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COLLECTIVE HEALTH AND HOSPITAL PSYCHOLOGY: COLLABORATIVE PRACTICES AIMED AT COMPREHENSIVE HEALTH CARE[1]

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ABSTRACT

This text approaches, in a reflective and critical way, the insertion of Hospital Psychology in the logic of Collective Health, considering the transformations in the care model and the centrality of the subject in its biopsychosocial complexity, also highlighting the collaborative and interdisciplinary practices that promote the integrality of care in the Unified Health System. Hospital Psychology is presented as an essential area to understand and intervene in the biopsychosocial aspects of illness, hospitalization and palliative care, working with patients, family members and multiprofessional teams. It differs from Clinical Psychology and Health Psychology by its focus on the hospital context and articulation with other areas of health. Interdisciplinary action, involving professionals such as nurses, physiotherapists and nutritionists, is emphasized as fundamental for humanized and patient-centered care. In addition, the text discusses the impact of the hospital environment on the mental illness of health professionals, proposing strategies to promote resilience and mental health. Finally, it reinforces the importance of ethical and political practices that value subjectivity, humanization and comprehensiveness in care, aligned with the principles of the SUS in the hospital context.

Keywords: Hospital Psychology. Collective Health. Completeness. Interdisciplinarity. Humanization.

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1 INTRODUCTION

The Multiprofessional Residency in Collective Health and Primary Care represents an essential training strategy for strengthening the Unified Health System (SUS), promoting collaborative and interprofessional practices aimed at comprehensive care. In this context, the joint action between nurses, physiotherapists and nutritionists stands out as fundamental for the construction of user- and community-centered care.

Specifically, in this text - Collective Health and Hospital Psychology - it is intended to address in a reflective and critical way the insertion of Hospital Psychology in the logic of Collective Health, considering the transformations in the care model and the centrality of the subject in its biopsychosocial complexity. In this sense, it is understood that psychological care transcends individualized care, assuming a fundamental role in health promotion, qualified listening and support for coping with illness.

In addition, the importance of the performance of multiprofessional teams in psychosocial care is highlighted, recognizing the interdependence between Nursing, Physiotherapy and Nutrition practices for care that is more sensitive to the needs of hospitalized (or not) users. This text, therefore, invites a reflection on the possibilities of comprehensive and humanized care, based on respect for the uniqueness of the subjects and on the appreciation of the knowledge and practices of each professional area in the hospital context.

2 HOSPITAL PSYCHOLOGY: BRIEF HISTORY AND BASIC CONCEPTS

Hospital Psychology is an area of activity that seeks to understand and intervene in the emotional and behavioral aspects involved in the process of illness, hospitalization, rehabilitation and palliative care. Its objective is to offer psychological support to patients, family members and health team professionals, promoting comprehensive care.

Thus, this specialty in psychology aims to understand the disease in its biopsychosocial dimension, considering the interdependence and interrelationship between biological, psychological and social aspects. It deals with the subjectivity present in any and all diseases, offering ways for a practice aimed at users, promoting health and well-being, instead of focusing exclusively on the symptom or disease (CFP, 2019).

Although inspired by Clinical Psychology, Hospital Psychology in Brazil was constituted as a specific field of action based on emerging demands from the hospital context and the health system itself. Its development gained strength especially in the 1970s and 1980s, when the presence of psychologists in university hospitals and higher education institutions intensified. These spaces were fundamental for the training of professionals and

the consolidation of practices aimed at the psychological care of patients in situations of illness (Ribeiro; Dacal, 2012; CFP, 2019).

During this period, psychologists began to be called upon to intervene in complex situations that involved not only the psychic suffering traditionally addressed by Clinical Psychology, but also the emotional impact of illness, hospitalization, chronic pain, grief and invasive procedures. The practice began to require the adaptation of clinical techniques to the demands of the hospital environment, characterized by urgency, brevity, and interdisciplinarity (CFP, 2019).

The consolidation of Hospital Psychology as a field of knowledge and practice occurred in parallel with important transformations in the Brazilian health system. From the 1980s onwards, with the Health Reform movement, a new model of health care was established, more democratic and centered on comprehensive care. The promulgation of the Federal Constitution of 1988 and the creation of the SUS established health as a right of all and a duty of the State, favoring the insertion of psychologists as part of the multiprofessional teams at the various levels of care (Mendes; L; Barreto, 2020; Belancieri, 2021).

