

# Application of the therapeutic relationship to people with common mental disorder

*Aplicação do relacionamento terapêutico a pessoas com transtorno mental comum*

*Aplicación de la relación terapéutica para personas con trastorno mental común*



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#### ABSTRACT

**Objective:** To report the results from applying a therapeutic relationship to people with common mental disorder.

**Method:** Quantitative, descriptive, before and after study, conducted with 112 records accessed from an extension project in mental health in primary health care in Santo André, São Paulo. Screening was performed using a Self-Reporting Questionnaire. Data was collected in October 2014 and analyzed using simple frequency measures.

**Results:** The entry score ranged between 7 and 18 points, and the higher the frequency, the more relationship sessions were necessary. At the end of the relationship process, 55% had a negative score and 45% passed the score  $\leq 3$ .

**Conclusion:** Therapeutic relationship as nursing care in mental health transcends the area of specialty. Continuous review and process redirecting led users to enlarge their view of the suffering triggers, build coping strategies and exercise changes in daily life.

**Keywords:** Mental Health. Primary Health Care Nursing. Mental health assistance.

#### RESUMO

**Objetivo:** Descrever o resultado da aplicação do relacionamento terapêutico a pessoas com transtorno mental comum.

**Método:** Estudo quantitativo, descritivo, tipo antes e depois, conduzido com 112 prontuários acessados de um projeto de extensão em saúde mental na Atenção Primária à Saúde em Santo André, São Paulo. Utilizou-se o *Self-Reporting Questionnaire* para rastreamento. Dados coletados em outubro de 2014 e analisados por meio de medidas de frequência simples.

**Resultados:** O escore de entrada variou entre 07 e 18 pontos, e, quanto maior, mais sessões de relacionamento foram necessárias. Ao final do processo do relacionamento, 55% da amostra apresentaram escore negativo e 45% passaram à pontuação  $\leq 3$ .

**Conclusão:** O relacionamento terapêutico como cuidado em enfermagem em saúde mental transcende ao espaço da especialidade. A reavaliação contínua e o redirecionamento do processo conduziram os usuários a ampliar a visão sobre os desencadeadores de sofrimento, construir estratégias de enfrentamento e exercitar mudanças no cotidiano.

**Palavras-chave:** Saúde mental. Atenção primária à saúde. Enfermagem. Assistência em saúde mental.

#### RESUMEN

**Objetivo:** Describir el resultado de aplicar la relación terapéutica para personas con trastorno mental común.

**Método:** Estudio cuantitativo, descriptivo tipo antes y después, llevó a cabo con 112 registros a los que se accede desde un proyecto de extensión de la salud mental en la atención primaria de salud en Santo André, Sao Paulo. Se utiliza el *Self-Reporting Questionnaire* de divulgación para el rastreo. Los datos recogidos en octubre de 2014 y se analizaron utilizando medidas de frecuencia simples.

**Resultados:** La puntuación de entrada osciló entre 7 y 18 puntos y cuanto más alta la relación más sesiones eran necesarias. Al final del proceso de la relación 55% tenían puntuación negativa y el 45% apasó la puntuación  $\leq 3$ .

**Conclusión:** La relación terapéutica como cuidados de enfermería en salud mental trasciende el ámbito de la especialidad. La revisión continua y el redireccionamiento del proceso condujeron a los usuarios a ampliar la visión de los factores desencadenantes de sufrimiento, construir estrategias de enfrentamiento y ejercitar cambios en el cotidiano.

**Palabras clave:** Salud mental. Atención primaria de salud. Enfermería. Atención en salud mental.

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## ■ INTRODUCTION

Common mental disorder (CMD) is a concept that was systematized by Goldberg & Huxley in 1992<sup>(1)</sup> to designate nonspecific somatic complaints that do not present signs and psychotic symptoms, that do not meet the criteria for depressive, anxiety or somatoform disorders, according to the International classification of Diseases (ICD – 10) and the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), but produce functional impairment comparable and sometimes superior to chronic mental disorders.

