

**Experience report on a psychological intervention with family members of hippotherapy practitioners****Relato de experiência sobre uma intervenção psicológica com familiares de praticantes de equoterapia****Relato de experiencia acerca de una intervención psicológica con familiares de practicantes de equinoterapia****Received: 29/08/2020****Approved: 01/11/2020****Published: 09/01/2021****Sabrina Martins Barroso<sup>1</sup>****Juliana Machado Ruiz<sup>2</sup>****Camila Aparecida Peres Borges<sup>3</sup>****Cleyton Magela Reis<sup>4</sup>****Dennis Gabiatti Lopes<sup>5</sup>**

This study aims to report the experience of an extension project based on a brief psychological intervention carried out with caregivers of horse riding practitioners. The project took place as a university extension, throughout 2018, and it consisted of 19 family caregivers. Initially, the caregivers' emotional state and routine were assessed. The focus of the intervention was defined based on the report of family members. Nine individual meetings or with couples of caregivers were organized, in which the routine of care, leisure activities, division of tasks and self-care were all addressed. It was possible to notice that interventions focused on caregivers can contribute to the improvement of the quality of care they provide to users of hippotherapy, and it can also have a positive impact on their quality of life. Therefore, it represents a health promotion measure.

**Descriptors:** Caregivers; Community-Institutional Relations; Psychology; Case reports.

O objetivo desse trabalho é relatar a experiência de um projeto de extensão baseado em intervenção psicológica breve realizado com cuidadores de praticantes de equoterapia. O projeto ocorreu como uma extensão universitária ao longo de 2018, e contou com 19 familiares cuidadores. Inicialmente, avaliou-se o estado emocional e a rotina dos cuidadores. Com base no relato dos familiares, definiu-se o foco da intervenção. Foram organizados nove encontros individuais ou com casais de cuidadores, nos quais abordou-se a rotina de cuidado, atividades de lazer, divisão de tarefas e autocuidado. Percebeu-se que intervenções focadas nos cuidadores podem contribuir para melhorar a qualidade dos cuidados prestados aos usuários de equoterapia e geram impacto positivo em sua qualidade de vida, representando uma medida de promoção da saúde.

**Descritores:** Cuidadores; Relações Comunidade-Instituição; Psicologia; Relatos de casos.

El objetivo de este trabajo es relatar la experiencia de un proyecto de extensión basado en una breve intervención psicológica llevada a cabo con los cuidadores de los practicantes de equinoterapia. El proyecto se llevó a cabo como una extensión universitaria durante todo el año 2018 y contó con 19 familiares cuidadores. Inicialmente, se evaluó el estado emocional y la rutina de los cuidadores. Basándose en el relato de los familiares, se definió el foco de la intervención. Se organizaron nueve reuniones individuales o con parejas de cuidadores, en las que se trató la rutina de los cuidados, las actividades de ocio, la división de tareas y el autocuidado. Se observó que las intervenciones centradas en los cuidadores pueden contribuir a mejorar la calidad de los cuidados que prestan a los usuarios de la equinoterapia y generar un efecto positivo en su calidad de vida, lo que representa una medida de promoción de la salud.

**Descriptorios:** Cuidadores; Relaciones Comunidad-Institución; Psicología; Informes de casos.

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## INTRODUCTION

**H**ippotherapy is a technique recognized for acting in the recovery of motor, sensory, cognitive and behavioral damages, through equitation, reeducative and ludic-sports measures<sup>1</sup>. With this intervention, biopsychosocial development of people with special needs is sought, working in an interdisciplinary way in the areas of horse riding, health and education<sup>1,2</sup>.

Hippotherapy is indicated for children and adults in several cases, including: cerebral palsy, stroke, traumatic brain injury, spinal cord injuries, syndromes, autism, attention deficit hyperactivity disorder, visual impairment, hearing impairment, phobias, stress and Down syndrome<sup>1,2</sup>.

Hippotherapy starts from the first contact between practitioner and animal. The practitioner must learn to approach the animal, interact and ride; as well as creating strategies for the horse to accept its commands. This process contributes to the development of affection and trust, in addition to collaborating to the acquisition of limits and respect, in which the practitioner is responsible to the animal and must comply with certain rules for the proper functioning of the treatment<sup>2</sup>.

In the equine therapy environment, the practitioner is the center of attention, however, the gains achieved require effort and patience not only from those who receive the treatment, but also from their families<sup>3</sup>. Given the indications, its practitioners have varying levels of functional dependence and require assistance from a caregiver in their daily lives. It is common for parents to be caregivers of practitioners of hippotherapy, and they need to learn exercises that will be performed at home, ways of applying medicines, basic hygiene care, food and the need to adapt the physical space shared with the practitioner<sup>2,3</sup>.

