



## Humanization in mental health care: nurses' understandings

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**Objective:** to know nurses' understandings of humanization in mental health care. **Method:** it is an exploratory research, with a qualitative approach, carried out with 12 nurses in a psychiatric hospital in the interior of the Northeast, Brazil, from September 2014 to March 2015. For data collection, semi-structured interviews were used, non-participant observation and observation of Nursing records, analyzing them from Bardin's Content Analysis. **Results:** four categories emerged: welcoming, autonomy, protagonism and co-responsibility. Humanized care appears linked to the asylum model, culminating in practices focused on the use of medication, disjointed actions and without patient participation in the treatment. The perception of humanization is of difficulty in caring for people in psychic crises, which makes the production of comprehensive care unfeasible.

**Conclusion:** the study contributes to the reflection of nursing care in mental health where it is necessary to modify the relationships that biomedical discourse maintains with those who seek a humanized practice.

**Descriptors:** Psychiatric Nursing; Nursing Care; Mental Health; Humanization of Assistance.

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## **Humanização no cuidado em saúde mental: compreensões dos enfermeiros**

**Objetivo:** conhecer as compreensões dos enfermeiros sobre humanização no cuidado em saúde mental. **Método:** trata-se de uma pesquisa exploratória, de abordagem qualitativa, realizada com 12 enfermeiros em um hospital psiquiátrico do interior do Nordeste, Brasil, no período de setembro de 2014 a março de 2015. Para a coleta de dados, utilizou-se entrevista semiestruturada, observação não participante e observação dos registros de Enfermagem, analisando-os a partir da Análise de Conteúdo de Bardin. **Resultados:** emergiram quatro categorias: acolhimento, autonomia, protagonismo e corresponsabilidade. O cuidado humanizado aparece atrelado ao modelo manicomial, culminando em práticas focadas no uso da medicação, ações desarticuladas e sem participação do paciente no tratamento. A percepção da humanização é de dificuldade de atenção às pessoas em crises psíquicas, o que inviabiliza a produção do cuidado integral. **Conclusão:** o estudo contribui para a reflexão do cuidado de Enfermagem em saúde mental onde é preciso modificar as relações que o discurso biomédico mantém com os que buscam uma prática humanizada.

**Descritores:** Enfermagem Psiquiátrica; Cuidados de Enfermagem; Saúde Mental; Humanização da Assistência.

## **Humanización en la atención de la salud mental: comprensión de las enfermeras**

**Objetivo:** se objetivó conocer las comprensiones de los enfermeros sobre humanización en el cuidado en salud mental. **Método:** se trata de una investigación exploratoria de abordaje cualitativo realizada con 12 enfermeros en un hospital psiquiátrico del interior del Nordeste, Brasil, en el período de septiembre de 2014 a marzo de 2015. Para la recolección de datos se utilizó entrevista semiestructurada, observación no participante y observación de los registros de enfermería, analizados a partir del análisis de contenido de Bardin. **Resultados:** se plantearon cuatro categorías: acogida, autonomía, protagonismo y corresponsabilidad. El cuidado humanizado aparece atado al modelo manicomial, culminando en prácticas enfocadas en el uso de la medicación, acciones desarticuladas y sin participación del paciente en el tratamiento. La percepción de la humanización es de dificultad de atención a las personas en crisis psíquicas que inviabiliza la producción del cuidado integral. **Conclusión:** el estudio contribuye a la reflexión del cuidado de enfermería en salud mental donde, hay que modificar las relaciones que el discurso biomédico mantiene con los que buscan una práctica humanizada.

**Descriptor:** Enfermería Psiquiátrica; Atención de Enfermería; Salud Mental; Humanización de la Atención.

## Introduction

The National Humanization Policy (NHP) is based on the recognition of users, workers and managers in different situations and contexts, betting on new practices, relationships and knowledge production guided by the principles of the Unified Health System (UHS). This policy points to changes in health production, management and care, with an emphasis on collective work, permanent education of health professionals and the training of academics in this area of work<sup>(1-2)</sup>.

Despite advances in the NHP proposal, fragmentation of the work process and relationships is still frequent, the overlapping of scientific and biomedical knowledge with common sense, the separation of body and mind in the practice of care and the devaluation of the rights of users and workers. These are challenges for the development of health practices, of an expanded and collaborative character, that consider the subject in his social context<sup>(3-4)</sup>.

With regard to mental health, humanization gained more emphasis with the Psychiatric Reform movement in Brazil, when the construction of substitutive spaces for differentiated care from the asylum model and the search for the social and cultural overcoming of stigmas linked to madness took place<sup>(5-6)</sup>.

