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ARTICLE

Call me for a conversation and I will enjoy it: analysis of a clinical-institutional experience with the nursing staff of a psychiatric hospital

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Abstract *The teams that work in psychiatric wards are direct heirs of a practice marked by the institutionalizing discourse but need to dialogue with the clinic and care advocated by the Psychiatric Reform. This article aims to analyze how mental health work occurs and what are the relationships between the way of working and the health of nursing workers of a university psychiatric hospital. The theoretical reference used was based on the concepts of activity and self body by Schwartz and the dimension of health established by Canguilhem, understanding that health work is also a work of creation, of production of knowledge and use of their capacities and tacit knowledge. BasedonConversations about Work and Health carried out with the nursing teams of the Institute of Psychiatry of Universidade Federal do Rio de Janeiro (IPUB/UFRJ), we address specific topicsrelated to nursing in mental health. We conclude that there is a very heterogeneous panel of speeches, which express the diversity of ways of thinking and acting in nursing work, so that each worker brings to the scene what they believe to be the best for the patient and it is in the name of that care ethicsthat the most dramatic issues revolvewithin a psychiatric ward.*
Key words *Nursing, Psychiatric hospital, Mental health, Health and work*

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Introduction

Working in a psychiatric ward in the current context is not clear-cut. When one thinks of the changes caused by the Psychiatric Reform movement, there are several possibilities for the narrative. In this article, we intend to give importance to the speeches of nursing professionals who remain working in this ward and in the historical period that can be considered post-Reform.

In the early 1990s, mental health care in Brazil was represented by a model that was based on psychiatric beds in private hospitals, almost exclusively funded by public resources. Currently, there is the perception among health professionals, managers and the public opinion that this assistance organization translated into an iatrogenic strategy, with high social and economic costs, with profound consequences from the collective and individual point of view[1].

At that time, Brazil went through a broad process of discussion about guidelines for the health sector, driven by the unfolding of redemocratization and anchored to the proposals brought on by the new Constitution of 1988, in the chapter that deals with the guidelines for health. This health sector process has its own path in the area of mental health, which had the hegemonic model centered on the psychiatric hospital, which was being questioned since the late 1970s, when the Mental Health Workers movement was implemented, later transformed into the National Antimanicomial Movement[2].

In this sense, as expressed by Amarante[3]:

"What we have seen, called the Antimanicomial Fight or Psychiatric Reform, has as its basic principle a rupture with this scientific tradition. First, by breaking up with the process of objectifying madness and mad individuals (by inscribing the man-nature or the normal-pathological question in ethical terms, that is, of relation rather than objectification). Secondly, by breaking up with the process of pathologizing human behavior, based on a teleological or ontological assumption of normality"

This process found several political, social and ideological obstacles, at first represented by the economic forces of the old resistances from the sectors that have their interests threatened, personified by the owners of private clinics, but also, and surprisingly, by the university segments of the psychiatric clinic, which, by sharing a biologicist and pharmacotherapeutic perception of mental phenomena, relies on a reductionist dimension when trying to demonstrate that human emotions can be enclosed in explanations involving neurotransmitters and synapses that only exist in the conceptual world.

In the literature about the changes introduced by the Psychiatric Reform, there are many narrative perspectives in which literature has been produced. The most recurrent highlights the dimension of the mad subject, a point of reference from which a whole new way of producing care is re-dimensioned, no longer based on a hospital-centric model, but constituted of devices that point to the social dimension, with construction of new services, spaces of sociability, exchanges and production of subjectivities, in substitution to the traditional therapeutic model.

Another narrative perspective of this process takes into account the dimension of the mental health worker. The field of work constituted by the logic of this substitutive network of care gains prominence, based on the reflection on conflicts, ambiguities and contradictions that are expressed in daily work relations, considering the manifestations that arise from the contradictions between the antimanicomial ideals and those inherited from classical psychiatry. In this perspective are the studies carried out in the Psychosocial Care Centers[4] (CAPS – *Centros de AtençãoPsicossocial*) and in Therapeutic Residential Service[5].

However, the discussion about the professionals who maintained their performance in the psychiatric hospitalization devices is small. It can be said that these workers are direct heirs of a care practice marked by the institutionalizing discourse, but, on the other hand, are forced to dialogue with representatives of this new way of thinking the clinic.

