

**FAMILY INTERVENTIONS IN THE FIRST-EPISODE PSYCHOSIS:
FACILITATORS AND BARRIERS FROM THE PERSPECTIVE OF THE HEALTH
TEAM**

**INTERVENÇÕES FAMILIARES NO PRIMEIRO EPISÓDIO PSICÓTICO:
FACILITADORES E BARREIRAS NA PERSPECTIVA DA EQUIPE DE SAÚDE**

**INTERVENCIONES FAMILIARES EN EL PRIMER EPISODIO PSICÓTICO:
FACILITADORES Y BARRERAS EN LA PERSPECTIVA DEL EQUIPO DE SALUD**

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ABSTRACT

Aim: Identify and analyze the possibilities and barriers perceived by health professionals to deploy and maintain, in a routine of an outpatient first episode psychosis service, care for the families of patients with mental disorders. **Method:** Qualitative study. For data collection, were realized two sessions of a focus group with the team of a first episode psychosis outpatient service. **Results:** Professional participants stressed the importance of the family at the beginning of treatment and their needs. This perception was interpreted as facilitators to the inclusion of the family. The barriers to a more active participation identified in the discussions are related to the family, the structure and organization of the service, and the professionals. The overvaluation of the biomedical model is present in all barriers. **Conclusion:** The study reinforced our understanding of the importance of including the family in the care, and contributes pointing the facilitators and barriers to effect this proposal.

Descriptors: Psychiatric Nursing; Mental Health Services; Family Therapy; Professional Practice; Psychotic disorders.

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RESUMO

Objetivo: Identificar e analisar as possibilidades e barreiras percebidas por profissionais de saúde para implantar e manter, na rotina de um ambulatório de primeiro episódio psicótico, o cuidado às famílias de portadores de transtorno mental. **Método:** Estudo qualitativo, cuja coleta de dados foi realizada através de duas sessões de grupo focal com a equipe de um ambulatório de primeiro episódio psicótico. **Resultados:** Os profissionais participantes ressaltaram a importância da família no início do tratamento, e suas necessidades. Essa percepção foi interpretada como um facilitador para a inclusão da família. As barreiras para uma participação mais ativa identificadas nas discussões estão relacionadas à própria família, à estrutura e organização do serviço, e aos profissionais. A supervalorização do modelo biomédico está presente em todas as barreiras. **Conclusão:** O estudo reforçou a importância da inclusão da família no tratamento desses indivíduos, e contribui apontando os facilitadores e barreiras para efetivar esta proposta.

Descritores: Enfermagem Psiquiátrica; Serviços de Saúde Mental; Terapia Familiar; Prática Profissional; Transtornos Psicóticos.

RESUMEN

Objetivo: Identificar y analizar las comodidades y barreras percibidas por los profesionales de la salud a implementar y mantener, en la rutina de un ambulatorio de primer episodio psicótico, el cuidado de los familiares de pacientes con trastornos mentales. **Método:** Estudio cualitativo. Para la recolección de datos, se realizaron dos sesiones de grupos focales con el equipo de una clínica para el primer episodio psicótico. **Resultados:** Profesionales participantes destacaron la importancia de la familia en el inicio del tratamiento, y sus necesidades. Esta percepción fue interpretada como un facilitador para la inclusión de la familia. Las barreras para una participación más activa identificadas en las discusiones están relacionados con la propia familia, a la estructura y organización del servicio, ya los profesionales. La sobrevaloración del modelo biomédico está presente en todas estas barreras. **Conclusión:** El estudio refuerza la importancia de la inclusión de la familia en el tratamiento, y contribuye señalando los facilitadores y los obstáculos a la realización de esta propuesta.

Descriptor: Enfermería Psiquiátrica; Servicios de Salud Mental; Terapia Familiar; Práctica Profesional; Los Trastornos Psicóticos.

INTRODUCTION

Psychosis, characterized by the presence of delusions and hallucinations, can occur in several mental disorders, with

schizophrenia and bipolar affective disorder being the most known. The first episode psychosis (FEP) usually occurs between adolescence and early adulthood.¹ The onset of a mental disorder deeply

affects the lives of patients and their families. This experience has been compared to the trauma experienced by disaster victims. Family members are bewildered as they struggle to understand the change in the behavior of their loved one, and frequently feel anguish, anxiety and guilt. Thus, it is important to shelter the family from the onset of the condition.²

