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# Qualified Listening to Relatives of Users at a Psychosocial Care Center

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## ABSTRACT

**Introduction.** The Psychiatric Reform introduced a new people-centered care model to replace psychiatric hospitals: the Psychosocial Care Center. Qualified listening can be used to achieve the integrality and humanization of the health care provided. It allows for the appreciation of content, the respect of its uniqueness, empathy, and the promotion of a space in which freedom of expression is provided. **Objective.** To identify the understanding of qualified listening from the perspective of the relative of a person with a mental disorder at a Psychosocial Care Center. **Method.** Qualitative, descriptive, exploratory study. Ten relatives over the age of 18 participated, contributing to the production of information. Data was obtained through the triangulation method, through semi-structured individual and collective interviews, observation, and field diary records. **Results.** For relatives, qualified listening translates into clarifying the illness, understanding the family's painful situation and providing help and support during the psychosocial rehabilitation process. **Discussion and conclusion.** Listening constitutes a means of consolidating care networks, through the strengthening of bonds and co-responsibility, in a centered and expanded family-user logic model.

**Keywords:** Qualified listening, family, mental health, interpersonal relations.

## RESUMEN

**Introducción.** La Reforma Psiquiátrica introdujo un nuevo modelo de atención, reemplazando a los hospitales psiquiátricos y centrado en la persona, el Centro de Atención Psicosocial. Para lograr la integralidad y humanización del servicio de salud brindado, se puede utilizar la escucha calificada. Permite la valorización del contenido dicho, el respeto a su singularidad, la empatía y la promoción de un espacio en el que se brinda la libertad de expresión. **Objetivo.** Identificar la comprensión de la escucha calificada desde la perspectiva del familiar de una persona con trastorno mental en un Centro de Atención Psicosocial. **Método.** Estudio cualitativo, descriptivo y exploratorio. Participaron 10 familiares mayores de 18 años, aptos para contribuir a la producción de información. Datos obtenidos a través del método de triangulación, a través de entrevistas individuales y colectivas semiestructuradas, observación y registro en diario de campo. **Resultados.** Para el familiar, la escucha calificada se traduce en brindar aclaraciones sobre la enfermedad, comprender la situación de dolor de la familia y brindar ayuda y apoyo durante el proceso de rehabilitación psicosocial. **Discusión y conclusión.** El dispositivo de escucha constituye una forma de consolidación de las redes de cuidado, a través de la afirmación de los vínculos y la corresponsabilidad, en una lógica familia-usuario centrada y ampliada.

**Palabras clave:** Escucha cualificada, familia, salud mental, relaciones interpersonales.

## INTRODUCTION

The weakening of the care model centered on the psychiatric hospital in the political context of social struggles in the late 1970s contributed to the Brazilian Psychiatric Reform. This movement reframed mental health care through changes in government policies, health services and the enactment of laws (Alves et al., 2020).

The Psychiatric Reform introduced a new people-centered care model to replace psychiatric hospitals: the Psychosocial Care Center ((PCC) Portuguese acronym CAPS). PCCs and Mental Health Service are considered equivalent terms in the text of this article. The Psychosocial Care Network includes PCCs, defined in ascending order of size/ complexity and population coverage (Ministério da Saúde, 2011; 2017).

This model seeks to go beyond the hospital-centered logic and create a care system focusing on welcoming and caring for people with mental disorders, considering (inter) subjective conditions, and life histories (Barbosa et al., 2020).

Under its anti-asylum perspective, mental healthcare involves the possibility of existing with difference, breaking away from practices of exclusion; and the search for the singularization of individual and collective life. Listening to others without judging them is one of the tools for achieving this (Almeida & Merhy, 2020).

The soft technology of qualified or sensitive listening can provide a metaphysical environment that goes beyond the physical body, with access to human subjectivity to achieve internal change. This is attained by listening to feelings of happiness, sadness, euphoria, pain, and anguish, with full respect for the person speaking and valuing every word spoken.

This soft technology, used to enhance encounters with the other, involves empathy, recognition and knowledge drawn from experience and managed through the encounter (Merhy et al., 2019).

