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ORIGINAL ARTICLE

PERCEPTION OF FAMILY MEMBERS ABOUT THE PSYCHIATRIC HOSPITALIZATION UNIT IN A GENERAL HOSPITAL

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ABSTRACT

Objective: to identify the perception family members about the care and organization of the psychiatric hospitalization unit in a general hospital. **Method:** Descriptive and exploratory research, with a qualitative approach, conducted in a general hospital in western São Paulo, including 13 relatives of people with mental disorders. The data collection instrument was a semi-structured interview script and the analysis took place using the methodological framework of the thematic content analysis proposed by Bardin. **Results:** From the analysis of the speeches, two categories were raised: a) "Relevance of environment and multidisciplinary team in the treatment of people with mental disorders", highlighting the physical environment, the treatment given by the multidisciplinary team and the contact and participation of family members during hospitalization; and b) "Weaknesses in care dynamics as a support in interpersonal relationships", where the aspects pointed out as still fragile in health care were highlighted. **Final Considerations:** The relatives' perception was predominantly positive in relation to the service offered and, even with the weaknesses pointed out, they feel satisfied with the hospital environment regarding the work performed by the multidisciplinary team and the inclusive care of the family in the therapy.

Keywords: Mental health. Hospitals, general. Family. Patient care team.

INTRODUCTION

Globally, the beginning of Psychiatric Reform took place in the 1960s of the XX century, started by the Italian psychiatrist Franco Basaglia, who set up meetings with people with mental disorders (PMD) and observed significant changes in their behaviors. From then on, he established the first "therapeutic community", which triggered the deinstitutionalization movement, resulting in the "Basaglia Law 180/1978"[1].

In Brazil, the Psychiatric Reform movement took place concurrently with the Health Reform, which aimed to democratize the health system. The positive results of this combination were followed-up in the Federal Constitution of 1988, reaching the promulgation of Law 8080/90, which provides for the regulation of the Unified Health System (SUS, as per its Portuguese acronym)[2].

Nevertheless, psychiatric hospitals remained in precarious structural and care conditions, with care based on the exclusion of PMD and punitive treatments. In addition, many professionals who worked in the area did not have the appropriate training. Faced with these situations, the Mental Health Workers Movement emerged, aiming to improve the quality of healthcare provided[3].

From this movement, Brazil started discussions on the rights of PMD, with the

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objective of replacing the old hospital-centered model, consisted of a *manicomial*/asylum nature, with humanized and diversified services, i.e., community-based services[3]. Thus, public care in mental health was supported by Brazilian legislation, starting from Law nº 10.216/2001, emphasizing milestones such as, for example, Law nº 10.708/2003 – which enabled rehabilitation-psychosocial care, organized through the Program "Back to Home" and Ordinance nº 3.088/2011, which instituted the Psychosocial Care Network (RAPS, as per its Portuguese acronym)[4].

Ordinance 3.088/2011 standardizes SUS mental health care, organizing the RAPS services at all levels of health care, in addition to including deinstitutionalization and psychosocial rehabilitation strategies. The available mental health services, such as psychosocial care centers (CAPS, as per its Portuguese acronym), protected homes, psychiatric emergency services and psychiatric units in general hospitals (UPHG, as per its Portuguese acronym), among others, should work in an articulated and hierarchical way, thus following the logic of priority SUS care networks[4].

The beds available in UPHG aim to provide a support in the hospital environment for cases where hospitalization is necessary. It is noteworthy that hospitalization should happen when all possibilities of extra-hospital care have been depleted, preferably by choosing short-term hospitalizations, until the person's clinical stability [3].Moreover, with the advances obtained from the Psychiatric Reform, it was necessary to change the previous paradigms, ensuring the right of PMD to live in a dignified hospital environment. The interaction between this hospital context and the family of PMD becomes fundamental to the treatment, thus facilitating a greater understanding about the psychological distress of their loved one and providing better coexistence among family members[3].

Accordingly, recognizing the importance of new mental health care devices is essential for the accomplishment of the care proposed in the framework of the Psychiatric Reform, especially considering that, with deinstitutionalization, there was a need for greater intervention and interaction between professionals and families in the care of PMD[5], imposing the burden of care on family members, which can often produce permanent stigmas[6].

