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Nursing Academics' knowledge of Mental Health and the emerging generalist Market

El conocimiento de los académicos de enfermería sobre Salud Mental y el emergente mercado generalista

O conhecimento dos Acadêmicos de Enfermagem sobre Saúde Mental e o mercado generalista emergente

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Abstract

The aim of this study was to identify and evaluate the knowledge of nursing students on Mental Health, answering the question: "Do nursing students feel prepared for the emerging market in Mental Health, aiming at psychosocial care, in practice?". It was a descriptive study, with a qualitative approach, conducted at a private university located in the State of Rio de Janeiro, with 17 academics from the last nursing periods. The data collected in the interviews were analyzed using Bardin's Content Analysis method, which made it possible to emerge three thematic categories: The clinical case, the paradigm of medicating, containing, and monitoring and social stigmas. The students found it difficult to rationalize the clinical case of a routine nature in general hospitals; with speeches full of stigmas and prejudices and difficulties in implementing the new model of assistance in Mental Health, proposed in graduation. On the other hand, curricular changes obtained so far have not been able to guarantee comprehensive care in the area, claiming to resolve gaps and uncertainties that will guarantee a more complete academic education, while the emerging generalist market demands professionals more and more apt in this issue of Health Public.

Descriptors: Mental Health; University Graduate; Nursing; Teaching.

Resumén

El objetivo de este estudio fue identificar y evaluar los conocimientos de los estudiantes de enfermería en Salud Mental, respondiendo a la pregunta: "¿Los estudiantes de enfermería se sienten preparados para el mercado emergente en Salud Mental, con miras a la atención psicosocial, en la práctica?". Se trató de un estudio descriptivo, con abordaje cualitativo, realizado en una universidad privada ubicada en el Estado de Rio de Janeiro, con 17 académicos de los últimos períodos de enfermería. Los datos recolectados en las entrevistas fueron analizados mediante el método de Análisis de Contenido de Bardin, que permitió emerger tres categorías temáticas: El caso clínico, el paradigma de medicar, contener y monitorear y los estigmas sociales. A los estudiantes les resultó difícil racionalizar el caso clínico de rutina en los hospitales generales; con discursos llenos de estigmas y prejuicios y dificultades para implementar el nuevo modelo de atención en Salud Mental, propuesto en la graduación. Por otro lado, los cambios curriculares obtenidos hasta el momento no han podido garantizar una atención integral en el área, pretendiendo resolver brechas e incertidumbres que garantizarán una formación académica más completa, mientras que el emergente mercado generalista demanda profesionales cada vez más aptos en este tema de Salud Pública.

Descriptores: Salud Mental; Graduado Universitario; Enfermería; Enseñando.

Resumo

Objetivou-se com o presente trabalho identificar e avaliar o conhecimento dos discentes de enfermagem sobre Saúde Mental, respondendo à questão: "Os acadêmicos de Enfermagem se sentem preparados para o mercado emergente em Saúde Mental, visando o cuidado psicossocial, na prática?". Foi um estudo descritivo, com abordagem qualitativa, realizado em uma universidade privada localizada no Estado do Rio de Janeiro, com 17 acadêmicos dos últimos períodos de enfermagem. Os dados coletados nas entrevistas foram analisados pelo método de Análise de Conteúdo de Bardin, o que tornou possível a emersão de três categorias temáticas: O caso clínico, o paradigma do medicar, conter e vigiar e estigmas sociais. Os discentes encontraram dificuldade em racionalizar o caso clínico de caráter rotineiro em hospitais gerais; com falas repletas de estigmas e preconceitos e dificuldades em implementar o novo modelo de assistência em Saúde Mental, proposto na graduação. Por outro lado, alterações curriculares obtidas até então não têm dado conta de garantir um cuidado integral na área, clamando por resolver lacunas e incertezas que garantirão uma formação acadêmica mais completa, enquanto o mercado generalista emergente demanda profissionais cada vez mais aptos nessa questão de Saúde Pública.

