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NURSING CARE IN MENTAL HEALTH FOR PRIMARY CARE: CONCEPTS, EXPERIENCES, AND PRACTICES

O CUIDADO DE ENFERMAGEM EM SAÚDE MENTAL NA ATENÇÃO BÁSICA: CONCEITOS, VIVÊNCIAS E PRÁTICAS

CUIDADOS DE ENFERMERÍA EN SALUD MENTAL EN ATENCIÓN PRIMARIA: CONCEPTOS, VIVENCIAS Y PRÁCTICAS

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ABSTRACT

Objective: to understand the nurses' perception regarding the Family Health Strategy Service (FHSS) for the treatment of individuals diagnosed with a mental disorder. **Method:** A descriptive study with a qualitative approach, with eleven nurses, carried out with the Family Health Strategy Service of a medium-sized municipality of Minas Gerais/MG - Brazil. The production of the data was obtained by way of semi-structured interviews, and the analysis was carried out by employing the thematic analysis technique. The study was approved by the Research Ethics Committee, protocol # 103/2010. **Results:** we identified three categories: 1. The concept of nursing care, 2. The experience and meaning of providing healthcare, and 3. The elements of individualized and group healthcare. **Conclusion:** there are a variety of concepts regarding healthcare, and the professional experience promotes paradigm shifts which interfere with the comprehension and the experiences of the healthcare. The existence of feelings of anxiety, fear, and incompetence in respect to the specific aspects of providing healthcare to the individual with a mental disorder, leads to the need for further studies and strategies geared towards those who provide the healthcare. **Descriptors:** Nursing; Mental Health; Primary Health Care; Nursing Care.

RESUMO

Objetivo: compreender a percepção dos enfermeiros da Estratégia de Saúde da Família sobre o cuidado à pessoa com diagnósticos de transtorno mental. **Método:** estudo descritivo, de abordagem qualitativa, com onze enfermeiras, realizado em Estratégia de Saúde da Família de um município de médio porte de Minas Gerais/MG. A produção de dados foi por entrevista semiestruturada e a análise empregou a Técnica de Análise temática. **Resultados:** identificaram-se três categorias: 1. A concepção de cuidado, 2. A vivência e o significado de cuidar e 3. Os elementos do cuidado individualizado e em grupo. **Conclusão:** existe multiplicidade de concepções de cuidado e a profissão experiencia mudança de paradigma, o que interfere na compreensão e na vivência do cuidado. A existência de sentimentos de angústia, medo e incompetência quanto aos aspectos específicos do cuidado à pessoa com transtorno mental leva à necessidade de novos estudos e estratégias voltadas ao cuidado de quem cuida. **Descritores:** Enfermagem; Saúde Mental; Atenção Primária à Saúde; Cuidados de Enfermagem.

RESUMEN

Objetivo: comprender la percepción de enfermeros de la Estrategia Salud de la Familia sobre cuidado a la persona con diagnóstico de trastorno mental. **Método:** estudio descriptivo, de abordaje cualitativo, con once enfermeras, realizado en Estrategia Salud de la familia en municipio mediano de Minas Gerais/MG. Datos recolectados mediante entrevista semiestructurada, analizados según Análisis Temático. Investigación aprobada por Comité de Ética en Investigación, protocolo n° 103/2010. **Resultados:** se identificaron tres categorías: 1. Concepción del cuidado, 2. Vivencia y significado del cuidar, y 3. Elementos del cuidado individual y grupal. **Conclusión:** existen múltiples concepciones de cuidado, la profesión experimenta un cambio de paradigma; ello interfiere en la comprensión y la vivencia del cuidado. La existencia de sentimientos de angustia, miedo e incompetencia respecto de aspectos específicos del cuidado a la persona con trastorno mental determina la necesidad de nuevos estudios y de estrategias orientadas al cuidado de quien cuida. **Descriptor:** Enfermería; Salud Mental; Atención Primaria de Salud; Atención de Enfermería.

