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Person-centered care in psychosocial care: challenges for the therapeutic relationship from professionals' perspective

Cuidado centrado na pessoa na atenção psicossocial: desafios para a relação terapêutica na perspectiva de profissionais

El cuidado centrado en la persona en la atención psicosocial: desafíos para la relación terapéutica en la perspectiva de los profesionales

Johnatan Martins Sousa[1]
Joyce Soares Silva Landim[1]
Fernanda Costa Nunes[2]
Nathália dos Santos Silva[1]
Thatianny Tanferri de Brito Paranaguá[3]
Ana Lúcia Queiroz Bezerra[1]

1. Universidade Federal de Goiás, Faculdade de Enfermagem. Goiânia, GO, Brasil.

2. Universidade Federal de Goiás, Instituto de Patologia Tropical e Saúde Pública. Goiânia, GO, Brasil.

3. Universidade de Brasília, Faculdade de Ciências da Saúde, Departamento de Enfermagem. Brasília, DF, Brasil.

Corresponding author:
Johnatan Martins Sousa.
E-mail: johnatanfen.ufg@gmail.com

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Abstract

Objective: to analyze the challenges for the therapeutic relationship from the perspective of person-centered care. **Method:** strategic social research, with a qualitative approach, carried out with 17 professionals from two Psychosocial Care Centers (CAPS) in central Brazil. Data were collected through individual online interviews with a semi-structured script and notes in a field diary. They were organized with the help of the ATLAS.ti software, submitted to thematic analysis. **Results:** four categories emerged on the challenges for the therapeutic relationship that addressed aspects related to health teams, users, family and work processes of the services studied. **Conclusion and implications for practice:** challenges were identified that interfere with the establishment of the therapeutic relationship between CAPS professionals, users and their families that make it impossible to implement the person-centered care model. Fragile interpersonal relationships constitute obstacles to bond building, which demands continuing and permanent education processes to transform this reality.

Keywords: Mental Health Assistance; Patient-Centered Care; Interpersonal Relations; Therapeutics; Community Mental Health Services.

Resumo

Objetivo: analisar os desafios para a relação terapêutica na perspectiva do cuidado centrado na pessoa. **Método:** pesquisa social modalidade estratégica, de abordagem qualitativa, realizada com 17 profissionais de dois Centros de Atenção Psicossocial (CAPS) da região central do Brasil. Os dados foram coletados por meio de entrevistas individuais *online* com roteiro semiestruturado e anotações em diário de campo. Foram organizados com o auxílio do *software ATLAS.ti*, submetidos à análise temática. **Resultados:** emergiram quatro categorias sobre os desafios para a relação terapêutica que abordaram aspectos relacionados às equipes de saúde, aos usuários, à família e aos processos de trabalho dos serviços estudados. **Conclusão e implicações para a prática:** foram identificados desafios que interferem no estabelecimento da relação terapêutica entre os profissionais dos CAPS, usuários e seus familiares que inviabilizam a concretização do modelo de cuidado centrado na pessoa. Relações interpessoais frágeis se configuram empecilhos para a construção de vínculo, o que demanda processos de educação continuada e permanente para a transformação dessa realidade.

Palavras-chave: Assistência à Saúde Mental; Assistência Centrada no Paciente; Relações Interpessoais; Terapêutica; Serviços Comunitários de Saúde Mental.

Resumen

Objetivo: analizar los desafíos para la relación terapéutica desde la perspectiva del cuidado centrado en la persona. **Método:** investigación social estratégica, con abordaje cualitativa, realizada con 17 profesionales de dos Centros de Atención Psicosocial (CAPS) del centro de Brasil. Los datos fueron recolectados a través de entrevistas individuales en línea con un guión semiestructurado y notas en un diario de campo. Fueron organizados con la ayuda del *software* ATLAS.ti, sometidos a análisis temático. **Resultados:** surgieron cuatro categorías sobre los desafíos para la relación terapéutica que abordaron aspectos relacionados con los equipos de salud, los usuarios, la familia y los procesos de trabajo de los servicios estudiados. **Conclusión e implicaciones para la práctica:** se identificaron desafíos que interfieren en el establecimiento de la relación terapéutica entre los profesionales del CAPS, los usuarios y sus familias que imposibilitan la implementación del modelo de atención centrado en la persona. Las relaciones interpersonales frágiles constituyen obstáculos para la construcción de vínculos, lo que exige procesos de educación continua y permanente para transformar esta realidad.

