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RESEARCH

From alienation to the nursing clinic: care of patients with psychiatric comorbidity

Da alienação à clínica da enfermagem: cuidado aos pacientes psiquiátricos com comorbidade

De la alienación a la clínica de la enfermería: cuidado a los pacientes psiquiátricos con comorbilidad

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ABSTRACT

Objective: to understand how nurses of mental health care for psychiatric patients with clinical comorbidities. **Method**: qualitative study based on the referential of historical and dialectical materialism. Interviews with nurses were conducted using semi-structured script. Sample determined in snowball. The interviews were recorded and transcribed in full. The data were analyzed through content analysis, including: organization and exhaustive reading of the material, exploration, grouping data into thematic units, processing of results, and interpretation. **Results**: the role of nurses is marked by the dialectic between knowing and not knowing, a movement that revealed two categories: clinic of psychiatric nursing, and alienation and subordination of nurse in the care process. **Final considerations**: the development of the nursing clinic, based on the therapeutic relationship, favors integral care towards the patient, whereas alienation/subordination distances the nurse from care and impairs care.
Descriptors: Mental Health; Psychiatric Nursing; Nursing Care; Comorbidity; Professional Practice.

RESUMO

Objetivo: Conhecer como os enfermeiros de saúde mental cuidam de pacientes psiquiátricos com comorbidades clínicas. **Método:** Estudo qualitativo embasado no referencial do materialismo histórico e dialético. Foram realizadas entrevistas com enfermeiros utilizando roteiro semiestruturado; amostra determinada em bola de neve. As entrevistas foram gravadas e transcritas na íntegra. Os dados foram analisados por meio da análise de conteúdo, contemplando: organização e leitura exaustiva do material, exploração, agrupamento dos dados em unidades temáticas, tratamento dos resultados e interpretação. **Resultados:** A atuação dos enfermeiros é marcada pela dialética entre saber e não-saber, movimento que revelou duas categorias: clínica da enfermagem psiquiátrica; e alienação e subordinação do enfermeiro no processo de cuidar. **Considerações finais:** O desenvolvimento da clínica da enfermagem, pautada na relação terapêutica, favorece o cuidado integral ao paciente, enquanto a alienação/subordinação afasta o enfermeiro do cuidado e gera prejuízos na assistência.
Descritores: Saúde Mental; Enfermagem Psiquiátrica; Cuidados de Enfermagem; Comorbidade; Prática Profissional.

RESUMEN

Objetivo: conocer cómo los enfermeros de salud mental cuidan a pacientes psiquiátricos con comorbilidades clínicas. **Método:** estudio cualitativo basado en el referencial del materialismo histórico y dialéctico. Se realizaron entrevistas a enfermeros mediante guión semiestructurado. Muestreo determinado de bola de nieve. Las entrevistas fueron grabadas e íntegramente transcriptas. Los datos fueron analizados por medio del análisis de contenido, contemplando: organización y lectura exhaustiva del material, exploración, agrupamiento de los datos en unidades temáticas, tratamiento de los resultados e interpretación. **Resultados:** la actuación de los enfermeros está marcada por la dialéctica entre saber y no saber, movimiento que reveló dos categorías: clínica de la enfermería psiquiátrica y alienación y subordinación del enfermero en el proceso de cuidar. **Consideraciones finales:** el desarrollo de la clínica de la enfermería pautada en la relación terapéutica favorece el cuidado integral al paciente, mientras la alienación/subordinación aleja al enfermero del cuidado y perjudica la asistencia.
Descriptores: Salud Mental; Enfermería Psiquiátrica; Atención de Enfermería; Comorbilidad; Práctica Profisional.

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INTRODUCTION

Since its advent and until nowadays, nursing has undergone several changes. This dynamism is understood as a profession whose presence is necessary in various contexts in which human beings need to be assisted and cared[1]. In the field of mental health it is no different, nursing professionals have been and are being requested to think about their practice and to transform their knowledge and practice in order to assist in the rehabilitation of patients[2-5].

