

Perception of the family about the professional support received in a children and youth mental health service

Percepção da família acerca do suporte profissional recebido em um serviço de saúde mental infanto-juvenil

Percepción de la familia sobre el apoyo profesional recibido en un servicio de salud mental infantojuvenil

Received: 20/11/2019

Approved: 22/04/2020

Published: 01/08/2020

Ingrid Moreira dos Santos¹

Belisa Vieira da Silveira²

Adaene Alves Machado de Moura³

Sandra Cristina Pillon⁴

This is a qualitative research carried out in Belo Horizonte/MG, Brazil, which took place in the first semester of 2018, with the objective of knowing the family's perception of the professional support received in a children and youth mental health service. The data were collected through a semi-structured interview and analyzed according to the content analysis proposed by Bardin. Nine family members of adolescents undergoing treatment and three health professionals have participated in the study. Three categories were constructed: *Mental disorder and Adolescence*, *Mental disorder and Family* and *Treatment offered to the family member at the service*. Family members reported that they would like the service to develop listening activities more frequently, since they felt fragile and feared the adolescent's clinical condition could deteriorate. In contrast, it has been noticed that the health professionals usually have few meetings with family members due to work overload. The need for more frequent actions and assistance directed to family members is perceived to alleviate the anguish resulting from the mental disorder of the adolescent being treated.

Descriptors: Mental health services; Adolescent; Family.

Esta é uma pesquisa qualitativa realizada em Belo Horizonte/MG, ocorrida no primeiro semestre de 2018, com o objetivo de conhecer a percepção da família sobre o suporte profissional recebido em um serviço de saúde mental infanto-juvenil. Os dados foram coletados por entrevista com roteiro semiestruturado e os dados foram analisados por meio da análise de conteúdo proposta por Bardin. Participaram nove familiares de adolescentes em tratamento e três profissionais de saúde. Três categorias foram construídas: *Transtorno mental e Adolescência*, *Transtorno mental e Família* e *Tratamento oferecido ao familiar no serviço*. Os familiares relatam que gostariam que o serviço desenvolvesse atividades de escuta com mais frequência, uma vez que se sentiam fragilizados e receosos a respeito da condição clínica do adolescente. Em contrapartida, os profissionais de saúde realizam poucos encontros com os familiares devido à sobrecarga de trabalho. Percebe-se a necessidade de ações e atendimentos mais frequentes direcionados aos familiares para aliviar as angústias decorrentes do transtorno mental do adolescente em tratamento.

Descritores: Serviços de saúde mental; Adolescente; Família.

Esta es una investigación cualitativa llevada a cabo en Belo Horizonte/MG, Brasil, ocurrida en el primer semestre de 2018, con el objetivo de conocer la percepción de la familia sobre el apoyo profesional recibido en un servicio de salud mental infantojuvenil. Los datos se recopilaron mediante entrevista con un guión semiestructurado y los datos se analizaron utilizando el análisis de contenido propuesto por Bardin. Participaron nueve familiares de adolescentes sometidos a tratamiento y tres profesionales de la salud. Se construyeron tres categorías: *trastorno mental y adolescencia*, *trastorno mental y familia* y *tratamiento ofrecido al miembro de la familia en el servicio*. Los miembros de la familia informan que les gustaría que el servicio desarrollara actividades de escucha con mayor frecuencia, ya que se sentían frágiles y temerosos sobre la condición clínica del adolescente. En contraste, los profesionales de la salud tienen pocas reuniones con miembros de la familia debido a la sobrecarga de trabajo. Se percibe la necesidad de acciones y asistencia más frecuentes dirigidas a los miembros de la familia para aliviar la angustia resultante del trastorno mental del adolescente que está siendo tratado.

Descriptores: Servicios de salud mental; Adolescente; Familia.

1. Academic of the undergraduate course in Nursing by the Minas Gerais Faculty of Education, Belo Horizonte, MG, Brazil. ORCID: 0000-0002-8287-673X E-mail: moreiraingrid57@gmail.com

2. Nurse. Specialist in Mental Health in Contemporary Practice. Specialist in Teaching and Higher Education Management. Master in Health and Nursing. PhD student Graduate Program in Psychiatric Nursing (PPGEP) at the Ribeirão Preto, Faculty of Nursing, University of São Paulo (EERP-USP), SP, Brazil. ORCID: 0000-0002-5966-8537 E-mail: belisavsilveira@gmail.com

3. Nurse. Specialist in Drug Abuse Prevention. Master in Health Sciences. PhD student at PPGEP-EERP-USP, SP, Brazil. ORCID: 0000-0001-7607-9841 E-mail: adaene_moura@hotmail.com

4. Nurse. Specialist in Chemical Dependency. Master in Gastroenterology. PhD in Psychiatry and Medical Psychology. Full Professor at PPGEP-EERP-USP, SP, Brazil. ORCID: 0000-0001-8902-7549. E-mail: pillon@eerp.usp.br

INTRODUCTION

Adolescence is a period of the life cycle marked by significant physiological, psychological and behavioral and/or relational changes, in which an individual, from his experiences, builds his identity and subjectivity^{1,2}. In contrast to the experiments inherent to adolescence, associated with the search for pleasure and social acceptance, there is a biological immaturity for the assessment of decision-making and the possible consequences, which make this period a phase of biopsychosocial vulnerability, with or without transient or permanent psychological suffering^{2,3}.

