

Family treating a member with mental disorders: genogram and ecomap

Família que convive com pessoa com transtorno mental: genograma e ecomapa

Familia viviendo con una persona con trastornos mentales: genograma y ecomap

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Abstract: Aim: to analyze the structure, bonds and support network of a family that lives with a person with mental disorder through the construction of the genogram and ecomap. **Method:** a qualitative, exploratory and descriptive study, conducted with two people from a family living with a person with mental disorder, in a hospital located in Rio Grande do Sul. A semi-structured interview guided by the Guide for Evaluation and Family Intervention was used. The analysis consisted of the construction of the genogram and ecomap, with the aid of genealogy software. **Results:** family bonds are weak. The support network is centered on emergency, outpatient and inpatient services; there is a precariousness of substitute services and places for social reintegration. **Conclusion:** the implementation of the genogram and ecomap in care for people with mental disorders are tools that help in the planning of care and interventions in the family context.

Descriptors: Mental Health; Mental Disorders; Family; Nursing; Psychiatric Nursing

Resumo: Objetivo: analisar a estrutura, os vínculos e a rede de apoio de uma família que convive com uma pessoa com transtorno mental por meio da construção do genograma e ecomapa. **Método:** estudo qualitativo, exploratório e descritivo, realizado com duas pessoas de uma família que convive com pessoa com transtorno mental, em um hospital, localizado no Rio Grande do Sul. Utilizou-se entrevista semiestruturada norteada pelo Guia para

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Avaliação e Intervenção na Família. A análise consistiu na construção do genograma e ecomapa, com auxílio de um software de genealogia. **Resultados:** os vínculos familiares são fracos. A rede de apoio é centrada no serviço de emergência, ambulatorial e internação, há precariedade de serviços substitutivos e de locais para reinserção social. **Conclusão:** a implementação do genograma e ecomapa na assistência a pessoas com transtornos mentais são ferramentas que auxiliam no planejamento do cuidado e intervenções no contexto familiar.

Descritores: Saúde Mental; Transtornos Mentais; Família; Enfermagem; Enfermagem Psiquiátrica

Resumen: Objetivo: analizar la estructura, los vínculos y la red de apoyo de una familia que vive con una persona con trastorno mental a través de la construcción del genograma y el ecomap. **Método:** estudio cualitativo, exploratorio y descriptivo, realizado con dos personas de una familia que vive con una persona con trastorno mental, en un hospital ubicado en Rio Grande do Sul. Se utilizó una entrevista semiestructurada guiada por la Guía de Evaluación e Intervención Familiar. El análisis consistió en la construcción del genograma y ecomap, con la ayuda del software de genealogía. **Resultados:** los lazos familiares son débiles. La red de apoyo se centra en servicios de emergencia, ambulatorios y de hospitalización, existe la precariedad de los servicios sustitutos y lugares para la reintegración social. **Conclusión:** la implementación del genograma y el ecomap en la atención de personas con trastornos mentales son herramientas que ayudan en la planificación de la atención e intervenciones en el contexto familiar.

Descriptor: Salud Mental; Trastornos Mentales; Familia; Enfermería; Enfermería Psiquiátrica

Introduction

The family can be considered as an open system interconnected with other social structures, composed of people who share a caring relationship (protection, food, socialization). Family members establish affective, coexistence, consanguineous or not consanguineous bonds, conditioned by socioeconomic and cultural values determined in a given geographical, historical and cultural context.¹

Also, the families and health professionals develop a collaborative role in assisting people with mental disorders, offering care and sharing difficult moments. This care includes assistance in daily activities such as self-care, work, leisure and social inclusion in the home and community context.² The family may also be co-responsible in accompanying the person to health services, assisting in medication, afford treatment costs, and overcome the difficulties of these tasks.³

Historically, the family has not always been seen positively in the care of a mentally ill family member. In pre-capitalist societies, care was attributed to the family, and, in its absence, the person with

mental disorder became a public situation, of justice or deliberation of the king. In the twentieth century, with the advancement of knowledge such as psychoanalysis and the movement of mental hygiene, the family began to be blamed for the emergence of a person with a mental disorder, moving away from their family environment, strengthening psychiatric institutions and culture of social isolation.⁴

