

RELATIVES OF SCHIZOPHRENIC OUTPATIENTS: FEELINGS AND ATTITUDES TOWARDS THE AGGRESSIVE BEHAVIOR

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ABSTRACT: Discovering the difficulties the family experiences is an imminent need for the consolidation of the psychosocial rehabilitation process. A qualitative research was undertaken to get to know and analyze family members' forms of coping with their relatives' aggressive behavior and the feelings these situations arouse. As a data collection tool, a script was used to interview ten family members living in the coverage area of a Primary Health Care Unit in Londrina, Paraná in 2012, and who had a relative with mental disorder monitored at a mental health service in the city. The results reveal difficulties to manage crises, search for professional and spiritual help and feelings the majority have in common, such as despair, suffering, fear of being victim of aggression, solitude and social isolation. To relieve these difficulties, it is considered important for the health service to intervene in the family context.

DESCRIPTORS: Mental health; Family relations; Aggression.

FAMILIARES DE PESSOAS COM ESQUIZOFRENIA: SENTIMENTOS E ATITUDES FRENTE AO COMPORTAMENTO AGRESSIVO

RESUMO: Conhecer as dificuldades vivenciadas pela família constitui-se em necessidade iminente à consolidação do processo de reabilitação psicossocial. Trata-se de pesquisa qualitativa para conhecimento e análise de formas de enfrentamento de familiares perante o comportamento agressivo de seus parentes, e os sentimentos que tais situações geram. Como instrumento de coleta de dados empregou-se roteiro de entrevista a dez familiares, residentes na área de abrangência de uma Unidade Básica de Saúde, em Londrina, estado do Paraná, em 2012, cujo acompanhamento do indivíduo com transtorno mental fosse realizado em algum serviço de saúde mental da cidade. Os resultados revelam dificuldades de manejo de crises, busca por auxílio profissional e espiritual, assim como sentimentos em comum à maioria, como a desesperança, o sofrimento, o medo de sofrer agressão, a solidão e o isolamento social. Com a finalidade de aliviar tais dificuldades, acredita-se ser importante a intervenção do serviço de saúde no âmbito familiar.

DESCRIPTORIOS: Saúde mental; Relações familiares; Agressão.

FAMILIARES DE PERSONAS CON ESQUIZOFRENIA: SENTIMIENTOS Y ACTITUDES DELANTE DEL COMPORTAMIENTO AGRESIVO

RESUMEN: Conocer las dificultades vividas por la familia es una gran necesidad para la consolidación del proceso de rehabilitación psicossocial. Esta es una investigación cualitativa para conocimiento y análisis de formas de afrontamiento de familiares delante del comportamiento agresivo del paciente, y los sentimientos que tales situaciones generan. Para obtener los datos, fue usado guion de entrevista a diez familiares, residentes en el área de abrangencia de una Unidad Básica de Salud, en Londrina, estado del Paraná, en 2012, cuyo acompañamiento del individuo con trastorno mental fuera realizado en algun servicio de salud mental de la ciudad. Los resultados apuntan dificultades de manejo de crisis, búsqueda por ayuda profesional y espiritual, así como sentimientos en común a la mayoría, como la desesperanza, el sufrimiento, el miedo de sufrir agresión, la soledad y el aislamiento social. Con la finalidad de quitar tales dificultades, se cree ser importante la intervención del servicio de salud en el ámbito familiar.

DESCRIPTORIOS: Salud mental; Relaciones familiares; Agresión.

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INTRODUCTION

The families of psychiatric patients have historically been distanced from the treatment of their sick relatives, mainly when this involves psychiatric internments. When the psychiatric reform started, which fights to reformulate the care model in mental health, it was considered important to rescue the relatives' participation in the treatment. The rapprochement of the mental patients with their family and community rescues their autonomy and preserves their subjectivity and individuality⁽¹⁾.

Based on this change in the treatment model, the resocialization of mental patients not only guarantees the defense of the rights to citizenship, but also offers therapeutic advantages⁽²⁾. The family is an important factor of resocialization and social reinsertion, as it is the first and main social institution the mental patient will socialize with. In addition, the family turns into the patient's support in case of difficulties, and is the instance in which the solutions for the problems will be elaborated⁽³⁾.

In general, the presence of a mental patient inside the family can affect its functioning. The home care experience and the more intense contact with the patient can alter the daily routine. In addition, giving frequent care and being constantly concerned with the patient puts a great strain on the family members. The adversities the caregivers experience require resources that help to live with the sick member and ratifies the idea that they also need care⁽⁴⁾.

