

INTERPERSONAL RELATIONSHIP BETWEEN USERS AND HEALTH PROFESSIONALS IN PSYCHOSOCIAL CARE

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ABSTRACT: The objective in this study was to identify how the interpersonal relationship is established between users and health professionals from the perspective of the users of a Psychosocial Care Center type II in Maceió, Alagoas. Qualitative and exploratory research, undertaken between 2010 and 2012. Data were collected from eight users. Triangulation was used through in-depth semi-structured interviews, non-participant observation and a field diary. Minayo's qualitative analysis was applied to the data. Three categories emerged: 1. Sensitive looking; 2. Establishing the bond; 3. Skills of professionals working at the mental health service. The following results were identified: relationship is fundamental for psychosocial care; it is important for the professional to adopt a humane look towards the user; the bond mitigates suffering; listening and attention skills are decisive to establish trust. The need is observed to discuss the theme interpersonal relationship with the professionals from the service, with a view to enabling them to create and strengthen the bond in comprehensive mental health care.

DESCRIPTORS: Interpersonal relations; Patients; Health Personnel; Mental Health Services; Nursing.

RELACIONAMENTO INTERPESSOAL ENTRE USUÁRIOS E PROFISSIONAIS DE SAÚDE NA ATENÇÃO PSICOSSOCIAL

RESUMO: O objetivo deste estudo foi identificar como se estabelece o relacionamento interpessoal entre usuários e profissionais de saúde, na perspectiva dos usuários de um Centro de Atenção Psicossocial tipo II em Maceió, Alagoas. Pesquisa qualitativa, exploratória, realizada no período de 2010 a 2012, coleta de dados com oito usuários. Utilizou a triangulação por meio de entrevistas semiestruturadas em profundidade, observação não participante e diário de campo. Dados tratados pela análise qualitativa de Minayo. Emergiram três categorias: 1. Olhar sensível; 2. A formação do vínculo; 3. Habilidades do profissional que atua no serviço de saúde mental. Identificou-se: relacionamento como imprescindível para atenção psicossocial; importância do olhar humano do profissional ao usuário; vínculo como amenizador do sofrimento; habilidades decisivas de escuta e atenção para estabelecer confiança. Observa-se a necessidade de trabalhar a temática do relacionamento interpessoal junto aos profissionais do serviço, a fim instrumentalizá-los sobre a criação e fortalecimento do vínculo no cuidado integral em saúde mental.

DESCRIÇÕES: Relações interpessoais; Pacientes; Pessoal de saúde; Serviços de saúde mental; Enfermagem.

RELACIONAMIENTO INTERPERSONAL ENTRE USUARIOS Y PROFESIONALES EN LA ATENCIÓN PSICOSOCIAL

RESUMEN: La finalidad de este estudio fue identificar como se establece el relacionamiento interpersonal entre usuarios y profesionales de salud en la perspectiva de los usuarios de un Centro de Atención Psicossocial tipo II en Maceió, Alagoas. Investigación cualitativa, exploratoria, desarrollada en el período de 2010 a 2012, recolección de datos con ocho usuarios. Fue utilizada la triangulación mediante entrevistas semiestructuradas a fondo, observación no participante y diario de campo. Datos tratados con el análisis cualitativo de Minayo. Emergieron tres categorías: 1. Mirada sensible; 2. La formación del vínculo; 3. Habilidades del profesional que actúa en el servicio de salud mental. Fueron identificados: relacionamiento como imprescindible para atención psicossocial; importancia de la mirada humana del profesional al usuario; vínculo como suavizador del sufrimiento; habilidades decisivas de escucha y atención para establecer confianza. Se observa la necesidad de trabajar el tema del relacionamiento interpersonal con los profesionales del servicio para equiparles sobre la creación y el fortalecimiento del vínculo en el cuidado integral en salud mental.

DESCRIPTORES: Relaciones interpersonales; Pacientes; Personal de salud; Servicios de salud mental; Enfermería.

