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ORIGINAL ARTICLE

Presence of therapeutic factors in group care in the waiting room

Presença de fatores terapêuticos em atendimentos grupais em sala de espera

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ABSTRACT

Objective: to identify and analyze the presence of therapeutic factors in care in the waiting room at a Psychosocial Care Center for Alcohol and Drugs, from the perspective of coordinators and group members. Method: a qualitative approach research of the convergent care type carried out with 14 people. Data collection took place through individual interviews, a checklist-type instrument based on Yalom's Q-sort of therapeutic factors and participant observation. Data were subjected to thematic analysis and organized with the ATLAS.ti software. Results: During the meetings, both from the perspective of the coordinators and the group members, the same therapeutic factors were identified: instillation of hope, universality, information sharing, interpersonal learning, group cohesion, existential factors, altruism, development of socialization techniques and imitative behavior. Conclusion: the value of care in the waiting room is recognized, significantly contributing to the therapeutic path of its participants.

Descriptors: Group Processes; Community Mental Health Services; Mental Health; Evaluation of the Efficacy-Effectiveness of Interventions; Substance-Related Disorders.

RESUMO

Objetivo: identificar e analisar a presença dos fatores terapêuticos nos atendimentos em sala de espera em um Centro de Atenção Psicossocial Álcool e Drogas, na perspectiva dos coordenadores e membros do grupo. **Método:** pesquisa de abordagem qualitativa do tipo convergente assistencial realizada com 14 pessoas. A coleta de dados ocorreu por meio de entrevistas individuais, instrumento tipo *check-list* com base no *Q-sort* de fatores terapêuticos de Yalom e observação participante. Os dados foram submetidos à análise temática e organizados com o *software ATLAS.ti*. **Resultados:** no decorrer dos encontros, tanto na perspectiva das coordenadoras e dos integrantes do grupo, foram identificados os mesmos fatores terapêuticos: instilação de esperança, universalidade, compartilhamento de informações, aprendizagem interpessoal, coesão grupal, fatores existenciais, altruísmo, desenvolvimento de técnicas de socialização e comportamento imitativo. **Conclusão:** reconhece-se o valor dos atendimentos em sala de espera, contribuindo significativamente no trajeto terapêutico de seus participantes.

Descritores: Processos Grupais; Serviços Comunitários de Saúde Mental; Saúde Mental; Avaliação de Eficácia-Efetividade de Intervenções; Transtornos Relacionados ao Uso de Substâncias.

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How to cite this article: Andrade JMM, Farinha MG, Sousa JM, Vale RRM, Esperidião E. Presence of therapeutic factors in group care in the waiting room. Rev. Eletr. Enferm. [Internet]. 2022 [cited _____];24:68907. Available from: https://doi.org/10.5216/ree.v24.68907.

Received: 05/11/2021. Approved: 11/06/2021. Published: 01/18/2022.

INTRODUCTION

Among the numerous possibilities of mental health care offered by Psychosocial Care Centers (CAPS), group interventions contribute to interpersonal interaction, enabling to work on relational difficulties in view of the collective experience of health care, the experience of belonging, autonomy and the exercise of citizenship[1]. There are different ways of working in groups and intervention in the waiting room is one of them. It favors reception, guidance, correct information about diseases, their treatments, enabling a broad understanding of the individual[2], in addition to contributing to health promotion, disease prevention and referrals to other services, when necessary.

Thus, as in other types of groups in the health context, waiting room groups can raise therapeutic factors (TF)[3], fundamental for the treatment and social reintegration of people who benefit from it. Eleven of them are precursors of the study of these resources to assess group intervention[4-5] and when they are present, it is possible to guide the therapeutic efficiency of the groups in providing meaningful experiences to the participants: instillation of hope, universality, sharing of information, altruism, corrective recapitulation of the primary family group, development of socialization techniques, imitative behavior, interpersonal learning, group cohesion, catharsis and existential factors.

Group technology foresees the application of different theoretical approaches and perspectives, instruments, methods and techniques in the field of group dynamics, based on inter- and transdisciplinary concepts proposed in the last two decades[6]. In this sense, it is necessary to pay attention to some official recommendations of public policies in the field of mental health that value group strategies in services, which by their nature work the collective in a multidisciplinary perspective[7]. In this way, the health education process is important in the planning of health actions, aimed at users, such as interventions in the waiting room[8].

