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CONCEPTIONS AND CARE OF NURSING STAFF WITH PEOPLE WITH PSYCHOTIC DISORDERS DURING HOSPITALIZATION

CONCEPÇÕES E CUIDADO DA EQUIPE DE ENFERMAGEM COM PESSOAS COM TRANSTORNOS PSICÓTICOS DIANTE DA HOSPITALIZAÇÃO

CONCEPCIONES Y CUIDADOS DEL EQUIPO DE ENFERMERÍA A PERSONAS CON TRASTORNOS PSICÓTICOS DURANTE LA HOSPITALIZACIÓN

Ana Julia Jacomelli Metzner de Oliveira[1]
Aldair Weber[2]
Giulia Delfini[3]
Rômulo Mágnus de Castro Sena[4]
Vanessa Pellegrino Toledo[5]
Ana Paula Rigon Francischetti Garcia[6]

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Objective: to understand how care for people with psychotic disorders is developed by the nursing team during hospitalization. Method: qualitative, descriptive and exploratory study based on the approach of historical and dialectical materialism, conducted with the nursing team in the period from January to June 2021, in a Psychiatric Hospitalization Unit of a university hospital. Semi-structured interviews were used and the results were determined by thematic analysis. Results: the participants were ten nursing professionals. Two categories were delimited: Dead work: promoter of nursing care in the asylum perspective and Living work in action: potentiality of nursing care through therapeutic relationship. Final considerations: nursing care to people with psychotic disorders permeates knowledge and practices of dead work and live work in act, being essential the professional development of the therapeutic relationship through the implementation of the Nursing Process.

Descriptors: Nursing Care. Nurse-Patient Relations. Mental Health. Psychotic Disorders. Hospitalization.

Objetivo: compreender como o cuidado com as pessoas com transtornos psicóticos é desenvolvido pela equipe de enfermagem diante da hospitalização. Método: estudo qualitativo, descritivo e exploratório, fundamentado na abordagem do materialismo histórico e dialético, realizado com a equipe de enfermagem no período de janeiro

Corresponding author: Aldair Weber, aldairweberr@gmail.com

[1] Universidade de São Paulo. São Paulo, SP, Brazil. https://orcid.org/0009-0003-6574-2603.
[2] Universidade Estadual de Campinas. Campinas, SP, Brazil. https://orcid.org/0000-0001-5258-5635.
[3] Universidade Estadual de Campinas. Campinas, SP, Brazil. https://orcid.org/0000-0002-3030-6647.
[4] Universidade Estadual de Campinas. Campinas, SP, Brazil. https://orcid.org/0000-0001-6802-0786.
[5] Universidade Estadual de Campinas. Campinas, SP, Brazil. https://orcid.org/0000-0003-4009-1042.
[6] Universidade Estadual de Campinas. Campinas, SP, Brazil. https://orcid.org/0000-0002-0478-707X.

a junho de 2021, em uma Unidade de Internação Psiquiátrica de um hospital universitário. Utilizou entrevistas semiestruturadas e os resultados apurados pela análise temática. Resultados: participaram dez profissionais de enfermagem. Foram delimitadas duas categorias: Trabalho morto: promotor do cuidado de enfermagem na perspectiva manicomial e Trabalho vivo em ato: potencialidade do cuidado de enfermagem por meio da relação terapêutica. Considerações finais: o cuidado de enfermagem às pessoas com transtornos psicóticos permeia saberes e práticas do trabalho morto e trabalho vivo em ato, sendo essencial o profissional desenvolver a relação terapêutica por meio da implementação do Processo de Enfermagem.

Descritores: Cuidados de Enfermagem. Relações Enfermeiro-Paciente. Saúde Mental. Transtornos Psicóticos. Hospitalização.

