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Original Article

Mental health in Primary Health Care: (dis)encounters between nurses and patients diagnosed with schizophrenia*

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Objective: to understand the collective imaginary about patients diagnosed with schizophrenia by nurses in Primary Health Care, focusing on their possible reverberations regarding mental health care. **Method:** qualitative research oriented by the psychoanalytical investigative method, developed with 15 nurses. The instrument used was the Drawing-Story with Theme Procedure, and the data collected were interpreted psychoanalytically to capture fields of meaning. **Results:** in the collective imaginary of most participants, is central the belief that the continuity of mental health care of patients diagnosed with schizophrenia is an exclusive responsibility of "specialized" health professionals and/or services, and it seems to significantly affect the (dis)encounters established between the nurses and those patients. **Conclusion:** this belief is incompatible with the precepts of the Brazilian Psychiatric Reform and with the role of nurses in Primary Health Care.

Descriptors: Mental Health; Primary Health Care; Nurse-Patient Relations; Schizophrenia; Prejudice.

Saúde mental na Atenção Primária: (des)encontros entre enfermeiros e pacientes com diagnóstico de esquizofrenia

Objetivo: compreender o imaginário coletivo sobre pacientes com diagnóstico de esquizofrenia por parte de enfermeiros inseridos na Atenção Primária, com foco em suas possíveis reverberações no tocante à atenção em saúde mental. **Método:** pesquisa qualitativa, orientada pelo método investigativo psicanalítico, desenvolvida junto a 15 enfermeiros. O instrumento utilizado foi o Procedimento de Desenho-Estória com Tema, e os dados coletados foram interpretados psicanaliticamente visando à captação dos campos de sentido. **Resultados:** no imaginário coletivo da maioria dos participantes, ocupa lugar central a crença de que o acompanhamento de pacientes com diagnóstico de esquizofrenia é responsabilidade exclusiva de profissionais e/ou serviços de saúde "especializados", o que aparentemente atravessa, de modo marcante, os (des)encontros que se estabelecem entre os enfermeiros e os referidos pacientes. **Conclusão:** essa crença é incompatível com os preceitos da Reforma Psiquiátrica Brasileira e com o papel a ser desempenhado, na Atenção Primária, pelos enfermeiros.

Descritores: Saúde Mental; Atenção Primária à Saúde; Relações Enfermeiro-Paciente; Esquizofrenia; Preconceito.

Salud mental en Atención Primaria: (des)encuentros entre enfermeros y pacientes con diagnóstico de esquizofrenia

Objetivo: comprender el imaginario colectivo sobre pacientes con diagnóstico de esquizofrenia por parte de enfermeros de la Atención Primaria, enfocándose en sus posibles reverberaciones con respecto a la atención en salud mental. **Método:** investigación cualitativa, orientada por el método investigativo psicoanalítico, desarrollada con 15 enfermeros. El instrumento utilizado fue el Procedimiento de Dibujo-Cuentos con Tema, y los datos fueron interpretados psicoanalíticamente para capturar campos de sentido. **Resultados:** en el imaginario colectivo de la mayoría de los participantes, es central la creencia de que la continuidad de la asistencia a pacientes con diagnóstico de esquizofrenia es responsabilidad exclusiva de profesionales y/o servicios de salud "especializados", lo que aparentemente afecta de manera significativa los (des)encuentros que se establecen entre los enfermeros y esos pacientes. **Conclusión:** esta creencia es incompatible con los preceptos de la Reforma Psiquiátrica Brasileña y con el papel que deben desempeñar los enfermeros en la Atención Primaria.

Descriptores: Salud Mental; Atención Primaria de Salud; Relaciones Enfermero-Paciente; Esquizofrenia; Prejuicio.

Introduction

The Brazilian Unified Health System [*Sistema Único de Saúde* (SUS)], based on the principles of universality, integrality and equity, aims at enabling access to health services for all citizens and offering an articulated and continuous set of health actions in line with the needs of each case, doing so without prejudices or privileges of any kind[1]. The foundation of the Family Health Program [*Programa Saúde da Família* (PSF)] has fostered the implementation of these principles by redirecting the assistance flow from Primary Health Care, and has contributed towards consolidating the Brazilian Psychiatric Reform by fostering the transition from the asylum model to the community model[2-3].

