v. 1, n. 8, 2021

International Journal of Health Science

POWER RELATIONS IN MENTAL HEALTH PRACTICE: THE NURSING TEAM'S VIEW

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Abstract: Objective: To understand the power relations present in the daily life of the nursing team at a Psychosocial Care Center for Alcohol and Drugs III. Method: Study with a qualitative approach. Data were collected through participant observation and semi-structured interviews with 10 professionals from the nursing team. From the Content Analysis, the following categories emerged: 1) Power in question: professionalism and work control; 2) Psychiatric power on stage: still searching for the truth. Results: Power relations contribute to the emergence of conflicts between the multidisciplinary team, influence the quality of care and awaken in the nursing team the need to consolidate their practice. Conclusion: Health work promotes the interaction of knowledge and powers between professional categories and the process of changes and challenges that permeate mental health services make this environment full of power relations and conflicts.
Keywords: Nursing, Multiprofessional team, Power, Mental health.

INTRODUCTION

The Brazilian Psychiatric Reform is a social and political movement that involves changes in practices, values and knowledge and aims to deinstitutionalize and build strategies that value psychosocial care, which is based on changing the traditional model centered on disease and medicalization to a more humanized and liberating practice[1].

Thus, a new health care service emerged, the Psychosocial Care Center (CAPS), considered a strategic device in mental health, which advocates treatment under a new clinic based on social reintegration, the construction of autonomy and the protagonism of the subject. in your treatment and in your life[2].

The CAPS were created by Ordinance of the Minister/Ministry of Health 224/92 and present some modalities, highlighting the CAPS Alcohol and Drugs (CAPS ad) and CAPS ad III[2].

The CAPS ad serves people who are suffering from psychological distress due to the use of crack, alcohol and other drugs, and is recommended for municipalities or health regions with a population of over seventy thousand inhabitants. CAPS ad III is open 24 hours a day, including holidays and weekends, offering back-up beds and night shelter, being recommended for Municipalities or regions with a population of over two hundred thousand inhabitants.[2]

According to the principles of the Psychiatric Reform, the CAPS must be a service that develops from a practice centered on the subject, considering their singularities and potential[1]. In this context, care goes beyond mental illness, which must be understood as a process of human suffering, in which the suffering subject must be understood as a social and political body.[3]

This service values multidisciplinary teamwork and allows professionals to understand the needs and particularities of human beings (physical, psychological, social and spiritual), which will enable interdisciplinary care based on the psychosocial model.[4]

For this, a minimum team of physicians, social workers, occupational therapists and a nursing team composed of nurses and nursing technicians is required.

Health work promotes the interaction of knowledge and powers between the professional categories that make up the multidisciplinary team of a CAPS AD III and the process of changes and challenges that permeate mental health services make this environment full of power relations and conflicts.

The power-knowledge relationship is present in the daily lives of health professionals. Power is present in relationships, it is an action of one another. Every human relationship is

considered a power relationship, which may exist between men and women, parents and children, teachers and students and in the work environment[5].

These power relations need to be managed and understood, as they can influence the attention to CAPS AD III users and the success of their treatment. Therefore, it is highlighted that the nursing team needs to carry out a critical analysis of the power relations present in their daily lives, as it is the professional category that remains at the CAPS 24 hours and monitors all stages of the user's treatment, their difficulties and achievements, managing to establish an interpersonal relationship.

The study is justified by the scarcity of research on this topic and the need to reflect on the presence of power relations in the mental health service and how this relationship can impact the user's care and treatment success. The study aims to understand the power relations present in the daily life of the nursing staff of a Psychosocial Care Center for Alcohol and Drugs III.

METHODOLOGY

Descriptive study with a qualitative approach developed in the Zona da Mata Mineira. The study setting was a CAPS ad III.

The intentional-type sample consisted of ten nursing professionals, including nurses and nursing technicians, who worked at the CAPS AD III. During the period of data collection, there were 15 professionals in the institution, and 10 professionals participated in the research and the others refused to participate in the study.