Qualified listening comprises moments when one person listens to another and as a result, the latter listens to themself, creating further reflection and awareness (Dell'Olio et al., 2023).

Listening to patient preferences when making health care decisions is increasingly regarded as an essential element of evidence-based practice (Swift et al., 2021).

Qualified listening occurs when certain steps are followed. It involves listening carefully without interrupting the speaker, observing their verbal and nonverbal language, and focusing on their ideas, concerns, and expectations, so that the listener is better equipped to answer questions and identify techniques and technologies that will meet speaker's demands (Santos, 2019).

In this context, professional support for the relative of a person with a mental disorder should prioritize qualified listening because this makes it possible to evaluate spoken content, respect its uniqueness, empathize and provide a space guaranteeing freedom of expression. Thus, as the relative organizes their feelings and expresses them in discourse, the perception that they are with someone who is willing to listen to their story usually enables them to deal with the conflicts and difficulties experienced.

Given that the discourse of the relative who directly experiences the drawbacks of a family-user-service relationship has the potential to contribute to the improvement of health actions, this study is useful for encouraging the use of listening in Mental Health Services. The aim would be to provide subsidies for professionals to utilize this interpersonal relationship technology in the field of psychosocial care. The purpose of the research was to identify the understanding of qualified listening from the perspective of the relative of a person with a mental disorder, in other words, the relative's perception of qualified listening.

## METHOD

### Study design

Qualitative research, with a phenomenological, descriptive, and exploratory approach, making it possible to understand the meanings of qualified listening arising from the experiences of relatives, in the context of PCCs. The National Humanization Policy (NHP) of the Unified Health System of Brazil was used as a theoretical framework. The NHP recognizes that communication, empathy and listening strategies provide decent, humanized care (Santos et al., 2018).

The study has adopted the Consolidated Criteria for Reporting Qualitative Research (COREQ), a 32-item checklist for interviews and focus groups (Tong et al., 2007).

### Subjects/ sample description

Ten relatives over 18 contributed to the production of information for this research, in which their loved one had been using PCCs for over three months. This period provided scope for the experiences of a relative that permitted a sustained analysis of their understanding of qualified listening.

Although the relationship between a relative and users is common among families, ways of reacting to the exacerbation of an illness can vary. The participation of the family in PCCs enhances care, strengthening the bond with the user and the trust between them, enabling greater psychosocial rehabilitation. In addition, relatives are more likely to continue to use health services to obtain support and solution.

### Places

This study was conducted at a Psychosocial Care Center II, designed for young people and adults. These centers operate in municipalities with over 70,000 inhabitants, serving

people with severe, persistent mental disorders and those with needs due to the use of crack, alcohol and other substances, according to the organization of the local health network (Ministério da Saúde, 2011; 2017).

This PCC offers activities such as therapeutic workshops, family meetings, group care, individual care, management council meetings, home visits, active community searches, drug counseling and dispensing, referral to other services, awareness and training about the network. It is visited on a daily basis by professionals, users and relatives, and occasionally by professors and students in the field of health.

## Measurement instruments

The information was produced through the triangulation of individual in-depth interviews, direct observation, and field diaries. The individual interview technique was used with the research participants, guaranteeing them more privacy so they could comfortably express their experiences, emotions, and feelings.

This semi-structured interview was based on a script and designed to identify the point of view of participants, which allowed greater freedom of expression and more openness to interact with them. It made it easier for researchers to obtain the results required for their study. The interview was held at the PCC, in a cozy, private area, according to the availability of participants, and was scheduled ahead of time. The interview script was structured around guiding questions such as the following: what do you understand by qualified listening? how do you feel about being heard or not heard? and what effect does listening produce in you?

Interviews were recorded and filmed using a portable recorder and video camera, with the prior consent of the interviewees, and subsequently analyzed. Recording and filming ensured more reliable transcriptions and the observation of both verbal and non-verbal expressions (such as gesture, gaze, and facial expression). The content of the discourse was transcribed in full and subjected to further analysis.