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● INTRODUCTION

The Psychosocial Care Centers (CAPS) are strategic devices in the replacement of the asylum model to a community care model that emphasizes the users and their suffering in the symbolic, material and affective relationships grounded in their life spaces, whether at work, leisure, in the city, health and mental health care spaces⁽¹⁻²⁾.

The goals of the CAPS are to recover, reintegrate and rehabilitate the users by following principles of the Health and Psychiatric Reform and of the National Humanization Policy - PNH⁽³⁻⁴⁾. The intent is to reduce hospitalizations in psychiatric hospitals; it permits experiences of interaction, leisure and learning; it promotes contact with the family and the community⁽⁵⁾. In short, it withdraws the individual from a poor and restricted relationship universe and opens actual, symbolic and affective doors in which the possibilities of experience exchanges with other people are expanded.

In that sense, attention is needed to some peculiarities of care delivery in CAPS and the decisive importance of interpersonal relationships for these possibilities to find forms to take place.

One of these peculiarities refers to the conditions in which the health team accomplishes its work, in which users in mental suffering are no longer conceived as passive care objects and gain an active posture in their treatment, demanding other strategies and care technologies⁽⁶⁾.

Hence, in mental health services, like in all relations between the team and the user, establishing the bond is a starting point for free expression, guaranteeing this and other civil rights.

Thus, elements like the unconditional positive consideration – respect, acceptance and appreciation in view of all expressions of feelings⁽⁷⁾; qualified listening – availability to listen, give voice to the suffering, pay attention to what is said, understanding of the feelings^(4,7-11); empathy – understanding the other in his/her perspective^(7-8,10,12-13); and the consequent construction of a bond – sensitivity to suffering, interaction and trust^(4,7-13), make up a positive interpersonal relationship, which facilitates the opening to experience, determining comprehensive care delivery⁽¹²⁾.

Personal relationship processes that value the user's potential and autonomy permeate the entire psychosocial care field, proposed by the Brazilian Psychiatric Reform. Thus, health professionals need to develop relational skills that approach them to the understanding and to the desired comprehensive care⁽⁷⁾.

Based on these considerations, this research was guided by the following question: how is the interpersonal relationship between users and health professionals developed at the CAPS from the perspective of the attended users?

To answer it, the objective was to identify how the interpersonal relationship between users and health professionals is established from the perspective of the users at the CAPS type II in Maceió, state of Alagoas, Brazil.

● METHOD

Qualitative and exploratory study, as it applies to the study of relationships, representations and opinions, products of the interpretations that human beings develop of how they live, build their artifacts and themselves, feel and think⁽¹⁴⁾.

Developed at a CAPS type II, located in Maceió, Alagoas, which offers psychosocial care to adults. Inclusion criteria: users attended for more than three months, a period favorable to the interpersonal relationship experience; over 18 years of age, able to contribute with the production of information. And the exclusion criterion: users without cognitive conditions to answer the questions, suffering from mental disorientation, problems in speech and the course of thoughts, hallucination, delusion and aggressiveness. The number of participants was defined based on the data saturation criterion, totaling eight interviewees.

This research complied with the ethical principles of research involving human beings, in accordance with National Health Council Resolution 466 from December 12th 2012⁽¹⁵⁾. Approval for the study was obtained on 08/25/2009 from the Research Ethics Committee at Universidade Federal de Alagoas, registered under

opinion 010756/2009-54.

To collect the data, between April 2010 and September 2012, the triangulation of in-depth interviews was used, as well as non-participant observation and a field diary. Information was produced through a semi-structured script with open guiding questions, a previously organized field diary in which records of observations, problems, impressions and feelings of the researcher were described during the interviews or afterwards, but always on the same day as the interview.

Audio recording was used by means of a camera and a voice recorder, which granted greater reliability and interaction between the researcher and the subjects. The duration of the interviews ranged between 40 and 90 minutes, moving on according to the subjects' tolerance, up to four meetings were held for participants who required more time and more frequent interviews.