Studies on the family theme gained visibility in 1950 with the emergence of family therapies, focusing on changes in relational and communication patterns in the family system. However, from Law 10,216 of April 6, 2001, called the Psychiatric Reform Law, the relationship of the family with the person with mental disorder began to receive more attention because, with deinstitutionalization, the family began to be considered as part of care.⁴

However, sometimes the family is unprepared and faces difficulties in assuming the role of caregiver, such as non-adherence to treatment by their family member, overload, financial expenses, among others.² In some cases, these situations can contribute to emotional disorders occurring in the family context. Also, possible isolation, self-mutilation, and aggression in the mentally ill person can generate anxiety, anger, fear, and guilt in the caregiver.⁵

Based on these aspects, family members are subject to physical and mental overload since there may be impairment of social, occupational, and financial life.² External relationships also contribute to care, minimizing these difficulties. These relationships characterize the support network, made up of people and/or institutions that participate in this process.⁶ This network can support the family in different aspects such as psychological, social, financial, among others, helping in the process of adaptation to care and to life.⁷

The elaboration of the genogram and the ecomap used the data obtained to perform interventions that seek to improve the affective bond and care to users and their families, help them to understand the dynamics, restructure behaviors and improve relationships. It also allows health professionals to rethink practices to improve them, and to identify weaknesses and potentialities, enabling the evaluation and planning of joint strategies that contribute to

coping with problems experienced by the family. Thus, we need more appropriate therapeutic strategies, improving the quality of life of users and their families.⁸

In this perspective, the research question of this study was: how are the structure, bonds, and support network of a family that lives with a person with a mental disorder? It aims to analyze the structure, bonds and support network of a family living with a person with mental disorder through the construction of the genogram and ecomap.

Method

It is a qualitative, exploratory, and descriptive study performed with two family members, named in a fictitious way as Ana (mother) and Abel (father). Next to the index person called Alex, they were "Family A."

One of its members with a medical diagnosis of a mental disorder should be hospitalized during the data collection period and have a higher number of readmissions registered at the Psychosocial Care Unit (*UAP*) of a General Teaching Hospital, public, located in a municipality in the state of Rio Grande do Sul as the family selection criteria for the interview. The criterion for the inclusion of family members was to be closer members of the person with a mental disorder, to understand their daily lives better. The exclusion criterion was not being able to communicate verbally, being evaluated by the researcher based on the perception of the multi-professional team of the service.

UAP is an inpatient unit of a large hospital composed of nursing staff, a psychologist, a social worker, an occupational therapist, and a psychiatrist. It also has the Multi-professional Residency in Health and Medical. It has male and female wards, totaling 30 beds, where people are allocated according to team criteria, attending people with a mental disorder.

The invitation of the members to participate in the research was intentional because the closest members were chosen, which was verified by verbal confirmation of the service team

and the evolution of the index person's medical records. Alex did not participate in the interview due to significant cognitive impairment, which hinders to understand and concentrate during the interview to answer it.

We used the Guide for Family Evaluation and Intervention to guide the interviews, advocating that the genogram is intended to provide an overview of the family, its structure, and the socio-demographic data, among others. When doing it, it is important to present at least three generations to provide information about relationships over time. The ecomap seeks to present information about family relationships with external elements, showing the important links between family and the world, and demonstrating the flow or lack of resources and family deprivation. Both enable a structural assessment of the family, the genogram internally, and the ecomap externally.⁹

Therefore, there was a semi-structured interview performed with each of the family members with an average of 50 minutes. The interview script was organized in two moments, based on an instrument prepared by the researchers. The first moment was intended for the characterization of respondents and the recording of data related to the person with a mental disorder. The second moment dealt with the central theme of the study, containing the following guiding question: tell me about your family context since the diagnosis of your family member/beginning of the follow up until today. We used a digital recorder for the interviews, later transcribed in full after the consent of the participants. The meetings took place in a private room at the hospital in August 2017.

Data analysis consisted of an in-depth reading of the interviews and construction of the genogram and ecomap diagrams, initially drawn with the family during the interviews and detailed by the researcher according to the data obtained. To help this construction, we used genealogy software available on the internet, called GenoPro[®] version 2016. The family validated the genogram and ecomap drawings. We communicated the objectives and ethical aspects of the research to the participants, who signed the Informed Consent Form (ICF). We

preserved the anonymity of the interviewees through the adoption of fictitious names determined by the researcher.