Descritores: Saúde Mental; Graduação; Enfermagem; Ensino.

Introduction

Mental illnesses and disorders affect more than 400 million people worldwide, according to the World Health Organization. According to the United Nations (UN) body, between 75% and 85% of affected individuals do not have access appropriate treatment. In Brazil, it is estimated that 23 million people experience these problems, with at least 5 million at moderate to severe levels[1].

The old model asylum, full of stigmas, presented a context of social exclusion, neglect and abandonment. Psychiatric hospitals and nursing homes created for permanent hospitalization. Cast model, based exclusively on hospitalization without quality of life and without humanized care. The patient was stereotyped before society, generating contempt, bitterness and often fear around him. The changes began to occur with the development of the Unified Health System (SUS), Psychiatric Reform and the National Mental Health Policy.

Nursing education conflicted with medical education, summarizing the disease in a set of symptoms, and assigning interventions to them. Before the Psychiatric Reform, the model of nursing care was discriminated, limiting care. The new psychosocial model provides that the nurse helps the patient to regain his autonomy, social inclusion, participation of groups and integration with others. In addition to supervision, administration, food, and hygiene functions. Although the theory is full of basics and clear guidelines, the practice is still deficient. Nurses continue to perform the same activities as in the past, basically focused on the asylum model, limiting their actions to check vital signs, medications, and hygiene, leaving aside the therapeutic process[2,3].

The nurse has a fundamental role in caring for clients in psychological distress and needs professional training that requires personal, professional, and social skills, in which it covers all human complexity and its mysteries4. It seeks to recover the integrity of the being, restoring its essence. Study adds that ‘’ The nurse has social authorization to touch the person in all their complexity - inner, social and cosmic’’[5:2].

Resolution No. 03, of November 7, 2001, institutes National Curricular Guidelines for the Nursing Undergraduate Course, which highlights that the nursing professional must be able to intervene on problems that influence the health-disease process, identifying risk factors health and promoting holistic care for human beings, humanized care, mainly in the field of mental health[6].

The new health paradigm gave health professionals after psychiatric reform the duty to review their role in this care. Nurses who did not even have an established original role required commitment and professionals capable of developing new techniques. Interdisciplinarity, social reintegration, qualified listening, comprehensive view, welcoming, bonding, expanded clinic, accountability and the search for autonomy stand out. Interdisciplinarity today is a requirement of SUS for its professionals to proceed with a proposed mode of psychosocial care[5].

Due to these changes, as previously described, changes in the university scope were made to adapt the proposals of the Psychiatric Reform and the National Mental Health Program. Theoretical subjects in Mental Health are mandatory according to the curriculum guidelines, although they vary in hours and period offered (which also influences learning)[7].

Considering the new care model, the gateway today expands to any sphere of health care. This client can be in the care rooms of a family clinic and even in an emergency care at a general hospital. This demand requires interdisciplinary preparation and strategies that go beyond the doors of services inherent to Mental Health and extends to any health action and, consequently, to any professional who may be receiving this client in another sphere of care.

Studies over the years have questioned that some undergraduate nursing courses, for not meeting demands that do not cease, only accumulate. Even in 2019, the same questions permeate mainly studies in the mental health area, where the fragmentation of care begins even before the first contact with the patient, that is, it begins at graduation[7,8].

Given this, the teaching of Mental Health still consists of slow processes and structures that differ from what is expected for the current scenario, with plastered and little functional practices. The discussion of academic training in the area is not new, although it still does not provide answers that can bring nurses to the labor market capable of dealing with the intense changes and especially the growing demand for work since the population with mental disorders grows every year.

The question that guided this study was "Do nursing students feel prepared for the emerging market in Mental Health, aiming at psychosocial care, in practice?". To answer this question, the study aimed to identify and evaluate the knowledge of nursing students on Mental Health.

Methodology

This is a descriptive study, with a qualitative approach, conducted at a private university located in the State of Rio de Janeiro.

