The family in mental health: support for clinical nursing care*

A FAMÍLIA EM SAÚDE MENTAL: SUBSÍDIOS PARA O CUIDADO CLÍNICO DE ENFERMAGEM

LA FAMILIA EN SALUD MENTAL: AYUDA PARA EL CUIDADO CLÍNICO DE ENFERMERÍA

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ABSTRACT

This is a theoretical reflection on the clinical nursing care in mental health that is offered to the family. In view of having a family member with mental suffering, the family would delegate the care to that relative to the mental institution, thus there should be collaboration between the nursing and medical team to organize the environment and ensure family and social isolation. With the Psychiatric Reform, based on the proposal for psychosocial care, the family becomes the center of attention for health care professionals. The necessary support for clinical nursing care includes making conceptual changes in implementing health education, interdisciplinary work, and in the broadened clinic, so as to ensure comprehensiveness and subjects' autonomy. Clinical nursing care should permeate the subjects' politicalization, in which the actors militate to reach autonomy, and the practices involve dignity, creativity, welcoming, interdisciplinarity, hearing, and knowledge sharing.

DESCRIPTORS
Family
Mental health
Nursing care
Psychiatric nursing

RESUMO

Trata-se de reflexão teórica sobre cuidado clínico de enfermagem em saúde mental dado à família. Diante da existência de um membro em sofrimento psíquico, a família delegava ao manicômio o cuidado do seu parente, cabendo à enfermagem colaborar com o trabalho médico, organizando o ambiente e garantindo o isolamento familiar e social. Com o advento da Reforma Psiquiátrica, pautada na proposta de atenção psicossocial, a família passa a ser alvo de atenção dos profissionais de saúde. Enquanto subsídios para o cuidado clínico de enfermagem em saúde mental, acredita-se na necessidade de mudança conceitual, na implementação da educação em saúde, no trabalho interdisciplinar e na clínica ampliada, garantindo a integralidade e a autonomia dos sujeitos. Compreende-se que o cuidado clínico de enfermagem deve permear a politização dos sujeitos, na qual os atores militam em busca da produção de autonomia e as práticas envolvem dignidade, criatividade, acolhimento, interdisciplinaridade, escuta e compartilhamento de saberes.

DESCRITORES
Família
Saúde mental
Cuidados de enfermagem
Enfermagem psiquiátrica

RESUMEN

Reflexión teórica sobre cuidado clínico de enfermería en salud mental a la familia. Ante un miembro en sufrimiento psíquico, la familia delegaba al manicomio el cuidado de su pariente, correspondiendo a la enfermería colaborar con el trabajo médico, organizando el ambiente y garantizando el aislamiento familiar y social. Con el advenimiento de la Reforma Psiquiátrica, pautada en la propuesta de atención psicosocial, la familia pasa a ser foco de atención del profesional de salud. Como adyuvantes del cuidado clínico de enfermería en salud mental, se cree en la necesidad de cambio conceptual, en la implementación de educación en salud, en el trabajo interdisciplinario y en la Clínica ampliada, garantizando integralidad y autonomía de los sujetos. Se comprende que el cuidado clínico de enfermería debe facilitar la politización de los sujetos, para que los actores militen por la autonomía y las prácticas involucren dignidad, creatividad, respaldo, interdisciplinaridad; escuchar y compartir conocimientos.

DESCRIPTORES
Familia
Salud mental
Atención de enfermería
Enfermería psiquiátrica

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INTRODUCTION

This is a theoretical reflection concerning nursing care provided to the families of individuals experiencing psychological suffering considering the mental health care based on psychosocial care developed in the context of the Democratic Psychiatric Reform.

The family is based on cultural kinship relationships and is historically determined, including basic institutions. It is a key element not only for the *survival* of individuals but also for the protection and socialization of its members, transmission of cultural and economic capital and group property as well as gender relationships and solidarity among generations[1].

The family is an institution in which individuals begin their developmental processes. Through the family, individuals incorporate behavioral patterns, moral, social, ethical and spiritual values, among others. The nuclear family participates in the individual's personality development and contributes to one's character, as well as what notion of ethics and solidarity one adopts[2]. According to the authors:

> Because its structure, composition and function is so complex, the family does not escape from experiencing multiple conflicts over its life cycle. It is subject to transformations in its existence and often needs to reconsider its positions in the face of diverse realities and adversities to which it is submitted in order to overcome and find balance.

