Social Representations of Nursing Care in Mental Health in Primary Care

Representações Sociais do Cuidado de Enfermagem em Saúde Mental na Atenção Básica

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ABSTRACT

This research aimed to analyze the tools used by nurses for the development of mental health care in the Family Health Strategy and the limitations to their production. This is a qualitative case-study research. The data were collected through semi-structured interviews and analyzed from the Thematic Content Analysis, based on the Social Representations Theory. Two categories emerged: tools used for the production of mental health care and the limitations to its effectiveness. The research participants anchored their social representations in elements that portrayed the possibilities / limitations for mental health care, mainly related to the user with mental disorder. Thus, the research participants acknowledged referral / medicalization, welcoming / bonding / listening as possibilities for the production of mental health care, and pointed out deficiencies in the formative processes and fear as limiters for the production of this care.
Keywords: Mental Health Services; Family Health Program; Qualitative research; Nursing.

RESUMO

Esta pesquisa teve como objetivos analisar as ferramentas utilizadas por enfermeiras para o desenvolvimento do cuidado em saúde mental na Estratégia Saúde da Família e as limitações para a sua produção. Trata-se de uma pesquisa qualitativa do tipo estudo de caso. Os dados foram coletados por meio de entrevistas semiestruturadas e analisados a partir da Análise de Conteúdo Temática, a partir da Teoria das Representações Sociais. Foram depreendidas duas categorias: ferramentas utilizadas para a produção do cuidado em saúde mental e as limitações para a sua efetivação. As participantes da pesquisa ancoraram suas representações sociais em elementos que retrataram as possibilidades/limitações para o cuidado em saúde mental, principalmente, relacionadas ao usuário com transtorno mental. Destarte, as participantes da pesquisa reconheceram o encaminhamento/medicalização, o acolhimento/vínculo/escuta como possibilidades para produção do cuidado em saúde mental e apontaram as deficiências nos processos formativos e o medo como limitadores para a produção deste cuidado.
Palavras-chave: Serviços de Saúde Mental; Programa Saúde da Família; Pesquisa Qualitativa; Enfermagem.

NOTA

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INTRODUCTION

The insertion of mental health actions in basic health services has been stimulated by the World Health Organization since the 1990s, since the emotional aspect must also be considered in the health-disease process of the people. We emphasize that the introduction of mental health actions in primary care should not be seen as a new task or as a new workload, but as a possibility of integrality effectiveness in the production of health care[1].

In addition, primary care teams, especially family health teams, are a strategic resource for coping with important mental health problems, such as common mental disorders, alcohol and drug abuse and other forms of psychic-controlled suffering that do not require specialized psychosocial attention[2].

The issue of mental health in particular in the context of basic care services has become so important that it has been a concern not only of the government and researchers of Brazil, but also of other countries. In a study in which the authors examined mental health problems in primary care in the United Kingdom, they observed deficiencies in clinical practice and the need for mental health training for practitioners working in this setting, developing mental health actions[3].

In another study, the authors took the study of mental health policies in the primary care work teams in England and identified a lack of clarity in the country's mental health policy, one of the factors that contributed to the difficulties encountered by professionals in mental health[4].

The above statements highlight the relevance of basic care as an important mental health care equipment. In almost all Brazilian municipalities, the health care model adopted has been the Family Health Strategy. Thus, knowing how the nurses of these teams represent the possibilities and limitations for the production of mental health care will contribute to the deconstruction of practices and the planning of new health care strategies.

As a theoretical reference, we use the Theory of Social Representations that involve two universes of thought: the consensual and reified universes, corresponding to the formation of common-sense "theories" 5 and those identified with scientific knowledge[5], respectively. The formation of social representations is based on several elements, and the sociocognitive processes of objectification and anchoring are used in the analysis of the data of this research. Objectification links the idea of unfamiliarity with that of reality, becoming the true essence of reality[6]. Anchoring is a process that transforms something strange and disturbing, that intrigues us, into our particular system of categories and compares it with a paradigm of a category that we think is appropriate[6].