The observation in this research was direct, structured, and systematized, with detailed notes, enhanced by filming and photographs. To achieve this, the following details were recorded: physical posture (way of looking, talking, walking, acting, body language), description of the scene (contribution, where you spend most of your time), description of the activities taking place at the time; relationship between user-family, professional-family, family-family; reflective analysis of listening by the observer; response to demands and needs.

## Procedure

Sampling was based on multiple cases, in the subclassification of the sample by contrast-saturation, according to the depth of the information collected and analyzed, which refers more to interview-based studies that can incorporate several cases, as these are analyzed in less detail (Poupart et al., 2008).

As the data was collected, and the recorded and filmed material of the interviews was explored, the theoretical saturation of the data was identified. This ensured that new elements or information were not added. This was also confirmed during a detailed reading of the data at the pre-analysis stage, as well as when the thematic categories were defined.

Data collection is considered saturated when no new elements are found and the addition of new information is not required, as it does not change the understanding of the phenomenon under study (Thiry-Cherques, 2009).

The semi-structured, face-to-face interviews were only administered by the nursing team of researchers, with no time limits. Each participant was interviewed once, according to the aims of the research. During the interviews, only the researchers and the participants were present. Neither the professional team nor the user were there, to ensure the privacy of the relative.

## Statistical analyses

The information was drawn from the experience of the relatives of PCC users. An analysis of this data was undertaken to identify the socio-demographic profile of the participants interviewed, essential to understanding the reality of the population studied.

The data was organized and systematized through content analysis and divided into categories that emerged from the discourse of interviewees, and convergent with the objective proposed in this research. It was analyzed in keeping with the Bardin (2016) method, involving three stages, namely pre-analysis, material exploration, and obtained results treatment and interpretation:

- *Pre-Analysis*: data organization stage, which involves systematizing the initial ideas, to create an accurate scheme of successive operations by arranging and organizing the data. The hypothesis and initial objectives of the research are recapitulated, creating indicators to guide the final interpretation. It will involve the following tasks: exhaustive readings of the content transcribed from the interviews, the creation of a corpus corresponding to norms of validity and the determination of the clippings, form of categorization and more general concepts that will guide the analysis.
- *Material exploration*: coding operations and compliance, according to previously established criteria. This stage involves classifying the data, and establishing the central ideas and empirical categories of the study.

- *Obtained results treatment and interpretation*: results are treated in a way that ensures they are significant and relevant. Inferences and interpretations are suggested, and a final analysis proposed of the theoretical and empirical material of the research, which is in keeping with the stated objectives. Results were discussed on the basis of the knowledge produced in the area.

Categories are rubrics or classes, bringing together a group of elements (or registration units, in the case of content analysis), under a generic title, based on the common characteristics of these elements (Bardin, 2016).

Five categories were found by regrouping meaning units, with themes that converged with qualified listening and divergent themes, identified as unqualified listening, associated with the proposed objective and interview script.

### Ethical considerations

The study adhered to the required ethical standards and was approved by the Research Ethics Committee of the Federal University of Alagoas, with process number 23065.010756/2009-54. Study participants received a Free, Prior and Informed Consent (FPIC) form detailing the objective of the research and the procedures and providing contact details of the researchers. The FPIC forms contained participants' signatures or fingerprints showing that they had had the purpose of the research explained to them and agreed to participate.

## RESULTS

Most of the relatives had used the service for three months to three years, were female, aged over 42, Christian, and single or in a stable relationship. They had an incomplete elementary education and earned one to two minimum wages.

Users had used the service for over three months, although most of them did not specify for how long. Most of the users were male, aged between 18 and 42, Evangelical, single or in a stable relationship, with an incomplete elementary education, and earned between half and one minimum wages.

Since this was qualitative research, no time limit was set for the interviews. Once the answers to the questions had been obtained, the interviews ended. The average length of the session time was approximately one hour, and no more than one hour and 30 minutes.