Since psychiatry emerged as a form of medical knowledge responsible for unveiling madness, the family of the individual in psychological distress has been removed from the treatment process; patients were committed to a psychiatric facility. In this modality of care, family members were alienated from the treatment, feeling guilty in the face of prohibitions regarding visits[3].

In the institutionalization of madness, where medical knowledge becomes the ruler and holder of the 'mentally ill individual', the removal of individuals from their social and family milieu became a premise of the treatment proposed at the time because the family was seen as the one causing the disease, reinforcing isolation as a therapeutic measure. The family consented to the patient's hospitalization, and such consent was expressed through gratitude for being relieved of the problem[4].

These two positions attributed to the family— of being an accessory to the hospitalization believing that healing would be achieved in the asylum and also of being the causer of the individual's suffering— were, for a long time, responsible for the family's lack of willingness to become

a therapeutic resource itself for the individual in psychological distress[4]. Moralizing psychiatry insisted on separating the patient from his/her family environment, permitting the least possible contact with family members[5].

> This procedure was justified to 'protect' the family from madness. It intended to prevent the remaining members from becoming contaminated with the negative influences of mental patients, a symbol of indiscipline and moral disorder, especially the most vulnerable individuals such as children, adolescents and young women.

The nursing care provided in psychiatric facilities was characterized by use of repression, punishment and surveillance. The recipient of care did not receive humane care and was often treated with violence and no encouragement. The patients' potentialities were reduced until they became incapable of living in society[6]. In this context the family, separated from its ill member, believed it had left him/her in a place appropriate to provide care, under the responsibility of qualified professionals.

Nursing workers within a psychiatric facility environment were coadjutant actors in the process of rehabilitating the mad/alienated individual, acting as executors of a disciplinary order issued by the doctor/alienist. Hence, they were devoid of professional autonomy, supporting their actions on the biomedical model with segregated purposes, depriving the individual of family and social interactions.

Until the 1990s the work of psychiatric nurses within psychiatric facilities was mainly focused on the administrative field, bureaucratic and based on the biological model. Nursing care was not directed to the patient or his/her family, but it was focused on keeping the *therapeutic environment*, so it was a true stage of interventions where the medical power was exercised[7].

This situation persisted because nursing, as well as other health professions, was influenced by hegemonic productive organizations dominated by Taylorism and Fordism, and the Flexinerian model in the educational field, which is marked by an exaggerated concern with technical rationality and expertise[8].

However, nursing became influenced by human relations and the focus was no longer only on the disease's physiological and biological aspects but came to be considered within the context of the patient's relationships. Then, nurses became psychotherapists, a role driven by the work of H. Peplau, who defined the essence of nursing through the development of this skill acquired through formal knowledge of patient counseling[9].

Among the nurses who worked in psychiatric nursing, the following stand out: H. Peplau, who developed

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The family in mental health:
support for clinical nursing care
Silva KVLG, Monteiro ARM

Rev Esc Enferm USP
2011; 45(5):1232-7
www.ee.usp.br/reeusp/

1233

the Theory of Interpersonal Relationship; Trevelbee, who established the relationship of person to person; and Mizone in Brazil, who became concerned with humanization of care[9].

Only with the advent of the Psychiatric Reform was a new way of thinking about the health/disease mental/care continuum defended. The replacement of the concept of disease seen as a suffering existence is strengthened when care is valued and the adoption of its territory as a social space of constant search for one to fully exercise citizenship.

In Brazil, the first movements of family members emerged from the visit of Basaglia to Brazil and the mobilization promoted around his conferences. The Rádice journal reported the creation of an association of families and mental patients in Barbacena, MG, Brazil after Baságlia visited the asylums in that city. The journal considered the movement frankly critical of the role of the psychiatric facilities, indicating a struggle against mandatory hospitalizations, violent practices and defense of non-biological theories for explaining mental diseases[10].

In the current context of public policies, institutionalizing practices, among them asylums, are avoided in the care delivered to chronic patients. This change occurred due to the conception of the family and community as places and actors essential to social protection[11]. The authors assert:

> The family as the ultimate expression of privacy, is a place of intimacy, where meanings are constructed and feelings are expressed, where psychological distress, which life imposes on all of us, is externalized. It is perceived as an affective niche of relationships necessary to the socialization of individuals, who develop the feeling of belonging to a relational field initiator of relationships in society life[11].