The inclusion criteria adopted were nursing professionals; nurses and technicians, who worked in a Psychosocial Care Center for Alcohol and Drugs III in the morning and afternoon. The exclusion criteria were nursing professionals who did not wish to participate in the research and those absent during the period of data collection, that is, leave and vacation. The research instrument was participant observation, recorded in a field diary and semi-structured interviews with the following variables: characterization of the participants and guiding question: How the nursing team perceives the power relations in their daily lives at the Psychosocial Care Center for Alcohol and Drugs III?

The initial approach to the participants took place in person at the CAPS ad, in which the individual invitation was made, the objectives explained, the reasons for carrying out the research, the right to participate or not and the possibility of withdrawing from the study at any time without any type of damage. Permission was requested from the CAPS coordinator and research participants to monitor the daily lives of these professionals and the possibility of recording in a field diary.

Data were collected after signing the Informed Consent Form (FICF), according to resolution 466/2012, from August to November 2016 through individual interviews recorded in audio (MP3), carried out at CAPS AD III, in offices in order to promote privacy to participants.

The interviews lasted from forty minutes to sixty minutes, in which only the researcher and the participant participated. After collection, the data from the interviews were submitted to Content Analysis proposed by Minayo. They were transcribed in full, manually organized in the Microsoft Word 2007 Program, followed by a floating reading of the participants' testimonies. Subsequently, successive readings were carried out in order to cut the testimonies into thematic units and construct analytical categories.

In this study, the following categories emerged: (a) "power in question: professionalism and work control", (b) "psychiatric power on the scene: still in search of the truth". In order to preserve anonymity,

all participants were treated with the letter "E" followed by the number corresponding to the order of the interviews.

This research followed the ethical precepts and aspects provided for in resolution 466/12 which regulates research involving human beings and was approved by the Ethics and Research Committee of the Federal University of Juiz de Fora under protocol number 1,459,570 on March 21, 2016.

RESULTS

The characterization of the research subjects revealed, as shown in table 1, that 70% of the nursing workers are female, with an average age of 45 years and 80% are married. Regarding training, all reported that they completed an undergraduate or technical nursing course between 2004 and 2012, 90% had no specialization in mental health and 50% reported having participated in training courses in mental health without a specific approach to nursing. Regarding professional performance in mental health, 90% have been working at CAPS ad for less than one year, due to the type of contract lasting one year. Only 10% of the participants reported having worked in a mental health service (asylum model) before the CAPS AD and informed that they had contact with mental health only during their undergraduate or technical course and that this would be their first contact as a professional in the psychosocial care model.

Variable	N	Value (%)
Gender		
Female	7	70
Male	3	30
Age (years)		
36 to 42	3	30
43 to 48	5	50
49 to 55	2	20
Marital status		
Single	2	20
Married	8	80
Course Completion Year		
2004 to 2008	7	70
2009 to 2012	3	30
Specialization in mental health		
Yes	1	10
No	9	90
Mental health training		
Yes	5	50
No	5	50
Experience in mental health		
Yes	1	10
No	9	90

Table 1 - Socio-demographic characterization of the nursing professionals who participated in the study.

Source: Larivoir COP, et al., 2016.

POWER IN QUESTION: PROFESSIONALISM AND WORK CONTROL

This category portrays that the presence of power in the relationships of the multidisciplinary team is part of the daily life of the CAPS Alcohol and Drugs III and generates feelings such as sadness, lack of motivation and impotence in the nursing team.

The presence of power in the relationships of the CAPS multidisciplinary team is declared by members of the nursing team:

> Unfortunately, the psychologist exerts a very strong power over our team. He has greater decision-making power than the nurse. It's very bad for our work (E10).

