

ASSISTANCE RELATION WITH PSYCHIATRIC PATIENT: BEYOND THE MEDICAL PARADIGM

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This is a descriptive, exploratory case research that intends to analyze a non-directed interaction of a nurse with a schizophrenia female patient. The interaction was recorded, transcribed and subjected to thematic analysis. We have identified five themes, which were discussed based on the scientific literature on interpersonal relationship and non-directed assistance. The results have showed us the importance of listening, genuine interest and professional availability, that, when recognized by the patient, provide identifying and addressing their real needs. Establishing a bond has been shown capable to stimulate the patient confidence regarding the professional.

Descriptors: Interpersonal Relations; Schizophrenia; Psychiatric Nursing.

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RELAÇÃO DE AJUDA COM PACIENTE PSIQUIÁTRICO: ALÉM DO PARADIGMA MÉDICO

Estudo de caso exploratório-descritivo com o objetivo de analisar interação não diretiva da enfermeira com uma portadora de esquizofrenia. A interação foi gravada, transcrita e submetida à análise temática. Foram identificados cinco temas, os quais foram discutidos com base na literatura científica sobre relacionamento interpessoal e relação de ajuda não diretiva. Os resultados permitiram identificar a importância da escuta, do interesse genuíno e da disponibilidade do profissional que, ao ser reconhecida pela paciente, favorece a identificação e a abordagem de suas verdadeiras necessidades. O estabelecimento do vínculo se mostrou capaz de estimular a confiança do paciente no profissional.

Descritores: Relações Interpessoais; Esquizofrenia; Enfermagem Psiquiátrica.

RELACIÓN DE AYUDA CON PACIENTE PSIQUIÁTRICO: ADEMÁS DEL PARADIGMA MÉDICO

Estudio de caso exploratorio descriptivo con el objetivo de analizar una interacción no directiva de la enfermera con una portadora de esquizofrenia. La interacción fue grabada, transcrita y sometida a lo análisis temática. Fueron identificados cinco temas, quiénes fueron discutidos con base en la literatura científica sobre relación interpersonal y relación de ayuda no directiva. Los resultados permitieron identificar la importancia de la escucha, del interés genuino y de la disponibilidad del profesional que, cuando reconocidos por el paciente favorecen la identificación y el abordaje de sus verdaderas necesidades. El establecimiento del vínculo se mostró capaz de estimular la confianza del paciente en el profesional.

Descriptores: Relaciones Interpersonales; Esquizofrenia; Enfermería Psiquiátrica.

Introduction

Mental disorder is a condition associated with intense suffering for the patient and family. Suffering is caused not only by experienced psychic changes, but also by losses in personal relationships, in social and affective life. As a result of changes, the individual begins to realize that the disorder is full of anxieties and limitations. Therefore, suffering is recognized as a subjective process, social and cultural that goes beyond the organic dimension⁽¹⁻³⁾.

Thus, it is understood that the approach with mental disorder individuals should be broader than the purely biological approach, defended by the medical paradigm and adopted by the psychiatric hospital model. In this paradigm in which the doctor-patient relationship is vertical, the individual experiences the disorder passively,

without assuming his/her autonomy in the disease process. It constitutes a reductionist approach and strictly biological, assuming the disease as the focus of intervention, an oppressive and dehumanizing practice⁽⁴⁻⁵⁾.

The biopsychosocial paradigm, in turn, is more complex because it requires a multidisciplinary approach for mental disorder; it recognizes the subjectivity and the meaning attributed to suffering by the individual, considering the doctor-patient horizontal relationship with recognition of the potential and co-responsibility of the individual in his/her treatment, and therefore, subject to his/her history⁽⁶⁻⁹⁾.

The doctor-patient relationship is essential in nursing care in biopsychosocial rehabilitation of mental disorder

individuals. The therapeutic relationship helps the mental disorder individual to better express his/her feelings and to understand the experience, because it reproduces the positive experiences of the doctor-patient relationship in other interpersonal relationships^(8,10 to 13).

The professional concern during the knowledge process of the patient and his/her reality is to understand what he/she communicates, to identify his/her needs, to support his/her decisions and to guide when needed. The ultimate objective of all these actions is to help the person so that he/she finds resources to overcome the limitations and difficulties^(8,10 to 14).

The approach centered on the individual is a transcending way comparing to the traditional psychiatry paradigm and it materializes through the non-directed assistance. It is recognized as a life philosophy that believes in the potential for growth, recovery and cure human being, therefore, it is not limited to the therapy environment^(8,15-16).

