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Person-centered care in psychosocial care: What do professionals think, feel, and do?

Cuidado centrado na pessoa na atenção psicossocial: o que pensam, sentem e fazem os profissionais?

Cuidado centrado en la persona en la atención psicosocial: ¿qué piensan, sienten y hacen los profesionales?

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ABSTRACT

Objective: to understand professionals' perceptions and experiences regarding person-centered care in psychosocial care. **Method:** This is a qualitative intervention research study guided by the Person-Centered Clinical Method framework and conducted with 30 professionals from two Psychosocial Care Centers in central Brazil. Experiential workshops, group techniques, field diary notes, and a professional questionnaire were used to collect data, which were then subjected to thematic content analysis. **Results:** there is an ambivalence between thinking and acting, with some professionals' thinking based on asylum logic and others on the psychosocial care model. The contrast between positive feelings (e.g., love, hope, faith) and negative feelings (e.g., sadness, fear, danger, and judgment of patients) influences professionals' practice. **Final considerations:** actions such as understanding and respecting patients, developing protagonism, individualizing treatment, developing the Singular Therapeutic Project, resocializing, and offering health education promote person-centered care.

Descriptors: Mental Health; Patient Care Team; Education, Continuing; Professional Practice; Patient-Centered Care.

RESUMO

Objetivo: compreender as percepções e vivências de profissionais sobre o cuidado centrado na pessoa na atenção psicossocial. **Método:** pesquisa-intervenção qualitativa, norteada pelo referencial do Método Clínico Centrado na Pessoa, realizada com 30 profissionais de dois Centros de Atenção Psicossocial da região central do Brasil. Oficinas vivenciais, técnicas grupais, anotações em diário de campo e questionário profissiográfico foram utilizados para coleta de dados, submetidos à análise de conteúdo temática. **Resultados:** há uma ambivalência entre pensar e agir, com alguns profissionais com pensamentos baseados na lógica manicomial e outros no modelo de atenção psicossocial. O contraste entre sentimentos positivos, amor, esperança, fé e sentimentos negativos como tristeza, medo, perigo e julgamento dos usuários interferem na prática dos profissionais. **Considerações finais:** ações como compreender e respeitar as pessoas assistidas, desenvolver o protagonismo, individualizar o tratamento, a construção do Projeto Terapêutico Singular, ressocializar e oferecer educação em saúde favorecem o cuidado centrado na pessoa.

Descritores: Saúde Mental; Equipe de Assistência ao Paciente; Educação Continuada; Prática Profissional; Assistência Centrada no Paciente.

RESUMEN

Objetivo: comprender las percepciones y vivencias de profesionales sobre el cuidado centrado en la persona en la atención psicosocial. **Método:** investigación-intervención cualitativa, guiada por el referencial del Método Clínico Centrado en la Persona, realizada con 30 profesionales de dos Centros de Atención Psicosocial (CAPS) de la región central de Brasil. Se utilizaron talleres vivenciales, técnicas grupales, notas en diario de campo y cuestionario profesiográfico para la recolección de datos, sometidos a análisis de contenido temático. **Resultados:** existe una ambivalencia entre pensar y actuar, con algunos profesionales basando sus pensamientos en la lógica manicomial y otros en el modelo de atención psicosocial. El contraste entre sentimientos positivos (amor, esperanza, fe) y sentimientos negativos (tristeza, miedo, peligro y juicio de los usuarios) interfiere en la práctica profesional. **Consideraciones finales:** acciones como comprender y respetar a las personas atendidas, desarrollar su protagonismo, individualizar el tratamiento, construir el Proyecto Terapéutico Singular, resocializar y ofrecer educación en salud favorecen el cuidado centrado en la persona.

Descriptores: Salud Mental; Grupo de Atención al Paciente; Educación Continua; Práctica Profesional; Atención Dirigida al Paciente.

INTRODUCTION

It is essential for person-centered care to be attentive to the needs and preferences of the individual being treated. It is necessary to pay attention to the changes that occur in the patient throughout the care process. The term "person" is used to emphasize the holistic approach to care, considering the person as a whole, not limited to the illness or specific symptoms, but also considering their well-being, desires, and the broader social and cultural context[1].

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Scientific evidence in the Brazilian scenario context of psychosocial care points to institutionalization and action based on the classic psychiatric model, being grounded in a territorial psychosocial care model. Although patients are not confined to the Psychosocial Care Network (*Rede de Atenção Psicossocial - RAPS*), they are connected to services with a strong biomedical foundation focusing on medication prescriptions[2].

In this regard, researchers highlight the importance of breaking away from biomedical and asylum-based models by holding weekly meetings to promote interdisciplinary collaboration in community mental health services, aiming to reduce the barriers imposed by mental healthcare practices in asylums, and emphasizing the importance of collaborative work developed by teams. This process aims to foster collective collaboration and a comprehensive discussion on health habits[3].

A cross-sectional study of 220 mental health nurses in South Korea which identified person-centered care predictors among these professionals, including moral sensitivity, revealed that nurses need ongoing education to implement person-centered care, which in turn requires organizational and political support to implement these practices in the workplace[4].

Furthermore, a study conducted in the Netherlands highlighted some challenges to incorporating person-centered care based on open dialogue in the mental health context, such as: understanding and communicating the concept of person-centered care in practical settings, which requires knowledge management processes; difficulties in interpersonal processes, as transformations of paradigms rooted in mental health practices can generate emotional discomfort; and the need for involvement of various actors linked to the phenomenon of person-centered care[5].

In the context of professional training, a qualitative document analysis study which analyzed Swedish national medical, nursing, occupational therapy, and physical therapy programs found no content related to person-centered care in national guidance documents. However, local programs more frequently identified content related to this topic in nursing programs than in medicine, which requires standardization in the delivery of this content in higher-level health programs[6].

In the context of community mental health services in Brazil, researchers point out that some team members continue to work within the biomedical model[7]. Although some professionals practice care based on the psychosocial and person-centered care model, this is still insufficient to overcome hospital-centric and segregating practices[8]. Other team members end up preserving the biomedical model, which hinders consolidating interdisciplinary practices in the psychosocial care setting[9]. This highlights setbacks in the National Mental Health Policy[10].

Faced with these challenges, the Pan American Health Organization (PAHO) developed guidance material on community mental health services to promote person-centered and rights-based approaches to effectively implement person-centered care in the mental health context. People with psychosocial care needs still face prejudice, neglect, and coercive practices and abuse[11] in contemporary times.

Furthermore, a theoretical reflection which sought to identify the ethical principles and theoretical frameworks of person-centered practice revealed that the paradigm shift toward person-centered practice involves domains such as philosophical knowledge, theoretical frameworks for clinical practice, teaching and research, as well as approaches to implementation and regulation which need to be interconnected to systematically operationalize person-centered care[12].

One tool which can be used by multidisciplinary teams to systematize person-centered practices is the Person-Centered Clinical Method (PCCM), which encompasses four components: 1. Exploring health, illness, and the illness experience; 2. Understanding the person as a whole; 3. Developing a joint problem management plan; and 4. Strengthening the relationship between the person and the physician/healthcare professional[13].

In light of the above, this is a pioneering study on person-centered care in community mental health services in Brazil. It combines the process of Continuous Health Education (CHE) to qualify and transform professionals' practices to strengthen the psychosocial and person-centered care model, aiming to contribute to the recommendations of the Pan American Health Organization and the World Health Organization[11].

Furthermore, it will be possible to address research gaps on how person-centered care impacts user satisfaction and the healthcare quality[14]. Therefore, the aim is to answer the following question: What are the perceptions and experiences of professionals from two Psychosocial Care Centers regarding person-centered care in their daily practice? In view of this, the objective of this study was to understand the perceptions and experiences of professionals regarding person-centered care in psychosocial care.

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METHOD

This is a qualitative intervention research study[15] guided by the theoretical framework of the Experiential Learning Cycle (ELC)[16] and the Person-Centered Clinical Method[13]. Intervention research aims to intervene in reality, but does not focus on immediate change resulting from established action. It creates a new relationship between theory and practice, as well as between subject and object, to enable this institutional transformation[15]. This study's report followed the criteria of the Consolidated Criteria on Reporting Qualitative Research (COREQ)[17].