This occurred, essentially, due to two reasons. Firstly, because Primary Health Care is the level of health care that provides initial contact with the health system and aims at health promotion, support, and recovery[4]. Secondly, because one of the basic objectives of the Brazilian Psychiatric Reform is to value the territoriality in mental health actions, respecting the singularities of each patient[5]. It should be emphasized that the notion of territoriality encompasses political, economic, cultural and affective relationships that come in concrete spaces as a result of life in society[6]. Moreover, it is interesting to highlight that, besides the creation of PSF, several other legal frameworks related to public health policies have reinforced the value of Primary Health Care for the restructuring of mental health care in Brazil.

In this conjuncture, nurses have a crucial role to play as interlocutors and catalysts of programs aimed at collective health[7], since they are concerned both with the administration and organization of health services and with the implementation of clinical practices. Therefore, it became necessary to incorporate the so-called "light technologies", i.e., strategies and techniques oriented to relationships in favor of health production processes, among which embracement[8], to the work of nurses working in Primary Health Care. It should be clarified that embracement is considered, by the Ministry of Health[9], as an essential tool to build the bond with any patient, so that it represents a guideline for the humanization of assistance.

However, some Brazilian studies have shown that nurses working in Primary Health Care, despite their relevance to mental health care, often limit themselves to automatically refer people in psychic suffering to "specialized" health professionals and/or services, instead of embrace them, discrediting the exercise of autonomy and depreciating territoriality[10-12]. Such studies have also implied that, at least in part, this fact derives from stereotypes and prejudices anchored in socially shared beliefs about "madness". After all, they pointed out that people in psychic suffering tend to be labeled – including by health professionals – as deviant, abnormal, dangerous and dysfunctional, and, consequently, would be subject to interventions with normative and individualistic bias.

The exploration of the collective imaginary, in its psychoanalytical sense, is capable of providing useful elements for the delimitation of beliefs of this nature[13]. It happens that the collective imaginary has been conceived, in the light of Psychoanalysis, as the non-conscious ideational-emotional substrate of the meetings that are established between different social groups[14], since it encompasses a set of human manifestations that, through multiple expressive modalities, configure a kind of existential place inhabited by individuals and collectives[15]. The psychoanalytic concept of collective imaginary, thus, has guided a wide range of recent studies which, with distinct thematic outlines, have shed light on essential elements of group subjectivities[13-19].

None of these studies, however, investigated the collective imaginary of nurses regarding patients in severe psychic suffering, despite the pertinence of the subject. It is worth mentioning that patients diagnosed with schizophrenia tend to experience a psychic suffering particularly accentuated because it is a mental disorder whose symptoms, impairing the affective, social, family and professional functioning, may be highly debilitating[20]. In view of the above, this study aimed at understanding the collective imaginary of patients diagnosed with schizophrenia by a group of nurses in Primary Health Care, focusing on their possible reverberations regarding mental health care. This focus also supports the circumscription of this study as an excerpt from a research developed with more comprehensive objectives.

Method

Following the example of other researches on the collective imaginary[13-19], this study is framed as a qualitative research oriented by the psychoanalytic investigative method, which can be developed inside or outside health care settings and is differentiated by the use of methodological strategies originated from Psychoanalysis with a view to producing scientific knowledge around a variety of human issues[21]. It should be emphasized that Psychoanalysis, besides being a therapeutic practice and a theoretical system, also is an investigative method[22], specifically of a constructive-interpretative character.

The scenario of this study was constituted by the Primary Health Care health services of one of the four sanitary districts of a municipality in the interior of Minas Gerais, Brazil. This sanitary district was selected due to the ease of access by the researchers. At the time of data collection, it comprised of 21 nurses. All of them were invited to participate in this study, but

there were six refusals. Thus, the participants were 15 nurses active in Primary Health Care, who – as is common in qualitative researches – composed a convenience sample, because they were not selected based on statistical criteria. Their age ranged from 28 to 60 years and their experience as a nurse ranged from one to 16 years, and 14 were female.