Although the value of group strategies is recognized, with or without a focus on the waiting room, there is a gap in the literature that presents a greater focus on the experiences of nurses in the coordination of therapeutic groups, as the nursing professional can work with groups in different approaches, including a psychotherapeutic focus, provided that they are trained for this purpose[9].

Given this panorama, in addition to the importance of the presence and impact of TF in the process of group interventions, this study aimed to identify and analyze the presence of TF in the waiting room at a Centro de Atenção Psicossocial Álcool e Drogas (CAPSad - Psychosocial Care Center for Alcohol and Drugs), from the perspective of coordinators and group members.

METHOD

Kind of study

Qualitative approach research, of the convergent care type, characterized by the approximation between investigation, care and participation of individuals involved in the practice of health care, aiming to enable strategies for solving problems and transformations that can improve the quality of the service[10]. Consolidated recommendations for the dissemination of qualitative studies (COREQ) were used to guide the stages of the study.

Study location and period

The research was carried out in a CAPSad in the interior of the State of Goiás between the months of February and May 2013.

Data source

Data were obtained through semi-structured individual directed interviews with 14 people, 10 service users and four companions, and through participant observation of the group coordinators in 20 meetings in the waiting room.

The inclusion criterion was being 18 years old or older and having participated in at least two meetings. And as exclusion criteria, present change in the level of consciousness and discernment, disorientation and/or psychomotor agitation[11]. Therefore, participants were selected by non-probabilistic convenience sampling.

Data Collection Procedures

Through Participant Observation, one of the professionals recorded in a field diary the manifestations in the waiting room visits[12]. On that occasion, the checklist of identification of TF observed in the group based on Yalom's Q-sort was filled out by the coordinators[4].

The group coordinators worked in the unit: one nurse and two nursing technicians. The conduction of the group intervention followed the system of co-coordination among the professionals, while one assumed the role of coordinator, the other remained as co-coordinator and the third in the role of observer. The appointments lasted an average of 60 minutes with the participation of five to 13 people while waiting for the medical appointment.

For the individual interviews, a semi-structured script was created, which also included the TF framework[5], n addition to questions about participation in group meetings: 1) How was the experience of participating in these meetings? 2) How do you rate your participation in waiting room meetings? 3) Do you remember any situation that marked you during the meetings? 4) Could you describe what happened? The interviews were audio-recorded, transcribed and analyzed.

Data analysis

Data were subjected to thematic analysis[12] and organized using the ATLAS.ti version 6.2 software. A careful reading of the transcripts and organization of the data began, followed by the elaboration of codes, identification of quotations and families, finally, the elaboration of networks/networks and discussion of the results with the literature.

Ethical procedures

All ethical procedures recommended by Resolution nº 466 of 2012 were followed, with the approval of the Comitê de Ética e Pesquisa com Seres Humanos (Ethics and Research with Human Beings Committee), protocol nº 215/2012 and Termo de Consentimento Livre e Esclarecido (TCLE - Informed Consent Form) signed by the participants.

RESULTS

Most participants were men (64%), aged between 31 and 60 years (85.72%), who were undergoing treatment at the service and participating in the waiting room groups for more than six months (71.42%) . Based on the identification of the presence of the TF, Table 1 shows the number of manifestations of the TF observed by the coordinators in absolute frequency, based on the instrument used. Table 2 shows the TF identified by the group members through individual interviews.

Table 1. Therapeutic factors observed by the coordinators of the waiting room group, Goiânia, GO, Brazil, 2013.

Therapeutic Factors	Total Therapeutic Factors identified in the meetings (N=20)
Instillation of Hope	20
Universality	20
Sharing Information	20
Interpersonal learning	20
Group Cohesion	20
Existential Factors	13
Altruism	11
Development of socialization techniques	11
Imitative Behavior	5

The analysis of the interviews allowed revealing the senses and meanings of the participants' reports through the category *Therapeutic factors in the waiting room*, which identifies their presence during the appointments.

Table 2. Therapeutic factors evidenced in interviews with participants of the waiting room group, Goiânia, GO, Brazil, 2013.