Palabras clave: Atención a la Salud Mental; Atención Dirigida al Paciente; Relaciones Interpersonales; Terapéutica; Servicios Comunitarios de Salud Mental.

INTRODUCTION

The therapeutic relationship is an important mechanism for transforming health service users' life trajectory, and demands from professionals skills to build bonds, exercise empathy, active and qualified listening. Furthermore, it demands assertive communication through the provision of information and articulation of shared care, when appropriate.[1] It is a care technology that integrates knowledge aimed at fully understanding the person, including their limitations, potential, possibilities and care demands, which contribute to personal development and resilience.[2]

Person-centered care has been recognized worldwide as an important component of patient safety. It has an impact on the reorganization of the health system by encouraging a partnership relationship between users, multidisciplinary health teams, managers and political authorities, with the aim of promoting progress in the health sector.[3]

In the mental health scenario, patient safety acquires a more complex character in relation to other sectors of the health sector, due to the environment prone to the occurrence of adverse events, the risk of violence and difficulties in accessibility to health institutions. In this sense, person-centered care constitutes an important care model for minimizing these problems.[4]

Thus, the Pan American Health Organization (PAHO) prepared a document to promote person-centered approaches in the context of community mental health services, with the aim of deconstructing care practices anchored in the biomedical model.[5]

Furthermore, one way to implement person-centered care in community mental health services is by using the Person-Centered Clinical Method (PCCM), which consists of the systematization of four components: 1. Exploring health, illness and the experience of illness; 2. Understanding the person as a whole — the individual, the family and the context; 3. Developing a joint problem management plan; 4. Strengthening the relationship between the person and the physician/health professional.[6]

This method stands out, as it favors the deconstruction of the hierarchical relationship between professionals and people seeking care. From this perspective, those seeking treatment abandon the posture of passivity in the face of health care, and professionals no longer monopolize the decision-making process in relation to care aimed at the person, family and community, uniting objective and subjective aspects during the therapeutic trajectory.[6]

The fourth component of a PCCM entitled "Strengthening the relationship between the person and the physician/health professional" expresses the aspects necessary to strengthen the relationship established between people and health professionals. These are elements such as compassion, empathy, power sharing, healing, trust, continuity and constancy of the care offered, hope, self-knowledge, practical wisdom, transference and counter-transference,[6] which demands investments from healthcare teams that go beyond technical competence.

Research on person-centered care in the context of psychosocial care is still incipient, as most studies focus on the field of Primary Health Care (PHC),[7] which suggests the proposition of a research agenda for implementing person-centered care in mental health institutions and other fields of care.[8] Furthermore, it is imperative to carry out studies that investigate the relationship between professionals and users of mental health services from Psychiatric Reform's perspective to elucidate how relationships are established in the management of this type of care.[9]

Considering the above, it is urgent to carry out investigations that address the issue in community mental health services to fill this gap and elucidate the configuration of the relationship established between professionals, users and their families. Therefore, the objective was to analyze the challenges for the therapeutic relationship from the perspective of person-centered care.

METHOD

This is strategic social research, with a qualitative approach,[10] which followed the guide Consolidated criteria for Reporting Qualitative research (COREQ).[11] Social research is focused on the universe of meanings through experiences lived by people, their actions, worldview and human relationships, including the researcher. In the strategic modality, the meanings of a given problem are analyzed with reference to the historical process, and are concerned with triggering reflections for its future resolution. It is through the worldview of the people involved in the research process and social science theories that as yet unresolved phenomena are elucidated.[10]

The research was implemented in two Psychosocial Care Centers (CAPS - *Centros de Atenção Psicossocial*) in a municipality in the central region of Brazil, one being a Child and Youth Psychosocial Care Center (CAPSi - *Centro de Atenção Psicossocial Infantojuvenil*) and a Type III Alcohol and Drug Psychosocial Care Center (CAPSad - *Centro de Atenção Psicossocial Álcool e Drogas*).

A total of 44 professionals worked at CAPS, 22 in each service during the data collection period. The inclusion criterion was to be providing direct assistance to users and their families and, as an exclusion criterion, to be on official leave from work due to leave or vacation. All professionals eligible for the study population were invited to participate. Of these, 17 accepted, six from CAPSi and 11 from CAPSad III.