To treat the data, qualitative analysis⁽¹⁴⁾ was applied, which affirms that it is an intense process that demands attention and time in the organization process, in the understanding of the material produced in the field, until reaching the moment of transition between experience and the theoretical elaboration. The following steps were undertaken: organization of all material produced; horizontal scanning in which excerpts were taken from the texts, pasting and classifying them per themes; understanding of relevant structures of the material classified through exhaustive reading, reclassifying the excerpts through synthesis, guaranteeing the wealth of the information, search for internal logic, homogeneity, distinctions and meanings produced; secondary interpretation through more in-depth reading, permeated by the guiding question and the research objective⁽¹⁴⁾, culminating in the decoding of the three thematic categories that were analyzed in the light of the Brazilian and international literature.

After the transcriptions, all interview content returned to the participants to validate the convergence with the answers given and their perspectives. Only one interviewee asked to remove a paragraph because he considered he would be identified and also argued that that statement would really bother him.

The participants were treated in their dignity and their autonomy was taken into account. Cultural, social, moral, religious and ethical values were respected. The study presented no potential risks for the participants; no damage to the physical, mental, moral or spiritual dimension was expected in any of the phases and no problems occurred in the course of the research.

The freedom to reject participation or to withdraw one's consent in any phase was respected, without any penalty. No request in that sense occurred until the end of the study.

To guarantee the interviewees' privacy, the confidentiality of the information and to comply with ethical and legal premises, they were coded as "users" by means of the letter U, followed by the number corresponding to each, ranging from U1 to U8. For the sake of this study, the 32 criteria of the Consolidated criteria for reporting qualitative research (COREQ) were used in their three domains, which discuss the research team and reflexivity, study design, data analysis and conclusions⁽¹⁶⁾.

● RESULTS

The development of this research permitted understanding how valuable it is to establish interpersonal relationships inside a CAPS and how the users of these services perceive this relation with the professionals who deliver care.

Based on the exhaustive reading of the content presented, three categories could be identified that converged with the objective proposed and that signal the following constituent elements for the interpersonal relationship to take place in this health care space: 1) Sensitive looking; 2) Establishing the bond; 3) Skills of the professional who works in psychosocial care.

Category 1 – Sensitive looking

In the context of psychosocial care, the professional needs to look sensitively at the user he maintains the interpersonal relationship with. This is about looking with compassion. The meaning of looking used here moves towards a broader, integrated and careful perception of this user's expressions, in his subjectivity and

singularity.

To favor the interpersonal relationship, the user affirms that the moment of extreme weakness the illness provokes needs to be taken into account. The participant U1 compares himself with the glass that can break, includes the summit of human sensitivity. This human who carries his fears, anxieties, anguish, sadness, concerns and difficulties needs enhanced, sensitive and judicious care.

The person, when he is going through a hard time, gets very sensitive, like glass, if you don't take care it falls on the floor and breaks. People need to be as careful as possible. (U1)

The professional J., she helped me a lot for almost a year... My mind is very weak, I need help! (U2)

One cannot mention sensitive looking without empathy. That is put forward as the guiding element of the positive interpersonal relationship and effective welcoming.

The professional needs to feel as if he were that person, needs to understand what she is going through; gets close and asks what she is feeling. (U3)

Sensitive looking happens when the need of the user who is suffering can be understood, beyond what is being said, but through that many other signs, such as gestures, looks and even silence.

But nobody knows that I am suffering inside. (U6)

Category 2 –Establishing the bond

When the user refers to the interpersonal relationship, he draws an analogy with the relation developed with the service professionals. This professional's actions can make him feel safe, trusting, received and welcomed; if not, when the relation does not develop the positive potential of the bond, it can cause difficulties, mistrust and distancing. The greater the bond, the greater the possibility to influence it, mainly towards mitigating the suffering.

One of the interviewees affirmed that individual care not only favors a climate of trust, but also the strengthening of the bond, and face-to-face contact happens in a singular manner. This can favor the development of the therapeutic conversation.