The Psychiatric Reform was a movement that exposed the need of rethinking the care provided to patients. During the pre-Reform period prevailed the biomedical model, whose focus was disease and not man in its integrality, and restricted the nurse to a position of subordination and alienation regarding medical practice[2].

With the Psychiatric Reform, the psychosocial model was proposed, which aimed for deinstitutionalization through the replacement of asylums for equipment inserted in the community, allowing care of the patient in psychological distress in their own social environment[5-6]. In this model, multiprofessional teams are agents, wherein the nurse is the professional able to assume a novel way to perform clinically, whose main focus is the subject in their existence/suffering, becoming a therapeutic agent that must leave the place of the professional with prepared answers ready for the patients' problems and that considers themselves as someone working with the patient towards the same goal[4-5,7].

This research aimed to analyze more in depth the care of psychiatric patients with clinical comorbidities due to questions raised from experiences with patients and mental health professionals, where it was possible to observe that patients had their suffering extrapolated and equally manifested in their bodies through undone beards, nails not cut, feet with cracks and precarious hygiene conditions.

It is worth mentioning that care is not limited to biological or psychological issues, but occurs simultaneously, by considering that the body of an individual is not separated from their mind, and that their psychic structure depends on these two dimensions[5].

Such a dependency can be seen in a study showing that individuals with psychological distress have a two to three times higher risk of death, in addition to reduction of 20 years in life expectancy, when compared with the general population[8]. In this way, the role of the nurse in the psychosocial model requires greater awareness of the needs of the patient, in such a way that the clinic develops actions directed towards the subject's distress without, however, abandoning the biological issues[5]. It is also part of the competence of mental health professionals to act in reducing morbidity and mortality that stems from problems related to metabolic, cardiovascular and endocrine abnormalities, sexually transmitted infections, among others common in public health contexts, in order to discuss and problematize such clinical comorbidities with the team and the subject[1,9]

In this way, the nursing care developed towards psychiatric patients with clinical comorbidities is the research object of this study.

OBJECTIVE

To understand how nurses of mental health care for psychiatric patients with clinical comorbidities.

METHOD

Ethical aspects

This project was submitted and approved by the Research Ethics Committee of the School of Medical Sciences of the State University of Campinas. Data collection was conducted upon signing of the Informed Consent Form by the individuals, respecting the ethical principles as described in Resolution 466/2012, which deals with research involving humans.

Type of study and theoretical-methodological framework

This is a qualitative study based on the approach of historical and dialectical materialism, which aims to understand phenomena through their meanings and considers social representations as able to condition the construction of reality, which is itself considered contradictory[10]. Thus, this approach allowed for considering the role of the nurse in their historical, dynamic and transformation contexts[10].

Study scenario and data source

The study was conducted in the Center for Psychosocial Assistance (CAPS III) of the municipality of Campinas. It was possible to interview nine nurses who work in five of the six CAPS of the municipality.

Sampling was conducted in snowball[11]. After requesting an interview via telephone, the three nurses who accepted first were the seeds that indicated the next nurses to request an interview to. The end of the interviews took place when the researcher's concern was answered[12]. Participants were identified by the acronym ENF followed by an Arabic number.

The following were considered inclusion criteria: nurses working for at least one year, and that treated psychiatric patients with clinical comorbidities.

Data collection and organization

The data were collected through interviews using a semi-structured script with the following main questions: Have you ever treated any psychiatric patient with clinical comorbidities? Tell me how you treated them. The interviews were recorded on digital audio and transcribed in full.

Data analysis

The data were analyzed through content analysis, including the following stages: organization and exhaustive reading of the material, exploration, grouping data into thematic units, processing of results, and their interpretation[13].

RESULTS

The data were organized in order to support the two categories, based on the dialectic that represented the contradictive movement between knowing and not knowing.

Category 1 – Clinic of psychiatric nursing

This category consists of discourses that refer to the presence of the psychiatric nursing clinic in the process of caring of the psychiatric patient with clinical comorbidities, determining knowledge.

The findings of this category showed the process of care as focused on the subject, articulating psychiatric Nosology with therapeutic conducts aimed at stimulating the patients' autonomy. Thus, these conducts favor the accountability of subjects for their health, which may indicate less relevance when looking through the lens of biomedical care.