Objetivo: comprender cómo el cuidado de las personas con trastornos psicóticos es desarrollado por el equipo de enfermería ante la hospitalización. Método: estudio cualitativo, descriptivo y exploratorio, basado en el enfoque del materialismo histórico y dialéctico, realizado con el equipo de enfermería en el período enero a junio de 2021, en una Unidad de Internación Psiquiátrica de un hospital universitario. Se utilizaron entrevistas semiestructuradas y los resultados obtenidos por el análisis temático. Resultados: participaron diez profesionales de enfermería. Se delimitaron dos categorías: Trabajo muerto: promotor de la atención de enfermería en perspectiva manicomial y Trabajo vivo en acto: potencialidad de la atención de enfermería por medio de la relación terapéutica. Consideraciones finales: el cuidado de enfermería a las personas con trastornos psicóticos permedia saberes y prácticas del trabajo muerto y trabajo vivo en acto, siendo esencial el profesional desarrollar la relación terapéutica mediante la implementación del Proceso de Enfermería.

Descriptores: Atención de Enfermería. Relaciones Enfermero-Paciente. Salud Mental. Trastornos Psicóticos. Hospitalización.

Introduction

Psychotic disorders are considered one of the most disabling health conditions today, since they can affect the functionality of the person and are associated with reduced quality of life and expectancy[1]. It is estimated that its incidence is 26.6 per 100,000 people per year, reaching 1% of the world population when considering the most common psychotic disorder, schizophrenia[1-2].

They are characterized by positive symptoms (hallucinations and delusions), negative symptoms (apathy, social withdrawal and reduction of emotional expression) and can be divided into: affective (manifestations of major depression and bipolar disorder), non-affective (schizophrenia and psychotic disorders characterized by negative symptoms, delusions, hallucinations, altered judgment of reality), functional (psychiatric disorders) and organic (secondary to non-psychiatric medical problems)[1-2].

In this sense, it is extremely important to follow the person with psychotic disorder in mental health services, which should structure care beyond medical treatment, following the precepts of the biopsychosocial care model[3]. It is necessary to involve the family, stimulate the development of social skills, offer therapeutic spaces, indicate assertive pharmacotherapy and have a team that manages crises[3]. In this context, nursing appears as a profession based on permanence and not on visits, which allows the constancy of the relationship[4].

However, these people are susceptible to episodes of worsening of the mental picture, mainly due to lack of continuity in health follow-up, which may lead to the need for hospitalization to stabilize the picture[5]. Nevertheless, sometimes, if this strategy is necessary, it should be used in the last instance, and the priority is to implement mental health care from a territorial perspective, with singular attention directed to the biopsychosocial dimension[6].

In Brazil, mental health care is structured in the Unified Health System through the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*), whose one of the objectives is to organize mental health services in a territorial logic[6]. Among them, there is the Psychiatric Hospitalization Unit in General Hospital (PHUGH), which aims

to assist the person with severe mental disorder who is presenting acute symptoms or is in crisis[7].

In PHUGH, care is provided by the multiprofessional team, of which nursing technicians and nurses are part[7]. In this context, the nursing team pays attention to acute symptoms and plays a leading role, in its work process, of recovery and maintenance of mental health care through practices that transcend the biomedical perspective and contemplate the biopsychosocial care model[7-8]. Thus, the possibility of linking and building a comprehensive and humanized care plan through therapeutic relationship, priority tool for recovery and health promotion, is opened[7-8].

In this context, during the work process, each professional has ideas, concepts and values about health, health work and how it should be carried out, thus having two dimensions: living work in action, characterized by the use of light technologies that allow the relationship, and dead work, marked by the use of light-hard and hard technologies, which gain prominence through a product[9].

It is endorsed that nursing professionals have developed good practices in mental health care, using techniques such as embracement and listening, besides actively participating in the construction of therapeutic projects[8]. However, there are still remnants of care supported by the empirical view, that is, carried out by actions aimed at biomedical logic, which pervades the history of the profession and may imply an assistance that disregards scientific knowledge and strengthens the permanence of stigmas related to people with psychotic disorders[10]. Therefore, reductionist actions that influence the practice of nursing care may be competing with those based on the biopsychosocial care model[10].

This study is justified by the high incidence of people with psychotic disorders and the importance of longitudinal follow-up offered in health services based on the biopsychosocial care model, considering the need for hospitalization in PHUGH at times the picture worsens, with nursing playing a central role in integral and humanized care built through therapeutic relationship[1-8,10].