Therefore, the research of the Social Representations about the tools and their limitations for the production of mental health care in basic care, in the perception of nurses of the Family Health Strategy, refers us to a particular knowledge of the group studied, elaborated from their scientific knowledge and their life experiences in a particular sociocultural context.

The present research had as objectives: to analyze the tools used by nurses for the development of mental health care and the limitations for the production of mental health care in the Family Health Strategy.

METHOD

It is a research of qualitative approach of the descriptive and exploratory type in which the methodological reference of the case study was used.

The case study method consists of an empirical investigation that analyzes a contemporary phenomenon in depth and in its real life context, especially when the boundaries between the phenomenon and the context are not clearly evident[7]. In the present study the case was composed of nurses who worked in family health teams in the city of Vitória da Conquista, located in the southwest region of the state of Bahia.

The data were collected after approval of the research project by the Committee of Ethics in Research of the Municipal Foundation of Education and Culture of Santa Fé do Sul -SP by the Opinion of no. 118 on November 29, The data were collected between February and April 2013, through semi-structured interviews, these being recorded and having an average duration of 20 minutes. To do so, we elaborated a roadmap composed of two parts, the first consisting of questions related to the sociodemographic profile of the study participants and the second with the following guiding question: "For you what would be the possibilities / instruments and limitations for the development of health care mental health in the Family Health Strategy?" Nineteen nurses participated in the study, with inclusion criteria being respected: to be in the Family Health Strategy of the urban zone for at least three months and to be in the professional practice during the period of data collection.

Prior to the beginning of the data collection, we conducted a pilot case study, with two nurses who did not participate in the final sample of the study, whose purpose was to help us refine the plans for data collection in relation to the data content and procedures to be followed. After the data collection of the pilot case, we performed the internal validation, being the external validation made by the members of the Nucleus of Research and Qualitative Studies (NUPEQS) of the State University of Campinas (UNICAMP). The sample was determined by the exhaustion criterion. For the analysis of the data we used the technique of Analysis of Thematic Content

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that was unfolded in the following stages: pre-analysis, material exploration and, treatment of results, inference and interpretation.

For the identification of the different thematic clippings from the nurses' statements, used in the discussion of the results, we used the letter "E" of interview and the sequential number in which the interviews were performed.

RESULTS

In relation to sex, 100% of the sample is female, a fact expected by the great predominance of female work potential in the profession. The age group of the participants in the sample studied ranged from 24 to 43 years. The nurse with the shortest time in the family health services has been in the services for three months and the longest time has been for 15 years.

Regarding participation in a specific mental health training course, 16 (84.2%) nurses reported having participated in a 40-hour course offered by the Municipal Health Department, whose objective was to raise awareness among family health workers mental health in the context of the Family Health Strategy services. Only 3 (15.8%) nurses participating in the research did not participate in this course.

Based on the analysis of the interviewees' statements through the steps that comprise the Thematic Content Analysis process, we performed the pre-analysis (respecting validity standards in qualitative research), the exploration of the material, in order to identify the which were essential to the construction of the thematic categories: tools used for the development of mental health care (referral of the user with mental disorder, drug treatment and fostering, bonding and listening) and limitations for the implementation of mental health care (ignorance / weaknesses in the formative processes in mental health, mental health: a matter of affinity and the imperative of fear) and finally the interpretation of the data obtained.

DISCUSSION

Category Thematic 1. Tools used for the development of mental health care

After reading the nurses' statements, we noticed that they used different elements that they consider relevant to the production of mental health care in basic care, such as: referral process of the patient with mental disorder and drug treatment as a form of care; the bond, reception and listenin.

The referral of the person with mental disorder is represented by some nurses as a form of care, this referral can be associated to a difficulty on the part of the professional in meeting a specific need in mental health, as well as a way to offer this user specialized services required in some circumstances.

> *"It would be a very forward thing [the user with mental disorder] [...]"* (E1).
> *"[...] we refer [the person with mental disorder] to the NASF psychologist himself ..."* (E3).
> *"[...] it is this question of identification [of the mental disorder patient] and referral [...]"* (E19).

