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Articles

Dramatization as a device for Permanent Education in Mental Health: an intervention-research

A dramatização como dispositivo para a Educação Permanente em Saúde Mental: uma pesquisa-intervenção (resumo: p. 15)

La dramatización como dispositivo para la Educación Permanente en Salud Mental: una investigación-intervención (resumen: p. 15)

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The article analyzes repercussions of dramatization as a device for permanent education in mental health in Primary Care. An intervention-research was conducted with twenty workers from two teams of the Family Health Strategy, based on the theoretical-methodological framework of Institutional Socioclinic. Dramatization was used as a device to enable the process of in-service education, allowing to observe the disarticulation of work and the centering of care in three axes: disease, medication and medical or nursing decisions as instituted actions in the service. However, it provided learning through problematization of work and self-looking.

Keywords: Mental health. Permanent education in health. Primary health care. Institutional socioclinic.

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Introduction

The Family Health Strategy (FHS) is one of the care institutions encompassed by the Psychosocial Care Network (RAPS in the Portuguese acronym) and, because it is territory-based and considers the context of insertion in community life projects, it has the possibility of contributing decisively to the effectiveness of psychosocial care for users with mental suffering/troubles. In this way it is able to direct care toward the (re) construction of their autonomy, social mobility and cultural accessibility[1]. Moreover, the long-lasting and longitudinal contact of the individual with the health system, the continuity and completeness of care, and the coordination of the clinic within the health system should be enabled by the FHS[2,3].

Mental health in Primary Health Care (PHC) still experiment hardships and barriers in the daily routine of professional practices, such as the difficulty in developing teamwork for care, resistance and prejudice in the discussion of cases, weak technical qualification or regarding the ethics of welcoming, as well as the reduced power of influence in the dialogue between health services belonging to RAPS[4]. It is worth mentioning the current context in which PHC and other public policies are, due to the numerous attacks suffered by the return of the asylum-like perspective in the national health policy landscape, by underfunding, and by the setback in policies of protection and defense of citizenship and diversity. Offering comprehensive and longitudinal care becomes therefore, an extremely challenging process[5].

Moreover, the medical-hegemonic rationality still presides over the practice of many services, and the care remains centered on the prescription of drugs, psychiatric knowledge, and, consequently, in conducts directed, mostly, to gnoseological descriptors, where the worker takes second place to the conduction and welcoming according to the listening of subjective processes, life projects, and affective stories[6,7]. In this sense, it is understood that training itineraries involving services, researchers, social movements and projects of teaching-service-entities integration can be an important strategy for the strengthening and implementation of actions and care in mental health in PHC[8].

The Permanent Education in Health (PEH) is a political and pedagogical principle within the Brazilian National Health System (SUS), put in place to strengthen the education spaces of the health system, with the potential to question and modify the practices, where the experience at work is a principle for educational processes, i.e., it serves to problematize the daily practice, as well as creates the possibility of self-analysis and self-management[9,10]. The very experience in the process can point out guiding clues for its facilitation, such as reflection and attention to the process of doing, planning and thinking the PHE, considering the hegemonic way of organizing and planning the training and activities in the services, based on external determination[11].

The devices to action - for Institutional Analysis (IA) and Institutional Socioclinic (IS) - are diverse and provisional items (writings, speeches, and videos, among others), created for specific intervention situations, which can destabilize the established modes of operation, provoke collective analysis, and also act as analyzers[12,13]. Building these devices enables a look at the reality of possible changes, allowing the opening of instituting movements as the

formative and evaluative process destabilizes what has been established[14]. The analyzers can be natural, that is, daily situations that reveal something latent in the group and provoke collective analysis, or created by the facilitator/institutional analyst[12].

According to Monceau[13], the practice of dramatization allows collective reflections in act, based on psychodrama and arena theater. Dramatization, as an operative device, proposes to the group to occupy different roles from their positions to stage daily work, which can be obstacles or weaknesses for the care/team work as well to "allow the participants to express what they have perceived (by acting or watching) and to use the dramatization, which has just been done, as a common support for reflection"[13] (p. 211). It is worth mentioning that this is also the basis of Augusto Boal's Theater of the Oppressed, in which everyone involved takes the lead and proposes solutions, in a context in which everyone is on the same level of dialogue and power, taking action and rehearsing possible solutions to the problem/demand identified[15].

