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Practices of primary health care nurses in the care for people in psychological distress

Práticas de enfermeiras da atenção primária à saúde no atendimento à pessoa em sofrimento psíquico

Prácticas de enfermeras de la atención primaria de salud en el cuidado a personas con sufrimiento psicológico

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ABSTRACT

Objective: To understand the practices of nurses working in Primary Health Care in caring for people in psychological distress.

Method: Qualitative study conducted with 30 nurses working directly in Primary Health Care. Data were collected from January to March 2023 through semi-structured interviews, which were fully transcribed. The resulting material was organized in the IRaMuTeQ® software and subjected to the thematic content analysis, anchored in the precepts of Eric Cassell's Theory of the Nature of Human Suffering.

Results: Five categories emerged: 1. Causes of Psychological Distress (14.65%), 2. Needs of the person in psychological distress (31.3%), 3. Team case discussions (26.5%), 4. Care network for the person in psychological distress (15.99%) and 5. Care instruments (11.57%).

Final considerations: The practices that nurses perform involve listening spaces to express feelings, case discussions within the team and matrixing and the understanding that psychological distress is the result of environmental, social, and family factors. However, they report a lack of training to assess individuals experiencing psychological distress and request the development of institutional protocols and training to support care.

Descriptors: Primary health care. Nursing. Mental health.

RESUMO

Objetivo: Compreender as práticas de enfermeiras que atuam na Atenção Primária à Saúde no atendimento à pessoa em sofrimento psíquico.

Método: Estudo qualitativo realizado com 30 enfermeiras com atuação direta na assistência na Atenção Primária à Saúde. Os dados foram obtidos no período de janeiro a março de 2023 por meio de entrevistas semiestruturadas, que foram transcritas integralmente. O material resultante foi organizado no software IRaMuTeQ® e submetido ao processo de análise de conteúdo temática, ancorada nos preceitos da Teoria da Natureza do Sofrimento Humano de Eric Cassell.

Resultados: Emergiram cinco categorias: 1. Causas do Sofrimento Psíquico (14,65%), 2. Necessidades da pessoa em sofrimento psíquico (31,3%), 3. Discussões de casos em equipe (26,5%), 4. Rede de atendimento da pessoa em sofrimento psíquico (15,99%) e 5. Instrumentos do cuidado (11,57%).

Considerações finais: As práticas que as enfermeiras realizam envolvem espaços de escuta para expressão de sentimentos, discussão de casos em equipe e matriciamento e a compreensão de que o sofrimento psíquico é resultante de fatores ambientais, sociais e familiares. Relatam, no entanto, que não possuem formação para avaliar a pessoa em sofrimento psíquico e solicitam o desenvolvimento de protocolos institucionais e capacitações para subsidiar a assistência.

Descritores: Atenção primária à saúde. Enfermagem. Saúde mental.

RESUMEN

Objetivo: Comprender las prácticas de los enfermeros que actúan en la Atención Primaria de Salud en el cuidado de personas en sufrimiento psicológico.

Método: Estudio cualitativo realizado con 30 enfermeros que trabajan directamente en la Atención Primaria de Salud, los datos se obtuvieron de enero a marzo de 2023 mediante entrevistas semiestructuradas, las cuales fueron transcritas en su totalidad. El material resultante fue organizado en el software IRaMuTeQ® y sometido al proceso de análisis de contenido temático, anclado en los preceptos de la Teoría de la Naturaleza del Sufrimiento Humano de Eric Cassell.

Resultados: Emergieron cinco categorías: 1. Causas del sufrimiento psicológico (14,65%), 2. Necesidades de la persona en sufrimiento psicológico (31,3%), 3. Discusión de casos en equipo (26,5%), 4. Red de atención a la persona en sufrimiento psicológico (15,99%) e 5. Instrumentos de cuidado. (11,57%).

Consideraciones finales: Las prácticas que realizan los enfermeros involucran espacios de escucha para expresar sentimientos, discusión de casos en equipo y apoyo matricial y comprensión de que el sufrimiento psicológico es resultado de factores ambientales, sociales y familiares. Informan, sin embargo, que no cuentan con capacitación para evaluar a personas en sufrimiento psicológico y solicitan el desarrollo de protocolos institucionales y capacitación para apoyar la asistencia.

Descriptores: Atención primaria de salud. Enfermería. Salud mental.