To gather data, a semi-structured script was prepared with the following guiding questions: what is your relationship like with users and family members during assistance? What is the influence of this relationship on care? All data collection instruments were constructed collectively by the doctoral student and the supervisor, and were assessed by researchers, a psychologist specializing in mental health and a nurse from the health and patient safety management area.

It is worth mentioning that, before collection, a pilot test was carried out with 11 CAPS professionals to verify whether collection strategies and techniques were adequate, at which time a simulation of data collection dynamics was carried out.

Emerging information was used strictly to readjust research instruments. After adjustments, the field was approached through a video call meeting, due to the COVID-19 pandemic, mediated by the municipality's mental health coordinator, during which the study proposal was presented and a letter of consent was requested for inclusion in the services.

Subsequently, meetings were scheduled with managers and multidisciplinary teams of services to raise awareness among professionals to participate in the study, providing a link to access a file on Google Forms containing the Informed Consent Form (ICF), a sociodemographic and professional characterization form and scheduling participants' availability to carry out an individual online interview.

The interviews took place via Google Meet between June and August 2021. They were conducted by two nurses, the main researcher, a doctoral student and specialist in mental health and psychiatric nursing, and a master's student in nursing, graduate student in auditing. The interviews lasted from 15 to 48 minutes, with an average of 25 minutes, and were recorded in video format. A field diary was also used, where researchers' perceptions were recorded, which contributed to interpretations and inferences during the analytical process and data discussion.

Data emerging from the interviews were transcribed in full and subjected to thematic analysis,[12] in accordance with three stages: pre-analysis, marked by text skimming and organization of analyzed data; material exploration, which consists of coding data to formulate categories through the identification of registration units and context; and treatment of obtained results and interpretation, which materialize the information resulting from the analytical process. The ATLAS.ti software was used to assist in organizing the data. The entire analytical process was carried out by two researchers, to establish a consensus on the analysis product, later checked by the research co-supervisor and advisor.

The research is part of a matrix project entitled "*Estratégia educativa e suporte organizacional dos profissionais de saúde para o envolvimento do paciente no cuidado seguro*", approved by the Research Ethics Committee, with Opinion 4,298,136 and Certificate of Presentation for Ethical Consideration Certificate of Presentation for Ethical Appreciation (CAAE - *Certificado de Apresentação para Apreciação Ética*) 22469119.0.0000.5078.

All participants signed the ICF electronically, due to the advent of the COVID-19 pandemic, in accordance with Resolution 466 of 2012[13] recommendations and Circular Letter 2/2021/CONEP/SECNS/MoH guidelines for research procedures with any step in a virtual environment.[14] To preserve confidentiality and anonymity, participants were coded by the letter P, numbered from 1 to 17, according to the order in which the interviews were carried out and the type of CAPS to which they were linked (CAPSi and CAPSAD).

RESULTS

Participant characterization revealed that the majority were female, with 15 of the 17 professionals ranging in age from 33 to 61 years old. The study included different multidisciplinary team degrees: five nursing technicians; three nurses; five psychologists; two social workers; a speech therapist; and a pharmacist. Regarding training in mental health, seven participants had specialization in the area.

Categorization

From the content analysis process, four categories emerged: Challenges for the therapeutic relationship related to the health team; Challenges for the therapeutic relationship related to users; Challenges for the therapeutic relationship related to the family; Challenges for the therapeutic relationship related to work processes, as illustrated in Figure 1.

The "Challenges for the therapeutic relationship related to the health team" category includes aspects that hinder the relationship regarding workers' practice and their way of being, such as the difficulty in opening up to new things and an authoritarian attitude towards users, which makes it difficult to build a bond:

> [...] *building a bond with a teenager is sometimes not easy, as they already come with a different worldview, with other changes in culture, in ways of seeing the world* [...] (P4 CAPSi).

> [...] *They* [users] *want to watch a movie for up to ten hours, or watch any program, and they're like that, they really don't let them, they can't, they'll turn off the lights or professionals want to watch something else and want users to watch what professionals want, got it?* [...] (P10 CAPSad).

Not working with groups and the lack of planning for group care were other challenges that emerged in participants' statements that make the relationship between professionals and users and their families difficult in relation to those who carry out these activities:

> [...] *is that, at CAPS, I only work with individuals. The other psychologists work some individually, but also do therapeutic groups. I don't do a group* [...] (P4 CAPSi).

> *As I am a nursing technician, I don't have this group planning thing, these things* [...] (P8 CAPSad).