On the other hand, this situation can be related to the perception that the study participants have about the health-disease process, in which the logic of the specialization of care gains more visibility. Prescription of medications and their administration are represented as a form of production of mental health care. Such practice is associated with a concept whose core is limited to disease and cure. The use of medicalization understood as a generator of care in mental health can be seen as something that softens the symptoms, however, masks the suffering leading the user to worsen the picture or even chronicity[8].

> *"[...] I administered the medication on him [person with mental disorder]"* (E9).
> *"[What] [medical] does at most is to exchange revenue [...]"* (E10).
> *"[...] since when I graduated in fact the participation of the people was exclusive in exchange for revenue ..."* (E12).
> *"[Her] client's medication with mental disorder is in the closet [...]"* (E16).

In this context, an important demand related to mental health comes daily to basic health care services, considered the "gateway" of the health system, with the expectation that the professional can respond to their suffering quickly and effectively. However, a number of circumstances hamper the reception and treatment of users. The lack of guidelines of the Ministry of Health, the lack of technical preparation of the professional, the precarious working conditions, the lack of investment by the managers among others, cause that the demand in mental health is treated only with medication, thus producing a medicalization of suffering[9].

The referral and emphasis given to medicalization as elements that aim at the instruments / possibilities for the production of mental health care converge towards an individualized, passive and indicative of low resolution. In the clippings of the E10 and E12 statements the representation about the possibility of mental health care is based on the use of medications, and anchors what the other staff member, the doctor, produces. This shows that the daily practice of the nurse in the Family Health Strategy, produces and reproduces from what emerges in its consensual universe.

Other elements that emerged from the speech of

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some interviewees were: reception, bonding and listening as essential devices for the development of mental health care. These constitute a tripod of great importance in the production of mental health care and are closely related. In this way, there is a commitment to welcoming, establishing links and encouraging shared responsibility of cases as a resource to avoid the logic of referral[9].

In the E3 section, although there is a recognition of the host as a possibility for the production of mental health care, it does not take it in its essence and affirms that the institution of programmatic actions is that it configures the development of mental health care . The presented situation shows how materiality about actions gains space in professional practice and subjectivity becomes secondary.

> *"[...] we seek to welcome and listen [person with mental disorder], but there is no specific programmatic action [...]"* (E3).
>
> *"[...] we seek to have a better reception, to welcome [the user with mental disorder] ..."* (E9).
>
> *"... she [person with mental disorder] needs an accompaniment and I think the host until this exists you welcome, you receive, you forward"* (E13).

In this way, the reception developed in the Family Health Units constitutes a device for the formation of bond and the production of care between worker and user. These meetings with the users enable the nurse to identify health demands in their territory. This implies the construction of collective and individual resources of care[10].

The link as a relevant element in the production of mental health care increases the effectiveness of health actions and contributes to the user being a partner in this process. This instrument should be understood as a space for the construction of autonomous subjects (worker-user), since there is no link building without the user being recognized in the quality if the subject speaks, judges and desires[11].

According to the fundamentals and guidelines, printed in the National Policy of Basic Attention, the link consists in building affective and trust relations between the user and the health worker, which allows to deepen the process of co-responsibility for health, built over time, as well as carrying a therapeutic potential[12].

> *"[...] these patients [users with mental disorders] are suspicious right? Even creating a bond with the new professional takes time [...]"* (E2).
>
> *"[...] within this logic of family health is the close bond that you have with the community ..."* (E5).
>
> *"[...] I referred the [user with mental disorder] to CAPSi, and then she returns to talk, she even moved to the area, but she created that bond with me so she comes back to me [...]* (E18).

The formation of the bond is the approximation between the user and the health worker, both with intentions, interpretations, needs, reasons and feelings. However, in a situation of imbalance, different abilities and expectations, the user seeks assistance, in his physical and emotional state, weakened by the health worker, supposedly able to attend to and care for the etiology of his fragility[13].