> I had two workshops, right? Which I don't do anymore. But on the part of other professionals, vanity speaks louder. Outsiders saw my work and came to congratulate me, but it bothered me. I think that nursing taking on two workshops was very good, it gave us power, recognition. (E1)

The power relationship can also be perceived during the participant observation technique. Professionals experience in their daily lives relationships that generate conflicts arising from the worldview, values, training and knowledge of each one. And this relationship is very present between the nursing team and psychology, which can generate surprise, as in the asylum environment, power was centralized in the physician, in his physical presence, and nursing was the watchman6,7.

In this sense, it is highlighted that, historically, nursing assumes a posture of subservience, based on characteristics such as obedience, humility, respect and hierarchy8.

Although work at CAPS ad must be carried out by a multidisciplinary team, in daily life there is still a lack of collective responsibility and interaction between this team.

By revisiting the field diary records, it is possible to validate this argument, based on notes referring to team discussions about the unique therapeutic project (PTS) for users.

> After a CAPS team meeting led by a psychology professional, professional E4 said: "did you see how psychologists and doctors discussed the PTS and didn't even want to hear our opinion (from nursing)?" "... in the end they just informed us what to do, follow what was prescribed on the paper, period". (notes of observation)

Thus, it is clear that the opinions of psychologists and physicians were a priority, limiting the nursing team to follow prescriptions and determinations, with no opportunity to contribute and express themselves.

It is necessary to clarify that the unique therapeutic project corresponds to a care plan with objectives and actions aimed at psychosocial care and its principle is to respect singularities and value the potential of the subject in psychological distress. Therefore, it is clear that power relations interfere in the construction of this therapeutic project, as it must be developed in an interdisciplinary and harmonious way9.

In this sense, it is essential to look at the administrative power present in CAPS ad, the management is centered on the psychologist, which gives this professional hegemonic power, previously centered in the hands of the psychiatrist. The testimonies of the participants illustrate this new "hierarchy" that is urgently needed in this CAPS:

> The psychologist rules here, in everything. For you to have an idea of what happens, the doctors do the consultations. They don't run things, they don't come to give orders. (E7)

> I cannot release over-the-counter medication, prescription medication. Then they get into trouble because we say no to them. (E1)

The speeches presented express the power of other professionals over the practices of the nursing team and it is clear that nursing professionals often do not understand and find it difficult to carry out a critical analysis of power relations in their daily lives10.

This power relationship between nursing and psychology apparently happens due to the fragility of the nursing profession in terms of its expertise, that is, its specific knowledge. [7].

One way to reduce this power is to seize knowledge, so a way for nursing to reduce the power that psychology exerts over it in CAPS ad would be to appropriate specific knowledge and thus be an autonomous, empowered profession with control over its work. Based on the above, the following statements are taken:

> There is a strong dispute in CAPS. we don't have autonomy, I can't release the team and I don't have space. We don't have the autonomy to decide, do things, even when we know what we're doing (E6)

> Sometimes someone from psychology comes and determines something for us, but we can't do it, either because we don't have material or because it involves over-the-counter medication. Then we don't say anything, it seems like there's nothing to say. We have a council, there is a law that guides, you know. (E9)

Respondents criticize the way they exercise their profession and the need to have a theoretical foundation to support their practice, gain autonomy and position themselves in front of other professionals [11,12].

Respondents criticize the way they exercise their profession and the need to have a theoretical foundation to support their practice, gain autonomy and position themselves in front of other professionals [13].

Therefore, it is up to nurses to reflect and propose nursing actions based on this specific knowledge and to develop innovative and dynamic mechanisms for their daily practice. You must motivate your team, value individual potential, have decision-making power, be an agent of change, empower yourself and your team. These characteristics will also reflect on care planning, recognition, valuing this professional and his team, in addition to contributing to a more autonomous practice12.