Insomnia, irritability, fatigue, difficulty concentrating, forgetfulness and somatic complaints are characteristic of CMD, representing one of the most important causes of morbidity in Primary Health Care (PHC), indicating the need to implement public policies due to the considerable impact in the individual's quality of life and the health system, due to the high demand<sup>(2)</sup>, generating overloads due to the costs, the high hospitalization rate and unnecessary request for tests<sup>(3)</sup>.

The prevalence of CMD in the world varies from 24.6% to 45.3% and in Brazil, it ranges from 28.7% to 50%<sup>(4)</sup>. Although prevalent in the general population, it is more associated with women, the elderly, people with low socioeconomic and educational levels, and is included in the projections for 2030 as one of the most disabling disorders<sup>(5)</sup>. The need to provide mental health care, whether in medical-psychological consultations, through advice or guidance groups, is indicated for about 10 to 12% of the population suffering from CMD<sup>(6)</sup>.

It is in PHS (Primary health care services) that people with CMD seek to be accepted, understood and have their needs met. However, nonspecific complaints common to this disorder are not immediately recognized by professionals due to higher valuation for physical complaints, legitimated by the biomedical model<sup>(6)</sup>. Few cases are diagnosed and many are often underestimated, especially when physical symptoms are not present, and reflected in the inadequate treatment and pilgrimage of users through health services<sup>(3)</sup>. The World Health Organization (WHO) points out the importance that the PHC has in developing actions to promote mental health and highlights tracking, routing and monitoring of people with mental disorders<sup>(6)</sup>.

The misunderstanding about the expression of suffering in people with CMD is allocated to the technical incompetence of the teams and services to recognize people in these circumstances. Stereotypes of people with multiple complaints as being problematic and hysterical, commonly used adjectives, compromise the clinical practice before this health condition<sup>(7)</sup>. The PHC is a fertile place for the

provision of mental health services in a geographically known territory and enables proximity for health professionals to know the life story of its users<sup>(8)</sup>.

Redirection of the care model in Mental Health (MH) calls for the inclusion of their practices in the PHC. However, in this scenario, therapeutic actions performed by nurses, both for people with severe and persistent conditions and those with mild complaints, compatible with CMD, need to be consolidated. Mental Health strategies in this field are welcomed and strengthen the participation of nurses in the agenda of the necessary link between these two areas. It is in this scope that this study is presented, showing results of an extension project that connects the recognition of people in mental distress and the pragmatic nursing actions, anchored in the theory of the therapeutic relationship (TR)<sup>(9)</sup>.

TR, or person-to-person relationship, comprises planned interactions between the nurse and the person who needs help with defined goals and mutual commitment. As a therapeutic process centered on the person, it constitutes a repertoire of knowledge and practices that enables understanding the human being in its complexity, and its application promotes growth and behavior change among those involved.

TR theory includes four phases with its own characteristics: Pre-interaction, the professional gathers the information necessary to develop the relationship and acknowledges feelings arising from impressions of the person consulted; Introductory or orientation phase, in which those involved have committed to the TR; Full development of TR, with resolution of user-identified problems, and Closure: analysis phase on the achievement of goals set and re-evaluated throughout the process<sup>(9)</sup>. The phases are not rigid and may overlap.

A study on CMD indicates the need for PHC organization in the development of promotional activities focusing on mental health and highlights the construction of nursing practices to address this population<sup>(4)</sup>. The application of TR to people with CMD is a knowledge gap, since this care technology is most commonly performed in specialized areas of mental health and is new to the field of PHC. Therefore, we are interested in knowing: what is the effect of applying TR technology in people with CMD? Starting from the research question, this study aims to: describe the result of applying the therapeutic relationship (TR) to people with common mental disorder.

## ■ METHOD

Quantitative, descriptive study type before and after where the evaluation criterion is subjective and can the

patients themselves can be used as their own control, in addition to or as can specific questionnaires validated for this purpose<sup>(10)</sup>. Held in the Projeto de Extensão de Enfermagem em Saúde Mental (Nursing Extension Project in Mental Health), at the PHC, entitled Nursing Serviço de Enfermagem em Saúde Mental (SESM, or Nursing Service in Mental Health – NSMH, in English), developed in a Basic Health Unit in the city of Santo André, Southeastern Brazil. SESM was carried out from July 2012 to August 2014, based on the TR technique, supported by TR theory<sup>(9)</sup>, as an academic teaching and learning space.