User marginalization, focus on pathology during the psychosocial rehabilitation process and limitation of the autonomy of people assisted by CAPS were other challenges for the therapeutic relationship and person-centered care, as demonstrated in the reports:

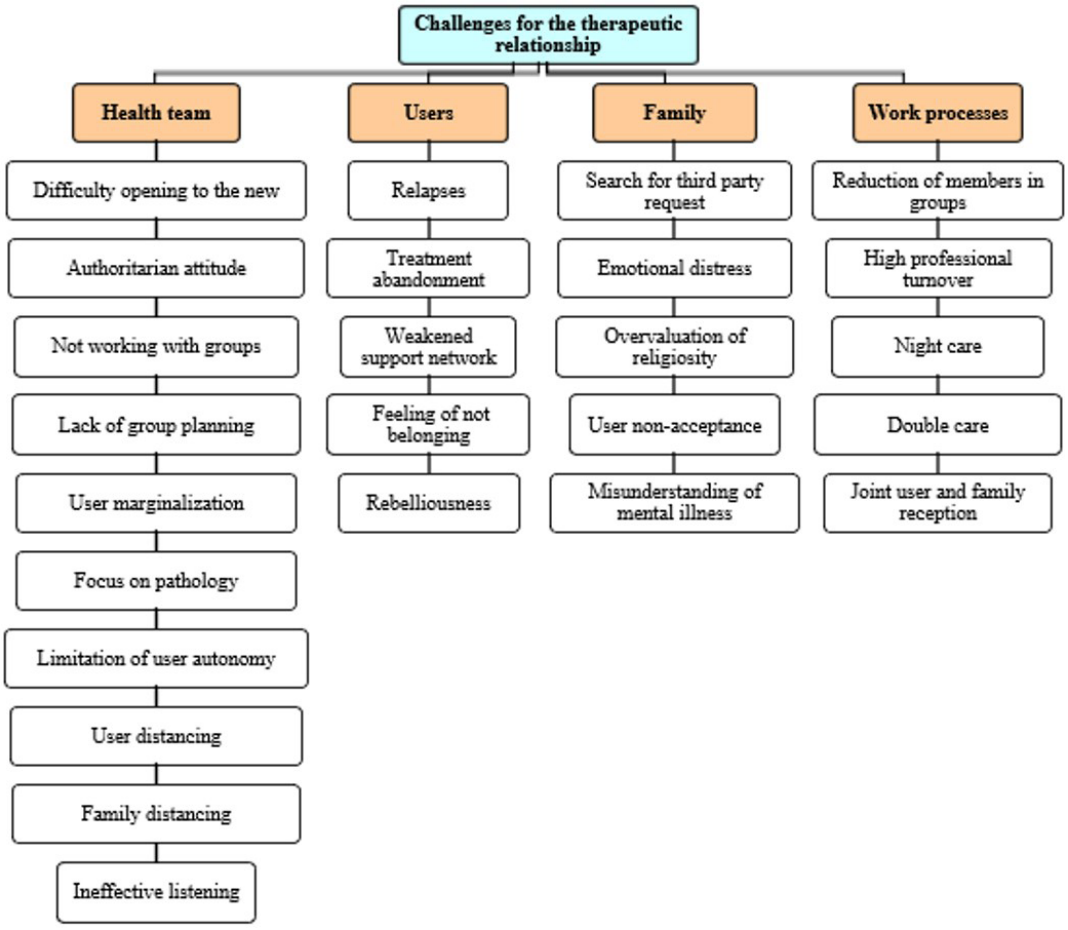

Figure 1. Coding tree of study categories. Aparecida de Goiânia, Goiás, Brazil, 2021.

> [...] *other* [professionals] *say, "Ah, I'm going to be there a lot giving a spoonful to criminals, marginalized people and so on". So, there's this, I'm being very honest, because it's an anguish of mine, because this really exists, and there's this there.* (P10 CAPSad).

> [...] *I see that he* [user] *is sick, especially those who don't have any support, there's no point. Their chance is CAPS, it's the treatment there with us, there is no other, because people, they have to take strong medications. In my opinion, it is unlikely that there will be a job that she is capable of, because the medicine can make her dizzy, you know, the medicine makes her drowsy, so her work functions are impaired.* (P13 CAPSad).

> [...] *from the moment I don't have autonomy for anything, you know, I can't watch, let's say, football, if I can't watch the Olympic games now, you know, because I think this regime is in jail, in jail that's how it is.* (P10 CAPSad).

