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RESEARCH

MEANINGS OF FEELINGS EXPERIENCED BY WORKERS ATTENDING TO PEOPLE IN PSYCHOLOGICAL CRISIS: A PHENOMENOLOGICAL STUDY

SIGNIFICADOS DOS SENTIMENTOS REVERBERADOS POR TRABALHADORES NO ATENDIMENTO À PESSOA EM CRISE PSÍQUICA: ESTUDO FENOMENOLÓGICO

SIGNIFICADOS DE LOS SENTIMIENTOS EXPERIMENTADOS POR LOS TRABAJADORES EN LA ATENCIÓN A PERSONAS EN CRISIS PSÍQUICA: ESTUDIO FENOMENOLÓGICO

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ABSTRACT

Objective: to understand the meanings of feelings experienced by workers attending to people in psychological crisis in an Alcohol and Drugs Psychosocial Care Center (CAPSad III). **Method**: a qualitative study based on Alfred Schutz's social phenomenology theoretical framework, in which 14 workers from a CAPSad III in Porto Alegre, state of Rio Grande do Sul, Brazil, were interviewed during January and February 2022. The used instrument consisted of a semi-structured questionnaire with generating questions. The collected information was transcribed and subjected to phenomenological analysis, aiming to gather significant information. **Results**: two main categories emerged from the analysis, revealing workers' feelings and frustration regarding crisis care. It was evident that fear associated with the perceived dangerousness of mental illness is still present in workers' discourses. The need for protective mechanical restraint produces sadness and distress in the worker, in contrast to the joy and relief generated when the crisis is resolved through verbal management and bond establishment. Managing recurring crises poses a challenge for the team, associated with workers' feelings of inadequacy and overload. The main feelings of frustration are related to low family engagement, social problems that overshadow mental health care, and unmet expectations in the worker-user relationship. **Conclusion**: to understand these feelings, it is necessary to establish authentic therapeutic relationships between worker and user, aiming to address the crisis through verbal management and bonding.
Keywords: Sentiment Analysis; Mental Health; Qualitative Research; Drug users; Crisis Intervention; Substance Abuse Treatment Centers.

RESUMO

Objetivo*: compreender os significados dos sentimentos vivenciados por trabalhadores no atendimento a pessoas em crise psíquica em um Centro de Atenção Psicossocial Álcool e Drogas (CAPSad III).* ***Método****: estudo qualitativo fundamentado no referencial teórico da fenomenologia social de Alfred Schutz, no qual foram entrevistados 14 trabalhadores de um CAPSad III na cidade de Porto Alegre/RS, durante os meses de janeiro e fevereiro de 2022. O instrumento utilizado consistiu em um questionário semiestruturado com questões geradoras. As informações coletadas foram transcritas e submetidas a análise fenomenológica, visando reunir informações significativas.* ***Resultado****: da análise emergiram duas categorias principais, que revelaram os sentimentos e a frustração dos trabalhadores frente ao atendimento de crises. Evidenciwou-se que o medo associado à periculosidade relacionada à loucura ainda está presente nos discursos dos trabalhadores. A necessidade de contenção mecânica protetiva produz tristeza e angústia no trabalhador, em contraste com a alegria e alívio gerados quando a crise é resolvida por meio do manejo verbal e do estabelecimento de vínculo. O manejo de crises recorrentes configura um desafio para a equipe, sendo associado ao sentimento de insuficiência e sobrecarga dos trabalhadores. Os principais sentimentos de frustração estão relacionados à baixa adesão dos familiares, problemas sociais que sobrepõem ao cuidado em saúde mental, e quebra de expectativas na relação entre trabalhador e usuário.* ***Conclusão****: para a compreensão desses sentimentos, é necessário estabelecer relações terapêuticas autênticas entre trabalhador e usuário, visando lidar com a crise mediante o uso do manejo verbal e do vínculo.*
Palavras-chave: *Análise de Sentimentos; Saúde Mental; Pesquisa Qualitativa; Usuários de Drogas; Intervenção na Crise; Centros de Tratamento de Abuso de Substâncias.*