Therefore, the individual therapy is important, because you trust [...] that thing becomes completely different, the relationship gets stronger. (U1)

It is clear that the bond results from attitudes of not judging, demonstrating kindness, being open to listen to them, take care.

She does not criticize me [...]. It's the mode, the kindness that treats. (U2)

It means you saying what you are feeling. (U4)

The professional M., she has listened to some things already... how it was experienced really. It's ... the pain I feel like, you know? Because I also need, to talk to some people. (U7)

The professionals are excellent people... when we've got a problem, they get close and talk, give advice, support. It's a union, like a family really. (U5)

They indicate that the relationship is established over time, gaining trust.

As the consults went by, you gain confidence, and express everything you are feeling. (U1)

Transmitting safety, that's what professional X also transmitted to me. And, as a professional, she probably has different cases, but not one is like the other. You see? (U3)

The professional "P" gave me the opportunity to throw it out without "shoving" my finger down my throat to vomit, without the need to have my body ache, headaches, hallucinations, hearing voices. (U3)

Category 3 – Skills of the professional working at the mental health service

The paradigm change in care delivery to people in mental suffering is taking place gradually. In view of the statements, it is clear that the road ahead is still long, starting with the necessary change in the professional who delivers care.

For the human relationship to happen, the parties need to take interest and like to spend time together. In mental suffering, it is important to maximize the complicity, solidarity and strengthening of the bond.

It can be verified that the attention to what the professional is saying generates an effective therapeutic relationship in the treatment of disorders and situations that oppress the user in the course of his life.

The professionals I like to talk to most are X, Y, W and WX, I don't talk to the rest no, because... there are things I like and things I don't like. (U1)

Qualified listening is a fundamental skill for all health professionals and its importance for user care should be highlighted.

The professional "V" listened to me... Then she looked at me and told me: you're gonna tell me your life story, in your own time; if you want you can repeat the same case as much as you want [...] So she gave me the opportunity. (U7)

The user mentions difficulty in the interpersonal relationship with some CAPS professionals, mainly when they have not developed the skills yet to deal with the singular and subjective aspects of people in mental suffering. In this relation, the situation of feeling humiliated on certain occasions is mentioned.

I face difficulty to deal with professionals at the CAPS who are unable to cope with people in mental suffering. We go through some humiliations [...] (U1)

While saying that he likes everyone in the CAPS, he mentions coping difficulties when the professional is unskilled to deal with the user.

[...] I like everyone, there's nothing to say about any of them, except for that person I've talked about, professional X, they say he's also ignorant. (U1)

It's not because it's the SUS, I know it's difficult in the SUS today, you know? But if it were fifteen minutes, ten minutes whatever to see me, to assess my case and my problem, not just mine [...], but that of several other people who are there today: abandoned, suffering. (U8)

When the user establishes an interpersonal relationship based on trust, he considers that it is true what the professional tells him about his adaptive way of coping with his own problems.

The professional K said that my mind is kind of hiding from the problems, then I pass out, which is a way not to go through that. (U5)

● DISCUSSION

Through the psychiatric reform process, paradigms have been overcome. The model of a well-structured care network is proposed for users in mental suffering. Until ideal care is achieved, however, much remains to be modified and restructured.

Hence, the use of light technologies in health is a condition for holistic care, in which sensitive looking, bonding, welcoming and qualified listening are fundamental. These technologies permit understanding the mental suffering based on the individual who suffers, valuing his experiences and needs^(8,13,17).

Thus, comprehensive care needs to be perceived as a process that intends to put an end to the biomedical model and values the subjectivities the subject presents. In that perspective, listening is an important tool and its meaning differs from hearing. While hearing is related to the act of perceiving the sound, listening goes beyond, being an attitude that requires attention, understanding and valuation of the subject⁽⁹⁻¹⁰⁾.