The instrument used in this study was the Drawing-Story with Theme Procedure [*Procedimento de Desenho-Estória com Tema* (PDE-T)][23], which has been widely adopted in psychoanalytical researches on the collective imaginary[14-18]. Due to its ludic character, such instrument is capable of facilitating emotional communication through the constitution of a relational field between the researcher and the participants[24]. Essentially, when using PDE-T, each participant is requested to elaborate a drawing with a theme previously defined by the researcher according to the research objective and, subsequently, to create a story about the drawing and a title for the story.

In this study, PDE-T was used individually, but in a collective context, during the intermission of a meeting in which the participants were present, at a time specifically designed for that purpose. In other words, each of them carried out the activity separately within the group in which they were inserted, in line with the approach used in previous researches[14,16]. The participants were asked to draw a patient diagnosed with schizophrenia being assisted by a nurse in Primary Health Care, to write, on the back of the sheet of paper, a story about the drawing, and finally to give it a title, as well as to inform sex, age, and time of experience as a nurse.

All ethical precautions regarding researches with human beings were duly observed and this study was approved by a Research Ethics Committee (Opinion 2.496.299). Therefore, the researchers committed to keep the identity of the participants confidential and not to make public in which health services they work. The data collected – that is, the drawings and the stories of the participants – were analyzed seeking to capture the fields of meaning that support their collective imaginary. The fields of meaning, it is worth mentioning, correspond to the core of the collective imaginary, since they are constituted by non-conscious contents that, although referring to individual interiority, have an intersubjective nature, because they are continuously molded from daily social interactions[24].

In order to make possible the capture of fields of meaning, and following psychoanalytic researches on the collective imaginary performed previously[13-16], it was used psychoanalytic interpretation, operated in accordance with the procedures recommended in the literature[25]. Thus, the researchers have examined the productions of the participants in an exhaustive form and based on the free-floating attention, in order to unveil their possible non-conscious structuring rules, i.e., the assumptions of the psychic functioning distinct from that which determines the conscious intention in relation to patients diagnosed with schizophrenia. The results produced were then discussed and validated during a meeting of the respective research group. This approach proved to be important in previous psychoanalytic researches, as it enabled the refinement of lines of analysis delineated by the researchers without, however, incurring in reductionist uniformity[13-16].

Results

The field of meaning captured in response to the objective of this study was named as follows: "I consult, I don't refuse, I refer when I can". This title, obviously alluding to the Brazilian popular saying "I owe, I don't deny, I pay when I can" ("*Devo, não nego, pago quando puder*"), is justified insofar as, in the collective imaginary of most participants, is central the belief that the continuity of mental health care of patients diagnosed with schizophrenia is an exclusive responsibility of "specialized" health professionals and/ or services. Such belief seems to influences directly the (dis)encounters that are established between the nurses and the referred patients.

Thus, the rationale of referring patients seems to prevails, according to which, in Primary Health Care, it would be the responsibility of the nurses to perform only an initial and brief consultation of patients diagnosed with schizophrenia and, subsequently, to refer them, particularly to the subsequent levels of health care. The following story is representative in this regard: *[...] right after the consultation with the nurse [the patient diagnosed with schizophrenia] is transferred to the psychologist. If the psychologist is not available [...] the same nurse, along with the social worker, they talk [sic] to him to calm him down and resolve the situation until the day of the consultation with the psychologist.* (Participant 8)

However, the rationale of referring patients is revealed more clearly in an extremely concise story in which no initial embracement in Primary Health Care is even mentioned:

Patient in crisis was referred to E.R. for assistance. (Participant 11)

It is important to emphasize, in the story created by participant 8, the use of the verb "to resolve", which suggests that the situation illustrated is seen as a problem that demands a punctual response. In another story, the same verb is also conveyed, but the problematic nature of the situation is given greater prominence: *[...] when receiving a patient [diagnosed with schizophrenia], we try to embrace and solve the problem [...].* (Participant 5)

Such stories indicate that participants typically tend to consult patients diagnosed with schizophrenia as soon as they arrive at the health service and, by referring, the participants absolve themselves from the continuity of mental health care of these patients. Another story also supports this argument by postulating that the nurse should: *[...] listen, support and refer this patient [diagnosed with schizophrenia].* (Participant 2)

It should be noted that an analogous movement was observed during data collection. Every nurse present at the meeting was invited to participate in the study. The majority accepted the invitation, as already informed. The researchers then began to present the instructions for PDE-T, explaining that the participants should draw on the sheet of paper that was being distributed at that time and use a pencil that would be made available subsequently. However, only four participants waited for the pencil to be handed out to begin the activity. The others used pens they already had in hand as if they were trying to "get rid" quickly of the activity with which they had agreed, whereas they could have initially refused it or else given up on it even after the previous agreement.