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INTRODUCTION

With the establishment of the Psychosocial Care Network (PCN)[1], mental health services began to be integrated with the other services of the Health Care Networks (HCN). In this logic, actions of different technological densities were incorporated through technical, logistical and management support systems, aiming to ensure a comprehensive, articulated and continuous care, based on the principles of autonomy and recognition of the social determinants of health-disease-suffering-care processes[2].

Primary Health Care (PHC), as the main entry point for the population into the Unified Health System (*Sistema Único de Saúde*- SUS), is responsible for longitudinal follow-up, coordinates care flows and ensures access to mental health care[3]. However, to conduct and sustain mental health interventions in this field, it is necessary to develop more accessible care for people in psychological distress, using light technologies such as listening, welcoming, empathy and bonding and carrying out activities in the territory, aiming for social reintegration and promoting autonomy[4].

Distress is at the origin of the human condition, and finding an adequate definition to describe it is not a simple task. It is necessary to use different views to reflect on this complex phenomenon. The word distress refers to something marked by a state of negative experience, however, depending on the point of view, it can become positive. Understanding the existence of distress is necessary for the person to be able to understand the dynamics of living with it, above all, that it is not a permanent manifestation, and that it is so particular to the person who suffers[5].

Over time, in Western culture, there have been various forms of understanding and connotations about distress, as well as the way of feeling it, usually associated with pain, but also as something functional, which occurs integrated into people's daily lives. Thus, clinical interventions in health care for people in distress must go beyond those restricted to medicalization[6], since the person who suffers must be understood in their psychological, social and spiritual dimensions[7].

A study conducted on human suffering reinforces the premise that there are people who suffer and are not sick and many can be seriously ill and still not suffer[8]. Therefore, when assisting a person in psychological distress, the health professional must consider the life story, the multiple spheres, and the particular worlds, considering that nothing happens to one part without the others also being affected[8].

Among the professionals who can lead these interventions in PHC are the nurses, who assume considerable importance in caring for people in psychological distress, however, they need to conduct their health care practices in line with the psychosocial care model, from the perspective of preventing harm, promoting health and providing comprehensive care[9].

To do so, they must adopt care practices in the territory, within a multiprofessional team, towards care that produces autonomy, social inclusion and psychosocial rehabilitation, breaking with the asylum logic[10]. However, invariably, these professionals end up referring patients to specialized services or adopting practices related to medicalization, as opposed to comprehensive care, which uses light technologies and is centered on the person in psychological distress[11].

When considering the multidisciplinary nature and limits of each professional's role, it is possible to exchange experiences that enable comprehensive care, resulting in collective practices that favor the reinsertion and permanence of the individual in psychological distress in their social life[12].

In the field of mental health, there is integration between PHC and services at different levels of health care, a reality also observed in the USA and Canada, with the promotion of shared care, with professionals working together, closer and more staggered, in a system that works in an integrated and organized manner according to the logic of the HCN with a focus on PHC[13].

In Brazil, considering that the PCN devices and health care levels need to act interdependently and be referenced, practices based on a medicalizing aspect are still observed, which urgently needs to be deconstructed[4]. Since PHC nurses often work in a fragmented health network and conduct their practices under the logic of the biomedical model, which disregards the individual in psychological distress in its entirety, the question arises: What are the practices of nurses working in PHC in providing care for people in psychological distress in a city in the interior of São Paulo? The study aimed to understand the practices of nurses working in Primary Health Care in the care for people in psychological distress.

METHOD

Qualitative study, following the Consolidated Criteria for Reporting Qualitative Research checklist[14], guided by the Theory of the Nature of Human Suffering[8]. According to the author of the theory, the health-disease process comprises the collective and individual dimensions since suffering and illness, although they can be shared, are personal and singular experiences. According to the precepts of the theory, suffering, is associated with situations that people perceive as a threat to their integrity, accompanied by the fear that destructive consequences may happen[8].

In general, the theory assumes that the root of suffering is not easily evidenced, and that the judgment of health professionals about its origin may not reflect the perception of the individual and, to identify suffering and assist appropriately, it is necessary for the health professional is able to listen, understand feelings and fears, legitimizing their narratives. In this process, the author argues that it is necessary to overcome the idea of a division between mind and body in order to understand the manifestations of the other and their suffering[8].

The study was conducted in a municipality in the interior of the State of São Paulo, Brazil, located approximately 57 km from the capital, where PCN is represented in 04 health regions (I, II, III and IV) and has 35 BHUs,07 FHSC multiprofessional teams to offer support to all BHUs,01 Street Clinic team,01 CECCO,02 Adult Psychosocial Care Centers II and III (PCC II and PCC III), 01 Child and Youth Psychosocial Care Center (PCC CY), 01 Psychosocial Care Center for alcohol and other drugs type III (PCC AD III), 02 Type II Therapeutic Residential Services (TRS), and 10 mental health beds in a general hospital, specialized matrixing, including mental health.