The relevance of this issue is due to the fact that the literature on nursing work has had relatively few studies focused on mental health. In fact, most of the bibliographic material produced in Brazil has as its protagonist the context of general hospitals and maternity hospitals[6-8]. The few studies that deal with nursing work in mental health are focused on the Psychiatric Reform issues[9,10], outside the hospital environment[5]. Some studies carried out in psychiatric hospitals[10] do not directly address the issues of care under the influence of Psychiatric Reform, limiting themselves to issues of aggression and restraint[11], so prevalent in mental health work. As for the study carried out by Rodrigues et al.[12] it describes the trajectory of a psychiatric hospital from 1994 to 1998, considering the encountered difficulties and conflicts in the search for care compatible with the precepts of the Psychiatric Reform.

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In the context of this discussion, it is worth asking: what is the nursing work like in a psychiatric ward at times of Reform? How do the nursing teams deal with different ways of thinking the clinic and mental health care? How does the nursing staff in a psychiatric hospital experience the transition between the hospital-centric model and the one brought on by the Reform precepts? Seeking to contribute to the understanding of these issues, this study aims to analyze how the work in mental health takes place in the context of a university psychiatric hospital, from the perspective of nursing teams.

To deal with these issues, we chose to use a theoretical framework that takes into account the knowledge and experience of workers, the general aspects and specificities of the activity, its norms and variability, the demand for dialogue between the several disciplines and the constant questioning about their knowledge[13], as described in the following item.

Theoretical magnifying glass for article reading

When we raise these questions about the work of the nursing staff in a contemporary psychiatric ward, the challenge that arises is under which theoretical and methodological perspectives these questions could be evaluated. We believe that, when approaching work at the microlevel, as under a *magnifying glass*, that is, from what is called work activity, this field of human experience seems especially conducive to the answering of questions that involve singularities in the treatment of life situations. Thus, we sought a theoretical approach that would favors this visualization of the microlevel.

The theoretical framework used in this article takes into account the health dimension established by Canguilhem[14], according to which "it is linked both to the environment in which we live, and to the capacity that we have and developed, individually and collectively, to transform it according to our yearnings"[15]. According to the authors:

This is an idea associated with the capacity to produce new life forms (and not simply the absence of disease) and that emphasizes the existence of a body dimension only accessible to the subject themselves, signaling the need for constant dialogue with those who experience their body, their pain and their illness to understand them.

When transposing this health dimension into the work environment, one might think of it as an attempt to achieve balance more or less acceptable among its own norms, from its own history, with the social collective, which is broader, or of the life of the nation or the social economic, and human universe. The workers discover the best way to act by inventing a way of working more in keeping with their values. But the disease, or the pathology, is also the permanent risk of not being able to maintain this balance, the risk that this debate of norms will develop at a permanent disadvantage.

Therefore, it is possible to think that the normative in certain situations can become pathological in others, so that it is up to the individual to evaluate this subtlety of transformation, because it is the subject who bears the consequences of these changes and also the one who is able to re-standardize their living conditions, thus ensuring their health[14].

The concept established by Canguilhem regarding the re-standardization perspective applied to the health dimension is taken up by Schwartz, in establishing the bases that underlie the ergological perspective, as each person will deal with the "gaps" or deficiencies on their own way, because they cannot do it in a standardized way.

These gaps are related to what French ergonomics refers to as the distance between the prescribed and the actual work[13]. For the French-speaking ergonomists, the prescribed work constitutes the rules and the ways of performing the work that is conceived and codified by a higher authority and, therefore, characterized by not being defined by the worker. However, since it cannot be fully described, the work performed is different from the prescribed one and thus, it is called the actual work [16]. Therefore, the actual work refers to what the worker actually puts into action, what really happens in their workplace.

The existence of these gaps is even more evident as the actual work moves away from the prescribed one and seems to be more easily overcome by the category of workers which we highlight in this article when prescription does not become a hindrance to the performance of actual work. According to Duraffourg et al.[17], the prescribed work tends to dissolve, that is, it may be:

Formalized in the books on the organization, it can be pinned to a mural, be the object of schematics, models, reasons. It is recordable, visible, can be verbalized. On the other hand, anything that is actual is hardly seen and expressed. As many workers say, "I'm used to it," and they can't verbalize their way of doing it!