The articulation between the NHP and the Mental Health Care Policy is capable of enabling an open and community care model, which offers comprehensive care to the user. Therefore, the reception, autonomy, co-responsibility and the protagonism of the subjects are principles of the NHP considered essential in mental health care because they are means of transformation and qualification of health practices and knowledge<sup>(6-7)</sup>.

In the context of mental health care, the worsening of psychological suffering, the predominance of the use of drug therapies and recurrent psychiatric hospitalizations place nurses facing the need to develop actions that consider intersectorality, interdisciplinarity, the empowerment of users, in addition to bringing the family and community closer together, placing humanization as a structuring element of their know-how<sup>(8)</sup>.

Thus, this study aimed to understand nurses' understandings of humanization in mental health care.

## Method

This is a research with an exploratory focus, with a qualitative approach, carried out in a psychiatric hospital in the interior of the Northeast, Brazil. The health institution was chosen because it is part of the organization of mental health services established by the municipal management and because it is a reference in the West and Upper West regions of Rio Grande do

Norte to act in the face of psychic crises, as approved by the criteria of the National Evaluation of Hospital Services Program - NEHSP/Psychiatry.

This site has an area of more than ten thousand square meters and is divided into four units, namely: the Women's Care Unit (WCU); the Male Care Unit (MCU); the Female Intensive Care Unit (FICU) and the Male Intensive Care Unit (MICU).

The population of this research was composed of 17 nurses who worked at the psychiatric hospital. Inclusion criteria were: being a nurse working at the establishment for more than six months and working directly with patients. The exclusion of nurses who were on vacation, with medical or maternal leave and that worked only on night shifts or on weekends were highlighted. Thus, a final sample of 12 nurses was worked with, taking into account a convenience sample.

The entry into the field was prepared, previously, by the meeting with the Nursing coordination of the referred health institution. This contact was initiated through the delivery of a formal document, which described the request for the hospital space for the research, as well as the days, sectors and hours of in-person observation of the researchers and the agreement to make the Nursing records available to the use of data that would enhance the study. Also in this document, the methodology to be developed on site was described, reiterating the ethical nature of the work. It was requested that the information contained in the document be shared with the hospital's nurses so that all interested parties were made aware of the research content and of the researcher's presence in the service.

The entry into the field took place in September 2014, lasting six months, which allowed contemplating the morning and afternoon shifts, from Monday to Friday, of the activities performed by Nursing. Each nurse, who allowed the observation of their activities, formalized their participation in the research with the signature of the Free and Informed Consent Term (FICT).

For the data collection of the study, semi-structured interviews, non-participant observation and observation of Nursing records were used. These were directed and systematized based on a script for observing the care of nurses in the psychiatric hospital, taking into account the principles of the National Humanization Policy: welcoming, autonomy, protagonism and co-responsibility.

The observations were recorded in a field diary, which made it possible to get closer to the subjects and the research location, making the records a source of knowledge construction and reflection of the practice.

Then, the interviews and observation records were analyzed using Bardin's Content Analysis technique divided into three basic steps: pre-analysis, in which the

field diaries were organized from the observation script; in the exploration of the material, specific techniques were applied according to the research objective and in the third stage the treatment of results and interpretations took place<sup>(9)</sup>.

In order to maintain the nurses' identity preservation and the organization of observations and records in the field diary, the letter "E" for nurses was used followed by Arabic numerals to identify them.

Under the aegis of Resolution 466/2012, this research was duly submitted to the Research Ethics Committee (REC), being approved with opinion nº CAAE 14628813.1.0000.5294.

## Results and Discussion

The participants were 12 nurses of both sexes, ten female and two male, with an average age of 38 years, between 26 and 58 years old. They worked at the psychiatric hospital for a period of one year to 30 years and an average length of service of ten years and nine months. As for training, two had an undergraduate degree and ten had a specialization, six of which in the mental health area.

The interviewees' speeches were highlighted and organized in registration units, according to their similarities and pertinence, emerging in a quantity of 82 content analysis units grouped into four themes, which will be discussed in four categories: welcoming, autonomy, protagonism and co-responsibility.

### Welcoming

It was observed that the reception performed by nurses was intended for the initial care of the patient in the psychiatric hospital. In a small room, called reception, the nurse collected information with the patient who showed cooperation; in other situations, the service was focused only on the observation of their physical state or the reports of family members.