This study is justified by the importance of valuing the interaction of the PMD family during the therapeutic treatment of hospitalization, believing that understanding the way family members perceive admission to a UPHG can value the subjectivity, individuality and singularities relevant to each family, thus providing greater social interaction among its members and, potentially, assisting in the recovery process of PMD[3].

Therefore, the question is: How does the family perceive the structural and care dynamics of a psychiatric hospitalization unit inserted in a general hospital? In order to answer this question, this study has the objective of identifying the perception of family members about the care and organization of the psychiatric hospitalization unit in a general hospital.

METHOD

An exploratory and descriptive research was conducted, with a qualitative approach. Data were collected from April to June 2017, in a psychiatric hospitalization unit of a general hospital, located in the countryside of western São Paulo. The chosen unit works with 24 beds for hospitalization and observation of patients who have suffered from an acute mental disorder and also for drug addicts in abstinence. The team is made up by: one psychiatrist, two residents, one psychologist, one nurse and four nursing assistants, on a 12 X 36 hour shift scale, in addition to two social workers and one occupational therapist, within 30 hours a week.

The criteria for inclusion of the participants were: family members who spontaneously attended the UPHG service to visit the hospitalized PMD, as long as the family member was over 18 years old and was the main caregiver of PMD. Participants who did not have a family link with the hospitalized PMD or who did not live with him/her daily were excluded.

Thus, the study had the participation of 13 family members of people admitted to UPHG, who were in line with the inclusion criteria and accepted to participate in the research, being

excluded 11 people from this study.

A semi-structured questionnaire was designed, based on a pilot study[3] with the following guiding questions: (1) What is it like for you to have a family member admitted to a psychiatric unit in the general hospital? (2) Describe what you consider important when admitted to the general hospital (3) Describe what you think could be improved on admission to the general hospital. In order to better characterize the research subjects, the following data were also collected: gender, age, profession, kinship and time spent living with PMD.

The interviews were audio-recorded, after the end of the visit to PMD and conducted in a reserved room within the unit itself, preserving the confidentiality of the information and counting on the presence of only the family member and two interviewers – one who conducted the interview and the other who followed the process, both co-authors of the research, trained by the main author. The interviewers are related to the study location, where they performed practical activities during graduation. However, they have no relationship with the participants.

The interviewed family members were informed at the beginning of the interview about the confidentiality of their names and their rights; and, after signing the Free and Informed Consent Form (FICF), the interviews started, which lasted an average of 20 to 40 minutes. Participants are named, from now on, as "E" and the sequential numbering.

In order to process the data, the participants' speeches were transcribed in full, immediately after the interviews, with a view to performing successive readings of the material to identify the general meaning of the collected content and start the data analysis. In this phase, the relevant units for the study and the significant categories were extracted from a thorough reflection of the material.

The analyses of the data obtained in the testimonies were made based on the methodological framework of the thematic content analysis proposed by Bardin, which consists of a set of methodological instruments in constant improvement, applied in extremely diverse discourses. This data analysis technique oscillates between two poles: the accuracy of objectivity and the fecundity of subjectivity. In order to constitute the thematic categories, the following steps are proposed: pre-analysis; exploration of the material; treatment of results and interpretations[7].

The pre-analysis, the document organization phase, took place in three fluctuating readings with the purpose of choosing important points, formulating hypotheses, choosing analytical indexes and developing categorical indicators to support the interpretation of the data; the material exploration phase consisted of four systematized readings in order to make groupings and associations that answered the objectives of the study, so that the analytical categories could be built. Lastly, the results treatment phase encompassed the moment when the inferences and the interpretation of the results found were made, discussing them based on the pertinent literature[7].

This research was approved by the Research Ethics Committee CEP and CAPI (as per its Portuguese acronym) – belonging to the University of Western São Paulo, under CAAE nº66068417.7.0000.5515. The guidelines of Resolution 466/2012 of the National Health Council were also respected, where the participants signed a FICF in two copies.

RESULTS AND DISCUSSION

Of the 13 people interviewed, 11 were female and two were male. The age ranged between 39 and 68 years. The highest degree of kinship was the mother, followed by siblings and children. The average coexistence with the PMD relative was 30 years. The analytical categories are described below according to the data found.