Literature shows that families are suffering with these challenging emotional and practical experiences because they must play the role of caretakers, for which they are not prepared.³ The strategies used to deal with issues related to the illness and care are often insufficient. Thus, studies show the need to offer efficient family interventions, improve the caregiver's mental health status and potentialize their role in patient care.^{3,4}

Some studies suggest that, by means of task sharing and support, family interventions can minimize the effects of stress factors, help improve the patient's condition and reduce the number of relapses and psychiatric admissions. In addition, families often report the need for information and professional support to help them deal with the condition of one of their members.^{3,5,6}

A qualitative study conducted in a university hospital in Norway assessed how the benefits of family intervention were perceived by patients suffering a first episode psychosis and their families. It showed a greater development of insight and acceptance of the condition, as well as improvements in communication, planning and problem-solving skills.⁷

In Australia, a qualitative study conducted in a mental health service assessed an intervention addressed to family members who are caregivers of individuals who experienced a first episode psychosis. Its finding showed that family participation in this type of activity helped reduce their feelings of isolation and stigma, made family members feel others were listening to their issues, increased their knowledge on the condition and enhanced their skills to support the affected family member.⁸

Although the studies presented above indicate that family intervention has positive results, the inclusion of the family at the onset of this condition and start of treatment is still not a routine procedure in many services.⁹ Furthermore, even when family interventions are routine, family members do not feel fully included in the treatment process. What prevents or

inhibits family interventions in mental health services? In light of this question, this study aimed to identify the facilitators and barriers to implementing and maintaining family interventions after a first episode psychosis, as perceived by healthcare professionals in an outpatient health team.

METHOD

This is a qualitative study based on data collected from a focus group with professionals of the multidisciplinary team of a First Episode Psychosis Outpatient Service (FEPO) in a teaching hospital.

The FEPO offers drug treatment and psychosocial treatment to family members and patients through a psychoeducation group, as well as family interventions based on the Calgary Family Assessment and Intervention Models (CFAM/CFIM).¹⁰ The FEPO is inserted in a teaching institution, therefore the cross-functional team is composed by a fixed and a floating team. The fixed team has two supervising psychiatrists, one psychologist, and two specialist nurses who are responsible for the families' individual care, totaling five professionals. The floating team has nine professionals: five medical students in the second year of

medical residency in Psychiatry who provide individual medical care, two third-year residents, and two post-graduate nurses who are doing a family-oriented internship in the FEPO.

All the professionals were invited to participate. The invitation was made in person and via e-mail by one of the researchers. Seven professionals took part, namely all the fixed team members and two floating team members (one resident physician and one post-graduate nurse). The other professionals could not participate because of schedule problems.

We emphasize that the individual assistance of the families is part of the extension project of two researchers of this work, being the authors of this research close to the FEPO team. This condition may set an important bias that may limit the study. However, we believe that this condition does not affect the relevance of the work, since there are few services such as FEPO in Brazil. In addition, our framework shows that a collaborative link between researchers and care workers provides benefits in providing care at both individual and collective levels, as well as advocating the great potential of participatory approaches in transferring knowledge to the effective transformation

of practice.¹⁰ To ensure data quality, these were extensively discussed with the team.

Data were collected between September and December 2014 through two focus group sessions held in a private location and audio recorded. One researcher acted as a coordinator during the sessions, while another acted as an observer, taking notes in a field diary. In the first session, a script was used with the following guiding questions on the importance of family inclusion in the care of individuals with a first episode psychosis: “How do you perceive the role of the family in patient care? In the service where you work, is there any form of interaction with the families? What are the difficulties, according to your perception, of including the family in the care of patients at this service? Which factors facilitate inclusion?” After this session, which lasted 30 minutes, the discussion was transcribed by one researcher and the transcription was read in full. Then, a narrative of the topics discussed was written and, together with the transcription, submitted to the participants in the second session of focal group in order to validate the information obtained and obtain a more profound understanding of the identified

topics. The second focus group lasted 59 minutes.

The material obtained from the focus groups was initially analyzed using the transcription of the fully recorded discussion, with the participants’ identification, followed by a reading session of the material. In the second stage, the material was read to identify the argument cores. The narrative was constructed from the categorization of argument cores to primarily summarize the material, while maintaining the essence of the narrative with regard to the story it told, without necessarily following the original sequence or reproducing the lexical forms of the group.¹¹ Two researchers independently categorized and identified the argument cores. Then, they wrote the group’s narrative, which was read in the second session of focus group. In this session, the participants deepened the discussions on the topics presented and collaborated with the final wording of the narratives.

The second focus group meeting was attended by a fixed-team psychiatrist, a psychologist, two specialist nurses, a post-graduate nurse, plus the coordinator and the observer.