Dramatization can offer a ludic aspect for reflection directed to the daily practice[13], to the professionalized work, and to education through/at work. This constitutes a space for building living relationships, because it provokes and calls workers to question their own work, interrogating the automation of daily practice and awakening to new forms of work[16]. The work, as one of the structuring axes of the reflection and learning process, based on the self-analysis and self-management of the collectives, is also part of the PEH and IA/IS principles[13,17]. By having role-playing as one of the devices capable of provoking the group to think about the daily practice, it can potentiate PEH spaces in the daily life of health services. Thus, the objective of this article was to describe the effects of role-playing as a device for permanent education in mental health in Primary Health Care.

Method

This is a research-intervention, with information contained in the database of a doctoral research[f], based on the theoretical framework of Institutional Analysis in its Institutional Socioclinics strand, and carried out in the period from March 2016 to February 2017 in two FHS teams of a large city in the state of Mato Grosso. This research modality, from its political character, seeks the transformation of static meanings, putting them into question, expanding their theoretical and methodological bases, while enabling knowledge production and new ways of doing practice[18]. We adopted the elements of the Consolidated Criteria for Reporting Qualitative Research (COREQ), a checklist developed to promote explicit and comprehensive reports of qualitative studies, helping to report important aspects such as study components, context and findings[19].

For both IA and IS, professional practices include the ways of relating within the working collective group and with institutions, of thinking these relationships and assigning values, it is constituted by a set of updates and by the workers' implications, provoking reflection and collective analysis[13]. Just like IA and IS, PEH seeks to promote professional reflexivity, paying attention to the way professional practices are inscribed in institutions, where the denial or gradual forgetting of their social mandate produces the opposite of what those practices were created for, and can be problematized by a process of collective analysis[20].

[f] Rezio LA. Permanent health education for mental health training in primary care guided by the principles of institutional socioclinic [thesis]. Ribeirão Preto: Escola de Enfermagem de Ribeirão Preto; 2018. doi:10.11606/T.22.2019.tde-19032019-195235

The research-intervention was offered to the management, involving them in the choice of the units for study. After that, the invitation to participate in the research was made to all workers of the two FHS chosen, interested in the PEH process, totaling twenty workers, 11 from team I, and nine from team II. Among them we interviewed 11 community health agents, two physicians, two nurses, two nursing technicians, two receptionists, and one typist.

The first stage of the research-intervention was to enter the field to get closer to the workers and, consequently, to the intervention territory, producing a field journal about the "doing" of the research-intervention. In it, we noted accounts of the group movements, the resistances, advances, and contents discussed, containing some speeches and expressions of the involved observer, reflecting the daily research activity and the historical-social context[21]. Next, we used semi-structured interviews with all the workers individually, composed of ten guiding questions about the daily work, mental health practices in the HFS, and experiences in PEH. Using the answers, analysis and group restitution, we listed themes to guide the PEH meetings, the third stage of the study, from which we used part of the data for the production of this article. Twelve meetings were held with each team, each lasting an average of two hours. We used as a source of data the transcripts of the interviews and meeting recordings, and the notes from the research field diary.

During the intervention, some devices were created, agreed upon with the workers and built during the research, so that their very development already produced analysis[13]. The devices created to make the in-service education possible were: drawings and conceptual schemes, collages, relaxation, reflections based on musical lyrics and videos, games with guiding themes, collective diary, self-portraits, and dramatizations. In this production we will deal only with the dramatization.

Collective analysis processes may produce better understanding of institutional phenomena and diverse possibilities of work when the device promotes the development of professional reflexivity, allowing critical analysis of institutional changes and real questioning about the ability to meet social needs in health[20]. The role-playing was used in two moments in the two teams: 1) to discuss the approach to people in mental distress, in crisis situations or being monitored by the HFS team; and 2) to make the restitution regarding the research analysis, under the facilitation of PHE (*facilitator* 1).

