


Therapeutic relationship in nurses' work process at Psychosocial Care Centers

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Objective: to understand how nurses perceive the therapeutic relationship in their work process at Psychosocial Care Centers. **Methodology:** a qualitative, descriptive and exploratory study, based on the historical-dialectical materialism approach. The data were collected through semi-structured interviews, based on content analysis in conjunction with thematic analysis, and discussed through the dialectic between dead work and living work in action. **Results:** the participants were ten nurses. The therapeutic relationship emerged from the dialectical tension between dead work, considered as previous and alienated work, and living work in action, which is where the therapeutic relationship takes place. **Conclusion:** dead work was evidenced by reproduction of the care model in which bureaucratic work is assumed by nurses and delegitimizes the patients' role. Living work in action was identified by the establishment of the therapeutic relationship, developed through coexistence, in exchanges of trust, through workshops, in the role of reference and through the relationship as a defining experience of the professional career. The dialectic tension becomes a process rich in consumption of light technologies, which helps nurses recognize their role in the new mental health care model, where praxis becomes a possible path in the context of their work.

Descriptors: Nursing; Mental Health; Nurse-Patient Relations; Psychiatric Nursing; Mental Health Services.

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Relação terapêutica no processo de trabalho de enfermeiros de Centros de Atenção Psicossocial

Objetivo: conhecer como os enfermeiros percebem a relação terapêutica em seu processo de trabalho nos Centros de Atenção Psicossocial. **Metodologia:** estudo qualitativo, descritivo e exploratório, embasado na abordagem do materialismo histórico-dialético. Coleta de dados realizada por meio de entrevistas semiestruturadas, a partir da análise do conteúdo em conjunto com a análise temática, e discutidas pela dialética entre trabalho morto e trabalho vivo em ato. **Resultados:** participaram dez enfermeiros. A relação terapêutica emergiu da tensão dialética entre o trabalho morto, considerado como trabalho progressivo e alienado, e trabalho vivo em ato, sendo este o lugar da relação terapêutica. **Conclusão:** o trabalho morto foi evidenciado pela reprodução do modelo de atenção em que o trabalho burocrático é assumido pelo enfermeiro e deslegitima o protagonismo do paciente. O trabalho vivo em ato foi identificado pelo estabelecimento da relação terapêutica, desenvolvida no convívio, nas trocas de confiança, por meio das oficinas, no papel de referência e pela relação como experiência marcante da trajetória profissional. A tensão dialética torna-se um processo rico em consumo de tecnologias leves, o que contribui para que o enfermeiro reconheça seu protagonismo no novo modelo de atenção à saúde mental, em que a práxis se torne um caminho possível no contexto de sua atuação.

Descritores: Enfermagem; Saúde Mental; Relações Enfermeiro-Paciente; Enfermagem Psiquiátrica; Serviços de Saúde Mental.

Relación terapéutica en el proceso de trabajo de enfermeros de Centros de Atención Psicossocial

Objetivo: conocer de qué manera los enfermeros perciben la relación terapéutica en su proceso de trabajo en los Centros de Atención Psicossocial. **Metodología:** estudio cualitativo, descriptivo y exploratorio, basado en el enfoque del materialismo histórico dialéctico. Los datos se recolectaron través de entrevistas semiestructuradas, basadas en análisis de contenido en conjunto con análisis temático y se los discutió por medio de la dialéctica entre trabajo muerto y trabajo vivo en acción. **Resultados:** participaron diez enfermeros. La relación terapéutica surgió de la tensión dialéctica entre el trabajo muerto, considerado como trabajo anterior y enajenado, y el trabajo vivo en acción, que es el lugar de la relación terapéutica. **Conclusión:** el trabajo muerto se evidenció en la reproducción del modelo de atención en el que el trabajo burocrático es asumido por los enfermeros y se deslegitima el rol de los pacientes. El trabajo vivo en acción se identificó por el establecimiento de la relación terapéutica, desarrollada a través de la convivencia, en los intercambios de confianza, a través de talleres, en el rol de referencia y a través de la relación como experiencia definitoria de la trayectoria profesional. La tensión dialéctica se convierte en un proceso rico en consumo de tecnologías ligeras, que ayuda al enfermero a reconocer su rol en el nuevo modelo de atención a la salud mental, en el que la praxis se convierte en un camino posible en el contexto de su trabajo.