Despite the important role played by family caregivers, there are few support programs for such caregivers in Brazil<sup>4</sup>. Studies<sup>4-7</sup> indicate that there are few intervention proposals to assist family caregivers of people with any pathologies, in breach of the resolutions on mental health in Brazil and that indicate that the services are unable to meet the demands for guidance and assistance from family caregivers.

Specifically in hippotherapy, there are no interventions designed for caregivers and the guidance given to family members is focused on practitioners. Effective support for family caregivers can help them maintain their quality of life<sup>3,6</sup>, minimize overload and other emotional issues that may arise as a result of the role of caregivers, in addition to helping them maintain good feelings about being able to care for a loved one<sup>8,9</sup>.

In this sense, extension proposals can represent an important tool for changing reality, bringing university knowledge closer to the community and contributing to fill gaps in performance with caregivers. Considering this reality, the objective of this work is to report the experience of an extension project based on a brief psychological intervention carried out with caregivers of horse riding practitioners.

## METHOD

The present work is an experience report derived from a university extension project developed with family caregivers of equine therapy practitioners who attended the Associação Mineira de Equoterapia (AME), in the city of Uberaba, Minas Gerais state, throughout 2018.

AME is a philanthropic institution founded in 1998 to serve people with various special needs. It consists of a multiprofessional team in the areas of Physiotherapy, Psychology, Occupational Therapy and Riding. When the work was conducted, the institution served 71 registered practitioners. Of these, 67 were continuously monitored by family or professional caregivers. All family caregivers were invited to the extension project.

The extension project was registered at Universidade Federal do Triângulo Mineiro (UFTM) under document SIGPROJ 112391.480.29341.14042012). The project also had the

authorization of the institution where it was carried out and all participants received explanations about the work and signed the Free and Informed Consent Form, allowing their results to be communicated in scientific events and works.

The work was developed by three undergraduate psychology students at UFTM, supervised by a teaching psychologist and AME psychologist. This team invited all family caregivers who attended the institution during the project's development period. There was a script previously elaborated for each meeting, based on the brief service reference, in a cognitive-behavioral approach and themes indicated by the AME Psychology sector. The proposals for each meeting were summarized in Table 1.

**Chart 1.** Itinerary of meetings with family members. Uberaba, 2018.

Meeting	Proposition	To do
1 <sup>st</sup>	Establishing a link and collecting information	- Explain the nature of the project; - Listening empathetically about aspects of the caregiver's experience, identifying interventional focuses and themes of individual interest.
2 <sup>nd</sup>	Survey of demands	- Application of emotional state assessment scales, prioritizing the overload scale - Screening about misinformation about the pathology of the person under care, possibilities of treatment and crisis management; - Screening about the main difficulties as caregivers; - Screening of the patient's non-encouraged potential.
3 <sup>th</sup>	Setting goals	- Setting goals for self-care; - Setting goals as a caregiver - Clarifications about the practitioner's pathology and other points raised in the previous meeting.
4 <sup>th</sup> to 6 <sup>th</sup>	Planning	- Survey of concrete possibilities for routine restructuring and self-care activities; - Working with guilt feelings in the caregiver x self-care relationship; - Survey of possibilities for assigning care activities or milder forms of monitoring the practitioner by the caregiver.
7 <sup>th</sup>	Planning	- Teach progressive physical relaxation and diaphragmatic breathing techniques; - Work on the importance of "escape valves" and preparation for loss in the lives of caregivers; - Activity planned for home: Physical relaxation training.
8 <sup>o</sup>	Individual theme development	- Meeting aimed at developing previous agenda items that need to be better worked out and specific proposals for the caregiver's reality; - Verification of physical relaxation learning.
9 <sup>o</sup>	Closing	- Return of the characteristics observed in the scales; - Resumption of the themes worked; - Feedback on the development of the work.

The family members were approached individually while waiting for the riding session of the person they cared for. The work was organized in the form of nine meetings (8 thematic and 1 closing/feedback), based on individual conversations or with couples (according to the preference of the participants), with a maximum time limit of 50 minutes each, which was the duration of hippotherapy sessions.

Throughout the meetings, the caregivers' routine and hobbies were identified and systematized, and the planned themes were adapted, when necessary. The team used non-punitive active listening, a technique of the cognitive-behavioral approach<sup>10</sup>, to seek to understand the family's life stories, as well as their life routine before and after becoming caregivers, their personal expectations, and the participants were encouraged and helped to identify their personal needs.