Experiential learning is achieved through a cycle of four sequential stages: 1. activity (implementing a lived experience of a given situation through games, role-playing, and other resources); 2. analysis (broad discussion of what was experienced in the activity stage to construct a diagnostic process through presenting ideas, perceptions, opinions, emotions, and feelings of the group members); 3. conceptualization (systematization of lived experience through concepts and theoretical foundations to develop individual "cognitive maps"); 4. connection (correlations of what was experienced and reflected upon with professional practice and life in general)[16].

The intervention consisted of an experiential training process on person-centered care and took place from October to December 2022. Four three-hour group meetings were held in a workshop format with a 15-day interval between meetings, following the ELC framework of activity, analysis, conceptualization, and connection[16].

The first meeting of the training process aimed to introduce the topic of person-centered care to professionals to understand their perceptions of this phenomenon in their daily work. The second meeting aimed to stimulate reflection among group members on the first PCCM component: 1. Exploring health, illness, and the experience of illness; the third meeting sought to address the second and third components of the PCCM: 2. Understanding the person as a whole; and 3. Developing a joint problem management plan. Finally, the fourth and final meeting aimed to discuss the fourth PCCM component with the teams: 4. Strengthening the relationship between the person and the physician/healthcare professional[13].

Thus, a total of 30 professionals from two Psychosocial Care Centers (*Centros de Atenção Psicossocial - CAPS*) in a city in central Brazil participated in the group meetings: a Type III Alcohol and Drug Psychosocial Care Center (*CAPSad III*) and a Child and Adolescent Psychosocial Care Center (*CAPSi*). The meetings were held at *CAPSad III*, and the *CAPSi* team traveled.

Of the 30 professionals, 15 were from *CAPSi* and 15 from *CAPSad III*. Professionals who provided care to service users were included, while team members who were away from work due to leave or vacation and those who worked solely in administrative activities were excluded.

The experiential training process was registered as an extension project entitled "Educational Workshop for Person-Centered Care in Psychosocial Care". All meetings were planned and facilitated by two researchers specializing in Group Dynamics and Team Management, Group Consulting and Management, and Mental Health.

The first data collection stage was preceded by a snack to encourage greater interaction between the teams. The Informed Consent Form (ICF) was subsequently presented, and after signing the ICF participants were instructed to complete the professional profile questionnaire to characterize their sociodemographic and professional background. After completing the questionnaire, stationery was provided so that each participant could create their own name tag with the name they would like to be called.

The data for this study are the result of the first meeting of the experiential training process which focused on understanding mental health professionals' perceptions of person-centered care. To this end, the empty figure technique[18] was used in the ELC activity stage. The professionals were randomly divided into three groups, counting one, two, and three. Each person with the same number was assigned to a group. Each group received construction paper and stationery to draw a blank figure, which could then be filled with phrases, drawings, collages, and other resources, according to their creativity.

Each group meeting lasted three hours, totaling 12 hours. The sessions were documented through audio recordings, field journal entries, and the facilitators' insights to contribute to the data analysis and discussion process. The facilitators also took photographs of the professionals' work.

The facilitators instructed the participants that each group would be responsible for answering a question related to person-centered care: Group one - What do I think about person-centered care?; Group two - What do I feel about person-centered care?; Group three - What do I do about person-centered care?

After completing the empty figure construction and fulfilling the second stage of the ELC (analysis), a discussion circle was used in which each group elected a representative to be the speaker and explain their work to the others, along with collaboration from other group members for further elaboration.

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Next, the dialogued exposition strategy was used in the conceptualization stage of the ELC, with the facilitators presenting slides on introductory aspects of person-centered care. Finally, the "Suitcase and Trash" technique was used to evaluate the meeting, by which the facilitators distributed two slips of paper to each group member. They were instructed to record on one slip what they took from the meeting to put in the suitcase, and on the other what they would leave in the trash.

The data were subjected to thematic content analysis according to three sequential stages: 1. Pre-analysis; 2. Exploration of the material; and 3. Processing of results: inference and interpretation[19]. The materials to be analyzed were initially selected and skimmed: the drawings of the three subgroups, transcriptions of the representatives of each group (P1, P2, and P5) who presented their production of the empty figure professionals, and the recordings made by the participants on the technique slips (the suitcase and the trash) at the end of the workshop meeting. Next, the data was coded by identifying the recording units and context, which were organized and approximated by similarity, allowing to construct the core meanings. Finally, thematic categories were constructed.

This study is linked to the anchor project approved by the Research Ethics Committee. All participants signed the informed consent form in accordance with the recommendations of Resolution No. 466 of 2012 and were coded by the letter P, numbered from 1 to 30, according to the order in which they spoke in the group meetings.

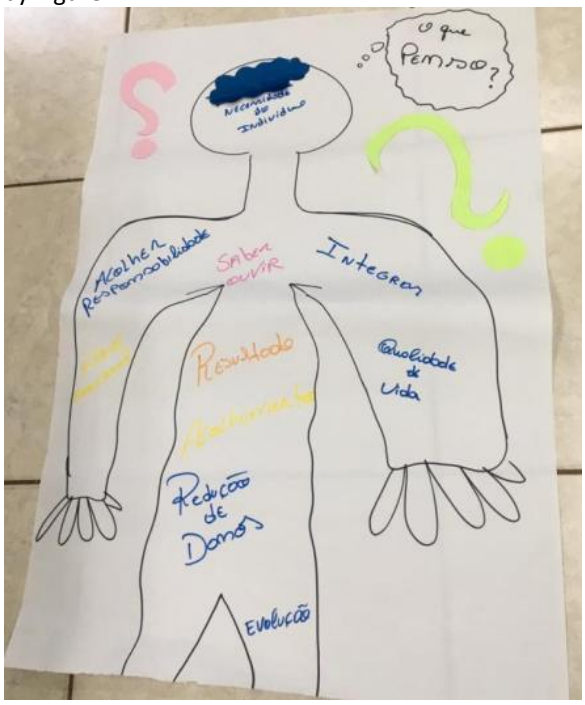
RESULTS AND DISCUSSION

The study involved 30 professionals, 19 of whom were between 30 and 49 years old, and 28 participants were female. Participants' educational backgrounds included three nurses, 11 psychologists, one social worker, eight nursing technicians, two pharmacists, one educator, two physical therapists, one music therapist, and one physical educator.

Content analysis of the groups' productions (drawings and narratives) revealed the professionals' perceptions and experiences regarding person-centered care. This led to the development of the thematic category "Person-centered care in psychosocial care: What do I think, feel, and do?" This category included three categories: 1. Person-centered care: what do I think?; 2. Person-centered care: what do I feel?; and 3. Person-centered care: what do I do? These categories highlight the professionals' perceptions, emotions, and experiences regarding person-centered care in their daily practice.

Person-centered care: what do I think?

This category elucidates professionals' perceptions of what they think person-centered care is in the context of their work at *CAPS*, represented by Figure 1.



Notes: "*O que penso*" = "What do I think"; "*Necessidade do indivíduo*" = "personal needs"; "*Acolher / responsabilidade*" = "Welcome / responsibility"; "*Saber ouvir*" = "Know how to listen"; "Qualidade *de vida*" = "Quality of life"; "*Resultado*" = "Result"; "*Redução de danos*" = "Harm reduction"; "*Evolução*" = "Evolution".
Figure 1: Product of the empty figure technique representing the question 'What do I think about person-centered care?'. Aparecida de Goiânia, GO, Brazil, 2022.

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In the "What They Think" activity, professionals reported a lack of alignment between their thoughts and actions, which causes them to act without reflecting on their practice. This occurred because they often planned to do something one way in their daily practice, but ended up executing it another. This discrepancy between thinking and acting/doing was also observed in the drawing of the empty figure, where the arms were depicted as larger and more robust compared to the head.

This visual representation leads us to believe that this presentation of the arms as larger than the head may be associated with a more intense approach to doing in relation to the concern for critical reflection or theoretical foundation of what professionals are doing in their daily work at *CAPS*, which, as reported by the participant, is an instinctive action:

> *[...] we stick with the term "what I think," but within a service, "what I think and what I do" - in our understanding - are very close, because they are two concepts that sometimes we think one thing and then do another. It can create an over-impression, that it's not what I think, it's what I do, but because it's something kind of instinctive sometimes. [...] (P1)*

There is a complexity to healthcare practice that goes beyond "reflecting" to "applying". This finding strongly calls for considering the power of educational spaces, including analyzing everyday practice, as in CHE. Furthermore, the participant's statement highlights the dynamism of daily action in a *CAPS* unit, where decisions are made within the context of meetings.