According to data from the World Health Organization (WHO), one in five adolescents has problems related to mental health and half of all mental disorders are triggered in adolescents around 14 years of age⁴. In addition, the sooner the first psychotic outbreak occurs, the greater the severity of suffering for the individual and the impact on certain aspects of his life, which requires monitoring of the individual and his family.^{5,6}

In adolescence, by itself, changes in family dynamics occur, since norms and relationships need to be readjusted in the face of new demands and the growing autonomy of young people⁷. Study shows that this family reconfiguration and conflicts, as well as very imposing and inflexible measures are often associated with mental health problems among adolescents⁸.

In families where pre-existing conflicting relationships exist, the onset of the disease in the child or adolescent causes the web of problems to intensify, aggravating the illness process⁹. Thus, the disease process in the family inevitably contributes to the triggering of imbalances in family relationships. Most of the time, the mental illness of a loved one arouses several negative feelings in the family, such as guilt, anger, incompetence, fear, insecurity, shame, among others. In addition, the family still needs to manage the symptoms related to mental disorder, adapt to the new medication routine and consultations in specialized services, which impacts on the social life of caregivers⁸⁻¹⁰.

Nevertheless, family members of people with mental disorders carrying the burden of care usually seek hospitalization and/or temporary institutionalization of the individual, in search of relief and rest when the day to day becomes unbearable. The daily routine of living with a subject in crisis, without adequate treatment, causes physical and psychological exhaustion, also in the family⁸.

In this sense, becoming a mental health caregiver for an adolescent implies associated psychological suffering, due to: chronic character of the disease, stigmas strongly linked to mental disorder, little knowledge about the disease and, often, low social and professional support caregivers¹¹.

It is important that health services offer spaces for listening and intervention to family members of adolescents in psychological distress, since those actions benefit the mental health of caregivers and/or family members and enhance their performance to act for the recovery of the individual¹². Cooperation between service health professionals and family contributes positively to psychosocial rehabilitation, by easing the suffering experienced by both during treatment^{13,14}.

The family has a potential protective role, since it is the individual's first socializing nucleus. Functional families that offer affect and economic support to children and adolescents are relevant elements for maintaining the individual's mental health and well-being.

Community aspects, such as school involvement, belonging to a group of pro-social peers, access to health and cultural services, as well as characteristics inherent to the adolescent (self-esteem, abstinence from using psychoactive substances, self-confidence and others) are protective factors to the early onset of mental disorders^{2,9}. Thus, it becomes relevant to promote approaches to adolescents in their entirety, considering individual, family and community aspects in the health-disease process.

In Brazil, the current legislation addresses the rights and protection of people suffering from mental disorders, providing mental health care, of any nature, which should be directed to the person and their families, in addition to assistance and the promotion of health actions to people with mental disorders with the due participation of society and the family¹⁵.

Child and youth care units can be important devices to minimize the number of hospitalizations, which are sometimes unnecessary, favoring the strengthening of care actions based on the right to family and community life, reinforcing the paradigm of social insertion for the promotion of mental health. Thus, it is recommended that the services have actions aimed at the adolescent's families, so that they do not feel helpless or lost in relation to how to approach and care for the young person with mental disorder¹⁶.

Despite Brazilian legislation and positive evidence about the bilateral benefits of including the family in assisting people with mental disorders, this practice is not yet part of the routine of most mental health services, which impacts on the continuity of treatment and the prognosis of the disease, but also, in the daily and mental health of the family caregiver^{14,17,18}.

Based on these assumptions, the present study aims to know the perceptions of family members about the professional support received in children and youth mental health services.

METHOD

This is a research based on the qualitative approach, which consists of an empirical investigation of a contemporary phenomenon within its context in real life, especially when the boundaries between the phenomenon and the context are multifaceted, involving the social, psychological and behavioral aspects¹⁹.

The research was developed in a traditional service in child and adolescent psychiatric care in Belo Horizonte, Minas Gerais (MG), Brazil. The service linked to the Hospital Foundation of the State of Minas Gerais, was founded in 1947 and is considered a center of excellence of national reference in the training of professionals in the Unified Health System (SUS).

The service's mission is to ensure and promote excellence in the reception, treatment and social inclusion of children and adolescents, offering secondary and hospital outpatient care to users of the Unified Health System. The therapeutic possibilities offered in the referred service involve: psychiatric urgency, crisis follow-up, joint accommodation, bed-crisis, permanence day, psychotherapeutic care (individual and group), therapeutic workshops, ambulatory and sheltered home, carried out by a multidisciplinary team involving psychiatry, neurology, psychology, occupational therapy, social service, speech therapy, nursing and physiotherapy.

For the research, family members accompanying adolescents hospitalized or on permanence days (PD) for more than two weeks were considered, and family members of adolescents in the first crisis or who had cognitive or psychological changes that prevented participation were excluded.

In relation to professionals, those who have been working for more than six months were included and individuals who were on leave due to vacation or sick leave for more than 30 days were excluded.