Descriptorios: Enfermería; Salud Mental; Relaciones Enfermero-Paciente; Enfermería Psiquiátrica; Servicios de Salud Mental.

Introduction

Initiated in 1970, the Brazilian Psychiatric Reform (*Reforma Psiquiátrica Brasileira*, RPB), was decisive in changing the mental health care model, providing an expanded view of care, previously centered on the asylum model⁽¹⁻²⁾.

With its advances from 1991 onwards, Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS) were created, belonging to the Psychosocial Care Network (*Rede de Atenção Psicossocial*, RAPS), implemented from 2011, whose principle is comprehensive care for patients with a focus on their biopsychosocial aspects, allowing the development of the new care model⁽¹⁻²⁾. In addition to comprehensive care, this enables patients' reintegration into society and strengthening their social ties^(1,3-5).

In this network scenario, multidisciplinary teams became protagonists of the actions proposed by the RPB, especially those that allow psychosocial rehabilitation and inclusion of users^(1-2,6). Regarding the core of Nursing, as members of the multiprofessional team, nurses no longer assume a protective role and occupy the place of therapeutic agents, with the therapeutic relationship as their main action, built through assistance based on each patient's uniqueness, which then turns into the protagonist in the care provided⁽⁶⁻⁸⁾.

The therapeutic relationship is understood as an important Nursing care technology, as it allows patients to have their life experiences recognized by nurses, receiving encouragement to be part of their care process and decision-making⁽⁹⁻¹⁰⁾. Thus, the therapeutic relationship emerges as the main action of nurses' practice in mental health, their responsibility being to develop skills to establish a relationship with the users, to understand the meanings of their acts and behaviors⁽⁹⁻¹⁰⁾.

For a meaningful therapeutic relationship in humanized mental health care, it is necessary to consider important aspects such as empathy, self-knowledge, self-awareness and authenticity⁽⁹⁻¹⁰⁾. However, a strong influence of the biomedical model is still observed, which makes it difficult for nurses to develop their practice autonomously and implement care centered on the patients' needs⁽⁹⁻¹⁰⁾.

An alternative for carrying out this care is the Nursing Process (NP), characterized as a methodology that systematizes and qualifies nurses' work, being fundamental for the development of scientifically-based care^(6,8).

In the mental health context, its application favors nurses to assume an autonomous stance, with the work method characterized by the Nursing history, diagnosis, planning, implementation and assessment stages, intrinsically linked to a theoretical framework that provides support for the clinical practice, identified by the therapeutic relationship^(6,8-9,11).

Thus, through praxis, characterized by the articulation of knowledge and doing, which in the Nursing context materializes in the NP, nurses can

rely on the therapeutic relationship framework, a tool that aims at identifying the patients' singularities and active participation in their care plan, thus allowing the development of their autonomy^(6,8-9,11-12).

However, the literature points to factors that contribute to the difficulty of implementing the therapeutic relationship in the practice, namely: increased work demand, fear due to patients' behaviors and resistance to acting respecting the principles recommended in the new mental health care model^(5,9-12).

Considering such difficulties, this study is justified by the need to know how the therapeutic relationship takes place in the practice of nurses who work at CAPS^(5,9-12), as this supports the care process and makes it in line with the new psychosocial care model, which demands care strategies from nurses that encourage each subject's protagonism and the recognition of their uniqueness^(1,5,8,10-11). Thus, the objective is to understand how nurses perceive the therapeutic relationship in their work process at CAPS.