Nurses from all BHUs in the four health regions were invited to participate in the study. As inclusion criteria, working time for at least 01 year in PHC, direct working in care and voluntarily accepting to be interviewed. As an exclusion criterion, nurses in administrative activities. At the time of the study, the city's health network had 109 nurses, 56 of whom worked directly in PHC. The municipality's Continuing Education and Nursing Coordination sector supported the study and sent invitation messages and contact information for the researcher via email to all BHUs. In this way, all nurses had the same opportunity to participate in the study.

The data was collected between January and March 2023, through individual interviews by one of the authors who is a nurse, doctoral student, with 18 years of experience in the area and works in a PCC in the municipality. A pilot test was conducted with a nurse specialized in mental health, who did not work at the research site, with adjustments to the triggering question.

A semi-structured script was created to conduct the interview. The script contained closed questions to address sociodemographic/occupational characteristics and open questions that allowed the interviewee to speak freely about the topic studied.

The open questions asked to the nurses were: Tell me about your experience in attending to a user experiencing psychological distress (Triggering question); In your understanding, what is distress? And what is your understanding of psychological distress? During care for a user, how can you identify that he/ she is in psychological distress? What do you do to intervene when you are faced with a user in psychological distress? Do you use a specific instrument to evaluate and identify the user who is in psychological distress. If yes, what would it be? When a user experiencing psychological distress needs care from other services in the network, how do you share care? Tell me about which circumstances you refer a user in psychological distress to another service.

The study assumed that the practice of nurses who work in PHC in caring for people in psychological distress is not based on the Psychosocial Care model, but on a reductionist logic regarding people's experiences.

Data collection ended when theoretical data saturation was reached, with no new elements to deepen the theorization of the study object[15].

In order not to compromise the work routine, the interviews were previously scheduled according to the availability of the professionals and conducted in the PHC units, individually, in private rooms and conducted in their entirety by the responsible researcher, lasting approximately 40 minutes and recorded on a cell phone audio app and then transcribed.

After transcribing each interview, all material was gathered into a single textual corpus and for data processing, the textual content was organized and subjected to lexicographic analysis, with the support of the free software *Interface de R pour Analyzes Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ®), version 0.7 alpha 2, which offers different analysis possibilities based on lexicometrics. This approach is useful when the exploration of a text or set of texts is carried out based on hypotheses regarding the language use in the construction of meanings and the way in which vocabulary is distributed in different corpus partitions[16].

Lexicometric procedures included Descending Hierarchical Classification (DHC) to obtain a reliable classification of text segments, distributed in homogeneous lexical classes, through the identification of coinciding words, with the transformation of text segments that are regrouped into classes of meaning, and Similarity Analysis, which is based on the co-occurrence of words in graphically represented text segments, allowing the visualization of relationships between the linguistic forms of the corpus, revealing how texts on a given topic of interest are structured[17]. The criteria for including elements in their respective classes are: frequency greater than twice the average number of occurrences in the corpus and association with the class determined by the chi-square value equal to or greater than 3.84, considering that the calculation is defined according to degree of freedom 1 and significance of 95%[17].

Subsequently, the material was submitted to Thematic Content Analysis[18]. The phrases with meanings reflecting the practices of nurses in caring for individuals experiencing psychological distress were coded, grouped, and regrouped into themes. When constituting the analytical narratives and preparing the interpretative syntheses, the results were discussed based on the theoretical framework[8]and complementary literature.

This study was approved by the Research Ethics Committee with Human Subjects, under opinion number 5,788,216 with Certificate of Presentation for Ethical Appreciation CAAE: 62834122,4,0000,5392. The procedures complied with Resolution number 466, of December 12, 2012, of the National Health Council.

It is noteworthy that, after accepting to participate in the research, participants signed the Informed Consent Form. Participants' anonymity was ensured, and their statements were identified using the letter "I" for interviewee, followed by a cardinal number corresponding to the order of statements during the presentation and discussion of the results.

RESULTS

Thirty nurses participated in the research, the majority (93.3%) were female, aged between 40-49 years (36.66%), graduated between 1-10 years ago (66.66%), working in PHC between 1-10 years (66.66%) and without any specific training in mental health (93.33%).