The SESM is part of a Nursing Extension Project in Gerontology (Projeto de Extensão de Enfermagem em Gerontologia), started in 2010 and completed in 2014 at the same location, which provides services to aging and/or elderly people, as well as their caregivers. Users coming to SESM are sent from nursing consultations in gerontology, coordinated by teachers of the elderly health discipline. The criterion to forward users to SESM is in the mental health demand detected subjectively by the professional. The user experiences three stages in SESM:

1st stage: Nursing Consultation conducted by faculty, nursing student of the mental health discipline nurses who take part in the project. At this stage questions are raised that will be added to the patient's record in the service. They address demographic data, family and social life, difficulties/conflicts that brought the patients to the consultation, mental status exams, the context of the history of life, all this information subsidizes the development of TR and the systematization of nursing care.

TMC screening is also performed through the *Self-Reporting Questionnaire* (SRQ-20)<sup>(2)</sup>, an instrument recommended by WHO for studies in PHC. The SRQ-20 contains 20 questions related to mental health condition IN the last 30 days, with yes/no answers, divided into four areas Depressive/Anxious Humor, Somatic symptoms, Vital energy decrease and Depressive thoughts). With a Final Score consisting of the sum of each affirmative answer, which can vary from 0 (no likelihood of CMD) to 20 (extreme probable CMD). According to the cutoff point  $\geq$  seven (score considered for both sexes)<sup>(4)</sup> the person is inserted in the next step, where the number of three consecutive absences without justification is agreed for as grounds for termination. Autonomy was considered as inclusion criteria to participate or not in the proposal.

In the 2nd step, the completion of the TR developed by general nurses and/or mental health nursing specialists, project volunteers, takes place. TR interactions are conducted in a private atmosphere with weekly and/or biweekly meetings, according to the contract between

user-nurse, lasting fifty minutes each. Each meeting takes place according to the information and systematized goals in pre-interaction and subsequent events<sup>(9)</sup>. The user to tell their story over and over again. tells his story one, two, three or more times. This replay process is a way of putting pieces together and cognitively organizing the event so that it can be integrated into the parts together and cognitively organizing the event that caused the suffering, and helps the user talk about it. In conducting the TR, the nurse provides support for the user to re-establish a sense of control over little day-to-day things. It also allow them to make decisions for themselves and to take an active role in planning allows space and time for the patients to make decisions by themselves and develop an active role in planning their future. their future. The user is led to recognize and express As time goes by, memory will reveal other parts of the event. thoughts and feelings (anxiety, anger, helplessness, guilt), evaluate egocentric behavior, depressive symptoms, anxiety, etc. The victimization story will probably change over time as they learn new things and us

Over the course of TR, the individuals have their tension diminished, and begin to see real possibilities for change in family and social relationships, finding meaningful solutions to their lives. It gives the user an opportunity for the possibility to feel they belong to a group, are recognized, valued and able and empowered to meet daily demands. In the process, users learn new things and make use the new information to reorganize their memories. of new information to reorganize and (re)define their memories and their life history<sup>(9)</sup>. Application of TR is a complex task and requires knowledge and practices from the nurse to understand the totality of the human being, regarding its limitations, possibilities, immediate needs and potential<sup>(11)</sup>, and self – knowledge, for the way the nurse experiences their relationship with the user can influence their behavior and actions in the workplace<sup>(12)</sup>.

The TR is a technology carried out by nurses, where its conduct is limited to members of the nursing team. In SESM, sharing the TR process with the health team happens through case discussions. Preserving history and securing access to information only to those who can contribute to the continuity of care is an ethical project issue and one of TR itself.

