III: Caregiver self-care

In this module, the interventions will focus on relieving the burden and anguish by welcoming the multiple issues experienced by caregivers. Barroso, Bandeira and Nascimento[27], state that the family burden resulting from care causes difficulties for caregivers to find time for their own care. In addition, in some cases, care interferes with occupational life, distancing the individual from work and social life. Life planning based on the person being cared for can cause despair, impotence and personal changes[28]. Thus, caregivers experience tiredness, impatience, the need for support[29]. Therefore, in order to avoid stress, tiredness and allow the caregiver to have time to self-care, it is important to talk about the participation of other people in the provision of care.

FINAL CONSIDERATIONS

During the meetings, it is expected to create a space where family members can share experiences, aiming at strengthening the group to deal with the difficulties and complexities of daily life, as well as enabling a discussion on mental health and the search for strategies to ease the burden of care and suffering of the family. In addition, it is believed that the insertion of family members in the new mental health care model makes it possible for care to be shared. Therefore, the possibility that the service link with family members is strengthened through this welcoming strategy is considered.

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