Thus, this study aims to understand how care for people with psychotic disorders is developed by the nursing team during hospitalization.

Method

This is a qualitative, descriptive and exploratory study, developed based on the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ), in order to maintain scientific rigor. The theoretical and methodological reference used was the historical and dialectical materialism, which aims to discover the fundamental laws that govern the organization of men in society through the movement of thought, by considering the dynamics and historicity of reality from the empirical context[11-12].

The nursing practice implies values and knowledge that tend to be transformed over time by the various changes in scientific and technological evidence[11-12]. Thus, taking care of the human being as an object of work, the method of historical-dialectical materialism constitutes a guide for actions and strengthens the process of nursing work in the scientific environment, allowing following the historical moment and global transformations[11-12].

The theoretical reference to discuss data used were the concepts of historical-dialectical materialism: work process, living work in action and dead work[9].

The study was developed in a university PHUGH in the interior of São Paulo, defined as a research site, because it constitutes a field of practical activity, teaching and extension of the researchers involved in the study. It is inserted in the RAPS of the municipality, which aims to create, expand and articulate points of health care for people with mental distress[11]. The unit has 14 mixed beds and a multidisciplinary team composed of nurses, nursing technicians, psychiatrists, social workers, multiprofessional mental health residents and students from professional improvement programs. In this scenario, the nursing team is composed of 7 nurses, 14 nursing technicians and 1 nursing supervisor.

The nurses and nursing technicians of the PHUGH were invited to participate in the research, electing for the study those who accepted the invitation and met the following inclusion criteria: be a member of the nursing team, have provided assistance to people with psychotic disorders at least once and be present at the time of data collection. Those who were absent from work during data collection were excluded. The participants were ten professionals from the nursing team, four nurses and six nursing technicians. Their average age was 40 years, and they were divided into seven female professionals and three male. There was a refusal to participate in the survey.

Data collection was carried out from January to June 2021 through interviews with semi-structured script, which, in addition to the guiding question, allows the inclusion of new questions in order to explore the participants' unique experiences about the phenomenon[11], being recorded and transcribed in full.

The guiding question was *Tell me how you perform care with the person with psychotic disorder*. The interviews lasted an average of 30 minutes and were conducted in reserved spaces at the PHUGH. The inclusion of new participants was suspended at the moment when the recurrence of data was identified, the researcher's concerns were answered and the objective of the study was achieved, thus characterizing the theoretical saturation[13].

Data analysis was carried out through content analysis, following the steps of thematic analysis: familiarizing with the data by repeated readings; generating initial codes in order to organize the data into related groups of ideas; classifying the different codes into potential categories/themes; revising them for refinement by reading the extracts gathered in each category; defining and naming the categories, writing a detailed analysis for each one; and producing the report after selecting vivid and convincing examples of the extracts[14]. The data were validated in a research group of the institution.

The project was approved by the Research Ethics Committee of the institution involved, with Opinion n. 5.126.315, Certificate of Presentation of Ethical Appreciation (CAAE) 52351621.7.0000.5404, and all participants signed the Informed Consent Form. Anonymity was maintained by coding with the terms "N" for nurse and "NT" for nursing technician, followed by an Arabic numeral, according to the order of the interview.

Results

Based on the interviews, it was possible to understand how nursing care is developed with the person with psychotic disorder, through the knowledge and forms of work organization described in the two categories presented below.

Dead work: promoter of nursing care in the asylum perspective

The nursing team showed to demarcate its assistance by performing technical procedures directed to the body, regarding hygiene care, feeding, medication, vital signs and containment, without locating them as interventions that enable the therapeutic relationship, essential in the context of mental health. They included listening to the person as just another routine task and not as an integral part of the provided management.

> *We follow the dynamics of the ward, we have baths and meals early, and later we pay attention and listen to the patient a little.* (NT6).

> *Basically, we medicate him and sometimes control him.* (NT1).

> *We get there, check the vital signs, prepare the medication.* (NT5).

The professionals pointed out behaviors that can refer to the asylum model, marked by the borderline relationship with the body of the hospitalized person, devaluating their autonomy, discrediting what is reported and trying to lead them to obedience.