In this new scenario, Hospital Psychology is no longer an isolated practice and has become part of the proposals of Collective Health, dialoguing with the principles of equity, universality and humanization. The work of the hospital psychologist began to include not only direct patient care, but also educational actions, support for family members, conflict mediation and articulation with other areas of health (Mendes; L; Barreto, 2020), such as Nursing, Physiotherapy, Nutrition, Medicine, Social Work, among others.

In addition, the consolidation of the area was driven by the creation of academic leagues, specialization courses, scientific publications and professional associations, such as the Brazilian Society of Hospital Psychology, founded in 1993 and the arduous struggle of the Psychology Councils System. These initiatives contributed to the recognition of Hospital Psychology as an area of specialty, with its own practices and an ethics oriented towards the integral care of human beings in vulnerable situations (CFP, 2019; 2022).

Thus, Brazilian Hospital Psychology is the result of a trajectory marked by institutional struggles, political transformations and theoretical advances, and is affirmed today as a fundamental practice in the context of hospital care and health promotion in its biopsychosocial dimension.

2.1 DIFFERENCES BETWEEN CLINICAL PSYCHOLOGY, HOSPITAL PSYCHOLOGY AND HEALTH PSYCHOLOGY

Clinical Psychology, Hospital Psychology and Health Psychology share theoretical foundations of Psychology, but differ in their contexts of action, objectives and approaches to psychological suffering and health conditions. Below, we highlight the main differences between these three specialties according to Resolution No. 23/2022 (CPF, 2022):

Clinical Psychology is one of the most consolidated aspects of Psychology, with a focus predominantly on the individualized care of psychic suffering. In this specialty, in general, the work takes place in contexts such as private offices, specialized clinics or institutions that are dedicated exclusively to the practice of psychotherapy. In these spaces, the clinical psychologist establishes a direct and continuous relationship with the patient, developing a therapeutic work based on bonding, qualified listening and the analysis of subjective processes.

The focus of Clinical Psychology lies in the understanding and management of emotional suffering and internal conflicts experienced by the subject. The emphasis is on subjective and intrapsychic aspects, such as feelings, thoughts, memories, fantasies, and behavior patterns that impact the individual's mental health. This model recognizes that human suffering is multifaceted and demands a careful and personalized approach, aimed at listening to and interpreting the subject's internal experiences.

Among the main objectives of this approach are the diagnosis and treatment of mental disorders, as well as intervention on emotional conflicts and relational difficulties. Psychotherapy is the therapeutic instrument par excellence, adopting different theoretical lines — such as psychoanalysis, the cognitive-behavioral approach, existential phenomenology, among others — that guide the reading of the clinical case and the treatment plan (Dutra, 2004).

The intervention model adopted is mostly centered on the therapist-patient relationship. This relationship is understood as the privileged space for the emergence, elaboration and transformation of psychic contents relevant to the process of healing or alleviating suffering. The therapist, through active and empathetic listening, seeks to access the deep mental processes, often unconscious, that contribute to the patient's suffering, promoting the expansion of consciousness, the resignification of experiences, and the strengthening of internal resources, aiming at self-esteem, autonomy, and quality of life (CFP, 2022).

Hospital Psychology, on the other hand, is developed in the context of health services, especially in various hospital environments, such as wards, intensive care units, outpatient clinics, oncology, pediatrics, palliative care, among others. Its practice is inserted in the logic of comprehensive health care, with the objective of considering not only the physical aspects

of the disease, but also the emotional, cognitive, and relational dimensions that emerge in the process of illness (CFP, 2022).

The main focus of Hospital Psychology is the hospitalized patient, but its performance also extends to the support network of this patient — family members, caregivers and a multidisciplinary team — recognizing the psychological impact that physical illness and hospitalization can cause in everyone involved. Coping with the disease, invasive medical procedures, the abrupt change in routine and, often, the threat to life, mobilize intense emotions such as fear, anguish, sadness, anger and feelings of helplessness, requiring specialized care (Santos, 2022).

Among the main objectives of Hospital Psychology is the emotional support to the patient throughout the process of illness, hospitalization and, in some cases, anticipatory or effective grief. The psychologist acts to favor the expression of feelings, promote empathetic listening and facilitate the emotional elaboration of experiences lived in the hospital environment. In addition, their work contributes to improving adherence to medical treatment, mediating communication between patients, family members, and the health team, as well as managing subjective crises resulting from hospitalization (CFP, 2022).