Relevance of environment and multidisciplinary team in the treatment of people with mental disorders

During the hospitalization period, PMD absorb some aspects of the place where they are inserted, which are related to the physical environment, the treatment provided by the team and the participation of relatives. Currently, hospital services are focused on establishing safe and pleasant physical spaces that provide cognitive, physical and spiritual support, aiming

to integrate patients' social relationships with family and hospital team[8].

Accordingly, in the category analyzed here, the perceptions of family members are presented, which emphasize the potential of the service with regard to mental health care nowadays, in an environment that provides good interpersonal development, besides the importance of the multidisciplinary team in the treatment of mental disorders.

> [...] I thought the space was pretty good, everything was clean, enough nurses to be watching them (patients), there is a place for them to go out, perform the activities and take a sun, an air [...] **(E2).**

In the speech presented, it is possible to infer that the physical structure of the psychiatric hospitalization sector can act as a facilitator in the care process, thus allowing for an alternative environment, which is not just its ward room/bed. Outings for activities in open spaces can act as a therapeutic tool during hospitalization.

The physical changes in hospitalization spaces took place as a result of Law nº 10.216/ 2001, which provides for the protection and rights of PMD, redirecting the care model in mental health and reformulating the psychiatric hospitalization process in several aspects. Thus, a suitable environment for treatment is made possible, which can offer safety and development conditions for therapy and comprehensive care [9].

> I like it here because it has a TV room, there is the place where people sit outside and talk [...] even I like to stay here, because it transmits tranquility, for her (patient) and for us too, because, in other places, we didn't even go there, as she herself said: you shouldn't come here, cause it's ugly and sad **(E6).**

According to the previous report, it is noticeable the importance of environment for family members, considering the physical space as something determinant and contributory for the treatment in mental health.

From the discussion about the environment, hospitals seek to develop and make environments more pleasant, thus seeking to understand the patients' needs. This is because a good environment, together with some interaction with the family during the hospitalization period, can help the person to overcome his/her fears and anxieties, cooperating for his/her rehabilitation and reintegration into society, when his/her mental disorder is worsening[10].

> I think because he is here inside a hospital that has everything, he has several resources from the hospital, from the unit. It has several sectors, in general, of all specialties. I think that if something more serious happens, beyond his problem, he would have resources inside the hospital, so we wouldn't have to run to take him to another specialist **(E5)**.

Accordingly, a positive positioning of the family in relation to the hospitalization of a loved one is highlighted, reflecting the perspective of a service that covers the most diversified health care services and improving the care of PMD. This acceptance is linked to the fact that the service offers health care not only in psychiatric context, but also in clinical-surgical therapy, thus enabling care from a perspective related to severe PMD admitted to a general hospital due to a clinical and/or surgical complication[11].

The legislation referring to mental healthcare, such as Law nº 10.216/2001 and Ordinancen 3.588/2017, has been subsidizing a standard of treatment that establishes objectives for the hospitalization period. It also ensures that this treatment is comprehensive, provided by a multidisciplinary team, composed of doctors, nurses, pharmacists, social workers and occupational therapists who seek, in individuality, a common good: theim provement of PMD through the various health services and treatments[12.13].

Mental health care should be supported by the psychosocial model. Therefore, more than treating the symptoms, help is needed to conquer the identity of PMD, highlighting its potential and emotional balance. It is recommended that the care provided by the multidisciplinary team acts in an interdisciplinary way in the different health services, through strategies to encourage the psychosocial inclusion and the socio-cultural reintegration of people who are in psychological distress[14].

> Here, the treatment and the exams are different. Everything here has a routine and a schedule and

> they tell all of this to us at meetings that are constant [...]. She (patient) thinks it is great here, because she says that everyone's treatment is the same [...] they never treated someone as inferior **(E9)**.

It is possible to identify in this interview, that the principles of equality and equity are present in the care provided, considering conditions equal to the different levels of complexity of the system and treating people unequally (particularly) – who are unequal in their singularities. All those who need health care and attention, do not necessarily need the same type of care. In UPHG, PMD has easy access to clinical examinations and also to monitor its physical health, unlike services where there is no clinical care in the same environment. Thus, when PMD presents clinical comorbidities, then its treatment ends up being fragmented or even interrupted. A fact that can be observed even in the context of primary health care, when comprehensive care is not preserved[11].