> *We try to see if the patient actually took the drug, if he is hiding an object somewhere.* (NT5).

> *There is a lady here, for example* [...] *she used to say that she couldn't walk and now she's walking, doing everything. So, you know? "No, I'm not taking shower in the chair", so I took her by her arms, put her in the chair and took her to the shower.* (NT1).

The nursing team sometimes showed difficulty in considering the uniqueness of the person with psychotic disorders, when describing care as equal for all, since they deal with symptomatology, which may result in the absence of recognition of the patient as a person beyond their suffering.

> *There is not much difference, the care is equal to all.* (NT3).
>
> *The care is usually the same to all.* (NT5).
>
> *We treat the patient, we treat their acute condition, we don't even know these patients well.* (NT1).

The professionals recognize the assistance still marked by the biomedical care model when pointing out the small doses of medications prescribed by the medical team, because they understand as the objective of drug treatment the induction to rest, which denoted the difficulty of the nursing team to consider verbal management as effective and to perform care based on biopsychosocial premises.

> *He* [doctor] *prescribes the doses of some drugs that are too low, since the patient is a user, and prescribes the same dose that a non-user would not even rest.* (NT1).
>
> *And we don't always have the support from the doctor regarding the drug issue, because it is something very important sometimes left aside. They think that just talking will help. And it doesn't.* (NT2).

It was possible to identify in the nursing team's speech fragments of stigmatized look at the person with psychotic disorder, often demarcating experiences of aggression and pointing them as something common in this work context. Moreover, they cited the importance of male presence in the team, which goes back to aspects of the asylum model and nursing home care, which provides for the need for physical strength, mainly aiming at carrying out contentions.

> *I think aggression is one of the worst, because it can cause irreversible damage, here in the ward we have had several cases.* (NT2).
>
> *There was a psychotic patient who attacked an employee and he ended up in the ICU, so it was something like that, I think it left its mark on the entire team.* (N1).
>
> *There is a problem that the morning staff talks about a lot, that there are no men in the morning. So the nursing staff is a bit cornered, especially when it is women.* (NT1).

Finally, it was noted a lack of theoretical basis to execute care, marked by a management with disarticulated behaviors of scientific justification, as to discredit the suffering of the person, considering their experience as out of reality, as well as to enter into their delusional structure to obtain what the team wants.

> *We always observe the behavior, the reactions to any stimulus, and we try to bring them back to reality through verbal contact.* (N2).
>
> *Once I told him that I was part of that crime and he accepted the medication from me only because I was his ally in the PCC. We tried to do it that way and the treatment flowed, it went well and they accepted the contact, they didn't attack me.* (NT5).

Living work in action: potentiality of nursing care through therapeutic relationship

Different work tools were identified, from listening, embracement, empathy and therapeutic activities proposals. Such ways of thinking care allowed the valuation of their uniqueness, seeing them beyond the worsening of the psychic condition, resulting in different handling of the needs identified for each one.

> *We try to talk or sometimes involve him in some activity.* (NT2).
>
> *I think the most important care tool is listening, understanding how he symbolizes that moment or how he symbolizes issues he's going through.* (N4).
>
> *There must be an embracement, listening and empathy with the patient, otherwise we won't be able to reach them.* (NT6).
>
> *If there are ten psychotics here in this environment, each one responds differently, reacts differently, manifests, presents differently. And that's the challenge because you're often managing one and another who is also psychotic approaches and it's not the same way of managing them.* (N2).

Thus, the various characteristics of psychotic disorders represent unique subjective aspects of each person, and it is important to identify such particularities to think about nursing care. After assessing the needs, the professionals identify the Nursing Process (NP) as a guiding possibility of the work to be developed by the nursing team, with emphasis on the prescription of care by the nurse.

> *We can think that production in psychosis is very important in the sense of thinking about how this elaboration says a lot about the subject's subjectivity.* (N4).
>
> *As a nurse, I will also make the prescription according to what each type of patient needs through nursing prescriptions. If the patient needs a calmer, safer approach so that he feels good and comfortable, to talk*

about what he is feeling, hearing, seeing, we try to do this through SNC [Systematization of Nursing Care]. (N2).