The Research Ethics Committee approved this study following the ethical precepts of Resolution 466/12 of the National Health Council,¹⁰ under Opinion 2,009,636, CAAE 65186917.8.0000.5346, issued April 10, 2017.

Results

The family was interested, willing, and collaborative during the process. Figure 1 shows its genogram.

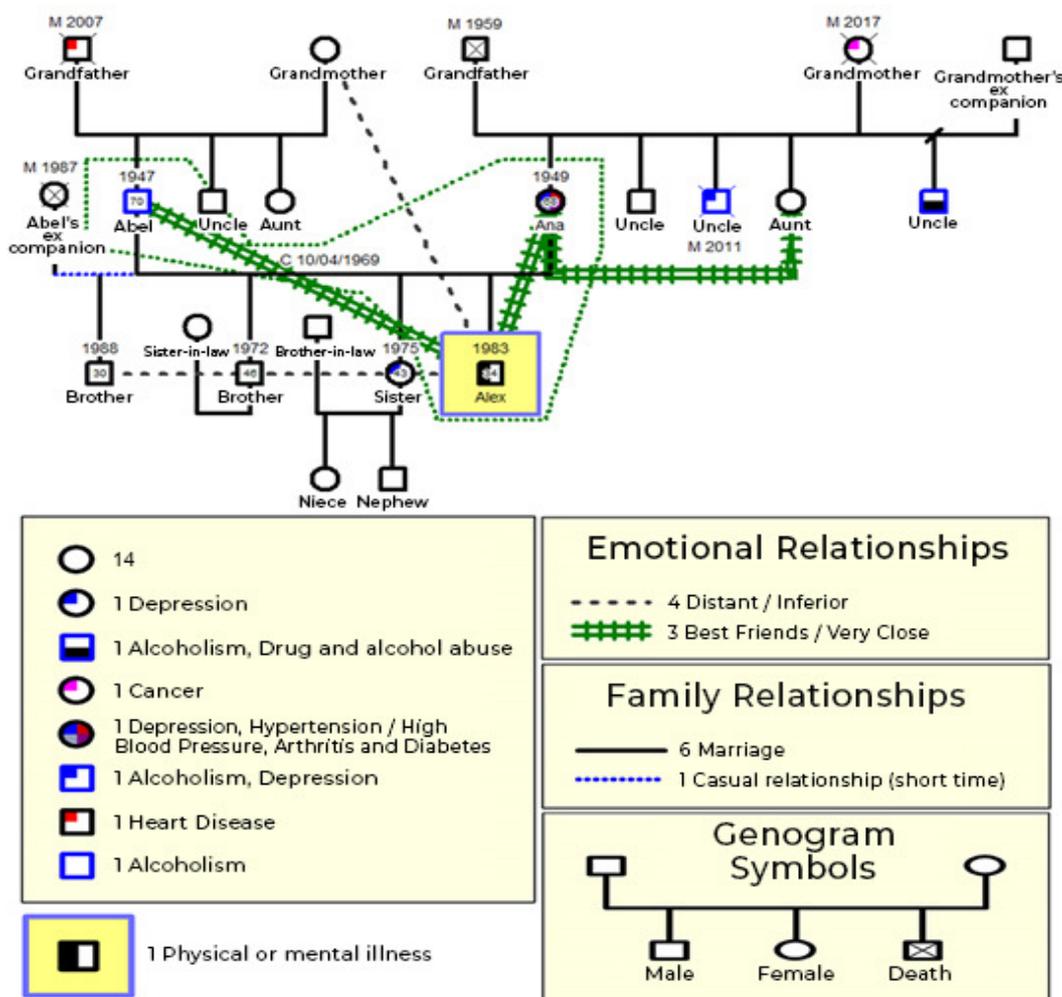


Figure 1 –Family A Genogram. Rio Grande do Sul, Brazil, 2017

The interviews were conducted with Alex's parents, 34 years old. Alex studied until the 4th grade and received the Continued Benefit (*BPC*). He was diagnosed with moderate intellectual disability and presented the first episodes of aggression in 1997 at 14 years old when he started a psychiatric follow-up at the Psychiatry Outpatient Clinic of the Hospital. His first hospitalization at UAP was on 11/07/2002 at 19 years old. At the time of data collection, based on medical records, information from UAP parents and staff, Alex had more than 30 hospitalizations.