The intervention model adopted is predominantly brief and focused on the crisis situation. It is a work that requires specific interventions, but with high potential for impact, aimed at emotional stabilization and psychic reorganization in the face of unexpected or traumatic situations. Hospital Psychology is also characterized by an integrated performance with the multiprofessional team, favoring interdisciplinary care and the construction of shared therapeutic conducts. This integration allows for a broader view of the patient, promoting a more humane, ethical, and effective approach to coping with the disease (CFP, 2019; 2022).

The practice of the hospital psychologist requires sensitivity, qualified listening and technical competence to deal with pain, finitude, uncertainties and limits imposed by the clinical condition. Their contribution is fundamental for the hospital environment to become a more welcoming space, where psychic suffering is recognized and cared for with the same legitimacy as physical suffering.

And Health Psychology focuses on understanding and intervening in processes related to health and disease, from a broad, integrative and interdisciplinary perspective. Its field of action is vast and diversified, including spaces such as hospitals, basic health units, schools, companies and institutions linked to the formulation and execution of public policies. In these different contexts, the health psychologist works in collaboration with other professionals, composing interdisciplinary teams that aim to expand care beyond the traditional biomedical model (Coelho et al., 2013; Belancieri, 2021, CRP, 2022).

According to Matarazzo (1980), Health Psychology refers to a set of scientific, educational and professional contributions that the different psychological disciplines provide for the promotion and maintenance of health, prevention and treatment of diseases, identification of the etiology and diagnosis of factors associated with health, disease and dysfunctions, in addition to the analysis of the health system and the formulation of public policies. This definition highlights that Health Psychology is not just the application of Clinical Psychology to the health environment, but rather an area that encompasses broader aspects related to physical and mental health.

In this sense, the focus of Health Psychology lies in the analysis of the complex relationships between health and human behavior, seeking to understand how psychological, social and cultural aspects influence the process of illness and the well-being of individuals and collectivities. Thus, its performance is not restricted to the rehabilitation or treatment of diseases that have already taken place, but invests heavily in strategies for disease prevention and health promotion, with a view to improving quality of life in different phases of the life cycle (Ribeiro, 2011, CFP, 2022).

Among its main objectives, the identification and analysis of factors that contribute to the emergence and maintenance of health and disease conditions stand out, as well as the development of evidence-based interventions aimed at collective health. This includes everything from health education actions and lifestyle changes, to emotional support for patients with chronic diseases or in situations of psychosocial vulnerability (CRP, 2019).

Health Psychology adopts the biopsychosocial model as a theoretical and practical framework, recognizing that health is the result of the dynamic interaction between biological, psychological, and social factors. This model supports a preventive and promotional approach, which values the subject's role in self-care and the construction of healthier environments. These practices are often included in public health policies, which reinforces the social and ethical commitment of Psychology to the transformation of the population's living conditions and the reduction of health inequities (CRP, 2019; 2022; Belancieri, 2021).

2.2 INTERFACES WITH THE SUS

The work of the hospital psychologist is deeply aligned with the principles of the Unified Health System (SUS) and the guidelines of Collective Health, especially with regard to the pillars of Universality, integrality and equity.

The principle of universality establishes that access to psychological care must be guaranteed to all individuals who need it, without any form of discrimination. Thus, qualified listening and acceptance of the subjective aspects of suffering should be available at all levels

of hospital care — from screening and hospitalization to discharge follow-up and palliative care (Brasil, 2010).

Comprehensiveness, on the other hand, implies a broader approach to care, in which the psychologist should not restrict himself to the symptoms or the immediate complaint, but consider the subject in his or her totality — body, mind, life history, social and cultural bonds. This perspective requires articulation with the other professionals of the health team and recognition of the emotional, relational and existential dimensions that go through the disease process. Clinical listening should be sensitive to the singularities and multiple meanings attributed by the patient to the experience of the disease and hospitalization (Brasil, 2009; 2010).

Equity, in turn, requires from the psychologist an ethical and critical posture in the face of the social inequalities that cross the health-disease processes. Psychological care should be guided by the recognition of the conditions of vulnerability of the subjects — whether economic, racial, gender, generational or related to access to rights — and by the active search for strategies that reduce these inequities. This means adapting clinical interventions to the patient's social context, promoting accessible, culturally sensitive, and effectively inclusive care (Ayres, 2009; Dimenstein, 2001).

