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EXPERIENCE REPORT

Hygiene and mental health: body care in the clinical intervention in a CAPSI

Higiene e saúde mental: o cuidado com o corpo na intervenção clínica de um CAPSI

Higiene y salud mental: el cuidado con el cuerpo en la intervención clínica de un CAPSI

Valdinei Santos de Aguiar Jr [1], Adriana Maria de Oliveira [2], Lília Cláudia Almeida de Araújo [3]

ABSTRACT

Objective: report the experience of personal hygiene as an aspect of the clinical intervention in a Psychosocial Care Center for Children and Adolescents (CAPSi) in the state of Rio de Janeiro, Brazil. **Method:** this is a descriptive study, with an experience report design, organized into two moments: at the first, a workshop with guardians was created, consisting of psychologists, nursing teams, pharmacists, physicians, and dental team (the latter two as guests from the primary health center); at the second, problems/limitations were identified, as well as the need for creating strategies that could keep the participation of guardians in the workshops. **Results:** low adherence of parents was found, leading us to think of other actions more effective. **Conclusion:** it is hoped that this study can provide significant reflections on strategies for mental health in primary care and contribute to the practice in a CAPSi. **Descriptors**: Hygiene, Mental health, Care, Clinical intervention.

RESUMO

Objetivo: relatar a experiência da higiene pessoal como aspecto da intervenção clínica de um Centro de Atenção Psicossocial Infanto-Juvenil (CAPSi) no estado do Rio de Janeiro. **Método:** trata-se de um estudo descritivo, do tipo relato de experiência, organizado em dois momentos: no primeiro foi criada uma oficina com os responsáveis, composta por psicólogos, equipes de enfermagem, farmacêuticos, médicos e equipe de odontologia (os dois últimos como convidados da unidade básica de saúde); no segundo foram identificados problemas/limitações, assim como a necessidade da criação de estratégias que sustentassem a participação dos responsáveis nas oficinas. **Resultados:** evidenciou-se uma baixa adesão dos pais, levando-nos a pensar outras ações mais efetivas. **Conclusão:** espera-se que este estudo possa trazer importantes reflexões acerca de estratégias para a saúde mental na atenção básica e contribuir para a prática do CAPSi. **Descritores:** Higiene, Saúde mental, Cuidado, Intervenção clínica.

RESUMEN

Objetivo: reportar la experiencia de la higiene personal como un aspecto de la intervención clínica en un Centro de Atención Psicosocial para Niños y Jóvenes (CAPSi) en el estado de Río de Janeiro, Brasil. **Método:** se trata de un estudio descriptivo, un reporte de experiencia, organizado en dos momentos: en el primero, se creó un taller con los cuidadores, que comprende psicólogos, equipos de enfermería, farmacéuticos, médicos y equipo dental (los dos últimos como invitados del centro de salud primaria); en el segundo, se identificaron problemas/limitaciones, así como la necesidad de la creación de estrategias que podrían mantener la participación de los cuidadores en los talleres. **Resultados:** se constató una baja adherencia de los padres, que nos llevó a pensar en otras acciones más eficaces. **Conclusión:** se espera que este estudio pueda proporcionar reflexiones importantes sobre estrategias para la salud mental en la atención primaria y contribuir a la práctica de un CAPSi. **Descriptores:** Higiene, Salud mental, Cuidado, Intervención clínica.

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INTRODUCTION

The Psychosocial Care Centers (CAPS) “are institutions designed to embrace patients with mental disorders, stimulate their social and family integration, support them in their efforts to seek autonomy”.[1] A CAPS for children and adolescents (CAPSi), in turn, due to the subjective, physical, and legal characteristics of its users, requires a peculiar intervention strategy, as well as the an effective interconnection to the network of health, education, social work, and justice/guarantee of rights, since embracement must go beyond the notion of treating mental disorders, aimed at social inclusion and quality of life.

The organization of the Brazilian National Health System (SUS), grounded in Law 8,080/1990[2], establishes that “health is a fundamental human right, and the State should provide the conditions required for its full exercise”. It institutes that the provision of health care for the population must go beyond treating diseases; thus, we have to act not only for recovery, but also on disease prevention and health promotion. In line with the perspective adopted by the World Health Organization (WHO) - which recommends that health, rather than the absence of diseases, is the state of full physical, psychological, social, and moral well-being - SUS, as a set of actions and services, is based on this broad view where health promotion receives or might receive due prominence[4].