Ana (mother), 68 years old, is a housewife and retired. Abel (father), 70 years old, is also retired and cares for a family farm. Ana and Abel have been married for 48 years and have three children, one woman, and two men. Abel has a child from an extramarital relationship; Ana assumed motherhood because the mother of the child committed suicide with a firearm when the child was five months old.

Alex's maternal grandfather was a farmer and died in 1959; his grandmother was a housewife and died of kidney cancer in April 2017. His paternal father was a railwayman and died of heart complications in 2007, and his retired grandmother is alive but does not maintain contact with Alex.

Alex has an uncle and an aunt on his father's family. On her mother's family, she has an aunt and three uncles, two of her uncles are alcoholics, and one of whom committed suicide by hanging in 2011 that was undergoing treatment for depression.

Alex has three brothers, 30, 43 and 46 years old, who live in the same municipality, but according to reports by Ana and Abel, they help little in care and do not maintain ties with Alex. Ana and Abel are overloaded, as they are the main responsible for the care. Abel is always involved with the bureaucratic issues of detention and long-term care facilities.

Abel does everything; he runs after everything [...]. I'm always present, one Saturday I come to visit and the other I go outside [ranch] because I get tired, to air my head a little. (Ana)

Family members became the main providers of care and support. In the case of this family, Ana has arthrosis, prediabetes, hypertension, and uses antidepressant medications. Abel has already been admitted to a treatment unit for alcohol and other drug users but has not been followed up after discharge.

We observed that it is a psychosocially vulnerable family, in which Alex's health care is centered on his elderly parents. In this sense, it is important to use the ecomap to know the bonds between the family and visualize their support network, as shown in Figure 2.

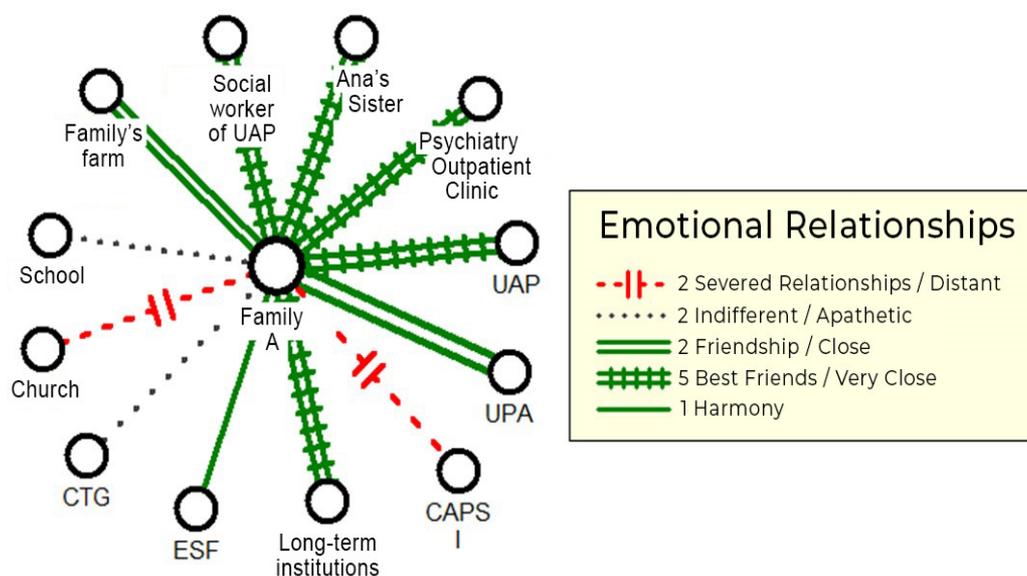


Figura 2 –Family A Ecomap. Rio Grande do Sul, Brazil, 2017

Note: UAP (Psychosocial Care Unit); UPA (Emergency care unit); CAPS (Psychosocial Care Center); ESF (Family Health Strategy); CTG (Gaucho Traditions Center).

During the interview, Ana and Abel did not report serious conflicts, but the family did not have many strong ties between their members. Ana has a good bond with her sister, saying that she listens to her in difficult times.