Hospital institutions include the unique therapeutic project (PTS), based on the broader assessment of the clinical case, with well-defined therapeutic objectives, intervention proposals and results assessment. This strategy is proposed by the multidisciplinary team with a view to recovering the patient from admission to discharge. Its planning should include actions that favor the active participation of the user and his/her family, thus promoting greater autonomy and sharing of information and knowledge. This also involves the existence of a referral and counter-referral system that allows the referral of the patient and the longitudinality of care[15], in addition to the use of services and resources from the community to which the person belongs.

> [...] I've always been treated well here. When he is interned, they call me at the meeting and let me know about the things that happen at the hospital, about his medications, about how he is, about exams, these things, so I feel like helping him to recover […]**(E3)**.

According to the excerpt, it is possible to infer the importance of family care in the psychiatric hospitalization unit, because when you are with those you care for outside the hospital, PMD will feel better welcomed and supported.

This aspect facilitates treatment and care, since it presents greater interaction between the PMD undergoing treatment and the family member, thus helping in the process of care, insertion and rehabilitation. The family becomes a generator of benefits, and contact with the hospital provides it with knowledge about the therapeutic method, psychological help and information about the progression of its relative's treatment. This is because adapting to a new routine can be complicated for both parties involved, who face changes in their daily lives, in their quality of life, in addition to possible prejudices and the non-acceptance of mental distress by a good part of society, causing anguish and great discomforts[16,17].

> The employees treat us differently, talk to us, explain things ... you perceive that everyone speaks the same language [...], even she (patient) made friends with the nurses, so she feels safer here inside [...]. **(E5)**.

In the passage cited, the importance of qualified listening, clarification of doubts and the attention provided to the patient and his/her family by the professionals is identified. Thus, it does not consider the person only as having a mental disorder, but as someone with needs, which can be mitigated in the general hospital through the welcoming performance of the team.

The bond is manifested in the formation of emotional ties between health professionals and users/family, i.e., in the creation of welcoming, trust and clarity of communication between these actors. The link depends on how health professionals get involved in the care offered to users [15].The multidisciplinary team gained greater incentive and importance in the treatment of PMD after the Psychiatric Reform movement and the onset of the legal framework in the area of mental health. This team should develop a holistic view, be flexible, have cooperation and, above all, perceive its own value and importance in being an instrument that aims to meet all the physical, psychological and social needs of PMD[17].

As an important tool in the treatment and rehabilitation of PMD, PTS stands out again. At the time of its development, the family is required to participate in the planning, creating a bond with health professionals, based on comprehensive care, welcoming, thus valuing

the family in a humanized way. Consequently, it helps in the process of acceptance and adherence to treatment by patients in psychological distress, respecting their limits. Conversely, it produces clinical and health co-responsibility, as well as a resolutive intervention. Without welcoming and bonding, this mutual accountability is not observed[15].

Weaknesses in care dynamics as a support in interpersonal relationships

The conceptual guideline of the Brazilian Psychiatric Reform – conception of psychosocial rehabilitation – directs to the duty to understand the subject included in the social context. The challenging scenario imposed on mental health therapists considers the relationship between the territory and the user, thus creating means and possibilities for the individual in this social circuit, ensuring rights, such as civil and social ones[18].

Accordingly, this category presents the perceptions of family members about the weaknesses related to the work process found in the psychiatric hospitalization unit of a general hospital. As a highlight, the occupational therapy service is emphasized– with the need to classify patients according to the degree of psychological impairment during hospitalization – and the turnover of the medical staff of residents, which happens periodically.

> [...] they (patients) do nothing for a long time, they get anxious, because occupational therapy is only in the morning, and in the case of my daughter, this is very harmful, because she is not busy. If she had more activity time, she would occupy her mind [...] The only thing she (daughter) says she doesn't like isn't having anything to do, to be doing nothing, to be lying most of the time **(E11)**.

In this statement, it is possible to infer that there is a weakness in the care dynamics with regard to the time allowed for therapeutic activities. There is a recognition of the need for occupational therapy, which would avoid the monotony and anxiety of the patient. Nonetheless, this practice is not well structured in relation to the time allotted, due to professional hiring issues.

