# Contributions of biographical and relational aspects to Mental Health nurses' professional identity

*Contributos dos aspectos biográficos e relacionais na identidade profissional de enfermeiras em saúde mental*

*Contribuciones de aspectos biográficos y relacionales a la identidad profesional de las enfermeras de salud mental*

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**ABSTRACT**
**Objective:** to analyze the contributions of biographical and relational processes in the constitution of the professional identity of nurses working in Psychosocial Care Centers. **Method:** a qualitative study of the multiple-case type conducted with 10 nurses from six Type II CAPS in Salvador, Bahia, Brazil. The data were collected between June and August 2022 through semi-structured interviews. **Results:** in a patriarchal society, Christian affiliation and gender markers relegate nurses to exploitation and devaluing job positions, sustaining clientelistic practices in Mental Health. In addition, precarization of the working conditions and overlapping of functions, frequently subordinated to capital-related interests, weaken the profession in the Mental Health field. **Final considerations:** the need for an interconnection between the psychosocial Mental Health care model and the Nursing profession core is identified. The study contributes to strengthening a consolidated, valued and socially recognized professional identity.
**Descriptors:** Nurses; Psychiatric Nursing; Mental Health Assistance; Nurse's Role; Identity Crisis.

**RESUMO**
**Objetivo:** analisar os contributos dos processos biográficos e relacionais na constituição da identidade profissional de enfermeiras atuantes em Centros de Atenção Psicossocial. **Método:** estudo qualitativo, do tipo estudo de caso múltiplo, realizado com 10 enfermeiras de seis CAPS tipo II em Salvador, Bahia, Brasil. Os dados foram coletados entre junho e agosto de 2022, por meio de entrevistas semiestruturadas. **Resultados:** a filiação cristã e os marcadores de gênero, em uma sociedade patriarcal, relegam as enfermeiras a posições de exploração e desvalorização, sustentando práticas assistencialistas na saúde mental. Ademais, a precarização das condições de trabalho e a sobreposição de funções, frequentemente subordinadas aos interesses do capital, fragilizam a profissão no campo da saúde mental. **Considerações finais:** identifica-se a necessidade de diálogo entre o modelo de atenção psicossocial em saúde mental e o núcleo da enfermagem. O estudo contribui para o fortalecimento de uma identidade profissional consolidada, valorizada e socialmente reconhecida.
**Descritores:** Enfermeiras e Enfermeiros; Enfermagem Psiquiátrica; Assistência à Saúde Mental; Papel do Profissional de Enfermagem; Crise de Identidade.

**RESUMEN**
**Objetivo:** analizar las contribuciones de los procesos biográficos y relacionales a la constitución de la identidad profesional de enfermeras que trabajan en Centros de Atención Psicosocial. **Método:** se realizó un estudio de caso múltiple cualitativo con 10 enfermeras de seis CAPS tipo II (Centros de Atención Psicosocial) en Salvador, Bahía, Brasil. Los datos se recopilaron entre junio y agosto de 2022 mediante entrevistas semiestructuradas. **Resultados:** en una sociedad patriarcal, la afiliación cristiana y los marcadores de género relegan a las enfermeras a posiciones de explotación y devaluación, mediante prácticas paternalistas en salud mental. Además, las condiciones laborales precarias y las funciones superpuestas, frecuentemente subordinadas a los intereses del capital, debilitan la profesión en el campo de la salud mental. **Consideraciones finales:** se identifica la necesidad de diálogo entre el modelo de atención psicosocial en salud mental y el núcleo de la enfermería. El estudio contribuye al fortalecimiento de una identidad profesional consolidada, valorada y socialmente reconocida.
**Descriptores:** Enfermeras e Enfermeros; Enfermería Psiquiátrica; Atención a la Salud Mental; Rol de la Enfermera; Crisis de Identidad.