The institution's technical team provided a list containing the names of the adolescents who constantly had a companion. Thus, family members were interviewed individually. As it is a reference hospital, it was commonly observed young people from different regions of the State of MG, many without companions, due to the different places of residence, as well as adolescents admitted by court order, mainly for psychosocial factors.

Data were collected from April to June 2018, through an audio-recorded interview with a semi-structured script, with the prior authorization of the participants. The material was transcribed literally and in full, constituting the corpus of analysis. The number of participants was determined by the data saturation criterion²⁰.

The data were analyzed and interpreted through content analysis proposed by Bardin, and the content in the analytical process allowed the construction of thematic categories²¹.

To guarantee confidentiality in relation to the participants' identities, the letter F was assigned to each family member (F), according to the occurrence of the interviews, and the same criterion for health professionals to the letter P, followed by a numerical sequence (F1 , F2, F3 ... and P1 ...).

Ethical assumptions in compliance with Resolution no. 466/2012 of the National Health Council (CNS) were guaranteed. Data collection started after approval by the Ethics and Research Committee of the Hospital Foundation of the State of Minas Gerais under CAAE nº 60584516.2.0000.5119 and Consubstantiated Opinion nº 1,772,544. All participants signed the Free and Informed Consent Form²².

RESULTS

The study was carried out with nine relatives of adolescents hospitalized or in PD and three health professionals from the service (two psychologists and a social worker).

Of the nine family members, seven were women as their main caregiver, with a low level of education, eight had incomplete primary education and five came from cities in the interior of the state of MG. As for the age group, two family members were between 30 and 40 years old, four between 41 and 50 years old, one between 51 and 60 years old and two were over 60 years old. Seven family members stated that they had another family member with a mental disorder.

Only one family member did not report the presence of another family member with a mental disorder, however he reported that an uncle of the hospitalized teenager had severe behavioral changes, but there was no definite diagnosis. As for the modalities for treatment in the service, six family members accompanied the adolescents during their hospitalization and the other youngsters in the assistance in PD.

All of the professionals interviewed were female, with academic training for over 10 years and worked in the service for about a year and 6 months. It should be noted that they had training and adequate work time that allowed them to answer about the dynamics of the service's operation and the assistance to the family in mental health. At first, the research was intended to also interview the reference technicians (RT) of these adolescents, as recommended by the Policies of the Ministry of Health.⁴ However, the present service has this professional only in the PD unit, providing for the future implantation of the TR in inpatient units.

As it was mentioned before, categories from the speeches of the participants were created according to the analysis proposed by Bardin. Chart 1 presents the emerging categories.

Chart 1. Categories and subcategories from family members and professionals about mental health support. Belo Horizonte, MG, 2018.

| Category | Subcategories |
|--|--|
| 1. Mental Disorder and Adolescence | <i>1.1 Conceptions about mental disorder for family members and health professionals</i> |
| | <i>1.2 Causes and manifestations of mental disorder</i> |
| 2. Mental disorder and family | <i>2.1 Family feeling about mental disorder</i> |
| | <i>2.2 The impact of mental disorder on family members</i> |
| 3. Treatment offered to family members in the service | <i>3.1 Family members' perceptions of the treatment performed at the service</i> |
| | <i>3.2 Professionals' perceptions of the family's insertion in the service</i> |

1. Mental disorder and adolescence

Mental disorder is often misunderstood by family members and even health professionals. In the subcategories below, the difficulties of family members and professionals in understanding this theme, as well as the manifestations and causes of this disease in adolescents were addressed.

1.1. Conceptions of mental disorder for family members and health professionals

The family members expressed little understanding about the concept of mental disorder, with this, they experience greater suffering in their daily lives, since, due to the lack of knowledge and understanding, they are surprised by the symptoms, the change in behavior and the crises inherent to the disorder:

I think that the person, like his case is like this, he imagines the bad things, thinks about the bad things and sometimes he thinks that it is happening and gets nervous about it, this is his case. (F3)

I don't know how to explain [...] (F5)

I think he is a person with a very weak head, he is unable to live alone, to live life alone, it will always depend on me and if he depends on me I will have to live for him, because of him. (F7).

The service professionals were also asked the same question, in order to know their perceptions about mental disorder and to point out the difference between consolidated theoretical knowledge and family knowledge based on the experience of the disease:

I understand that he is a person who is not in his normal mental faculties, he is not well structured emotionally. (P1)

Every day that I find myself thinking about the juvenile disorder it brings me to the issue of family, family vulnerability which I think is what really happens, so it potentiates the disorders and when you will research, when you will evaluate more deeply you run into a more social issue. (P2)

I realize that today the mental health of children and adolescents is very much linked to the contemporary world, stress, overworking the family that often the child has been going through that mental disorder for a long time and help is not sought, you know, sometimes they say: my son has been locked up in the house for two years. (P3)

1.2. Causes and manifestations of mental disorder

In the statements of the participants, it is clear that the mental disorder was often associated with some event in the family, such as trauma, loss, disappointment, that is, many family members associate the onset of the disease with some relevant social aspect.