The RT is a person-to-person relationship where both participants (professional and patient) are transformed. When dealing with the complexity of user demands, nurses need to appropriate knowledge about the human condition and mental health. Identifying with aspects of the user's life is natural in this process, but it is imperative to separate what is yours from what is the other's,

so to not compromise the TR. To achieve this, exploring self-awareness through a therapeutic process or under the supervision of an experienced TR/mental health professional is necessary, paths that strengthen the nurse, so to avoid attitudes and feelings such as moral judgments, anger, rejection. In SESM, nurses are supervised by an SM specialist to better cope with the demands brought about in the care process.

The process determines the 3rd and final step as being the evaluation for the RT closure, with the criteria being how the user evaluated the changes and how they realize the establishment of new standards for addressing the issues that triggered suffering, followed by reapplication of SRQ-20. The user may be sent to groups of different modalities in the BHU (Basic Health Unit).

Over the duration of the Nursing Extension Project in Gerontology, 600 patients were treated. The data presented here were collected in October 2014, from the medical records of patients who were entered the SESM, from July 2012 to August 2014. Data were entered in Excel for Windows 2003-2007 and the analysis obtained by simple frequency measures. In 2014, Resolution No. 466/2012 had already been approved, but the period in which users have entered the SESM still obeyed Resolution No. 196/96 by, which the study was approved, in accordance with the protocol No 214/2010. In the project submitted to the Ethics Committee, the fact that data would be collected from medical records of users entered in SESM was highlighted in the confidentiality agreement.

## ■ RESULTS

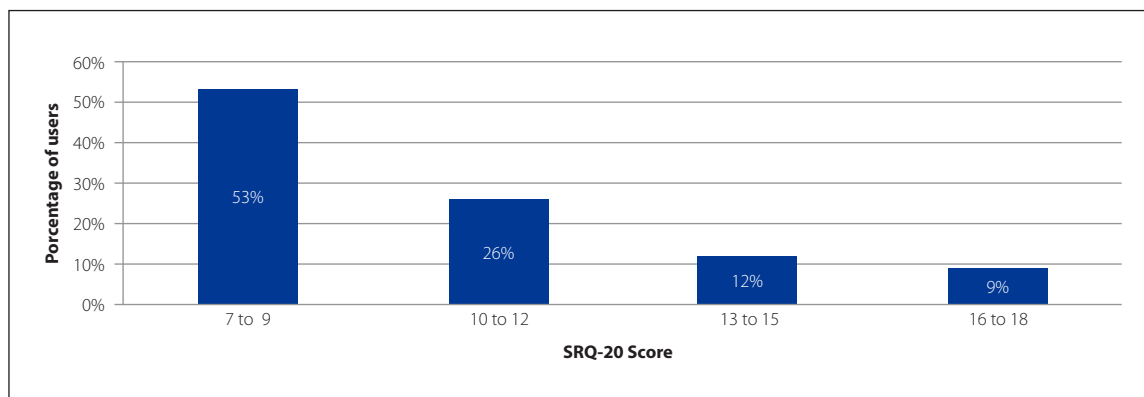
This is a retrospective research based on records, and the sample was established from an Extension Project

with the participation of users who met the inclusion criteria. Refers to 112 patients seen for nearly three years in SESM, aged between 45 and 82 years, with an average age of 65, mostly females (83.93%), married (52.68%), widows (24.11%), with one marriage (85.72%), Catholic (46.43%) Protestant (33.03%), elementary education (56%) and (54.47%) with a family income of 1 to 2 times the minimum wage (BLR 545.00). Over the SESM consults, only two users missed one session each, and there was no loss in continuity in relation to any user. The SRQ-20 found that users attended at SESM had an input score between 7 and 18 points (Figure 1).

In Figure 2, highlight is given to the aspects investigated by the SRQ 20 when the user enters SESM, before receiving the intervention of the TR. A significant presence of symptoms related to CMD is observed in the four SRQ-20 groups (Depressive/Anxious Humor, Somatic Symptoms, Vital Energy Decrease, Depressive Thoughts), with affirmative answers in 100% of each group, according to the question.