*The admission of patients happens here at the reception. I fill out a checklist if the patient speaks, but usually he does not speak or is very aggressive, so I ask the family. There is a family that exaggerates the patient's clinical condition, in this case, I use only the observation of how the patient arrives at the hospital to complete the document. (E2)*

The nurse aims more at the demand of those who brought the patient to the health service than what the patient has to say about their anguish. It is worth noting that welcoming is a technology of encounter, built every day, as a subjective space for building bonds and redefining suffering, going beyond the initial care or the physical space of the health service. Through listening to life history, embracement affirms powerful

relationships between professionals and users in the health production processes<sup>(10-11)</sup>.

In the reception room, a checklist on the patient's body condition is used, consisting of quick questions, some of which are multiple choice.

*I ask about the number of previous hospitalizations; psychiatrist who accompanies the patient; psychotropic drugs you use; main complaint that triggered that crisis; period in which the first behavioral changes were identified, as well as personal and socioeconomic data. Then, I refer the doctor to determine the diagnosis and the medication regimen. (E7)*

*Once admitted, the patient is taken to his ward and begins to live different situations than he was used to. The sector nurse checks the medical record and records his admission: the patient arrived at the MICU on a stretcher accompanied by the reception nurse. Makes use of hypertensive drugs, does not verbalize and has injuries in various parts of the body. Third admission to this institution due to alcohol abuse. It is under the care of Nursing. (E9)*

This form of reception demonstrates its format along the lines of traditional psychiatry, which is based only on the clinical framework centered on illness, on the organic complaint and on the medical diagnosis. The observations demonstrated a superficiality of the relationships between nurses and patients as a result of the devaluation of the expression of the patient's feelings in psychological distress and the events of their life. Such fact launches the need for a continuous and networked reception, from the entrance to the exit of the internment, making it one of the essential devices in the work in mental health<sup>(10,12-13)</sup>.

### Autonomy

To enter the WCU, it is necessary to ring the access doorbell and wait for someone to open it, as the control with the doors is very strict in all sectors of the psychiatric hospital. The door was opened by one of the patients, who was authorized by Nursing.

*Some patients give us this autonomy, but I cannot do this with everyone because there are many patients and we must always be vigilant. Today, I have more than 50 people here in this sector alone. There are a lot of people to coordinate and the majority cannot be trusted. Of course, their autonomy is in deciding which room to stay in, the clothes they want to wear, whether they want to eat or not, they exchange hygiene products and slippers. (E11)*

Autonomy is considered by nurses as an incentive for patients to make choices and some functions, recognizing the limits and potential of their illness process<sup>(14)</sup>.

*They always want to change rooms, but we are the ones who decide their room. We need to be aware of everything that happens here. (E2)*

*You already know your discharge, it will only happen when you are really well, and the doctor does it. (E4)*

The care relationship is permeated by the nurse's difficulty in helping patients in psychological distress to make their choices independently, since there is a greater need for surveillance, in order to maintain control. These attitudes contribute to the compromise of the patient's autonomy and strengthening the dependence on the psychiatric institution<sup>(12,14)</sup>.

It is up to the psychiatric institution, considering the patient in psychological distress as a social being and a citizen, to function as a space of passage to the extent that it would allow, to its users, autonomy in relation to the continuity of their treatment in the psychosocial care network. In this perspective, there is a need for articulation with the support network and the search for resources in the territory. Nursing, on the other hand, needs to think about the patient's life history and needs, developing its activities based on listening interested in the responsibility for care, in the help relationship and in achieving autonomy<sup>(15-16)</sup>.

### *Protagonism*

It was observed that the psychiatric hospital is an environment that dispenses with the role of the patient. Its hegemony over health actions is still cultivated, reproducing a less democratic management model, which does not favor the emergence of transforming subjects in the ways of managing and doing health. However, the human being is a being dependent on his networks and, thus, the relationships that involve the subjects impact the construction of a shared and protagonist responsibility<sup>(15)</sup>.

*Last week, I was making a note on the chart and I was punched by the patient. The other day, she apologized to me, said she was beside herself. How am I going to ask someone like this to participate in the construction of your therapeutic project? I immediately tell the doctor to reevaluate their medications. (E5)*

For the construction of a therapeutic project, it is necessary to value the patient's knowledge in the sense that he has commitment and protagonism in decisions, such as an agreement with the professional, avoiding division, dispute and impositions. The protagonism is linked to the process of building partnerships between professionals and patients as they all jointly elaborate alternatives for leading a path that respects the cultural values of the different collectives<sup>(2,4)</sup>.

Nurses seek partnerships with users as a form of participation in the treatment and construction of knowledge, however, there is the belief that their disease affects the ability to act and think.