Methodology

Type of study and theoretical-methodological framework

This is a qualitative research study conducted according to the Consolidated Criteria for Reporting Qualitative Research (COREQ)⁽¹³⁾, with a descriptive and exploratory perspective. A theoretical-methodological approach based on historical and dialectical materialism was adopted, which contributed to the interpretation of historical and social reality⁽¹⁴⁻¹⁵⁾. This is constantly changing through dialogue and the way in which individuals relate to others to meet their needs⁽¹⁴⁾.

Considering the Nursing context, it can be stated that this method contributes to understanding the gaps that exist in the work process, consolidated by three essential elements in the health area: the work activity, the object to which the work is applied, and the instrument used to carry out this process⁽¹⁴⁾.

In order for the work process to be conducted, it is necessary to consider the dimensions: living work in action and dead work⁽¹⁶⁾. Living work consists of operating the task as protagonism/freedom and is constructed according to the needs of the people involved in the process, which aim at producing relationships and care⁽¹⁶⁻¹⁷⁾. Dead work is characterized as protagonism/reproduction, in which work is previous and incorporated into its instruments⁽¹⁷⁾. These two dimensions are learned through the use of technologies, characterized as light, light-hard and hard, which correspond to interpersonal relationships, standards and equipment, respectively⁽¹⁷⁾.

Study scenario

The municipality chosen to carry out the study is located in the inland of São Paulo and has a RAPS

comprised by CAPS III, CAPS Alcohol and Drugs, CAPS Children and Youth and psychiatric hospitalization beds in a general hospital, among others⁽¹⁸⁾.

After approval of the study by the institution managing mental health services in the municipality, all six existing CAPS III were indicated to carry out data collection⁽¹⁸⁾. These operate 24 hours a day, serving nearly 300 users per month in each service, whose most frequent demands are serious mental disorders such as psychosis, bipolar affective disorders and addiction to chemical substances. Care is provided by multiprofessional teams and nurses' main responsibilities are based on individual and group care, home visits and therapeutic workshops, in addition to matrix support within the network.

Study participants

Each CAPS III has a team comprised by a mean of three nurses, totaling 18, all of whom were invited and 10 agreed to participate. The inclusion criteria were being a nurse, working at CAPS III, having established a therapeutic relationship with a patient at the service and being present during the data collection period.

Data collection and organization

The data were collected by the main researcher through interviews with a semi-structured script⁽¹⁹⁻²⁰⁾ containing the following guiding questions: "Do you

consider using the therapeutic relationship in your work process as a nurse?" and "Tell me how it was."

The interviews were recorded in digital audio and later transcribed. Theoretical saturation was reached when data repetition was identified, without adding new elements, nuances, dimensions and variability regarding the set of categories⁽²⁰⁾.

Data analysis

The data were analyzed and validated in research group meetings. Content analysis was used, as well as characterized by the description of qualitative data, in conjunction with thematic analysis (TA), defined as a process of interpreting qualitative data with the objective of finding patterns of meaning among the data⁽²¹⁾.

TA includes the following steps: 1. Exhaustive contact with the material and formulation of initial codes; 2. Grouping of the codes generated into related ideas to form main topics; 3. Naming of the topics; and 4. Exploration of the relationship between the topics among themselves and with the context that emerged, to understand their meanings and discuss them with the existing literature on the subject matter⁽²¹⁾. The coding process is represented in the code tree shown in Figure 1.

Discussion of the results was based on the perspective of understanding the health work process, grounded on the dialectical dimension between dead work and living work in action⁽¹⁶⁻¹⁷⁾.