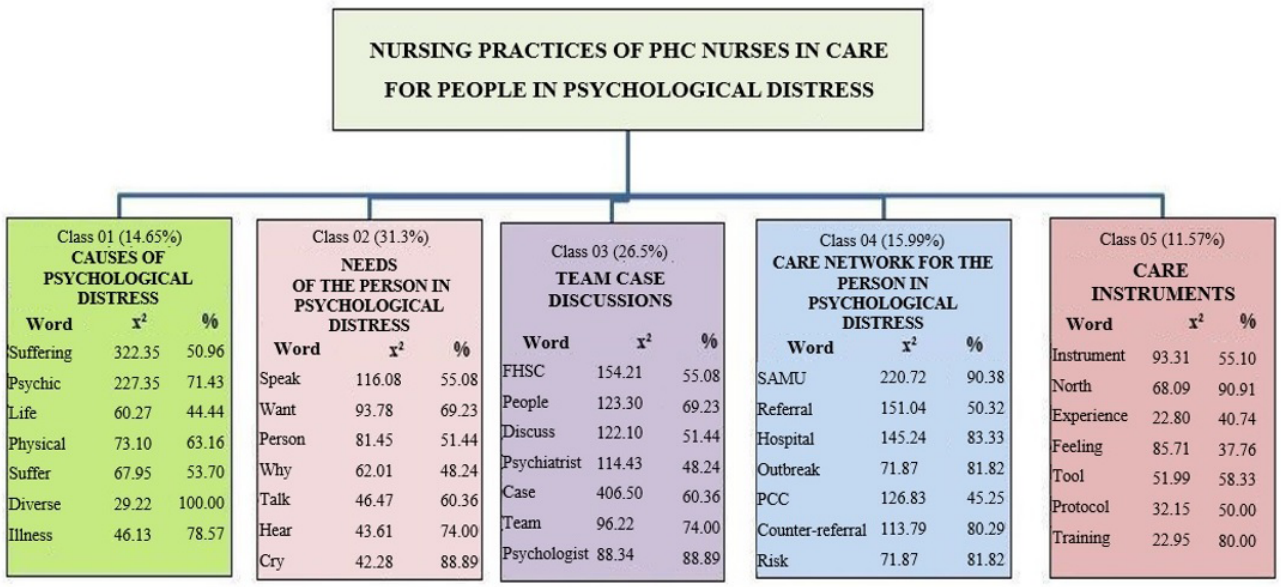
In the IRaMuTeQ results, from the total corpus of transcribed interviews, there were 69,030 word occurrences, distributed in 4,218 forms. Using DHC,1,985 text segments were analyzed, an amount equivalent to the use and retention of 90.13% of the corpus for the construction of classes arising from the content, which is considered good, indicating the degree of similarity in the vocabulary of the five resulting themes. The dendrogram, represented in Figure 1, demonstrates the classes/categories arising from the most significant and interrelated content.

Category 1: Causes of psychological distress

The typical vocabulary of this category pointed out to the view that nurses have about the psychological distress of the individuals they attend in PHC using the words distress, psychological, life, physical, suffering, diverse and illness.

In the following statements, the nurses understood that suffering is intrinsic to human beings and that its intensity is directly linked to the way each person reacts to it, as a process that can generate evolution. Psychological distress was also identified as resulting from processes of loss that

Figure 1 – Dendrogram resulting from the Descending Hierarchical Classification: Practices of PHC Nurses in the Care for Individuals in Psychical Distress. São Paulo, São Paulo, Brazil, 2023



Source: IRaMuTeQ database, 2023.

precipitate depressive conditions, concerns, and the various relationships that the person can establish, including those within the family nucleus.

> *I think suffering is part of everyday life. Now, how we manage this, positively or not, I think this can cause pathology. What focus do I give to suffering? Everyone suffers. It's part of it. Suffering can also be something positive for you to evolve.* (I10)

> *Usually this suffering comes from home, from something very personal. The patient lost his job; got into debt, can't get out of it and has a child to take care of and then get depressed, they don't want to take a shower anymore, they no longer have the will to live, they feel like a burden for someone and then get into suffering that they can never manage to go out. Or people with family or relationship problems in different areas usually have a connection with this when they come to me.* (I20)

In the statements of I11, I24 and I05, psychological distress was pointed out inseparably from physical issues, in which the person presents numerous complaints in this sphere that are not related.