However, disseminating and applying this concept requires, at least, two aspects: overcoming the hospital-driven paradigm - which is still in force with intense strength in social practices and representations - and health democratization. It is also worth emphasizing that it is understood that health democratization does not happen only regarding access to health services, but it also concerns knowledge and a (more) effective participation in health care. It is specifically in these aspects - knowledge and participation - in the health promotion domain that we observe that personal hygiene practices, among others, become a key factor to the commitment to a broader notion of health, a better quality of life of individuals and communities, and a health democratization which is effective and transformative.

The same piece of legislation (Law 8,080/1990) providing for the State’s obligation in relation to the population’s health status establishes that “the State’s duty does not exclude that of people, family, companies, and society” (Art. 2, § 2)[5].

Then, having this premise as a basis, it is assumed that health democratization also permeates the invitation to society, families, and, even more specifically, people to participate in the promotion of collective and individual health. Self-care - which includes not only recovery from diseases, but also preventing them through physical activities, leisure, and health care, for instance - is established as a health promotion act and a commitment to the broader view of health and citizenship.

So, that is when comprehensiveness, as a principle called upon in the guidelines of SUS must drive health programs, removing as much as possible the leading role played by the

hospital as a specific locus of health care and establishing new ways of care. The term comprehensiveness itself already suggests a critical review of the paradigm of increasing specialization/fragmentation that has guided the construction of scientific knowledge. It puts into question how the fragmentation of knowledge and application in the search for a thorough decomposition of parts may have disregarded the complexity and interdependence of the various factors that make up health. Thus, the person as a whole and correlated to her/his environment carries the possibility of a knowledge on her/his health that goes beyond the fragmented specialization and it may ultimately guide the promotion of one's own health[5,6].

However, this kind of knowledge, like knowledge as a whole, is not something given *a priori*. It is something to be constructed, a walking/doing elucidated in the dialectics between experiences and perspectives on the world, concepts, and oneself.

Then, the proposal of a hygiene and personal care program is introduced as a therapeutic resource and a means for promoting citizenship in a Psychosocial Care Center for Children and Adolescents (CAPSi) in Itaguaí, Rio de Janeiro, Brazil, initially envisioning three aspects in the application of this program:

a) Its possibilities as intervention in the psychological clinic in the mental health field;

b) The contribution by nursing and the effectiveness in preventing some specific diseases and in promoting health;

c) Health democratization by means of a collective construction of knowledge on self-care as an instrument of citizenship.

The purpose of this study is reporting the experience with the process to create workshops of personal hygiene as an aspect of the clinical intervention in a CAPSi. It aims to demonstrate that, in this service, personal hygiene not only relates to physical health promotion and disease prevention, but also provides subjective transformations as it allows attributing new meanings to care and greater democratization to health.

METHOD

This is a descriptive study, with an experience report design, conducted in the CAPSi in Itaguaí. This is a public institution operating from Monday to Friday from 8:00 a.m. to 5:00 p.m. It provides care for children and adolescents up to 18 years with severe mental disorders.

The information was recorded in a field diary and transcribed whenever there were interventions with the hygiene workshop, something which culminated in the final text of this experience report. This experience involved the multidisciplinary team in health education related to personal hygiene.

We shared basic concepts of hygiene with parents of children attending the service. We also informed children about the importance of hygiene measures at home.

We followed a script for designing and organizing the experience report on personal hygiene of patients with mental disorders (Table 1).

N	Steps
1	Clinical psychological intervention
2	Contribution of the multiprofessional team to health promotion
3	Collective construction of knowledge
4	Hygiene care: patient and family
5	Identifying problems
6	Possible solutions as a team

Table 1-Script for the experience report.
Source: prepared by the authors.

RESULTS E DISCUSSION

EXPERIENCE DESCRIPTION

The object of this study is personal hygiene as an aspect of the clinical intervention in a CAPSi, which constitutes a gateway to mental health care and provides care for patients with mental disorders in the context of childhood and adolescence.

We identified the need to create a beauty workshop aimed at patients and family members due to the body hygiene deficits noticed by staff during sessions. The objectives were reinforcing the importance of basic bodily care, answering to questions, and discussing them as a group.

The workshops enabled a closer relationship between staff and family, as they seek to walk in order to allow the subject to establish bonds of self-care, work, and affection to others, determining the political and social purpose associated with the clinic. In current health services, emphasis on the particularity of each case, multiprofessional work, listening and respect for the individual with a mental disorder, and the creation of new intervention strategies in the social and clinical field allowed the return of activity as a significant resource in clinical treatment and psychosocial rehabilitation.

The workshop is more closely linked to the issue of object than speech itself, because its operation, whatever its tendency is, always refers to a product, a material production. The workshops produce subjective and socializing effects by operating on a concrete material surface, which allows establishing enjoyment outside the subject's body[7].