The dramatization proposal was based upon Monceau[13], so we proposed to the group to occupy different roles from their positions/assignments in the service and create scenes that would identify it as a problem situation. In an improvised way and without compulsory participation, the group dramatized four typical scenes from daily life that were obstacles to be faced from the workers' point of view, or some difficulty present in team work and identified as a weakness for mental health care.

The research was approved by the Research Ethics Committee, under Opinion CAAE nº 53029016.2.0000.5393. We sought to guarantee the anonymity of the workers and preserve the confidentiality of the information, starting the interviews only after signing the Informed Consent Form (ICF).

The speeches were identified using the letter T, when referring to the workers, followed by Arabic numerals. The research diary entries were noted with this nomenclature, followed by month and year. In addition, there was the participation of two PEH facilitators, invited from other network services, who mediated the development of the dramatization, instigating reflection, encouraging discussion, and problematizing what emerged from the health professionals' speeches, identified as facilitators 1 and 2.

Results

The first collective reflection was that role-playing as a device highlighted what was established in the service, becoming an analyzer, because it allowed the team to identify that the work was centered on the decisions of the nursing and medical professions.

> Guys, this theater was a mess [...] very bad, are we really like that? (T19)

> I think that a good part of what happened here is what we are, we go straight to the nurse to talk [...] we don't have many meetings to discuss. (T16)

> In the scene, it was the doctor and the nurse who decided most, right? [...] we leave it to them, as they know best. (T13)

The two teams dramatized different situations, but both exposed a disarticulation in their work. In one of them, care was centered in the psychiatric disorder, in drug prescription, and in medical or nursing decisions (medical-hegemonic model). In the other, there were disjointed actions and little discussion of cases in the team or sharing of problems related to the work in collective spaces, as in the case of the team meeting itself, for example:

> I fell down there at the school doorsteps. (T6, representing service user)

> And your medicine? Are you taking it right? (T8, representing the Community Health Worker - CHW)

> The CHW brought her case here and said she is sleepy and has no medication, she suffered a blow and I wanted to know what we could do; if you can visit her. (T16, representing the nurse and dialoguing with the doctor)

> Why? She doesn't have any medicine? (T8, representing the doctor)

> We saw that we didn't discuss the case as a team; the case would come to the nurse, from the nurse straight to the doctor [...]. So when we did the theater it was nice because we saw that what we were doing was automatic, we didn't discuss the case. (T16)

The analysis of the dramatization of the daily work produced reflections within the team, from the collective discussion about the psychiatric-hegemonic model of care, the hierarchical way of working, and the presence of power relations based on the supposed knowledge of the higher-level categories, or more specifically on the knowledge and practices of nursing and medicine:

> On stage, she barely held the patient's hand, [...] she goes to the patient's house and when she's done, she passes alcohol on her hand in front of him. (T17)

> The patient told her that she was assaulted, that she hurt her face, that some medications were missing, that she is not working for fear of losing her benefit. [...] There is a biological dimension, a social dimension, economic work situation, legal situation, which is: who was the aggressor, why did this aggressor act this way and what was done? There is a question of law: which benefit should she receive? [...]. When it came back to the nurse, only the logic and the dimension of medication came: the other dimensions were lost [...]. I wanted to understand that. (PEH Facilitator 2)

> But in practice it is also like that [...]. And there's more: the look is also more for wound and medicine [...]. And how is this discussed in the team? (PEH Facilitator 1)

> Usually, we talk with the nurse, who in turn, talks with the doctor; there are not many team meetings. (T8)

> We saw that we didn't discuss cases as a team, the case came to the nurse, and from the nurse straight to the doctor. (T16)

Dramatization as a PEH device triggered self-analytical processes by the workers, a collective analysis directed to the daily practice and to teamwork, and even broadened the understanding of the problem presented, which produced training in/by the work.