At the end of each meeting, students made notes on the topics worked on, the feelings reported by family members and their own feelings for experiencing the experience of talking to caregivers. These notes were taken to the supervision meetings and were part of the proposal's continuous self-assessment process.

## RESULTS

Nineteen family caregivers (5 men and 14 women) participated in the project, aged between 26 and 63 years. Such caregivers were fathers, stepfathers or mothers of practitioners and cared for people diagnosed with cerebral palsy, autism or Down syndrome.

Conversations with caregivers showed that mothers had more reports of overload and indicated a much more intense care routine than fathers. In general, the fathers worked full-time and assisted practitioners in the care provided during the night, in tasks such as bathing and preparing for sleep. Some mothers had full-time jobs, but reconciled the task of caring for the demands of work. The demands of the care tasks and possibilities of sharing these activities with other family members were discussed with the caregivers and some individual goals were built during the meetings.

Another point worked with family members was the possible relationship between overload, negative emotional symptoms (of depression and stress) and how these aspects could harm their self-care. Many family members reported dysfunctional beliefs about not being able to be good caregivers, having abdicated their lives and resenting the person they cared for because of that, among others.

Family members who showed this type of speech responded to a scale of depressive symptoms and were screened for depression in degrees between moderate and severe, but none of these caregivers had sought psychological/psychiatric monitoring. Thus, during conversations with such caregivers, this was another point worked on and two referrals were made to health services in the city, to assess a possible diagnosis of depression.

When analyzing, with family members, the activities they performed before becoming caregivers and those they maintained at the time of the intervention, it was possible to notice that caregivers abdicated many individual daily activities, related to work or leisure and claimed to have had to do this to taking care of practitioners.

The family routine started to be built around the needs of the practitioner. Caregivers did not find time or valued activities such as listening to music, appreciating a meal or resting, even caregivers who performed leisure activities before taking this role abandoned these practices to find time to perform care activities (taking the person they cared to medical appointments, school and extracurricular activities) and social (going to the town square or other children's birthday).

From the construction of the caregiver's routine, it was observed that the moments when caregivers did something focused on their own well-being or self-care were rare, and they had difficulty finding other people to share the responsibilities for care. Dysfunctional beliefs about the lack of self-care and time for leisure activities were the object of intervention.

When discussing with family members their possibilities of adapting to the routine, and the need to value self-care, there was a plague of beliefs about the inability to perform these actions and resistance to trying to make changes in the family routine. Throughout the meetings and the progress of the discussions, some caregivers showed astonishment at being able to make changes in their daily lives to include handicraft courses or self-care activities (jogging, seeking treatment for their own health issues, going to the beauty salon to do their nails) and be able to perform care activities.

In the dialogue spaces, it was possible to notice that caregivers did not complain so much about the activities they needed to do, but about personal relationships. There were reports of criticism received from the husband/wife, interference from other family members in the family's nuclear dynamics, failures in marital communication, problems related to domestic service and the performance of employees hired to help at home and the way they felt for perceiving themselves excluded from family planning, unrecognized and devalued, despite their dedication.

The course of the meetings made it possible to perceive the impact of the caregivers' experience on the family dynamics, including the extended family. The reports spoke of a lack of support to care for, distance between the couple, blaming one of the parents for the practitioner's pathology on the part of the extended family, lack of dialogue and absence of family activities.

The lack of knowledge about the pathologies and the lack of preparation of the environments to deal with children with special needs appeared as another complication reported by the caregivers of practitioners of hippotherapy. This unpreparedness forced them to answer recurring questions about the pathologies of practitioners, to deal with erroneous or derogatory comments about the people they care for, and to deal with prejudice, open or veiled. There were reports about the children not receiving invitations to parties from other children, about difficulties in going to restaurants because people looked strangely, hearing comments denoting pity that the practitioner was "disabled", among other social comments that caused suffering for caregivers.

Conversations with caregivers also showed disinformation even among caregivers. Some parents did not allow practitioners to perform possible activities at home, such as taking cookies out of a jar to eat or sleep alone in their rooms, for fear that they would choke. Others did not believe that the person they cared for would be totally dependent. These were aspects worked on during the meetings, showing parents public cases of overcoming physical or intellectual limitations and the role of supporters in the development of functional independence and being of competence. These were aspects that were largely highlighted in the returns with family members and the institution.