Hence, the workshops might be in an unprecedented field, an intersection between the clinic's place, specifically, on one side, and the place of collective activities, with an eminently sociopolitical nature, on the other. The workshops might be, in fact, in the field of a possible treatment for psychosis, an expanded clinic, which combines politics and clinic.

In line with the ideals of resocialization, rather than developing skills, the workshops aim to introduce, in the culture, the difference that madness represents, inviting the patient with a mental disorder to “get included in some form of social bond, i.e. participating in a group of signs that enroll her/him as a social and political subject as much as it is possible to her/him”[7].

Our experience and practical experience in child/adolescent mental health has led us to think through issues related to care, including personal hygiene. We witnessed several situations of children and adolescents in poor hygiene conditions, something which was not consistent with the reality of their guardians (in some cases). This restlessness of the team was discussed during staff meetings, the cases that we identified during our provision of group or individual therapy that showed poor personal hygiene. After the discussion of problems and in line with the team, we decided to resort to some strategies, in order to achieve the cooperation of guardians and children/adolescents to improve the physical health status. To organize ideas, we divided our experiences and strategies into the following steps:

- First moment: a therapeutic workshop with guardians, consisting of psychologists, nursing team, pharmacists, physicians, and dental team (the latter two as guests from the primary health center), was created. Aspects of oral, body, and scalp hygiene were covered. Initially, parents were committed, actively participating in the process through workshops. It is believed that they are useful treatment devices, which must give rise to new practices and ways that professionals must adopt to provide a comprehensive care, towards the psychosocial rehabilitation and the construction of citizenship by individuals with mental illness and, also, seek knowledge to support their family members[4]. However, over time, parents’ presence decreased until no guardian attended the workshops anymore.

When we faced this limitation, we took the case back to the meeting. We discussed about the possible reasons for the lack of guardians’ interest, although many knew how important body care is, because our perception was directly reported to parents when a problem was identified, with individual discussion of the best way to help them.

- Second moment: after assessing the problem of poor adherence of guardians to the workshops, we identified the need to create another strategy that resumed the previous one and contributed to their adherence, as the problem with personal hygiene persisted.

A beauty workshop was created, aiming to advise some children/adolescents who showed more precarious personal hygiene. The activities comprised washing the scalp, nail care, oral hygiene, and makeup. Guidelines were provided to patients who had some degree of understanding and to their guardians about the importance of hygiene among children and adolescents, and there was concern to avoid invading the space of these parents regarding their responsibility as active individuals in the therapeutic process of their children. The adherence was satisfactory in the first month of the workshop. However, it could not be maintained due to patients’ absences.

The guardians were asked about the absences of children in the workshop when they attended the service with their children to continue care, others were asked during the parents’ meeting, which occurred on the last Tuesday of each month. The reasons were

varied, among them lack of financial resources to attend the workshops, change of address, husband's unemployment, parents' physical and mental burden, and difficult access, because some patients were provided with care more than once a week. In some cases, it was possible, along with the social worker, provide assistance with government resources. This assessment was made according to each case.

Given these observations, we decided to construct a reflective study addressing the role played by the teams along with the CAPSi and its possibilities as intervention, contributions, effectiveness in promoting health, and collective construction of knowledge to change reality.

It is believed that the workshops promote actions for psychosocial rehabilitation and promotion of citizenship that evoke interaction and participation. They incorporate the family in the recovery of these individuals. These activities enable communication between individuals and an increased social and working network[6,8].

We identified the need for new adaptive strategies to achieve the original purpose of the team, in order to reach patients and families within the context: hygiene. It is known that the process is gradual and that there is a need for continued commitment. However, it is worth emphasizing that family is an active institution in the process of adhesion and response to the therapy proposed, either in clinical intervention, health promotion, or construction of collective knowledge, both for the provider and the receiver.

It is understood that, by providing care for the patient with a mental disorder, we identify her/his actual needs and how valid it is to talk effectively about the advice and personal care procedures. We also must help her/him (patient and family member) by answering to questions, enabling an organization that suits her/his life situation and perspective.

In these spaces, the actions, which used to focus on signs and symptoms, classification of the various nosographic elements, and medication for madness, take another approach, i.e. embracing the patient and talking of health, therapeutic projects, citizenship, rehabilitation and reintegration into society, and, especially, life projects[9].

There is also a need for embracing, regarded as one of the main attitudes taken by the professional working in health services, as it aims at the quality of care and favors a humanized assistance. Embracing involves the idea of close relationship between worker and user by means of an assistance that encompasses the various issues of the individual and promotes listening to her/his needs, something which goes beyond reception, acceptance, is the production of new values of solidarity, social responsibility, commitment, and citizenship by establishing a bond between workers and users[8].