> The team needs to discuss the conducts so that we can try to improve and evaluate how we are doing. For example, a theatric that we did, only after we presented and discussed it, we realized that we hardly discuss the case, we stay in the same routine as always. [...] It's been a while since the whole team sat down. (T6)

> We realized that they only look for the doctor to solve the problem; they don't call to discuss with the whole team, because she (the doctor) never has time. (T17)

> We decide things in the meeting, but when the time comes, we don't do it [...] then each one does their own thing. (T9)

As a way to depersonalize the roles in the group, so that the problematization does not focus only on a specific professional, and still remaining focused on teamwork and work management, it was proposed to the team to reflect on the reading and discussion about types of teams and work management, using an article by Marina Peduzzi[22].

Considering what is recommended for PHC and thinking that it would be interesting to continue this analysis, we tried to deal ethically with the conflicting issues of the work using this reading. Peduzzi's[22] article was proposed because it presents a concept and typology of teamwork, as well as criteria to recognize it.

> To have a team that joins for action, but does not add up to improve and only overlaps the actions, because it does not discuss, does not plan and there is another team that will add up. [...] Like our little theater. Each team member does his/her isolated action, not discussing to improve. (T6, after reading the text)

From the dramatization, reading of the text, and analysis of the scene, it is possible to learn about the work and the type of team, whether it is a 'group of people team' or an 'integration team', interweaving associations with the scenes represented.

> I understood that we are a 'group of people team'; the CHW team brings the problems to the unit, then the other team (the doctor and the nurse) comes together. (T8)

> To be an 'integration team' would be ideal, but we are still a 'group of people team'. (T16)

Discussion

By understanding the key role of collective decision-making processes, the autonomy of professionals at work, the expansion of the view of what it is and how to produce health, the expansion of the clinical approach directed to care and, consequently, the appreciation of other instruments of work by the team, the service and the network, there is a chance of paying attention to the principles of comprehensiveness and humanization of care and the composition of teams capable of creating learning opportunities within the working context.

The goal of using dramatization as a PEH device, allowing the staging of approaches to people in mental distress and the restitution of perceptions and analyses by the facilitators and the team in self-analysis, produced the emergence of a collective in reflection and the problematization of the team's difficulties in expanding the look and the care in health/mental health. The use of restitution and dramatization guided by the IS principles was relevant for potentiating the development spaces of the PEH in act.

Restitution considers the intervention as a whole allowing mainly to ensure that the working pact is permanent and remains active among participants, besides sharing and testing the interpretations of the PEH facilitator[13,23], producing a collective analytical process. Therefore, when PEH facilitators share/return their analysis and perceptions towards the collective, it is an opportunity to pause the scene in order to have a look directed to the daily work and the health education process[11]. The effect was immediate in the dynamics of analysis, because the representation of the scenes in the dramatization denounced instituted modes at work, based on the biomedical-psychiatric model, with care centered on medication, medical knowledge (drug prescription and disease diagnosis), as well as symptoms profile[6,7].

The Psychiatric Reform and the Anti-Asylum Struggle are constituted as an instituting social movement motivated by the agenda of replacing this model, defense of a user-centered care mode, and by directing the attention to the psychosocial approach. Even though the scenes were based on daily problems, the discussion was directed toward the representation of professionals, which favored de-personification and had the effect of freeing the group to speak[13], causing a quick detachment, provoking reflections and self-analysis of the work, activating a process of PEH.

There are infinite numbers of possibilities in the process of creating a device aiming at a certain purpose, consequently, the effects produced by them are also diverse, but they must have the capacity to provoke the institutions' speech (of the instituted ideas or those that constitute the body of actions), the destabilization of the instituted modes of operation in the daily practice[21]. It is important to emphasize that PEH requires the abandonment of our own subject, this process is collective and produced by all those involved, including facilitators and researchers, since they are also trained in the same hegemonic school of thought in health, directed toward the biologicist, procedure-centered, and medicalizing model. The deterritorialization of the behavioral and management grids of the work process implies all the actors on the scene[24].