The manifestations are perceived by the family through the change in behavior, mood, personality and attitudes of the adolescent. That is explained in the statements:

And my son keeps that in mind, because I and his father are separated and his father left the house. After that he got worse, then he thinks it's my fault, but it's not. (F7)

When she has the crisis, she keeps taking a knife, saying that she will kill us, because I am separated from my ex-husband [...] her father raped her and she does not forget her father. (F8)

She had an outbreak, she started it [...] It gave her symptoms, you know, I stayed in her corner just reading the Bible, then she lost interest in things and everything. Then she stopped talking, then she didn't want to eat anymore saying she was going to die, she didn't want to drink more water, or juice. He said that her presence in the cemetery would make the family unite over his grave. (F9)

2. Mental disorder and family

Mental disorder tends to generate negative feelings in family members, so the following subcategories explain the feelings about the disorder and the impact of the disease on family members.

2.2. Family feeling about mental disorder

The mental disorder generates an inexplicable feeling in the family, such as difficulties in expressing the feelings arising from the disease, with negative emotions being common:

I get really sad, right, I wanted him to get better and sometimes when he gets very agitated very nervous, I'm afraid of him. (F3)

Feeling? Gee, it hurts me too much. (crying) That's it, sadness ... Oh, that's right, you can't talk. It hurts, right, you see the person you love this way, right. (F4)

When I see him taking a knife, I feel a little insecure. Will it happen again, will it repeat itself? You know I'm sad, I didn't think he was going to have this case. (F5)

[...] I already suffered a lot with this boy, I just suffered so much because of him [...] he doesn't take a shower for three days and if I may say he thinks he's bad with me, he wants to beat his grandfather, he swears at us whatever name he finds, fight on the street if you let [...] (F6)

[...] I feel really bad, really bad, we think it will happen to everyone, except you [...]. It's a feeling of fear, very sad when you see your child, you raise him and this happens and you can't do anything[...]. (F7)

2.3. Impact of mental disorder on family members

The presence of a person with a mental disorder has a very large impact on the social, emotional and financial relationships of their caregivers. Often, it is necessary for family

members to stop performing their daily activities to take care of the person with mental illness, giving up their dreams to live according to their loved one, which weakens the family emotionally, which can cause more difficulties in the care of the family and puts them in an illness process that also requires health care:

I left the service because of her, it's been over a year. (F1)

I did my nails, I did my hair and I don't do it anymore, I don't do anything, for me nothing else is funny, I don't think it's beautiful anymore. (F6)

We live in Mário Campos' (interior of Minas Gerais). We came here to see if I changed the medicines and cause of that I am not working. I had a very different life expectancy, dreams that today I see that [...] (crying). (F7)

It broke up with us, took our floor off, her little sister just cries and with that we are left with no floor, you know, without floor, without structure. (F9)

3. Treatment offered to the family by the service

A good relationship between service and family members has been extremely important, meeting not only the need of the person with mental illness, but also the demand and need of family members, who due to overload and their peculiar responsibilities may be weakened, as well as the person with a disease, specialized care by the health team, either through brief psychotherapy and follow-ups (individual or group).

3.1 Family members' perception of the treatment offered at the service

Family members revealed that they did not receive any care offered by the service, except for meetings directed to family members of adolescents in PD or informal conversations, when necessary. In the inpatient units, family members who accompany the adolescents generally participate in consultations that occur only at the time of hospitalization, so they do not have assistance on an ongoing basis during hospitalization:

Not with me. Until today there was no, the psychologist even said: if you want to talk to me, that's fine, but specifically for the parents, in my case I don't know if there is, maybe even have, but I really don't know about it. [...] I think it's good, right, as in my case, as I'm saying, I get a little lost. (F1)

No, only himself. (F5)

No. The service you have for us is the psychologist who occasionally talks to us very little. They occasionally have a meeting with everyone, but like that, the first time is good, but then it gets that very repetitive thing. (F7)

Just like the doctor saw the way he was, the crisis he was here now, something he never did. Just like I told her, he was trying to cut his wrist out of nowhere. Then she said: at the time of the consultation we talked and walked away. I'm desperate. (F7)

It is observed in the F7 report, the explicit need and postponement of professional assistance, at the time of the adolescent's psychotic crisis. After the family members reported that they did not receive specific assistance, they also mentioned the desire to receive some type of assistance in the service:

I wish there was something for us, because our heads get better, we talk to one another and distract a little, right? [...]. (F6)

I think this is from escort to escort, maybe an entertainment that they like to do, even handicrafts, workshops, embroidery for the women they like. (F4)

In contrast, the professionals mentioned the types, the frequency, the professional who attends the family members and the barriers, such as lack of resources and family involvement:

We serve the family. We have meetings on Tuesdays with me and on Thursdays with the other psychologist, right, and the workshops are sometimes given by the OT and the parents participate. (P1)

A meeting is held every day, where both family members and patients are heard, right, there is the psychologist who also has a workshop where family members get involved. There is also listening. As the demand arises, wiretaps are performed. In the workshops, we face the resource factor, budget, then we have to use creativity. But it ends up being very difficult, because of this lack of resources, to offer a workshop; it is difficult for teenagers, it is even more difficult for the family, but when they propose to participate there is no problem, they participate. (P2)