User and family distancing during the care period in CAPS and ineffective listening emerged in participants' reports as obstacles to the fluidity of the relationship between them in the context of psychosocial care:

> [...] *the other pharmacist does this part of pharmaceutical care with users, integrative practices that she does acupuncture, and she also does auriculotherapy, so this direct part with users is handled by the other pharmacist. I work in the medication department, I work in the pharmacy, only what is related to the medication that is available in the pharmacy, I do not have direct contact with the patient treated, she is the one who carries out these integrative practices.* (P13 CAPSad).

> [...] *sometimes, we don't have much contact with the family, only when the family, sometimes, even comes to bring some belongings for the users who stay here for night care that we call, right, then, they sometimes ask to talk to the nurse who is on duty, because here we are on duty, we work 12/60, so it's one day on and two days off* [...] (P14 CAPSad).

> [...] *so, if I don't do this listening, if I don't do the reception and if, in some way, they* [users] *feel confronted, if they don't feel listened to, they often feel judged, because they are a user of alcohol and other drugs. There is this particularity, the form of prejudice that they suffer daily is something to which they become very negatively responsive* [...] *if they don't feel listened to, generally it turns into defiant or hostile behavior* [...] (P17 CAPSad).

Therefore, the challenges identified for the therapeutic relationship, related to professionals in community mental health services, are diverse, such as difficulty in opening up to new things, an authoritarian attitude and not working in group care. Lack of group planning, user marginalization, focus on pathology during the psychosocial rehabilitation process, limitation of user autonomy, user and family distancing and ineffective therapeutic listening were also highlighted as challenging aspects.

The statements in the "Challenges for the therapeutic relationship related to users" category also reveal that relapses in the use of psychoactive substances, therapy abandonment and a weakened support network harm the relationship:

> […] *suddenly, they* [users] *relapse. They are, like, ashamed of having relapsed, so we have to show them that this happens, that this is how it is, that he cannot give up, that he did the right thing* […] *this confidence that We have to pass it on for them to stay in treatment.* (P8 CAPSad).
>
> […] *because it is a huge suffering for them* [users]*, starting the detox treatment, and there are many who unfortunately end up leaving, you know. We try, the team talks, I also talk, we try in the groups we have, but even so, they abandon treatment* […] (P13 CAPSad).
>
> […] *many times, they* [users] *come, and we never know if they will return, because, often, they want treatment, but because of the craving itself, because of their own fragility, or because of the weakened and impoverished support network that they are at the moment, they are unable to maintain treatment immediately* […] (P17 CAPSad).

Participants express that the feeling of non-belonging of marginalized users in the CAPS space itself and the rebellious behavior assumed by them due to the feeling of insecurity are obstacles to the therapeutic relationship with the team, during the care process, as shown in the statements:

> […] *in my point of view, despite being in a therapeutic space, they* [users] *are still seen as marginalized, they are marginalized, you know. There, they don't feel like they belong there, because they feel marginalized there.* […] (P10 CAPSad).
>
> […] *There is another particularity that is very specific, in my opinion. Users of alcohol and other drugs have a rebellious attitude. If they do not feel welcomed and safe in this treatment... this is very specific to alcohol and drug users and homeless people* […] (P17 CAPSad).

The challenges that arise in the scenario of psychosocial care for the therapeutic relationship, related to users, are episodes of relapse among users of alcohol and other drugs, abandonment of the therapeutic process, having a weakened support network, feeling of not belonging to the service and rebellious behavior.

The "Challenges for the therapeutic relationship related to the family" category points out that the search for service at the request of third parties and the emotional distress of those who assume the role of caregivers are other factors that interfere with the quality of relationships:

> […] *the bond, also, with the family, has many variables, there are mothers, there are fathers who don't believe in our service, but they came because there is a determination, a need for the school, referral from a guardianship council, he came here because he had a crisis and had to be taken to the emergency room, the emergency department told him to come here* […] (P4 CAPSi).
>
> […] *I realize that many families arrive and deliver, they say, "I can't handle it anymore, I don't want it anymore, you know, take care of it for me a little"* […] (P9 CAPSad).