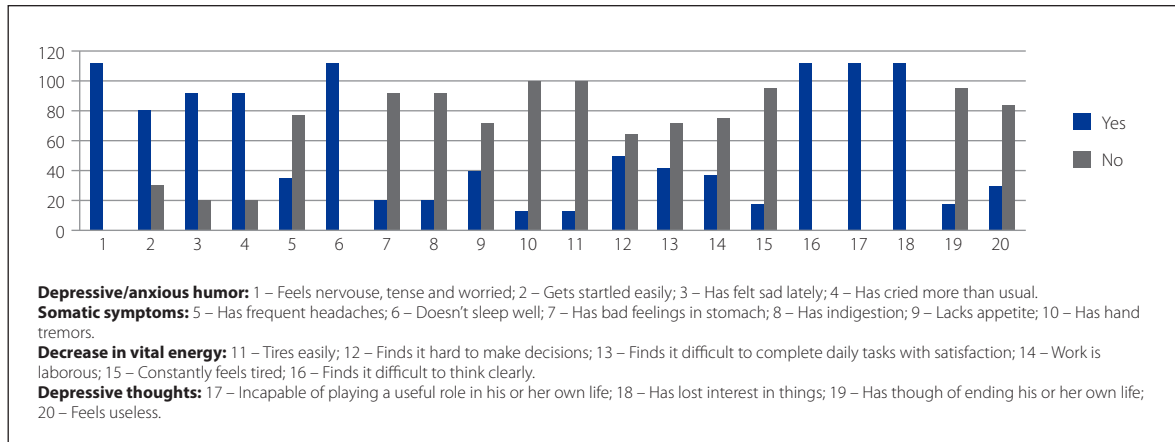
In the group corresponding to the “Depressed/Anxious Humor”, the percentage of Yes answers in the question “feels nervous, tense or worried” was 100%. 82.14% of the sample said it “has lately felt sad” and/or “has been crying more than usual.” In the second group, “Somatic Symptoms” yes responses for “sleeping poorly” were (100%), followed by “lack of appetite 34.82%”. In the same group, 69% said No to “has frequent headaches.”

In the third group, “Vital Energy Decrease” the answer was Yes in 100% of the answers for “difficulty to think clearly.” In contrast, in this group, 88% answered No to the question “tires easily”. In the fourth and last group “Depressive Thoughts”, 100% of subjects answered Yes to “have lost interest in things” and “unable to play a useful role in your life.”



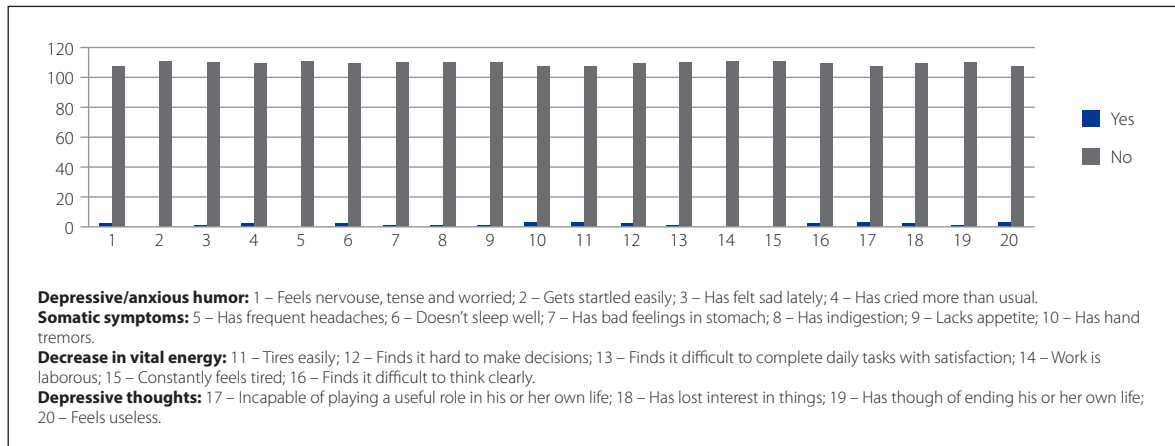
**Figure 1** – Score of SRQ-20 in users attended by the Nursing Service in Mental Health (SESM), Santo André – SP, 2014

Source: Medical records of patients seen in SESM, 2012-2014.