In this approach, there is no room for professional paternalistic attitudes. It is recognized that the most effective mechanisms to assist others are not professional behaviors, but the individual himself, the professional is only a facilitator of this discovery process of these potential^(8,15).

There is great resistance of professionals and health care services in adopting a person centered approach, because it contradicts and challenges the traditional medical paradigm of psychiatry, characterized by professional detachment, judgmental attitudes, by establishing diagnostic and technical language. Therefore, it is necessary that studies show the therapeutic effects of the assistance grounded in humanistic approach, centered on the person under the care of nurses.

Thus, this study intends to analyze a non-directed interaction of a nurse with a schizophrenia female patient.

Methodology

This study was developed during "Interpersonal nurse-patient relationship" classes, held at the Graduate Program in Psychiatric Nursing, School of Nursing of Ribeirão Preto (EERP/USP). It is part of the research entitled "Research and teaching of interpersonal relations in nursing," with permission of the Ethics Committee of EERP/USP, protocol 0151/01.

To achieve the proposed objectives it was used qualitative research on exploratory and descriptive case study. The case study is a type of research that proposes to search a complex phenomenon with a limited number of individuals or groups.

From case study there are recognized the two methodological approaches: a descriptive and exploratory research. Exploratory research considers the prior insertion of the researcher in the field where the research will be conducted and its contact with the phenomenon to be studied. It allows us to consider hypotheses and reflections.

In descriptive research the researcher tries to understand and from this understanding he describes the

phenomenon studied in all its nuance and complexity, as well as factors associated with it. Therefore, a descriptive exploratory is a case in which, based on the exploitation of a particular phenomenon, from the experience of the researcher in the research field, tries to describe, understandably, a limited reality⁽¹⁷⁻¹⁸⁾.

This research was a non-directive interaction, lasting about 40 minutes, at the home of a patient with schizophrenia, located next to a Family Health Center (FHC), in the countryside of the state São Paulo. The patient was chosen for the interaction, as she had already a pre-established relationship with the nurse who was accompanied her for a period of four months during an internship program of the undergraduate course.

First, it was explained to the patient the purpose of the interaction and the ethical aspects related to her participation. After understanding and clarification of doubts two copies of the informed consent were signed. The interaction was recorded, fully transcribed, with identification of the nurse's speech with the letter "N" and the patient's speech with the letter "P", and later, it was presented to teachers and students during the classes, based on the academic content of non-directivity of person-centered therapy.

The interaction was held in the house of the patient, with nurse and patient sitting facing each other at a distance not exceeding one meter, so as to avoid the establishment of asymmetrical relation by empowering the professional figure.

Patient Mrs. M., 59 years old, female, separated, mother of four children, living for three years in the city of Marília. She lives in a two-room in a rented place. She has a distant relationship with her family who live in another city. Medical diagnosis: urinary calculi, cholelithiasis without surgery, diabetes mellitus, schizophrenia, hypertension, hypothyroidism, mild mental retardation and varicose veins of the lower limbs. She makes use of the following medications: Atenolol 50mg (1-1-0); Indian Chestnut 280mg (1-0-1); Enalapril 20mg (1-1-1); Haloperidol 10 drops early and at night, Omeprazole 20mg (1-0 - 0); Promethazine 25mg (0-0-2) and Puran 25mg (1-0-0).

Mrs. M. frequently goes to FHC. She attends the Unit, daily, during assistance period, and whenever possible, during the period reserved for scheduled appointments. She always complains a lot, requiring the professionals' attention. Since she does not live with her family and has some limitation to administer her own medication, the FHC team is responsible for preparing her daily use medicines. Mrs. M. has a very strong bond with the professionals, possibly to compensate the lack of her family.

For the interaction analysis between the nurse and this patient there were selected text fragments, grouped into thematic units, from which there were created dialogues with the scientific literature on interpersonal relationship and non-directive assistance.

Results

During the interaction with the patient it was not noticed any inhibition or fear to the voice recorder.

However, some issues considered important by the patient, such as her dissatisfaction with the house, could not be widely discussed, because although the interaction occurred in a more reserved place, she was not comfortable to talk about the house. This is recognized in the scientific literature when it is stated that the local where interactions occur can positively or negatively influence the course of an interaction⁽¹⁰⁾.

By analyzing the interaction transcript it was possible to identify five themes, which address the professional-patient relationship, medications, anxiety, problems with housing and suffering due to family relationships.

Professional-patient relationship

It was found a few factors that contributed to the interaction development: the pre-established nurse-patient relationship, the availability of time and availability to listen to the other person. These factors have made possible to address some experiences and perceptions of the patient that, in four months of assistance had not been addressed or given due weight.