Coping with problematic behaviors that involve verbal and physical aggressiveness, agitation, "nervous crises" and the destruction of objects is a frequent challenge for the relatives of mental patients⁽⁵⁾. In that sense, it is important for the health service to intervene, promote activities that grant the family further knowledge on the disease and provide orientations on how to manage behaviors and care⁽⁶⁾. In addition, the family suffering needs to be understood to mitigate the burden and offer opportunities for them to share doubts and anguish⁽⁷⁾.

This gives rise to the need to research on this theme, based on the empirical hypothesis, with support from the literature cited in this study. In many cases, the relatives of mental patients have doubts as to how to act appropriately at times

of crisis, particularly at moments of agitated or aggressive behavior. Without appropriate support, the family members suffer more and contribute less to the psychosocial rehabilitation process of their sick relative.

METHOD

This research was developed in a population sample from the coverage area of a primary health care service (UBS) in Londrina, state of Paraná between September and October 2012. An exploratory and descriptive qualitative research was undertaken. The sample consisted of ten relatives of patients diagnosed with Schizophrenia, whose inclusion criterion was having experienced a crisis with aggressive or violent behavior of their sick relative. The exclusion criterion was the presence of a mental disorder in the relative as well, as identified in his/her own report. The theoretical saturation method was used to close off the sample⁽⁸⁾.

A semistructured interview was applied with seven questions that involved aspects regarding the interviewee: sociodemographic: gender and age, presence of any health problem, how (s)he feels and acts when the relative has a crisis, what (s)he does to feel better and what could help him/her at those moments: and aspects on the mental patient: name of the disease, length of diagnosis and past aggressive or violent behavior. The interview was digitally recorded.

The following methodological steps were taken for the data analysis: ordering, classification and final analysis of the data. The ordering of the data comprised the transcription of the recordings; rereading of the reports and organization of the material according to the analytic proposal. To classify the data, the relevant reports were analyzed according to the researcher's interpretation, including the interviewees' central ideas, reading the texts repeatedly. Finally, thematic content analysis was applied. The analysis categories were defined through the interpretation of the interviews⁽⁹⁾.

To identify the family members, their initials were used, guaranteeing the anonymity of the interviewed subjects. The project received approval from the University's Research Ethics Committee, under CAAE: 06394012.0.0000.5231.

All ethical aspects of research involving human beings were respected, and none of the family members refused to participate in the research.

RESULTS

According to the research proposal and based on the analysis of the interviewed family members' statements, two main categories emerged: ⁽¹⁾ forms of coping with crises and ⁽²⁾ emotional expressiveness and burden.

Characteristics of subjects

The participants were selected with the help of employees from the UBS they attend. The fact that the entire sample consisted of relatives of schizophrenia patients was due to the fact that this was the most prevalent disorder and attended to the research objectives. Ten caregivers closest to the schizophrenia patient participated in the research: six mothers, two sisters, one father and one partner. The ages ranged between 40 and 62 years and only one is male. Concerning the family members' occupation, out of ten interviewees, eight were housewives, one was retired and another worked at home as a seamstress.

Ways of coping with crises the families used

The search for professional help is one form of coping the family members use. It can be evidenced in one of the relatives' narratives, who refers to the family member's internment as a resource that brings relief, in the belief that the relative will receive better care with the health professionals:

I feel happy if they take him to the hospital! Because there I know he's on the medication, then I know he'll get better, then I feel happier. And after he comes from the hospital he's well. (MLF)

Another interviewed family members also affirms calling on the Mobile First-Aid Service in situations that cause aggressive behaviors:

Ah, it's no use, when he starts hitting and swearing we really have to call the Mobile First-Aid Service,

because what am I going to do? There's nothing we can do. (MLF).

Besides these families, others reveal that they'd feel much better and safer if they could intern the family member indefinitely, where he would live in a dignified manner and receive comprehensive care different from hospital, they refer to this place as a "recovery house":

It's that, in my case, because I am unable to, impossible, but it would be good right, like a recovery house to take good care, like here at home, then we'd stop worrying, right. (LRO)

I tried to find some clinic to leave him there directly, but I couldn't. Because we think it's better for him to stay there with a lot of people to take care of him than here. (VCP)

One participant mentions that she would like to participate in a "support group", as she would learn how to cope better with her husband with a mental disorder:

If I had a support group I could participate in, you know, for the family to know how to deal with him, because the family feels lost. (SAS)

Besides the professional care, the family members mentioned other coping resources, such as spiritual help. The relatives mention the importance of religious involvement:

There's nothing to help us, right, the help has to come from up there, God alone, prayer, we can pray, right. (FES)

We ask God, right, ask for prayer, pray a lot. There's nothing else to do. (AAO)

Emotional expressiveness and burden

The analysis of the interviews reveals that the mental patients' family context is permeated by the subjectivity that derives from a range of feelings the study participants report on, such as fear, impotence in view of crises and sadness as

a result of daily experiences, generally disturbed by the disease process:

[...] *I feel great fear, terrified, often, like, I feel kind of immobile, it seems we kind of freeze inside, it leaves us immobile, out of fear of reacting and he getting more aggressive.* (SAS)

[...] *I get scared and think that he might even suddenly kill us.* (MLF)

In addition, the feeling is overcome with feelings of compassion and pity, understanding that the patient is not guilty of his aggressive behavior, according to one participant:

[...] *I pity him, because it's not his fault, because he was not like that [...] I don't like to see him sad.* (MLF)

In addition, compassion appears when they think that the relative could have a different life and there is a feeling of revolt when, sometimes, they forget about the relative's disorder. The intertwining between revolt and compassion evidences this family's feeling of ambivalence:

[...] *she comes onto us, if we don't defend her she breaks us, then we get revolted, because you do everything, I give her medicine in the mouth, I help her shower, but we don't know, because at that moment her head is not working straight, just at that moment [...] after it passes I feel pity, because she could have a normal life, I really pity her.* (MCF)

The relatives mention the lack of friends and relatives, as the patient expulses any visits and, at the same time, does not permit the family to go out. According to one participant:

[...] *Because she's very violent, we're really stuck at home and, when relatives come to visit, she touches them. We get very lonely. Whoever comes here, despite knowing that she has the problem, gets really upset because she touches them, swears. [...] The people took distance, they're afraid.* (FES)

The interviews revealed reports of anguished parents concerned about the future, they're afraid that, if they die, there is nobody to take care of their son:

[...] *I explain her things in detail and tell her that she has to pay attention, so that one day if we're absent, because we're not going to stay alive forever, so that she won't make mistakes [...].* (DFC)

I need to live long, right, because, you see, she's 36 years old, she'll depend on us. I've got a son, but he doesn't have time for us. (FES)

The relatives also mentioned feeling exhausted and emotionally burdened, according to the following statements:

[...] *we can't even sleep well.* (MLF)

[...] *sometimes there are so many things that I forget.* (LRO)

[...] *I have to follow her all day, I help her shower, eat, I give the medicines [...] Some I catch her eating raw meat! So I can't leave her alone much and I have to postpone my things.* (DFC)

During the interview, the participants mentioned illnesses that started after the family member's mental disorder appeared, including vascular, cardiac, rheumatic conditions and even psychological problems, as the following statement suggests:

[...] *I've started feeling great exhaustion, great fatigue [...] the doctor said it's depression, kind of an emotional burden [...]* (SAS)

DISCUSSION

Working on their anxieties and gaining self-knowledge is the first step for the family members to deliver care to the mental patient. To cope with the conflicting situations and being able to serve as caregivers, they need to gain strategies⁽³⁾. In this process, the participants demonstrate that they need and are anxious to get professional help,

mainly to cope with aggressive behaviors.

The relatives feel the need for a supportive health service. The health services' welcoming of their needs makes them feel that they are being cared for as well. In addition, it allows them to gain clarifications and advice and makes them learn to cope with situations that would have caused the patient's internment earlier⁽¹⁰⁾. In that sense, the families value the group intervention, which has revealed to be an effective therapeutic measure. Focus groups permit an environment that welcomes experiences and makes them perceive that other people face the same difficulties⁽¹¹⁾.

A qualitative study involving relatives of mental patients who participated in a self-help group revealed that the families expect more than medication prescription from the professionals. They want them to provide orientations about how to cope with the patient and, if these are not provided, at least indications on where to obtain this information. As they do not find the support they want and need at the health service, these families turned to the self-help group⁽⁶⁾.

The existence of environments to discuss the care delivered to the family member suffering from a mental disorder and the family's daily life reawakens the hope that the patient's autonomy will improve and that the family burden will decrease⁽⁶⁾. The satisfaction with the mental health service, in addition, influences the stress level of psychiatric patients' caregivers. The greater their satisfaction, the lesser their stress burden⁽¹²⁾.

When the problems cannot be solved as there exists no cure for these people's psychiatric disorder, the caregivers use forms of coping centered on emotional control, such as spirituality and religion. Although no solution to the problem, the search for help in religion grants support to cope with adverse situations, as it helps with the psychological adaptation to the physical and emotional burden⁽¹³⁾.