**Figure 2** – SRQ-20 score of users seen in the Mental Health Nursing Service (SESM) before performing the TR. Santo André – SP, 2014

Source: Medical records of patients seen in SESM, 2012-2014.



**Figure 3** – SRQ-20 score of users consulted in Mental Health Nursing Service (SESM) after completion of TR. Santo André – SP, 2014

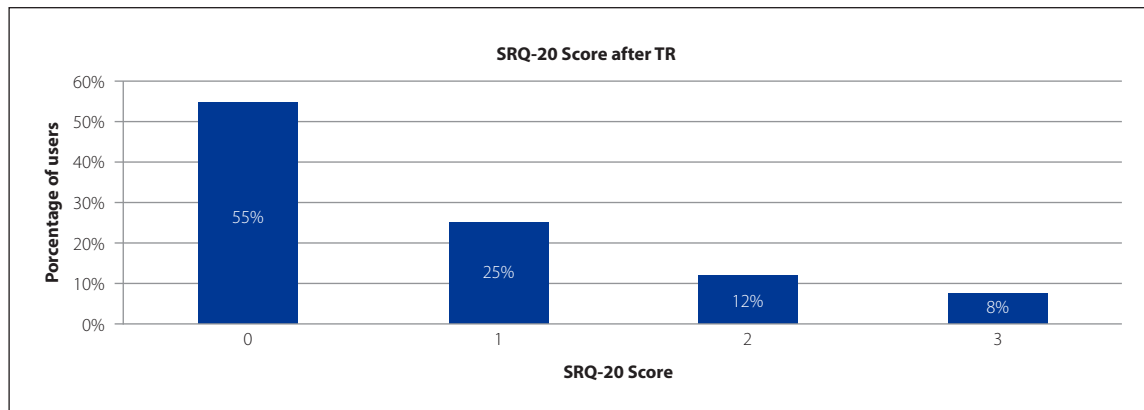
Source: Data from medical records of patients seen in SESM, 2012-2014.

However, 85.72% answered No to the question “Has been thinking of ending your life.” After receiving intervention by TR with 4 to 18 sessions, the result indicates change in SRQ-20, improving the emotional distress and the score decreased in all matters (Figure 3).

There was a 100% negative response to “startles easily;” “has frequent headaches,” “your job is painful” and “feels tired all the time.” To the question “Do you feel nervous, tense or worried” before TR, 100% of users said yes and after TR only 2.68% had positive response. In the question “Has felt sad lately” 82.14% before the TR answered yes, while afterwards, less than maintained this response. When asked about “Has been crying more than usual,” 82.14%

said yes, and after TR only 1.78% maintained this response. In the question “does not sleep well”, before TR, 100% of the sample said Yes, after TR, 98.21% said they had no trouble sleeping. As for “It’s difficult to think clearly”, before the TR, 100% of the sample complained of this difficulty and after, 98.21% denied having it. Feeling “Unable to play a useful role in your life”, after TR 97.32% said No, and “Having lost interest in things” 98.21% said No.

Of the sample, 73 (65.18%) of the users with SRQ-20 scores between 7-10 underwent 5.5 TR sessions. 23 (20.53%) of the users with scores between 11-14 underwent 9.5 TR sessions. Of the sample, 16 (14.28%) of the users with SRQ-20 scores between 15-18 underwent 14.6



**Figure 4** – SRQ – 20 score of users who attended the Nursing Service in Mental Health (SESM), Santo André – SP, 2014

Source: Data from medical records of patients seen in SESM, 2012-2014.

RT sessions. It was found that, the higher the score in the SRQ-20 (1st. Screening phase) the more TR sessions were necessary for the person to contact the experience of suffering, find meaning and significance to this experience, develop means to face it and establish a steady state. The final score of the users subjected to the TR went from 0 to 55%, 1 to 25%, 2 to 12% and 3 to 8% of the sample. For 55% of the sample, the SRQ-20 was negated and 45% passed the score  $\leq 3$  (Figure 4).