> *I learned over time that we focus on the subject, right? So, is the pathological issue important? Yeah, but by having a therapeutic conduct we'll focus more on the subject than on the disease, isn't that right.* [...] *Actual handling of the cases ends up being something different* [...] *I think it depends on the case.* (ENF-5)

> *With coexistence I also think it's an ideal space, so demands emerge and it is a more spontaneous thing.* [...] *I enjoyed those moments where they are also responsible for their clinical health, which you can care in another way. We tried to deconstruct the idea that it's only possible to handle these things via medication, via doctor, that there are other professionals who can also do clinical orientations, yeah?* (ENF-8)

The interviews revealed that the psychiatric nursing clinic is based on the nurse-patient relationship and starts from the moment they meet, of permanence, and of bond. In the process of caring, permanence enables the relationship to occur and promotes the identification of biological changes.

> *We pay more attention to the people who come here more often, those that are always here because of the bond, because of group activities, and then we can tell when there's something different, when the disturbance isn't only due to the psychological part.* (ENF-3)

> *The person used to come here with some glycemia disturbance and was extremely confused* [...] *"Hey, that doesn't occur when he is in crisis, there's something different". Then I checked blood glucose and it was either very high or super low* [...] *Those that visit us little we can't perform care completely, both the psychological and clinical parts.* (ENF-3)

> *I think it's easier for the nurse that is good in regards to mental health and is quite updated on this subject to deal with clinical issues* [...] *and it depends on how much I get involved or not with the patient.* (ENF-1)

It was revealed in these discourses that nurses recognize the disadvantages of looking at the care towards the subject in a fragmented manner, considering only psychiatric Nosology. In this context, it was pointed out that this fragmentation into body and mind results in difficulties for caring patients and has as consequence the fragmentation of care into the distinct points of attention that constitute the system.

> *So this was a case we could not identify that it was a toothache, but we were treating this disturbance as if it were because of the pathology... schizophrenic with mild intellectual disability, anyway ... we believed it was that. It was also a case that stayed with us... that we couldn't look at that more clinical issue of his.* (ENF-5)

> *There is a certain slowness in perceiving these things, and for the system, for basic care as well, I think it's more difficult to look at a user of the mental health department as a patient who needs care with their body, so it is a very dismembered thing that is left and we know it can't be, but is.* (ENF-6)

Category 2 - Alienation and subordination of the nurse in the process of caring for the psychiatric patient with clinical comorbidities

This category is composed of lines that refer to various forms of alienation and subordination that permeate the work process of nurses and demarcate "not knowing".

It is evidenced through these lines that the work process still maintains pillars in biomedical knowledge. Thus, the work of the nurse in CAPS is permeated by the alienation to the other's knowledge, the nurse does not occupy the place of who exercises their autonomy and makes their practice dependent on doctor practice, in a context in which prescription is adhered to or demonstrates, due to ignorance of the clinical treatment, the fragmentation of care and difficulty in continuing treatment.

> *A hypertensive crisis that's nothing serious, that doesn't have... that is a symptomatic hypertensive crisis we can take care of, we can prescribe the medication if there's a doctor here. If there is a doctor here he usually gives this kind of support, but we don't have a doctor available 24 hours.* (ENF-4)

> *There's always a patient with decompensated diabetes and we perform it, if it is possible, if there's a doctor here, for instance, and we can prescribe medication we do, and... if not, we refer them.* (ENF-2)

> *Users appear and require a bed, and usually come without that kind of care, do not bring clinical medication, the family can't access it ... can't have access to medications, so we have a hard time in that sense. What will I have to do? I'm going to have to call in the health center where they receive treatment to see the prescription treatment seeing as they don't even have the prescription with them.* (ENF-9)

It was possible to identify there is also the difficulty of the nurse in staying in their place for conducting care and, as a consequence, the nurse performs various tasks.