In the current context, the process of psychiatric reform cannot be considered a simple change in physical structures, but a re-elaboration of conceptions, devices and ways for people to relate with madness, becoming committed to the interests of those to whom one provides care[12].

In relation to the theme *family in mental health*, one needs to focus on practices intended to be innovative, believing that deinstitutionalization only occurs with the effective participation of families. When considering mental health care, the inclusion of families is an essential element for Psychiatric Reform[13].

The relevance of including the family in mental health actions was defended through the Final Report of the 3rd Mental Health Conference, which established that, as alternative services were constructed, these should plan strategies of actions directed to families, becoming committed to projects of social inclusion, respecting families' subjectivity. The process of progressive replacement of psychiatric beds by other forms of providing care requires

that the role of family members in providing care to mental health patients be strengthened[14].

In this direction, health policies and social care introduce services directed to the family and community. Among the social policies that implement collective services based on the combination of modalities of care grounded in the family and community, the Psychosocial Care Center (CAPS[a]) stands out as a new space where mental health care is provided.

CAPS defends the view that the inclusion of families should implement a singular dynamic in which the relationship with families should support the idea of support and coping with psychological suffering, be integrating, welcoming, caring and include the actors of this relationship in the routine spaces of life. The partnership established with the family is a guarantee that care will be continued and treatment will be developed[15].

Health professionals should reflect on the interventions implemented with individuals in psychological suffering and their family members, identifying the needs of this group. Professionals should work with the concept of recovery, one of the most recent additions in psychiatric rehabilitation, which means to reformulate life aspirations and adapt to the disease, if necessary[3]. Hence, a greater concern with the individual instead of with symptoms is observed, which emphasizes the possibilities of living with limitations and increasing potentialities, both within the family and the community.

Families who live with a situation of chronic disease continue with the same functions performed by other families, though they add another responsibility, that of caring for the family member with a mental disease. Such families are in a situation of risk, with greater vulnerability because the chronic disease, given its characteristics and when not under control, sucks the energies of the family because when it manifests it alters the family context and routine[16].

The family should be seen as a unit of care, that is, the caregiver in situations of health and disease of its members. The role of health professionals is to support the family and strengthen it when it becomes fragile. Hence, the approach in mental health is not restricted to medication and potential hospitalization only, but also to actions and procedures intended for the family and social reintegration[17].

The growing importance attributed to the participation and integration of families in the therapeutic project of those in psychiatric suffering is seen in current studies, highlighting the premise concerning the delivery of care consistent with the individual's context and family dynamics[18]. We consider it essential that families become involved with the lives of users of extra-hospital services, which is ideal to understanding the limitations and poten-

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[a] Acronym in Portuguese.

The family in mental health:
support for clinical nursing care
Silva KVLG, Monteiro ARM

tialities of families, promoting support during rehabilitation actions and social inclusion of those involved.

Care provided to families should include support during coping with daily problems, preventing the transformation of problems experienced during the disease, focusing on guidance and education to prevent and cope with the chronic health condition[16].

As health professionals, we should pay attention to the difficulties faced by some families in dealing with patients diagnosed with psychological distress. Prejudice also reflects on the family, who may deny the disease or abandon the patient. The effective participation of families as the most important group in the lives of individuals experiencing psychiatric suffering is an essential tool for achieving success in nursing care.

REFLECTION

The family has remained throughout human history as a permanent social institution. Such a fact may be explained by the family's ability to change and adapt, resilience, and for being acknowledged by society and those who integrate it. The family is a potential source of support and cannot be excluded when one deals with individuals. It is necessary to recognize the importance of the family in the current context of health, revealing health actions based on health promotion and education for well being as a starting point for improving the conditions to which it is subject.

In analyzing nursing practice in mental health and the proposition defended by the reform of psychiatric care, we reflect on the support provided to the family caregiver concerning clinical nursing care in mental health.

First of all it is necessary to change concepts concerning mental disease and disability, welcoming psychosocial rehabilitation and integral care provided to all the family members. The implementation of care should be based on an ideology of citizenship, ethics and humanization[9].

Nursing actions should be guided by education in health as a strategy to promote the health of the family of the individual in psychological distress. It is the role of nurses to transmit knowledge, propose solutions for problems, and be willing to teach, learn and help the family to find the means to assuage or solve their problems. Therefore, in order to change, one needs to appropriate knowledge, humanized knowledge, in which one understands the human being in its complexity of biological, cultural and historical dimensions[19].