In the hospital environment, the psychologist works together with other professionals, such as nurses, physiotherapists, social workers, occupational therapists, nutritionists and doctors, composing multiprofessional teams focused on comprehensive care. This collaborative action is essential to face the complex demands that involve human suffering in hospitalization contexts, such as the emotional impact of the diagnosis, the experience of pain, grief, adherence to treatment, and coping with finitude (Azevedo; Crepaldi, 2016). Alongside these professionals, the psychologist must take into account the social determinants of health, recognizing that factors such as housing, food, access to education, affective bonds, and community support directly interfere with the way the patient gets sick, lives, and dies (Belancieri, 2021).

Thus, the performance of the hospital psychologist must transcend the traditional biomedical logic, incorporating the principles of the expanded clinic and the humanization of care, as recommended by Brazilian public health policies. Listening, bonding, ethical communication and subject-centered care become fundamental strategies for the construction of practices committed to health as a universal right and to subjectivity as a legitimate dimension of care (Zurba, 2011).

2.3 HOSPITAL PSYCHOLOGY AND COLLECTIVE HEALTH

From the perspective of Collective Health, Hospital Psychology assumes an expanded role, integrating individual care with the understanding of the collective and institutional dynamics of the hospital. This approach is in line with the principles of the SUS and the policies of humanization of care, promoting interdisciplinary and ethical-political practices centered on the integrality of care (Brasil, 2009; 2010).

The hospital psychologist, in this context, not only acts in listening to the patient in psychic suffering, but also participates in educational actions in health, contributes to clinical discussions with the multiprofessional team, develops strategies to support health professionals in emotional suffering and promotes the humanization of the hospital environment as a relational space, welcoming and respectful of subjectivities. This position is in line with the proposal of the Extended Clinic, formulated by the Ministry of Health, which proposes the integration of knowledge and the recognition of the multiple dimensions involved in the health-disease process (Brasil, 2009).

It is, therefore, a practice in which the psychologist recognizes the inseparability between clinical care and social commitment. Hospital performance cannot be neutral or merely technical, as it involves decisions that directly impact the ways of living, suffering and dying of the people cared for. Thus, the psychologist must incorporate a critical and reflective posture, articulating his or her listening to the concrete reality of the subjects — marked by social, ethnic-racial, gender inequalities, and access to rights (CFP, 2019; Ayres, 2009).

In the context of the Multiprofessional Residency in Collective Health, this approach gains even more importance. The hospital field is understood as a privileged territory for the training of professionals committed to an interdisciplinary, inclusive and comprehensive health model. Hospital Psychology, in this context, proposes to train residents based on principles such as integrality of care, the transversality of actions, the acceptance of diversity and the uncompromising defense of human rights. This implies an education that articulates technical-scientific knowledge with sensitive listening, ethical responsibility and critical analysis of public health institutions and policies (Brasil, 2006; Brazil, 2012).

Thus, Hospital Psychology, when practiced from the perspective of Collective Health, contributes to the construction of care that is more sensitive to the needs of the subjects, more dialogical and horizontal in the institutional space, and more committed to the production of health as a social right and collective construction.

3 COLLECTIVE HEALTH IN THE HOSPITAL: CONTRADICTIONS AND POSSIBILITIES

The presence of Collective Health in the hospital space constitutes, in itself, a field of tensions, contradictions and powers. Traditionally, hospitals have been organized under a

hospital-centric logic, centered on disease, on the technification of practices and on the fragmentation of care. This logic prioritizes biomedical interventions, focusing on the immediate resolution of clinical problems, often reducing the subject to his or her pathological condition and making its subjective, social, and cultural dimensions invisible (Merhy, 2014; Silva, 2005).

In this model, biomedical knowledge assumes a hegemonic position, influencing both the technical division of labor and the hierarchy among health professionals. The clinic, in this context, tends to be restricted to the biological body, disregarding the multiple determinants that affect the health-disease-care process (Merhy, Franco, 2008). Hard technology (equipment, exams, procedures) often overlaps with soft technology, represented by listening, bonding, and welcoming (Rodrigues et al., 2024).

In contrast, Collective Health proposes an expanded logic of care, based on the notion that health care goes beyond the biological and incorporates social, economic, environmental, and political dimensions of human existence. This approach values comprehensive care, interdisciplinarity, the protagonism of the subject and social participation as guiding principles of health practices (Ayres, 2009; Pine; Guizardi, 2006).