> *The referral requested the nurse to solve it because... but that's it, it just asks for solving when the situation is on the brink and what should actually be passed on to the nurse, and the nurse's attentive, so doing it, we can't... because we're taking care of other things that sometimes aren't even related to nursing, you understand?* (ENF-1)

> *We end up assuming too many tasks that are not ours and put it all together and, in everyday life, the patients with severe cases... and we can't do what's supposed to be done.* (ENF-7)

The interviews showed that the alienation and subordination of nurses extrapolate the work environment in CAPS and also comprises health services that constitute the system.

> *He comes here with the bandages all dirty, with flies on top of them... he only goes to the Health Center on Mondays, he didn't go on Friday, what do I do? I can't apply it because I have no structure to apply the bandages here.* (ENF-2)

> *What makes me feel more like this is the health center, like, we end up doing the role of a health center and the health center loves that because they just send more tasks for us to do.* (ENF-7)

DISCUSSION

Based on the findings of this study, the dialectical movement distributed among the categories has shown to require the theoretical foundation of the concepts of clinic, alienation and subordination.

In the context of mental health, it is not uncommon to relate the concept of clinical nursing to a pathology approach, referring to the medical practice wherein the clinical view is focused on the complaint presented by the patient[14-15]. With the emergence of pathological anatomy, favoring the biological view of the disease and the body, there was a transformation in the explanatory model for diagnosis and cure of diseases and, thus, during the 19th century, the clinic directed towards pathological reactions was constructed[14-15]. In the 20th century, the medical view started to consider the spaces external to the patient's body, including psychological and social perspectives[14].

Today we can identify that the clinic is pervaded by the use of technology for the determination of diagnostics and drug treatment, as it seeks in pharmaceuticals the medicalization of problems in an attempt to put an end to human suffering[14]. In nursing, such a discussion has been historically built by the composition of the clinic in medicine, which favors the action of medical knowledge through the organization of spaces and bodies[2,5,15].

Starting from the implementation of new equipment, post-Psychiatric Reform, there was the possibility of constructing an extended clinic structured with a basis on the subject in suffering and that, through reception and care, may contribute to the articulation of the subject in their territory, and not outside it, heightening the potential of transformations on the subject and society[16].

In this perspective, there is the possibility of reconstruction of the nursing clinic centered on care, migrating to an interventionist model that has as its objective to cure, for a model that has as its premise to care[15]. This reconstruction requires the appropriation of knowledge specific to nursing, while keeping in mind the knowledge of the subject who searches for interventions[15-16].

Hence, it is important to consider that the development of the clinic can't occur linearly, as it is permeated by constructions and deconstructions of the area of care and marked by complexity in considering that mental health problems originate from determinants of several causes, which allows for working in different ways with the aim of achieving the best possible meaning for the person's existence[17]. For such, it is necessary to reorganize the work process in mental health in order to understand the psychosocial and political needs of the subject, surpassing the tutelary paradigm[17-18].

If, on the one hand, the practice of nursing is based on knowing and leads to a possibility of care, on the other, in the results of this study was observed that the lack of knowledge can demarcate the movement of alienation and subordination of nursing in a coping reality.

Alienation can be defined as a contradictive relationship that occurs when man establishes a state of estrangement with the products of their work and with their social relations, in which their work ceases being affirmed and recognized, creating a negative valuation that produces suffering and discontent[19]. This estrangement arises when the agent of the work is alienated from the means of production and property, their activity is alienated with regards to the other and they lose control over their working process. Thus, in the context of alienation, human marks of the subject in the world and their subjectivity cease to belong to man, culminating in the non-recognition of self and leading them to face work as a means of ensuring survival[18-19].

This depiction of alienation, inherent to the capitalist system, emerges from the social and technical division of labor and reproduces within work the ideological and political relations of social classes that reinforce social inequality and the difference between the owner of profit and the owner of workforce, establishing a relationship of domination[20].

Based on this setting, health work has transformed throughout history into a source of subordination, characterized as a limitation upon the control of the subject over their own work, resulting from fragmentation and hierarchization of the work process[20-21]. This scenario allows to reaffirm to health professions a sense of valuation of intellectual work by devaluing manual labor[18-20].