The family member is accompanied by the whole team, by social work, by psychology, by occupational therapy, by nursing, the doctor also always tries to attend to the family, there are the parents' meetings, the morning meeting every day. So we try to always involve the family to the maximum. (P3)

Despite the absence of targeted care for family members, according to their perception, there is a lot of satisfaction with the service in relation to the treatment offered to adolescents in crisis:

I have nothing to complain about, the service is very good they are very attentive to her. (F1)

Here is good! Thanks to God the treatment is good, you know, I like everyone here. (F6)

Look, here is very good, I have nothing to complain about them. (F7)

3.2 Perception of professionals about the insertion of the family in the service.

Professionals perceive with great importance the participation of the family in the treatment of their loved ones with mental disorders. Considering the need for more humanized treatments for individuals in psychological distress, not only is the person with mental illness seen as part of the process, but the family also intervenes as an essential part of this process of social reintegration and psychosocial well-being:

I think it is fundamental, not least because these patients cannot be unaccompanied and the parents are responsible for these adolescents, so I think it is very important that families are present. (P1)

It is extremely important for the family to be present in the treatment of the adolescent, because if the relative is close, being present will help the adolescent to stabilize in the social environment, to better adhere to the treatment. (P2)

The family is fundamental, you know, if you don't have a family it is very difficult for the teenager to be able to build it on their own, there is a case that we deal with sheltered young people, who have no family or who are away from families and we perceive a hindering in the improvement process. They feel distressed and end up looking for someone to get that support. So, the family helps them a lot, they have to be together, they have to be present. (P3)

DISCUSSION

The study shows that most of the burden has been the responsibility of the female relative. This may be due to either the fact that the couple is separated or because they need to give up their social life to live for the sick family member, and in this case, the father needs to keep his job to support the family. In the meantime, it is clear that "responsibility for income" is still associated with the male gender and "responsibility for care" to female. In the case of the absence of male support, it is strictly up to the woman to generate income and maintain care, which further increases this burden²².

Care is directly linked to the feminine for an additional reason that refers to the differentiation between the masculine and feminine principles. Historically, the roles of women and men are different. The reserved area belongs to the woman, which is considered fragile where "home" and ethics is expressed by her fidelity to the husband, by reproduction and responsibility in the development of the child. However, man is responsible for the public area, and his respectability results from the ability to provide the family with food and respect^{22,23}.

This shows that the conception that women are born with knowledge about care, which does not belong to the male universe, is still valid. Increasingly, the traditional and cultural habit of taking care of the home and children is associated with the woman and it is up to the man to support the family financially that is in the process of change²².

Among the vulnerability factors is the previous history of mental illness in the family, which may be associated with the occurrence of mental disorder in other family members. Long standing evidence^{2,4,24} shows the hereditary and/or genetic character of mental illness. In addition to genetic factors, the aspects inherent to the individual (ability to cope with negative aspects, impulsivity and use of psychoactive substances) are associated with an earlier manifestation of mental illness.

Social and economic aspects also interfere in the onset of adolescence. Studies have shown that the precarious family socioeconomic situation and the low level of education of parents and / or guardians were significantly associated with more fragile health behaviors, such as: inadequate nutrition, difficulty in accessing health services, living in violent and unsafe environments, use of psychoactive substances, emotional and psychological problems^{2,25}.

Mental disorder means more than a set of symptoms, as it has other symbolic, moral, social or psychological representations for the patient and the family. The family lacks knowledge about the signs, symptoms and effects of the illness of their relative and, they have difficulties when discussing about the subject. When families understand the psychological suffering faced by their family members, they have more capacity to cope with the management of problems related to the disease, with autonomy and security and less suffering²⁶.

As presented in the statements, family members feel obliged to direct a large part of their time, giving up their daily lives to take care of their loved ones. In addition to pain, for many family members, mental disorder is understood as a reason for shame. In most cases, this may be due to the lack of more qualified knowledge about mental disorder by family members²⁶.

Commonly, family members have difficulties in expressing their ideas and understanding about mental illness clearly. They had many difficulties in talking about their perceptions about mental disorder, in view of the reports of daily experiences about the adolescent's illness, which may be implicit in their suffering as a family caregiver. Thus, it is perceived that suffering is superior to knowledge about the disease, which makes it difficult to identify the first signs and symptoms of a crisis, implementation of prevention and intervention actions under the guidance of the team¹⁰.

Thus, it is recognized, in the worrying characteristics revealed, that family members and health professionals have difficulty in clearly describing and conceptualizing the phenomenon of psychiatric illness among children and adolescents. In the professionals' report, it can be noted that most adolescents are from dysfunctional families with high levels of biopsychosocial vulnerability. Evidence shows that adolescents who experience difficulties in family relationships, such as discussions between parents and family members, separation of guardians, parents who use alcohol and/or drugs and low emotional support during childhood, are more likely to develop mental health problems in relation to those who had good communication within the family^{27,28}.

The professionals' reports suggest that the social factor has important implications for triggering mental disorders among adolescents. It is common for such problems to emerge from crises, most often after a negative personal event, of great emotional and / or psychological impact on the individual^{10,26}.