Among the testimonials of the relatives interviewed (identified in the statements as Relative, followed by a number), the following thematic categories were established for data organization: 1) How relatives understand qualified listening; 2) Suggestions of relatives for qualifying listening; 3) Why relatives feel they have not been listened to; 4) What happens to relatives when they feel listened to; 5) What happens to relatives when they do not feel listened to.

### Category 1 - How relatives understand qualified listening:

The professional's support serves as a help parameter for relatives.

> *"They are understanding, you know they support you when you need it, they talk. Sometimes they have more patience than people who are family" (Relative1).*

> *"I think it's very good (...) they have a lot of patience with her" (Relative 2).*

It seems that the paths to this listening foster sharing, exchange, and mutual commitment.

> *"They share a lot with us [...]. Because this is a family, you have to be with the doctors, the psychologists, the parents, the wives, the husbands. The children are together, they must always be together. So they listen to me and I try to take on board all the suggestions they make I also try to remember these and learn from them" (Relative 3).*

### Category 2 - Suggestions from a relative to qualify listening:

Families realize that a large number of professionals, as well as encouragement and mutual support, could qualify listening.

> *"Organize more, hire more people, to work, to help. It would be nice to have more people here, I would like to see more people here giving encouragement [...], coming here and talking to them, that's a beautiful thing, one thing supports the other. I think that is beautiful"* (Relative 4).

For the relative,

> *"That moment is a unique moment in our lives. [...] it's very important. Suddenly, it can be both the patient's improvement and ours as well"* (Relative 5).

As a relative notes in the following statement, the professional should offer them help and support.

> *"Every relative who comes to the PCC is suffering, so we need attention, and this exchange with the professional, because I think we come here, it is worth getting commitment like that. This exchange of experience encourages both the professional and the family to look after patients at home, you know?"* (Relative 6).

The relative still views therapeutic communication as providing more activities for the user.

> *"He's here doing something, something for him to learn, develop, for him to do. Professionals don't look at this, they must be with them twenty-four hours a day, providing attention, encouraging, playing, but this is missing a lot for them. There are times when they are idle, doing nothing, just sleeping, and wanting to eat"* (Relative 4).

The importance of more active participation of relative in PCCs.

> *"I see many people come in, and talk to the doctor; the family should be together. If there are two places here, it is to so they can have their mother or their father or their brother, but no, they come in alone. So, this is wrong, this I think is wrong, I don't agree with it; the family should be present here 24 hours a day"* (Relative 4).

### Category 3 - How relatives feel they have not been listened to:

The relative describes the sharing of information among professionals, the breach of ethical confidentiality, as a way of not feeling heard.

> *"I only talked to professional L once, I don't even remember her name now and she disappointed me[..] Isaid I was very agitated about professional L and she called me and I came here to tell a story that the woman already knew and I felt strange about that [...] I liked talking to her, I felt relieved"* (Relative 7).

### Category 4 - What happens to relatives when they feel listened to:

Sharing these moments of listening lifts a burden and makes people feel they are contributing to the treatment of their relative.

> *"When we go home, we feel lighter because we did something good for someone"* (Relative 5).

> *"When he is very sick, he only gets better if he comes here to talk to the psychologist [...] he becomes a different person"* (Relative 8).

Families are extremely grateful to the staff for their attitudes, unlike what happens when they are hospitalized.

> *"In '87 she had a crisis, and since then she has been hospitalized about eight times. Every time she comes here, she recovers at CAPS. I thank the staff and the team very much. I take care of her on my own I thank CAPS employees in general"* (Relative 9).

### Category 5 - What happens to relatives when they do not feel listened to:

Likewise, group therapy can create barriers for some, hampering free expression, requesting the guarantee of specifics.

> *"In the case of my son, he only feels good when it is him and the doctor. As a group, after this change* (individual appointments were replaced by group therapy) *he started to complain a lot saying that he didn't want to come here anymore"* (Relative 1).

The discourse of s relative shows concern about the lack of attention paid by some people towards their relative.

> *"I don't think I know, then I can't even ... There's no way to say ... There are times when I hear a lot of complaints ... even if it is hard for them to get her, you have to say how it is, look, today you will have this for you. So, there are times when they get upset, they criticize people a lot when they don't pay much attention to them"* (Relative 4).