It is important that even though it had occurred earlier interactions with the patient, each interaction held has its own characteristics due to the uniqueness of each meeting, what makes us think that the professional-patient relationship is not simple and immediate, but gradually built^(10,19).

The patient reported feeling cared for the nurse when introduced her to a third person who appeared in the course of interaction:

P: [...] *is opposite of the girl who took care of me.*

The bond that was evident in the interaction is recognized as part of the care plan as it contributes to greater satisfaction and patient adherence to health services. Typically, it happens from the first contact, this assistance is understood not only as the waiting room activity, but also with gestures and attitudes. The care is not passive, but an active process when the professional recognizes the patient as having the right to be treated with dignity and respect, valuing his/her autonomy and uniqueness⁽¹⁹⁾.

By analyzing the details of the professional-patient interaction it was observed that the fact that both have had previous intense contact has favored the patient to create an overvalued idea and proximity to the nurse, when she talks to her using some characteristic expressions.

P: [...] *Last night I did not sleep at all, girl!*

P: [...] *It is not all right, girl, I still go there with a companion.*

P: *Who doesn't gal?*

P: *Wow, blessed R.! [Laughter]*

Used medications

In the interaction it was possible to notice some recurring subjects used by the patient, as the use of medication. It is interesting to note that right at the start of the interaction when the nurse asks the patient to tell how she is doing, so to allow her to approach a subject of greater relevance and meaning according to her perception, the medication issue is introduced in order to justify her status current.

N: *Mrs. M., Tell me how you are. It has been a while since I do not see you...*

P: *So so... I'm not going very well, R., because I have insomnia! Did not get the "prazolam" yet!*

N: *Alprazolam?*

P: *Alprazolam. A [doctor] sends me to another, one pushes for another one and Mrs. M. is sleepless [accelerated speech].*

N: *Since that time, Mrs. M?...*

P: *Since that time I don't sleep, girl! [Exalted speech] I make lemongrass tea, yes, there is also lemongrass there, but it doesn't work. I have to take a depressant.*

In this passage it is evident the fact that the nurse and the patient had had previous contacts over an assistance of four months has facilitated the beginning of the interaction. Calling the patient by the name from the beginning has valued her unique way of being, reflecting the way the patient referred to the nurse also calling her by name throughout the entire interaction.

When the patient introduces the medication subject, the nurse just questions its name through the repetition technique, which allowed the patient to continue her speech, showing the most afflicted issue, that is, the fact that they were not prescribing her medication.

The used techniques by the professional during an interaction are not predetermined. They come according to the need of the moment since it is clear that the ultimate objective is to get the patient to reflect and to find meaning to his/her experiences. Answers should not be given. Through repetition, the professional just calls the patient's attention to a particular subject, and the patient decides to continue or not to speak, as according to his/her need and desire⁽¹⁵⁾.

The medication issue is perceived as clearly linked to protection for family relationships, showing psychological addiction to the medication.

P: *If she prescribed the Alprazolam I was even going to my son's house; I would stay at least eight days there.*

Throughout the interaction it was not possible to fully understand the medication issue reported by the patient, because she referred to the medications Alprazolam and Clonazepam from time to time. Faced with this impasse, the nurse used the clarification technique in order to understand the message^(10-11, 15).

N: *Excuse me, Mrs. M., but let me understand something... Why the change from Alprazolam to this one [Clonazepam]?*

P: *Because Alprazolam was given me by Dr. J. [...] And this one was Dr. S... No! It was a new one that replace S. Get it? It was a new doctor.*

N: *And then you never came back to the other?*

P: *Never came back to Alprazolam.*

N: *Has you not adapted to this one [Clonazepam]?*

P: *If I could sleep with this one? I did.*

Although the nurse has been using some closed questions, which can induce responses, this allowed her to understand the issue involved regarding the medication.

N: *Now I understand ... You feel like that because you are out of that medicine. How long have you been without the medicine?*

P: *I'm 30 days without the medication [...] Oh, my Goodness! So, R., if Dr. S. had given me Alprazolam...*

N: *Let me explain something to you, Mrs. M. I do not know why they have chosen not continue with Alprazolam. To be honest with you I do not know why. Bu,t this Clonazepam has similar*

function as Alprazolam. Why are you getting anxious and not sleeping? Because you are not taking it?

P: Yes, I'm not taking it, it doesn't quiet the mind.

N: If you had Alprazolam and not taken it, you would be the same.

P: Really?

N: There is no point just wanting Alprazolam if you are not taking [Clonazepam] as you should; it is not going to solve it anyway.