The disconnect between thinking and acting can undermine psychosocial clinical practice based on critical and reflective thinking. One alternative to reversing this phenomenon is to invest in teaching practices during the training period which consider the community's reality to assign meaning to the content being taught. Therefore, teachers need to act critically and reflectively to develop individuals through teaching based on social situations[20].

Considering that the needs of the user was identified by the group as an aspect related to person-centered care in psychosocial care:

> *[...] So how do we think about caring for the individual in particular? I think we mainly think about the individual's need, about why they are coming to seek the service, we think about why this individual is seeking the service, what led them to be here. [...] (P1)*

The verb integrate was recorded in the drawing representation, which, according to the participants, means the integration of the needs that users bring to the community mental health service teams:

> *[...] integrate it into the needs they are seeking. (P1)*

Some participants associated person-centered care with meeting the needs of *CAPS* users. A scientific study indicates that hierarchical logic still persists in the healthcare context, in which technical knowledge, characterized by specific, linear actions often decontextualized from the user's reality, prevails over the professional-user relationship. From this perspective, there is a vested interest in maintaining hegemonic power on the part of healthcare professionals rather than in opening up space for discussion and negotiation with users about their demands and care needs to strengthen their autonomy for self-care[21].

Users are often not heard or supported in their real health needs. Furthermore, they are often not encouraged to develop their own leadership in self-care. This suggests a lack of empowerment among patients in the healthcare process, with few opportunities for them to actively participate in decisions related to their well-being and to be encouraged to take an active role in their treatment and improvement. This runs counter to person-centered care, which encourages active participation by patients throughout the rehabilitation process, including their involvement in their Singular Therapeutic Project (STP).

It was argued that listening to patients is essential to implementing person-centered care, as it is through listening that professionals create expectations about patients' treatment:

> *In a way, we need to know, well, we think about how to listen, about knowing how to listen to this patient, and knowing how to listen would already be an action [...] and then, as we sometimes create this expectation in the patient, so sometimes we hear something from him and we already create certain expectations in search of results, in search of good welcoming [...] (P1)*

Qualified listening is a powerful strategy for welcoming people with mental healthcare needs. It is essential for understanding people's needs when seeking care[22], which fosters closer understanding of the user's experience in the psychosocial rehabilitation process.

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Responsibly welcoming people, knowing how to listen appropriately to the needs users bring and then seeking to address them comprehensively was also highlighted by the group as an aspect of person-centered care:

> *[...] I think about having responsible welcoming, what is the difference between me doing welcoming and triage, because in a triage I will only collect information and pass it on, in welcoming I won't, I will collect this information and I will work with it, it would be the responsibility that I am having in being a good listener to this user, in knowing in fact what their demand is, and providing it in a comprehensive way [...] (P1)*

Responsibly welcoming, deviating from this triage procedure, was highlighted as an important action for identifying clients' care needs, which promotes person-centered care rather than just psychopathology. A study that evaluated the results of comprehensive welcoming at two Type III *CAPSads* in central São Paulo found that this practice did not satisfactorily meet quality standards for protecting and respecting human rights.

Emotional support was reported to highlight the professionals' contradictions between reason and emotion that interfere with the care provided to clients and their families:

> *Emotional support would also be an action, but emotional support is driven by emotions, and within what I think, the emotional side, many times it will contradict what I think, because I'm seeing a situation, I think cohesively that I have to do something and the emotional side tells me to do something else, and these are the contradictions that we find within the service. (P1)*

This finding reveals an important dimension of conflicts in decision-making which goes beyond a reason/emotion dichotomy. Therefore, the clinical-institutional supervision system is essential to assist professionals in decision-making processes, given that clinical-institutional supervision has a history of being guaranteed through Ministry of Health notices.

According to the group, the emotional support offered to patients is often influenced by the contradictions between the professionals' own thoughts and feelings, at times revealing professional-centered care. A qualitative study conducted with 16 *CAPS* patients revealed that the relationships that offer emotional support were associated by the participants with terms such as help, support, commitment, care, and availability that permeate them. When seeking assistance, they seek people who represent these keywords[24].

They also demonstrated that the concept of Harm Reduction (HR) represents *CAPSad* care; however, not all team members share this idea, as expressed in the reports:

> *Harm reduction is what we think of the service here specifically, alcohol and drugs, right? Harm reduction is the service's proposal, but is it really what I think? [...] so we have to think, what does the user bring to us at the time of reception? That's why sometimes the term harm reduction gets very confusing within the service because when the user arrives, they don't say they want to reduce, they say they want to stop, and throughout the treatment, they see the possibility of reducing [...] (P1)*

> *[...] but what we really think, do we want them to just reduce or do we want them to stop? It's something I think about for the service or I think about for them, right? These are questions that lead us to truly reflect on harm reduction. (P1)*

The group representative raised questions regarding the HR approach for *CAPSad* users, asking whether this approach is truly what people want during the psychosocial rehabilitation process. This finding is noteworthy because care practices in specialized psychosocial care services solely based on abstinence are reminiscent of the biomedical model, as not all users are able to abruptly stop using psychoactive substances.

HR strategies aim to mitigate the harm caused by alcohol and other drug use, taking into account people's desire to continue using the substance or their inability to stop for a certain period. Therefore, the principle of HR is not to reinforce use, but rather to provide comprehensive, collective and individual assistance to vulnerable individuals[25].

Furthermore, despite the potential of HR actions for alcohol and other drug users, a qualitative study with six healthcare professionals from a *CAPSad* revealed that participants had difficulty following HR recommendations[26], which corroborates the study's findings.

Improving users' quality of life was highlighted as the purpose of person-centered care:

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> *[...] I think of the user as the central focus and improving their quality of life; this is a thought that all of us who work in healthcare, whether mental health or health in general, think about improving their quality of life, and how can we do this? I think we improve their quality of life when we start to integrate, to do everything we've been discussing and start putting into practice, and we can see an improvement in this individual's quality of life. (P1)*

Promoting a better quality of life for users and their families was identified by the group as something related to person-centered care in the psychosocial care setting. Several factors contribute to the population's quality of life, including maintenance of urban green spaces[27]. Therefore, it is important that *CAPS* professionals encourage social reintegration of users through practices in the territory that include green spaces so that people with mental healthcare needs can occupy community spaces and not be isolated within community services.

Person-centered care: what do I feel?

This category reveals the feelings and emotions of participants that permeate person-centered mental healthcare, demonstrating contrasts between positive and negative feelings, as represented in Figure 2.

Notes: "*Medo*" = "Fear"; "*Insegurança*" = "Insecurity"; "*Felicidade*" = "Hapiness"; "*Frustração*" = "Frustration"; "*Gratidão*" = "Gratitude"; "*Raiva"* = "Anger"; "*Empatia*" = "Empathy"; "*Aversão*" = "Aversion"; "*Impotência*" = "Impotence".
Figure 2: Product of the empty figure technique, representing the question 'What do I feel about person-centered care?'. Aparecida de Goiânia, GO, Goiás, Brazil, 2022.

The feeling regarding person-centered care was also expressed based on the ambivalence between reason and emotion, which has repercussions on professional practice:

> *[...] we put in several emotions, that's what the colleague said, because sometimes we want to act in a certain way, but... our emotions keep screaming [...] (P2)*

It is important for mental health professionals to develop emotional intelligence to effectively manage their feelings to avoid acting impulsively and driven by emotions. Emotional intelligence can be understood as the ability to recognize, understand, and manage one's own and others' emotions. Professionals in the healthcare field frequently deal with situations of great pressure, stress, and intense emotions from both patients and their colleagues. Having

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emotional intelligence can promote better outcomes in patient care, as professionals will be better able to deal with the tensions experienced in the workplace[28]. Furthermore, emotional intelligence can contribute to improving interpersonal skills, helping healthcare professionals communicate more effectively, collaborate better as a team, and establish empathetic and trusting relationships with patients. This in turn can lead to a more positive care experience for everyone involved.