It is argued that families should be included in the process and share responsibility for the integral care provided to the patient, which is essential to enabling a congruent inter-relationship with the needs of the patient and family[15]. Consequently, the family member feels safe in exposing his/her care demands and confident that there are professionals committed to his/her situation, willing to walk a continuous path in which competence and solidarity coexist.

Therefore, the participation of the family in the mental health care service and care provided to the patient can favor an affective proximity among the family members, breaking with prejudice related to disability and dangerousness, debunking the idea of social exclusion[15].

Another topic relevant for the development of clinical care in mental health nursing care is team work, in an interdisciplinary sense, since issues involving mental health and family are complex and require one to look at it from different perspectives, which involves multiple disciplines and specialized knowledge approaching care needs and potential solutions to problems faced by these individuals[20].

To achieve it, interdisciplinary education in nursing requires interdisciplinary teaching programs seeking a more integrative analysis of health problems, encouraging a care practice characterized by the exchange and integration of knowledge[8].

Nursing care needs to develop a new logic of work organization based on integrality, which should start with professional education committed to the acquisition of skills and competencies focused on this field[21]. Interdisciplinary work should be directed and highlighted, so that academic education is such that hierarchy or power does not prevail, rather the encounter with another is encouraged to improve the living and health conditions of individuals who experience psychological distress.

The work with families should encourage individuals to transform themselves to obtain a better quality of life, which requires one to dive into themes such as conceptions in mental health, family function and structure, role distribution, considering those factors that favor the mental health-disease continuum being deemed relevant[2].

It is argued that the enlarged clinic is a path to be followed in the mental health field when providing health care to the family. This proposal encompasses the object of the clinic, aggregating to it, in addition to disease, health problems, as well (situations that increase the risk or vulnerability of people). The most important enlargement however, would be to come to see that there is not a health problem or disease that is not embodied in individuals, in the people. Hence, the object of clinic is the individual and not the disease[22].

The disease, in the Enlarged Clinic (the individual's clinic) would never occupy the place of the individual; it is in the individual's life but it never completely displaces the individual. The individual is biological, social, subjective and historical, and therefore, his/her demands change over time, since his/her values, desires are socially re-

The family in mental health:
support for clinical nursing care
Silva KVLG, Monteiro ARM

Rev Esc Enferm USP
2011; 45(5):1232-7
www.ee.usp.br/reeusp/ 1235

constructed. Therefore, the care needs of family members living with the individual in psychological distress should provide nurses with information that not only concerns the evaluation of epidemiological risks, but also social and subjective risks.

Enlarging the objective or the purpose of clinical practice is essential: in addition to seeking health production through distinct means—curative, preventive, rehabilitation or palliative care—the clinic can also promote the increase of the patients' and family members' autonomy. Such autonomy should be seen as the enlargement of the individuals' ability to deal with their own network or system of dependencies[22].

We perceive the degree of individuals' autonomy under our care to be increased when we verify that their ability to understand and act over themselves and the world of life has increased. Therefore, we see that self-care improves not only understanding of their health/disease process, but also their ability to use power and establish a commitment and contract with another[22]. Clinical care should be an instrument to empower family members so they would find alternatives to deal with psychological suffering that they experience themselves and that another experiences, whether it accrues from living together, lack of information or need for social support.

CONCLUSION

Nursing workers need to question what the meaning of their work is, the value of their practice, and the role of efficiency in the lives of those involved in care. Propositions of conceptualizing work with families should give priority to methodologies that generate solidarity, that facilitate ways to cope with contexts in which psychological distress is experienced, and a space where ethics is the basic value.

Therefore, further research is needed to identify and implement new care technology for nurses to work with the family of the individual in psychological suffering in the diverse spaces of the mental health network, as well in the Family Health Strategy, services that specialize in mental health and community.

We understand that clinical nursing care should permeate the conceptual sphere of what professional practice is as well as the concepts concerning psychiatric suffering and new paradigms instituted by psychiatric reform. Actors need to engage in politics, new nomenclatures involved in psychosocial care should be accredited, acknowledging the professional, the service's user and family members as protagonists in the production of their own autonomy, who therefore, deserve attention from a practice involving dignity, creativity, welcoming, interdisciplinary work, active listening, and the exchange of knowledge.

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The family in mental health: support for clinical nursing care
Silva KVLG, Monteiro ARM

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