The participants' speeches showed that the subjective manifestations of people hospitalized with psychotic disorders cannot be allocated to a nursing diagnosis within the NP, which makes it impossible for them to build the systematization of care in an integral way. Anchoring in taxonomies, they found the possibility of elaborating care through prescriptions aimed only at behavioral changes, such as inadequacies in front of expectations, pointed out as hetero and self-aggressiveness, and characterize the demand for flexibility to carry out work planning.

The way in which the subject experiences this delirium, this hallucination, can lead to changes in mood, which can lead to changes in behavior. This can cause the subject to go through this period with an impulse of hetero aggression or self-aggression. We do not have a diagnosis that reflects the symptom of delirium. Hallucination may occur, although it is less frequent for us, but there is no delirium. And we end up making prescriptions more focused on a possible inappropriate behavior. (N4).

Here, no day is the same as the other. There is no monotony, every day is a new adventure, a different challenge, planning has to be much more flexible. (N2).

The nursing team identified the importance of continuity of care after episodes of exacerbation of psychotic disorder that required hospitalization, mainly through the articulation of the network of services in which follow-up will occur from the time of hospitalization. Considering the particularities of psychotic disorders, nursing care is carried out in the perspective of achieving therapeutic adherence, given the occurrence of multiple rehospitalizations due to lack of follow-up treatment.

At the outpatient level, he has a treatment, here we will just stabilize him, and then refer him to the outpatient clinic. (NT1).

Understanding that it is an acute ward, we return him to the network, and it is not uncommon for our patient to be readmitted. He will return due to lack of therapeutic adherence. (N4).

Participants cited some challenges in caring for the person with psychotic disorders, describing institutional aspects and scientific rationality as barriers to valuing subjectivity. They consider that the work process should occur in multiprofessional performance, but due to the lack of professionals, the nursing team becomes the protagonist of some care actions. They then resort to communication at the time of duty and in the visits of professionals as spaces for discussion of cases, from the perspective of the multiprofessional team's performance, seeking to think the best ways to care.

Even if we think of care, which is initially structured based on a look at the subject's subjectivity, we are within an institutional perspective within the field of scientific rationality. (N4).

There is a lack of professionals. There is a lack of a multidisciplinary team to provide this support, often listening, a psychologist, an OT to perform other types of activities. So we in nursing end up with this whole package, having to observe everything and help in any way we can. We always like to embrace the patient, see more or less how they are doing, we talk a lot among ourselves both during the shift change and during visits, which are discussions with the multidisciplinary team, to try to understand this patient as much as possible and offer the best care on a daily basis. (N1).

Finally, the interviewees described the experience of caring for a person with psychotic disorder through the division of labor that occurs in daily life, assigning to the nurse activities that require the use of light technologies, such as listening. Meanwhile, they problematize the work dynamics of the nursing technician, since the high demand for basic care distance them from the possibility of potentializing their work beyond technical procedures, which denote support in light-hard technology.

The technician talks to the patient, tries to extract some thread that will be able to clarify some problem of the patient, but usually the one who has time to do this is the nurse. How is he [the patient] *going to identify with you if you only have time to arrive, medicate and leave? Arrive, give a bath and leave? Arrive, make the bed and leave?* (NT1).

Discussion

The findings of this study revealed that both nurses and nursing technicians develop part of the care for the person with psychotic disorder through alienated practices with a technicist, hygienist and reductionist focus, which differ from what the Psychiatric Reform proposes and are associated with the model of biomedical care in mental health[8].

This model of health care is structured in the individualized practice, in a unique knowledge and focusing on biological aspects, resulting in exclusionary care practices to the detriment of the appreciation of subjectivity that permeates the therapeutic relationship as a possibility of care with the person in psychic suffering[15]. Thus, perspectives of mental health care that oppose the biomedical model find barriers to be executed, being reported even by participants in this study that, the operationalization of other strategies of care, such as listening, is often understood only as a routine task, not composing the general structure of the complex mental health care.