Because of this, Ergology favors the concept of "antecedent norms", which encompasses the ergonomic concept of prescribed work[18]. According to Vieira-Júnior and Santos[19] the concept of "antecedent norms" [...] is broader than its precursor [prescribed work], as it incorporates several dimensions present in work situations, such as the acquisition of worker intelligence, the collective experiences, the know-how, the historical constructions analyzed as cultural and scientific heritage, the dimension of values, which transcends the monetary question and is positioned in the sphere of politics, debates and conflicts that end up constituting the hybrid character of this concept.

Work is never pure performance, mainly because the environment is always unfaithful, since it never repeats itself overnight, or from one situation to another, and it is necessary to use one's own capabilities, one's own resources and choices to manage this infidelity. This is what Schwartz calls the "void of norms," because the antecedent norms here are insufficient, since there is not only performance[13]. That is why one could say that there is no performance, but use. Use of oneself, but with this sometimes simple but also complex duality, which is the use of oneself "by oneself" and "by others." And it is precisely because there are these two moments at the same time, or these two polarities of use, that all work is problematic and fragile, and fit in a drama.

The use of oneself by oneself is related to the position that each worker takes in relation to the norms they face, confronting and altering them, making choices and taking risks, while the use of oneself by others refers to a set of different statutes, since one never works totally alone. The "others" may be the coworkers, or they may be outside of immediate proximity. All this is present in the intimacy of the choices that the worker makes about this or that procedure, turning the work into a deeply collective reality and deeply individual, since it is profoundly unique.

It is in this sense that Schwartz and Durrive[13] state that in every work activity there is always "the use of oneself", in such a way that the worker and his whole being is summoned to the exercise of their activities, and not just parts of their body. Even in the most Taylorist of scenarios, the activity produces a dialectic between heterodetermination (the use of oneself by another) and singularization (the use of oneself by oneself), and it is not possible to understand the worker as a simple performer capable of the preceding norms.

To talk about the worker and the questions they produce, Ergology does not use the concept of subjectivity, but rather of "selfbody", considered the "closest arbiter of the activity" and not a delimited, defined subject, but an enigmatic entity that resists the attempts to be objectified.

Thus, the "selfbody" is the arbiter and manager of these variabilities that drive them to choose to work "for themselves" or "for others," thus managing their work. According to Schwartz and Durrive[13], this management is crossed by economies of the body, by sensory and visual signals, by a type of intelligence that goes through the muscle, the neurophysiological, but then goes through the unconsciousness of the body itself and by the history.

Workers are constantly confronted with variabilities when carrying out their activities, requiring the constant making of choices related to the performance of their work activities. As a result, the entity that arbitrates and decides is not entirely biological, or entirely conscious or cultural, and that is why the idea of the "selfbody" is put by the authors as preferable to the notions of subject or subjectivity.

Thus, one has the advantage of not conveying "[...] *a certain number of possible misunderstandings or evidence that creates obstacles", since every concept carries with it a history, stakes and values*[13].

The questions one should ask are: How can we bridge this gap between the prescribed and the actual work? What types of inventions one has to do to be able to work? The answers to these questions involve the consideration of other questions, including those that address the environment in which workers are inserted. It is about the environment and its infidelity that Schwartz and Durrive[13] clarifies that, as the environment never repeats itself, the worker needs to make their own choices to manage this infidelity, managing this infidelity through the "use of oneself".

The concepts of ergology have already been used in the context of nursing activity[20]. Oliveira and Alessi[21], when talking about analyzing the nursing work in mental health, focused on the possible contradictions and challenges involved in the work process of nursing in mental health in the context of the Psychiatric Reform.

Silva and Azevedo[5] valued the perception of nursing workers about mental health care in a university hospital, concluding that workers had difficulties in their care activities when caring for suffering patients, with the limitations being more valued than the potentialities. As for Muniz et al.[22], they point to the need to find a way for the nursing team, in the context of psychosocial care,

to overcome care restricted to vigilance, restraint and injections, seeking the contextualization of care with the logic of the Psychiatric Reform.

A literature review of studies on subjectivity in nursing work from the ergological perspective, discloses the gap between the prescribed organization and the actual organization of work, in which complications give rise to creative freedom. Thus, it was evidenced that nurses experience moments of articulation of their actions and interactions, showing a tendency to overcome fragmentation[23].

Unveiling the dynamics of situations between work and their health, with particular focus on mental health, implies a dedicated commitment to approximation and theorizing, capable of broadening the interpretation of a seemingly given and unchanging picture, which conditions the construction of organizational alternatives, and whose consequences are certainly not restricted to workplaces alone.