The trigger events that scored the SRQ-20 are linked to issues of everyday life that have been reported during the TR as input demand and were raised throughout the sessions. Aspects such as the loss of a loved one “mourning” (child, spouse, mother) 23 (20.54%), “acute-chronic diseases with them” 31 (27.68%), “acute-chronic diseases with members of the family”, 20 (17.85%), family problems, 34 (30.36%) and marital infidelity 11 (32,35%), some double-quoted.

To deal with these events they “sought divine help” (church, prayer, sang church songs, talked to God), “avoided being alone” 44 (39.30%), (went out, had fun, talked to neighbors, go to the third age group, walked, cared for grandchildren or took a bus and went around in circles), 33 (29.46%), “preferred to be completely isolated” (did not see and so little talked with others) 15 (13, 40%) used “other strategies” (increased consumption of coffee and cigarettes, reading, watching television, crochet, use of alcoholic beverages, going out with no destination and self-medication) 14 (12.5%) and were unable to inform 6 ( 5.36%).

## ■ DISCUSSION

The study sample originated from a predominantly industrial area on the outskirts of the ABC Paulista, met-

ropolitan region of São Paulo. This scenario presents less variability in their socioeconomic conditions, with a population that lives and works around a petrochemical complex. Consistent with the literature, the findings indicate that the CMD predominated in the female population<sup>(3,13)</sup> in people with advanced age<sup>(14)</sup>, in an increasing progression of age increase<sup>(15)</sup>, married<sup>(4)</sup>. They are distinguished only in the variable marital status, in which the population of widowed/divorced/separated individuals prevails<sup>(4)</sup>.

The region, scenario of this study, shows population density in urban areas, with part of the population living in poverty clusters. Unfavorable environmental factors such as unequal access to health care, unemployment, inadequate housing conditions, low income, association of decreased purchasing power, leading to psychological problems due to reduced financial contractuality and poor performance of social roles, increase the likelihood of the occurrence of CMD<sup>(16)</sup>.

Although for some professionals, TR is a tool with little prestige and is understood only as a friendly relationship with the user<sup>(17)</sup>, it is a intersubjective care technology that enables interference on the needs of the person in distress. When developed, it implies respect for the particularities and ways of thinking and acting of the other and an effort to help the person gain mastery and realistically face the stressful events of life<sup>(17)</sup>. Authenticity and honesty are qualities desired in the TR therapy and useful to help people find real solutions to problems<sup>(18)</sup>.

In the theory of interpersonal relationships, it is considered that from the uniqueness of the human design, it is possible to appreciate, understand and accept people as they are, respecting their individualities, limitations and potential<sup>(9)</sup>. It was by analyzing that each person has their own time, and even having established the four phases of the



TR, a significant improvement was detected from the fourth interaction in people who entered with a score between 7 and 8 points. Possibly those who viewed the problem as specific and resolvable with brief therapeutic intervention.

Understanding those with less suffering coping potential and unable to test new patterns of behavior, up to eighteen TR sessions were required. This allows the user to lead the development of objective and subjective coping strategies of the reported experiences as soon as possible, and provide perspective for the future with new alternatives for that critical moment of life. When dealing with triggering events and building responses to the suffering threat, clinging to global and rooted beliefs and religion, alcohol, drugs, craft activities, fighting, fleeing or freezing are common measures.

To cope with stressful situations and as a strategy to cope with traumatic events and certain circumstances, most people develop poorly adapted coping responses. The different ways of trying can activate protection mechanisms, changing the mood and behavior of an individual<sup>(19)</sup>. It was on this understanding that the application of TR enabled the individual, respecting each proposition, (re) defining triggering events, developing new skills to face and gain more power over them and design their own future. It is therefore noteworthy that during the process 29 (25.89%), "wished to leave the emotional suffering and improve health" and 23 (20.54%) had "plans to realize dreams like buying a home, traveling, improving family life".