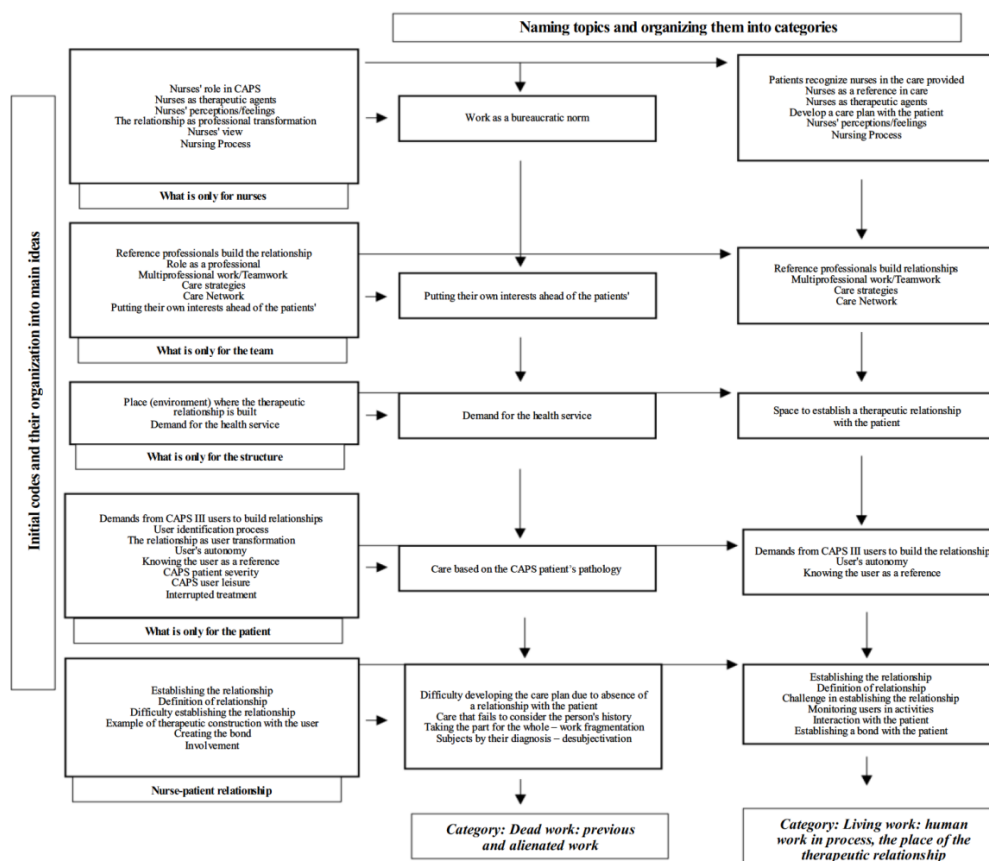


Figure 1 – Illustration of the process of coding, naming and organizing results into categories

Ethical aspects

The study meets all the criteria set forth in Resolution 466/2012, which regulates research involving human beings, and was approved by the Research Ethics Committee of the State University of Campinas, under opinion No. 4,421,168. The participants signed the Free and Informed Consent Form before the interviews were initiated. To guarantee anonymity, the statements were identified by the letter (I) for "Interviewee", followed by the number corresponding to the chronological order in which the interviews took place.

Results

Ten nurses who work at the CAPS III in the city studied participated in the research. The understanding of how the therapeutic relationship takes place in their work process emerged from the dialectical tension between two categories.

Dead work: previous and alienated work

It is possible to identify that nurses point out role overload, qualifying it as bureaucratic. When starting care, they sometimes plan for the other, based on their expectations, and have trouble listening to the user and establishing a therapeutic relationship, which can result in care that does not respond to their needs.

We have overload of duties, seeing all the patients daily, carrying out the SNC [Systematization of Nursing Care], having a Nursing team to evaluate, Nursing rosters to do, ordering materials, being a nurse is quite bureaucratic. (I6)

We feel entitled to think and solve and plan for the patients, in what the other is not with us, what the other is not aware of, what the other doesn't agree with, sometimes, expectations that solely and exclusively concern me and not them. [...] Create a care plan that doesn't reflect what that user needs, because I'm not able to listen to them, and this happens when I don't have a good therapeutic relationship. (I8)

The participants also point out difficulties caring for the patients based on the report of unique aspects of their history, as well as characteristics related to psychopathology or in moments when the psychological conditions deteriorate, in which the task of caring for the users becomes more laborious through the therapeutic relationship.