Family misunderstanding, situations involving verbal and physical aggression, fights, are factors that contribute to the triggering of psychological distress in adolescents. The family relationship is the basis for the adolescent's emotional development, even more for the one in psychological distress, both for preventing a crisis, as well as for maintaining and recovering²⁸.

The evaluations reported by the relatives of the adolescents who suffer from mental disorders occurred through the observation of the behavioral change of this adolescent, indicating attitudes considered as diagnostic criteria for the mental disorder such as irritation, nervousness, restlessness, isolation, agitation and aggression^{10,26}.

Reports such as sudden changes in mood and/or behavior can be confused and ignored by family members. Part of the initial signs and symptoms of an onset are related to the changes and instabilities inherent to adolescence, which confuses the observer, making it seem like a simple more excessive manifestation of this phase of life^{26,27}. In addition, some signs were manifested since the childhood of this individual, not being perceived with strangeness by the family, but as a natural personality trait which makes the diagnosis and monitoring of the worsening of the symptoms difficult²⁷.

Mental illness, like any other chronic illness, profoundly affects not only the patient, but also the entire family. It is noticed that anguish is present in all interviewed family members, deeply affected by suffering, a feeling present in all aspects of their lives, becoming the companion of all hours, throughout the trajectory of the sick family member. Feelings are manifested in various forms and intensities, leaving deep marks in the lives of families¹⁷.

At the time of the crisis, people with psychological distress may present an episode of aggression, causing anguish, insecurity, sadness and fear as mentioned in the reports of family members. Therefore, this is the moment when the family's relationship with the adolescent with mental disorder tends, then, to be more dramatic, as the evidence is more intense and threatening to the safety of the family group and the adolescent himself. The fear of suffering an aggression and the relational tension makes the family member need to be always vigilant

so that the adolescent does not put his own life or that of others at risk, which aggravates the caregiver's burden²⁴.

Living with the family member with a mental disorder causes an overload characterized by difficulties such as: problems in the relationship with the family member with the disease, stress due to living with the patient's unstable mood and the dependence of the person with psychological suffering, as well as the fear of relapses and unexpected patient behavior during crises^{12,25}.

Family members can go through different stages in coping with the illness process, from the acceptance and understanding of the disorder to a feeling of helplessness and insecurity, for not being able to solve the problem of the sick young person. This last aspect causes the family caregiver to also suffer, being able to get sick together, with depression and anxiety disorders being the most common problems²⁴.

The mental disorder does not only reflect on the life of the sick individual, but reflects on the experience of the family group, since each family member interprets and mobilizes feelings in a different and unique way. The disease is an adverse and unexpected event that disrupts the family's way of being and living, requiring a new method and adaptation to the new situation^{9,26}.

The non-remission of symptoms, social failures and the abnormal behavior of the family member with mental disorder contribute to the emergence of tensions and suffering in the family nucleus, this alters their daily routine⁹. In view of the overload and suffering of the family members, the family member needs to develop symbolic resources to face this illness, which highlights the importance of the welcoming and care service for this caregiver.

Ordinance 224/92 recommended family care as one of the activities to be developed by mental health professionals. Ordinance 336/2002 that regulates Psychosocial Care Centers (CAPS) associates family care among the actions to be performed by health professionals, and Ordinance 251/2002, which stipulates guidelines and standards for assistance in a psychiatric hospital, includes programs own and interdisciplinary aiming at treatment according to the needs of each user and their family²⁹. It is noticed that there are several ordinances that address the importance of insertion and a service aimed at family members. There are specific programs to be carried out with these individuals, such as workshops, operative or conversation groups, individual consultations with the reference technician, among others.

There are several therapeutic modalities aimed at the family, direct interventions (behavioral management centered on the family or family therapy) with more immediate involvement of the family and which have specific objectives to be worked on over a period of time. Indirect interventions (psychodynamic therapy or cognitive-behavioral therapy) incorporate the perception of the family as informers of the family process¹⁴. There are different approaches to the family, but their use depends on the training of the professional and the context, with psychoeducational, behavioral interventions and systemic family therapy being the most used.^{14,30}

Actions aimed at the family of people with psychological distress should be structured in a way that benefits and strengthens the professional/family/service relationship, understanding that family members are fundamental in the treatment of adolescents with mental disorders^{14,28}. However, in the speeches of the participants, differences were observed between the perceptions of family members and professionals, which suggest that the activities developed for the family members are not frequent or that the purpose or development of these activities is not clear to the companions.

In the reports, it was observed that families have a lack of exclusive care, which happens infrequently in the service. In this sense, it is important to highlight that the process of building the therapeutic plan must involve the sick subject and his family and reveal their social and biographical situation. In this sense, it is important that professionals recognize the family as the target of care, which needs support for the normalization of their family routine^{29,30}.

The family's involvement in the therapeutic process makes the interventions more efficient, increases the resources for the patient, especially their adherence to treatment. As the family is an important factor in protecting health or manifesting the disease, it is necessary to train professionals so that they can recognize the needs of families and give them due attention and attention^{5,9,17}.

The family, in the work process, is an indispensable element when considering the resizing of mental health care. Psychosocial rehabilitation is not limited only to the use of psychotropic drugs and interventions, but also to actions and procedures aimed at family, social and professional reintegration and improving the quality of life of the mentally ill and their surroundings²⁹.