The mission of the TR is to lead others to discern problems and find means of moving forward. Although the target set in the process has not been reached, the commitment to continue is crucial in the person-to-person relationship. The individuals need time to process changes, 18 (16.07%) "could not be optimistic about the future and believed that they would be more and more alone." For 16 (14.28%) "they could not see themselves removed from the problems, did not find alternatives and had no prospect of improvement" and 11 (9.82%) reported "fear of loneliness" and 15 (13.40%) did not know how to answer.

Faced with demands, the management of mental health issues needs to be expressive, escaping the logic of non-qualified referrals to other services. Due to the dynamic and extension of the national territory and its population, PHC is conceived to offer resolute care practices and be responsible for the effectiveness of care. The complexity of care and the unique health needs of individuals, families and communities, require actions at this level of care, health promotion and protection and disease prevention through the principles of longitudinality and comprehensive care<sup>(11)</sup>.

However, in certain areas of primary care, the teams do not have the conditions to offer mental health care and do not always understand what mental health care is. To overcome this gap, it is important that health professionals working in PHC understand that suffering does not necessarily mean being ill, or present some illness in the same way that the person may be seriously ill and not present suffering<sup>(8)</sup>.

Users of the care services in this modality do not feel understood by their emotions, and complain that professionals do not individualize and contextualize their needs. So, the effort to meet the care demands due to health problems of psychosocial origin and the inclusion of the subjective dimension of users, require joint efforts by MH (mental health) with primary care. The focus of MH care has changed dramatically in recent decades, more and more people with needs in this field are treated outside the classical clinical context. Nurses working in PHC often feel they do not have the necessary skills to deal with these demands, and although it is believed that general nurses, a significant workforce in PHC, know the assumptions of TR, this has not been applied as MH action<sup>(20)</sup>.

By recognizing the TR as a care tool, nurses allow the user to take an active role in decision-making and coping with their grief. To answer the need for MH in PHC, it is necessary to recognize the potential of TR in the scope where it needs to be supported. Also, understanding this technology applied to the PHC may be the main intervention to promote awareness and work with the difficulties of its population through a central instrument for all nursing practice.

Currently, the joint efforts of MH and PHC is a challenge, and the nurse can make use of the SRQ-20 to reverse the under-reporting of CMD and plan interventions. SESM arose from the consonance of its idealizers in the belief that it is possible to develop specific actions in a field meant for other health demands. Also, anchored in the proposition of offering conditions for people to process their suffering, and in this perspective, sensitize nurses to build an effective MH practice in this scenario.

## ■ CONCLUSION

The study aimed to describe the result of the application of TR to people with CMD. The TR is a care technology in mental health nursing that transcends the specialty field. Through continuous review and redirection of assistance in TR, it was possible to drive users seen at SESM towards a broader view of the suffering triggers, building coping strategies and exercising changes in daily life.

The conclusion is that the study participants were suffering and needed a place to share their troubles and that the proposed TR at the PHC enables listening and understanding of emotional distress in non-specialized space, and when applied in this scenario, awakens to practice the generalist nurse. Appropriating the TR in PHC leads the nurse to take the position to arbitrate the person to create new ways of producing health and is an important tool to promote the MH as the individual with CMD learns to deal with everyday issues and suffering.

The experience of this study was aggrandizing to the entire project team. It values the use of a restricted theory to areas of specialized care, and that is unusual in the setting in which it was applied. It demonstrates the viability and potential of the experience of an extension project such as that of SESM being conducted in the PHC, and allows the plasticity of the nurse's work to meet the new paradigm of MH.

The results of this study are relevant to nursing in the field of education, reinforcing the emphasis that should be given during the training of nurses on the TR theory. In research, studies focusing on its implementation need to be further explored to support behavior in care practice. Additionally, in the field of care management, it is an instrument that is linked to the dynamics of teamwork. The impossibility of ensure improvement in the CMD scores, only improvements to the TR process, stand out as a limitation. Furthermore, it reinforces the user's protagonism and the role of nurses in internal availability to build objective and subjective coping strategies to suffering.

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