> *Physical suffering leads to psychological suffering as well, and sometimes the opposite also happens. For example, people with chronic wounds experience great suffering, with restrictions in their lives because of that wound. So, they end up having psychological suffering due to physical suffering. But, I think no one is exempt from suffering. Being alive implies suffering, it implies having to relate. But sometimes, people don't find the tools in themselves to deal with it, and things become pathological.* (I11)

> *Psychological distress in care here sometimes comes in a very veiled way. It comes with different complaints. Sometimes I have pain in my arm, I have pain in my leg, I have pain in my spine, and the complaints are not interconnected and then you see that this person is suffering with several pains that are not communicated, but in fact this suffering is psychological.* (I24)

> *It is usually a person who is anxious, eager to find out why they are feeling those symptoms, sometimes very vaguely. It is not a physical illness causing cause everything they feel. There are many people who come with nonspecific pain. If we go by what they say, we'll schedule a physician, an exam that they want, go look for a specialist and don't get to the bottom of what's causing all that. So, you see that they are in that suffering and really managed to say that, but I think most people can't. Most people look to their body for something to justify what they are feeling and that is where it becomes more difficult.* (I05)

Category 2: Needs of the person in psychological distress

This category reveals the practice of nurses in caring for people in psychological distress, considering what they need immediately when they arrive at the PHC unit for care.

The words speak, want, person and because denote the practice of these professionals regarding the urgent needs of individuals in psychological distress. The availability of professionals to provide care was highlighted, as can be seen in the following statements:

> *So, what do we think? They need medication, a major intervention. [...] It's talking about anguish because we know that when we talk about anguish it certainly alleviates the pain, it alleviates what he is feeling. When we bring them in for a speech and tell them what you're feeling? Automatically, they calm down.* (I1)

> *I try to let the person speak and tell me a little about their story, because I think it comes a lot from childhood, it's not a one-off thing. Many times, I let them speak.* (I10)

> *First, I listen, I let the person speak, talk, cry, I think it's important because, often, this user doesn't have a space at home or someone in which they feel safe to do this, so I let the patient talk.* (I22)

From the words speak, listen and cry, it was revealed that nurses understand the needs of the person who arrives at the PHC unit, when they hear their demands, welcome their cries or when they establish a conversation. Such practices enable recognition and relief of suffering, as well as the identification of risks, as reported in the following statements:

> *Talking to the person, they start talking and I start noticing something different, I can't get there and already have that clarity, looking at them and talking is in pain. So, what happens here, sometimes, they arrive, they start talking and then they start crying.* (I19)

> *Letting them cry is letting them feel what they feel because, sometimes, we are so used to holding on to our feelings and when they explode, they explode all at once. So, when you arrive at my office and I see that there isn't*

something cool, I say, let me know what you're feeling so I can understand what you have, how I can help you. There are cases that we really need to hear, because if they leave here, they might not come back. (I02).

However, in the statement by E17, the idea persists that medicalization or the intervention of another professional may be more effective:

So, as a nurse and within my limitations, in this area, what I try to do is to dedicate the time that this person needs, which is to listen and let the person speak without interrupting, both because I feel that no matter how much I can't help them as a psychiatrist, medication or as a psychologist with techniques, I feel that just the person talking and venting [...] I didn't do anything, I just listened. But the person is already extremely relieved to be able to count on someone. (I17)

Category 3: Team case discussions

This category originated from lexicons arising from nurses' practice of discussing clinical cases with the FHSC team.

The words FHSC, people, discuss, psychiatrist, case, team, and psychologist are strongly associated with the case discussion between the nurse who cares for the person in psychological distress and realizes the need for the opinion of other professionals to manage the situation, which can be verified in the following statements:

We work together: we end up referring this patient, discussing their case within the FHSC matrixing meeting and then, we end up directing them to the best possible way to receive care. Each professional taking care of this patient, a FHSC or clinician or directing it to PCC. (I13)

We prioritize discussing these cases in matrixing. So, when I get a patient who I think is a mental health case, I take their name and I will discuss it as a team. (I17)

We are able to welcome, follow up, ask for the approval of psychology and a clinician who also provides initial medication and leaves an adjustment for a shared consultation with a psychiatrist, if this is the case. (I27)

We have the FHSC team here. So sometimes, if it's a case that I feel I won't be able to handle alone, I try to ask for help from a professional who I think can handle it better than me, let's say. A psychologist, an occupational therapist, or even a psychiatrist, if available, we can share the case with them. That's when they're here. (I29)

Category 4: Care network for the person in psychological distress

This category highlights the means and equipment used by nurses to refer individuals experiencing mental distress when they believe it to be necessary.