The family has a strong bond with the resident social worker of UAP, who accompanies the case along with other professionals. They also have strong bonds with health services, such

as the Emergency Care Unit (UPA), the Hospital Psychiatry Outpatient Clinic, and the UAP, where the boy has been readmitted several times.

It's wonderful the work here, even my sister, who doesn't come here, always says that the best place for Alex to be is here, they are all very attentive, all great, they treat everyone very well. (Ana)

Alex was sent to a Psychosocial Care Center (CAPS), but there was no adherence, his stay most of the time is away from his family and his home. The family and the staff of this unit identified several readmissions of Alex. He alternates his stay between his parents' house, where he stays a few days, the UAP, and long-term institutions. Institutionalization often happens because of the difficulty that the family has to take care of the person with a mental disorder, putting them and themselves at risk.

He went home, stayed for a week or so, but it was enough, punching himself, breaking the thermal and punching and punching the walls and looking for a knife to stab himself. (Ana)

I had to hide all the food, everything, he seemed to go there to wait, and he came running and gave me a push, twice he knocked me over, but I'm glad I fell sitting down. (Ana)

Alex's parents reported that he suffered physical assault in one of the institutions and was found, by Abel, improperly restrained, with his impaired circulation, fainted and bruised. He was taken to hospital, where he spent a few days in the Intensive Care Unit (ICU), diagnosed with pneumonia.

He was restrained with the strips of this fineness, well-tied, his hands were that thickness of swollen [...]. His hands were purple, his bound feet were purple, and he was simply cold and [...]. He was dying [...]. When I had finished untying his hands, I had not untied his feet, he fainted, no longer breathed, I had to massage him, and he was not coming back, not coming back, until he snored and came back. They didn't find oxygen; they said they didn't have it, so I said to call the SAMU [Mobile Emergency Care], you have to help him! I untied his feet and sat him down to breathe better. (Abel)

Abel's speech goes back to the last century when people with mental disorders or considered “abnormal” experienced the asylum model. Regarding the transformation of this model, it is worth mentioning the difficulty that parents reported when going out with Alex on the street because since he was an adolescent, he suffers from stigma and prejudice, as observed in the mother's speech:

Rage, strength crises, they kept bothering him down the street, bothering him. (Ana)

In the neighborhood where the family resides, there is a church, school, Gaucho Traditions Center (CTG), and Family Health Strategy (ESF), which is a little frequented by the family. There are few places for recreation and social interaction.

Discussion

The shared construction of the genogram and ecomap enabled the family to report their daily life and relationships, making clearer aspects of their context, which may be relevant for data collection and subsequent intervention.¹¹ Family participation in the family is indispensable for the construction of diagrams, as it contributes to the creation of bonds between the participants and the health professional, besides providing an intervention that contemplates the integrality of the family.¹²

Being an absent or psychosocially vulnerable family can be a negative factor in the health and illness process, including the increasing length of stay. Also, the family vulnerability affects the quality of relationships, and may or may not contribute to the exhaustion of the main caregivers and also of the professionals.¹³ When there is little participation of some family members in care, the burden of other members increases, causing losses related to hospitalization and relationship in the family members.

Family members become the primary care and support providers. These factors also contribute to the increased burden, defined as the feeling of weight that the family carries for performing the role of caregiver and the difficulties to perform this role daily. Overloading can be objective when related to daily tasks, financial loss, and routine change, or subjective when it involves emotions and concerns about the person with a mental disorder. Family overload refers to the effects of psychiatric disorder on the family, not the person itself.¹⁴

The strong relationships and the help and support of family members reflect on the care provided, as they are factors that provide more safety, comfort, and tranquility for those who are caring. It is a way for the family to invest in ways to provide well-being through practices that generate satisfaction and mutual help.¹⁵ We also observed that there is no support from neighbors, unlike other studies.^{11,16}

The practices developed in the UAP should be contemplated by the multi-professional team, seeking a humanized care and also, comprehensive care, understood by a close relationship between the professional, the user, and their family.¹⁷ Despite the family's bond with an inpatient unit, it is important to bond with substitute services, as this is part of the redirection of the care model in mental health.