The research subjects were 17 nursing students who met the following inclusion criteria: being over 18 years old, of both sexes, being properly enrolled in the course, having attended the discipline of "Mental Health". The anonymity of the research subjects was maintained, being identified by the number that indicated the order of the interviews conducted. All participants consensually signed the Free and Informed Consent Term (ICF) and the Recording Authorization Term.

Data collection took place between July 26 and 28, 2019. The collection took place by recorded interview and guided by a semi-structured instrument elaborated in two parts, the first composed by the sociodemographic data and the training profile of the research subjects, and the second containing six guiding questions for this study: 1) What did you think of the Mental Health discipline? 2) What do you know about Psychiatric Reform and the new care model? 3)

Are you interested in the area? Because? 4) Do you think you would be prepared to assist a client with a psychiatric condition in any sphere of health, where he may appear eventually? 5) Clinical Case: Client arrives at the General Hospital accompanied by his curator. He is extremely agitated, with incomprehensible speech and his curator probably refers to angina pectoris. He says that the client is hypertensive and does not eat properly. He resides in a therapeutic residence with a medical diagnosis of paranoid schizophrenia. You, as a nurse on duty, need to approach him to perform a blood collection and begin the procedures. How would you approach it to start nursing care for this client? 6) Would there be any suggestion for reinforcement or improvement on the part of the faculty regarding Mental Health? (Internships, extension courses, lectures, graduate courses, technical visits, etc.).

Despite the psychiatric history and the research theme being Mental Health, the clinical case proposed to identify which paths the clinical reasoning of the research participants would be guided by; because the impairment that led to the emergency is described as physical.

After data collection, the interviews were transcribed in full, the data were analyzed according to Bardin's Content Analysis[9]. The content analysis categorized themes emerging from the narratives of the study participants, following the steps pre-established by the adopted methodological framework, namely: pre-analysis, material exploration and data treatment, inference, and interpretation.

Thus, three thematic categories emerged: 1- The Clinical Case. 2- The paradigm of medicating, containing, and monitoring and 3- Social Stigmas.

The research was developed according to the criteria set out in Resolutions in force No. 466/2012 and No. 510/2016 and approved by the Research Ethics Committee of the Iguaçu University (CEP / UNIG), receiving Opinion No. 3,410,039.

Results and Discussion

The 17 students of the Nursing course at a Private Education Institution in Rio de Janeiro were interviewed. The requirement was that they had already taken the Mental Health course. Of the 17 students, only 01 were male. Regarding previous academic training, only 01 had it in administration. In the variable referring to the period in which each participant is in the Nursing Graduation, the results were 35% of the participants were in the 7th period, 41% in the 9th period and 24% in the 10th period.

Regarding the training year, 41% of participants would graduate in 2019.2, 35% in 2020.2, 18% in 2019.1 and 6% in 2020.1. The fifth and last variable referred to the period that the research participants took the Mental Health discipline, taking into consideration that it is offered in the 6th period in the institution's disciplines, 53% of the interviewees took it in the 5th period, 35% in the fourth, 6% in the sixth and 6% in the seventh periods, respectively.

The Clinical Case

The proposed clinical case was: Client arrives at the General Hospital accompanied by his curator. He is extremely agitated, with incomprehensible speech and his curator probably refers to angina pectoris. He says that the client is hypertensive and does not eat properly. He resides in a therapeutic residence with a medical diagnosis of paranoid schizophrenia. You, as a nurse on duty, need to approach him to perform a blood collection and begin the procedures. How would you approach it to start nursing care for this client?

The clinical case was developed to assess how the student would behave in front of a patient presenting with angina pectoris in an emergency care. However, as this client previously had a psychiatric diagnosis, the entire work process about the client's physical signs and symptoms, given the condition of extreme discomfort and pain caused by his clinical condition, was limited to his psychiatric condition. Recalling that the objective of the present study is not to analyze or suggest that a graduate prepare this student in a specialized way for the Mental Health area, but rather in a generalist character, with enough luggage to work in any service unit.