Listening emerged as another possibility / instrument for the development of mental health care. In this aspect, some interpersonal skills need to be developed, among which, listening is understood as an indispensable instrument for the aid relationship[8].

> *"[...] When the mouth shut up, the body speaks, is not it? [...] When you promote a group that you allow people to talk to, you are also promoting mental health [...] "* (E1).

E1 recognizes that the non-sharing of the user about their needs and anxieties contributes to the manifestation of physical illness. Thus, the inability to express or transmit emotions and feelings - including aggressiveness - results in an important mechanism of aggression to the body and, consequently, the cause of illness[14].

> *"... she [user with mental disorder] needs, perhaps, to speak, to be heard to have an exchange [...]"* (E3).
>
> *"... when we hear someone at the family planning clinic, that the woman is upset about some problem, then I think I'm taking care of her mental health there. [...] "* (E5).

In listening, we place ourselves in the external objective and internal space of the other, through a participation, a sharing of the lived, unlike listening that is characterized only by the finding of something through the auditory system, that is, an action that demands a neurological constitution[15].

Therefore, the health service must organize itself to assume its central function of welcoming, listening and offering a positive response, capable of solving most of the population's health problems or minimizing their damages and suffering. Proximity and the capacity for reception, bonding, accountability and resolution are essential for the realization of basic care as a contact and "gateway" of the health care network[12].

One of the nurses interviewed uses the term qualified listening to designate the relationship established between worker and user in order to identify the needs from the user's perspective. This listening refers to a user-centered approach and involves careful listening. Qualified listening is now represented as a possibility for the implementation of mental health care in the Family Health Strategy by the nurse.

> *"[...] I think that an action that is tied to mental health care in family health is the qualified listening of this pa-*

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> *tient [person with mental disorder] so that you know what he / she is accepting, what he / she is looking for [...] "* (E18).

Even the hearing being identified as an inherent element in the production of mental health care in the Family Health Strategy, a nurse affirms that the way the work process is organized and considering the time necessary to listen, are factors that make it impossible to operate it, in her work. This is something that compromises the direct assistance to the user when one thinks of the integrality of the care.

> *"[...] if we could take one day, take an hour for these people [people with mental disorders] to be heard ..."* (E17).

Such a situation is of concern since the absence of listening may have a negative meaning for the user, that is, that he or she does not deserve the professionals to devote time or even be seen as a lack of professional interest for him, which can lead you to build or expand a sense of devaluation[8].

At the end of the present category, which discussed the tools used by nurses for the development of mental health care, we observed that the study participants, although they did not appropriate the instruments / possibilities for the production of mental health care in their work processes , have demonstrated that they know the resources inherent to their management. The identification of elements that hinder the practical development of this care will contribute to new reflections in the sense of (re) thinking mechanisms for mental health care to be concretely carried out in the daily practice of the nurse, in the scenarios of the family health teams. Some of these difficulties are discussed in the next thematic category.

Category Thematic 2. Limitations to the implementation of mental health care

There is great difficulty in implementing what is advocated by public policies. Mental health practices in basic care are closely linked to the biomedical model, which contributes to the lack of professional training[16]. Regarding mental health training, the nurses participating in the study portrayed in their speech a deficiency in their undergraduate training processes and after their insertion in health services, a situation that is associated with the invisibility that mental health care in the Health Strategy of the Family acquires. In the speech fragment of E1 mental health care is perceived as complex and the unpreparedness associated with training makes this care not incorporated into the nurse's work process.

> *"[...] everything that we do not understand people find it complicated and complex ... I do not have any capacity for mental health at all, other than that same seven-day training that, in my opinion, is very little for such a complex thing [...] I do not see myself still, doing a follow-up, a care with enough firmness, not mental health dexterity. [...] my training is very recent [graduated in 2011], I consider very good, but, it is still aimed at the individual, we still can not open our eyes to the general and mental health is this . [...] "* (E1).