A qualitative study involving six families of mental patients appoints that the mental disorder diagnosis causes the family's denial, who feels frustrated in view of the disease prognosis. The family members feel impotent when they are confronted with conflicts that are mental and emotional instead of physical. According to the study participants, the feeling of impotence in view of a physical problem would be less intense

when compared to the mental disorder⁽³⁾.

The context these families experience is permeated by fear and insecurity. These feelings are frequently related to the fear of manifestations of violent behaviors. The aggressiveness and violence increase as psychiatric problems develop. They arise when the impulses and personal control are unbalanced. The impulses can increase due to the organic or neurological commitment, in addition to conflicts aroused by the environment. Control, in turn, tends to decrease in view of mental frailty. Thus, any condition that increases the impulses in individuals with reduced control can cause violent acts⁽¹⁴⁾.

The patient's agitated behavior and inappropriate reactions limits his/her family's social interaction. Thus, their relation with the external world is disturbed. The relative is afraid of the aggressive attitudes and sometimes feels constrained by the patient's behavior⁽¹⁵⁾. The prejudice and distancing from the community the interviewees mention is a true difficulty the families face. It is observed, however, that the prejudice is not only present in society, but arises inside the family, which hampers life with this family member even further⁽¹⁵⁾.

The participants' concern with the wellbeing of the mental patient is clear. Some relatives, when asked about their feelings, do not answer objectively, but mention the concerns and daily care for the family member, directing this kind of response to all questions, which demonstrates a high level of concern. This concern is constant in these people's life and care becomes the essence and priority in the relationship with the family member. The families experience a painful process and feel insecure with regard to care⁽¹⁶⁾.

In addition, due to the implications life with the reality of the mental disorder causes, the family members feel exhausted. These people are burdened by demands involving the function of taking care of their relatives with mental problems. This burden combines factors like intense concern, high care frequency, the financial difficulty the disease entails and the bother the care sometimes causes⁽⁴⁾.

A cross-sectional correlation study involving one hundred relatives of psychiatric patients demonstrated a very high stress level in the caregivers, closely related to the burden the patient causes. Nevertheless, unexpected

information appeared: the lesser the patient's competences, the higher the family members' level of satisfaction, demonstrating the existence of a co-dependence between the caregiver and the mental patient⁽¹²⁾.

The burden of care is classified in two ways: objective and subjective burden. These families' life situation (housing conditions, income, level of autonomy of the patient) and the characteristics of the treatment (s)he needs contribute to the origin of the "objective burden". It refers to costs the disorder entails, problems in the family and professional routine and the care frequency the disorder requires. The combination of these living conditions with the "objective burden" can give rise to the "subjective burden"⁽¹⁷⁾.

The "subjective burden" is characterized as a personal perception on care for the patient and the feelings, problems and concerns this activity generates⁽¹⁸⁾. This type of burden is apparent in the relatives who participated in this research when they report on their intense concern with the patient, at times when they demonstrate revolt and anger because of their condition as caregivers and when they evidence extreme insecurity about the future, concerned with the continuity of care for the patient after their death.

The mental disorder suddenly transforms these family members' lives, the changes in the external and internal relationship, the new daily reality and the new family roles create suffering. Although weakened and overburdened, the daily family life is permeated by affection and care. They transmit a different look on life and its values⁽¹⁶⁾. One needs to understand, however, that even prepared to offer care and independently of its limitations, the family can choose to take care of the patient with mental disorders or not⁽³⁾.

FINAL CONSIDERATIONS

This study is limited by the fact that no conclusions can be drawn, as the actions of the health service were not subject to investigation. Nevertheless, the advances made in this study permitted reflection on the reality of families who have a member with a mental disorder. Their reaction at times of crisis, their emotional expressiveness and means of coping were the main contributions of this research.

It is important for these family members to know how to cope with their emotions and with the situations the psychic suffering creates in order to permit a healthy social midst for individuals suffering from schizophrenia and for the family as a whole. Professional and religious help was sought as a way to cope with crises and aggressive behaviors, the first aiming to solve the problem and the second aiming to seek sentimental and spiritual comfort.

In that sense, the health services need to intervene in the family context to promote a space for the family to expose its feelings, clarify doubts and receive directions on how to manage aggressive behaviors. Permitting comprehensive care delivery to these people, including respect for the family system and the cultural and religious feelings that exist there is fundamental. In this context, nurses are very important professionals, given their educational background, proximity and attributions, and are able to articulate the organization of support groups for relatives, home visits and other intervention strategies.

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