RESUMEN

Objetivo: *comprender los significados de los sentimientos experimentados por los trabajadores que atienden a personas en crisis psíquica en un Centro de Atención Psicosocial de Alcohol y Drogas (CAPSad III).* ***Método****: se llevó a cabo un estudio cualitativo basado en la fenomenología social de Alfred Schutz. Se entrevistó a 14 trabajadores de un CAPSad III en la ciudad de Porto Alegre, RS, durante los meses de enero y febrero de 2022. Se utilizó un cuestionario semiestructurado con preguntas generadoras como instrumento de recolección de datos. La información recopilada fue transcrita y sometida a análisis fenomenológico para obtener información relevante.* ***Resultado****: del análisis surgieron dos categorías principales que revelaron los sentimientos y la frustración de los trabajadores frente a la atención de las crisis. Se evidenció que aún persiste el miedo asociado a la peligrosidad relacionada con la locura en los discursos de los trabajadores. La necesidad de recurrir a medidas de contención mecánica genera tristeza y angustia en los trabajadores, a diferencia de la alegría y el alivio experimentados cuando la crisis se resuelve a través de la comunicación verbal y el establecimiento de vínculos. La gestión de crisis recurrentes plantea un desafío para el equipo y se asocia con sentimientos*

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de insuficiencia y sobrecarga en los trabajadores. Los principales sentimientos de frustración están relacionados con la falta de apoyo por parte de los familiares, los problemas sociales que se superponen al cuidado de la salud mental y la ruptura de expectativas en la relación entre el trabajador y el usuario. ***Conclusión****: para comprender estos sentimientos, es necesario establecer relaciones terapéuticas auténticas entre los trabajadores y los usuarios, con el objetivo de gestionar las crisis a través de la comunicación verbal y los vínculos establecidos.*
Palabras clave: *Análisis de Sentimientos; Salud Mental; Pesquisa Qualitativa; Consumidores de Drogas; Intervencion de Crisis; Centros de Tratamiento de Abuso de Sustancias.*

INTRODUCTION

After the enactment of the Psychiatric Reform Law nº. 10,216, the asylum model in Brazil was redirected to the psychosocial model, with the premise of offering care in freedom and guaranteeing rights through the creation of substitutive services[1]. In 2011, the Ministry of Health instituted the Psychosocial Care Network (RASP) to enhance different points of care and mental health intervention arrangements. This new model ensures that people with psychological distress and those who use alcohol and other drugs receive care in Psychosocial Care Centers (CAPS), Primary Health Care (PHC), Mobile Emergency Care Service (SAMU), Emergency Care Units (UPA), Emergency Rooms, and General Hospitals, aiming to articulate different points of care to promote qualified attention to crisis situations according to the user's needs[1].

The Psychosocial Care Center (CAPS) is the main substitutive service, designed to care for people with severe and persistent psychological distress, as well as those who abuse alcohol and other drugs[1]. This service comprises a team of health workers that offers comprehensive, humanized care in freedom, considering family and community[1,2]. CAPS can be classified as CAPS I, CAPS II, CAPS III, and CAPS IV, organized in ascending order of complexity and population coverage[2].

The Alcohol and Other Drugs Psychosocial Care Center (CAPSad) is currently the reference service for people with psychological distress due to alcohol and other drug use. The CAPSad III modality offers 24-hour care, with 8 to 12 reception and observation beds, in municipalities with over 150,000 inhabitants. Individual care, therapeutic groups and workshops, home visits, family care, and community activities are conducted on-site to promote social inclusion[3].

CAPS represent an important transformation in mental health care, but significant challenges remain for consolidating the psychosocial model, with attention to people in crisis being one of the main barriers[4]. It is observed that discourses constructed throughout the history of traditional psychiatry, with an exclusionary and biomedical character, still promote practices of rights violation and social exclusion[4]. Additionally, there are difficulties in implementing alternatives to hospital care, such as in municipalities that do not have CAPS or where services are precarious, with few workers and inadequate physical spaces, resulting in predominantly hospital-centered crisis care[5].