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INTRODUCTION

The public health policies in Brazil, especially regarding primary healthcare and mental health, are anchored in new possibilities of healthcare marked by an epistemological logic of wholeness, horizontality, and universality, promoting health and preventing health hazards and illnesses beyond the curative and rehabilitative context.¹ The relational dimension is emphasized, in which the establishment of links between subjects and the more egalitarian relations is prioritized, in line with the principles of the extended and shared clinical practice.²

Studies have evidenced the importance of humane mental healthcare in primary healthcare, while the literature has highlighted the need for ongoing mental health education in order to make it possible to meet the demand for an expanded clinical practice which is humanitarian with relational instruments such as in the case of the welcoming, listening, and bonding.³⁻⁵ Being confronted with this, our concerns relate to: what is the concept of healthcare and what is its significance for nurses when dealing with people diagnosed with mental disorders; and how is this healthcare established when practicing the family health strategies of a municipality in Minas Gerais - Brazil.

This study aims to understand the nurses' perception regarding the Family Health Strategy Service for the treatment of individuals diagnosed with a mental disorder.

THEORETICAL FRAMEWORK

The concept of healthcare or care in the general sense is widely discussed, taking on a variety of versions depending on the epistemological approach and the spaces defined and analyzed. Understanding the term historically, healthcare has always been present in the different dimensions of the process of living, illness, and death, even before the emergence of professions.⁵

From the perspective of the existentialist, according to the philosophy of Heidegger, caring in the universal sense is constituted in the very dimension of the being that is present, in the act of removing thyself (i.e., it is a movement to exist, arising with the happening and the time).⁷ This means to say that the act of providing care is found throughout the actual attitude and situation, and therefore it is a way of being that is essential to humanity.⁵ In this sense, care can be understood as a human trait and is not

unique to nursing; however, this doesn't mean that nursing is no longer a profession that is directly related to caring for the human being, as the nurse's respective know-how is based on providing care to the other, by supporting the respective biopsychosocial needs.

Care is represented by five ontological categories: as a human condition, as a moral imperative, as affection, as a therapeutic action, and as a relationship or interpersonal interaction.⁷ It can be differentiated into three domains - the body, the person, and the disease - each of which interact with and complement each other, whereas the conceptual framework of King encompasses three systems: the personal, the interpersonal, and the social.⁸

The existential and humanistic theories value the relational context in respect to the perceptions and the comprehension of the meaning of the experience for the person. In this context, care is understood as a way of being, to relate to and assume responsibility for the other; in this manner, it is a way of being in the world and, as such, an ontological-existential phenomenon, with the ethics and aesthetics of existence and of nursing.⁶

For this to take place, it is necessary to be present and to relate to the other as though the body is a palpable object of care, that this body materializes by way of the manifestation of its sociability and in an I-YOU and I-IT relationship.⁹⁻¹⁰ Therefore, care arises as an interactive process between individuals in a way that manifests as an artifact of helping that enables growth, by way of mutual trust and the quality of relationships. Accordingly, it can also be understood as an attitude that embraces all human dimensions and understands it as a broad range of therapeutic interventions involving all the competencies and skills belonging to the theoretical and practical field of nursing.¹¹

METHOD

This is a descriptive study with a qualitative approach which is applied to the study of relationships, perceptions, and opinions that people make about how they live, feel, and think.¹² It was carried out with eleven nurses from the Family Health Strategy Service of a medium sized municipality of southern Minas Gerais - Brazil in 2011.

The subjects were eleven nurses chosen by way of intentional sampling. There was no exclusion criteria and the inclusion criteria was: being a nurse stationed at one of the

FHSS municipal units in an urban area, and that the healthcare facility where the nurse worked was managed by the Municipal Healthcare Authority. The nurses agreed to participate in the study by the signing of the Written Consent Form, and none of the nurses refused to participate.

The instrument utilized for the production of data was a semi-structured interview, which was chosen due to its dynamic and open character in an objective and subjective context.¹² The guiding question was: How is it for you when caring for a person diagnosed with a mental disorder in your healthcare facility?

The interviews were conducted by one of the authors, lasting approximately sixty minutes, at the FHSS location in a private place without interruptions, being recorded on electronic media and later transcribed.

The data were categorized according to the framework for the analysis of thematic content, attending to the three phases of the analysis of the material, which enabled the approach and exploration of the interview content, the selection of thematic units, and the inferences and interpretations, permitting the revelation of the underlying content.¹³

The ethical aspects were respected in compliance with Resolution 196/96 of the National Health Council.¹⁴ In order to ensure the privacy and confidentiality of the participants, the statements were identified by the letter E followed by a number in order of sequence. The research project was approved by the Research Ethics Committee of the Universidade Federal de Alfenas under protocol No. 103/2010.