Aiming to give materiality to these questions, this article will analyze the empirical material obtained from an institutional-clinical activity called "Conversations about Work and Health" (hereafter called *Conversations*), in which the team of the Workers' Mental Health Care Project of Universidade Federal do Rio de Janeiro (PRASMET – UFRJ) went to IPUB male and female wards to create a moment of dialogue with nursing workers, involving discussions and dialogues about working on the wards and their association with health. The flow of care and institutional-clinical activities performed by the PRASMET team were described in another article[23].

Methods

This descriptive-qualitative article integrates the research entitled "University work and mental health: the face and reverse sides of mental illness in university psychiatric nursing professionals", approved by the Ethics Committees of the Sergio Arouca National School of Public Health (ENSP/Fiocruz) and the Institute of Psychiatry of Universidade Federal do Rio de Janeiro (IPUB/UFRJ).

The research group that develops its activities with the category of nursing workers is included in PRASMET – UFRJ and the results shown in the present article are based on the recordings collected during the *Conversations about Work and Health*. Eleven *Conversations* were carried out with the teams working in the male and female wards of IPUB, on the day and night shifts, and all 40 participants were consulted as to whether or not they gave their consent to the use of the recordings made during these activities (Free and Informed Consent).

The dialogue with the category of workers was based on a flexible script that sought to address basically four thematic axes: (1) the professional career until coming to work at IPUB, (2) the nursing work routine at the Institute, (3) the ways of working and dealing with the unexpected and (4) the issues that need to be modified in the workplace. The recordings of the *Conversations* were transcribed *ipsis litteris*.

The analysis of this material was made by reading the transcripts and selecting excerpts from the narrative established at a first moment with the workers, using thematic categorizations. During the material exploration phase, the construction of the categories was carried out, which, guided by the study questions, allowed organizing the content exposed in the speech of the selected group, aiming to understand and explore the material based on the identified topics.

Results and discussion

During the *Conversations*, the conflicting feeling that involves the work of nursing in this context was very evident. The central question that permeated the study concerns the conflicts that invade work relationships and situations in a psychiatric hospital in the post-Reform period. Thematic aspects revolve around this central axis, which will be discussed later in more details.

It was possible to identify four thematic discussion groups, which involve the perceptions of work issues influenced by the Psychiatric Reform perspective, the containment strategies and care dimension that this procedure produces, the inclusion of physical aggression as something that seems to be prescribed in the work routine of psychiatric nursing and the issues that arise from the working interface between the nursing staff and other professional categories, medical or not. In the present article, we focus on the first topic, and the other issues will be discussed in a future publication.

The division by topics was a writing exercise, which tends to facilitate the understanding of the most recurring thematic cores of the workers' speeches and, on the other hand, incurs in the limitation of reducing the atmosphere of contagious ebullition of feelings that characterized the environment at the meetings.

In the speeches from the *Conversations*, we observed that the physical device of the psychiatric bed now represents the space around which the discussion about the role and limitations of the nursing professionals' performance has been gaining increasingly more strength. It seems to have become the stage for the dialogue between polarized ideological currents, which in IPUB have earned the nickname of *Capsistas* and, due to the antagonistic position, the *non-Capsistas*.

Historically, this can be explained by a more traditional training model that had the asylum as a teaching and learning scenario. This contrast is expressed, for instance, in the speech of one of the nurses who participated in the *Conversations*:

My story does not take place inside the psychiatric hospital; I think I also need to situate you. I did my residency, I worked in CAPS for years and then I passed the civil service exam; at first I was happy to have passed the exam, but sad of being in this ward, a place that is hard, with inhospitable conditions, a very difficult place because we deal with suffering, in a place that does not give you the slightest structure. It is too hierarchical, there is no horizontality, between the relations, the relations are always on a hierarchical level, either between nurses and doctors, or the nurses and the direction, and so forth; so, it is very difficult to guarantee autonomy, to be able to work with the user. It is very difficult, it causes burnout, *we also have a limit, we do activities, try to do something different, but we have an institutional limit.* (the emphasis is ours).

We observe in this speech the criticism of the institutional culture, which strives for hierarchical relations, very different from the way they experienced it during their training. Therefore, they realize that, by not being able to work according to their wishes and expectations, the individual becomes ill. When one thinks that "everyone wants to be subject to their norms"[14], what is being debated is the individual's capacity to do something and at the same time build themselves, while maintaining their individuality, in line with their values and establishing their own way of confronting norms. The impossibility of this occurrence is something that causes "burnout", as stated above, being, therefore, the illness associated with the impossibility of re-normalizing the environment, or even balancing the demands of the environment and the entire content of the existing norms with the set of expectations, personal values and individualities.