Furthermore, professionals reported that overvaluation of family members' religiosity, in opposition to the care offered by CAPS, in addition to user non-acceptance and misunderstanding of mental illness, are restrictive factors for implementing the therapeutic relationship during mental health care:

> […] *we have some difficulties in building this bond, depending on the beliefs that a family has, which does not believe in any other form of knowledge other than religion, spirituality, does not believe in medicine, medication. We face some barriers here for treatment to be effective, because families, with different cultural backgrounds and perceptions of life, hinder adherence to treatment.* (P4 CAPSi).
>
> […] *for that family that still accepts, because there are families that don't even accept the user, they try to reestablish this bond, sometimes they succeed, and sometimes they don't.* (P14 CAPSad).
>
> […] *there is, therefore, a difficulty of ignorance itself, of not believing much in parents, especially men. Parents have more difficulty accepting their children's pathology, believing that medicine and psychotherapy can help* […] (P4 CAPSi).

Therefore, it is considered that the challenges that arise in the daily routine of community mental health services to establish a therapeutic relationship related to users' families are: searching for service at the request of third parties; emotional distress suffered during the period of mental health care; overvaluation of religiosity to the detriment of psychosocial care; non-acceptance of people with mental disorders or psychological distress; and the misunderstanding of mental illness.

The "Challenges for the therapeutic relationship related to work processes" category demonstrates that the reduction of members in groups due to the COVID-19 pandemic and the high turnover of professionals in CAPS harm bond creation:

> [...] *we* [professionals and users] *have a very close relationship, it was only during the pandemic that there was a reduction in cases. Here, we even reduced the number of users in the groups, which can now have up to fifteen people in the group in an open space, so there was a reduction* [...] (P6 CAPSi).

> [...] *and they* [users] *have to want to, because many don't want to participate. Sometimes, they don't join the group, it really depends on the group too, there's this matter of wanting, of the professional who is teaching the group. There are many who join and don't even want to leave the group, nor do they want to change professionals, because this city hall system changes professionals a lot, without being certified, so, sometimes, for them, this change of professionals is very difficult; they create bonds.* (P14 CAPSad).

Therefore, participants vocalized situations of the reception configuration operationalized throughout their trajectory at CAPS, such as night care and listening carried out in pairs of professionals and/or together with users and family members. These are procedures that can inhibit people from expressing all their questions and interacting with the team:

> [...] *so,* [users] *who are in night care, we don't have that thing anymore... because those who go to day care have much more need to be talking than those who are in night care. They go there to spend the day and it seems like they need to talk, to talk about what's going on, tell a story, talk about life.* [...] (P8 CAPSad).

> [...] *It happened a lot a while ago, as soon as I joined, I've been with the company for three years, we approached it as a pair, and then some situation arose and I didn't look into it further because I had another professional. This user never came back, so I try to be careful. Generally, in the first contact with them, if they arrive with their family, I always make contact with the user alone* [...] (P17 CAPSad).

> [...] *because, often, when they come with their family, they arrive with different demands, so, if I only provide one service with just the two of them together, I miss the users' story and I also lose the family member's story.* [...] (P17 CAPSad).

Regarding the work process of the services investigated, the challenges for the therapeutic relationship were identified as the reduction of members in the groups due to the COVID-19 pandemic, and the high turnover of professionals with fragile employment relationships. The precariousness of work and the little interaction between users and professionals in night care were also negative aspects highlighted. Reception carried out by two professionals at the same time, or carried out with users in the presence of family members, was pointed out by workers as inhibitors of self-disclosure of health problems and situations of those seeking care.

DISCUSSION

In the scenario of community mental health services, the success of the person-centered care model based on psychosocial care depends, among other factors, on the therapeutic relationship between professionals, users and their families. It is necessary to strengthen ties between all social actors involved in mental health care, to allow greater participation of people in their own care, and thus enhance behavioral changes towards a better quality of life.

In the "Challenges for the therapeutic relationship related to the healthcare team" category, it was evident that the difficulty of opening up to new things and the authoritarian attitude of some professionals towards users are barriers to building a bond. An integrative literature review aimed to investigate the relationship between the professional bond - patient who uses alcohol and other drugs - and adherence to addiction treatment revealed that the relationship between these important actors gives the user the opportunity to feel more confident, comfortable and respected in its subjectivity, in addition to favoring decision-making and greater adherence to the therapeutic plan.[15]

In relation to the authoritarian attitude adopted by some professionals, it is important that there is a deconstruction of this way of relating. The therapeutic relationship consists of the encounter between two distinct universes, the person seeking care and the health professional, however, despite the differences, they socialize a world common to both historically situated.[16] Therefore, when coming into contact with the different, it is necessary for professionals to adopt a flexible stance, so as not to generate relational barriers that could impede the global understanding of the person being assisted.