RESULTS

The study subjects were 11 nurses, aged from 25 to 52 years of age, with the mean age being 39 years; 60% were married, 30% single, and 10% divorced.

Regarding religion, 60% were Catholic, 20% Protestant, and 10% Spiritist. Time since graduation ranged from two to twenty-six years, with a mean of twelve years. Ninety percent had a post-graduate degree in the Family Health Program, with an emphasis on management and primary care, while most had an additional post-graduation degree in general. They worked eight hours a day, Monday through Friday, and had been in their respective units for between one and twelve years. Three of them had experience working in psychiatric hospitals.

♦ Categories of Analysis

Three categories emerged from the discourses which enabled the response to the identified concerns: a concept of care for a person diagnosed with a mental disorder with two dimensions of care; the notion of technical care and as a relational act; and the experience and meaning of caring for people with mental disorders, with two subcategories. The subcategories included the "naturalness" of the generalist care in correlation with the difficulties in specialized care, and the healthcare provided by the nurses in the FHSS to the people diagnosed with mental disorders in two modes: individualized and group care.

DISCUSSION

♦ The concept of care for a person diagnosed with a mental disorder

In this theme, two dimensions of care were categorized: the notion of technical care and as a relational act.

In regards to the concept of technical care, the nurses revealed it as a procedure and action involving the activities they provided to someone, to a group or to the community.

The care would be what we develop with the patient, in respect to some procedures necessary to restore health, not forgetting that we also have developed group and community activities. E11.

This concept resembles the care proposed by Wanda Horta (i.e., care in the assistance with an emphasis on procedure, concerning equipment and technique), while it also approaches the concept of care according to the transcultural theory of Leininger, in which it is defined as an act of assistance, support, or facilitation to the other, as it also emphasizes that the nursing staff provides care that is congruent with the socio-cultural reality of the patient.⁸

This framework is consistent with two studies¹⁵⁻⁶ performed in different regions of Brazil, in which the authors discuss the biomedical and curative character of the individualized actions, grounded in the clinical practice and the medicalization. In this context, care is presented as direct actions aimed at meeting the biological needs of the people.

The care is a relational act when nurses allude to the interpersonal relationship established with the person and his or her family.

[...] I always try to put myself in the place of the other. Not just the other's perspective. I want to know about the

family... About everything the patient is going through... Because I want to know where the problem comes from. [...] Then we are able to help in the best way. E4

The care can be understood as the basis of moral and ethical aspects of nursing, implying with diligence, responsibility, help, and a desire.⁷

When nurses refer to interpersonal relationships, they tend to approach the humanistic theories of nursing as in the theory of interpersonal relations of Peplau and Travelbee, as well as the Person-Centered Approach.

The interpersonal relationship is extremely important, it is essential. To me, we have to be truthful in the first place because that is what will allow you to connect with another person. The primary aspect is your own self, it is you accepting the others without judgment, without prejudice. E6

The attitudes of empathy, of unconditional positive acceptance and congruence, are inferred, while the use of the therapist as a mediator of the relation with the care is also inferred.

These possibilities are consistent with some notes in the literature where scholars elucidate the need to overcome the hegemonic model of health and pave the way for a humane practice in which there is an understanding of man that is holistic, historical, political, and culturally determined, while also presenting the complex suffering and anguish which differs from physical illness.^{7,16-7} If the person is unique, whole, free, and metaphysical, the care cannot be generalized, fractionated, dependent, and solely physical.

♦ The experience and meaning of caring for people with mental disorders

It was possible to identify two subcategories: the first referred to the "naturalness" of the generalist care in comparison with the difficulties in specialized care, and the second involved the feelings that arise when providing care, such as compassion, fear, and anxiety, as well as helplessness.

In relation to care in the form of general technical assistance, the nurses of the Family Health Strategy Service seemed to experience it with ease and confidence as long as there were no manifestations that could be considered divergent from this.

I try to treat them like I treat everyone who comes here. My jokes are the same, my care is basically the same. But, remembering that each and every one has specific characteristics and needs. E4

Perhaps this is a reflection of the training that nurses receive, being that the degrees in nursing predict that students should develop abilities and skills grounded in the scientific and intellectual rigor of an education that is general, critical, and reflective.¹ On the other hand, postgraduate programs, despite predominating the managerial aspect of the FHSS, can also contribute to the abilities and technical care skills of the nurses.