CONCLUSION

Mental illness has emotional, physical and financial impacts on family members and leads to routine changes to promote care for the person in distress. Thus, there is a need for treatment directed to the family member to relieve the anguish resulting from the mental disorder of the family member being treated, making more systematic and frequent actions and assistance to these family members necessary, since the presence of the family is fundamental in the adolescent's therapeutic process.

Among the limitations of the study, we highlight the peculiarities of the sample of adolescents and those of the place where the study was carried out, since the research was developed only with adolescents hospitalized or on a day-to-day basis, not including adolescents in outpatient follow-up. Therefore, the results must be evaluated with caution. However, this study is important to rethink the dynamics of family care at the participating institution.

REFERENCES

1. Savage JE, Rose RJ, Pulkkinen L, Silventoinen K, Korhonen T, Gillespie N, et al. Early maturation and substance use across adolescence and young adulthood: a longitudinal study of Finnish twins. *Dev Psychopathol.* [Internet]. 2017 [cited in 21 fev 2020]; 30(1):79-92. DOI: 10.1017/s0954579417000487
2. World Health Organization. Health for the World's adolescents: a second chance in the second decade [Internet]. Geneva: WHO; 2014 [cited in 21 fev 2020]. Available at: https://www.who.int/maternal_child_adolescent/documents/second-decade/en/
3. Sawyer SM, Afifi RA, Bearinger LH, Blakemore SJ, Dick B, Ezech AC, et al. Adolescence: a foundation for future health. *Lancet* [Internet]. 2012 [citado em 21 fev 2020]; 379(1):1630-40. DOI: 10.1016/s0140-6736(12)60072-5
4. Organização Mundial da Saúde. OMS: 1 em cada 5 adolescentes enfrenta problemas de saúde mental [Internet]. Brasília, DF: OMS Brasil;2018 [cited in 21 fev 2020]. Available at: <https://nacoesunidas.org/oms-1-em-cada-5-adolescentes-enfrenta-problemas-de-saude-mental/>
5. Martín Gutiérrez R, Payá González B. Las Psicosis de inicio temprano: una revisión. *Rev Psiquiatr Infanto-Juv.* [Internet]. 2016 [cited in 21 fev 2020]; 33(4):458-68. DOI: <https://doi.org/10.31766/revpsij.v33n4a2>
6. Trotman HD, Holtzman CW, Ryan AT, Shapiro DI, MacDonald AN, Goulding SM, et al. The development of psychotic disorders in adolescence: a potential role for hormones. *HormBehav.* [Internet]. 2013 [cited in 21 fev 2020]; 64(2):411-9. DOI: 10.1016/j.yhbeh.2013.02.018
7. Jaworska N, MacQueen G. Adolescence as a unique developmental period. *J Psychiatry Neurosci.* [Internet]. 2015 [cited in 21 fev 2020]; 40:291-3. DOI: 10.1503/jpn.150268
8. Rodríguez-Meirinhos A, Antolín-Suárez L, Oliva A. Support needs of families of adolescents with mental illness: a systematic mixed studies review. *Arch PsychiatrNurs.* [Internet]. 2018 [cited in 21 fev 2020]; 32:152-63. DOI: <https://doi.org/10.1016/j.apnu.2017.09.004>