It seems reasonable to consider, therefore, that something equivalent can happen with certain regularity in the daily work of the participants in Primary Health Care. That is, perhaps many of them, although they do not refuse to consult patients diagnosed with schizophrenia, they commonly do so by seeking to pass them on as soon as possible to other health professionals and/or services. The story of participant 8, cited above, also indicates this trend, as well as the following story, in which a nurse immediately redirects the patient to the psychologist, who takes the responsibility for embracement: *[...] the nurse calls for the psychologist, who embraces the patient and schedules subsequent appointments.* (Participant 9)

It is possible to suggest that, with respect to the mental health care of patients diagnosed with schizophrenia in Primary Health Care, the participants, in general, seem to strive to follow very closely guidelines established in handbooks on mental health care and, consequently, end up not personalizing the health care, which may result in excessive protocolization. This line of reasoning is supported by figures 1 and 2, which refer to flowcharts present in this kind of handbooks. Likewise, mere obedience to the aforementioned guidelines may contribute to the fragmentation of health care, as evidenced by the following story: *[...] the whole team is involved in the case and delegate [sic] functions to each one in order to minimize crises and decompensations.* (Participant 14)
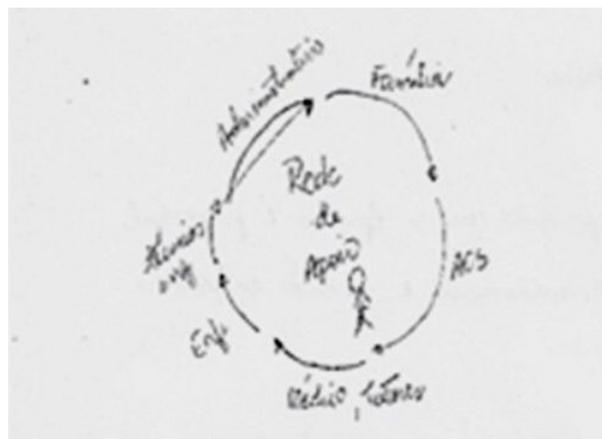
(Clockwise, it reads "*família*" [family], "*ACS*" [community health agents], "*médico, tutores*" [physician, tutors], "*Enf*" [nurse] "*técnicos enf*" [Nursing technicians], and "*administrativo*" (technical administrative), and, in the center, it reads "*rede de apoio*" [support network])

Figure 1 - Drawing elaborated by participant 13
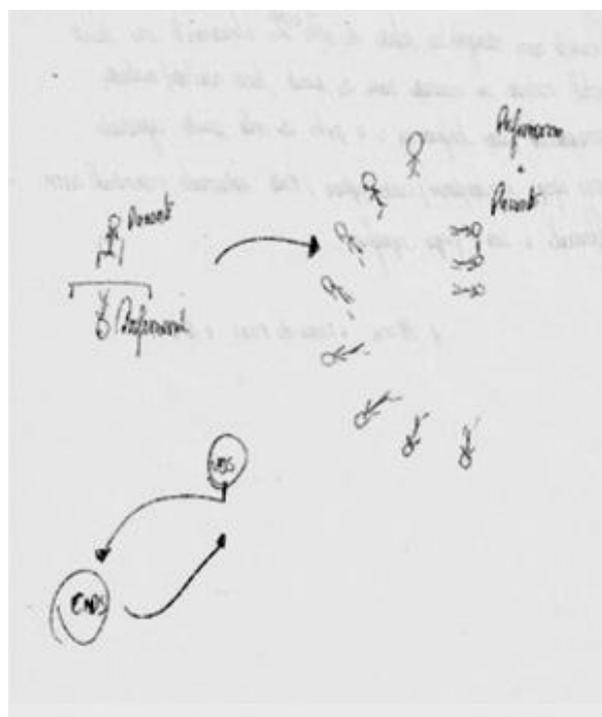
(Clockwise, it reads "*profissionais*" [professionals], "*pacientes*", [patients], "*CAPS*" [Psychosocial Attention Center], "*UBS*" [Basic Health Unit], "*profissional*" [professional], and "*paciente*" [patient])