**INTRODUCTION**

Consolidated by means of Law No. 10,216/2001, the Brazilian Psychiatric Reform represented a breaking point from the hospital-centered and asylum model, instituting the Psychosocial Care logic and new Mental Health assistance modalities. In addition to mere changes in the care field, this complex social process proposes an epistemological break from the traditional psychiatric paradigm and calls workers, users and communities to commit to devising a new social place for people in mental distress situations[1,2].

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In this context, Nursing work took on the central role by demanding practices based on deinstitutionalization, interdisciplinarity and articulation with community-based devices, especially Psychosocial Care Centers (*Centros de Atenção Psicossocial*, CAPS). That transition involved a paradigmatic challenge by substituting restraint and surveillance practices with promotion of autonomy, social reinsertion and comprehensive care for psychologically distressed people[3-5].

In this sense, nurses' professional identity emerges as a central reflection axis in the Mental Health field, as redesigning work processes in this context goes beyond adopting new techniques and involves identity transformations and taking on new stances in the care scope. A number of research studies indicate that, as they work in settings marked by paradigmatic transitions, nurses experience challenges related to indefinition of roles and fragmentation of care practices. Such aspects exert a direct influence on how their professional identities are constructed, frequently in tension between the legacy of the traditional psychiatric model and the innovating perspectives proposed by Psychosocial Care[6].

In order to understand how the identity of nurses working in the Mental Health field is developed, Claude Dubar's theoretical-philosophical framework was adopted in this research proposal[7-9].

Studies on this theme have been gaining notoriety in the literature and indicate that expanding nurses' performance scope, considering the incorporation of competencies related both to the psychosocial clinical field and to the professional core, comes along with difficulties at the time of clearly articulating who they are and what they do in their profession. As a result, their role has been scarcely understood or even made invisible by the other professional categories, by the users of services and by the professionals themselves[11].

Given the aforementioned, the objective of this study was to analyze the contributions of biographical and relational processes in the constitution of the professional identity of nurses working in the assistance provided at Psychosocial Care Centers.

## THEORETICAL FRAMEWORK

According to Claude Dubar, professional identity can be understood from the articulation of two processes configured in the duality between the individual and collective spheres: the relational process and the biographical process. The first one refers to a gradual construction of social and professional identities based on the categories offered by institutions such as families, schools, job markets and companies. The second one is related to identifying, in a legitimated environment, the knowledge, practices and competencies pointed out and stated by the subjects in the institutions. Both processes take place intrinsically and simultaneously but are not necessarily coincident and may require from each person strategies to get real identities (assigned by the subjects) closer to virtual identities (assigned by others), as well as to reconcile part of their previous identifications (legacy identities) with the desire to develop new identities for themselves in the future (target identities). Given the paradigmatic transition scenario in the Classical Psychiatry field for the Psychosocial Care area, this theoretical framework proves to be useful to analyze the identity constitution of nurses working in Mental Health assistance[7-9].

Although progress has been made in terms of the epistemological fundamentals of care in this area, a number of achievements are still necessary in the practice to reach a satisfactory assistance quality standard in the Psychosocial model and in the Unified Health System. This implies establishing certain group identity in Mental Health Nursing that leaves no doubts about its role in providing care in freedom[10].

## METHOD

This is a descriptive-exploratory study with a qualitative approach conducted with nurses working in Type II Psychosocial Care Centers from the municipality of Salvador (BA, Brazil). The territorial extension of the capital city of the state of Bahia is approximately 693 km², with an estimated population of 2,886,698 inhabitants and a specialized Mental Health network with 19 Psychosocial Care Centers of public administration[12]. One of the eleven participants selected for the Experimental Group withdrew from the study after the interview because she underwent significant emotional mobilization as a result of her participation. The Assessment phase was initiated with ten female participants.