The relative highlights the lack of listening by the other person, which constitutes another type of non-therapeutic listening, but if it happens. it can minimize the consequences on the relative caregiver's life.

> *"He's not 100% because I don't have support from my family. It's me, God, and him. The family doesn't want to help me, everyone says, 'Oh, I don't have time, I have work, I don't know what'Nobody really wants to help. So, it's just me, if it were like that, more family helping me would be better because he would have more support, he would spend more time with other people, he would be able to leave the room, I would take him for a walk, but nobody does that. He is just locked up at home."* (Relative 10).

The difficulty of accepting the relationship between a person without a mental disorder and a user of the Service.

> *"People ignored me, there were people who didn't support me, I found that very upsetting. They didn't support me, some were against me, it was very hurtful(...). A lot of people ignored me, didn't accept it, after they found out I was with her. So, this ... I felt bad. She felt bad too, she even talked and talked (...) it hurt her a lot. She felt bad too. To this day I'm a little ... hurt"* (Relative 4).

## DISCUSSION AND CONCLUSION

Data analysis has identified the Psychosocial Care Center as an environment that restores human lives and should adopt innovative care technologies (Clementino et al., 2017; Maynart et al., 2014). Qualified listening is considered a soft technology, which uses tools that value interpersonal relationships, a welcoming attitude and bonding.

Listening is regarded as an essential tool in mental health work. It is considered therapeutic as a health intervention strategy, providing guidance for professionals as regards the care provided. This listening allow an interpersonal relationship, through the availability of the professional to help, to be at the user's side at the moment when they need to express themselves (Santos et al., 2018).

Relatives understand qualified listening as support from a professional. Listening is portrayed as a way for the professional to deal with and understand that it translates into an apparent patience with the service user's family. In addition, it is associated with providing clarification about the illness, understanding the family's painful situation, and offering help and support during the psychosocial rehabilitation process.

The professional needs to be able to act with posture, and to be open to perform it, and it is used for the purpose of providing relief or solution to the health needs of the people involved in the process (Santos, 2019).

Furthermore, for the relative, it would appear that this type of listening prompts sharing, exchange, and mutual commitments. Living with and taking care of a relative with

a mental disorder is not easy, with tension increasing during times of crisis. Despite this difficulty, the relative makes an effort todeal with the issue. Thus, coexistence, constant observation, patience, love, the promotion of a peaceful environment and the way PCC professionals act are contributing to the family's ways of looking after the person who experiences mental suffering.

In the context of Psychosocial Care, a listening space should be provided in the PCC routine to support the relative, individually, to welcome them and as an instrument for seeking information and planning mental health care interventions (Rodovalho & Pegoraro, 2020).

The relative still regards therapeutic communication as providing more activities for the user. The professional should pay more attention to the user, so that they can develop, as relatives identify moments when they are idle and have no therapeutic activities.

The importance of more active participation by relatives in PCCs is highlighted by the relatives themselves. It is therefore necessary to support and include them in the caring process, to improve coexistence in society and in the mental health service itself, and to enable them to cope with the burden and feelings caused by looking after their loved ones (Ferreira et al., 2019).

In this context, relatives provide essential support as caregivers and do so willingly. At the same time, it is also seen as a responsibility with a potential impact on their everyday lives, such as stress symptoms, worry, anxiety and depression (Martins & Guanaes-Lorenzi, 2016; Kar, 2021).

The participation of relatives in PCCs is regarded as enhancing individual care, with emphasis being placed on the role of listening. Conversely, sharing information about the user among professionals can be considered a negative point. In qualified listening, there is an expectation of confidentiality. If this fails to occur, it creates a feeling of not being respected or listened to.

In this context, without qualified listening and sensitivity to the demands of the care-seekers, the forces that control users' ways of living predominate, and the choices of care projects, which mediate the capture of the live work and decrease porosity for the encounter (Merhy et al., 2019).