I have a lot of difficulty with some types of pathology, 060, it's not my thing, I can't handle it. [...] He's bringing me things about sexuality, probable abuse in childhood by close people, in these stories that we've already heard, we're tired of hearing. (I2)

It's not easy most of the times, because at the CAPS we also have crises for each patient and this sometimes affects the therapeutic relationship. [...] So, if the patient is persecutory

with you, this won't be the time for you to try to establish this relationship. (I9)

Living work: human work in process, the place of the therapeutic relationship

For those interviewed, the therapeutic relationship is seen as possible care when relating to the user, being established in everyday life through exchanges, conversations and small gestures. The workshop was identified as a possible space to develop this relationship.

It's a care relationship, taking care of others... It's possible to care if you have a relationship. (I10)

This happens in everyday life, in exchanges, in conversation, I realize that there are some things, mainly small gestures that we do. [...] The workshops are also an important space to establish these relationships. (I1)

The therapeutic relationship is built through day-to-day interactions and exchanges of trust. It is also identified in the expanded view, when patients recognize the figure of nurses as a reference for their care, defining limits and pointing out paths together.

The main thing is socializing, building everyday life, exchanging trust. (I3)

We call it a reference. If the nurse is this professional, we can have this broader view. This happens with care, with home visits, with attention to the territory. (I8)

He recognizes me, my role as a nurse, of taking care of him, of being there for him, of mitigating the risks of the excess alcohol he drinks. (I2)

Our role is to set some limits. Perhaps, together with users, we can envision different paths. (I1)

The purpose of establishing a therapeutic relationship is to learn how to construct the meaning of the disease with each patient, so that they can attribute meaning to their condition, adhere to treatment and achieve autonomy.

You will have to learn to work with him on certain meanings of the disease, so he can learn to give meanings to that condition, even to be able to adhere to the treatment. (I3)

That part where we talk about autonomy, I think it permeates the therapeutic relationship thing. (I7)

In addition, the therapeutic relationship is built based on the demands of users who can present themselves through closer care and exchanges. It is suggested that it is important for professional nurses to understand each user's integral vision, to develop care within CAPS.

Closer, intensive, daily care, with the user, weekly assistance, or three times a week, it's in these processes that we begin to build a relationship. [...] Arriving, introducing yourself, talking to him and you make exchanges, but much of this relationship is built based on the users' demands. (I1)

As nurses, we have this holistic view of patients regarding care, it's important to also have this within a CAPS. (I6)

In the CAPS routine, the therapeutic relationship is an experience that becomes part of the professionals' life due to the characteristic of proximity to the users, and generates feelings such as gratitude for the patients' progress.

This relationship impacted me a lot. It's an experience that I'll carry with me in my life, because it creates a relationship so close that this person feels like a loved one. (I5)

Seeing him trying on the necklaces, putting on the pendant he wanted, looking in the mirror... But that was a gratification for me, I saw that he was satisfied. I don't think he ever imagined he could buy it. (I7)

Nurses recognize that the role of reference has the potential to be linked to the therapeutic relationship. Furthermore, they consider multidisciplinary teamwork and construction of the case from the network as strategies for care.

When therapeutic relationships come to mind, I also remember the role of reference. (I9)

We work in mini-teams within the service, a multidisciplinary team, and then within the mini-teams we divide ourselves according to references. (I4)

So, it's through case discussions, building a network from the inside out, that we're able to put the case together. (I8)

Discussion

The nurses participating in the study report role overload, pointing out it as bureaucratic. When carrying out daily activities in the work process, the professionals can exercise protagonism/reproduction called dead work⁽¹⁷⁾. Despite the changes in care practice based on the RPB, which brought about new meanings to the way of caring, bureaucratic work still persists, reproducing aspects of the previous model based on behavioral surveillance actions and a biomedical perspective to sustain care⁽²²⁾.

Bureaucratic and administrative work is part of the duties that distance nurses from the opportunity to interact with the patients and contributes to the difficulty overcoming the asylum model⁽⁵⁾. In this context, the work process can acquire forms of alienation that limit non-knowledge, characterized by dead work, and face less flexibility given each patient's uniqueness, causing nurses to shift the meaning of the work method^(16,23).