In Brazil, the emergence of psychiatric nursing was marked by class difference and the social division of labor[20]. Still, it was assigned to nursing a character of mission and vocation, which put qualified formal education in the background and, therefore, this practice had its work conditions neglected. In this context, the idea that nursing practice could be performed freely or at very low costs was fortified and could generate relations of submission seen on the basis of the purchase and sale of the workforce and of the recruitment of women to exercise activities that did not require qualification[18,20].

Alienation, understood as a dynamic concept that requires change, not only produces alienated conscience, but also the awareness of being alienated[22]. This awareness impairs the acceptance of remaining inert to alienation, making the need to overcome it arise[19,20]. Hence, with the development of the nursing clinic throughout history, it is possible to identify a resistance movement against nursing practices subordinated and perceived as a support role for medical practice[18,20].

Next to the possibility of the development of the nursing clinic, there was the dialectical movement marked by biomedical knowledge, which inserts into the scene the category of alienation and subordination of the nurse towards their own practice. The interviews showed that, for some nurses, it is hard to think about possibilities of taking care that are independent of medical knowledge. This is shown in the discourses where the absence of the doctor and the lack of medical prescription impede the conduction of care, being necessary a referral to other services.

The biomedical model disconnects man from their social and cultural apparatus as it concerns exclusively with the complaint based on organic parameters that are disturbed[23]. It is important mentioning that this power relationship has determined the place of nursing throughout history based on the social and technical division of labor. This division culminates in the fragmentation of work within the nursing staff, in which intellectual work is assigned to nurses and manual tasks are assigned to nursing technicians and assistants[15]. This division is also reflected on a sphere of the multiprofessional team that establishes a performance role, while other professions are holders of intellectual knowledge[18,21]. Even when resisting this place with the construction of its own scientific basis since the 1950's[15], the interviews showed that nursing is still alienated and subordinated to biomedical knowledge as it continues acting in order to complement medical practice.

The consequence of this practice based on biomedical knowledge is exemplified in the process of care aimed towards the administration of medicines, physical care, and monitoring of patients' behavior[2]. In this reality, the work process is still organized in order to ensure the effectiveness and be complementary to medical practice[2].

The pursuit of subjectivity promotes the construction of the place of the patient as a citizen, which is fundamental for mental health policies nowadays[24-25]. Thus, the fact of using an approach that focuses on disease is characterized as a setback for nursing in mental health, even when it comes to identifying comorbidities that may be connected to the index psychiatric illness.

As a possibility of confronting this reality that produces alienation, it is observable in the results of this study that there are nurses who think the process of care as having a focus on the subject and perform the approach on a case-by-case basis. The literature points out the importance of considering the history of each subject and recognize them as beings that have a peculiar way of responding to the health/disease process and of structuring their life, instead of reducing them to a patient who needs to be treated[15-16]. In this context, nursing care turns its look back towards the unique aspects of the subject's life, which implies not merely dealing with biological and physiological demands[2]. Hence, the work process of the nurse is organized in a way as to encourage the development of a clinic that is focused on the subject and that considers the disease as part of the experience of their existence[15].

A tool of the clinic that can prioritize the focus on the subject, articulating psychiatric Nosology to integral care may be listening, characterized as a device that helps to minimize anguish starting from the production of meanings by allowing the other to be heard, and has its importance as a possibility to create a space for the circulation of the word and the development of the ability to think in new ways to deliver care[26]. This tool promotes the recognition of singularity, and can contribute with a proposal for care that goes beyond the biomedical perspective and medicalization[2].

In this sense, it is assumed that nursing practice can be developed based on practices that promote the scientific knowledge of the nurse by understand the subject, in order to think about interventions that promote the autonomy of the patient and allow their participation in the construction of health-promoting practices[15-16].

In nursing, the diseases that characterize comorbidity, for instance diabetes and hypertension, may be questioned by the nurse as topics that allow for the possibility of creating a space for the circulation of the word, which can promote the construction of singular forms of the subject to deal with their disease. Thus, the recognition of the subject in their entirety allows for care originated from integrality, an essential aspect to be adopted in the process of caring for the psychiatric patient with clinical comorbidities, as it enables action towards preventing complications and aggravations[27-28].