Embracing in the health field must be understood, at the same time, as an ethical/aesthetic/political guideline, constituting the ways to produce health and a technological intervention tool to improve the quality of listening, constructing a bond, ensuring access to the services with accountability and solution of problems[10].

This embracing regarded as a technical and clinical action allows analyzing the working process in health with a focus on relationships. Besides, it assumes changing the relationship professional/user and the social network, professional/professional, through technical,

ethical, humanitarian, and solidarity parameters, leading to recognition of the user as an active and participant individual in the health production process[11].

A factor of great importance is the communication referred and accredited by scholars in the health field as a significant tool in health actions. By believing that listen to the message conveyed, through verbal and non-verbal communication, implies understanding what the person expresses and identifying the meanings she/he attributes to reality. It is also worth taking into account that the professional may intervene only when she/he can help optimizing the information and accept people who are undergoing constant transformation, growth, and maturation, as well as seek for autonomy and self-fulfillment[8].

Therefore, by identifying adverse issues, it becomes easy to outline specific strategies for each group of interest and achieve success in actions, so that it is possible to reach the individual involved, without denying her/his duties and responsibilities related to her/his own health.

CONCLUSION

Despite the progression in the teaching-learning of guardians and patients in the process of health education involving hygiene and the strengthening of relationships between the team and family members, which positively impact on patient care, there still remains limitations that hinder the adoption of proper hygiene habits.

In our experience, we realize the need to move towards embracing, in the communication process and the quality of information provided. The latter, when mismanaged, can directly interfere with the absorption and adhesion to the hygiene proposals discussed by the multiprofessional team and identified as problems.

The reality of our reflection is valid for the construct of this study and the clinical practice, the role played by the multiprofessional team when faced with issues of hygiene and body care shows to be crucial so that this theme is understood by the family and the patient her/himself. Sometimes, we do not realize how much we influence and contribute to help the patient, either in the process of knowledge construction or any other procedure.

We regard as a challenge the communication process along with patients with mental disorders and their family in relation to body hygiene. We must always consider that advice should be ruled by the individuality and uniqueness of each client, taking into account each family and cultural context.

We must invest in staff training to meet the needs of the service, theoretical and/or practical, significantly contributing to the expansion of studies in the field. Furthermore, changes in the physical space can enhance discussions with the family and the patient, with better listening, decision making, and relationships with the team.

Greater commitment to embrace guardians and patients can contribute to a relationship of trust between professionals and users, providing better results.

Therefore, we hope that this study contributes to the practice in a CAPSi and that further studies on the theme can provide advances in public health and mental health, by proposing new health education actions.

REFERENCES

1. Brasil. Manual CAPS, 2004. Brasília (DF): Ministério da Saúde; 2004.
2. Brasil. Leis n. 8.080/90 e 8.142/90. Brasília (DF): Ministério da Saúde; 2003.
3. Saraceno B. Libertando identidades: da reabilitação psicossocial à cidadania possível. Rio de Janeiro: Tecora; 1999.
4. Brasil. Saúde mental no SUS: acesso ao tratamento e mudança do modelo de atenção. Relatório de Gestão 2003-2006. Brasília (DF): Ministério da Saúde; 2007.
5. Correia VR, Barros S, Colvero LA. Saúde mental na atenção básica: prática da equipe de saúde da família. Rev Esc Enferm USP. 2011; 45(6): 1501-6.
6. Tonini NS, Maraschin MS, Jorge CC, Silvestro J, Machado JG, Reche K. Acolhimento na perspectiva dos profissionais de saúde que atendem indivíduos com transtorno mental. Nursing. 2012; 15(173): 526-30.
7. Guerra AMC. Oficinas em saúde mental: percurso de uma história, fundamentos de uma prática. In: Costa CM, Figueiredo AC, organizadoras. Oficinas terapêuticas em saúde mental: sujeito, produção e cidadania. Rio de Janeiro: Contracapa; 2004.
8. Leite MMJ, Martini JG, Feli VEA. Programa de atualização em enfermagem: saúde do adulto (PROENF). Porto Alegre: Artmed; 2006.
9. Amarante P, organizador. Archivos de saúde mental e atenção psicossocial. Rio de Janeiro: NAU; 2003.
10. Brasil. Cartilha da Política Nacional de Humanização. Acolhimento nas práticas de produção de saúde. Brasília (DF): Ministério da Saúde; 2010.
11. Brasil. Reforma psiquiátrica e política de saúde mental no Brasil. Conferência Regional de Reforma dos Serviços de Saúde Mental: 15 anos depois de Caracas. Brasília (DF): Ministério da Saúde; 2005.

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