Thus, an expanded conception of crisis by CAPSad workers and managers becomes fundamental, encompassing aspects beyond acute psychiatric symptomatology, including socioeconomic, family, cultural, and community factors, enabling a multiprofessional, interdisciplinary, and intersectoral view of users' suffering situations[4].

For this care to be effective, it is essential to know the workers beyond their technical content on mental health care, also understanding how they feel during crisis care. This aims to identify sensations that become barriers to care, as well as those that enhance good care practices[5].

This study has as its guiding question: what are the feelings experienced by workers in caring for people in crisis in a CAPSad? For this understanding, Alfred Schutz's social phenomenology was used as a theoretical framework, focusing on the theory of the We-relationship, also called direct social relationship, where there is an encounter between individuals aware of each other's existence, in a face-to-face relationship that allows access to subjective experiences constituted through various exchanges and relationships, built from the past to the moment of encounter: the "here and now"[5]. Thus, this article aims to understand the meanings of feelings reverberated by workers in attending to people in psychological crisis in a CAPSad III.

METHOD

This manuscript was developed according to the guidelines of the Consolidated Criteria for Reporting Qualitative Studies (COREQ), which offers support for writing qualitative research.

This is a qualitative study, based on the social phenomenology of Alfred Schutz, resulting from a master's thesis in Nursing from the Federal University of Rio Grande do Sul, conducted in a CAPSad III located in the city of Porto Alegre, state of Rio Grande do Sul, Brazil.

Phenomenological sociology seeks to understand the meaning of actions, interactions, and experiences that individuals experience in the world of life, combined with the perception of their experiences[7].

The information collection was carried out exclusively by the main author of this manuscript, a trained nurse, previously trained to conduct the interviews. The inclusion criteria were: CAPSad III workers who

experience crisis situations in their daily work, with a minimum experience of three months working in CAPSad. Workers who were on vacation or maternity and/or sick leave were excluded. There were no refusals and all exclusion criteria were considered.

Participant selection followed a direct approach by the researcher to CAPSad III workers through a video posted on YouTube. The video explained the research objective and invited them to participate in data collection, selecting one worker from each shift as the initial sample. These initial participants then indicated new participants, and so on, until the saturation point was reached, following a non-probabilistic analysis technique. The "Snowball" technique was chosen as the information gathering strategy. The video was shown during a team meeting and subsequently deleted from YouTube. After the video, a table was sent to the worker to describe the name, phone contact, and work shift, identifying the initial participants who would then indicate new participants until reaching the saturation point.

The invitation for interviews was made through WhatsApp, and the Informed Consent Form was sent via email in duplicate. Interviews were conducted virtually via Google Meet (audio and video recorded) or in person at CAPSad (audio-only recorded), according to workers' availability and preference.

The service's population comprises 28 workers in a multidisciplinary team (two psychologists, two occupational therapists, one physical educator, five nurses, ten nursing technicians, two psychiatrists, one general practitioner, one social worker, three administrative assistants, and one team coordinator). The study sample included 14 participants: three nurses, two nursing technicians, two occupational therapists, one social worker, two psychiatrists, two psychologists, one physical educator, and one administrative assistant. The administrative assistant's inclusion is justified as this professional is the first to welcome service users.

For this article, open-ended questions previously identified through a questionnaire were selected, allowing qualitative data treatment through phenomenological interviews to find the phenomenon's essence. The guiding questions were: "What do you understand by crisis?", "Tell me what you have in mind when caring for people in crisis at CAPSad III?", and "What are your expectations regarding the user after crisis care?"

Data collection occurred between January and February 2022, with interviews lasting approximately 40 minutes. There was no need to revisit any interview for additional information, and no researcher change occurred until the end of collection. Interviews were conducted until information saturation.

The interviews and perceptions were transcribed and analyzed by the researcher electronically using Microsoft Office 2022, with prior authorization from the participants. The results were subjected to phenomenological analysis, consisting of the following steps: 1) initial reading of the transcribed discourses in search of the meanings of workers' actions; 2) identification of excerpts that present these meanings in the face of the crisis phenomenon; 3) identification of convergences of meaning units, gathering significant information found in the discourses to construct concrete categories of workers' actions in response to the crisis at CAPSad[7].