Establishing the bond needed with the user and favorable to the treatment is only possible through listening that goes beyond the superficial and apparent aspects and allows the listener to take on a form that can dive

into the subjectivity and particularity of the way in which each person manifests his mental suffering⁽¹⁰⁾.

In this respect, the concept of listening goes beyond the sense of auditory perception. This process includes "all senses through which we can perceive the reality, such as the sensory perception, thoughts, intuitions and emotional responses"^(13:8). In this perspective, it is fundamental for the parties to interact and for this interaction to be positive.

This study revealed the fundamental importance of establishing a positive interpersonal relationship for the success of psychosocial care. In the interviewed subjects' statements, fundamental aspects were perceived in the relationship process, such as sensitive looking, establishing bonds and the professionals' skill to cope with the demands characteristic of mental suffering.

That is linked to the need to break paradigms, which entails the deconstruction of bureaucratic and excluding spaces. In addition, the reform needs to happen not only in the institutions and health services, but also in the teaching spaces that prepare the future professionals, who should learn and apprehend a care practice that privileges the interpersonal relationship and that is mainly based on integrality⁽¹⁸⁾.

There is a consensus in the literature that the reform, together with the change in the psychosocial focus of the mental disorder, should be implemented urgently at the teaching institutions responsible for preparing these professionals, for them to see the subject who suffers beyond the disease⁽¹⁸⁾.

What can be verified in the statements is the limitation of the biomedical and hospital-centered model. Many professionals who take care of the user focus on the disease and the control of its symptoms guided by a Cartesian and reductionist model, to the detriment of the holistic view on the human being who needs a true help relationship⁽¹¹⁾.

Hence, the logic of the asylum model needs to be deconstructed, which isolates the "mental patient" to apprehend a comprehensive care practice, in which the protection of and respect for the user are fundamental, with openness to others care possibilities that are not limited to the diagnosis and the disease⁽¹⁹⁾.

In addition, the health team that takes care of the user with mental disorder is responsible for offering a therapeutic environment, a space where the user can be considered holistically. In this context, the interpersonal relationship is a means to develop the user's trust, comfort, feeling of being respect and of being a participant in the decision process⁽²⁰⁾.

● CONCLUSION

From the CAPS users' perspective, with a view to the establishment of the interpersonal relationship between users and health professionals, these professionals need to offer sensitive looking, permeated by empathy, which captures the need and what is happening with the user through non-verbal expression: gestures, looking, silence.

The interpersonal relationship is facilitated when the professional privileges the establishment of bonding with the user, presenting an openness that favors trust, acceptance, care. This relation happens when individual care is possible, which happens over time.

Establishing a relationship with the user requires skills from the professionals, such as the ability to talk, to constitute qualified listening, guide the user, deal with the suffering of people with mental disorders, patience and availability to help.

In view of the above, it is clear that the interpersonal relationship is a baseline process for care delivery to people attending the CAPS. Nevertheless, the defining importance of this process for care delivery to users in mental suffering should be highlighted.

These study results provide essential elements for bonding and evidenced the skills the professionals need to develop in their daily practice for such a fundamental therapeutic relationship in the person-to-person relationship in the CAPS.

These professionals should be made aware of the peculiarities of this service, in which the demand is subjective and expanded. The look on the user should go beyond the disease or a sample verbal complaint.

The professionals serving on the CAPS team, including the nurse, should make efforts to remain sensitive to what is exposed in the words, gestures, look tone of voice, in the context the user presents and in that many other nuances which only qualified listening and sensitive looking can achieve in the interpersonal relationship process.

The nursing professionals at the CAPS should consider the establishment of the interpersonal relationship in their practice, through bonding, trust, skills needed to take care of users with mental disorders.

One limitation in this study is the fact that the interviewing researcher was therapeutically close to the service users and sporadically supported the technical team upon demand. In addition, being an intentional sample, the participants recruited may not have held different perspectives than those expressed, also considering that some of the service users were unable to cooperate at the time of the data collection because their mental condition was very problematic.

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