In general, the caregivers who participated in the extension project provided, at the time of feedback on the work, that they noticed differences in their feelings and their routines throughout the realization of the meetings. Some indicated that they negotiated a better division of tasks with other family members and included leisure activities in the family's weekly schedule and reported their intention to maintain these changes in the future, as they perceived their positive impact on how they felt and on family functioning, without harming them. the care provided. There were no negative reports during the feedbacks.

Family members also reported that they would like proposals like this to be kept in the institution, as they interpreted that they helped them to help them problematize and organize points where they had difficulties.

## DISCUSSION

Throughout the meetings, it was noticed that family caregivers of hippotherapy practitioners were predominantly mothers of the participants. This profile corroborates that previously identified in studies with caregivers of people with different pathologies<sup>3,4</sup>. Most participants reported that they had to give up their jobs in order to dedicate themselves fully to care.

Some studies<sup>1,6,9</sup> indicate that it is common for family caregivers to reshape their life routine for the benefit of the people they care for, assuming strict commitments and schedules. This situation is aggravated when the role of caregivers is recent, as there is no training or prior preparation courses, which can lead caregivers to give up individual activities first, which would be essential for maintaining their physical health. and mental<sup>8</sup>.

In addition, following the trend observed in other studies<sup>5,7,8</sup>, overload and stress were observed in most caregivers. There was also identification of depressive symptoms in several caregivers, too. Caring tasks are a female responsibility and caregivers need to give up their own activities to provide the caregiver is part of the profile previously identified in women caregivers<sup>3,4</sup>. These findings show a social role attributed to women and an important source of the burden reported by caregivers.

The experience of overload is a frequent finding in work with caregivers<sup>5,8,9</sup> and may be related to the emergence of other negative emotional conditions, such as stress and depression<sup>11</sup>. These negative aspects are added to social pressures and make living as a caregiver a risk factor for the quality of life of this population and for the quality of care they provide to other(s)<sup>9</sup>.

It is more frequent to find studies that assess the emotional state of caregivers than intervention proposals to help such people<sup>6,9</sup>. Throughout this work, the organization of the meetings was based on the logic of brief psychological intervention with a cognitive-behavioral framework<sup>10</sup>, showing the possibility that similar works are well received by caregivers and have a positive impact on the lives of caregivers.

Such work can serve as a moment of listening, valuing the condition of a person, in addition to the recognition of work as a caregiver and, also, assist in the identification and early referral<sup>10</sup>. This possibility proved to be valuable when health aspects were resumed with caregivers and some of them, referred for depression, were referred to seek professional help. In the feedback given to the institution, after the end of the project, an indication was made of creating a follow-up service for family caregivers or of setting up a partnership network with professionals who could occupy this place, in case AME did not have the conditions to do it.

The main point of suffering highlighted by caregivers was not the amount of work to provide care, but subjective aspects, such as not feeling respected and recognized. These observations corroborate the studies on overload<sup>8</sup>, which highlight that caregivers may feel differently the exhaustion due to having to perform concrete care activities (objective overload) and the way they feel for needing to do this (subjective overload). Thus, interventions that focus on caregivers of people who practice hippotherapy need to include both moments to assist such caregivers in organizing their routines and objective division of tasks in order to preserve moments of self-care and leisure, as well as assisting them in the process.

## CONCLUSION

The work demonstrated how much the caregivers organize their lives according to the activities of the people they care for, often canceling their own needs. In the reported intervention proposal, it was decided to work trying to demonstrate, through conversations and the survey of their tastes, routine and feelings, the need for self-care.

Good results from this approach were observed and feedbacks were received from caregivers of horse riding practitioners who show that they perceived themselves benefited from the work. This perception illustrates the importance of institutions considering the demands of family caregivers and, if they are unable to provide such care, the importance of indicating their importance and helping family members to look for places in which they can meet their needs is reiterated.

There are some limitations that need to be noted. The project was carried out over two semesters and could not be continued, due to other professional commitments of the team that led it. In addition, as schedules were restricted, not all caregivers of equine practitioners were able to participate.

Despite these limitations, there were gains from experience. The opening of the AME to this work proved to be important for the family members who participated in the extension project and to make visible the lack of interventions with this focus. This opportunity also showed that it is possible to develop low-cost, fast-performing intervention works, capable of generating positive impacts on the lives of caregivers, and this study can serve as a basis for future work with other caregivers.

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**CONTRIBUTIONS**

**Sabrina Martins Barroso** worked in the design and orientation of the study, writing and review. **Juliana Machado Ruiz, Camila Aparecida Peres Borges** and **Dennis Gabiatti Lopes** contributed to the study design, conducted meetings with family members and writing. **Cleyton Magela Reis** guided the project and participated in the review.

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