The nurse evidences a recent formation, however, with elements present in her speech that portrayed the lack of knowledge about mental health. Situation that may be linked to the deficiencies in the pedagogical political project of the undergraduate course carried out, or the way the content on mental health, as core competence of the professional nurse was conducted.

In the clippings of the nurses' speeches in this study, there is an anchorage to the deficiencies perceived, specifically, in the discipline of nursing in mental health, especially when they refer to the practical part, whose abilities were developed exclusively in the hospital context, currently the main psychosocial rehabilitation device.

> *"We leave graduation without knowing how to work the individual, mental health in the family health unit [...]"* (E16).
>
> *"[...] I had a very hospitalocentric training, where I studied everything was very hospital ..."* (E17).

Regarding the academic formation of nursing professionals, it is perceived that this continues to be generated from a curriculum organized by specific disciplines with an emphasis on specialties. This lack of integration between the disciplines contributes to a teaching practice without interacting teachers and future professionals that will reproduce a fragmented care practice, contributing to a conformation of the asylum model[17].

The situation described above is worrying, since facing the reality, the new professional may experience a paradigmatic contradiction, since he is not able to deal with everyday situations in which users demand mental health actions in the family health services. This situation generates a practice of referral to specialized professionals without the minimum of reception and resolution in nursing care[17]. Establishing the dialogue between mental health and basic care in undergraduate nursing courses can be an important tool to change the situation that presents itself.

n addition, some nurses, through their statements, have shown that the training based on permanent health education emerges as something paradoxical, that is, at the same time as E8 indicates as a limiting factor the lack of motivation and interest of the worker with the subject,, E2 and E10 report that the training received by the Municipal Health Department was not sufficient for the concrete and effective operationalization of mental health care, specifically for users with mental disorders.

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"... I would say that I do not feel apt because, well, as much as we have had this training of forty hours ... I do not feel 100% sure of attending a patient with mental disorder [...] " (E2).

"What makes it difficult is just the people have the will to do, because we have the space, we have been trained so much the nurse, the whole team has been trained in mental health. [...] mental health I do not know, we do not have that, that encouragement of the team itself ... " (E8).

"... After the training [in mental health], for me it was the same thing ... The contact we have here is very little, with mental health patients. [...] The lack of preparation to deal with these people [...]" (E10).

From the previous speeches, we realize that education must be understood as a permanent process that is born during graduation and that must be maintained during the professional life. Training through the technical-scientific update is only one aspect of the qualification of the practices and not its core. This makes the training involve other elements such as the production of subjectivity, production of technical skills and thinking and the adequate knowledge of SUS[18].

Another element present in the fragments of the speeches of some nurses refers to the lack of affinity in dealing with users with mental disorders, as evidenced in the following E3 and E9 cuts. Lack of affinity can be justified by another element in which nurses anchored their limitations to the production of mental health care: fear in dealing with the user with mental disorder, which will be discussed *a posteriori*.

"It's [...] empowering right? [laughs] sensitizing, because, well, as much as we receive training, but if it's an area that I do not have much affinity for, I'll always have a blockade [...]" (E3).

"[...] I do not have management with mental health patients ... we have to be more sensitive when it comes to such a patient, is not it? And then I have the fear of losing my balance at the time, of not having that sensitivity that the patient needs, do you understand? [...] since college I never wanted to work with mental health patients [...]" (E9).

In this case, the feeling of fear emanating from the consensual universe overlaps with what is characteristic of the reified universe, that is, the knowledge that the research participants have about mental health care, since we perceive that the nurses anchored their meanings in mental disorder, understood as disease to represent mental health care.

Another aspect related to the training of nurses, present in the speech of a research participant, refers to the lack of collection by the health services management about the actions produced by the latter in the field of mental health. This situation corroborates that the incorporation of the production of mental health care does not materialize in the daily practice of the nurse.

"[...] all the professionals were trained ... It was a great course, everyone went through a training week, we learned a lot [...]. The whole team was trained, but we still have not been able to figure out how to put it into practice [...] lack of public policy, of collecting data, of getting results in relation to what I said about mental health. [...]" (E4).