Upon entering the hospital, Collective Health tensions the traditional model by proposing other ways of seeing, understanding and intervening in human suffering. It introduces practices such as expanded clinical discussions, health education actions, matrix support for teams, qualified listening to professionals in suffering and interventions that consider the territory and the life history of patients (Brasil, 2009; 2010).

In this sense, a fundamental contradiction emerges: how to guarantee integral, humanized, and equitable practices in a space historically structured for technification, standardization, and control of life? This tension reveals not only the institutional limits, but also the possibilities for transforming practices, especially when the team mobilizes to build spaces for shared care and collective listening.

The presence of Collective Health in the hospital can act as a device for institutional change, contributing to shift the view centered on the disease to a care more linked to subjectivity, territory and the production of autonomy. Initiatives such as the Family Health Support Centers, the Singular Therapeutic Projects and the experiences of multiprofessional health residencies have evidenced the potential of these practices to provoke shifts in the logic of hospital care (Brasil, 2009; Brazil, 2006).

It is, therefore, a dispute of meanings about what health care is. Collective Health, by being present in the hospital, opens space for new practices to emerge; practices that recognize the complexity of the subjects and that resist the technical homogenization of care.

Even in an environment marked by control and normativity, it is possible to affirm the power of an expanded clinic, ethical, sensitive and politically committed to life.

3.1 HEALTH AS A RIGHT AND SOCIAL DETERMINANTS IN THE HOSPITAL ENVIRONMENT

The hospital, as a public health facility, is one of the spaces where the principle of health as a universal right, guaranteed by the Federal Constitution of 1988 (Brasil, 1988), is materialized (or not). The performance of multiprofessional teams in this space must be aligned with the principles of the SUS: universality, integrality and equity.

Recognizing health as a right implies understanding the social determinants of health in the hospital context, since patients arrive at the hospital carrying stories marked by inequalities — lack of access to services, precarious housing, food insecurity, structural violence, among others. These determinants continue to act even within the hospital, influencing access, adherence to treatment, length of hospital stay, and discharge conditions (Belancieri, 2021).

The presence of Collective Health in the hospital requires, therefore, an attentive and sensitive look at the patients' living conditions, and this involves articulation with care networks, dialogue with the users' territories of origin, and valuing the subjective and social aspects of care.

3.2 VULNERABILITIES AND COMPREHENSIVE CARE

The notion of vulnerability is a central concept in the practice of Collective Health, especially in the hospital context, where human frailties are expressed in an intense and multifaceted way. Hospital vulnerability is manifested in physical (disease, pain, dependence), emotional (fear, loneliness, anxiety), social (inequalities, exclusion, precariousness) and institutional (bureaucratization, dehumanization, technification of care) dimensions. Recognizing these forms of vulnerability is essential for health professionals and residents to be able to build comprehensive, sensitive care committed to the right to health and dignity.

In the field of health education, especially for residents in the areas of Nursing, Physiotherapy and Nutrition, this recognition implies an active and transformative posture. It is about going beyond the traditional clinical response and incorporating practices that consider the subject in his or her biopsychosocial totality. In this sense, Ayres (2009) and Campos and Guerreiro (2008) emphasize that qualified listening, welcoming and contextual

analysis of the social determinants of health become essential devices for an effectively humanized practice.

Acting in a multiprofessional team is another pillar of this proposal, based on the valorization of interdisciplinarity and the horizontality of work relationships. Such an approach recognizes the different professional knowledge as complementary, enhancing comprehensive care. The articulation between team members, especially in the planning of hospital discharge and in the link with Primary Care services, is essential to ensure continuity of care and avoid avoidable readmissions (Agreli; Peduzzi; Silva, 2016).

In this context, the insertion of Collective Health in the hospital should not be seen as a merely care displacement, but as a deeply ethical and political formative opportunity. Residents are called upon to articulate technical-scientific knowledge with a commitment to equity, social justice and the strengthening of the SUS. It is a clinic that stands as a space for listening, bonding and resistance in the face of the processes of medicalization and fragmentation of care (Brasil, 2006; Pine; Guizardi, 2006).

Thus, by recognizing and intervening in the various dimensions of vulnerability, health professionals reaffirm care as an ethical, transformative practice committed to life in its complexity.