The only interviewee who followed the line of reasoning presented, given the treatment needs for the field of physical illness, had been a scholar with a scholarship from the city of Rio de Janeiro, having therefore obtained an extracurricular internship in a unit offering Mental Health experience in the previous year. The nine interviewees who were based on common sense, reported their clinical reasoning to the traditional idea that if the psychiatric client seeks an emergency service it will probably be due to a crisis in his mental picture.

> *''But as he must be a little disoriented because of schizophrenia, it is difficult to imagine, it is exceedingly difficult [...] I am even lost thinking about how to act in this case. Totally in doubt''* (Participant 1).

> *''I would ask for help from his caregiver, right, because I have more knowledge and would do anything to try to talk to him. Because you don't have much to do. Apparently, he has a crisis, and I don't think I'm able to deal with it directly''* (Participant 15).

> *"[...] because if he is in crisis it is probably because he is not being medicated, right?''* (Participant 13).

This raises the following question: How is the formation of Mental Health Nursing in Brazil? Mental Health cannot be thought of just as a specialty, it is knowledge that cannot be neglected for a generalist nurse. The author also points out that this knowledge is not enough in the classroom, that it also adds a combination of social relationships and conditions of existence[5].

According to the National Guidelines for the Nursing Undergraduate Course, Resolution CNE / CES No. 03/2001[10], the profile that nurses must present in their training must be generalist, humanistic, critical and reflective, making it capable of acting in complex situations. However, the teaching-learning process in many Higher

Education Institutions is still based on traditional pedagogy, where '' is often restricted to the reproduction of knowledge. The teacher 'passes' the contents and the student retain and repeats them, without question, in a passive attitude, becoming a spectator, without the necessary reflection and criticism"[11:143].

With this, it is thought about teaching still based on the hospital-centered model, directing professionals to old methodological references or who maintain the common sense they had when entering the University. Nursing training institutions are still giving clinical focus, focused on diseases and the biological model based on medical orders, without professional autonomy. Summing up the individual to a set of symptoms that need intervention[12].

The paradigm of medicating, containing, and monitoring

For many years, Psychiatric Nursing was based on assistance aimed at medicalization, containment, and social exclusion. With the arrival of the Psychiatric Reform, the new paradigm of psychosocial assistance provided new instruments for the practice of Nursing, strengthening social inclusion, and bringing to the category a new role before this client for decades so marginalized[13]. However, it is complex to disconnect totally from years of hospital-centered practices that were retained in the social imaginary about madness, and that remains present in students when they enter Higher Education. The problem is that it remains when they graduate.

> *''Yeah, well, first I would try to see with his companion what the real situation is, if he has had this situation before, how he behaves, you know, I would also ask about family members and in the patient itself I would try to address it in the dialogue, right, even it was difficult, I would try to avoid as much as possible to force the situation, you know, no matter how many times we think it's the only solution, the only option we have [...]''* (Participant 4).

> *''So, first I would evaluate to see if he is able to be alone, if he would need any restraint, or something like that. If he needed, I would try to restrain his caregiver, otherwise we would have to call for help and make the effort. That's what I would do''* (Participant 10).

> *''[...] then I would talk to the person to try to minimize the situation and make him calm and, if I couldn't, then I would have to use brute force. I don't see another option''* (Participant 16).

Despite the Higher Education Institutions investing in curricular change seeking to meet the new paradigm, students apparently go through the discipline with the idea that if patients do not obey commands, brute force is still the only option. This posture, as the study concludes, only proves that despite countless cultural and social transformations regarding Mental Health assistance, the imaginary of some professionals and students remains unchanged[14].