It is worth highlighting the power of training spaces and clinical-institutional supervision for teams to address their emotions, feelings, fears, and doubts regarding their performance. The goal is not to present a "ready-made recipe", as professional life is indeed conflictual and complex; the goal is to offer professionals support to improve their daily practice.

According to the group, love is a feeling present in the work of professionals in community health services when providing care to users, especially children and adolescents:

> *[...] We at our service, we represent the little hearts in our eyes, because the first feeling we have when dealing with the user is love, truly, I don't know if it's because they are children and teenagers. (P2)*

The feeling of love applied to what one does in their professional practice was cited by one participant as an important element of person-centered care. A study which sought to understand the meaning of love for different social actors in diverse contexts revealed that people associate it with positive feelings, the most important thing in life. Furthermore, love enables the expression of each individual's subjectivity and shifts the focus away from the outside world and negative feelings, which fosters more productive interpersonal relationships[29].

The professionals inserted question marks in the empty figure drawing, which, according to them, symbolize confusion when faced with certain situations they encounter in the workplace and are unsure of the best course of action:

> *Questions about feelings of confusion, of not really knowing what to think at that moment [...] (P2)*

Confusion about certain situations during their clinical practice in psychosocial care also appeared in the professionals' empty figure drawing, revealing the challenges faced by the teams. The need for healthcare professionals to adapt and reinvent themselves is highlighted, especially when faced with academic training that is often aligned with the fundamental principles of the Unified Health System (*SUS*). These professionals face the challenge of forming teams which promote user inclusion and build intersectoral care networks, aiming for comprehensive care.

From this perspective, CHE can be an important strategy to encourage an exchange of experiences, collaborative work, and integration of diverse social actors. This approach contrasts with the traditional Continuing Education model, which is primarily based on knowledge transmission and often results in few changes in healthcare professionals' practices[30].

Therefore, reinvention of healthcare professionals includes adopting more collaborative and integrative approaches which promote constructing broader care networks and including users as protagonists of their own care, in line with the principles of the *SUS*[30].

Lightning bolts were also represented in the empty figure drawing, which, according to the group, illustrates the fear that professionals have of users:

> *[...] the bolts are of fear, because we are also afraid of dealing with them [users] [...] (P2)*

The fear felt by users was expressed by one study participant, demonstrating the stigmatization of people with psychosocial care needs, even within specialized services. This can hinder implementing person-centered care and requires action to transform this reality.

A case study that reported on an intervention using active methodology in the field of practice of the Community Mental Health Network in the southeastern region of Brazil at a private medical school found that including students in the field of practice, especially at the beginning of the course to foster interaction with people with mental disorders is a factor that contributes to reducing stigmatization[31].

The drawing of the zipper on the figure's mouth was brought up by the group to express the desire of some of them to speak to the people they attend, but they cannot truly express their thoughts:

> *[...] The mouth is a zipper, who put on the zipper? (P2)*

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Me, because sometimes we want to talk, but we have to talk and we can't say what we think. (P3)

The group raised the issue of wanting to say something to patients, but remaining silent. It is important to question whether this unspoken speech is loaded with value judgments regarding the lives of those being cared for, as speech is not the only form of communication; nonverbal language, such as body language, can also express judgments. Thus, this behavior runs counter to therapeutic communication and can inhibit patients from expressing themselves authentically and truthfully. A professional's conduct may be fraught with moralism and authoritarianism, especially when caring for people who abuse or are addicted to drugs, which hinders successful HR practices.

Communication is essential in the healthcare context. It plays a crucial role in information exchange between healthcare professionals and patients, facilitating mutual understanding and contributing to comprehensive, qualified, and humanized care. Effective communication in the healthcare setting is not limited to information transmission; it also involves the ability to actively listen, demonstrate empathy, build bonds with patients, and provide emotional support. These are fundamental aspects for the reception and recovery of patients. On the other hand, communication failures can result in a series of negative effects, from errors in treatment administration, lack of adherence to the care plan, dissatisfaction with the care received, and even conflicts within the healthcare team[32].

Therefore, it is crucial that healthcare professionals develop and/or improve communication skills and not only be attentive to the technical but also the relational aspects of interacting with patients undergoing treatment. Therefore, investing in improving communication within the healthcare context is essential to ensuring quality care and promoting better outcomes for patients undergoing treatment and the entire team.

The reports revealed that the tears in the drawing allude to the multidisciplinary team's feelings of sadness when welcoming patients and their families and confronting their harsh reality:

> *The tears are of sadness, because really, I'm going to talk about myself in particular, because with the girls there isn't a moment at CAPS where I feel joy or happiness when welcoming them [...] every moment of treatment is more of a moment of sadness, you know, of feeling, of the situation they go through as a family, society [...] (P2)*

A single-case, mixed-method study conducted with professionals from six *CAPS* using the Itra Work-Related Injury Assessment Scale revealed the presence of psychological harm, such as sadness, with a critical rating[33]. This corroborates the research findings and highlights the importance of care actions focused on professionals.

Given this reality, one strategy for the care of mental health professionals is Integrative and Complementary Health Practices, which promote comprehensive care and consider the subjectivity of each person, taking into account the wishes and desires of those being cared for[34].

The feeling of hope intended for users in the psychosocial rehabilitation process was expressed in the figure drawing by the clover:

> *[...] what we put in the pocket was a clover, which doesn't mean luck, but hope, which is sometimes kept in our pocket to give to them [users] [...] (P2)*

According to scientific evidence, promoting hope is an essential care strategy that needs to be developed by nurses specializing in mental health and psychiatric care, in which the therapeutic relationship plays a prominent role in this process taking into account the feelings of the patients served[35]. However, this competence must be extended to all members of multidisciplinary *CAPS* teams.

Feelings of aversion to the issues users raise were expressed, which triggers a lack of understanding of the patient's subjectivity through the professionals' prior judgments. This reflects the moralism and values of those who care for the person seeking help at *CAPS*, which can interfere with the care provided:

> *[...] the issue of aversion to a situation that they present and our first feeling is of not understanding what they bring and the family brings, and we... it can also be produced as a judgment, the judgment of this aversion. (P2)*

As the participants expressed, the feeling of aversion to situations brought up by users is a reality they experience, generating judgments and a lack of understanding of the individual as a whole, revealing a disconnect with what is proposed by the person-centered care model. This finding is not isolated to the investigated services. Qualitative research conducted at a Type III *CAPS* revealed that nursing care for users of alcohol and other drugs is marked by challenges in implementing personalized, comprehensive, and judgment-free care[36].

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In tur, group 2 wrote the word “faith” in their drawing, meaning the faith they place in users so that they can evolve during the psychosocial rehabilitation process:

> *And finally, we put faith in our legs, that’s what we have, believing that they will get better. (P2)*

Professionals mentioned that faith in users’ ability to positively improve contributes to psychosocial rehabilitation. Believing and demonstrating this confidence, especially to alcohol and other substance users, is extremely important for greater effectiveness of care and building a bond with professionals to develop autonomy, as scientific evidence indicates that a lack of life plans directly influences reuse and the increased use of psychoactive substances such as alcohol[37].

The issue of danger was raised, especially in relation to the aggressive behavior of autistic children and users who self-harm and attempt suicide:

> *There’s the danger there, the danger is because we treat autistic children, and there are some who are very aggressive, so they bite, they hit, they pinch, they push. (P4)*

> *Even the danger too, there’s the danger of self-harm, [...] self-extermination, which we have a lot of at CAPS, and we have to keep an eye on them. (P2)*

The participant’s perception of danger surrounding autistic children clearly demonstrates the teams’ lack of preparation in approaching this population. The need for CHE (Higher Education Program) to improve the practice of professionals working in psychosocial care encompass the topics of HR, individuals on the autism spectrum, self-harm, and other important issues.

An integrative literature review on nursing care for children with autism spectrum disorder (ASD) highlighted challenges such as the limited knowledge of these professionals and limited opportunities for nursing staff training in caring for this group[38], which undermines consolidating the person-centered care model.

The danger was also associated with users who engage in self-harm and attempted suicide, requiring professionals to broaden their knowledge on this topic to assertively address these situations and meet the needs of these individuals. A systematic literature review with meta-analysis that identified the prevalence of self-harm in adolescents and the factors which influence it found that the main factors that influence this practice are female adolescents, older age, unfavorable economic conditions, experience of family conflicts, parents with few years of education, experiencing violence, bullying, and having contact with friends who exhibit suicidal behavior[39]. This demonstrates the complexity of the phenomenon of self-harm in adolescence.