The device's network that assists people with mental disorders in an open, community and their territories is necessary. Since users and family members are satisfied with these services, this may be linked to comprehensive care, reception, social reintegration, improved quality of life and helped with people with mental disorders.¹⁸

In this sense, the CAPS is the appropriate space to provide comprehensive care to people with severe psychological distress, seeking their social reintegration, promoting articulation with other network services, strengthening the bonds between the person and the family, and avoiding psychiatric hospitalizations.¹⁹ This highlights the importance of investing in the health

network to encourage solidarity and identify the potential resources of the territory in the process of psychosocial rehabilitation.

However, it is clear that instead of replacing the asylum model, out-of-hospital services are now part of the network, coexisting with existing services such as outpatient clinics and psychiatric hospitals.²⁰ The family did not provide justifications for Alex's non-adherence to CAPS, and these factors are known to be related to the revolving-door, as called in international literature.²¹

The revolving door can be a consequence of deinstitutionalization when it is treated as de-hospitalization. Public policies provide for the reduction of psychiatric beds, without enabling the necessary conditions for out-of-hospital care, negatively reflecting the care to the user and family, resulting in readmissions.²⁰ Thus, mental health care that should be continuous ends up fragmented, as each service only performs what it considers to be within its competence, without the necessary communication.

In this context, we should pay attention to the revolving door issue in the Psychiatric Reform process, as evidenced in this study. This identification is important because it stimulates to reflect the search for strategies to minimize this factor, reinforcing the process of transformation of the mental health care model.

In addition, Therapeutic Residential Services (SRTs) can be a resource, which is defined as housing for people with mental disorders who are discharged from long psychiatric hospitalizations, who lack social support or family ties to enable their social reintegration. The city in which Alex resides does not have this service, making the housing option the long-term institution for people with low autonomy and significant problems of social behavior.

The asylum model evidenced in the results showed that in the period preceding the movements of the Psychiatric Reform, social exchanges between health workers and hospitalized people were extinct, such as communication, affection, and welcoming. They did not receive decent treatment, often suffered violence and had their potential reduced until they were unable to return

to social life. Mechanical restraint was also performed with inadequate bands as a form of punishment, that is, without therapeutic purposes.²³

Currently, mechanical restraint is used but guided by Resolution 427/2012 of the Federal Nursing Council, which standardizes nursing procedures in the use of mechanical restraint of patients. It should be done when it is the only possible means to prevent immediate or imminent damage to the person or others and cannot be prolonged beyond the strictly necessary period. Professionals are forbidden to use mechanical restraint for discipline, punishment, and coercion, or the convenience of the health institution or team. The person should be monitored to prevent adverse events from occurring or to identify them early.²⁴

Finally, there is difficulty in implementing the Psychiatric Reform for the socio-cultural dimension, emphasizing stigma, prejudice, and exclusion. In this context, health professionals play an important role as educators in society, keeping in mind that working with the community is a slow process, as it involves culture and ingrained prejudices.

Conclusion

The psychosocial vulnerability of the family that lives with people with mental disorders is a factor that affects the care process provided to them, considering the importance and the role that is attributed to family members. Also, the bonds of the family with each other and their external relationships are fundamental. When they are fragile or nonexistent, caregiver burden increases and becomes an obstacle to care.

The scarcity of substitutive services that fulfill their duties as provided for by public policies, as well as the absence of SRTs, contribute to the revolving door, increased readmissions and institutionalization in long-term institutions, hindering for family members to take care of them by the lack of spaces for rehabilitation, reception and interpersonal relationships. There is a need for investment and qualification of health or specialized services

to meet the demand in mental health and to provide spaces for living and leisure for people with mental disorders and their families.

Family care professionals can look for instruments, such as the genogram and the ecomap, to better understand the context in which the family is inserted, its potentialities, its weaknesses, its structure, its bonds and its network that may assist in the design of intervention strategies that assist in the promotion and recovery of health.

This study contributes to nursing teaching and practice by discussing evaluation and intervention strategies for the families, as it enables a greater understanding of co-responsibility in care and available resources. It can also contribute to the reflection of support actions aimed at families.

We consider expanding the investigations to cover other aspects since the study does not have the presence of the index person and in a hospital context. Interviews conducted at home, outside hospital facilities and/or with people who are not hospitalized can foster discussions from another perspective.

We suggest the implementation of the genogram and ecomap in the care of people with mental disorders, as they are tools that provide important information for care planning and interventions in the family context. It can be used by nurses and/or other members of the multi-professional team to strengthen comprehensive care.

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