The performance of the multidisciplinary team through interdisciplinary practices can assist the performance of occupational therapy, also contributing to the improvement of PMD, recovering skills, assessing their physical and mental impairment through the activities offered, contributing to the person's return to society. Occupational therapists assist in this recovery through strategies considered by users as a way to take over leadership in health care[19].

> [...] I think they could evaluate the condition of each patient to put him in a room where there is another patient more similar, for example: if the patient is well, in the room, they couldn't leave someone who was very aggressive together. So [...] my brother is very well; and, in his room, there are some people on the side who're shouting, calling, end up disturbing the person who is better [...] sometimes, he (brother) is sleeping, then the man starts to shout out [...] **(E4)**.

The note presented in the above report highlights the need for more careful bed management, which happens in a systematic and periodic way. The demand for UPHG is highly variable in terms of personal and symptomatic characteristics; and, at the time of hospitalization, a person may present an acute picture of psychological symptoms, different from other hospitalized patients who may already be stabilized.It is not always possible to reconcile the demand with the possibilities of the environment, but an ordinary and effective management of the beds could mitigate such differences, since some patients and family members end up feeling uncomfortable with the situation experienced. However, with the Psychiatric Reform and the progressive closure of psychiatric hospitals, the number of beds destined for PMD started to be reduced; and, in UPHG, it should not exceed 10% of the hospital capacity, reaching a maximum of 30 beds[3]. This can justify the difficulties in performing bed management and the adjustments, when necessary.

Bed management is a process of planning operational capacity, as well as controlling supply and demand of beds, according to the criteria for accommodation by patient, i.e., in line with his/her clinical condition. One of the worrying factors on the topic is the difficulty on the part of health professionals in relation to the organization of the best flow. Thus, a place that

should be pleasant, harmonious and organized, thus providing well-being and comfort to patients, may become a cause for concern and dissatisfaction for users and their relatives[20].

PMD during its length of stay within the UPHG where the study was developed receives full-time care from medical residents of the psychiatry specialty. These contribute to the UPHG fixed team, carrying out diagnostic and therapeutic interventions, as well as developing and executing therapeutic plans and other activities related to the practice of medical residency.

> [...] one thing that I think is bad is the fact that the residents are changing all the time, then one doesn't pass the case to the other, there is no continuity, and they keep changing; for the patient, I think it's awful [...] **(E11)**

According to the interviewee, the fact that the surveyed UPHG is located in a hospital that is a practice field for students with medical specialization generates difficulties in the treatment of PMD, as there is a rotating flow of residents who are responsible for the patient's daily medical care. This means that there is no continuous monitoring and with the time necessary to understand each case, causing the need to establish new links more frequently [10], as the interviewee explains.

The residency is a service of great learning for resident professionals, since it generates the opportunity to understand training and health care. With the daily work, the challenge arises to occupy themselves with the professional and multidisciplinary practice in mental health, thus enabling the establishment of the doctor-patient bond[21].In order to optimize the relationships between professionals and users, the other professionals responsible for each area of health care – the preceptors, nurses, psychologists, among others – should provide actions aimed at meeting the needs of PMD, thus emphasizing the importance of bonding as a tool that helps the exchange of knowledge between the technical and the popular, converging them to perform therapeutic acts both at the collective and individual levels[22].

With regard to occupational therapy, a justification may be related to the scarcity in the workforce in general hospitals, due to the lack of valorization of these professionals in the health care process, thus not being considered as fundamental by the service management[23].

The occupational therapist (OT) seeks to discover the difficulties of the people assisted, regardless of the medical diagnosis, in order to design strategies with them and their families for psychosocial rehabilitation. In the mental health context, OT can adhere to group care, emphasizing therapeutic workshops – resources that are configured as an opportunity to promote autonomy and social inclusion[24]. Currently, the job market for this category has expanded in the area of mental health. It was noticed that, over time, this professional has adapted to the different realities of health in Brazil, thus actively participating in the development and implementation of policies, management of services and teams and conquering its space[23]. It is up to other professionals who provide health care, especially in mental health, to perform their functions in an autonomous and interdisciplinary way, so that the need for the presence of a OT can be perceived and the team becomes more complete and, consequently, more trained to offer dignified and effective care to PMD.