The previous fragment reinforces how much the nurse is accustomed to a model of capitalist production, whose logic of health productivity, especially the collection of what is produced, anchors the social representation of it.

Fear of the user with mental disorder has been identified and portrays the social representations that some nurses have about the limitations to the production of mental health care. Expressively, this situation can be seen in the fragments of the following speeches.

"[...] comes a patient with severe mental disorder and if he comes in outbreak here in the unit? Understood? Then we get a little confined to it, half afraid ... " (E2).

"[...] I arrived at the house [of the person with mental disorder] super frightened ... it is this fear that the team stays ..." (E12).

"[...] the fear of the professional in dealing with certain disorders ... we do not have the preparation to deal with that disorder at that moment; that outbreak. [...] " (E15).

"[...] the great majority of professionals have some fear of working with the mental health patient, I think it is out of fear. [...] there are professionals who are afraid of aggression ... " (E16).

Most of the nurses participating in the study, in representing the limitations to the production of mental health care, have brought in elements that have anchored in fear in dealing with people with mental disorders. This situation has contributed to and continues to contribute to the social exclusion that occurs in the territory and within the physical space of the health unit.

The social imagery of "crazy" and "madness" emerged in the nurses' speeches, since, as subjects of history, they assimilated the concepts received from social life, through their consensual universes, this space, where, naturally, their representations are produced. In this section, Foucault[19] in his work "History of madness" points out that the stigmatization of the "madman" prevailed over time which consequently made possible the social exclusion of these people.

Therefore, the social representations of "madness" are still marked by stigmas and prejudices, from the con-

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cepts crystallized in the nurses' speeches. This stereotyped fear-like feeling is associated with the aggressive aspect attributed to the user with mental disorder, especially in crisis situations.

Dangerousness, aggression and fear are part of the same process of historical construction in which a vicious circle is manifested in which the notion of danger increases the perception of aggressiveness, increases the stigma of exclusion and feeds health workers' fear[20]. Thus, looking at aggression only as a destructive and unhealthy manifestation contributes to the practice of interventions directed to the adjustment and framing of the subject. It is necessary for the nurses to perceive, in these manifestations of aggressiveness in crisis, more hope than despair, more need than badness, more appeal than destructiveness and begin to intervene with the subject and the subject [20].

In light of what has been discussed in this category, we see that the work of nurses in the Family Health Strategy of this sample faces different limitations that directly or indirectly contribute to the way mental health care is represented. It was noted that the production of mental health care has been relegated to the needs of nurses, health services and training institutions.

CONCLUSION

Mental health care for the nurses of the Family Health Strategy gained representation from the abnormality, that is, from the process of mental "sickness" of the users, with that the social representations of the study participants were crystallized from the figure of the user with mental disorder. The user with mental disorder was a reference for the research participants to represent the possibilities and limitations for the production of mental health care in the Family Health Strategy.

As a possibility for the production of mental health care in the family health services, the nurses in our sample anchored their perceptions in elements that represented the referral of the user with mental disorder to specialized services of the psychosocial care network; the appropriation of the host, bond and listening as inherent elements of mental health care.

The social representations about the limitations for the production of mental health care in family health, according to the study participants, were associated with the deficiencies in their formative processes during graduation and in their professional trajectories, which shows a challenge to be overcoming by the training institutions, as well as for the management of municipal health services in order to qualify professionals so that mental health care in basic care is understood as inseparable from the production of care as a whole.

The search for strategies that deconstruct stereotypes of fear associated to the user with mental disorder is necessary for the realization of psychosocial attention in the context proposed by the Brazilian Psychiatric Reform in the scenario of the Family Health Strategy.

Therefore, although primary care teams, especially family health care, are considered important psychosocial care devices, the social representations of nurses working in this setting have revealed that it is necessary to dissociate beliefs and values about "madness" and "madness" "As well as investing in professional qualification so that family health services can be considered the main" gateway "for SUS users, including those with some degree of psychological distress or mental disorder.

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