This context of practices configures the dead work, organized through the use of light-hard and hard technologies in superposition to the light ones, which establishes greater appreciation for structured knowledge, standards and equipment, to the detriment of the production of links and relationships in the health work process[16-17]. This type of work brings the professional to a position of alienation, which only reproduces care, which makes it similar to a machine, without flexibility and possibility of creation[16-17]. Thus, it is possible to observe in the expressions of the study participants the presence of dead work in the care of the person with psychotic disorder, making it hostage of the machine work employed in order to discharacterize the autonomy and the referred symptomatology.

Therefore, the approach of care to the biomedical model contributes to workers to be disconnected from their social and cultural apparatus by having their attributions focused almost exclusively on organic parameters that are disturbed, which can promote the alienation of assistance[18-19]. This fact can be explained by the worker's distance from their work object, which detracts the care of the recognition of the person's history and brings them closer to the biomedical model of care, leading the professional to operate for healing purposes and corroborating dead work[18].

The approach to dead work raises the execution of practices that converge to the biomedical model of care and refer to the asylum model, distancing professionals from the recognition of subjectivity and uniqueness of the person[18]. This distance is perceived when nursing professionals identify the same care being offered to all, not recognizing the particularity of each person, aiming only to be decisive in the responses to the exacerbation scenarios of certain psychiatric symptomatologies, such as psychotic disorders.

The changes triggered by psychotic disorders manifest themselves from confused sensory perceptions, such as hearing voices that instruct the person to harm oneself or others, to disturbed thoughts, reduced ability to cope with external stimuli and communication difficulties[20]. In this scenario, participants described the drug resources prescribed by the medical professional as the main way to care for changes triggered by psychotic disorders, debasing tools and forms of care, such as verbal management.

In this context, the fact that the team considers drug prescriptions as the main therapeutic resource highlights the influence of the asylum and biomedical model in professional practice and the disregard of the person their its entirety, since the prescription of higher doses of medications is required by nursing staff in order to relieve symptoms through sedation[21]. Therefore, there is a fragmentation and alienation of knowledge about the health-disease process, which may lead to the professional's not being recognized regarding the efficiency of the therapeutic relationship in nursing care in mental health[8,11].

Professionals also characterize the person with psychotic disorders as aggressive and violent, a view resulting from experiences in the work environment that reinforce the stigma of the psychiatric patient. This fact may be related to the social and technical division of labor, since workers with a technical level, holders of operant and instrumental knowledge, have more direct contact with the hospitalized person during the care practices, which can leave them exposed to aggression[17,22]. However, it is noteworthy biomedical practices focused on technical aspects make fear and stigma emerge as determinants of care for this person.

As a strategy to minimize fear, the nursing team identifies the need for greater presence of the male figure in the composition of the professional staff, which again goes back to the asylum model, which values physical strength as a predominant care strategy in the physical and mechanical restraints. Pointing out gender as a determining factor for the development of nursing care in mental health may be related to the historical context of the profession, conceived under the character of mission and charity, who contributed to this work being attributed mostly to women, since the tasks are similar to those performed in daily life of women[23].

The social division of the capitalist mode of production also reflected in the sexual division of nursing work, which assigns which positions should be occupied according to gender[23]. Both male and female professionals, therefore, carry stigmatized and stereotyped images that echo in the relationships and production of health care[23].

Moreover, delusions and hallucinations are understood as characteristics and symptoms that need to be cured by the displacement of the person to the reality of the professional. There is a fragmentation of care, which happens without scientific foundation, in which subjectivity does not find space to be the main articulator of management through therapeutic relationship.

The literature discourages the nursing team from discussing and arguing about what the hospitalized person is experiencing during their approach[20]. When professionals exemplify the implementation of care according to situations experienced in everyday life, they show that the knowledge used is empirical, based on experiences without theoretical conceptualization. Nevertheless, nursing care in mental health should be in line with the biopsychosocial care model, which considers scientific support and light technologies as means to contemplate the integrality of the person, which will allow them to be the power in their treatment[8.16-17].

This study also allowed the identification of examples of practices of nursing professionals that approach what is understood as living work. This, in turn, is composed of light technologies and appears as an alternative that corroborates the establishment of the therapeutic relationship between nurse and patient, and is configured as a tool for the apprehension of demands and needs of the person through the recognition of the determinants of their health-disease process, being the main focus of work in nursing in mental health[9,16].