Through the present study, the dramatization revealed the centeredness of the work in biomedical-psychiatric practices, with decisions focused on nursing and medicine, reducing the possibility of other intervention strategies, corroborating the findings of Nunes *et al*.[25], who identified - as part of RAPS challenges - overcoming the fragmentation of care that happens due to the fact that professionals do not develop possibilities of care and broader interventions, based on each other's professional knowledge to integrate the team, resulting in little articulation and reduced collective discussion.

The way of working that has been revealed differs from the quality determinants of the SUS; however, this process demands a permanent reflection movement of health practices, as well as a continuous training process for health professionals[26]. In this sense, dramatization becomes a driver of possibilities to trigger analytical processes within the teams, aiming at the transformation of local practices, showing itself as an important device in the development of communication and in facing limitations and conflicts among professionals[27].

Participants were able to reflect on the care for people in mental distress and the daily work, using the role-play as a collective support for analysis and learning[13], which can result in the expansion of knowledge and improvement and/or development of skills for teamwork. PEH has the potential for change, protagonism, and innovation, by proposing that education through/at work is not an immaterial byproduct, but a fundamental part of the world of work[16,20].

The use of dramatization had the additional effect of analyzing, revealing the fragilities in the way of caring and thinking about mental health care from the practices (re) acknowledged as biomedical-psychiatric, when they make us see/feel the disarticulation of teamwork, and when evidencing the validity of power-knowledge relations that, most of the time, were experienced in a naturalized way by the FHS team members. Following Foucault[28], power is not fixed, it is moving and is in the small and multiple relationships in society, such as the movements of resistance to a certain order (or a certain recommended care). This resistance is also a form of exercising power.

Whenever workers were questioned about the existence of a hierarchy in the functioning of the work, it was evident that the figure of the physician is still the protagonist in this relationship, since the cases were passed from the CHWs to the nurse, who referred them to the physician, reinforcing the paradigm of medical knowledge as superior. This may be the result of a fragility and/or absence of spaces for conversation, which provoke questioning and problematization about the established places of hierarchical relationships. According to Villa *et al*.[29], valuing workers is one of the fundamental elements to change the power-knowledge relationships and all its reflection in the subjectivation and configuration practices of the health field.

Health work is collective, and this is the reason why it questions the technical and social division of labor that, besides establishing a division of intellectual or manual tasks, materializes inequality in daily work and reinforces the institution of different and siloed technical activities for each profession, a mechanism present in the capitalist production mode, despite the defense - in the same capitalist world - of polytechnics as a better intellectual and practical result[30]. The technical and social division, legitimated by the

teaching institutions (or Education) and reiterated by the care institutions (or Health) is usually managed, in large part, by the nurse, for being the one who has a comprehensive knowledge of services and networks, control of the administrative work process, technical and complementary support (community health agents, nursing assistants and technicians, among others), and knowledge of actions traditionally assigned to doctors that gain greater efficiency of the production chain when delegated[30,31], which seems to guard and watch over conservative or reactionary values.

The PEH, however, emerges in support of the dismantling of these and other instituted, in search of invention, creation, and reconfiguration of the given forms as a possibility to generate innovative and contemporary practices. Due to the fact that PEH constitutes its analysis in a contextualized way, guiding articulated interventions and not only knowledge transmission, it enables the democratization of the management organization. Thus, there may be greater opportunity to exercise participatory management and decision-making processes based on collective decisions[9]. As the PEH moves forward and allows a more horizontal participation and management, it is possible that among the teams there will be a review of work relations and knowledge-power relations, since as knowledge begins to be shared, so should power be distributed too. Professionals can recognize PEH as a social practice capable of providing transformations in work processes and user care[32].

The absence of reflection and discussion among professionals reinforces fragmented practices, favoring the disarticulation of the assistance offered[33]. Therefore, the time of collective analysis through dramatization was crucial to reveal the institutional crossings and enabled understanding and reflection on the biomedical-psychiatric model and the hierarchical relationships present there. According to Monceau[13], the moment chosen to put the dramatization into practice is decisive for its effectiveness, since its repetitive use can annul the effects on the team.