Finally, the light bulb in the drawing symbolizes the knowledge necessary for the team to facilitate psychosocial care:

> *[...] and the lamp is idea, ideas, knowledge. (P2)*

The professionals’ drawing depicts a light bulb that alludes to the knowledge necessary for their work in the psychosocial care setting. Therefore, it is important to not only acquire knowledge, but also to develop skills and attitudes to ensure that mental healthcare is aligned with the person-centered psychosocial care model.

In an increasingly competitive job market, regardless of location or area of expertise, developing knowledge, skills, and attitudes (KSA) by professionals is essential for the progress of organizations. It requires these workers to be dynamic in developing knowledge, as well as in applying it. It requires a willingness to take action to perform tasks and go beyond them[40].

Person-centered care: what do I do?

This category presents the actions of multidisciplinary teams in relation to person-centered care in their daily lives in community mental health services, as illustrated in Figure 3.

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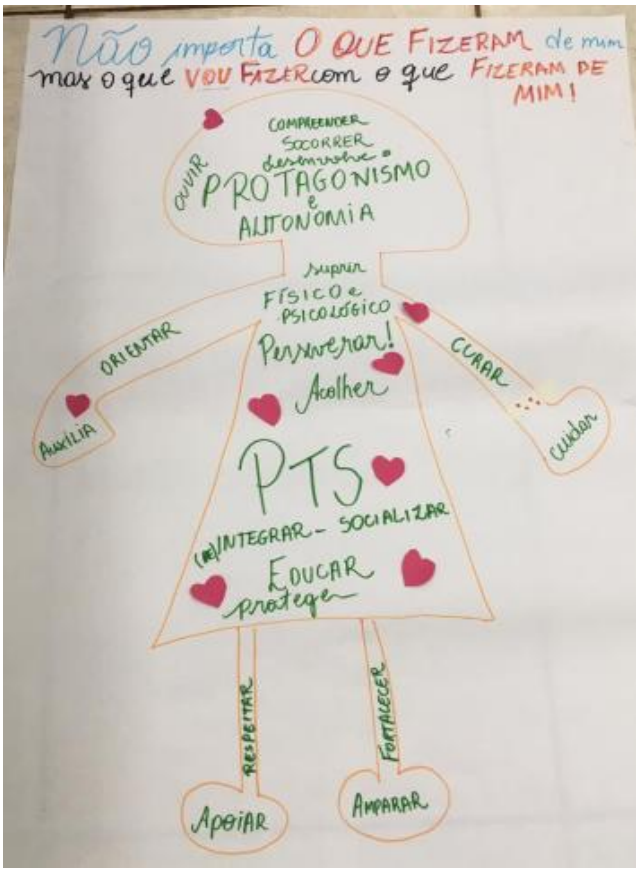

Notes: "*Compreender*" = "Understand"; "*Socorrer*" = Help; "*Protagonismo e autonomia*" = "Protagonism and autonomy"; "*ouvir*" = "listen"; "*Auxilia*" = "Assist"; "*Orientar*" = "Guide"; "*suprir*" = "supply "; "*físico e psicológico*" = "physical and psychological"; "*perseverar*" = "persevere"; "*curar*" = "heal"; "*cuidar*" = "care"; "*acolher*" = "welcome"; "*integrar – socializar*" = "integrate – socialize"; "*educar*" = "educate"; "*proteger*" = "protect "; "*respeitar*" = "respect"; "*fortalecer*" = "strengthen"; "*apoiar*" = "support" ; "*amparar*" = "assist".

Figure 3: Product of the empty figure technique representing the question 'What do I do about person-centered care?'. Aparecida de Goiânia, GO, Brazil, 2022.

In presenting the design, it was explained that individualizing care for each person being served is an action associated with person-centered care:

> *As it is person-centered, we tried to think in a more individual way, how we could individualize the service, so that it would be more personal, more related to that person. (P5)*

One tool which enables individualized care in the psychosocial care setting is development of the STP (Specialized Treatment Plan) together with clients and their families. However, there are challenges that need to be overcome, as highlighted by a study conducted at a *CAPSad* in central Brazil. This revealed contradictions in both the implementation and theoretical assumptions surrounding the STP. It demonstrated that the healthcare team sometimes operates according to the asylum model and sometimes according to the psychosocial care model[41], which weakens the person-centered care model.

The duality between the biomedical model and the psychosocial care model within community mental health services is a dilemma that requires training strategies for teams and managers to deconstruct a psychosocial care approach that labels clients based on their psychopathologies and prioritizes medication therapy over other non-pharmacological care strategies. Therefore, individualizing a therapeutic plan for each client, as highlighted by the group, is a tool that contributes to person-centered care.

It emerged in the group's presentation that the action of understanding is something linked to person-centered care, as this action contributes to listening to users and favors providing care:

> *So we talked about understanding, about helping, about listening [...] (P5)*

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Understanding the people attended by *CAPS* in order to provide them with care was mentioned by one of the participants as an attitude linked to person-centered care. According to Rogerian literature on the Person-Centered Approach, understanding differences is one of the values that must be cultivated by professionals who wish to provide person-centered care, as well as ideas of openness and consideration, combined with theoretical and practical teaching in the training process[42].

It was emphasized that actions to promote developing protagonism and autonomy among people attended by community mental health services is a factor that encompasses person-centered care:

> *[...] develop protagonism and autonomy, which is what we try to do a lot here, I'm sure that there you also try to develop in different areas [...] (P5)*

Developing user protagonism was cited as an action linked to person-centered care. Therefore, it is important for *CAPS* professionals to use care strategies which aim to encourage protagonism and autonomy in those receiving care. A qualitative study conducted with *CAPS* users showed that a music workshop utilizing musical, artistic, and cultural resources placed users as protagonists in the process and facilitated building bonds and psychosocial rehabilitation[43].

In the context of psychosocial care, the group demonstrated that actions such as giving users a second chance, persevering, and continuing to believe in recovery during the psychosocial rehabilitation process promote person-centered care:

> *We talked about the user's physical and psychological support, persevering, at least here that's what we do most, it's persevering, it's continuing to believe, giving a new chance, it's trying again. (P5)*

Giving clients a second chance contributes to establishing a therapeutic relationship, as it empowers them to believe in themselves and their potential. Together with the team and their family, they can transform their reality and reclaim their life plans, making them more independent both within and outside of community mental health services.

Belief in clients refers to empowering care, an attribute linked to person-centered care. This approach values each individual's individuality, recognizing that their needs, values, and preferences must be considered when planning care. Healthcare professionals must be open to listening and understanding what is important to each person undergoing treatment, allowing them to actively participate in decisions about their own care and treatment[1].

From this perspective, the relationship should not be hierarchical, in which the professional is seen as the expert and the service client as the receiver of instructions. Instead, a collaborative partnership should be established in which both parties work together to improve the client's well-being. This involves involving them in the discussion of treatment options, explaining potential consequences and alternatives, and respecting their choices and preferences. Furthermore, it is important to help them identify and define their own health goals, supporting them in the process of achieving them.

Ultimately, the partnership between healthcare professionals and service users promotes more person-centered care, which is more effective and satisfying for both parties. This approach empowers them to take an active role in their own care and fosters greater collaboration and trust between healthcare professionals and service users. The healthcare team must help people develop the skills, abilities, and confidence to actively and fully participate in this partnership[1].

Building the STP was highlighted as an action which contributes to establishing person-centered care:

> *And we talked about the STP, which is another model that we understand more about, about individualizing care, making it person-centered, we will maintain the therapeutic project. (P5)*

According to the group, developing the STP is a tool for implementing person-centered care, as it tailors care to each user. A scoping review study identified that although the STP is used in diverse settings and across various knowledge fields, it is particularly prominent in the mental health field, whether for clinical, management, or professional training purposes. Furthermore, it indicated that this resource is used as a way to develop user empowerment through interdisciplinary care[44].