The study was conducted with a simple random sample. The criteria to include participants were as follows: working as professionals in direct assistance at CAPS centers for over a year and accepting to voluntarily take part in the research by signing a Free and Informed Consent Form (FICF). The following exclusion criteria were considered: professionals on holiday or on other leaves foreseen in the labor laws. The Consolidated Criteria for Reporting Qualitative Research (COREQ) were adopted to devise and describe the research[13]. In addition, the guidelines on Sex and Gender Equality in Research (SAGER) were followed[14].

Once due authorization to carry out the project was obtained from the Municipal Health Secretariat, in-person meetings with the nurses were scheduled with the heads of the services, handing in booklets with the main information

about the project and the researcher's contact data at this first moment. The professionals that were interested filled-in a list-type form with their name, the unit(s) where they worked and their respective employment contracts, to later on schedule the interviews.

Data collection took place from June to August 2022. A semi-structured interview script with two parts was used. The first part consisted in the participants' sociodemographic data and professional background; in turn, the second one included the following guiding questions: 1) Can you describe yourself as a CAPS nurse? 2) Tell us what it means to be a CAPS nurse to you. 3) How do you feel when performing your role?

All the interviews were conducted in-person by the researcher in the participants' workplace and according to their availability and preferences. Each interview lasted a mean of 50 minutes. The testimonies were recorded in a mobile device after due previous authorization from the participants. Once the interviews had been fully transcribed, the transcriptions were forwarded via email for the participants to validate them. They were also informed about the possibility of including or removing data, if they deemed it necessary. The deadline specified for this response was ten days from the moment the transcribed material was sent; if the participants failed to answer before such deadline, the transcriptions were considered validated.

In order to ensure confidentiality, each participant was coded with an alphanumeric identification consisting in the letter "N" followed by a number corresponding to the order in which the interviews were conducted. After finishing each interview, the testimonies were transcribed in full and, simultaneously to each transcription, the theoretical data saturation technique was applied, which was the criterion used to delimit the sample[15]. Through this method, the statements were organized into thematic groups using a color-coded scheme arranged in a chart, with the objective of identifying the data saturation point, moment at which new relevant codes or topics ceased to emerge; finally, seven codes were identified. The data were organized with the aid of the NVivo® 11 software. This program allowed sorting the excerpts from the participants' testimonies by registration units, which eased systematizing the data in a single file and noticing connections that would hardly be detected manually.

The Content Analysis framework proposed by Minayo[16] was used to treat and analyze the data collected with the semi-structured script, following the three stages defined by this author: (1) Pre-analysis; (2) Exploration and coding of the material; and (3) Treatment and interpretation of the results obtained. Consequently, once the material had been organized, the data transcribed were skimmed to later on read them in-depth to choose the significant registration units in the participants statements that met the study objectives. Subsequently, the clippings from text fragments corresponding to the registration units were delimited. It was based on these clippings that it was possible to proceed with devising the empirical categories responsible for specifying the topics that guided discovery and structuring of the meaning nuclei. The theoretical framework used for data analysis was Claude Dubar's theory[7-9], as it supports the research proposal that is based on the constitution of nurses' professional identity.

The research protocol was approved by a Research Ethics Committee according to all ethical precepts in force; in addition, all the participants included in this study signed a Free and Informed Consent Form.

## RESULTS

The study participants were ten nurses with a mean age of 52 years old, distributed across the following age groups: 30-40 (n=3), 41-50 (n=4) and over 60 (n=3). Most of them had concluded their training more than ten years ago (n=6); in turn, six had between six and ten years since graduation, one of them had finished the course less than five years ago, and seven participants were graduates from public Higher Education institutions. All of them had some *lato sensu* specialization training, but not in the Mental Health area. As for gender, there were nine women and one man. In relation to race/skin color, six, three and one of them self-declared as brown-, white- and black-skinned, respectively.

The analysis of the interviews allowed assembling two data-derived empirical categories; the first one, called "The biographical process in constructing professional identity", groups the following topics: Self-perception, Training and learning paths for work, and Feelings about being a nurse in the Mental Health field. The second category, entitled "The relational process in constructing professional identity", included the following topics: Challenges inherent to working in the Mental Health field, Interdisciplinary work logic and Indefinition of duties.