These paradigm changes occur more easily when it starts early, still in training. Place of discussion, reflection, and construction not only of the whole theoretical and practical framework of the profession, but also the basis of what will allow the assistance of that professional throughout his career. And so, it points to the need to discuss and reflect with the students the meaning of madness, making it possible for them to reevaluate their concepts on the subject, reflect on the cultural baggage they brought and what needs to be left or replaced, their view of the mentally ill and implications for their care practice. It is important to demystify madness so that students can acquire the ability to perceive this patient as a subject who needs care, who is surrounded by limitations and that they are able to recover their autonomy and citizenship. The psychiatric reform movement uses the trajectory of madness and its meaning to gain understanding about more humanized care in Mental Health[15].

> *''It's complicated. I believe that the professional should know if he is really taking the medication correctly [...]. So, I, if I was in a situation like this, I would look for a doctor who understood a little more about the area, even to see the possibility of him having some medication, some care, you know, therapeutic, so that he can have it some treatment, [...] So I think the nurse alone, he needs help; psychologist, suddenly a social worker, from a doctor to come in with some medication, until he comes back with lucidity and you can approach [...]"* (Participant 13).

Psychiatric Nursing started in this hospital-centered model, basically based on following medical instructions, maintaining control over the patient, and ensuring hospital surveillance[16]. Participant 13 demonstrates the vision of this model that some nurses still believe to be the only form of approach in Mental Health, together with the idea of medicalization as the only alternative to crises, excluding the view of teamwork and Nursing autonomy. These perspectives also remove the student's interest in the area, causing feelings of aversion.

Social Stigmas

Throughout the history of civilizations, mental disorder has taken on different interpretations before societies. And the choice of treatment to be offered followed the same bias. The image produced by society is causally related to how this community will insert this individual in it and the stigma is related to this caricature, which may or may not be interconnected with the reality of this person[17].

Within this context, there is no way not to give stigma its importance, considering how much it still appears in the current scenario, present in various sectors of society. We found it in professionals, family members, in the patient himself (self-stigma) and it would not be different with undergraduate students. According to sociologist Erving Goffman[18], reference for many authors on the subject, stigma in the context of mental health is conceptualized as an attribute that makes this individual different from others who manage to fit into categories, often in extreme cases defined as someone bad, dangerous, or weak. This mischaracterization reduces him to someone unusual, reduced in his totality and even seen as spoiled in a social environment. These characteristics constitute a stigma, especially when the demerit effect on this individual reaches' extremes.

Stigma, however, is related to the way that society classifies people and classifies what is abnormal and unusual; thus, not having a direct association with the individual and the other, but with society and the other, being, therefore, a social construction. Stigma comes from a way of grouping people and those who do not fit in any way, leaving marginality behind. As the study concludes: "Currently, people with mental illness are not tattooed, but still bear the indelible marks of poverty, deprivation and homelessness; and are banned through more subtle methods, such as criminalization, unemployment and social intolerance"[19:460].

> *''[...] because people with mental problems only do what they want, regardless of anything [...]''* (Participant 7).

> *''[...] but I think I would approach him as if I were going to approach a child, like this''* (Participant 8).

> *[...] because it's no use, if the person is in crisis, is in an outbreak and you're going to talk, he won't hear you, understand?"* (Participant 13).

Professional stigma, considered a consequence of social stigma, starts with stigmatizing attitudes on the part of the professional, based on the assumption that the patient with mental disorder is different from the 'normal' patient and thus assistance becomes differentiated, which often becomes more painful and harmful to the user than their psychiatric condition itself. The problem is still so present today that there is a scale for measuring the stigma of professionals with patients with mental disorders - Scale of Attitudes and Opinions on Mental Illness (MDG), developed by Cohen and Struening in 1962 and still used in research recent.

> *"I would accept anything he would say to me, if he had an imaginary friend, if he had any other [...] I would join his. Agreeing with everything he said, and I would try to do the procedures within my technique normally, right?"* (Participant 2).

> *"[...] you can explain to him the treatment I need, because if not, the next nurse will also be at risk, because the person in crisis becomes aggressive. And then it's complicated''* (Participant 13).