In this study, when it came to specific know-how care in times of crisis or attacks as well as in cases of delusions, the nurses reported having difficulty in providing care due to lack of knowledge and, as a result, the feelings of fear, anguish, and helplessness emerged.

We perform the basics, the consultations, the administration and medications, vital signs. This is common for all who come here. My difficulty is when they have an attack. I have a certain difficulty in handling those severe cases. I'm afraid, I do not know how they will react. E10

I get a little hesitant. You do not know what their reaction will be. I do not like it when they are freaking out. [...] I get scared. Fear of aggression. E6

The feeling of fear was common in the statements of the nurses in dealing with not being able to predict the reaction of the patients and the possibility of being assaulted. This may be related to the stereotype attributed to these people who fit the stigma of dangerousness, among others.¹⁹ However, it may also be related to the lack of experience and knowledge regarding these disorders, considering that the nurses who worked in psychiatric hospitals did not refer to experiencing such a situation.

I have no difficulty, I am not afraid, I know how to relate with them because I have actually worked in a psychiatric hospital, and this helps me a lot here. E7

It is believed that, with some specific mental health training, it would make positive contributions for the patients and amplify the specific care, while it would also be less of a burden for the professionals.⁴

The stigmatization process can arise by way of different modalities and consequently have different results, among them reducing the person to the disease. This corresponds with the scientific rationality based on the principles of moral treatment and dehumanization of the other as a way of symbolic distancing and producing gestures or feelings of annihilation, among others.²⁰

The feelings of anxiety and helplessness pervaded the care as much for the assistance aspect as for the relational aspect.

And suddenly I was thinking about what else I could do to help them. I felt that ... It seems that I do nothing ... Do I have the tools as a nurse, in order to do more than just listening, if there is anything else, besides this... In regards to the mental health issue, I'm wondering: Could it be that I need to do something else? Am I doing it right? Besides just listening... Make a referral... E4

I have a little bit of difficulty with the medication, because I do not know much and sometimes about some pathologies. And we need to know, I need to undergo some training in this regard. E3

Such feelings highlight the importance of the caring for those who provide care. Working relationships in nursing generate various situations that can be potentially pathogenic as a result of being stressful activities both physically and emotionally.²¹ This also implies the importance of the matricial team and the continuing education in the services as supporting resources for the family health strategies team.²²⁻³

Moreover, the experience from the care generates a feeling of gratification when the nurses feel that they are a source of support for the subject.

They see in us a source of support, they lack attention. So we listen to them, we are welcoming. This is critical for them because they create bonds, and to us it is rewarding. E5

In these cases, the care is replaced by symbolic value of help and the professional feels useful propitiating the feelings of gratification.

♦ The elements of care specific for people diagnosed with mental disorders in the FHSS

Two modalities of care were found to be offered to this population in the Family Health Strategy Services: individualized care and the group modality.

● Individualized Care

In regards to care as individual assistance, procedures for clinical consultations, administration and delivery of medications, home visits, and referrals were identified (i.e., actions that are geared towards a cure from a disease-body perspective).

We have a more clinical than psychiatric approach, we make house calls, provide guidance, and administer intramuscular medication. E1

These activities concur with the results observed in other studies^{3,16-7}, and coincide with the concept of care as a procedure and technique, but without the meaning of what it is to care.¹¹ We point out that physical and

mental health as well as social functioning are essential components of the human condition and are closely related and interdependent.²⁴

In the same context, we also identified healthcare education activities prevailing in the guidance actions provided to the patients and to the family members regarding the correct use of medication along with the importance of adherence and continuity of care.

We are concerned with educating the patients about the importance of medication in the treatment and when to stop taking the medicine. In many cases, we have to also guide the family because they are the ones who provide the care. E9

The orientation activities are essential for nursing and are a part of the health education, that is, as a set of knowledge and practices aimed at the prevention of disease and promotion of health.²⁵ The primary healthcare should be expanded, holistic, and implemented, making it possible in this manner to represent a change in the qualitative aspects of the treatment model with health practices focused on whole person.²⁶

In regards to care as a relational act, we identified the welcoming and the listening as essential.