### The biographical process in constructing professional identity

This category refers to developing a "self-identity", based on the active internalization or incorporation process nurses make about identity elements incorporated throughout their social paths, from a time perspective.

The participants' self-perception in the context of CAPS work expresses an important relationship with the act of "helping" and is anchored in altruism and benevolence references.

*In my performance at the CAPS, I consider that I try to do all I can. First of all because I like it, right? [...] I'm devoted to the CAPS. (N1)*

*I really like helping people. I think that the more useful I am, the happier I get. (N4)*

*I tend to help in the best possible way. I think I'm responsible, organized, welcoming, kind. (N5)*

*I like to work with vulnerably people, those who need it the most. I over-identify myself with these people. I think that I have to devote myself to this. (N8)*

The feelings manifested by the interviewees about being CAPS nurses proved to be strongly linked to the integrality principle, understood as an expanded care conception that goes beyond diagnoses and technical interventions, also encompassing the subjective, social and cultural dimensions of the users' life.

*The bond I create with each person is different than in hospitals, where you go out, go over the shift change and your peer goes on from there. Here I end up looking at each person as a whole, not only regarding their mental health, it's the physical, emotional, religious, the entire social issue, do you understand? (N10)*

*I can't just stick to the diagnosis. When I do so, I just can't provide that expanded care. Then you need to really understand the whole life story, each person's, context to be able to intervene and work. (N5)*

Regarding the training and learning processes for Mental Health work, most of the interviewees stated not having undergone adequate training throughout their undergraduate studies to work in CAPS centers. In contrast, the professional practice was recognized as a privileged *locus* for nurses to produce their own knowledge about their work in Mental Health.

*When I started I had no notion about what a CAPS was like; actually, my training was more in a psychiatric hospital, right? In private clinics. (N1)*

*I didn't specialize in Mental Health. I underwent a public selection process, right? They called me and I actually learned while working. (N5)*

*I believe that now, with the practice, with the time I've been in the unit, and constantly learning from my peers and the patients, I feel more comfortable in this role within the unit. [...] It's constant learning. (N10)*

**The relational process in constructing professional identity**

This category encompasses the testimonies about the nurses' identity constitution, taking into consideration the others' points of view and the identity assignment actions that are legitimized through social categorizations operated in the systems where they interact and are involved.

In this sense, the testimonies were based on the adversities resulting from the precarious working conditions in CAPS centers and on verifying that the Mental Health work field is politically devalued. As a consequence, some of them assert that they frequently work extra hours or spend their own material and financial resources to perform activities in the services.

*It's a job where you don't have many resources, whether human resources or tools for the work process. [...] It's already happened and still happens to me a lot that I need to my work extra hours to have time to record, to note down the evolution. (N5)*

*You just don't see that your work really advances. [...] There aren't enough material resources, human resources, safety. (N9)*

*You try to group the materials you have; otherwise, you put money of your own to make them. [...] Either working in in-hospital assistance or here, I think that Mental Health is the most neglected, it's the least visible for the authorities. (N10)*

The interviewees' testimonies also reveal constituting elements of the work interdisciplinary dynamics, such as horizontalization of interprofessional relationships and a need to articulate different knowledge areas and practice to devise interventions in common.

*It's a different situation too. [...] It's because you work with a multidisciplinary team, with various opinions and you learn from each other. You don't just concentrate on Nursing techniques. (N8)*

*There's another thing that I noticed here in the CAPS: that issue of not focusing on medicalization. Everything here comes from branches that are important, but not central, you know? Everything is horizontally arranged here in the CAPS. I see it like that. (N5)*

Nurses' understanding about the interdisciplinary work logic also seems to be connected to the perception that their duties can be considered comparable or analogous to those of other professional categories.