9. Huang L, Stroul B, Friedman R, Mrazek-Rochester P, Friesen B, Pires S, et al. Transforming mental health care for children and their families. *AmPsychol*. [Internet]. 2005 [citado em 21 fev 2020]; 60: 615-27. DOI: 10.1037/0003-066X.60.6.615
10. Martins PPS, Guanaes-Lorenzi C. Participação da família no tratamento em saúde mental como prática no cotidiano do serviço. *Psicol Teor Pesqui*. [Internet]. 2016 [citado em 21 fev 2020]; 32(4):1-9. DOI:10.1590/0102.3772e324216
11. Fernandes CSNN, Nóbrega MPSS, Angelo M, Torre MI, Chaves SCS. Importância das famílias nos cuidados à pessoa com transtorno mental: atitudes de enfermeiros. *Esc Anna Nery Rev Enf*. [Internet]. 2018 [cited in 21 fev 2020]; 22(4):1-8. DOI: 10.1590/2177-9465-EAN-2018-0205
12. Bademli K, Duman ZC. Effects of a family to family support program on mental health and coping strategies of caregivers of adults with mental illness: a randomized controlled study. *ArchPsychiatrNurs*. [Internet]. 2014 [citado em 21 fev 2020]; 28:392-8. DOI: 10.1016/j.apnu.2014.08.011
13. Silva EM, Jorge MSB, Queiroz MVO. Perspectiva da família na convivência com o ser portador de esquizofrenia. *Rev Rene* [Internet]. 2016 [cited in 21 fev 2020]; 4(2):53-60. Available at: <http://periodicos.ufc.br/rene/article/view/5698/4085>
14. Jiménez L, Hidalgo V, Baena S, León A, Lorence B. Effectiveness of Structural-Strategic Family Therapy in the treatment of adolescents with mental health problems and their families. *InterJEnvironResPublic Health* [Internet]. 2019 [citado em 21 fev 2020]; 16(7):1-14. DOI: 10.3390/ijerph16071255
15. Brasil. Lei Federal 10.216 de 06 de abril de 2001. Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental [Internet]. Brasília, DF; 2001 [citado em 21 fev 2020]. Available at: http://www.planalto.gov.br/ccivil_03/leis/leis_2001/110216.htm
16. Ministério da Saúde (Br). Atenção psicossocial a criança e adolescente no SUS: tecendo redes para garantir direitos [Internet]. Brasília, DF; 2014 [cited in 21 fev 2020]. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/atencao_psicossocial_crianças_adolescentes_us.pdf
17. Eassom E, Giacco D, Dirik A, Priebe S. Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors. *BMJ Open* [Internet]. 2014 [citado em 21 fev 2020]; 4(10):1-12. DOI: 10.1136/bmjopen-2014-006108
18. Oliveira RMP, Loyola CM. Família do paciente psiquiátrico: o retrato de uma ilustre desconhecida. *Acta Sci, Health Sci*. [Internet]. 2004 [citado em 21 fev 2020]; 26(1):213-22. DOI: 10.4025/actascihealthsci.v26i1.1679
19. Gil AC. Como elaborar projeto de pesquisa. 5ed. São Paulo: ATLAS S.A.; 2010. 184 p.
20. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. *Cad Saúde Públ*. [Internet]. 2008 [citado em 21 fev 2020]; 24(1):17-27. DOI: 10.1590/S0102-311X2008000100003
21. Bardin L. Análise de conteúdo. Pinheiro LA, tradutor. São Paulo: Edições 70; 2016.
22. Guedes OS, Daros MA. O cuidado como atribuição feminina: contribuições para um debate ético. *ServSoc Rev*. [Internet]. 2009 [citado em 21 fev 2020]; 12(1):122-34. DOI: 10.5433/1679-4842.2009v12n1p122
23. Duarte RA. Configurações familiares e papel da mulher na política de saúde mental no Brasil. *Gênero* [Internet]. 2015 [cited in 21 fev 2020]; 16(1):155-78. DOI: 10.22409/rg.v16i1.750
24. Apter G, Bobin A, Genet MC, Gratier M, Devouche E. Update on mental health of infants and children of parents affected with mental health issues. *Curr Psychiatry Rep*. [Internet]. 2017 [cited in 21 fev 2020]; 19(10):72. DOI: 10.1007/s11920-017-0820-8
25. World Health Organization. The health and social effects of nonmedical cannabis use [Internet]. Geneva: WHO; 2016 [citado em 21 fev 2020]. Available at: https://www.who.int/substance_abuse/publications/msbcannabis.pdf

26. Pereira MAO, Pereira JA. Transtorno mental: dificuldades enfrentadas pela família. RevEscEnferm USP [Internet]. 2003 [citado em 21 fev 2020]; 37(4):92-100. DOI:101590/S0080-62342003000400011
27. Avanci JQ, Assis SG, Oliveira RVC, Ferreira RM, Pesce RP. Fatores associados aos problemas de saúde mental em adolescentes. Psicol Teor Pesq. [Internet]. 2007 [citado em 21 fev 2020]; 23(3):287-94. DOI: 10590/S0102-37722007000300007
28. Thiengo DL, Cavalcante MT, Lovisi GM. Prevalência de transtornos mentais entre crianças e adolescentes e fatores associados: uma revisão sistemática. J Bras Psiquiatr. [Internet]. 2014 [citado em 21 fev 2020]; 63(4):360-72. DOI: 10590/0047-2085000000085
29. Ministério da Saúde (Br). Legislação em saúde mental: 1990-2004 [Internet]. Brasília, DF: Ministério da Saúde; 2004 [citado em 21 fev 2020]. Available at: http://bvsm.sau.gov.br/bvs/publicacoes/legislacao_saude_mental_1990_2004_5ed.pdf
30. Lebow JL, Stroud CB. Family therapy. New York: American Psychological Association; 2016.

CONTRIBUTIONS

Ingrid Moreira dos Santos e Belisa Vieira da Silveira contributed to the conception and design of the research, data collection and analysis and writing. **Adaene Alves Machado de Moura** and **Sandra Cristina Pillon** worked on data analysis, writing and review.

How to cite this article (Vancouver)

Santos IM, Silveira BV, Moura AAM, Pillon SC. Perception of the family about the professional support received in a children and youth mental health service. REFACS [Internet]. 2020 [cited in *insert access day, month and year*]; 8(Supl. 1):512-523. Available at: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)

SANTOS, I. M.; SILVEIRA, B. V.; MOURA, A. A. M.; PILLON, S. C. Perception of the family about the professional support received in a children and youth mental health service. **REFACS**, Uberaba, MG, v. 8, p. 512-523, 2020. Supl. 1. Available at: *insert access link*. Access in: *insert access day, month and year*. DOI: *insert DOI link*.

How to cite this article (APA)

Santos, I.M., Silveira, B.V., Moura, A.A.M., & Pillon SC (2020). Perception of the family about the professional support received in a children and youth mental health service. *REFACS*, 8(Supl. 1), 512-523. Retrieved on: *insert access day, month and year* from *insert access link*. DOI: *insert DOI link*.