The welcoming is very important, the welcoming is essential. If a person has a clinical chart of mental illness, [...] Knowing how to listen to the people, their complaints, to where you will make a referral [...] What to do if it is to the psychologist, if it is to a clinic, what guidance do you provide. E2

I try to listen a lot. Because they come to us wanting to vent, when they have someone to listen to them, they get attached. E3

We also noticed that the welcoming is developed by these nurses in two ways: as a form of free listening valuing the light technology with emphasis on the creation and reinforcement of a bond, and predominantly as an action that aims at collecting information for referrals and guidance.

The welcoming as a form of free listening approaches the relationship of help (i.e., it is an approach that is focused on helping the other in solving a problem, it implies the willingness to help those who need support at a given time),^{3,17,27} approaching the humanistic aspect of therapeutic interpersonal relationships and establishing bonds.

This aspect is seen as an attempt to qualify the relationship between worker-user by way of humanitarian parameters of solidarity and of citizenship and is in line with the pillars of

the humane policies of the SUS (Brazilian Public Healthcare Provider); in other words, the welcoming in order to accommodate "being with" with a differentiated listening and interaction as well as being available to the patient, overcoming hegemonic model of care.¹

As a structured information-gathering mechanism, the welcoming can meet the demands. However, it reduces the listening strategy, devaluing the singular individual present and the possibility for the meeting to be genuine.³

♦ Care in group modality

The nurses reported that the group activities developed at the FHSS specific to the people with a mental disorder, especially for those with depression, were the therapeutic workshops (TW) which included manual exercises: embroidery, crocheting, and painting.

Group painting on fabric [...]. To get the women out of the house, who became very anxious, who came often to the unit with complaints, a variety of complaints. And the crochet group was focused more on depression. E8

The TW is consistent with the model of psychosocial rehabilitation, as a resource for social reintegration for separated and isolated individuals, aimed at citizenship by way of activities focused on work and/or artistic or craft activities. Thereby, these promote the exercising of citizenship considered by the expression of freedom and the shared experiences of the others, becoming therapeutic when it provides the individuals with a place to speak, to express themselves, and to be welcomed.²⁸

Other group modalities available to the population enrolled with the FHSS were: groups for guidance, physical activities (walking, stretching), healthy weight loss, memory, anti-smoking, and groups for individuals with conditions such as hypertension and diabetes.

Here we walk, stretching, groups of hypertensive individuals and diabetics, healthy living for the elderly. E1

The staff of the NASF hold groups for memory, there is Tai Chi Chua, hiking, and the group of seniors, we discuss mental health issues also. E5

Such activities concur with those verified in twelve municipalities of Rio Grande do Sul ²⁹, where the authors point out that such activities, when undertaken in group, propose changes in habits, health promotion, development of interpersonal relationships, greater breadth of the patient population,

among other advantages, and are also designed for the psychosocial process of rehabilitation and to promote citizenship.

Some of the advantages of group work in primary care are: it facilitates the communication between the professionals and the users; it generates good results for the clinical management of the disease and in achieving the goals of the professional and the patient during follow-up; it makes it possible to meet the high numerical demand of the population which arrives at the Primary Care and provides a solution for the scarcity of resources and time required for the daily work; it provides greater openness to users to display and share with others the experiences they are handling with the disease; and it facilitates the formation of social networks and community support.³⁰

Such advantages corroborate the possibility of extending the care of the family health strategy towards accessibility and comprehensiveness in the various dimensions of care together with the community and in the conceptualization of the expanded clinic.

CONCLUSION

The results coincide with other studies in the literature, both in terms of the design as well as in the expression of care in mental health in the family health strategy service.

The multiplicity of existing conceptions of nursing care was evidenced, which contributes to a profession with a variety of singularities supported by the cultural context in which the ideologies of health are perfected. The influence of health policies in the context of the nursing practice was also shown. Emphasis was placed on the profession as a paradigm-shifting experience and that this change directly affects the understanding of that which is experienced when providing care.

The experiences of the nurses signaled difficulties in relation to specific knowledge regarding mental health as well as feelings of fear, anguish, and helplessness experienced, denoting the need to pay attention to providing care to the caregiver. This implies the need for further studies that address this issue as it relates to the the demands of the nurses from the personal and professional aspects.

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