The research project was approved by the Ethics Committee at the Ribeirão Preto School of Nursing, report nº 794.561. All participants were educated and signed the Free and Informed Consent Form.

RESULTS

From the analysis of the focus group discussions, we produced two categories: facilitators and barriers. The first one includes the themes that favor family inclusion in the care offered by the FEPO. Two types of facilitators were identified, such as health worker's understanding the family role health workers, and offering family interventions in the first episode psychosis. The second category addresses the barriers of family intervention. Three types of barriers were recognized related to the family, the professionals and the service.

Understanding the family's role

Participants stated, *"family is critical and very important"* (Psychiatrist 1) in the care of individuals in the first episode psychosis. They stated, *"with the onset of the psychotic episode, the patient momentarily loses autonomy and needs someone to be responsible for their care"* (resident physician). The Brazilian healthcare policy also values the family's

role as caregiver. According to the Brazilian Psychiatric Reform, the family will assume the care in the home, *"administer drugs, give support, observe behavior"* (Psychiatrist II).

Offering family interventions in the first episode psychosis

In contrast, the family is impacted by the onset of psychosis and needs support and information to assume the role of caregiver, *"especially as regards the first episode psychosis"* (Post-graduate nurse I), as in the case of the individuals cared for in the studied service.

The professionals emphasized that, although it is not a requirement of the service, family members are usually present during the visits due to the patient's condition. *"The patients are usually in a very serious condition and requires someone to come with them"* (Psychologist).

In the professionals' opinion, the presence of family members during the visits is an opportunity for the team to encourage them to participate in the activities offered at the outpatient service, i.e., the family group and individual family care. One professional stated, *"Family members have to wait during the medical consultation, so they can take this time to*

participate in the psychoeducation group for families and patients” (Psychiatrist II).

The presence of a fixed team, responsible for the care offered to the family, also encourages patients and families to participate in the group. It, “creates a bond with the accompanying families” (*Specialist nurse I*). These activities also represent, “a space to be heard, clarify doubts and, in the case of the group, exchange experiences with other people facing similar situations” (*Resident physician*).

The FEPO offers care for families and the entire team works toward this proposal, thus becoming a facilitator for the inclusion of families in care. However, all the professionals agreed that the families do not get fully involved in the psychoeducation group and in individual family care. The analysis of the factors hindering family participation revealed three important barriers, discussed below.

Family-related barriers

The professionals mentioned the family itself as an important barrier to the participation in groups and individual care, although the team encourages and invites families to the activities. The professionals stated financial issues can make it difficult for the families to participate, since most users depend on public transportation to

get to the healthcare service and, “*the family often cannot afford the bus fare” (Psychiatrist II)*. Another aspect is time restriction, because family members that have jobs usually need to return to work as soon as possible.

Some patients and families have difficulty understanding the benefits of the interventions. Despite all the efforts made by the professionals to explain the relevance of family care, most families fail to acknowledge the importance of their participation. For some professionals, this difficulty is associated with our culture, because “*there is an overvaluation of the biomedical model – drug intervention” (Resident)* to the detriment of the psychosocial model.

Service-related barriers

“*At first, the service had two psychoeducation groups: one for patients and another for family members” (Psychiatrist II)*; however, the lack of rooms and professionals available for handling both groups simultaneously forced to maintain only one group for both families and patients. It should be noted that this configuration also works as a barrier since family members and patients may not feel comfortable discussing their concerns.

Another aspect of the service pointed out as barrier is that the group activity is scheduled at the same time as

the medical consultations. Since *“the service demand is high, when a large number of patients participates in the group, medical consultations are delayed and rushed. This generates resistance from the patients, who choose not to participate in the group so that they can be seen by the doctor earlier and with more time. It also generates resistance from the doctors, who do not want the visits to accumulate after the group sessions”* (Psychiatrist I).

Team-related barriers

The inclusion of the family in the care of individuals with mental disorder is still new in our context, and the professionals are not always prepared for this task. In the outpatient service, the learning in a systematized manner and with a theoretical basis on family intervention is directed to the third-year residents. However, medical care is performed by the second-year residents, who have not had much contact with family interventions.

Thus, some second-year resident physicians may not believe that interventions with the families can benefit the individual with a mental disorder, the family or the service. This can become an obstacle for encouraging the families to participate in intervention activities, individually or as a group, because *“they still have not gone through the experience and*

might have difficulties grasping intervention to convince the patient” (Psychiatrist II).