*The interdisciplinary logic is real. That's a fact. All knowledge areas really mix, right? I sometimes end up acting a psychologist, listening more in depth, or as a social worker, when I end up analyzing the users' social issues. Then I actually end up doing a little bit of everything. (N5)*

> *My work is more targeted at Social Assistance, Psychiatry, Psychology care, right? It's multiprofessional work. I end up encompassing other areas too. (N6)*

In this work context, nurses also express issues about the limits of their own performance, especially when in tension due to other professionals' idea of what they do.

> *People don't know much about what nurses do. In every institution, whether you like it or not, it's always "What's missing?" or "Who has to do this here?", and it's Nursing that bridges the gaps, right? It's Nursing that has to solve problems. And I don't know if it's up to Nursing or something more administrative, as this role is not so well delimited. (N9)*

> *I've already heard that the Nursing role of instructing how medications should be taken is not ours, it'd be the pharmacists'. And we fulfill that role. I think that we do have to give instructions in relation to medications! (N10)*

## DISCUSSION

Historically permeated by paradigmatic disputes between the asylum and psychosocial models and by public policies following different points of view, the Mental Health field emerges as an important contextual determinant in the participants' identity constitution in this study. Within this scenario, the professionals develop their paths supported by simultaneous movements of preservation of traditional identity frameworks and of tensioning when facing the transformation demands imposed by the Psychosocial Clinic approach[17].

The analysis of the results points to the origin of the religious meaning present in the professional identity of Nursing[11]. The commitment to the abnegation and devotion ideal in the act of serving others is also in line with this perspective of gender roles, present in the expression "doing the best I can for" and in the verb "help", frequently employed in the participants' testimonies. Such results reveal the persistence of legacies from the beginning of Nursing as a practice initially mostly developed by religious women.

From the lay practice to its professionalization, the Nursing field carries with it a legacy marked by Christian values and moral gender behaviors that were legitimated and accepted by society throughout time as characteristics inherent to nurses[18-21]. This finding emerges as an important contextual determinant for the reproduction of legacy identities, based on identifications related to the historical legacy linked to the origin of the profession, permeated by charitable and benevolent ideas and by vocational and servile care.

It is important to note that, by perpetuating religious identity affiliations and gender stereotypes, nurses remain in a system of symbolic values that constrains them to a lesser valued professional place in the work universe, which tends to impair their self-recognition as indispensable professionals for the Mental Health care requirements of the subjects and communities under their responsibility[20]. In addition, maintaining this legacy favors the reproduction of patriarchal and clientelistic practices and behaviors in relation to CAPS users, to the detriment of the citizenship and emancipatory dimension inherent to care, so essential in the current context of paradigmatic disputes in this performance field[13].

Regarding the training and learning processes required for work, the findings of this research corroborate data from the literature about deficits in the training processes of undergraduate courses in health (associated with the stigmatization of people with mental disorders) as elements that accentuate health professionals' historical disinterest in general for this performance area[21–23]. Despite the important curricular changes implemented after the Psychiatric Reform Law was enacted, it can be verified that there are still training institutions that continue to adopt the asylum model, with learning processes centered on procedures, on the biomedical conception about the madness phenomenon and in hospitals as the preferred *locus* for professional performance[2].

Although training processes are closely related to the constitution of professional identity, the relationships manifested in work routines (in their intersubjective spaces and for the transformation of the work reality) represent the basis for the socialization processes that build professional identities in continuous reconstruction processes[6,7]. Consequently and as for the clinical and psychosocial vicissitudes, the everyday practice in Mental Health services should be understood as a privileged *locus* for nurses to produce their own knowledge about their performance in this scenario and, consequently, a favorable territory for the construction of identity processes in tension with legacy and target frameworks, nuanced by the simultaneity and exchange of experiences with service professionals and users.

The work context in CAPS centers goes along the marking changes in health work processes, with the multiprofessional and interdisciplinary nature of professional practices and the consequent redimensioning of professional autonomy given the need to reconstitute specialized jobs standing out among them[24]. It is now worth noting the need to differentiate interdisciplinary health practices from others reduced to full flexibilization of duties and to dilution among the various knowledge areas and specificities, which tends to somewhat create mistaken conceptions about the professional objects and characterization of each category.