Nurses develop the care plan based on their expectations. When nurses set their expectations ahead of the patients', they highlight lack of knowledge regarding the articulation between their work process and the necessary attitude to develop the therapeutic relationship, as this disallows the knowledge coming from the patients, implying loss of their autonomy in

the face of distress, which can render the relationship itself unfeasible⁽²³⁾.

One possibility of action is the patients' participation with nurses in structuring the NP, favoring the construction of the therapeutic relationship^(6,23). This is part of the Nursing work process, which considers the patients' potential and encourages their autonomy^(6,23).

Delimitation of care based on a specific pathology contributes to reading the development of the work done as fragmented, with a focus on the biomedical model, which gains prominence through an expected result that is not flexible in view of each patient's singularities^(16,23). When carried out in this way, care is constructed based on knowledge about the pathology and removes knowledge about the therapeutic relationship from the scene^(16,23).

In turn, this can contribute to changing the care purpose by breaking the concepts of exclusion and biological practice, defined as dead work⁽¹⁶⁾. This is because the therapeutic relationship is congruent with changes in the health care model when it observes each patient in its entirety and, through encounter, allows permanence and bonding, care constructed by both⁽²³⁾.

Another finding that deals with the alienation of the work process is the way in which nurses see the patients' personal history and illness, in which facts and occurrences that marked the singularity of these subjects are taken in a generic way, disregarding the physical and emotional health components, without realizing that an act can mark the patients' life and the way of relating that they will have with others⁽²⁴⁾.

For the therapeutic relationship to be established, it is recommended that nurses provide a care environment in which trust is established so that, from this, the patients feel safe to contribute information and, thus, can remain active in the care offered and in the role of their uniqueness^(8,25).

When entering the field of relationships, corroborating living work, characterized by the protagonism of subjects articulated with the freedom to create responses according to their health and care needs⁽¹⁶⁻¹⁷⁾, the participants reported that it is only possible to provide care through a therapeutic relationship. This relationship is defined as the way of exchanging feelings and actions between two people, nurse and patient in this context, characterized by living work in action, generating a game of expectations and productions^(8,16,25).

The therapeutic relationship becomes essential for the development of interventions through the use of instruments that permeate care, using light technology, which also defines living work in action^(16,26). Nurses build living work through therapeutic relationships, which are incorporated in the NP based on care and the use of theoretical perspectives^(6,9).

An example is the interpersonal relationship, developed in four phases: guidance, identification, exploration and resolution^(6-9,11). Guidance is seen as the moment in which nurses and patients exchange knowledge in order to identify health needs; identification allows patients to express their feelings; exploration enables recognition of the problem by the patients and the establishment of bonds with nurses, now allowing for the implementation of the NP; and, finally, the resolution phase corresponds to the patients' recovery and the achievement of their autonomy^(6,27).

The interviewed nurses consider the workshops as an environment that enables developing the therapeutic relationship. Workshops are considered therapeutic when they offer a space for speech, expression and acceptance, contributing to each subject's process of social insertion and autonomy⁽²⁸⁾.

The therapeutic relationship was also identified in the interactions and exchanges of trust with the users. From the theoretical perspective of the interpersonal therapeutic relationship, the pillars of non-directivity and the updating tendency can be understood as a strong contribution to care, as the patients' potential to make decisions about their life is considered, when guided by nurses^(27,29).

To this end, it is important that nurses demonstrate confidence in the patients' ability to assimilate insights, elaborate on their distress condition and make resolving choices^(27,29). Living work in action is presented in its form of maximum freedom at this moment, as it allows nurses to use light technology and play a leading role at the moment of its production⁽¹⁷⁾.

Nurses identify their expanded perspective when they see themselves as a reference professional for the patients. In this case, they are configured as interlocutors between the service and the patients through the relationship and care with a focus on comprehensiveness⁽³⁰⁾.