The words SAMU (Mobile Emergency Care Service), referral, hospital, outbreak, PCC, counter-referral and risk allowed the contextualization of the possibilities employed for people in psychological distress such as referral, making association with this practice when they assess that there is presence of risk:

Sometimes, we request support from SAMU, the municipal guard, because they are patients who cannot be trusted too much. In nursing, we learn that if your life is at risk, run, you won't get ahead. So, you save yourself first and then save the third one. We learn this in college. (I18)

PCC 2, which is our reference, I try to forward only when I see that the BHU will not have a structure, for example. A person arrives there, imminent risk of suicide. Then they will either be taken to the hospital, if you see that it is imminent. And hospital, we call an ambulance and send it. Or some cases that we see is very serious, you won't be able to handle it. (I23)

When the patient arrives in distress, we stabilize, provide all that support, and then we make contact. If they're having an outbreak, having suicidal ideation, we stabilize them, call SAMU, handle the whole case, or we refer them to other places. We always contact the facility to maintain this bond. (I04).

However, it was noticed that there is no definition of when and where to refer. It was generally stated that a person in psychological distress is "someone who cannot be trusted too much" (I18). In cases where there is suicidal ideation or an "outbreak", nurses reported that they call SAMU or refer the person to PCC, demonstrating that there is no guideline on the practices that nurses perform in these situations, as highlighted in category 5.

Category 5: Care instruments

In this category, the text segments analyzed based on the words instrument, north, experience, feeling, tool, protocol, and training reveal reports of nurses' insecurity regarding the assessment of the person in psychological distress because they believe they do not have the necessary knowledge, from their training and, thus assess cases based on their experience, as highlighted in the following statements:

> *It makes me feel insecure because it's not my area of expertise. We feel this insecurity to provide care calmly. (I20)*
>
> *It's more the experience and the knowledge that we have. I didn't do anything in mental health, I didn't work on any of it, I didn't study. It is through experience that I end up making my assessment. (I8)*
>
> *It's even embarrassing to say, it's a lot of feeling. Sometimes, I even consider that I don't have the necessary technical knowledge to know where to refer them, but if I have doubts, I always refer them to a service or at least contact the family and talk about the shared concerns.* (I24)

Given the situations presented, nurses considered training important so that they can develop autonomy in caring for cases of people in psychological distress, highlighting the possibility of creating an instrument or protocol to guide their practices.

> *I think it would be very useful to have a tool for this, a guide and know what action to take in a way that is less dependent on the mental health team, so that you have more autonomy to deal with these cases. I think an instrument would be cool, but I think this also requires a lot of training, it's not just an instrument that will solve it.* (I11)
>
> *It's like we're not qualified for this. I find it interesting to have a protocol, to create a protocol of which professionals can provide care. What segment? What guidance? We prescribe care wonderfully, but clinically speaking, we can't do much.* (I18)

Through similarity analysis, it was possible to identify the connections between the words in the corpus (Figure 2). There is a synthesis of the classes through the words patient, because, speak, person and suffering. These words organize the content about nurses' practice in caring for people in psychological distress. In this type of analysis, the size of the words and the thickness of the lines that unite them represent how important a term is for understanding the studied phenomenon.

The highlighted words represent the person in distress (patient) and how they are perceived in this condition, and how their needs are addressed. The word speak and others related to it reflect practices that nurses undertake for people in psychological distress, such as letting (associated with letting them talk), talking, looking. However, in some situations, nurses understand that other practices are necessary, such as referring to PCC, for example (words linked to the patient) or discussing with other professionals (words linked to the case).

DISCUSSION

The nurses in the municipality in question believe that the causes of the psychological distress in the people they attend may be due to conflicting family relationships and losses throughout the person's life. In this sense, suffering arises from multiple events, especially external ones (other people, illnesses, unemployment, loss of loved ones, etc.), therefore, it cannot be reduced to a single cause[5].