Therapeutic Factors	Participating (N=14)
Instillation of Hope	14
Universality	14
Sharing Information	14
Interpersonal leaning	14
Group Cohesion	14
Existential Factors	13
Altruism	14
Development of Socialization Techniques	13
Imitative Behavior	11

Therapeutic factors in the waiting room

Nine TF[4] listed in Tables 1 and 2 were identified in the waiting room interventions. The instillation of hope was evidenced in hopeful manifestations regarding the success of the treatment at the CAPS, through the sharing of progress of other users who go through similar situations:

> (...)every time I leave here, that I participate in the waiting room, I know it's another day in my life that I'm 'reinforcing' myself so I can leave everything I've lived… I like to be part of the group because it increases my hope and my faith to see that other people are fine and hear the story of their lives, all that suffering and today they are better because they are participating in the same treatment as me. gives more hope (P12).

Another TF present was Universality, expressed by the users' speeches that they are not alone, as their issue is also part of other people's lives, generating emotional relief:

> (...)we know the problems of others and realize that ours is small (P10).

> (...)We see that it is not just us who have this type of problem and that other people also have it, right? (P7).

The *TF Information Sharing* was identified in group care based on the technical guidelines given to users by the coordinators:

> (...)I saw that I was extrapolating with the medication, because there were times when you (coordinator) provided guidance on the correct form of use and the importance of this. There was a girl that day who said she had to go to the hospital because she took a lot of medication and used

drugs most of the night. And seeing this made me change, today I take the right medicine (P11).

Interpersonal learning was another TF identified in reports that attesting that participating in waiting room sessions provided transformations in the users' way of acting:

(...) today I know what it is to respect people who like us, respect my limits (P14).

(...) talking became easier, interacting with people became better (P13).

Group cohesion was related to factors that contribute to the permanence of users in groups, influenced by the relationship established between all actors involved in the construction of group life:

(...)I am a homosexual and a drug user, since the first time I came here and participated in the waiting room, I have completely included myself in the group and I have not suffered any form of prejudice, everyone respects everyone. Before I was rejected by the people out there (P13).

The presence of *FT Altruism* was evidenced by the socialization of the intimate life of the group members in order to help other members:

(...) we go on conforming and being comforted with the story of others and thus being able to tell our own to help other people (P4).

(...) we know the problems of others and realize that ours is small, that is to say, it becomes a reason for us to participate more and be able to help our colleagues (P10).

There were testimonies that attest to the development of socialization techniques, manifested by the acquisition of social skills, an aspect observed by the coordinators and experienced by the group members:

Before, I was more closed with people and living with the group, it taught me to express myself, to talk about what I was feeling, it helped me to loosen up, to participate, have more courage to speak, to expose my feelings, problems that I already ha (P12).

The TF Imitative Behavior also emerged in group meetings, identified in reports of group members attesting to the adoption of new behaviors, drawing inspiration from coordinators and other members:

I remember the first day I joined your group 'was' you (coordinators), I didn't know what to do, 'where to look', I remember I kept my head down looking at my feet, then, from time to time I looked to one and to the other, but I listened to what they said. And, hearing what people in the group said gave me courage, motivation to speak, express myself and even cry (P13).

(...)I didn't have the courage to tell and when we're in the group, we get the courage to tell everything that has already happened (laughs) (P12).

Some statements make it possible to identify the TF Existential Factors, because during the group process, themes related to human existence and how to deal with them were problematized and reflected on by the group members:

We come here [in the waiting room group] because we need to, if we come here, we bring good things... Well, I learned and realized that life will have good and bad moments, ups and downs, that it will teach us to live better and face the outside world (P5).

DISCUSSION

In the waiting room groups of this study, several TF were identified from the perspective of coordinators and users: instillation of hope, universality, information sharing, interpersonal learning, cohesion, altruism, development of socialization techniques, imitative behavior and existential factors.

During the group meetings in the waiting room, the *Instillation of Hope* TF emerged through the report of hope for improvement provided by sharing moments with users who underwent the same treatment and were in better health conditions. The *instillation of hope* arises from the exchange with people who live in a similar situation, represented by the hope of a cure or improvement in the situation experienced[5].