It is interesting to note that even in cases where medical intervention is required, such as hypertensive crisis with presence of symptoms, the nurses do not consider any other possibility of developing an intervention that goes beyond medication, especially considering that the care model in mental health acknowledges the subject in their relationship with their territory and social network, which may indicate that, in addition to care at the moment of the crisis, in a second moment, it will be important to continue assisting integrally[1,16].

Considering the possibility of constructing the clinic with a focus on integrality, the respondents' lines allowed to identify that its foundation is the nurse/patient relationship.

In the late 70's, the nurse/patient ratio began to gain space as a key element of psychiatric nursing[3]. It is through psychiatric nursing, also known as a therapeutic relationship, that the interaction nurse/patient is supported, with the aim of helping the individual to find possible solutions[3].

The therapeutic relationship created between nurse and patient requires investment of both in order to promote the recovery of health. In this context, it is vital that the nurse holds the place of therapeutic agent, using the relationship as a pillar for care and as a means to get to know the life experiences of the individual, encouraging them to take responsibility for their symptomatic production and, consequently, for their choice of therapeutic decisions[17].

The lines of the respondents showed that the meeting, the permanence and the bond are aspects that enable the development of the therapeutic relationship, especially with patients who spend more time in service. The relationship between professional and patient does not occur immediately and is not a simple task. The relationship is built gradually and according to coexistence[29]. This context requires that the professional recognizes the patient's right to be treated with respect and dignity, nurses making themselves available for the meeting and for establishing the bond, which is part of the plan of care and encourages patient compliance towards the service[29].

It was observed that there are nurses who recognize the losses in care based on the fragmentation between body and mind when taking into account only psychiatric Nosology. As mentioned earlier, the increased risk of death due to biological problems in patients with mental disorders can emphasize the importance of the nurse of the CAPS in the recognition of clinical comorbidities and promotion of actions that prevent the worsening of the patient's condition.

The nursing practice is intrinsically related to the body. From the perspective of the nursing clinic, the body can be understood as articulated between real, imaginary and symbolic, where this structure is expressed through the symptom[16]. In this way, the

possibility of conducting nursing care that focuses exclusively in the body and its functions is excluded, and it is thought of an approach that frees space for the subject to express the function that is assigned to the organ through discourse[16]. Thus, it is understood that the biological comorbidity, manifested through the symptom, can be an unusual way of dealing with the suffering caused by the disturbance of the relation between body and drive[16,30].

Such a disturbance can be expressed in repetitions, be it persistent hyperglycemia due to improper eating habits, cuts and self-mutilation of the body, which manifest the resistance in giving meaning to the symptom and, thus, cause suffering[16,30]. In this context, it is essential to recognize clinical comorbidity as an aspect of the patients' singularity and that can be addressed through the listening, enabling the circulation of speech and even repeated acts by the individual as a means of making them question their own conflicts, which, by remaining hidden, will continue expressing suffering through the body[16,30].

The moments when physical care is carried out must be understood as an integral part of patients' care, so that they become subjects of care; and not just another moment, technical and automatic[31]. When performing techniques such as applying bandages, hygienic care, checking vital signs, the mental health nurse must stop conducting these practices in a purely technical and automatic manner, and make them therapeutic acts where it is possible to occur interaction nurse/patient and therapeutic listening[2,32].

Constructed this way, the nursing clinic contributes for interventions to be designed based on the particularities of the individual, and seeks to meet their needs integrally, breaking ties with a specific care that stems from the fragmentation between body and mind and that always incurs into previously determined interventions. Thus, the care of psychiatric patients with biological comorbidities is thought to develop through the relationship nurse/patient and, consequently, favors an approach of the symptom in a unique way.

The recognition of the subject in their integrality and singularity enables the development of the nursing clinic which, based on relations, can contribute to the autonomy of the individual in the pursuit of better health conditions. These findings evidence that in the care of psychiatric patients with comorbidity, the therapeutic relationship favors the identification of biological and behavioral changes resulting from diseases.