*We leave the patients here [FCU] very free because they are calm,*

*but in the FICU you have to keep an eye on them, you can't leave them alone because they are like children, they don't understand things well. We try to establish a partnership so that one can help others, feel useful and participate more in their treatment, but, in most cases, the people who make decisions because they are mentally ill. (E12)*

This perception limits certain decisions regarding treatment, once again showing that there is a hierarchical relationship of knowledge between patients and nurses and reinforcing the role of nurses who work in psychiatric hospitals to supervise and control<sup>(12)</sup>.

Users become protagonists when they gain an active voice in the face of therapeutic relationships that consider their life stories. It is still necessary to break with the epistemic method of psychiatry, the concept of mental illness as error and unreason, as well as the principles of moral treatment that still support the behaviors adopted in health services<sup>(15,17)</sup>.

*Why don't you want to have lunch, woman? Yes, go to lunch. Then you will be hungry and have to take the medication. Remember this so your stomach doesn't hurt. Don't you want to leave here? It will take longer if you don't eat. (E10)*

It was observed that the nurse's conduct is influenced by the centralizing power of the psychiatric hospital, which imposes rules that are often different from the patient's daily routines. In this way, anguish is masked by the medicalization of suffering, which does not consider the subjects' issues and prevents them from developing knowledge about what makes them suffer or about their care. The valorization of the speeches of these patients can provide important subsidies so that mental health actions can be rethought in favor of comprehensive and humanistic care<sup>(18)</sup>.

### *Co-responsibility*

Co-responsibility implies the involvement of health professionals, the patient's participation in therapeutic plans and actions and the articulation between health and support services<sup>(1)</sup>. However, the nurse's perception of humanized mental health care is referral, synonymous with difficult work.

*The doctors here are on alert. We call and they come here to change the medication and reevaluate the prescription. We don't have much to do, if I feel sick, I call the doctor, if I am in crisis and want to talk, I refer the psychologist. (E1)*

*There are some patients who are very mentally serious and who have other diseases as well. Performing a humanized care in these conditions that the hospital is in is very difficult, imagine in an emergency situation, it is even more difficult. (E6)*

It was observed that the interviewees deny the care to patients in psychic crisis as their responsibility and pass this function on to other professionals. Another fact verified was the lack of basic instruments, such as oxygen points and defibrillators, for urgent or emergency care at the psychiatric hospital, and it is always necessary to call the Mobile Emergency Care Service (MECS) to transport the patient to a general hospital.

These situations demonstrate the need to build new relationships and co-responsibility practices in order to meet the health needs of patients. It is worth mentioning that the recognition, by nurses and other professionals, of care, subjective and social elements, is paramount for humanized care<sup>(5,19)</sup>.

Nurses also reported the difficulty of sensitizing the patient to be co-responsible for their treatment, as well as involving other nurses and raising awareness among the family.

*It is difficult to call this treatment responsibility to patients because many do not even want to. We feel alone because the other nurse colleagues also get tired. We know that we need to take care with humanization, but it is difficult. The patient has already gotten used to just taking the medicine and the family supports it and thinks it is bad when he doesn't leave here with another medication on the list. (E8)*

This context reiterates the fragmented work, which can maximize the suffering that the patient is already in, discouraging his coping capacity in the face of their problems and their treatment.

The home environment and the suppression of symptoms, including the medicalization of suffering, show the lack of a deepening of clinical tools that break with this position of objectification of the one who suffers and with this imposition of corrective conducts based on their own concerns<sup>(10,16)</sup>.

The perspective of giving voice to the patient's suffering, based on the expansion of the clinic and focus on the subject, implies taking responsibility for the change in care. This can be thought of in health technologies that make it possible to understand psychological suffering from the user's context, valuing their experiences and paying attention to their needs, including the care for the different aspects that make up this individual's daily life<sup>(20)</sup>.

## Conclusion

The results found showed that nursing care in mental health, considering the principles of humanization, is not effective in the relationships between nurses, patients and other professionals.

Reception, autonomy, protagonism and co-responsibility were linked to the asylum model, culminating in practices more focused on the use of medication, disjointed actions and without patient participation in the treatment. The perception of humanization that permeates nurses is that it is difficult to care for people in psychic crises, which prevents the production of comprehensive care.

It should be noted that data collection took place in a single mental health service, which can be considered a limitation of the research. For the development of future studies, the discussion of strategies that materialize the incorporation of the principles of humanization for nurses and in the relationship with users should be deepened.

This study contributes for Nursing to evaluate its practices and relationships, considering the ideals of the Brazilian Psychiatric Reform, given that it is not enough to destroy the walls of the hospice, it is necessary to modify the relationships that the biomedical discourse maintains with those who seek their practice, in addition to to change the traditional psychiatric knowledge impregnated in institutions and practices.

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