In this sense, by understanding their performance as analogous to that of the other team members, nurses show certain tendency to valuing the knowledge and competencies inherent to other professional categories, to the detriment of recognizing and valuing their own knowledge and performance fields from their competency core. Grounded on weak bases of a different knowing-doing of the category, this path in the search for recognition tends to lead Mental Health nurses to reinforce their identity recognition from their historical demarcation of medical control, as it can also shift such identity affiliation relationship towards other traditionally privileged professional categories that present a more precise definition about "what to do" and "what not to do" in the Mental Health field.

In the context of work and interprofessional relationships, the performance scope and activities undertaken by workers possess a symbolic dimension in terms of self-fulfillment and of social recognition, which allows their self-identification by means of their jobs and, therefore, recognition by the others. The work environment also represents a performance setting, marked by confronting recognition desires, in an asymmetrical context of power relations that are established between individuals and institutions. However, work identity is grounded on different collective representations and anchored in the relational and social experience of power in the work context[6].

The nurses' difficulties defining their exclusive duties contributes to a non-specific view of the profession, which leads them to be oftentimes mistaken for "quick-fix" professionals by other workers who are unaware of or do not value their exclusive activities. Some studies indicate that this reality is not different in other countries[21,26]. As a consequence, they tend to renounce to the necessary power to demarcate their performance spheres in terms of their knowledge core and professional category, easing interference by other professionals or from the institution leaders about their performance scope. This "mortar" role naturalizes an identity linked to "doing everything", from which nurses may come to recognize themselves or be recognized, contributing to inaccuracy in the identity outlines of their professional core[26].

## Study limitations

The following stands out as a study limitation: having presented the experience undergone by professionals working in a specific local reality, although the findings are correlated with the state-of-the-art on the theme. Furthermore, it is valid to note that the qualitative approach is not intended for generalizations; however, the findings point to diagnoses and possible interventions targeted at the construction of nurses' professional identity in the Mental Health field.

## FINAL CONSIDERATIONS

In order to investigate the identity constitution of nurses working in the Mental Health field, this study started from an analysis about the biographical and relational identity processes. This analysis integrated the historical changes in the Nursing and Mental Health professional fields, which contextualize breaking points and continuities in the nurses' identity constitution process.

As for the biographical dimension of nurses' identity development, the findings of this study indicated that their self-perception is still strongly related to the historical legacies referred to the origin of the Nursing field as linked to Christianity and to gender issues rooted in a *macho* society whose intention was to assign roles and places for women. This situation places them in an unprivileged position when inserted in a social structure marked by power relations projected to the work universe.

As for the relational dimension of nurses' identity constitution, the scenario marked by limited appreciation of the Mental Health field contributes to worsening the working conditions in CAPS centers. Associated with multiplicity of functions performed, subordination and acceptance of precarious working conditions evidence the sociopolitical frailty of the profession, intimately linked to the insufficiency of critical-reflective training. Furthermore, the professionals reveal limited understanding about the interdisciplinary care logic, as they show a tendency to mirroring other categories in an attempt to characterize their work inserted in the horizontality of professional knowledge, impairing their relationship of identification with their own profession or their professional engagement in this performance field.

The results of this study evidence the need to devise new dialog possibilities between the psychosocial Mental Health model and the Nursing core, in cooperation with municipal managers and class councils. Likewise, the need stands out to deepen the discussion about the specificities inherent to nurses' work in the Mental Health field in spaces devoted to training or to knowledge construction as significant elements to strengthen professional identity and, consequently, social recognition and appreciation of the category.

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**Use of artificial intelligence tools**

Authors declare that no artificial intelligence tools were used in the composition of the manuscript "*Contributions of biographical and relational aspects to Mental Health nurses' professional identity*".