Thus, the therapeutic relationship favors an integral and less fragmented care, as well as allows professionals to withdraw from the position of alienated, which enables the claim and resumption of living labor in action, by focusing on care through light technologies and the recognition of each person's particularities and reality[9,16,18].

A contribution to nursing care can be the displacement of these professionals from dead work to living work, to become less alienated and susceptible to recognize themselves as social actors in their work. The dialectical movement exposed by the subjects of this study points to the development of care for dialogue, listening and acceptance, tools that are not valued in the current biomedical model. These practices configure the living work, which occurs at the moment of production of care and allows the worker to take the place of a living subject, with autonomy and freedom to act in the productive act[17]. Such liveliness is only possible by the application of light technologies, which refer to the production relations of bond, embracement and autonomy in the work process[16,19].

When nursing professionals recognize the singularity and subjectivity of the person as issues relevant to care, in addition to the sharpening of their mental condition, it denotes living work, since this identification encourages them to operate in care with greater creativity and flexibility when designing multiple determinants in the health-disease process[17,19]. It is also endorsed that the use of light technologies, such as listening, embracement and therapeutic groups, is identified by study professionals as powerful ways to value the uniqueness and health needs of the person with psychotic disorders, which guide the care to be carried out.

The appreciation of uniqueness is identified when the nurses participating in the study consider thee NP as a fundamental approach to develop individualized care. In order for this care to be possible and the professional to reach the position of active subject, it is necessary to learn the work process in which they are inserted[9]. This is linked to the development of therapeutic relationship for implementation of the NP, which enables the integrality of assistance by allowing the identification of issues that experience the person focus of care[9,11].

It can be considered that the NP organizes care for the person with psychotic disorder and is a tool of living work in action, because, despite demanding all kinds of technologies in health, it uses the light one as guiding of the others, which enables an integral evaluation and consequent flexibility in the care planning, which favors the active participation of the person in their treatment[9,11,16]. Therefore, one of the contributions of this study is the recognition that the therapeutic relationship, when articulated to the NP, can be an alternative to make it a living work.

With this theoretical support to organize care, nursing is able to participate effectively in the construction of multidisciplinary practices, structured in the Singular Therapeutic Project (STP). It is suggested that the nurse use the NP as a means to intervene in the goals established in the STP, which concretizes the nursing performance in the multiprofessional team with scientific, humanized and systematized assumptions[8].

Thus, the recognition of the particularities of the person configures the living work and gives the professional the possibility to institute singular diagnoses, as well as exercise autonomy to develop care, withdrawing from the position of alienated. The participants' speeches reveal certain difficulty to frame the subjective manifestations of hospitalized people in nursing diagnoses, resulting in a generalization attributed only to behavioral changes present in psychotic disorder[4,16-17]. The specificities and individualities of these disorders question some proposals already structured to think about nursing care, since it is observed that they do not respond to people's needs, which brings a scenario of possible rigidity in the systematization of care.

In this context, it is important to note that the NP is usually guided by classification systems, called taxonomies, which allow the standardization of care in a single and universal language, which again goes back to the biological perspective and is not consistent with the living work that considers the uniqueness of people[4]. This inflexibility may culminate in the lack of specific nursing prescriptions for the psychiatric clinic, which promotes the alienation of the worker who does not feel responsible for developing care according to the person's need and adopts practices already established, which distances the action of the professional from the living work in action[18-19]. This way of building the NP may explain the resistance of its adoption in psychiatric nursing.

Therefore, a dialectical tension is evident in the implementation of the NP, whose prescription must be carried out under an integral and individualized perspective, which will promote assistance that transcends that which is routine and protocoled by the institution[9,17]. In mental health, it is appropriate that the nurse take on the clinical reasoning to develop the NP[24].

Other findings of this study indicate that the care provided during hospitalization in PHUGH aims at stabilizing the acute episode for referral to ambulatory follow-up in the RAPS. Dialogue with the health network is sometimes still scarce, which undermines therapeutic adherence after discharge from hospital, culminating in readmissions, since the person is often placed in a passive position in their treatment[25]. The professionals demonstrated understanding of the importance of continuity of network care after discharge from PHUGH, which suggests the presence of a living knowledge and work about longitudinal care and follow-up in mental health.

