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Original Article

The speech of people hospitalized due to psychiatric crisis on treatment autonomy and credibility

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Objective: to describe the perception of people in psychiatric crisis about the credibility of their speech and its relationship with the promotion of treatment autonomy. **Method**: a study with a qualitative and descriptive-exploratory approach, based on semi-structured interviews, carried out in October and November 2019 with 12 men admitted to a public psychiatric institute in Minas Gerais, Brazil, selected for convenience. The research complied with ethical principles and was approved in September 2019, under number 3,566,943. The thematic content analysis technique was used for data treatment. **Results**: the participants reported a punitive perception in relation to hospitalization and treatment, devaluation of their statements in the construction of the Singular Therapeutic Project and ignorance about the implications of these perceptions for the work of the team that accompanied them and for the institution. **Conclusion**: despite the reconfigurations of the mental health care model, the users' speech is still marked by low credibility and low level of autonomy in the therapeutic process. Furthermore, in the hospital environment, the challenges for the consolidation of multidisciplinary care and for the user's participation in the treatment have been maintained.

Descriptors: Mental Health; Psychotic Disorders; Patient Participation; Hospitalization.

Discurso das pessoas internadas por crise psiquiátrica sobre credibilidade e autonomia no tratamento

Objetivo: descrever a percepção das pessoas em crise psiquiátrica sobre a credibilidade do discurso que emitem e sua relação com a promoção da autonomia no tratamento. **Método**: abordagem qualitativa, descritivo-exploratória, a partir de entrevistas semiestruturadas, realizadas em outubro e novembro de 2019, com 12 homens internados em um instituto psiquiátrico público em Minas Gerais, Brasil, selecionados por conveniência. A pesquisa cumpriu os princípios éticos e foi aprovada em setembro de 2019, pelo parecer 3.566.943. Utilizou-se a técnica de análise de conteúdo temática para tratar os dados. **Resultados**: os participantes referiram percepção punitiva em relação à internação e tratamento, desvalorização de suas falas na construção do Projeto Terapêutico Singular e desconhecimento sobre as implicações dessas percepções para o trabalho da equipe que os acompanhava e para a instituição. **Conclusão**: apesar da reconfiguração do modelo de assistência em saúde mental, o discurso dos usuários ainda está marcado por pouca credibilidade e baixa autonomia no processo terapêutico. Ademais, no âmbito hospitalar, têm-se mantido os desafios para a consolidação do cuidado multidisciplinar e para a participação do usuário em seu tratamento.

Descritores: Saúde Mental; Transtornos Psicóticos; Participação do Paciente; Hospitalização.

Discurso de las personas internadas por crisis psiquiátrica sobre credibilidad y autonomía de tratamiento

Objetivo: describir la percepción de las personas en crisis psiquiátrica sobre la credibilidad del discurso que emiten y su relación con la promoción de la autonomía de tratamiento. **Método**: enfoque cualitativo y descriptivo-exploratorio, basado en entrevistas semiestructuradas, realizadas en octubre y noviembre de 2019 con 12 hombres ingresados en un instituto psiquiátrico público en Minas Gerais, Brasil, seleccionados por conveniencia. La investigación cumplió con principios éticos y fue aprobada en septiembre de 2019, mediante dictamen 3.566.943. Para el tratamiento de los datos se utilizó la técnica de análisis de contenido temático. **Resultados**: los participantes refirieron una percepción punitiva con relación a la hospitalización y al tratamiento, desvalorización de sus discursos en la construcción del Proyecto Terapéutico Singular y desconocimiento de las implicaciones de estas percepciones para el trabajo del equipo que los acompañaba y para la institución. **Conclusión**: a pesar de la reconfiguración del modelo de asistencia en salud mental, el discurso de los usuarios todavía está marcado por escasa credibilidad y falta de autonomía en el proceso terapéutico. Además, en el ámbito hospitalario, se han mantenido los retos para la consolidación de la atención multidisciplinaria y para la participación del usuario en su tratamiento.

Descriptores: Salud Mental; Trastornos Psicóticos; Participación del Paciente; Hospitalización.

Introduction

The interpretations about mental distress and its repercussions have undergone important revisions in recent decades and present contradictions arising from the unique way of living of people who experience it and their interactions with the social field. The hospital-centric care model, historically constituted over the centuries, in which the institutions for treatment were gradually configured, had as its outcomes that Psychiatry became a field of segregating practices and that the mental hospital was translated as its symbol[1-2].

Under the influence of the international reformist experiences, especially under the aegis of Italian Democratic Psychiatry, the Brazilian Psychiatric Reform (*Reforma Psiquiátrica Brasileira*, RPB) movement began in the wake of the social movements of the 1970s, with the majority participation of newly graduated professionals who proposed breaking with the mental hospital model and giving voice to users, family members and workers, in addition to resorting to social participation, a decisive tool for its implementation[3-4].