DISCUSSION

This study identified the FEPO has always sought to care for the families of individuals with mental disorder due to the strong impact the onset of psychosis has on the family and their need to understand the condition. Moreover, at the start of treatment, patients are still highly symptomatic and momentarily dependent on care. This perception facilitates family inclusion in the planning of care for patients with mental disorders. The FEPO advocates an evidence-based practice, since literature stresses the critical importance of including the family early in the treatment plan.¹²

Early intervention, in which support and information is offered to the family during the patient’s treatment and recovery, increases the participation of caregivers in this process. It also improves adherence to medication, reduces relapse rates and improves the functional results and quality of life of the patient.^{1,13} As regards family members, it improves their knowledge, promotes their mental health and strengthens their coping strategies.¹⁴

The professionals participating in this research emphasized the importance of

the family in the beginning of treatment, and reported their needs at this time. However, they also recognized that the patients and their families rarely participate in the activities offered to them. Barriers for a more active participation, identified in the discussions, are associated with the family, the service and the team of professionals.

The belief that the biomedical model is the only effective model was pointed out as one of the barriers to family participation in intervention activities, as well as personal issues such as schedule constraints, transportation problems, and financial difficulties.

As regards the biomedical model, also identified as private medical-assistance model, medical hegemony or hospital-centric model, it is the prevalent model in the Brazilian healthcare system and has been consolidated as the dominant paradigm in mental healthcare in recent years.¹⁵ Its practice conception is based on diagnostics and drug treatment and centered on the physician.¹⁶ Therefore, there is a tendency to resort solely to drug treatment without considering other forms of care.

Another important barrier to the implementation of family interventions in

mental healthcare services is time. A study conducted to identify barriers to family psychoeducation found that time-conflicting demands are common because family members usually face significant burdens. These burdens can prevent them from attending and completing family psychoeducation.¹⁷

With regard to financial problems, according to a study conducted in Brazil with caregiving family members, the presence of mental disorder within the family means the affected individual must stop working for some time and another family member may need to change their work schedule to meet the demands of caring for the affected individual.⁶

With respect to service-related barriers, although the service advocates family intervention activities, it does not have a proper structure for these activities. Literature also stresses this lack of a proper structure of the healthcare services for working with the families.¹⁸ It also shows the lack of an organizational culture involving work with families could be influenced by traditional paradigms based on the predominance of mental disorder biological models, which tend to minimize the focus on the patient's social context. Thus, there is a need to change the

organizational setting of the services so that family participation in patient treatment can be effectively implemented.¹⁹

Another difficulty identified is the lack of knowledge and involvement of some professionals in the service. The participants explained that resident doctors responsible for the medical consultations have not yet reached the stage in which they are taught to value the families and how to conduct a family intervention.

According to a study conducted in the United States, the lack of experience, motivation and/or interest of workers on the adoption and implementation of evidence-based practices in the routine of an institution can prevent them from engaging in family-oriented activities.²⁰

Furthermore, our results reveal that the overvaluation of the biomedical model also occurs among professionals. The conclusions of the participants in this research coincide with those of other authors, indicating a frequent overvaluation of the biomedical model by some professionals, who see psychosocial interventions and family interactions as superfluous activities and do not believe in their efficacy.¹⁹

In this study, it was found that the overvaluation of the biomedical model is present in every barrier: those associated with the family, the service and the teams. One of the barriers to overcoming this belief is lack of training. As an alternative to overcome these team-related issues, literature suggests the provision of support and training for mental health workers so they may perform evidence-based tasks that include the families.²⁰ The ultimate goal is to effectively implement family interventions in the routine of an outpatient service. All team members must receive regular training and supervision. The establishment of a solid structure for interventions could enhance the involvement of families, insofar as their individual needs are met.

CONCLUSION

The aim of this research was to identify and analyze the facilitators and barriers to the implementation of family intervention in the routine of a mental health service. The recognition of the family's distress by the professionals was identified as a facilitator, as well as their acknowledgement of the family's need for information and support. They are, therefore, motivated to interact with

patients' families. The barriers identified are associated with the family, the organization of the service and the health teams, as also found in other national and international studies.

We believe our study provides valuable insight into the importance of including the family in the care of individuals suffering a first episode of psychosis. It contributed by identifying the facilitators and barriers to the achievement of such inclusion, and showed the need to incorporate knowledge and develop skills for working with families.

The main limitation of this study is that data were only collected from professionals working at the service. According to literature it is important to also include the patient, the family, and any workers associated with decision-making in healthcare management.

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