In any group, instilling hope is essential for motivating the person to join the group and receive support. It is important that the coordinator uses strategies that help in the task of increasing the participants' belief and confidence in the group's effectiveness. For this, it is necessary to reinforce positive expectations, correct prejudices, explain the power of the group to help people and encourage the testimony of participants who have attended other sessions about their improvement. In addition, as the groups usually include people at different stages of treatment, the exchange of experience between the members contributes to the improvement of users, working as a source of hope[5,13].

The importance of the group coordinator to increase the participants' belief and hope in the group's effectiveness is

evidenced in an investigation[14] that, according to patients, the waiting room is perceived as an important therapeutic resource to stimulate courage and confidence and to control, reduce or abstain from the use of psychoactive substances through the help and support of the facilitator.

Another TF evidenced in the waiting room group was *Universality*, expressed by the testimonies of users of not feeling alone with their problems, which were also experienced by other group members. The *Universality* allows group members to realize that they are not the only ones experiencing a problem[5]. In a group, coordinated by nurses, with hospitalized users in severe existential suffering, it was noticed that universality, together with catharsis, information sharing, hope and cohesion, were the first TF to appear[15].

The TF *Information Sharing* was vocalized by a member of the waiting room group when referring to the guidelines on drug therapy safely performed by one of the coordinators of the group intervention. *Information Sharing* includes all technical guidance offered by the coordination and direct advice of group members to other members[5]. A study carried out in a support group for family members of patients hospitalized in the Intensive Care Unit (ICU) revealed the presence of TF as an instillation of hope, existential factors, altruism, universality, cohesion, interpersonal learning and information sharing which provide comfort to group members[16].

The TF Interpersonal Learning also emerged in the speech of users who adopted new behaviors through the relationships established in the waiting room group. *Interpersonal learning* creates the opportunity to experience similar situations, within and outside the group context, and provides for changes in personal behavior, identification of difficulties and alternatives to face problems and try new behavior[5]. In an open group held with adults in a Psychology school service, the presence of interpersonal learning was perceived with reports from its members in the sense of learning to live, developing new manual skills, providing the expansion of the users' perspective on new knowledge and skills[17].

Another TF identified during the group sessions was the Group Cohesion evidenced by the report of acceptance of the subjectivity of a user by the other members of the group, which influenced their permanence in the group. *Group cohesion*, characterized by the members' relationships with the coordinator, other participants and the group as a whole, also refers to the union of all the forces that act on each person so that their permanence in the group is maintained[5]. The condition for other TF to be efficient is the presence of group cohesion. In interventions where this principle is outstanding, the participants feel they belong to the group, experience affection and comfort, value its members and feel valued, accepted and supported by the other components. This movement increases confidence to express feelings and experiences[5,13].

The TF Altruism was expressed by testimonies sharing the life story and internal universe during group meetings by CAPSad users. Altruism refers to sharing a part of oneself with other group members, which contributes to the process of mutual help between them[5]. With *altruism* in therapeutic groups, participants gain by offering help and not just by receiving, as part of the reciprocal sequence of give and take, benefiting from something that is intrinsic to the act of giving. Group care is unique in that it offers subjects the opportunity to benefit other people, and encourages role versatility, requiring individuals to alternate between receiving and sharing help[5]. A study carried out with 88 users of an outpatient mental health service that aimed to investigate the most important TF in the conception of group psychotherapy users, identified *altruism* as the second most prestigious therapeutic factor in their therapeutic process[18].

One of the group members expressed that when attending the waiting room group, he became more sociable, which substantially improved his interpersonal relationships, signaling the presence of the FT *Development of socialization techniques.* This TF expresses the ability to relate directly, honestly and intimately with other people in the group. Members of therapeutic groups acquire sophisticated social skills, such as: tuning in to the group experience, learning to respond usefully to others, acquiring methods of conflict resolution, reducing judgment and increasing the capacity to express empathy. These skills help people in future social interactions and form the foundation of emotional intelligence[5].

Research that investigated the perception of professionals about the therapeutic effectiveness of group care in four CAPSad identified the presence of TF as altruism, the instillation of hope, the development of socialization techniques, group cohesion and imitative behavior, associated with group evaluation[19].