Resocializing service users was also represented in the empty figure drawing as an action related to person-centered care in psychosocial care based on the verbs "integrate" and "socialize":

> *[...] We talked here about integrating and socializing, and we put a (Re) there, because in our case here, we do a lot of (re)integration and (re)socialization of people who face addiction [...] (P5)*

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The participants indicated that resocialization is closely linked to person-centered care iIn the context of mental healthcare for alcohol and other drug users. A quantitative study that evaluated the influence of assemblies held at *CAPS* II in Boa Vista on the humanization of mental health indicated that these assemblies contribute to weaken hospital-centered practices and promote resocialization of users and their families[45].

Educating both users and their families about issues related to mental disorders or drug addiction was also highlighted by the group as an action associated with person-centered care:

> *[...]mainly educate about the disorder, about addiction, about disability, educate to be able to empower these people, so I think that information is something that anyone needs, especially in their difficulties, in their needs. (P5)*

Educating patients and their families about mental disorders and drug addiction are actions that participants associated with person-centered care. It is important to emphasize that this pedagogical practice should consider the values of the individuals being served and not be influenced by stereotypes, prejudices, or value judgments on the part of healthcare professionals. This ensures that learning from the experiences of patients becomes more meaningful. Professionals must share their knowledge, present the risks and benefits of therapeutic alternatives, and explore the beliefs and values of patients in order to implement person-centered care[1].

The practice of health education processes has been identified as an important care strategy in the context of psychosocial care, as demonstrated by a study conducted at a *CAPS* in northeastern Brazil that used music in a group for health education purposes. This study demonstrated that this intervention led to greater patient engagement in group activities, improved self-esteem, communication, interpersonal relationships, and engagement of group members in seeking information related to care[46].

It was further reported that respecting the people being served is essential to provide comprehensive and personalized psychosocial care to users and their families:

> *Protecting, respecting, strengthening, as we also talked about, is what we propose to do, comprehensive and unique care, we need to do, to offer support and care, assist [...] (P5)*

It is paramount at all times in person-centered care to ensure that people are treated with dignity, compassion, and respect[1]. Therefore, respecting each person's subjectivity is essential for building a bond with the referring therapist and the community mental health service. It fosters a relationship of trust that encourages the client to disclose their care needs, fostering psychosocial and person-centered care.

The professional's testimony revealed that both physical and emotional healing is an action linked to person-centered care in psychosocial care:

> *[...] to care and heal, it would be in the most manual, physical way, as well as emotional. (P5)*

Focusing on the present moment and seeking to strengthen the user, regardless of past events, were also actions associated with person-centered care:

> *Then to finish, we included a phrase, which I forgot, forgive me, it was Sartre. Which says, that it doesn't matter what they did to me, but what I will do to them [...] Especially here at CAPS, we try to reinforce that the past doesn't matter, it doesn't matter what they did in history or the stigma that is placed on that person, what matters is now, what will be done, and for that, we have to consider the most individual part of each person. (P5)*

The act of healing physically and emotionally was a desire expressed by one of the professionals, which is related to person-centered care. While healing the signs and symptoms of pathologies is important when it comes to mental health issues, many cases are chronic, and the goal should be to restore autonomy to provide a better quality of life for patients. A study that investigated how psychological care is provided in the complementary health setting showed that the care provided by psychology professionals is based on individual and curative clinical care, focusing on symptom remission. It is unclear whether they consider other spheres and contexts of people's lives, such as social, economic, and political aspects, reinforcing the concept that health is the absence of disease[47], which runs counter to person-centered care.

Finally, the "suitcase and trash" technique was used as a form of evaluation at the end of the meeting. This demonstrated that the intervention provided professionals with opportunities for collective and interactive knowledge building, fostering exchanges, reflection, motivation, acceptance, and a fresh perspective on their practice. Furthermore, it helped participants recognize what was not so successful in their work, leaving aside

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prejudices, stigmas, fear, thoughtless behavior, insecurity, coldness, complacency, and other factors, as illustrated in Figure 4.

What do I pack in my suitcase?	What I leave/let go in the trash
"I bring knowledge about person-centered care"; "Reflection"; "Exchange"; "Hope and motivation"; "I bring confirmation that my professional investments allow me to broaden my perspective, offering a more welcoming and respectful perspective on the pain of other human beings who come to me asking for help"; "I have acquired new knowledge, opening up a new vision of the true meaning of mental health"; "I bring more knowledge"; "I bring that we are facilitators and must be horizontal with the other person"; "I bring acceptance"; "Knowledge"; "Wisdom and experience"; "I bring learning and reflections on my role in person-centered care"; "I bring learning and knowledge"; "Bringing learning about care to the user"; "I bring a new perspective and confidence"; "Care"; "I bring learning and knowledge"; "I bring the decision to seek more knowledge in the area I currently work in"; "I am bringing learning, enthusiasm, updating of work processes in the mental health network, involvement with "Team"; "Learning"; "I bring reflection on my performance: reception, conduct in groups and individually"; "I bring knowledge"; "I bring more knowledge of person-centered care, confirming that I am on the right path"; "I bring my speech as a demand"; "I leave contributions and information"; "I leave my participation"; "Equity"; "Possibilities"; "I bring suggestions for team training (continuing education), questions that were answered by the facilitators".	*"I let go of the idea that things don't work"; "Concepts and behavior"; "I let go of doing things without thinking. Rushing gets in the way of good work"; "Prejudice"; "I let go of impulses and negativity"; "I let go of my doubts and perceptions about comprehensive care and my demystification of comprehensive care"; "I let go of stigmas, prejudices, and fear"; "Fear of CAPS AD III and prejudice"; "Anxiety"; "I let go of insecurity"; "I let go of antipathy and coldness"; "Insecurity and a new perspective"; "Ignorance"; "Reflection and gratitude"; "That when we seek the user's "improvement" result, we are taking our own results into account. And in truth, we have to focus on the user, not on ourselves"; "I let go of complacency and helplessness".*

Figure 4: Product of the "suitcase and trash" technique recorded on the paper slips. Aparecida de Goiânia, GO, Brazil, 2022.

Through the "suitcase and trash" technique presented above, it is possible to observe that the CHE initiative in the form of an experiential workshop was able to raise awareness among professionals about the need for transformations in their practices toward more humanized and person-centered care. Furthermore, the technique revealed that many participants still harbored prejudices, stereotypes, distrust in the way *CAPS* operate, insecurities, complacency, among other issues which hinder the effectiveness of mental healthcare.

The training of healthcare professionals is often guided by a traditional, disease-centered perspective, fragmented, and supported by the biomedical paradigm, failing to foster comprehensive care and community participation in the health process[48].

In turn, CHE initiatives become essential in this context. They must focus on the collective and the context of the work process, promoting reflective, ethical, critical, and humanistic practices. In addition to improving the quality of services, CHE seeks to contribute to transform health practices, aligning them with social needs and promoting a broader, more integrated vision of care[49].

CHE promotes ongoing training of health professionals, providing them with more resources to deal with the complexity and diversity of health demands, in addition to becoming more confident in their practices. This contributes to more humane and effective practice, which is in line with the principles of the Unified Health System (*SUS*), such as comprehensive care, social participation, and health promotion as a right for all[49].

Study limitations

Conducting the study in a specific context confined to a city in the Brazilian Midwest can be considered a limitation of the study. Therefore, it is possible to affirm that the practice of person-centered care is only not consolidated in the community services investigated, which requires future research in other *RAPS* settings with multidisciplinary teams, managers, and service users.

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FINAL CONSIDERATIONS

The experiential training process provided the teams with opportunities to reflect on their professional practices, representing the first step toward demystifying prejudices, stereotypes, and asylum practices for implementing person-centered care within the context of psychosocial care. However, it also revealed that person-centered care within the teams studied is not yet a consolidated and standardized practice, revealing that individual thoughts, feelings, and actions interfere with the practice of person-centered care. Therefore, participants demonstrated in their drawings and accounts that they often act automatically without thinking about their practice. The expression of feelings such as fear, danger, and team judgment toward patients are phenomena which influence the professionals' behavior during their professional practice.

There is an ambivalence between thinking and acting in the studied teams, with professionals often acting without thinking, which can lead to practices lacking critical and reflective thinking and automated behavior. There is a contrast between positive and negative feelings and emotions which sometimes reinforce marginalizing users within community mental health services. Despite all these issues, professionals strive to provide effective and humanized care. Thus, actions such as understanding and respecting the patients, developing protagonism, individualizing treatment, developing the Singular Therapeutic Project, resocializing, and offering health education promote person-centered care.