In addition, in the context of the therapeutic relationship, it is valid that the nurse takes on attitudes that facilitate the responsibility of the person for their treatment, such as empathy, positive acceptance and congruence, that are configured as light technologies in the production

of health care and place the professional as a protagonist in their work process, which promotes liveliness and makes possible the flexibility of planning[9,16,21].

Teamwork arises to strengthen the living work in action during the assistance in the period of hospitalization, because it is configured as a fundamental resource in mental health care by enabling the exchange of knowledge, sharing of ideas, discussion of cases, planning and evaluation of actions[4,9,11,16]. In this sense, it is evident that the multiprofessional work allows the reunion of the nursing team with the protagonism of their work process and the resumption of living work in action.

The social and technical division of labor is not displaced from the work process apprehended in the reality of the nursing team studied. The professionals identify the fragility of care by highlighting the difficulty of nursing technicians in establishing a relationship with the person with psychotic disorder due to lack of time and opportunity during the shift, because they are busy developing the technical procedures required, not seeing the possibility of establishing the relationship at the time of care. This fact implies the reiteration of the social and technical division of labor, since, by responding to manual activities of care, they move away from their object of work[17].

It is noted, therefore, that the number of people hospitalized and the care requirements make it difficult for workers with a technical level to approach living work in action, since the reality of the shift and the structure of health production in the service induce the professional to use hard technologies, which engender dead work and alienation[16-17].

The alternative arises in calling the worker to reflect on their actions and experiences, in order to enhance their work and operate with quality in their environment, as well as visualize the moments of care as a possibility to establish a relationship with the person[17-18]. The recognition of difficulties arising from the work process is an important tool to expand the willingness of professionals to produce alternative concepts and practices to face the transformations in everyday life[17,19].

A limitation of the study concerns the historical and social context of the research scenario, considered based on the method of historical and dialectical materialism, and may not reflect the practice of all nursing professionals in a broader context.

The main contribution of this study is to reflect on the shift of nursing professionals from dead work to living work, when they recognize themselves as protagonists of care through dialogue, listening and acceptance[16,19]. As a result, the living work in action is developed by the therapeutic relationship articulated to the NP for construction of the STP valuing the singularity and subjectivity of people with psychotic disorders[8-9,11,16,18].

Final Considerations

This study aimed to understand how care for people with psychotic disorders is developed by the nursing team of a university PHUGH, which permeates knowledge and practices of dead work and living work in action.

The dead work appears as a promoter of nursing care based on the biomedical model of care and in the asylum perspective, when professionals develop their assistance through practices alienated with technicist, hygienist and reductionist focus, distancing themselves from the recognition of the subjectivity and singularity of the person.

The living work in action emerges as a potential of nursing care in line with the biopsychosocial care model to contemplate the integrality of the person, recognizing its uniqueness and subjectivity through the therapeutic relationship articulated to the NP, thus enabling the construction of the STP through dialogue, listening and embracement.

Collaborations:

1 – conception and planning of the project: Ana Julia Jacomelli Metzner de Oliveira, Vanessa

Pellegrino Toledo and Ana Paula Rigon Francischetti Garcia;

2 – analysis and interpretation of data: Ana Julia Jacomelli Metzner de Oliveira, Aldair Weber, Giulia Delfini, Rômulo Mágnus de Castro Sena, Vanessa Pellegrino Toledo and Ana Paula Rigon Francischetti Garcia;

3 – writing and/or critical review: Ana Julia Jacomelli Metzner de Oliveira, Aldair Weber, Giulia Delfini, Rômulo Mágnus de Castro Sena, Vanessa Pellegrino Toledo and Ana Paula Rigon Francischetti Garcia;

4 – approval of the final version: Ana Julia Jacomelli Metzner de Oliveira, Aldair Weber, Giulia Delfini, Rômulo Mágnus de Castro Sena, Vanessa Pellegrino Toledo and Ana Paula Rigon Francischetti Garcia.

Competing interests

There are no competing interests.

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