FINAL CONSIDERATIONS

From the results, it was possible to understand how family members perceive the structural and care dynamics of the unit, showing that this is a space of mutual support, humanized and comprehensive care.

The family perception was predominantly positive in relation to the service offered, and it was clear the satisfaction of the interviewees regarding the environment, the work performed by the multidisciplinary team, the comprehensive care and the inclusion of the relatives in the therapy, making them feel more oriented, supported and making them co-responsible for the treatment. However, some weaknesses were noted: the turnover of resident psychiatric doctors; the distribution of beds that fails to prioritize the symptomatic characteristics of hospitalized people; and occupational therapy activities that are impaired, due to the predetermined time for their accomplishment.

The limitation of this study is related to the fact that it was conducted only in a psychiatric hospitalization unit and with a small number of

interviewees– characteristic of the chosen method. This factor, when added to the fact that the data collection was only in a certain group of family members, does not allow many generalizations about the topic discussed.

It is concluded that the understanding of the family, as a co-participant in the therapeutic process, can positively influence the strategies of care in the context of mental health and, consequently, provide equity, autonomy, right and exercise of citizenship to people with mental disorders.

A PERCEPÇÃO DOS FAMILIARES SOBRE A UNIDADE DE INTERNAÇÃO PSIQUIÁTRICA EM UM HOSPITAL GERAL

RESUMO

Objetivo: identificar a percepção dos familiares sobre assistência e organização da unidade de internação psiquiátrica em um hospital geral. **Método:** Pesquisa descritiva exploratória, com abordagem qualitativa, realizada em um hospital geral no interior do Oeste Paulista, junto a 13 familiares de pessoas com transtorno mental. O instrumento de coleta de dados foi um roteiro de entrevista semiestruturado e a análise ocorreu mediante ao referencial metodológico da análise temática de conteúdo proposta por Bardin. **Resultados:** A partir da análise dos discursos, emergiram duas categorias: a) "Relevância da ambiência e equipe multidisciplinar no tratamento de pessoas com transtornos mentais", destacando o ambiente físico, o tratamento ministrado pela equipe multidisciplinar e o contato e participação dos familiares durante a internação; e b) "Fragilidades da dinâmica assistencial como suporte nas relações interpessoais", na qual foram evidenciados os aspectos apontados como ainda frágeis na assistência. **Considerações Finais:** A percepção familiar foi predominantemente positiva em relação ao serviço oferecido e, mesmo com as fragilidades apontadas, estes sentem-se satisfeitos com o ambiente hospitalar no que tange ao trabalho realizado pela equipe multidisciplinar e o cuidado inclusivo da família na terapêutica.

Palavras-chave: Saúde mental. Hospitais gerais. Família. Equipe de assistência ao paciente.

PERCEPCIÓN DE LA FAMILIA DE LA UNIDAD PSIQUIÁTRICA EN UM HOSPITAL GENERAL

RESUMEN

Objetivo: identificar la percepción de los parientes sobre la atención y la organización de la unidad de hospitalización psiquiátrica en un hospital general. **Método:** Investigación exploratoria descriptiva, con enfoque cualitativo, efectuada en un hospital general del interior del Oeste de São Paulo, abarcando 13 parientes de personas con trastornos mentales. El instrumento de recolección de datos fue un guion de entrevista semiestructurado y el análisis se llevó a cabo utilizando el marco metodológico del análisis de contenido temático propuesto por Bardin. **Resultados:** Del análisis de los discursos, surgieron dos categorías: a) "Relevancia del ambiente y equipo multidisciplinario en el tratamiento de personas con trastornos mentales", subrayando el entorno físico, el trato brindado por el equipo multidisciplinario y el contacto y la participación de los parientes durante la hospitalización; yb) "Debilidades en la dinámica de atención como apoyo en las relaciones interpersonales", donde se resaltaron los aspectos señalados como aún débiles en la atención. **Consideraciones finales:** La percepción familiar fue predominantemente positiva con relación al servicio ofrecido e, incluso con las debilidades señaladas, los parientes sienten satisfechos con el entorno hospitalario en cuanto al trabajo desarrollado por el equipo multidisciplinario y la atención inclusiva de la familia en la terapia.

Palabras clave: Salud mental. Hospitales generales. Familia. Grupo de atención al paciente.

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