After reading and discussing an article about the team typologies: 'integration team' or 'group of people team', the professionals started to realize that new forms of individual and collective action can establish less hierarchical relationships, allowing working with other possibilities of sharing knowledge and power. In the 'integration-team' work, there is an articulation of the work situations based on the proposal of integrality of health actions, which highlights the connections among the several interventions performed. In contrast, the 'group of people team' is characterized by fragmentation, which consists in the juxtaposition of actions and aggregation of neighborhoods among the agents/workers. Less inequality among the different jobs and respective agents, was associated with greater integration in the team, since the actions are built and thought in interaction, free of coercion and submission, but seeking consensus in the purposes of the work process and in the instruments to be used. The greater the emphasis given to the "flexibility of the division of labor, the closer we are to integration team; and the greater the emphasis on the specificity of the work, the closer we are to group of people team"[34] (p. 108).

PEH made possible not only valorizing team communication, but also of different types of knowledge, since the knowledge produced in the work experience, the know-how, is not configured by school learning, but in/by work experiences[10], making necessary the pause moment for sharing knowledge and know-how. PEH is done on a daily basis, in meetings, practices, and relationships with and among workers, users, social movements, and researchers involved, but it will not be education if it does not have repercussions on individual, collective, and institutional modes of subjectivation. It proposes the production of collective knowledge/power, considering the daily work, the knowledge of professionals and users, and their socialization[35].

Conclusion

By analyzing the effects of dramatization as a PEH device in mental health, we realized that – when used as a education/learning device - it became an analyzer, by provoking collective reflections and analyses from the scenes played by the workers, revealing the instituted way of working, where there was little discussion of cases in teams or sharing of problems related to the work in collective spaces. The practice had an immediate effect on the look at the work world, since it allowed to look/self-look, listen/self-listen, and feel/self-feel. Thus, it was possible for the team itself to identify the main difficulties and understand the self-analysis and reflection of the daily practice as an emergence of the collective.

To identify and create the movement of breaking the established modes through self-analysis and reflection on/by the work and in the collective is an extremely relevant step for changing the self, collective and institutional practices. The IA and some principles of IS enhanced the development of the PEH, by adding its constructs to the process of conducting the intervention, helping in the effectiveness of the reflection of/by the work, starting from the collective construction of new knowledge and articulating the sharing among professionals and the attention to the principles of integrality of care and the psychosocial care mode. The present production portrayed the intervention carried out in a localized way in two teams of the HFS (a certain place and country), however, it allows evidencing the presence of analyzers capable of transposition to other realities.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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O artigo analisa as repercussões da dramatização como dispositivo para a Educação Permanente em Saúde Mental na Atenção Primária à Saúde. Uma pesquisa-intervenção foi realizada com vinte trabalhadores de duas equipes da Estratégia Saúde da Família, pautada no referencial teórico-metodológico da Socioclínica Institucional. A dramatização foi utilizada como dispositivo para possibilitar o processo de formação em serviço, permitindo constatar a desarticulação do trabalho e o centramento do cuidado em três eixos: na doença, na medicação e na decisão médica ou de enfermagem como ações instituídas no serviço. Contudo, proporcionou aprendizado por meio da problematização do trabalho e do olhar para si.

Palavras-chave: Saúde mental. Educação permanente em saúde. Atenção primária à saúde. Socioclínica institucional.

El artículo analiza las repercusiones de la dramatización como dispositivo para la educación permanente en salud mental en la Atención Primaria de la Salud. Se realizó una investigación-intervención con veinte trabajadores de dos equipos de la Estrategia Salud de la Familia, basada en el referencial teórico-metodológico de la Socioclínica Institucional. La dramatización se utilizó como dispositivo para posibilitar el proceso de formación en el trabajo, permitiendo constatar la desarticulación del trabajo y el centrado del cuidado en tres ejes: en la enfermedad, en la medicación y en la decisión médica o de enfermería como acciones instituidas en el servicio. No obstante, proporcionó el aprendizaje por medio de la problematización del trabajo y de la mirada hacia sí mismo

Palabras clave: Salud mental. Educación permanente en salud. Atención primaria de la salud. Socioclínica institucional.