In this excerpt, the nurse tries to help the patient to understand the need for medication and the fact that Clonazepam has been prescribed in order to replace Alprazolam, considering that both have the same purpose. Interestingly, the confusion that the patient confusion between these two medications led her to stay a long period without medication, because for FHC professionals it was not clear that when the patient requested Alprazolam, in reality she was not being able to distinguish between two medications.

Anxiety

Throughout the interaction it was perceived great anxiety in the patient, which was evident through verbal and non-verbal communication.

P: [...] I'm super well, you know ... Anxious! I was nervous, I thought I was going to surgery and get well soon, and not get worried. Then, I didn't get it... It is going to be in 30 days. I said to the social worker: Schedule it! "Ah, no, the doctor said so".

N: But Mrs. M., is this anxiety because of this surgery or is there something else going on?

P: No, it is only due to insomnia. I cannot sleep and then I just want to do something, to work, I cannot sit still. I'm not that type because I have to react. The doctor said: "What courage, Mrs. M.! I have never seen a woman like you." And I tell her: "Doctor, you need to give me the prazolam prescription". And she says: "It is the other [doctor], it is the other!" And keeps tricking me...

The patient shows lack of understanding about the medical resistance to prescribe the requested medication. The fact that she is not part of her treatment plan, it is difficult for professionals to introduce her in the care plan or difficulty of understanding and acceptance her conduct increases her anxiety.

When the patient says that the surgery was postponed by medical order and that she feels "tricked" in relation to medication non-prescription is evident her perception of the hierarchy and the detachment of the professional figure that assumes, in this case, a paternalistic conduct by deciding to believe what is best for the patient, regardless her autonomy and right to be part in the decision process.

When asked about the reason for the anxiety, the patient attaches to insomnia, but in the course of interaction there are several explanations for this condition.

Noticing the anxiety of the patient during the reporting and her impatience regarding the medication, the nurse tries to control this anxiety by asking questions in order to try to clarify the content of the conversation, which is, confusedly, presented by the patient.

N: The other one you talk about is that one from the medical clinic, right?

P: It is the one from the Mental Health.

N: And doesn't she want to prescribe you Alprazolam?

P: She doesn't...

N: And neither Dr. S... [FHC doctor]

P: Dr.S. neither. One sends to other, who sends to other, and the time is flying.

N: What are thinking about this?

P: What do you think, R.?

N: I want to know what you are thinking... Because, look, from the time that we have known any of the doctors wanted to give the prescription for you ...

P: I don't know, R...

N: And you want the medication.

P: [Laughter] I don't know, R., if they don't want me to take it, maybe it will damage the head that is no alright.

When asked in order to clarify the direction of the conversation, the patient answers to questions in a more rhythmic way as she is asked to do a review of the current situation. An important moment is when the nurse asks what she is thinking about the doctors' resistance prescribing the medication; when, at first, she returns the question in order to know the nurse's opinion. Returning the responsibility for the patient's reflection, she seems to have an insight of the situation, which was only possible after her anxiety being contained and she could assume her autonomy to have the opportunity to reflect the experienced reality.

Problems with housing

Throughout the interaction, the patient was found to have more confidence in the nurse when there were issues addressed during the previous monitoring period.

P: Here, R., there are two rooms, a kitchen and a bedroom ... There is a big room over there, but she [the house's owner] has taken it.

N: I did not know you lived with another person.

P: She is the owner; I pay R\$120.00 for the two rooms. I have my double bed; it's above the wardrobe, to be placed here. She said: "there is no space, M.! There is no space! Oh, girl, so, I know it's the sleep; not sleeping is being terrible to me..."

N: Did you begin to get this way after he learned about the surgery?

P: Yes, Then I didn't sleep anymore.

After realizing that the patient spontaneously introduced the subject of housing, showing dissatisfaction with the situation, the nurse encouraged the continuation of the story to verbalize unawareness of the situation. However, when the patient appears to stop talking about housing and complains again about sleeping, the nurse changes the focus of the conversation and asks directly if the patient began to have trouble sleeping after she learned about the surgery postponement, the patient confirms, since a inductive question was made.

A little later, the patient reintroduces the housing issue.

N: What do you think about at night?

P: I can't sleep, R., I spend the all night awakened. Oh my God! [She decreases the voice tone]. I keep thinking on a house to move out, you know? I keep thinking on a house to set, to get it right. Everything was there for my stuff [in the other room], even B. [FHC nursing auxiliary] came here and found my house pretty. Everything was right, now, girl, it's all tight. That is no way, right...

N: So, are you thinking about another place?