Workers were identified with the letter "E" followed by the number corresponding to the order of the interview. The interpretation of results was based on the theoretical concepts of Alfred Schutz's Phenomenological Sociology and other scholars in the field of study.

To conduct this research, ethical aspects were respected in accordance with Resolutions nº. 466/2012 and nº. 510/2016, which ensure ethical engagement in scientific and technological development and provide guidelines for research in Human and Social Sciences involving the use of data obtained directly from participants. Due to the virtual collection of information for those who chose this method, the rights of interviewees were guaranteed, ensured by ethical procedures in research in the virtual environment.

The study was approved by the Ethics and Research Committee of the Federal University of Rio Grande do Sul and by the Hospital Mãe de Deus/Associação Educadora São Carlos (AESC) via Plataforma Brasil.

RESULTS

The participants in this study were 14 workers, of whom eight (51.14%) were male. The age range varied from 21 to 40 years, with nine (64.28%) in the age group between 30 and 39 years. The length of service ranged from 11 months to eight years, with the majority of interviewees, approximately eight participants (57.14%), working in the service between one and three years. Regarding mental health training, nine participants (64.28%) had specific training in the area.

Through analysis, comprehension, and interpretation under the social phenomenology framework, the information was divided into two concrete categories: Feelings reverberated in crisis care and workers' frustration in the face of crisis care.

Feelings reverberated in crisis care

It is noticeable that the feeling of fear, related to the dangerousness of the person in crisis, is still very present in workers' discourses, creating a barrier to care during crisis moments and potentiating practices of silencing symptoms:

> *Well, I get a little scared depending on the crisis; sometimes they are more nervous, shouting, I get a little scared.* (E10)

> *People started to fear the user there at CAPS, and instead of managing the crisis, people would distance themselves and try to silence his crisis with the discourse of "Ah, if you don't stop, if you don't stop!"* (E02)

> *I always try to think that he will have an outburst and resort to aggression.* (E13)

> *For patients with a more aggressive profile, I quickly start guiding the team, talking to the doctor so we can medicate... I try to act in a preventive way.* (E8)

Regarding crisis with psychomotor agitation, it was possible to evidence feelings of sadness and anguish on the part of workers when there is a need for protective mechanical restraint, demonstrating suffering when such practice becomes necessary:

> *One of the greatest tensions is that we don't need to physically restrain the person.* (E01)

> *In the afternoon, when I go to CAPS, there's the movement of physical restraint of a user who was my reference and with whom I had a bond, and participating in his mechanical restraint was very difficult and painful.* (E01)

> *I think it produces in me, but also in the team, an anguish of the need to intervene mechanically.* (E06)

However, there is also a feeling of joy and relief when verbal management and the bond between worker and user are sufficient during the care of the person in crisis:

> *I feel very happy when I see that the conversation was worth it, that it penetrated the patient, you see that the conversation helped at some point.* (E12)

> *I always hope to conduct the situation in a friendly manner.* (E13)

> *That we can have effective verbal, chemical management, I think that's one of the greatest expectations.* (E01)

The crisis is also understood as an acute moment of intense suffering for the worker that requires quick actions, where there is no space for feelings, constructing an idea of mechanical work and leaving aside subjective aspects that involve the crisis process, as well as the feelings that emerge in the worker, as if their body functioned like a machine, under pre-programmed commands, with no space for feeling:

> *I felt that I needed to protect her! There isn't much feeling because everything happens very quickly. During the crisis, there's no time to deal with a "normal medication" and check blood pressure. In the moment of crisis, thinking has to be very quick; it's about protection, protecting the patient so they don't hurt themselves or do something crazy, and automatically protecting ourselves as well.* (E12)

It is evident that managing recurrent crises, where the user arrives daily with the same suffering and mobilizes the team, contributes to feelings of negative countertransference and team overload, especially for the reference technician (RT). This occurs when the worker cannot see progression in the user's behavior, feeling demotivated and insufficient, because despite the care strategies developed by the team, the subject maintains projective behaviors and continues in the abusive use of psychoactive substances:

> *[...] there came a point when I couldn't handle the crises anymore, as they were happening every day, and since I always ended up taking charge of his crises—which were crises that frightened my colleagues—there were moments when they would warn me, "Come in earlier because he's already here!" And then it reached a point where I had a crisis with the team.* (E02)

> *I'll bring up a classic case from our CAPS, an alcoholic. And why do we call him an alcoholic? Because he always comes in intoxicated. This creates a commotion among the team because he always shows up intoxicated, always with demands. He can't really engage with his own process; he always projects it here, or onto others. This causes a crisis within the team, which is left unsure of how to deal with him every time he shows up.* (E08)

Frustration of Workers in Crisis Management

A feeling of frustration related to the professionals' impotence in managing users is evident, accentuated by the lack of family commitment to the treatment:

> *[...] we're there dealing with and putting out the fire of this final symptom, which is the crisis. But we can't reach the families because they're not interested either. I wouldn't say 'interested,' I think that's too strong a word. I don't blame the families individually. But the family has a resistance to recognizing that the crisis is also a family issue.* (E08)

> *But as a worker, I see a great challenge, a great difficulty in working beyond that individual, but working with the family axis.* (E07)

The low adherence of family members results in a feeling of inadequacy among workers regarding the resolution of social problems that overlap with their health functions, generating frustration due to their inability to resolve the user's needs:

> *This is very difficult! This is one of the impasses: When the user arrives in these moments of crisis, crying, "I'm going to commit suicide, I'm going to kill myself!" and there are issues far beyond what we can address, as I mentioned earlier: financial issues, economic crises, crises happening within the couple, within the family.* (E05)

The feeling of frustration and devaluation becomes evident when the healthcare worker's expectations are unmet, that is, when their guidance and interventions are ignored by the user:

> *As a professional, when the patient decides to leave, I feel upset and frustrated. Because we seek for the patient to stay in a collaborative manner and want to continue the treatment. I'm always reflecting on what could have been done differently.* (E11)

> *Gosh, we talked and talked, and it went in one ear and out the other! It happens! There are some who don't even care about what we say!* (E12)

Various emotions affect healthcare workers in dealing with people in crisis situations, such as fear and insecurity, marked by the history of mental illness in society, which associates individuals with psychic suffering as violent and dangerous. The anguish and sadness related to protective mechanical restraint, as well as the joy and relief evident when verbal management is successful, demonstrate the team's concern in avoiding the indiscriminate use of this resource, indicating advances in psychosocial care.

Users in recurrent crisis situations are the most challenging for the care team, generating feelings of inadequacy and overload. The main frustrations expressed by workers are related to the difficulty of family members in participating in the users' follow-up, the socioeconomic issues that hinder follow-up in CAPSad, and the low adherence of users to the care guidelines offered by the workers.

DISCUSSION

The work process is permeated by the experience of each worker, who finds themselves in a determined biographical situation, encompassing not only the physical space but also the status and social role, as well as the moral and ideological position[8].

Considering the worker's biographical situation becomes fundamental for the humanization of this professional, recognizing them as a subject who has a history and plays a certain social role, endowed with knowledge derived from their experiences in the life-world, called stock of knowledge at hand. This knowledge is formed by a code of interpretations that includes their past and present experiences, being essential in anticipating future action[8,9].

The presumption that a person in crisis is dangerous, requiring healthcare workers to protect themselves as if there were an imminent threat, is still frequent in the psychosocial field. This view highlights the prejudice and lack of knowledge among healthcare workers in addressing and managing psychiatric crisis interventions[10].

Healthcare workers are immersed in the social environment and are, therefore, equally affected by socially constructed stigmas. A dual process of stigmatization has been identified for the population that uses alcohol and drugs, related to historical perceptions of mental illness, which was considered dangerous and requiring social isolation, coupled with a moral judgment that directly associates drug use with illegality[11].