4 INTERDISCIPLINARY ACTION IN PSYCHOSOCIAL CARE

Psychosocial care, especially in the hospital context and at other levels of health care, demands a broader approach that goes beyond the compartmentalization of knowledge. It is a matter of recognizing that the processes of illness and care are complex, crossed by biological, psychological, social, cultural and institutional dimensions. In this scenario, interdisciplinary action is not only desirable – it is an ethical and technical requirement to ensure comprehensive care, one of the founding principles of the SUS (Giacomini; Rizzotto, 2022).

According to the authors, interdisciplinarity in psychosocial care is not limited to the juxtaposition of different professionals in the same space. It supposes the construction of an active, collaborative and ethical dialogue between the different fields of knowledge, guided by the unique needs of the subjects. This process requires listening, negotiation and co-responsibility among team members, which allows the construction of shared therapeutic plans, more appropriate to the real living conditions of the users.

The interdisciplinary perspective is strongly linked to the principles of the expanded clinic, which proposes a clinical practice based on valuing the subjective, social and cultural dimensions of illness (Brasil, 2009; Fields; Guerreiro, 2008). This approach makes it possible

to break with the fragmentation typical of traditional biomedical models, enabling more effective, humane, and contextualized interventions.

This practice translates into concrete actions such as: the joint construction of unique therapeutic projects; the use of soft technologies (such as qualified listening and bonding); the problematization of the social determinants of health; and the valorization of users' narratives as a legitimate part of the therapeutic process (Brasil, 2009).

Interdisciplinary work also plays a fundamental role in health education, particularly in multiprofessional residency contexts. In it, residents learn to deal with the real complexity of care, developing collaborative, reflective and critical skills. As Luz (2009) points out, this training requires professionals to abandon positions of absolute knowledge and open themselves to the collective construction of care, recognizing the limits and powers of their practices.

In this sense, interdisciplinary action in psychosocial care is more than a team management technique: it is an ethical-political practice that places the subject — and not the disease — at the center of the care process. It is in this space that the SUS is strengthened as a health and citizenship project, and health is affirmed as a right of all and a duty of the State.

4.1 CONTRIBUTIONS OF PHYSIOTHERAPY, NURSING AND NUTRITION TO PSYCHOSOCIAL CARE

Each area of the health field brings unique contributions to psychosocial care, such as:

a) Physiotherapy: acts significantly for psychosocial care by promoting improvement in mental, physical and social health. By using techniques such as music therapy, pilates, among others, they help to reduce symptoms of depression and anxiety, promoting pain relief. By facilitating bodily and functional reintegration, it contributes significantly to self-esteem, emotional well-being, and coping with illness. The physiotherapist also promotes socialization, reducing isolation, in addition to strengthening interpersonal bonds, including with the patient himself, through listening during the consultations, which favors the construction of humanized care (Souza Neta et al., 2023). According to the authors, physical activities performed in groups help prevent motor and cognitive decline, as well as improve sleep quality and reduce fatigue.

As observed, these are not only physical problems, but physiotherapy also positively influences the psychological and social state of individuals, promoting a better quality of life and integration into society.

b) **Nursing:** has a central role in the continuity and coordination of care. The constant presence of nurses in the patient's daily life favors the reception of emotional demands, crisis management, recognition of psychosocial vulnerabilities and articulation with other areas. Active listening and the bond built by nursing become powerful care tools, promoting the active participation of the individual in the therapeutic process (Villela; Scatena, 2004).

In addition, according to Silva et al. (2024), when planning individualized care (Singular Therapeutic Project), nursing can favor psychosocial rehabilitation and social inclusion, promote behavioral changes, interaction, and management of emotions, strengthening the patient's self-esteem.

Overcoming outdated and hospital-centric practices, promoting psychosocial actions that go beyond the biomedical model, aim to ensure humanized, comprehensive care focused on psychosocial care, promoting greater autonomy, quality of life and social insertion of patients.

c) **Nutrition:** understands food not only as a biological input, but as a cultural, affective and identity element. Nutritional listening should consider dietary restrictions, cultural habits, socioeconomic conditions, and psychological suffering that impact the patient's relationship with food. Humanized nutritional care embraces the subjectivity of eating, promoting autonomy and improving health conditions and quality of life. In addition, practices that encourage changes in eating habits, promoting self-care and increasing users' self-esteem, allow for more conscious food choices (Sauceda et al, 2017). Thus, Nutrition integrated with multiprofessional work contributes to the strengthening of bonds between users and professionals, promoting comprehensive and humanized care.