This study contributes to the field of mental healthcare, as it demonstrates that training processes that use experiential methodologies, aligning the intersection between theoretical knowledge, working with emotions and feelings, as well as the actions of group members, contribute to develop competencies (knowledge, skills, and attitudes) and make learning more meaningful, as it is based on situations within the mental health teams' own reality, strengthening work practices based on the psychosocial care model.

REFERENCES

1. Proqualis. Instituto de Comunicação Científica e Tecnológica em Saúde. Fiocruz. Simplificando o cuidado centrado na pessoa. Brasília (DF): Fundação Oswaldo Cruz; 2016 [cited 2024 Sep 18]. Available from: https://proqualis.fiocruz.br/sites/proqualis.fiocruz.br/files/Simplificando-o-cuidado.pdf.
2. Feitosa JBA, Lima ICS, Galiza DDF, Santos SD, Sampaio JJC. Modelos e paradigmas orientadores do trabalho multiprofissional em Centros de Atenção Psicossocial em um município brasileiro. Revista Portuguesa de Enfermagem de Saúde Mental. 2022 [cited 2024 Sep 18]; 28:1-19. DOI: https://doi.org/10.19131/rpesm.343.
3. Bessa SSO, Melo LG, Peixoto MT, Souza SL, Carvalho RC. User embracement in a psychosocial care center (caps): experience report of a doctor in training. Rev. bras. educ. med. 2022 [cited 2024 Sep 18]; 46(3):e122. DOI: https://doi.org/10.1590/1981-5271v46.3-20210402.
4. Jang SJ, Kim EH, Lee H. Moral sensitivity and person-centred care among mental health nurses in South Korea: a cross-sectional study. J Nurs Manag. 2022 [cited 2024 Sep 18]; 30(7):2227-35. DOI: https://doi.org/10.1111/jonm.13554.
5. Lorenz-Artz, K.; Bierbooms J, Bongers I. Unraveling complexity in changing mental health care towards person-centered care. Front Psychiatry. 2023 [cited 2024 Sep 18]; 14:1250856. DOI: https://doi.org/10.3389/fpsyt.2023.1250856.
6. Wallengren C, Billig H, Björkman I, Ekman I, Feldthusen C, Kjellberg IL, et al. Person-centered care content in medicine, occupational therapy, nursing, and physiotherapy education programs. BMC Med Educ. 2022 [cited 2024 Sep 18]; 22(1):492. DOI: https://doi.org/10.1186/s12909-022-03502-8.
7. Rissato D, Monteiro AD, Campos MC, Arcoverde MAM. Atenção integral à saúde mental dos adolescentes em conflito com a lei em privação de liberdade: uma avaliação sob a perspectiva dos profissionais do centro de atenção psicossocial infantojuvenil de Foz do Iguaçu. Rev. Pesq. Qual. 2024 [cited 2024 Sep 18]; 12(29):19-44. https://doi.org/10.33361/RPQ.2024.v.12.n.29.639.
8. Sousa JM, Farinha MG, Landim JSS, Lucchese R, Paranaguá TTB, Nunes FC, et al. Welcoming practice in psychosocial care for the person-centered care. Cogitare Enferm. 2023 [cited 2024 Sep 18]; 28:e92034. DOI: https://doi.org/10.1590/ce.v28i0.92034.
9. Alves CSB, Santo TBE, Casanova EG. Conceptions of interdisciplinarity in Psychosocial Care Centers among nurses who completed residency. Rev. enferm. UERJ. 2021 [cited 2024 Sep 18]; 29:e55570. DOI: https://doi.org/10.12957/reuerj.2021.55570.
10. Passarinho JGN. Retrocessos na política nacional de Saúde Mental: consequências para o paradigma psicossocial. Revista Em Pauta. 2022 [cited 2024 Sep 18]; 20(49):65-80. DOI: https://doi.org/10.12957/rep.2022.63451.
11. Organização Pan-Americana da Saúde (OPAS). Orientações sobre serviços comunitários de saúde mental: promoção de abordagens centradas na pessoa e baseadas em direitos. Brasília (df): OPAS, 2022. DOI: https://doi.org/10.37774/9789275726440.
12. Ventura F, Moreira IMPB, Raposo V, Queirós PJP, Mendes A. Person-centered practice: from idiosyncrasy of care to health innovation. Cad. Saúde Pública. 2022 [cited 2024 Sep 18]; 38(10)e0027812. DOI: https://doi.org/10.1590/0102-311XPT278121.
13. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Medicina centrada na pessoa: transformando o método clínico. 3. ed. Porto Alegre: Artmed; 2017.
14. Mendonza DS, Delgado LR. La implementación de prácticas de cuidado centrado en el paciente y su impacto en la satisfacción del paciente y la calidad de atención. Vitalia. 2022 [cited 2024 Sep 18]; 3(2):96-110. DOI: https://doi.org/10.61368/r.s.d.h.v3i2.38.
15. Rocha ML, Aguiar KF. Pesquisa-Intervenção e a Produção de Novas Análises. Psicol. cienc. prof. 2003 [cited 2024 Sep 18]; 23(4):64-73. DOI: https://doi.org/10.1590/S1414-98932003000400010.

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Artigo de Pesquisa
Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.87334