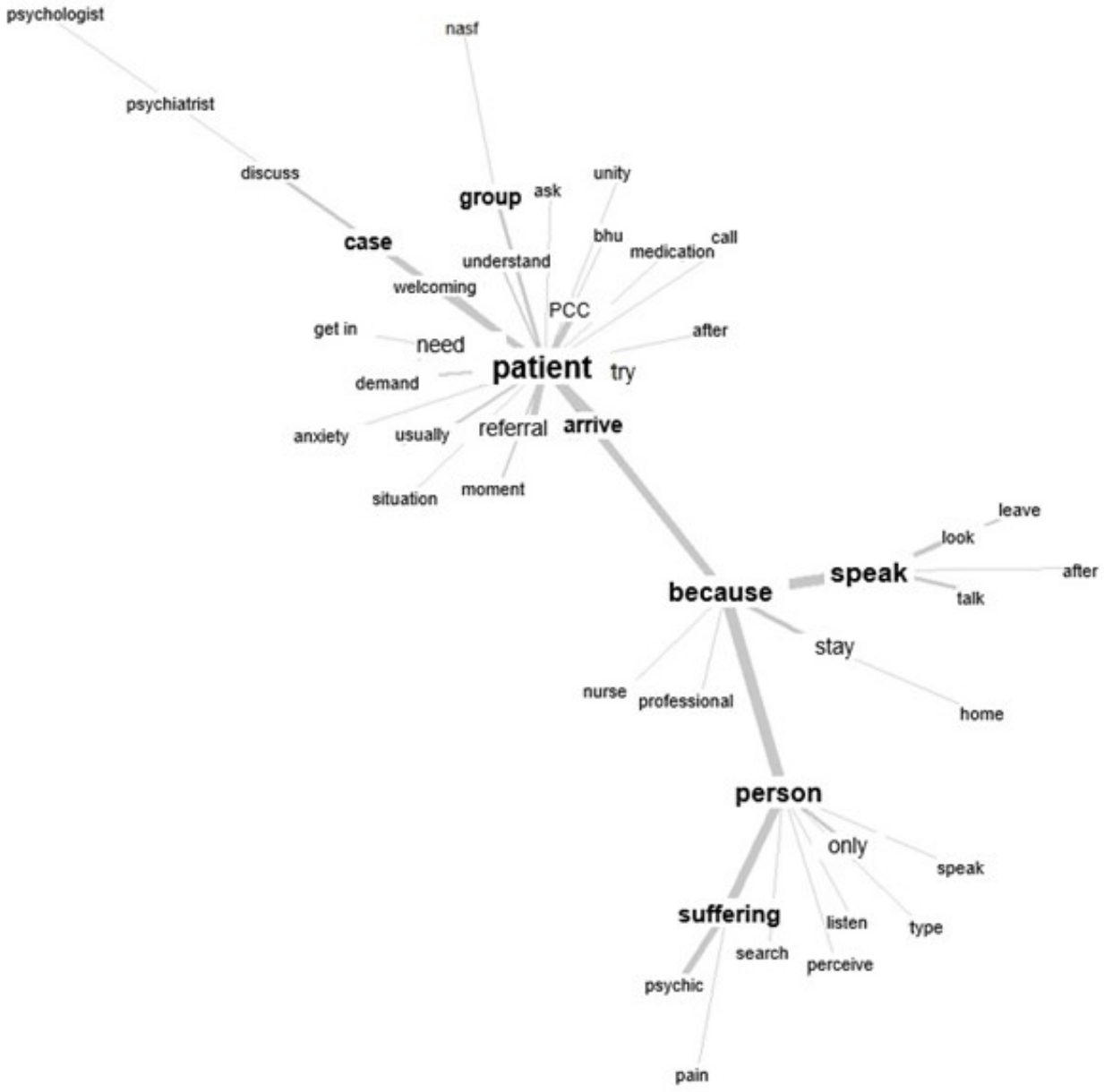
According to Cassell[8], suffering is a severe state of distress, associated with events that threaten a person's integrity and requires self-awareness and involvement of emotions with impactful effects on the body. The author also adds that a person has a past and accumulated experiences throughout life as a part of today and yesterday, giving meaning to the life events that are part of the person.

Following this understanding, nurses understand that suffering often appears veiled in the face of so many organic complaints, and that to manifest it, the body can function as a outlet for the implosions of personal and social conflicts, and that the discomfort that the person brings in consultations, generally it is not of the order of a physiological change. It generally involves a particular context of the person that is not included in care protocols that only highlight the objectivity achieved, that is, the disease as a phenomenon[6,19].

The nurse must then expand their understanding of the physical, emotional, mental, and psychological aspects that involve human suffering, as only then can, in fact, fulfill their goal of alleviating it. To do so, one must interact subjectively with the person, in a mutual exchange of understanding of personal and existential meanings and values[8].

It was highlighted in the present study that other ways must be envisaged so that the body is not overloaded as the only way of communicating and coping, with speaking and

Figure 2 – Similarity Analysis of the textual corpus.



Source: IRaMuTeQ database, 2023.

listening being ways that provide a space for resignification on personal and relational issues, facilitating the perception and creation of new dimensions that are less distressing, considering possible pathways within the healthcare network[12,20].