These power relations cause suffering in nursing professionals such as anguish and frustration due to the distance from some activities that were developed and that are important for users:

> But it was demotivating and the workshop was stopped. But who is harmed in this is not me, it's the user, right? And that's bad, I even have to review it, because they liked this work in the workshop a lot, you know. It's satisfactory, we had a huge garden, everything was beautiful, everything was tidy. They felt important, liked nature, this contact [...]. Then I got discouraged, but I want to go back, because they're not to blame. And it makes a big difference to them. It was a workshop that everyone liked (E1)

It can be seen in the report of E1 that the end of the therapeutic workshop caused anguish and regret in the professional from the moment he understood the impact it had on the quality of life of users who enjoyed the workshop and felt valued.

Therapeutic workshops are organized by professionals and interns and need to be understood as strategies that aim to produce life, rescue identity, opportunity to express themselves and social exchanges. However, these workshops are often not thought of from the perspective of the subjects, but only from the perspective of the professionals, their skills and disposition. [14].

In this sense, it is highlighted that the therapeutic workshop is a care technology that aims to strengthen the interpersonal relationship between professionals and users,

which provides freedom of expression and the opportunity for vocalization among users. For that, it needs to be planned with the participation of users and have well-structured objectives so that they are not reduced to a mere occupation of time [15].

It must be a warm, light, airy, free and alive environment. However, in the study setting, the workshops are held in a space with dim lighting, little air, no color and no life. Thus, it is understood that the environment also influences the development, adherence of users and the success of these activities.

It is necessary to reflect on nursing care, and reinforce that to take care of the other it is necessary to "be together", experience the present, look at the other in its existential dimension. This distancing from being together allows other professional categories to interfere in their work, in addition to disregarding the user in their biopsychosocial dimension [14].

PSYCHIATRIC POWER ON SCENE: STILL IN SEARCH OF THE TRUTH

This thematic category shows that even after the advances provided by the psychiatric reform, there is still the presence of psychiatric power in CAPS ad III, through practices based on asylum logic.

Madness must be understood beyond mental illness, and it is necessary to build new possibilities of relationship with the madman/madness, paying attention to the individual's subjectivities and the appreciation of their potential. [11].

In this sense, an anti-asylum movement emerged in Brazil, influenced by Basaglia, Foucault and others. The Psychiatric Reform movement goes beyond de-hospitalization and aims to propose a change in mental health practices and sensitize society to understand the subject with mental disorder and suffering from drug use as a human being [16].

However, "mini hospices" are being built inside some CAPS ad, with aspects that approach the logic of pious compassion that excludes the possibility of building the bond, which represses and is intended to generate dependence, gratitude and submission of the subject in psychic suffering [11]. It is noticed that the psychiatric power is evidenced in the speeches of the interviewees:

> The patient sometimes does not want to come to the CAPS, he is debilitated and the family wants him to be admitted here. (E3)

The practice of hospitalization and exclusion has a moral and social characteristic that produces segregation and alienated people, who are considered incapable of making decisions about their lives and have their behavior shaped and disciplined. [17].

It is noticed that in the CAPS ad where the research was conducted, users stay in back-up beds for a period of more than 14 days, which can be configured as hospitalization and reinforces the exclusionary practice based on asylum logic and loss of freedom.

When thinking about freedom, the idea of "panopticon" is underlined, which was interpreted by Foucault as the representation of a prison model with circular architecture and a high structure in the center with an observer who assumes the role of guard of the cells located below [18].

In this context, the subjects kept in this prison lose their freedom, develop feelings of insecurity, hesitation, fear and paranoia. If this idea of panopticon is shifted to modern society, it is observed that the CAPS ad in which the research took place reproduces this model as shown in the discourse:

> Just by looking at the patient, he leaves the place he is, he goes outside in fear, head down, uncomfortable. (E1)

At this point, it is necessary to revisit the records in the field diary that describe the architecture of CAPS ad and the constant

presence of the watchful eye surrounding users and alluding to the panopticon: this institution refers to a labyrinth, with narrow and long corridors, poor lighting, bars on the windows and the nursing station in a strategic location that allows professionals to view the wards, offices, corridor and external area of the CAPS ad.