Figure 2 - Drawing elaborated by participant 15

Also suggesting the risk of excessive protocolization, it is necessary to point out that the stories of some participants resemble Nursing notes on medical records, as in the example below: *The patient arrives at UBSF [Primary Health Care service] with schizophrenia, is seen by the nurse [...] After evaluation, a multi-professional approach is made with a psychologist and a physician [...].* (Participant 7)

The same applies to another story, in which the quality of health care provided by the health team was emphasized, but without informing if the nurse is inserted in it: *The patient comes to the health service with a diagnosis of schizophrenia, is seen by the multi-professional team, with respect*

and attention, is referred for evaluation in Psychiatry tutoring, performs periodic monitoring. (Participant 4)

Discussion

It is known that for many health professionals, embracement is mistakenly reduced to an administrative screening action followed by transference to "specialized" health professionals and/or services[9]. The results reported here indicate that such conception seems to be predominant among the participants of this study regarding the work developed by them in Primary Health Care with patients diagnosed with schizophrenia. Nevertheless, embracement needs to be thought of as a fundamental action to establish the bond with any patient, as already mentioned. Moreover, specifically regarding mental health care in Primary Health Care, embracement should make the patient feel safe in relation to his/her continuity in the health service he/she initiated, even if health care will be shared with another health service[26].

However, in order to be effectively responsible for any patient, every health professional needs to count on something that is generally not available to nurses working in Primary Health Care: spaces capable of promoting the containment of psychic suffering experienced as a result of their work. The relevance of such spaces was highlighted in a psychoanalytical study on the collective imaginary of physicians specializing in assisted reproduction on situations of difficult management[17]. The participating physicians considered that the negative result of the pregnancy test of a patient under treatment provokes an accentuated emotional mobilization, because, in a non-conscious manner, it marks the limit of their technical-scientific knowledge.

The results obtained in this study are similar to those resulting from a qualitative study whose purpose was to explore the assistance offered by Nursing professionals inserted in family health teams to "mental health patients"[11]. The authors found that referral was the most used resource by the participants with the public in question, because most of them hinted that they sought to quickly identify the complaint and assess the need for redirection to a "specialized" health professional. In summary, it was evidenced, as in this study, that participants tend not to take responsibility for mental health demands.

But what other factors could contribute to the predominance of the rationale of referring among the participants of this study? A theoretical study on mental health care in Primary Health Care[27] provided elements to help outline an answer to such question. For the authors, changes in health production processes – especially those recommended by the Brazilian Psychiatric Reform – are extremely complex, because they require changes in subjectivation processes. Also according to the theoretical study in question, it is necessary to transform the social place reserved for "madness", to effectuate the deinstitutionalization of health care and to overcome the dichotomy of health *versus* mental health, since clinical practices do not change automatically with modifications in public health policies.

Developing the topic of deinstitutionalization, another theoretical study[28] defended that mental health care must privilege territoriality, since only in this way can the patient be known in his/her daily life and needs, which is indispensable to consider the multiple determinants of the health-disease binomial in the construction of interventions to be implemented, preferably with the help of his/her community's resources. The authors also warned that, for this, there can be no discrimination between "mental health patients" and other patients. Nevertheless, this is often not the case, particularly regarding patients diagnosed with schizophrenia due to the stereotypes and prejudices that weigh on them, making health care more technical and less relational, as the results obtained in this study suggest.

It should be noted that stereotypes and prejudices can also harm the health care offered to the most diverse publics. After all, in a psychoanalytical study on the collective imaginary of nurses about interrupted pregnancy[18], it was observed the predominance of a belief that the voluntary interruption of pregnancy would constitute a hideous act that could only be perpetrated by an insensitive and cruel woman. On the other hand, a study on the psychoanalytical exploration of the collective imaginary of community health agents on patients in severe psychic suffering[19] revealed that they are usually labeled, in a non-conscious manner, as unstable and dangerous by them.