The results demonstrated that in the face of several situations in which psychological distress is presented, nurses enable listening, allowing space during care for the person to speak and cry. It was also concluded that, when listening to psychological suffering, one must explore the person's life story, a point that involves listening to social suffering, understanding that listening also involves listening to their dramas and plots, socially and psychologically constructed[7,21]. According to the theoretical framework, the importance of an exhaustive understanding of the person is emphasized, of

what made them who they are when they feel whole, threatened or disintegrated, in addition to exploring their view of the past, future, others, their lives, goals and purposes[8].

It was found that nurses believe that medicalization or help from another professional can intervene more satisfactorily for people in psychological distress. This finding may be related to deficient training on the topic of mental health, given that the disciplines still have reduced hours in most courses[22] and, therefore, the intervention may be directed to another professional, supposedly more qualified to provide care.

It was also found that when they do not feel able to deal with people in psychological distress, nurses frequently request assessments from the FHSC team or specialized care, which plays a very important role in case discussions, including matrixing as an intrinsic part of their work.

Matrixing is implemented using a plurality of technologies, including case discussion, which is a highly routine procedure in PHC health units, and its richness lies in the fact that an interdisciplinary team focuses on cases, and make multiple views about the process of people becoming ill, as well as numerous care proposals, expanding the scope of understanding about psychological distress[23].

However, it is worth noting that from 2019, discretionary funding was ended and the FHSC conformation parameters were discontinued, with significantdiscrediting of teams in subsequent years and, consequently, losses in the care for people in psychological distress[24].

When they assess that the person in psychological distress presents some degree of risk (risk for suicide as most cited), nurses refer them to other services such as PCC or call SAMU to refer them to the hospital and criticize that there is no definition and/or risk classification, nor where they should be referred.

In a recent study that analyzed mental health practices conducted by Family Health Strategy nurses, a similar reality was found, where the practice of referring people in crisis is constant, reported by more than half of the professionals, justifying a lack of support technical and training on mental health[25]. However, besides the technical and resource difficulties, the articulation of PHC with other components expands the possibilities of care and boosts the qualification of PCN[26].

The weaknesses of communication mechanisms and the lack of recognition of institutional care flows highlighted by nurses were also configured as obstacles to the development of comprehensive and continuous care, which compromises the construction of a collective language recognized by different professionals and managers[27].

Therefore, faced with the most severe and critical cases, it would be feasible to qualify the team regarding referral conduct and risk identification, so that they are aligned with the mental health urgency criteria. For this purpose, the establishment of a more structured flow, together with the other PCN services, would contribute above all to the demand of people in psychological distress[28].

It is a reality that risk stratification in mental health is a guiding strategy to guide referrals for specialized care to continue at the secondary and tertiary levels. However, it is necessary that the referral and counter-referral system and the local PCN are effective, organizing assistance[29].

Nurses demonstrate misalignment with the conception of the psychosocial care field when understanding crisis situations as "outbreaks" (psychotic), they feel insecure and without autonomy in caring for people in psychological distress. To overcome these issues, they considered that the establishment of instruments, protocols and flows can guide their practices and bring more "safety".

A study points out that the implementation of protocols in mental health care in PHC can qualify conduct and eliminate the reproduction of prescriptions and referrals, constituting a transformative step in assistance[30]. It is believed that associated with permanent health education actions, based on concrete situations that nurses experience, these technologies can imprint and consolidate practices aligned with the paradigmatic assumptions of Psychiatric Reform and Psychosocial Rehabilitation.

The present study contributes to the expression of generalist nurses, in care practice, regarding their perception on mental health practices in PHC in relation to people in psychological distress. A possible limitation of the study concerns the non-inclusion of managers, whose perspectives would enrich the understanding of mental health care management in the municipality. However, the findings can certainly support the reproduction of studies on the subject and strengthen the debate in other realities in the country.

FINAL CONSIDERATIONS

Nurses working in PHC conduct their practices based on the perception that psychological distress results from a process triggered by a heterogeneity of factors, often related to the social and family environment and with different forms of presentation, including signs and physical symptoms. It is possible to note, then, an expanded understanding of psychological distress, which is gradually assuming a dimension previously occupied by mental disorders.

The practices promoted by nurses are carried out through the promotion of spaces for listening and expression, discussion of cases with FHSC professionals and matrixing, in an attempt to enhance their care. However, they perceive shortcomings in training to assess individuals in psychological distress, expressed in insecurity when providing care. Therefore, they request the development of management instruments, such as institutional protocols and training to support care.

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