It is noticed that even with the abolition of psychiatric hospitals and the proposal to go to CAPS ad, the individual wants to resume his life and return home. In this sense, the user experiences a situation that oppresses him, as his freedom, dialogue, the possibility of expressing himself, his decision-making power and his identity are taken away from him11.

The professionals' discourses remain rooted in the traditional model of psychiatry:

> At reception, I ask a few questions in an instrument that I use, because we need this data, right?! It's time to collect data. (E2)

> Welcoming is the moment of the interview. We don't do it here at the clinic, but there are several professionals who do it. It is the patient's first moment here and it is necessary to get to know him better. (E4)

Welcoming aims at being together, being available, listening without judgment, alterity, respecting the singularities of the other. Welcoming has no defined place, it can happen at any time, given the individual's needs and the professional's sensitivity19.

It is a time when the professional must value sensitive listening, look beyond the disease and dedicate their attention to the user who needs to feel supported and valued, which allows for the opening up of bonding. Therefore, it is necessary to understand the human being as a whole, understand him as a subject who has a history and is capable of transforming it[19].

Nursing care must be longitudinal and transversal and must be supported by the integration of care technologies to evidence-based practice [20].

The importance of reflecting on the need for nursing to rescue its essence is perceived, that is, personal, social, moral and spiritual involvement, in addition to seeking complicity with others, social relationships and forgotten values.

It is necessary to consider the social relationship from the experience of the other and the group to which it belongs. This process of reflection must be encouraged during the training of professionals, considering psychosocial care, the expanded clinic, individuals and oneself as a socio-political subject, preventing the academic from becoming a professional who has an alienated practice.

FINAL CONSIDERATIONS

Power and knowledge are related, as knowledge conditions the production of power. Health work promotes the interaction of knowledge and powers between the professional categories that make up the multidisciplinary team of a CAPS AD III and the process of changes and challenges that permeate mental health services make this environment full of power relations and conflicts.

Nursing is inserted in a context full of challenges in which it needs to reinvent itself, improve and incorporate specific knowledge into its practice.

It is believed that this study can encourage new discussions about possibilities, proposals and attitudes for mental health practices, contribute to reflection and understanding of the singularities of individuals in psychological distress and the subjectivities of nursing professionals working in this field.

Based on the above, it is believed that a limitation of this study is that it only covers one mental health service, considering that

it is the only CAPS aimed at users of alcohol and other drugs in the city. The inclusion of other institutions that make up the city's psychosocial care network may broaden the discussions on this issue involving mental health nursing.

REFERENCES

1. Rodrigues AAP, Xavier ML, Figueiredo MG, Almeida Filho AJ, Peres MAA. Influências da Reforma Psiquiátrica no cuidado de enfermagem na Casa de Saúde Esperança em Juiz de Fora, Minas Gerais, Brasil (1994-1998). Texto Contexto Enferm, 2016; 25(2):1-10. https://doi.org/10.1590/0104-07072016001450014

2. Galhardi CC, Matsukura TS. O cotidiano de adolescentes em um Centro de Atenção Psicossocial de Álcool e outras Drogas: realidades e desafios. Cad. Saúde Pública [Internet]. 2018; 34(3): 1 -12. Doi: https://doi.org/10.1590/0102-311x00150816.

3. Dias MO, Souza NVDO, Penna LHG, Gallasch CH. Perception of nursing leadership on the fight against the precariousness of working conditions. Rev Esc Enferm USP. 2019;53(2):1-8. DOI: http://dx.doi.org/10.1590/S1980-220X2018025503492

4. Dall Agnol EC, Meazza SG, Guimarães AN, Vendruscolo C, Testoni AK. Cuidado de enfermagem às pessoas com transtorno de personalidade borderline na perspectiva freireana. Rev Gaúcha Enferm. 2019;40(4):1-9 doi: https://doi. org/10.1590/1983-1447.2019.20180084.