These practices complement each other, and their interdisciplinary articulation expands the possibilities of care, especially in situations of emotional suffering, chronic illness, terminality, functional dependence and social vulnerability.

4.2 COLLABORATIVE PRACTICES AND PATIENT-CENTERED CARE

The traditional logic of health care, marked by the fragmentation of actions and the hierarchization of knowledge, has been increasingly questioned in the field of Collective Health. In their place, collaborative practices emerge, which propose the overcoming of verticalized models of care. From this perspective, care is no longer something that is done

for the patient, but with him, recognizing his autonomy, uniqueness and decision-making capacity about the health and disease process itself (Mattos, 2009).

Collaborative practices presuppose an interdisciplinary and dialogued approach, in which different professional knowledge meets in a logic of horizontality. This model favors the shared construction of Singular Therapeutic Projects and the co-responsibility between team members and users, which strengthens bonds and expands the problem-solving capacity of health actions (Agreli; Peduzzi; Silva, 2016; Brazil, 2009).

Patient-centered care, in turn, is a fundamental guideline in the SUS and implies considering the subject in its entirety – biological, psychological, social and cultural. It is about listening to and valuing their narrative, understanding their values, their life context and promoting their active participation in decisions involving their care. Such an approach requires time, qualified listening, and ethical commitment to respect for autonomy and human dignity (Merhy; Franco, 2008; Fields; Guerreiro, 2008).

The articulation between different points of the Health Care Network is an indispensable condition for this care to be fully and continuously implemented. The integration between primary, medium and high complexity care, support services and community actions strengthens longitudinal care and avoids the fragmentation of practices, especially in hospital contexts, where the risks of discontinuity of care are more pronounced (Pinheiro; Guizardi, 2006).

4.3 QUALIFIED LISTENING, BONDING AND HUMANIZATION

Qualified listening is another essential pillar of health practices guided by the principles of humanization. More than listening to what is said, it is an exercise of ethical, empathetic and active presence, which seeks to recognize the other in their uniqueness, welcome their suffering and legitimize their modes of expression (Ayres, 2009; Brazil, 2009; 2010). Qualified listening creates a space of trust where patients can express their emotional, social, and clinical needs, favoring comprehensive care.

The therapeutic bond, in turn, is built in the daily relationship between professionals and users. It does not emerge spontaneously, but is the result of consistent practices that involve respect, care, sensitivity and commitment to the other (Merhy; Franco, 2008). The bond allows health professionals to access subjective dimensions that often escape technical protocols, expanding the possibilities of understanding and intervention.

The National Humanization Policy, instituted by the Ministry of Health (Brasil, 2009; 2010), proposes that the humanization of care be understood as a transversal guideline to health care and management, based on valuing relationships, strengthening the role of the

subjects and co-responsibility for care. In this sense, humanization is not a mere softening of care, but an ethical and political posture that recognizes the subjects in their complexity and seeks to build more democratic and respectful processes in the field of health (Deslandes, 2019).

In contexts such as hospitals, marked by intense technical and emotional demands, listening, bonding and humanization gain even more relevance. They are configured as clinical-political devices that can contribute to the transformation of institutional practices, bringing care closer to the real life of the subjects.

5 MENTAL ILLNESS AMONG HEALTH PROFESSIONALS IN THE HOSPITAL ENVIRONMENT: CHALLENGES AND CARE STRATEGIES

The hospital environment, although essentially focused on patient care, has also been configured as a critical space for illness for health professionals. The hospital routine is marked by multiple tensions, which intensify in the face of factors such as work overload, precarious bonds, pressure for productivity, and constant exposure to pain, suffering, and death. These elements contribute significantly to the psychological suffering of health workers.

In the specific context of nursing, research carried out by Belancieri and Cappo-Bianco (2004) and Belancieri (2005) in a university hospital revealed that 40% of the professionals presented symptoms of stress. The main stressors identified were: excessive institutional control, difficulties in interpersonal relationships, disrespect for professional ethics, routine and repetitive activities, and patient overload. These factors were associated with self-attributed psychosomatic symptoms, such as muscle pain, gastrointestinal disturbances, insomnia, and chronic fatigue.