The results reported here also are compatible, although more indirectly, with those obtained in a qualitative research study on mental health care provided by nurses in family health teams[12]. This is because, from the perspective of the participating nurses, the work developed by them with people in psychic suffering was not very resolute due to personal difficulties and lack of professional qualification. On the other hand, it was found that many – especially due to stereotypes and prejudices consistent with those presented by the participants of this study – blamed only the patients for not adhering to the proposed treatments.

Additionally, it is important to mention that there are relevant points of convergence between the findings of this study and those from a qualitative research aimed at analyzing the clinical practices of nurses and physicians regarding mental health care in Primary Health Care[10]. The authors noted that the work of such professionals was basically aimed at the bureaucratic compliance of protocols so that, oftentimes, it was not focused on the patient,

but rather on the mental disorder with which he/she was diagnosed, and limited to the activation of subsequent health care levels. It should also be emphasized that several participants, when defining mental health, alluded to stereotypes and prejudice.

It is worth emphasizing that the rationale of referring, in a broader sense, makes it difficult to carry out integrality as a principle of SUS and not only regarding mental health care. The concept of integrality, according to a theoretical study[29], concerns a social action in that it requires a democratic interaction for the offer of a health care capable of producing transformations in people's lives through embracement. And the author highlighted the importance of embracement both as a moment of encounter, in which the health professional seeks to respond to the suffering of the patient not reducing he/she to a mere body to be healed, and as a way of organizing clinical practices in line with the need to overcome the fragmentation of activities undertaken in many health services.

Finally, it must be admitted that the fact that many participants in this study have produced stories that resemble Nursing notes on medical records can be considered, in a certain aspect, understandable, taking into account that such productions are correlative to the language most familiar to them. This would determine a limitation of this study. Nevertheless, the results reported here have implications for the clinical practice of nurses and for future studies for at least two reasons. Firstly, because they show that the scope of the work developed by such professionals with patients diagnosed with schizophrenia can be impaired – especially in terms of integrality – by non-conscious contents. Secondly, because they point out that the circumscription of these contents is capable of promoting the overcoming of obstacles that still exist regarding the undertaking of mental health actions in Primary Health Care, particularly those that hinder territoriality.

It should be noted that the community model advocated by the Brazilian Psychiatric Reform requires co-responsibility for health care, an initiative through which health professionals, inserted in different levels of health care, are expected to jointly build strategies aimed at qualifying mental health actions. When this occurs, is usually observed, in addition to benefits for the patients, an increase in the resolution capacity of Primary Health Care and, in contrast, the decrease in the referrals carried out automatically, which optimizes the assistance flow within SUS[30]. However, it seems reasonable to propose that co-responsibility depends on an ethical commitment to a concept of mental health expanded to the point of avoiding tautological formulas, which are unfortunately still quite common among health professionals, who define the existence of a mental disorder as an impediment to any possibility of mental health[31].

Conclusion

It is concluded that this study allowed the understanding of collective imaginary aspects of patients diagnosed with schizophrenia by a group of nurses who work in Primary Health Care, focusing on their possible reverberations regarding mental health care and, thus, shed light on certain symbolic marks of the (dis)encounters that are established among these social groups. In summary, it was found that, in line with the beliefs of most participants, this public is seen as an exclusive responsibility of "specialized" health professionals and/or services, which is incompatible with the precepts of the Brazilian Psychiatric Reform and with the role to be fulfilled in Primary Health Care by nurses. This study, therefore, reinforces the findings of previous studies, as well as deepening them, as it is differentiated by the emphasis on non-conscious contents that constitute the ideational-emotional substrate of positions concerning mental health care. Nevertheless, due to the complexity that characterizes the subject, new researches are necessary, which, by the way, can benefit from the use of ludic strategies in data collection, as indicated by the results reported here.

Proposing supposed "solutions" to the obstacles pointed out here, regarding the development of mental health actions in Primary Health Care by nurses, exceeds the scope of this study and, moreover, would sound pretentious. Therefore, only suggesting a path that can be followed in this direction is more pertinent. It is the opening of spaces focused on the containment of psychic suffering experienced by nurses as a result of their work in the aforementioned level of health care. Spaces with this purpose may assume different characteristics, but should not be mistaken for training programs, since they must go beyond technical discourse, based on the principle that a more sensitive view regarding mental health issues tends to emerge in health professionals who are closer to their own emotional issues, or, in other words, who are willing to court their own insanity*.

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