Prejudice and stigma are social processes seen as similar, resulting in discrimination, categorization, labeling, stereotyping, and social rejection. These negative labels represent significant barriers to care, hindering the establishment of a bond between the worker, the user, and the family. As a consequence, there are inadequate and dehumanizing approaches to users, leading to low rates of treatment-seeking and adherence[11,12].

It is also necessary to consider the ongoing narrative dispute in the field of mental health. On one side, there is traditional psychiatry, which understands crises as the destabilization of an open system (the body) losing its functionality (homeostasis), and thus should be treated with a focus on restoring balance through medication,

mechanical and chemical restraint, as well as hospitalization in closed environments aimed at normalizing these bodies[10].

On the other side, we have the psychosocial care model, which considers crises more broadly, not limited to the exacerbation of psychiatric symptoms requiring immediate intervention. It views the crisis as a process of disorganization of the subject, which can be temporary or ongoing, focusing on the subjective understanding of the symptom and the development of actions in the psychosocial field, involving family and community. This care should not begin and end with the crisis but should involve the user's relationships[4]. These narratives intertwine in the daily lives of CAPSad workers during the care of users in crisis, making it crucial to revisit the process of psychiatric reform and ensure the rights of this population[4,10].

The experience of the encounter, by allowing the identification of the other in their entirety during a crisis, carries an intensity that can generate potential for care but also challenges. The resilience required in these situations can lead to moments of stress, conflict, and acute feelings that need to be managed by the entire work team, avoiding the reproduction of asylum practices due to the overload involved in this care [13].

To enhance the psychosocial model and care in freedom, it is essential to observe the users' social relationships, particularly family relationships, which should be evaluated by healthcare workers as a fundamental part of the assistance, in a unique and participatory manner, without neglecting the family member, who also needs care[14].

For greater family adherence to CAPSad, it is crucial that services operate with extended hours and offer alternative appointment times, facilitating access and promoting greater integration into the service and co-responsibility in the user's therapeutic process[15].

Another factor that hinders family engagement with the service is the family structure, which often places the burden on women (mothers, aunts, grandmothers, and stepmothers), who are responsible for the family's financial support, hygiene care, food, home organization, and child education, accumulating functions with a fragile support network[16].

When implemented, family groups have proven to be an effective tool for empowering families to deal with crises, developing a Singular Therapeutic Project (STP) together with the family, promoting spaces for sharing emotions to reduce overload, and encouraging co-responsibility for care[17].

To build a caring and co-responsible relationship with families, healthcare workers' actions should not be limited to a supply-demand mechanism but should be integrated into the micro-politics of everyday life, promoting encounters with families beyond necessity relations, with an interdisciplinary approach focused on care rather than demands[18].

Valuing aspects beyond the crisis, recognizing the user as a subject in a world of social relationships, is essential in care. However, moments when there is an imminent risk to the life of the user or others must be considered, requiring the use of mechanical and chemical restraint when other approaches prove ineffective[19]. The use of protective mechanical restraint does not define an asylum practice, but rather its purpose and context of application, focusing on the protection of the user and others, not as a form of control and guardianship[20].

When there is the possibility of care through verbal communication, therapeutic listening emerges as an excellent tool in addressing crisis situations, promoting greater organization and understanding in the face of the anguish experienced by the user. In this way, space is opened for the construction of new meanings for the crisis, creating joint possibilities stemming from the relationship between the worker and the user, without the need for an active approach to symptom disruption—such as mechanical restraint—by the healthcare team[5].

Mechanical and chemical restraint is still perceived as a form of control, focusing solely on ceasing the crisis symptom. These practices are related not only to the reduction of the user's suffering but also to the healthcare worker's feelings of anguish. There is an attempt to transform a complex and multifactorial problem into something simple to resolve, due to the difficulty of enduring the worker's own anguish related to contact with the other, who is experiencing an extreme moment of suffering[21].

This feeling may also be experienced in managing recurrent crises by users who frequently use the service, which may be perceived by the worker as stressful and exhausting. This situation is more related to the feeling of incapacity, where the worker confronts their own ego, feeling that what they are doing is not working[22].