Furthermore, in relation to children and young people, it is important that health professionals adopt a flexible, accessible and non-judgmental stance as well as using creative strategies to establish a closer relationship. An extension project with children and adolescents, through socio-educational actions using group technology resources, demonstrated that these activities contributed to the development of social skills, engagement, concentration, self-esteem, respect, self-worth, listening, reliability and motivation, in addition to improving school performance, family relationships and coexistence with the community.[17]

The non-involvement of professional categories working in CAPS in the planning and implementation of therapeutic groups were other aspects that emerged in participants' statements that harm the therapeutic relationship between team and users

and their families. Research[18-20] on group interventions in the context of CAPS demonstrate that this type of care is powerful and provides numerous therapeutic factors that allow measuring the evolution of group members during the psychosocial rehabilitation process.

Furthermore, it is important to highlight that professionals who provide mental health care in an individual format also need to build bonds with users, to promote the therapeutic relationship and person-centered care. A study with the purpose of characterizing the CAPS network and assistance in the Federal District, through the Information System, revealed that, among the 25 registered procedures, the majority were individual services.[21]

Furthermore, psychotherapy in an individual format is another form of ongoing care in community mental health services. Research that aimed to explore psychologists' practices in the care of psychoses in the CAPS of Santa Catarina pointed out that individual psychotherapy was mentioned by most participants as a tool for managing crises, building a bond with the service, developing social skills and a strategy for coping with symptoms, or even meeting users' demands.[22]

The marginalization of users in the CAPS environment by some professionals in the services studied emerged as a factor that hinders the therapeutic relationship. A literature review that aimed to verify the importance of PHC in combating the social marginalization of people with mental illness identified that the programs that are part of PHC are important to inform the community about the need for reintegration and psychosocial rehabilitation of people with mental disorders, favoring socialization and demystification of prejudices.[23]

The focus on pathology during mental health care in the CAPS investigated is not an exclusive and atypical reality in the context of community mental health services. Qualitative research, which aimed to analyze the conceptions of graduates of the psychiatric and mental health nursing residency about interdisciplinary work in CAPS in Rio de Janeiro, pointed out that the biomedical model is still cultivated in services, signaling the importance of continuing education,[24] which harms the consolidation of person-centered care and the psychosocial care model.

The limitation of users' autonomy in CAPS spaces due to the actions of some team members was another aspect highlighted that harms the quality of interpersonal relationships. An experience report developed in a CAPS in Minas Gerais by psychology students revealed that service users lacked autonomy in activities of daily living, requesting validation and permission from others to carry out actions and demonstrating a legacy of the asylum model.[25]

Professionals' statements also demonstrated that ineffective listening and user and family distancing from daily life in CAPS constitute barriers in the interprofessional relationship and with users. CAPS are part of the Psychosocial Care Network (RAPS - *Rede de Atenção Psicossocial*), adopting the expanded clinic as a guiding axis for mental health care, in which multidisciplinary teams share their disciplinary knowledge for a clinic centered on the person in distress, and have listening as a an essential tool to access the subjective experiences of each user.[26] Therefore, when this listening is not done properly, the people being assisted can distance themselves from the team and the service.

The "Challenges for the therapeutic relationship related to users" category revealed that relapses among those who abuse psychoactive substances, therapy abandonment and a weakened support network are factors that interfere with the bond with professionals. A phenomenological study, carried out with women treated at a CAPSad, showed that the experience of relapse is associated with their search to forget episodes of violence suffered and the loss of family members, which impairs adherence to the service,[27] weakening the support network due to the fact that bonds are strained due to this set of factors.

In this regard, the feeling of not belonging to CAPS due to the marginalization suffered by users by some professionals and the feeling of rebellion due to the issue of insecurity in relation to the therapeutic process were other barriers that emerged for the therapeutic relationship. An integrative literature review, which aimed to analyze knowledge about the care provided to people with mental disorders from the perspective of patient safety, concluded that the stigmatization of people with mental disorders is a factor that hinders safe care.[4]

The "Challenges for the therapeutic relationship related to the family" category revealed that the involuntary search for the institution by imposition and the emotional exhaustion generated by the caring role impede the fluidity of the therapeutic relationship. A study carried out in a type I CAPS showed that, when users have family support, adherence to the care plan is more satisfactory, however this support may be compromised due to family members becoming ill during the process.[28]

Study participants also pointed out that the overvaluation of religiosity by family members together with users' low acceptance and misunderstanding of mental illness are obstacles to the therapeutic relationship. A study on the relationship between spirituality/religiosity and mental health inferred that the inclusion of this topic during the training period of mental health professionals is extremely important so that they can manage these issues, that are important for users to consolidate humanized care.[29] This favors comprehensive care and holistic understanding of users and their families in a biopsychosocial and spiritual way.