Hence, it is possible to ascertain that interaction, listening and the availability of the nurse contribute to the recognition and approach of needs that can be assisted by the health team[29]. What is considered is that the development of the clinic is not limited to discarding biomedical knowledge, but aggregates it to other knowledge and practices which, together, qualify patient care[17].

In CAPS, the nurse is part of the multidisciplinary team and has the task of playing an active, innovative role towards mental health nursing practice[33]. In contrast to the possibility of development of the nursing clinic, the findings of this study also revealed that there is difficulty on the part of the nurse to determine what their place is. Hence, the team refers several demands to this professional. By accepting everything that is brought to them, nurses distances themselves from the place of therapeutic agent and become characters subordinated and alienated by the multidisciplinary team, which halts the development of the clinic.

Note that the lack of reflection and appropriation of the role of the nurse makes this professional assume tasks that do not compete exclusively with their profession, and it occurs more often with services outside the hospital environment, which present a new attitude towards nurses, a moment when their professional identities are distorted[33]. When one's own position is not well defined, it is unlikely to expect that other professionals that constitute the multidisciplinary team recognize that position. Given this context, the team assigns bureaucratic activities and execution of traditional care focused to the guarantee of hygiene and medicine administration to nurses[5].

It is highlighted that the multidisciplinary team gives very simplistic assignments to nurses and, on the other hand, empowerment of their knowledge and practice is not perceivable, nor does a different position of the team occur. Consequently, actual coexistence between the professionals and the collective development of therapeutic practices does not occur[27].

In fact, multidisciplinary teamwork does not imply in excluding the professional identity of the nurse in any way; however, this professional needs to be clarified with respect to legal support in order to conduct their activities and meet the assignments that are part of their competence in the field of psychosocial care.

Mental health care is performed together with the system, promoting matrix support actions. The matrix support strategy consists of a process of shared construction of the care plan among CAPS teams and the family health strategy, and aims to consolidate mental health care and enhance the integration of professionals[34]. In this research, the results showed that the nurse responds to the demands presented by health centers and, on the other hand, does not specify what is their work, contributing to an alienated practice, marked by distancing from their own practices.

The matrix support strategy faces challenges related to poor integration between services and there is still the idea that individuals in psychological distress experiencing a crisis should be treated in CAPS and then return to the basic care[34]. This fact shows the difficulty in conducting care integrally, and a lack of articulation between the services[34]. With this, CAPS professionals end up feeling responsible for care that should be shared with the system and that, by failing to be shared, compromises healthcare.

Study limitations

The study was conducted in a municipality of the State of São Paulo well known with respect to the Brazilian Psychiatric Reform movement, having a structured system of psychosocial care. Municipalities without such a system may present a distinct reality.

Contributions to the nursing field

Knowledge about the dialectical movement of nurses was characterized as a contribution of this study to nursing, in that it can identify knowing and not knowing in the face of the care of psychiatric patients with clinical comorbidities.

The development of the nursing clinic is considered a possibility of severing the connection to the context of alienation, and of promoting the role of the nurse in preventing worsening and promoting health, constructing care that gives autonomy to the patient, which is then integrated.

This study enables possibilities for others to approach the importance of the clinic of psychiatric nursing, pointing it as a possibility to reaffirm the place of nurses as professionals that are open to meeting the patient and, based on that, think of new forms of care, considering integrality and the subjectivity of the individual that is seeking care.

FINAL CONSIDERATIONS

The knowledge on how the nurses working in CAPS care for psychiatric patients with clinical comorbidities was appropriated by the clinic of psychiatric nursing, and by the alienation and subordination of the nurse in the process of caring for the psychiatric patient.

It was observed that the nurse is inserted in a context marked by a dialectical movement that either reveals a reality of alienation, or presents possibilities for caring. On the one hand, there are nurses that restrict their practice as they distance themselves from the place of the individual that cares, and alienate themselves towards the knowledge and practice of the other. On the other hand, there are nurses that, by appropriating nursing knowledge, see possibilities for care based on the therapeutic relationship and the moments when they meet the patient.

ERRATUM

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