P: *A bigger house, right, or even, spend some time with the children. Let's see what I do.*

It seems clearer for the nurse the patient's need to talk about housing. When using the repetition technique it favors the continuity of the patient's speech and the introduction of a second factor of great importance in her life, her family.

Suffering due to family relationship

As the patient mentioned the children to complain about the house, the nurse took the opportunity to try to understand the family relationships of this lady.

N: *Where do you children live?*

P: *They live on a farm; R. [...] I have four children, the other lives with his father, the sickly. I have a sickly child with mental problem.*

N: *With whom does he live?*

P: *With his father... I am separated.*

N: *For how long are you separated?*

P: *15 years.*

N: *A long time, right, Mrs. M.?!?*

Although the nurse has tried to encourage the patient to continue talking about her family, the patient is reflective for a moment to think of the time and seem not to contain the anxiety generated, when accelerates her speech and shifts entirely the focus of the conversation.

P: *It's been a long time, R., a lot! So... A long time... [Accelerates the speech]. So, did you really get a degree?! I wasn't seeing you, then I remembered you this week that I was there. I said: "I'm not seeing that white girls anymore", but I forgot your name, my mind is weird. And do you remember me?...*

N: *I do...*

P: *I recognized you by the face, the assistance center girl.*

Gently, the nurse tries to take the focus of herself and continues talking about the patient's family.

N: *But Mrs. M., continuing the children issue and thinking of another place to live, why do you not live with your children? What is going on?*

P: *Ah, well, R., it's because they live far from the assistance center, they live far [...] And I have to stay here, girl!*

It is curious that, although at first the patient has suggested the possibility of moving in with her children, when the subject is discussed by the nurse she cannot to control her anxiety and discomfort at the situation, so she tries to close the matter stating that she needs to stay where she is, seemingly asking to finalize the matter.

Realizing the patient resistance to talk about her family, the nurse left the subject, respecting the limit demonstrated by its high degree of anxiety and resistance. So she introduced other subjects.

P: *Yesterday I tried to change those plants there, but oh my God! I felt pain by getting those plants there.*

N: *Did you change their place?*

P: *I did, I put everything outside to water them. I like plant, I lived on a farm and there were plants, gardens...*

As the patient mentions the past, the nurse took the opportunity to try to reintroduce the marriage subject and seemed to become clearer the connection the patient makes between family relationships, previous and current housing.

N: *Was this when you were married?*

P: *I was married... Wow, girl! My house was neat, a neat, the aluminums were like mirrors!*

N: *Do you miss that time?*

P: *I do! [Answers promptly] A lot! Because all was organized, waxed house, eight rooms, I cleaned... I miss it a lot! Who doesn't, gal? Now I have to stay here, Jesus Christ! There's a lot in here [decreases tone of speech]...*

N: *Would you have condition to move to another place?*

P: *I will look for, R., near here... I can't stay here, tight. I want my bed, I put the mattress upstairs. I want my bed, to see if I can sleep. I must react! Well, my husband left me, but I need to react, right?*

At first, the patient was completely resistant to talk about her family. But because the nurse respected her limit and interest, the patient herself talked about the subject. This time, when the nurse makes the approach the patient talks about the reason for the split, verbalizing her suffering.

N: *Do you still get in touch with your husband?*

P: *No! He has another women and I don't care anymore. Not even if he wants I don't come back to him. I want to see my son.*

N: *What happened so you got separated? If you do not mind talking...*

P: *No... It's because he started drinking and hurting me. He hurt me and this is why I have bad thinking.*

N: *What do you mean he hut you?*

P: *He hit me! He hurt, girl, he hit. I felt angry about him. I don't like him, no way.*

It is evident the suffering experienced when the patient attributes the mental disorder, referred to as "bad thinking", to her husband's attitudes with her in the past. This opening of the patient was only possible because the nurse knew to respect her time to speak on the subject, which certainly increased the confidence of the patient in the nurse. It seems she has a mix of frustration by marriage breakup with distance from the family and a sense of struggle to show she can stay well alone.

Conclusion

In this research it was possible to identify that the bonding is able to boost the patient's confidence, suffering of schizophrenia. In respect of non-directed assistance, the therapeutic instrument used in care is the nurse itself and not just the technical procedures and medications, widespread in medical paradigm.

It is observed, thus, the humanization of nursing care. In the interaction with the patient suffering with schizophrenia, it was noticed the importance of listening, genuine interest and availability of nurses, which are recognized by the patient, favor identifying and addressing the true needs of the person who needs assistance, what characterizes the therapeutic relationship.

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