The studies also dialogue with Lipp's (2004) model, which describes the phases of stress - alertness, resistance and exhaustion. It was observed that a significant portion of the professionals were in the resistance phase, characterized by psychological symptoms such as irritability, anxiety and concentration difficulties.

More recent studies point to a significant increase in the prevalence of disorders such as burnout, anxiety, depression, moral distress, and insomnia among these professionals, especially after high-demand scenarios, such as facing the COVID-19 pandemic (Belancieri; Bellini, 2022; WHO, 2022). The consequences of this situation include physical and emotional exhaustion, absenteeism and, in extreme cases, abandonment of the profession.

The particularities of each professional category further aggravate this scenario: nurses face exhausting working hours, instability in employment relationships, and an intense

emotional load, resulting from direct and constant contact with the suffering of patients, without continuous emotional support and a harm reduction policy (Ampos, 2023). Physiotherapists deal with the complexity of the rehabilitation of critically ill patients, requiring sensitive emotional management in the face of chronic pain and functional limitations (Trevisan; Benatti; Cruz, 2022). And nutritionists, often made invisible in the hospital context, experience multiple institutional demands, scarcity of resources, and little recognition of their therapeutic role, resulting in symptoms of depression and anxiety (Silva et al., 2023).

To deepen these findings and seek strategies to strengthen the ability to cope with stress arising from the work environment, Belancieri (2011) and Belancieri and Kahhale (2011a; 2011b), explored the relationship between stress, resilience and quality of life of nursing professionals in the public health network, confirming the psychological stress index, in addition to average levels of resilience and a quality of life considered below ideal. The authors highlight the importance of promoting resilience as a fundamental strategy to face the adversities inherent to health care.

Resilience, understood as the ability to cope with challenging situations and overcome adversity, is not innate; It can be developed throughout life, based on appropriate experiences and support. Among the factors that favor their development are: the construction of positive interpersonal relationships with colleagues and supervisors, awareness of their own limits and emotions, the search for meaning at work, and flexibility in the face of change (Belancieri et al., 2010; Belancieri; Kahhale, 2011b).

Thus, the promotion of resilience among health professionals requires multidimensional actions, such as psychological support programs, offering safe spaces for emotional expression and the development of coping strategies; professional training, with training that addresses communication skills, stress management and self-care, as well as institutional policies, which value the well-being of health professionals.

To face this scenario, it will be necessary to implement integrated and continuous actions to promote mental health, with the active participation of Hospital Psychology, management teams and health professionals themselves.

Among the recommended actions, according to Belancieri and Kahhale (2011b), reflection groups and active listening circles stand out, which enable the sharing of experiences, mutual acceptance and the strengthening of bonds between colleagues. In addition, institutionalized psychological support guarantees access to individual clinical care and emergency support when necessary. Burnout prevention programs are also essential, focusing on educational actions aimed at stress management, non-violent communication, and regular self-care practices.

Another relevant aspect, according to the authors, refers to the creation of spaces for rest and emotional decompression, which value breaks as an integral part of preserving mental health during the workday. Clinical and institutional supervision also plays a central role in offering structured moments of reflection on professional practice, ethical dilemmas and moral distress experienced in daily hospital life. Added to this is the importance of policies of professional appreciation and institutional recognition, which strengthen workers' self-esteem and sense of belonging. Finally, the performance of internal humanization committees, with the active participation of professionals, contributes to the construction of healthier, collaborative, and inclusive environments.

These actions should be supported by public and institutional policies that value health work, ensuring adequate conditions for professional practice to prevent mental illness. In addition, it is essential that care strategies consider the specificities of each professional category.

In view of this reality, it is essential to promote comprehensive care for health professionals, in line with the principles of humanization and Collective Health. Health care cannot be restricted to the patient. Caring for those who care is an ethical, political and institutional premise. By recognizing the psychological suffering of health professionals and investing in strategies to promote their mental health, not only the well-being of these workers is strengthened, but also the quality of care provided to users and the sustainability of health services (Belancieri, 2011a).

In view of the above, it is observed that Hospital Psychology, when guided by the principles of Collective Health, proves to be a powerful intervention tool, capable of promoting comprehensive care for both users and health workers. By recognizing the hospital as a living, plural and contradictory space, the psychologist becomes an agent of articulation between individual suffering and institutional logics, collaborating for the construction of fairer, more solidary and humanized practices.

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