16. Moscovici F. Desenvolvimento interpessoal: treinamento em grupo. 17 ed. Rio de Janeiro: José Olympio; 2008.
17. Souza VR, Marziale MHP, Silva GTR, Nascimento PL. Translation and validation into Brazilian Portuguese and assessment of the COREQ checklist. Acta Paul Enferm. 2021 [cited 2024 Sep 18]; 34: eAPE02631. DOI: https://doi.org/10.37689/acta-ape/2021AO02631.
18. Moraes DX, Moreira ES, Sousa JM, Vale RRM, Pinho ES, Dias PCS, et al. "The pen is the blade, my skin the paper": risk factors for self-injury in adolescents. Rev. Bras. Enferm. 2020 [cited 2024 Sep 18]; 73(Suppl 1):e20200578. DOI: https://doi.org/10.1590/0034-7167-2020-0578.
19. Bardin L. Análise de conteúdo. Lisboa: Edições 70, 2018.
20. Andrade MAS, Conrado DM, Almeida RO. Desenvolvimento do pensamento crítico de licenciandos em Pedagogia a partir de uma questão sociocientífica sobre proliferação de escorpiões em Amargosa, Bahia. ID. 2023 [cited 2024 Sep 18]; 15(1):59-71. DOI: https://doi.org/10.34624/id.v15i1.32120
21. Backes DS, Zinhani MC, Erdmann AL, Backes MTS, Büscher A, Marchiori MRTC. Nursing care as a systemic and entrepreneurial phenomenon. Rev. esc. enferm. USP. 2022 [cited 2024 Sep 18]; 56:e20220249. DOI: https://doi.org/10.1590/1980-220X-REEUSP-2022-0249pt.
22. Kuse EA, Taschetto L, Cembranel P. O cuidado na saúde mental: importância do acolhimento na Unidade de Saúde. Espac. Saúde. 2022 [cited 2024 Sep 18]; 23:e874. DOI: https://doi.org/10.22421/1517-7130/es.2022v23.e874.
23. Boska GA, Oliveira MAF, Seabra PRC. Integrated embracement in psychosocial care centers for alcohol and drugs in the perspective of the protection of human rights. Ciênc. saúde coletiva. 2022 [cited 2024 Sep 18]; 27(6):2417–26. DOI: https://doi.org/10.1590/1413-81232022276.17692021.
24. Amadei GN, Barbosa GC, Pinho PH. Structural and functional analysis of the social network of users of the Psychosocial Care Center: the pathways of Psychosocial Care. Interface. 2023 [cited 2024 Sep 18]; 27:e220163. DOI: https://doi.org/10.1590/interface.220163.
25. Borges VLG, Cardoso ARR, Silva MRF, Cabral LMS. Damage decreasement in tobacco consumption. Physis. 2022 [cited 2024 Sep 18]; 32(4):e320401. DOI: https://doi.org/10.1590/S0103-73312022320401.
26. Oliveira JC, Bertoni LM. Usos de Drogas: Representações Sociais dos Profissionais de Saúde Mental de um CAPS AD do Nordeste do Brasil. PSSA. 2022 [cited 2024 Sep 18]; 14(2):175-190. DOI: https://doi.org/10.20435/pssa.v14i2.1181.
27. Londe PR, Mendes PC. A influência das áreas verdes na qualidade de vida urbana. Hygeia. 2014 [cited 2024 Sep 18]; 10(18):264-72. DOI: https://doi.org/10.14393/Hygeia1026487.
28. Nunes-Valente M, Monteiro AP. Inteligência emocional em contexto escolar. Revista Eletrônica de Educação e Psicologia. 2016 [cited 2024 Sep 18]; 7: 01-11. Available from: https://www.researchgate.net/publication/315037489_Inteligencia_Emocional_em_Contexto_Escolar
29. Andrade MA, Andrade LF, Sampaio PYS, Melo MSS, Hernandes RS. Amor: múltiplos significados por diferentes atores sociais. Res. Soc. Dev. 2022 [cited 2024 Sep 18]; 11(2):01-18. DOI: https://doi.org/10.33448/rsd-v11i2.25927.
30. Iglesias A, Garcia DC, Pralon JA, Badaró-Moreira MI. Educação Permanente no Sistema Único de Saúde: Concepções de Profissionais da Gestão e dos Serviços. Psicol. cienc. prof. 2023 [cited 2024 Sep 18]; 43:e255126. DOI: https://doi.org/10.1590/1982-3703003255126.
31. Pereira AA, Silva ER, Gilberd L, Costa AN. Estigma dirigido a pessoas com transtornos mentais: uma proposta para a formação médica do século XXI. Rev. latinoam. psicopatol. fundam. 2022 [cited 2024 Sep 18]; 25(2):383-406. DOI: https://doi.org/10.1590/1415-4714.2022v25n2p383.7.
32. Silva DL, Valladares-Torres ACA. A comunicação terapêutica em enfermagem - revisão integrativa da literatura. Revista Eletrônica Multidisciplinar de Investigação Científica. 2023 [cited 2024 Sep 18]; 2(3):01-16. DOI: https://doi.org/10.56166/remici.2023.5.v2n3.1.15.
33. Lima ICS, Sampaio JJC, Ferreira Júnior AR. Work and illness risks in Territorial Psychosocial Care: implications for mental health care management. Saúde debate. 2023 [cited 2024 Sep 18]; 47(139):878-91. DOI: https://doi.org/10.1590/0103-1104202313911.
34. Muricy AL, Cortes HM, Pinho PH. Experiência das práticas integrativas e complementares no cuidado em saúde mental em terras baianas. Hygeia. 2023 [cited 2024 Sep 18]; 19:e1925. DOI: https://doi.org/10.14393/Hygeia1967244.
35. Mendes L, Ramos L, Nicolau C, José S. Intervenções de enfermagem promotoras de esperança na reabilitação psicossocial orientada para o recovery - revisão integrativa da literatura. Revista Portuguesa de Enfermagem de Saúde Mental. 2022 [cited 2024 Sep 18]; 28:1-19. DOI: https://doi.org/10.19131/rpesm.357.
36. Metello IG, Santos TM, Silva TCS, Ferreira RGS, Queirós PJP, Peres MAA. Atuação da equipe de Enfermagem no Centro de Atenção Psicossocial Álcool e Drogas. SMAD, Rev Eletrônica Saúde Mental Álcool Drog. 2022 [cited 2024 Sep 18]; 18(2):79-87. DOI: https://doi.org/10.11606/issn.1806-6976.smad.2022.181264.
37. Pereira CAA, Risso ET, Pucci SHM. Contribuições da psicologia na elaboração do Projeto de Vida com usuários de álcool. REASE. 2023 [cited 2024 Sep 18]; 9(10):2321-2334. DOI: https://doi.org/10.51891/rease.v9i10.11792.
38. Nascimento AS, Gomes AM, Santos BCC, Neves WC, Barbosa JSP. Atuação do Enfermeiro na assistência à criança com Transtorno do Espectro Autista (TEA): uma revisão integrativa. REAEnf. 2022 [cited 2024 Sep 18]; 19:e10523. DOI: https://doi.org/10.25248/reaenf.e10523.2022.
39. Bezerra KA, Nascimento FP, Nóbrega IS, Araújo-Monteiro GKN, Santos-Rodrigues RC, Marcolino EC. Self-mutilation among adolescents: a systematic review with meta-analysis. Texto contexto - enferm. 2023 [cited 2024 Sep 18]; 32:e20220219. DOI: https://doi.org/10.1590/1980-265X-TCE-2022-0219pt.

Research Article
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Artículo de Investigación

DOI: https://doi.org/10.12957/reuerj.2025.87334

40. Martins LSS, Nascimento GM, Tavares MPA, Barbosa AS, Santos ISS, Souza JNS, et al. CHA recomendado por profissionais de marketing: uma análise dos conhecimentos, habilidades e atitudes de interessados pela área. Rev. Foco. 2023 [cited 2024 Sep 18]; 16(1):e841. DOI: https://doi.org/10.54751/revistafoco.v16n1-113.
41. Costa CN. Práticas de cuidado em saúde mental a partir do Projeto Terapêutico Singular. SANARE. 2023 [cited 2024 Sep 18]; 22(1):41-49. DOI: https://doi.org/10.36925/sanare.v22i1.1682.
42. Abreu ACV, Vieira EM, Castelo-Branco PC. Formação do psicoterapeuta centrado na pessoa: ética e figuras de alteridade. Rev. Subj. 2022 [cited 2024 Sep 18]; 22(2):e10260. DOI: https://doi.org/10.5020/23590777.rs.v22i2.e10260.
43. Magalhães JLB, Braga FW. Música, cultura e arte: percepção dos usuários de um Centro de Atenção Psicossocial (CAPS) sobre uma oficina terapêutica. REAS. 2023 [cited 2024 Sep 18]; 23(4):e11974. DOI: https://doi.org/10.25248/reas.e11974.2023.
44. Depole BF, Marcolino TQ, Oliveira GN, Cunha GT, Ferigato SH. Projeto Terapêutico Singular: uma visão panorâmica de sua expressão na produção científica brasileira. Cad. Bras. Saúde Ment. 2022 [cited 2024 Sep 18]; 14(38):1-25. Available from: https://periodicos.ufsc.br/index.php/cbsm/article/view/73119.
45. Formiga WDD, Zanin L, Flório FM, Oliveira AMG. O impacto das assembleias na humanização em saúde em um centro de atenção psicossocial. Cad. saúde colet. 2023 [cited 2024 Sep 18]; 31(1):e3101021. DOI: https://doi.org/10.1590/1414-462X202331010210.
46. Machado DG, Guimarães JMX, Morais APP, Mendes LCB, Sampaio JJC. "MusiCAPS": a música como estratégia de educação em saúde no Centro de Atenção Psicossocial. Dialog Interdis Psiq S Ment. 2023 [cited 2024 Sep 18]; 2(1):45-51. DOI: https://doi.org/10.59487/2965-1956-2-8163.
47. Nagel DGF, Lasta LL, Areosa SVC. SUS e saúde complementar: a experiência da saúde mental em Venâncio Aires/RS. Revista de Psicologia. 2022 [cited 2024 Sep 18]; 13(2):198-212. Available from: https://www.redalyc.org/articulo.oa?id=702173204017.
48. Lima JVC, Turini B, Carvalho BG, Nunes EFPA, Lepre RL, Mainardes P, et al. A educação permanente em saúde como estratégia pedagógica de transformação das práticas: possibilidades e limites. Trab. educ. saúde. 2010 [cited 2024 Sep 18]; 8(2):207-27. DOI: https://doi.org/10.1590/S1981-77462010000200003.
49. Barth PO, Aires M, Santos JLG, Ramos FRS. Educação permanente em saúde: concepções e práticas de enfermeiros de unidades básicas de saúde. Rev. Eletr. Enf. 2014 [cited 2024 Sep 18]; 16(3):604-11. DOI: https://doi.org/10.5216/ree.v16i3.22020.

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Use of artificial intelligence tools

The authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Person-centered care in psychosocial care: What do professionals think, feel, and do?*"