In our *Conversations*, we observed that only the most recently trained nursing professionals had clinical experience in out-of-hospital care devices, while for workers who did their training a longer time ago, the standardization of teaching Mental Health contents in the context of the Reform did not exist yet [22]. The basis of the activity of these professionals is empirical and was described by the oldest nursing technician of the group:

When I arrived here (over 30 years ago), *there were two of us, the team consisted of two technicians, there was no nurse ... There were 50 women here, on the other side there were 40 men and so, if one of us got sick or if something happened, for whatever reason, it was only one. And we worked like this: we were the doorkeeper, when necessary we were the cleaning team, we gave medication, we took care of the patient as a whole and I think this is very exhausting. I liked the changes that took place, after Cristina Loyola onward, because it was after her that some very good and some very bad changes occurred, such as patients together, mixed ward. (...) But I also think that psychiatry has changed a lot, both for us, employees, as well as for our patients. We, IPUB employees, as I have already toldyou, who isa young person, who works at CAPS, I think we are considered the devil with a trident who pokes.*

Why?

Because we are seen as the repressors, we are seen as those professionals who when we do not know yet, we contain, we give medication and I have no experience of CAPS, but it seems that it does not happen there. Even more so because they are not patients who are in the acute phase, they are very "light", but I would like it to change too, to have more professionals involved, the multiprofessional team. That now has the good side, and has the bad side, because this coexistence is sometimes very good, sometimes it is not."

The difficulty in synthesizing a series of demands originating from a 24-hour stay next to the patient, the impossibility of partnerships, the difficulties of establishing a dialogue with other hospital professionals and the challenge in dealing with a plurality of theories and practices are important issues to be pointed out in the daily practice of these professionals[21].

It is important to emphasize the fact that during our *Conversations* there is a very heterogeneous panel of speeches that express the diversity of ways of thinking and acting in nursing work, but there is something subtle that brings them closer and that deals precisely with this ambitious attempt to reconcile the "doing" with the conservation of the individuality. This homeos-

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tatic exercise gives origin to the richness of the inventions we encounter in our activity, but it is also from this place that conflict situations arise, as it is not entirely possible to reconcile all personal values.

Therefore, there is a excess of norms (often paradoxical ones), with workers being permanently called upon to make choices and being in daily contact with the multitude of ways of thinking and doing, experiencing the constant tension of confronting them[18].

When taking a more historical look at this issue, one should mention the UFRJ Anna Nery School of Nursing, founded in 1923 in Rio de Janeiro. It is considered the first "modern" nursing school in Brazil, according to official historiography. However, until 1949, there is no subject related to mental illness in its curriculum, when it started to include the internship at the National Psychiatric Center - Engenho de Dentro. With the need to include psychiatric reform references in nursing education, what is observed, from a practical point of view, is a certain lack of definition of psychiatric nursing professionals about their role in this type of care, often producing a "escape" towards the performance of bureaucratic-administrative activities, which becomes a possible identity for these professionals who experience a practice characterized by the lack of definition of their role. Miranda et al.[25] draw attention to the difficulty experienced by the psychiatric nurse when approaching psychiatric nursing care, based on the discussion about new ways of caring and teaching to care in psychiatric nursing.

With the arrival of nursing professionals trained in the context of the Psychiatric Reform, based on the experience in devices such as the Psychosocial Care Centers (CAPS), a work space context with greater possibility of social exchange is created and a new care mentality is reestablished, different from that based on activities that simplify the care of the psychiatric nursing to a "gentle herding". This process occurs with discomforts in daily relationships, as we can observe in the statements of professionals heard during the *Conversations*. Unlike the institution's older professionals, who mostly came to the specialty due to the need for rapid absorption into the market, newly recruited nursing professionals have undergone qualified technical training, work in an area they have chosen to work, and require working conditions that are adequate to their internal and clinical-institutional availabilities, regardless of whether they are nursing aides and technicians or nurses. When talking with the nurse who was the most recently hired after she passed the exam, who had a history of qualification in Mental Health, we heard the following report:

I passed (the exam) *6 months ago. When you hear the old ones talk, I think it's another trajectory! I think it represents a lot of different trajectories here, from different moments in psychiatry, in politics, maybe each one has a different experience, from a different place of experience; I think I'm the newest.*

Moreover, regarding the conception of the object that permeates the work process of nursing in mental health, despite an initial expectation that the nurses' discourse could be predominantly oriented according to the asylum-related logic, since we were inside a psychiatric hospital conceived in a classic organicist model, what we saw in our *Conversations* pointed to ambivalence regarding the discourse and care practices of these professionals. Even the professionals that graduated from the empirical school of IPUB, as the reported above, have already been touched by the new ways of looking at and devising patient care practices. On the other hand, there is a trend towards maintaining the traditional practices – which include taking care of the expression of patients' sexuality, medications prescribed by the doctors, clothing, laundry and mainly the drug control of patients in crisis – although the speech already points to activities of interpersonal relationship and interdisciplinary work, further defining the nursing workers, immersed in contradictions and potentialities.

However, what we observed in our *Conversations* is a process characterized by tendencies to constantly review ways of doing what is best for the patient. As stated by the same nursing technician who has worked longer at the institution:

"Because we need things to change, to evolve! Why do we have to do such procedure? Because, I think we did, when we started, because we had no idea, thirty-something years ago we had no knowledge. From the moment we get more knowledge, get more information, you say: no, let's improve things here!

"*And that's what happened, I started saying no, another no here, she said no here, another one there and we started saying no, so let's get everyone together and see how it's going to be done*. Our way." (the emphasis is ours).

In one article dealing with the relationship between nurses and doctors in a teaching hospital, Oliveira and Alessi[21] observe that, although

they recognize the limitation of the psychiatric medical model in the approach of the subject with mental disorders, nursing workers still routinely deal with the 'mental illness' by controlling the users' behavior, and despite criticizing the treatment offered by the institution – based on the organicist model – they do not perceive themselves as agents of transformation of this reality. However, what we saw in our activity is that this way of doing things finds important openings for the construction of new ways of care, even among professionals whose activities go back to the most fundamental times of the institution.

Final considerations

We observed specific aspects related to the category of nursing professionals that work in mental health in psychiatric wards, which reflect the dilemmas faced in daily practice and the entire creation of strategies they use to continue working, disclosed from the theoretical framework used in the analyses.

One aspect present in the *Conversations*, and which permeates some speeches presented here, comprise the work situations in which workers strive to seek what seems best for the patient, such as promoting contact with the family, which may mean one less anxiolytic drug, using the expression "no, don't medicate" or even talk to the patient about their own containment.

When we reflect on the specific needs and possibilities of nursing work in the mental health team, from the perspective of expanding the intervention object proposed by the Psychiatric Reform, the work in this area gains new outlines, such as, for instance, the need for this redesigned object to correspond to new instruments and, in this sense, some changes in therapeutic practices happen, such as the incorporation of "atypical" workers in the team, including plastic artists, physical education teachers, among others; in addition, the purpose of the work proposed in this conception no longer admits the notion of "cure", but of rehabilitation, social reintegration. The instruments for this purpose, therefore, cannot continue to be the coercive physical and chemical means, but others that will provide the listening to and the valorization of the citizen-subject that suffers from a mental disease[4].

These changes in the mental health work process lead us to consider the need for changes in the division of this collective work[24]. This interdisciplinary work presupposes the coexistence of technical actions specific to each professional category and the performance of some common actions, aiming to construct a common working language with less horizontalization of power relations. However, this approximation of the professional areas in the technical work plan – performance of activities with a gradual dilution of the peculiarities– is accompanied by pressure regarding the aspect of the values of the different works, since hierarchical relationships are maintained and reproduced, especially between medical and nonmedical professionals, regarding the salary and the fact that the physician is responsible for usercare[25].

Concerning the perception of ambivalences related to the discourse and care practices of the professionals, it is necessary to establish a dialogue between the most diverse sectors of the Institute, in order to assert the leading role of nursing in its most diverse ways of thinking and caring in this so delicate modality of health care.

Contrary to what one might think, what was observed in our *Conversations* was not a stage of vanity in which each worker brings to the scene what they think is best for themselves, but what they believe to be best for the patient and it is, in fact, in the name of that care ethics that the most dramatic issues revolve within a psychiatric ward.

Collaborations

LL Telles, SR Jardim and L Rotenberg participated in the scientific design of the article, considering the stages of field activities, writing, reading and review.

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