Many services are not responsible for the sequence of care, making it difficult to listen and contributing to poor service quality. This creates a sense of discomfort, suffering, insecurity, and a feeling of abandonment (Albuquerque et al., 2015).

Conversely, when relatives feel listened to, this relieves the burden on them and gives them the sense that they are contributing to the treatment of their relatives. Moreover, listening creates a sense of gratitude in family members.

Knowing how to listen is an important skill for a good understanding of the care and response to the underlying reasons leading a person to seek health service, especially if the listening is qualified. By listening to the other person, the professional shows they value them, and they will feel safe and respected (Albuquerque et al., 2015).

Effective listening creates new perspectives and alternatives for assisting a person, so that when a professional listens, they are also welcoming. This can help the person feel that they are capable of looking after their own health, both physical and mental. Although qualified listening may not obtain immediate answers, it can help the participant find pathways of possibility and resolution (Albuquerque et al., 2015).

This type of listening is different from the concept of hearing. When they engage in qualified listening, professionals uses instruments to perceive the emotions and feelings expressed, rather than just the words said. This listening considers discourse in context, understanding and respecting the person who uttered it (Pessoa et al., 2018).

Relatives also describe what happens when they do not feel listened to. They understand that changes in the way therapy is provided interfere with listening. For example, the individual therapy that was replaced with group therapy is mentioned. According to the relative, this change should not have occurred. They believe that it is better to guarantee individual therapy, because there are certain personal experiences the user does not feel comfortable sharing with other members of the group.

Furthermore, the lack of attention to users by professionals translates into unqualified listening or not listening, which can hamper the patient's recovery. The concentration of care in a single relative is also cited as a problem. The relative states that if the other members of the family group actively participated, as they do, the user would achieve a significant improvements in their treatment, as this would increase the possibility of socializing with other people.

The family is a crucial factor in the recovery of an individual with a mental disorder. It follows the moments of therapeutic evolution, crises at home and suffers together with the user. Thus, the same degree of attention and support given to the user should also be provided for the relative so that the latter becomes stronger and better equipped to help the service user.

The discourse of relatives shows that not having their choices or preferences accepted is associated with not feeling listened to. Listening to the preferences of the person and taking steps to accommodate them when making mental health care decisions can enhance treatment experiences and improve treatment outcomes. It should, therefore, become part of routine clinical practice (Swift et al., 2021).

Limitations of this study include the small sample of relatives of users of a mental health service, although the content has been analyzed in detail. It is worth considering that this is only part of the understanding of how qualified listening happens and how it is perceived, since this study only explores the perspective of relatives. Further studies on the subject will undoubtedly contribute to the consolidation of better quality, more extensive mental health care. In regard to

nursing, it raises the question about the use of qualified listening during nursing care practices in mental health services.

The idea of examining the concept of welcoming in PCCs through the qualitative understanding of qualified listening was prompted by the desire to understand its dynamics, the way the actors interact and the senses/meanings they construct in relation to their practice in this field of knowledge.

At the same time, the qualitative study is also a research method, which enabled those researched to participate in the study methodology procedures, and made it possible to explore the subjective experience. Oliveira (2007) conceptualizes qualitative research as a process of reflection and analysis of reality through the use of methods and techniques for a detailed understanding of the object of study in its historical context and/or according to its structure.

In conclusion, this type of listening provides access to the subjective human field, from the moment the professional engages in professional listening, as it produces a feeling of appreciation, understanding, trust and respect in the other person. When this type of listening fails to occur, when it is not qualified, it has the potential to create frustration and negative feelings, such as sadness, anguish, and a lack of confidence, weakening the psychosocial rehabilitation process. The remarks of relatives show a clear correlation between qualified listening and clarifications about illness, understanding the family's painful situation and offering help and support during the psychosocial rehabilitation process.

Qualified listening constitutes a means of consolidating care networks, through the strengthening of bonds and co-responsibility following the centered and expanded family-user logic. Through this subjective tool, it is possible to guarantee the bond required for the psychosocial rehabilitation of those comprising the family unit.

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### Conflict of interest

The authors declare that they have no conflicts of interest.

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