5. Wermuth MAD, Santos ALC. Michel Foucault e a Arquealogia/genealogia do poder: da sociedade disciplinar à biopolítica. Rev Quaestio Iuris [Internet]. 2016; 1(9):405-24. doi: 10.12957/rqi.2016.17727

6. Silva IS, Arantes CIS. Power relations in the family health team: focus on nursing. Rev Bras Enferm [Internet]. 2017;70(3):580-7. DOI: http://dx.doi.org/10.1590/0034-7167-2015-0171

7. Foucault M. Arqueologia do Saber. São Paulo: E. Edições 70, 2016.

8. Mattar e Silva TW, Velloso ISC, Araújo MT, Fernandes ARK. Configuration of power relations in physicians and nurses' professional practices. Rev Bras Enferm. 2020;73 (Suppl 1): e20180629.doi: http://dx.doi.org/10.1590/0034-7167-2018-0629

9. Lopes LLT, Silva MRS, Santos AM, Oliveira JF. Multidisciplinary team actions of a Brazilian Psychosocial Care Center for Alcohol and Drugs. Rev Bras Enferm. 2019;72(6):1624-31. doi: http://dx.doi.org/10.1590/0034-7167-2018-0760

10. Almeida DB et al. Práticas de liberdade das enfermeiras militantes pela construção de outras modalidades de objetivação da enfermagem. Rev. baiana enferm. 2018; 32 (25160):1-11. DOI 10.18471/rbe.v32.25099

11. Foucault M. Vigiar e Punir: Nascimento da prisão. 42. ed. Petrópolis 2014. 302 p.

12. Bettin AC, Thohehrn MB, Porto AR. Processos relacionais em uma equipe interdisciplinar de atenção psicossocial. Rev. enferm UFPE on line. 2019; 13(2):322-9. doi.org/10.5205/1981-8963-v13i02a235197p322-329-2019

13. Marcelino CF, Alves DFS, Guirardello EB. Autonomia e controle do ambiente de trabalho por profissionais de Enfermagem reduzem índices de exaustão emocional. REME – Rev Min Enferm. 2018; 1101(22):1-6.doi: http://dx.doi.org/10.5935/1415-2762.20180029

14. Feo R, Rasmussen P, Wiechula R, Conroy T, Kitson A. Developing effective and caring nurse-patient relationships. Nurs Stand. 2017; 31(28):54-63. doi: 10.7748/ns.2017.e10735.

15. Cruz MPC, Monteiro CFS, Ibiapina ARS. Therapeutic workshops about mental health as a tool for psychosocial rehabilitation: perception of family members. Rev. enferm. UFPE. 2016; 10(11):3996-4002. doi.org/10.5205/1981-8963-v10i11a11482p3996-4002-2016

16. Fernandes RL, Miranda FAN. Analysis of the theory of interpesonal relationship: nursing care in psychosocial care centers. Rev enferm UFPE on line. 2016; 10(Supl. 2):880-6. DOI: 10.5205/reuol.6884-59404-2-SM-1.1002sup201624

17. Laurido NC. The dynamics of work in hospitals and the insertion of nursing in power relations according to Foucault. REAS-Revista Eletrônica Acervo Saúde.2018; 13(Suppl): 1551-6. DOI: 10.25248/REAS311_2018

18. Almeida DB et al. Nursing disciplinary resources: a historical and foucauldian study. Acta Paul Enferm. 2017; 30(6):598-606. https://doi.org/10.1590/1982-0194201700084

19. Lopes PF, Melo LL, Moreno V, Toledo VP. Embracement of people with mental illness at an emergency hospital service: a qualitative research. Rev Bras Enferm. 2020;73(2):e20180671. doi: http://dx.doi.org/10.1590/0034-7167-2018-0671

20. Campos DB, Bezerra IC, Jorge MSB. Mental health care technologies: Primary Care practices and processes. Rev Bras Enferm [Internet]. 2018;71(Suppl 5):2101-8. [Thematic Issue: Mental health] DOI: http://dx.doi.org/10.1590/0034-7167-2017-0478