In general, these users, in their search for identification, break norms and challenge the team. The institutional space of the health service, which operates within established norms, feels threatened, causing a rupture that is considered a problem for the team. This team often shows little reflection on other modes of existence of people, generating needs beyond measures related to

prescription, diagnosis, and referrals, as established by the biomedical model[22].

Mental health work is complex and requires plasticity on the part of the worker in the "we relationship," where they recognize the user as more than an object of intervention, but as a subject with a history, desires, and beliefs[7].

Social experience involves relationships lived with beings similar to oneself. The relationship with the other is built from different aspects and levels of proximity, depth, and anonymity. In other words, the subjects with whom one relates may be their relatives, friends, or even mere strangers[8].

In an anonymous relationship, the other is devoid of meaning; in this type of social relationship, the other is not perceived in their uniqueness and is merely "someone," "one among many," resulting in the depersonalization of the subject. The more anonymous the relationships between workers and users, the fewer the possibilities of understanding the other's subjectivities, and the less information is retained as important in this relationship[8].

Anonymous relationships established by healthcare workers, also known as exclusively mechanical work, are still frequent in services, often responsible for generating "bad encounters." The so-called "bad encounters" are related to the healthcare worker's broken expectations, when they do not achieve the expected therapeutic outcome or when they feel insufficient in the face of the suffering experienced by the user[23,24].

The image constructed of the healthcare worker as an "omnipotent" being, who "does not suffer" and who has the duty to "know all the answers regarding the other's suffering" is in the idealized imagination of the healthcare worker themselves, in a way that dehumanizes them and constructs a hero image[23]. This attitude reflects in the power relations established with the user, as well as in how they see themselves, amplifying feelings related to the fear of making mistakes, guilt for presumed failure, shame for not meeting expectations, and fear of showing vulnerability before the other[23,24].

This socially constructed figure can cause a sense of alienation in the worker, especially in situations and realities that escape their control, generating a feeling of oscillation between omnipotence—the one who knows all the answers—and impotence—a person with limits and vulnerabilities—making it challenging to encounter their own potential. Thus, it becomes necessary to understand the healthcare worker as human, demystifying the idea of the hero, assuming their vulnerabilities, relinquishing positions of dominance, and building shared care[25].

The expectations workers create are shaped by the experience they accumulate in life. However, for it to be possible to approach the user's experience and truly understand them, the worker needs to step away from self-centered positions, opening a path for connection and listening. Thus, from this subjective perspective on the other, it is possible to collectively think about paths of care.

The study faced limitations during the interviews due to the COVID-19 pandemic. Most of the interviews had to be conducted via online platforms, which made it difficult to establish a close relationship between the researcher and the interviewees. Additionally, the workers' overload and fear of virus contamination may have influenced the interviewees' responses and their availability to participate in the research. In face-to-face interviews, the use of Personal Protective Equipment and social distancing hindered the relationship between the researcher and the interviewee.

CONCLUSION

The distance that separates feelings from words. I have thought about this. And the most curious thing is that when I try to speak, not only do I fail to express what I feel, but what I feel slowly transforms into what I say (Clarice Lispector).

The feelings expressed by workers in their care for individuals in crisis involve a mix of emotions. To understand them, it is necessary to establish genuine therapeutic relationships of mutual recognition between the worker and the user, building a "we relationship," where feelings are not denied but understood through bonding and listening. This approach helps avoid anonymous relationships that result in purely mechanical and meaningless work.

The worker must detach from self-centered positions, embracing their vulnerabilities and respecting the diverse modes of existence of the person in crisis, focusing on understanding the symptom rather than merely suppressing it. The feeling of omnipotence, in which the worker believes they must resolve all the user's life demands, hinders the recognition of small progress in the therapeutic relationship and fosters a sense of incapacity, discouraging the worker from engaging in mental health care.

Therefore, it is essential that the worker promotes the care of the person in crisis through verbal interaction and bonding, as there is a sense of joy and satisfaction that accompanies this relationship. It is also necessary to consider the family and think of ways for the service to adapt to accommodate the family member, transforming the feeling of frustration into creative potential, that is,

observing what is not working and modifying strategies accordingly.

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