In the "Challenges for the therapeutic relationship related to work processes" category, statements that refer to institutional issues are grouped, such as the low participation of users in therapeutic groups due to the COVID-19 pandemic. A study that analyzed the impacts of pre-existing social conditions in Brazil on mental health in conditions of restricted interpersonal contact due to the COVID-19 pandemic pointed out that distancing between people can have a negative impact on mental health, worsening the health situation and intensifying alcohol and other drug consumption.[30]

Another aspect cited by professionals was team turnover, which hinders the establishment of bonds with users and family members. Research carried out in a type III CAPSad revealed that 90% of professionals had worked in the service for less than a year, due to high team turnover.[31] These data corroborate the findings of this study, showing that the consolidation of safer and longer-lasting employment relationships can positively influence mental health care and the relationship between the health team and users.

Furthermore, variations in the reception, such as night reception, in which the user does not verbalize as much as those in daytime reception, or reception in pairs of professionals, together with users and family simultaneously, appeared in the statements as situations that inhibit people who find it difficult to express themselves fully.

Reception in the context of CAPS is still a challenge for professionals, as it depends not only on workers' individual initiative, but also on the service's organizational culture, guided by work processes anchored in interdisciplinarity,[32] which demands training from teams.

CONCLUSION AND IMPLICATIONS FOR PRACTICE

Challenges were identified that interfere with the establishment of the therapeutic relationship between CAPS professionals, users and their families, ranging from issues linked to health teams to the people assisted and service work processes, which makes the implementation of person-centered care model unfeasible. Also, fragile interpersonal relationships constitute obstacles to the establishment of bonds and consequent adherence and involvement of people in mental health care. They mean that professionals are unable to holistically access care needs, which demands continuing and permanent education processes to transform this reality.

The study brings contributions to the field of mental health care, as it diagnoses the factors that hinder the therapeutic relationship consolidation in the psychosocial care scenario, which is the first step towards the foundation and structuring of continuing education processes, on an ongoing basis, aimed at CAPS multidisciplinary teams for transforming professional practices. It also contributes to teaching, as it draws attention to the need for investment by training institutions, to offer content related to person-centered care, through problematizing and experiential pedagogical practices.

As a limitation of this study, it is worth noting that interviews were carried out only with members of CAPS multidisciplinary teams, and the inclusion of other people involved in the mental health care process, such as users, their families and mental health service physicians, would be important to enrich the discussion on the topic.

Due to the above, it is recommended that new studies be carried out on the subject of patient/person-centered care and the therapeutic relationship in the context of psychosocial care that consider users' and their families' perspectives for greater depth and elucidation of the topic.

AUTHORS' CONTRIBUTIONS

Study design. Johnatan Martins Sousa. Fernanda Costa Nunes. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra

Data collection. Johnatan Martins Sousa. Joyce Soares Silva Landim.

Data analysis. Johnatan Martins Sousa. Joyce Soares Silva Landim. Fernanda Costa Nunes. Nathália dos Santos Silva. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra

Interpretation of results. Johnatan Martins Sousa. Joyce Soares Silva Landim. Fernanda Costa Nunes. Nathália dos Santos Silva. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra

Writing and critical review of manuscript. Johnatan Martins Sousa. Joyce Soares Silva Landim. Fernanda Costa Nunes. Nathália dos Santos Silva. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra

Approval of the final version of the article. Johnatan Martins Sousa. Joyce Soares Silva Landim. Fernanda Costa Nunes. Nathália dos Santos Silva. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra

Responsibility for all aspects of content and integrity of the published article. Johnatan Martins Sousa. Joyce Soares Silva Landim. Fernanda Costa Nunes. Nathália dos Santos Silva. Thatianny Tanferri de Brito Paranaguá. Ana Lúcia Queiroz Bezerra.

ASSOCIATED EDITOR

Cristina Rosa Baixinho

SCIENTIFIC EDITOR

Ivone Evangelista Cabral

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