When patients recognize nurses' role in terms of care and the established therapeutic relationship, the professionals play a leading role and may feel motivated to provide assistance, in order to contribute to the transformation of their work process^(16,27).

Such transformation is marked by the dialectical tension found in nurses' stance: at the same time that they bring their expectations to do for others, they also envision identifying possible paths for providing care to the patients. Care developed in partnership requires nurses to know what should be put in motion to establish the therapeutic relationship, especially in the exploration phase, when they help the patients to identify their problems and, consequently, strengthen the relational bonds^(6,9,23,27).

Therefore, in the field of relational care, nurses who assume the role of protagonists in their work process can enable patients to take the lead in view of their ability to identify and solve their health problems^(17,23,27). The moment nurses see mutual protagonism in this transition scenario, they are able to offer assistance through living work, which renders the fragmented view unfeasible^(16,31).

The purpose of the therapeutic relationship evidenced by nurses is to provide the meaning of illness, enabling adherence to the treatment and the development of autonomy. It is possible to observe this result when nurses understand the patients' need for protagonism in their actions and, thus, allow them to reach new knowledge that can stimulate the development of their autonomy⁽³²⁻³³⁾.

From the moment patients achieve autonomy, nurses realize that the therapeutic relationship has been developed and that the resolution phase, based on the theoretical framework of the interpersonal relationship, has been reached, which corroborates with the practices developed by the nurses based on the psychosocial rehabilitation model^(6,8,11,27,33).

The patients' demands are seen by nurses as the foundation for developing the therapeutic relationship, as they are presented through close care and exchanges, which are possible due to the use of light technology, which elevates the protagonism of living work in action^(16,25,27). Listening is the essential tool of the therapeutic relationship and, through it, the patients' demands can be identified to establish comprehensive care⁽³¹⁾.

Nurses identify the therapeutic relationship as a remarkable experience in their career, especially when they mention the patients' progress. This perception can refer to the resolution phase of the therapeutic relationship, in which space is opened for the patients to direct their demands to the nurses and seek their own solutions with them^(6,27). As support for this phase, nurses use empathy as a guiding strategy for care^(6,27,29).

This condition places nurses in the position of person-centered management, in order to perceive and understand each patient's subjective world, considering their unique experience and focusing on care supported by living work in which professional and patient mutually transform each other through the therapeutic experience^(16,27,29).

Nurses also recognize themselves as the patients' reference professionals when establishing the therapeutic relationship, which shows the association between development of the singular therapeutic project and the NP, as it is located in the circulation of knowledge between the field and the nucleus⁽³⁰⁻³¹⁾.

Furthermore, it is possible to determine that nurses identify multidisciplinary teamwork and the construction of cases, based on the RAPS, as strategies for care in the mental health field. This way of acting allows developing interdisciplinary actions that delimit health work, based on organization of the work process that articulates knowledge and practice and places the professionals in the performance of living work in action^(16,31,34).

Conclusion

The therapeutic relationship takes place in the work process of CAPS nurses through the dialectical tension between dead work and living work in action. With regard to dead work, reproduction of the care model in which bureaucratic work is assumed by nurses was evidenced, which implies overload and acquires forms of alienation. Even when they propose to draw up the care plan, they do so based on their expectations and the specific pathology, which denotes fragmentation of their work process and delegitimizes the patients' protagonism, which corresponds to not knowing about the relationship. Such finding can negatively contribute to the paradigm shift, resulting in rigidity in the face of each patient's uniqueness.

Living work in action was identified by the establishment of the therapeutic relationship that is developed in coexistence, in exchanges of trust, through workshops considered therapeutic, in the role of reference and through the relationship as a defining experience of the professional career. In this sense, nurses assume the position of protagonists of their work process, based on relational care, which can also result in the patients' protagonism, composing collaborative work to achieve new knowledge that can have repercussions in the development of these individuals' autonomy.

In this way, dialectical tension can become a process rich in consumption of light technologies, which helps nurses recognize their role in the new mental health care model, where praxis becomes a possible path in the performance context.

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