The TF Imitative behavior was also revealed in the reports of the group members when they socialized, who started to mirror themselves in other users and in the group coordinators, starting to reveal themselves in the group context. In the group, both the coordinator and the other members become models of new and healthier behaviors. *Imitative behavior* can be the first step towards internalizing new behaviors and values[5]. In a group dedicated to the treatment of alcoholics such as Alcoholics Anonymous, the TF imitative behavior can benefit the newly accepted members of the group who witness the progress of older members and start to put into practice new behaviors inspired by these successful experiences, favoring progress in the evolution of the treatment of alcohol dependence[20].

The TF *Existential Factors* also emerged during the group interventions due to the testimony that the experiences provided by the group favored the confrontation of adverse

situations in human life. Existential factors are elements in the group process that help to deal with the assumptions of human existence, such as death, isolation, freedom and lack of meaning[5]. These data reinforce the importance of the proposal made in this study, which undertook waiting room groups, valuing this type of care to face crisis situations arising from the consumption of alcohol and other drugs.

The contemporary care model in mental health reinforces the importance of nurses' performance with care practices that work with the subjectivity of users[21]. For this, it is important that mental health education aimed at nursing professionals is centered on the student[22] and encompasses theoretical and practical aspects of group technology that guide the work of group coordinators in the various scenarios of health care and in the educational field[6,23].

Continuing Education in Health should be highlighted in favoring new learning, development and improvement of skills of professionals working in the services. Therefore, contributing to adherence and participation in groups, in addition to activities proposed by them, including nurses[24].

It is noteworthy that the use of group practices in the context of Mental Health is implicit in public policies in the area and legitimized by the Federal Council of Nursing (COFEN)[25] for the performance of specialist nurses, technicians and nursing assistants under supervision.

Even so, it is known that in the care setting these days, nurses do little to assume or lead group practices in their care, often prioritizing actions related to physiological care such as: control and administration of medications, measurement of vital signs and hygiene body. Therefore, there are pressing challenges to be overcome by the category in order to transform this scenario. Challenges also for the training apparatus that needs to undertake content that address the use of group technology.

CONCLUSION

It is possible to affirm, at the end of this study, that meetings in the waiting room, in which the sharing of experiences with people in similar situations is possible, significantly contributes to the therapeutic path of its participants. Based on the National Mental Health Policy, which considers group practices inherent to the care provided in CAPS, group care is essential and can be successful depending on the competence of the team that leads the groups, assuming a therapeutic and/or educational character aimed at the specificities of the costumers. In particular, we reiterate the use of waiting room groups in addition to waiting times for medical appointments or any other assistance, considering that they are therapeutic spaces that require competence in driving. The practice of group strategies should be seen from a multidisciplinary perspective and inherent to the organization of community services in mental health.

For assertiveness in conducting groups, coordinators are expected to have specific training related to group technology and/or to systematically participate in permanent education strategies in the work processes of health services, such as moments of institutional clinical supervision of their practices. Likewise, it is essential that they use resources to assess the effectiveness of groups, such as, for example, the presence of TF widely discussed in the literature.

Other services of varied specialties may benefit from this modality of care, as in a short period of time, it is possible to welcome, approach, break stigmas, inform and offer support. Its strength is also in the possibility of adapting it to the demands and needs of the services and their respective users.

There is, however, a need to invest in the education and training of health professionals in group interventions. It is certainly a great challenge towards humanized health practices resulting from a slow process of awareness and incorporation of knowledge and guidelines of the Psychiatric Reform by health professionals.

This study had limitations inherent to any research with a qualitative approach that does not intend to generalize the findings. On the other hand, it brings contributions to nursing practice and other professional categories working in CAPS, as it demonstrates that waiting room groups are important care tools in the context of psychosocial care, with numerous TF, and also to optimize the time of users who are idle waiting for care at the health unit.

The undertaking of the professionals who worked in the coordination of waiting room groups must be praised, demonstrating and validating that Nursing (nurses and nursing technicians) are able to play the role of group facilitators in the services. Further investigations into the possibilities of using the waiting room are needed, not only in the context of mental health care, but also in other health care settings, given its power and resolvability as a practice of group care.

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