> *"Then, immediately now, at this moment of the interview, I have no idea how I was going to approach this client, right. But I believe that right away we can't immediately show up wearing a coat, right? There is the question of the conversation, the interview with the patient, to be able to take advantage of the most opportune moment to perform the collection"* (Participant 17).

> *''I wouldn't [...] serve him as I would any other client, but with a more detailed approach, you know, because he is a psychiatrist. He won't understand much of what I'm saying to him. But for sure I would try to fulfill my role as a nurse yes''* (Participant 9).

Another point raised in a survey is that inadequate training and professional unpreparedness are important factors that cause negative attitudes towards this customer when he appears for care. Professionals can still develop their own prejudices arising from their education or as baggage from previous experiences with former patients, giving them a sense of knowing the pattern of each type of client that appears, as if there could be patterns in Mental Health. This analysis with previous experiences is extremely important since a large part of the interviewees had a nursing technician and had already experienced contact with the Mental Health stage, from the Technical Nursing Course[17].

On the 5th and 6th of July 2019, the V International Forum on New Approaches in Mental Health took place, organized by the Institute of Psychiatry of the Federal University of Rio de Janeiro (IPUB). Among several topics addressed, a discussion room on the care of the nursing professional caught my attention when it was described the care of nurses from other non-specialist areas, mainly in hospital emergencies, the reports were incompatible with the quality of the humanized service to which the nursing must be guided. The findings were listed, as follows: they usually blame the family, trace a relentless search for culprits, refer to lack of proper preparation, frustration, and revolt, stigmatize the problem, blame the drugs, debauches teach the patient to do harm to themselves even, they classify as weakness of the individual, label that every individual most distant from the social environment has a disorder and does not know how to deal with their own feelings when treating suicide cases. A line that was described in the presentation of this work cited realized shocked the audience: ''Didn't you want to die? Are you crying now? Do it right!''[20].

In Mental Health, this look goes back years of struggle for basic rights conquered. The nurse as a professional member of a multiprofessional team, present in all spheres of health and closest to the patient at the time of treatment, needs to be able to take care of the demand that epidemiological data already point to in the coming years. If the academic looks at this client with fear, uncertainty, danger signs or believes that he is a non-sociable individual, his entire role in the new care model is fragmented[2].

A work carried out with teaching nurses, pointed out that one of the necessary skills for this student to be able to understand the look that must direct this client wherever he finds it is self-knowledge. With this acquired competence, the nurse can create connections, bonds. The teacher needs to be able to bring out this therapeutic relationship so that it goes beyond pre-established biologizing paradigms in the individual who starts the course[5].

Therefore, a study concludes in its study that feelings of insecurity and stigma should not lead students to learning paths that distance them from the patient, often with repulsion, even if they are not fully aware. This learning must be built in a way that can generate a self-perception of how to feel and perceive this client, envisioning more humanized practices not only of caring, but mainly of teaching[21].

Final Considerations

This study aimed to identify and evaluate the knowledge of students about Mental Health, which showed weaknesses in customer service with mental disorders. They

presented statements full of stigmas and prejudices, inability to identify the role of nurses in the process of social insertion and self-care promoted to this client.

When directed to a clinical case with a routine character, they demonstrated a lack of knowledge about expressions and content relevant to the new care model, limiting the assistance to psychiatric diagnosis, which in a physical emergency care becomes just a detail. The neglect of looking at this human being beyond his diagnosis marks years of struggle for more humanized assistance, advocated by SUS.

It is concluded, therefore, that since the paradigm shift suffered with the psychiatric reform and the change in mental health care through substitute devices, curricular changes have been made to ensure a comprehensive approach to the area. However, they are still guided by uncertainties and gaps that make all the difference in the training of this future generalist nurse who can find this client in any sphere of care. In view of the growing demand from clients with mental disorders, it is necessary to carry out a constant curriculum analysis to prepare these future nurses, so that they can discern basic knowledge, make pertinent decisions, and intervene based on an updated scientific framework so that care is carried out with quality.

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