Services named as extra-hospital or substitutive were created, such as support devices, spaces for welcoming and care based on social interactions, without the need to isolate the individuals from their social environment and/or their daily lives. The subject in psychological distress becomes the protagonist of the relation and of their life project[5-6]. However, the care strategy that is configured as the spatial and social isolation of the person in mental distress, whether in a closed regime with permanence/resistance of hospitalization in some hospitals, or in open services with daytime stay and nightly hospitality, has been justified by the clinical conditions generally evaluated in light of psychological organization, or its absence, and in light of the strategies for coping with distress that the person is able to use in critical moments.

Evidence related to risks for oneself and others, associated with episodes of aggressiveness, manifested or not by violent attitudes, continue to determine distancing from the social environment. Even if those who suffer do not show the same understanding, the risks of self-extermination or hetero-aggressiveness continue to be recorded in the medical charts as the most frequent manifestations on arrival at the services and can be used to justify hospitalization.

The definition of crisis indicates both the sense of separation, change and transient imbalance and that of a possible opportunity for growth. Crisis as a life experience has been associated with the need for immediate professional care based on theoretical-practical knowledge linked to a (psychosocial) model to respond to the subjective, practical and social demands of the person who is undergoing mental distress[7]. The crisis must be understood as multifactorial, insofar as the conceptual and contextual appropriation of the different clinical, historical and social meanings.

There is also the dimension that a crisis is the psychological trigger that puts the person in a vacuum, in a position of questioning[8-9]. In some cases, disconnected and confusing speeches are present, with differentiated use of language; by distancing from the predictable linearity of discourse, what the person says may not be understood or valued. With the difficulty in communication, autonomy is impaired, insofar as needs, desires, emotions and feelings are not expressed by the person as at other moments.

The response to the crisis comes from the urgency that is revealed in it and needs to be carefully evaluated, aiming at proposing proportionally resolute measures, which promote containment to the users, in the sense of borders, so that they may obtain the necessary resources to deal with this moment of ruptures.

Hospitalization must be understood as a limit-strategy for protecting the health and life of the person who suffers or of their coexistence circle; it is a decision to be made in moments of radical crisis, as it drastically affects the person's daily life and care, sometimes without their consent. In the hospital model, care is guided from a psychopathological perspective, which directly affects the Singular Therapeutic Project (STP). It must also be taken into account that the hospital routine organizes the care offered, always prioritizing risk control and regulating, at times, contact with the user[10].

In the current model, mental health services for crisis care must guide their practices through the construction of the STP, with direct participation of the user and inclusion of their social network, described in the perspective of territory. It is a set of therapeutic care proposals resulting from the collective, interdisciplinary and/or intrasectoral discussion of the clinical case[11].

Carried out at the time of admission to a public psychiatric institute, this research sought to give voice to the users, in order to understand their perceptions about the credibility of their speeches and their relationship with the promotion of autonomy in treatment.

Method

This is a qualitative and descriptive-exploratory research study, which analyzed the users' speeches and, although it did not aim at generalizing the results, promoted their active and consistent participation, seeking to deepen the biopsychosocial dimension existing in their speeches[12].

The participants were selected by non-probabilistic convenience sampling and the following inclusion criteria were defined, based on the medical records: those with admission diagnoses of psychotic crisis (presence of delusions and/or hallucinations and/or disorganized speech

and/or disorganized behavior, with lack of insight as to the nature of the symptoms, causing major impairment of the critical judgment of reality), concomitant with a minimum hospitalization period of ten days.

The following conditions were used as exclusion criteria: use of psychoactive substances, completed diagnosis of intellectual disability and having a legal guardianship. All the interviewees were represented by the letter P (Participant) and numbered according to the order of the meetings, ensuring anonymity.

Data collection was conducted through semi-structured interviews, using a pre-defined script based on the research objectives, in the period of October and November 2019. The questions elaborated by the researchers addressed the following: the hospitalization moment and its reasons; the user's relationship with the reference team and with the other patients; the difficulties experienced during hospitalization and for maintenance of the mental health treatment; and the way in which each participant identified how their speeches were received by the reference team during the hospitalization period.

The interviews were recorded and transcribed. Data analysis aimed at understanding the life story, the history of hospitalizations and how the user perceived that their speech was considered in the construction of their treatment, during the hospitalization period. The transcriptions were analyzed based on the thematic content analysis technique proposed by Minayo[12], as an effective technique for interpreting qualitative research in health; this author states that qualitative methodologies are those capable of incorporating meanings and intentionality as inherent in social structures, relationships and acts, understanding them as significant human constructions.

In this technique, the frequency of the themes that are repeated in the core of the analyzed texts is verified. Subsequently, the researcher performs three phases: pre-analysis of the collected data: floating reading (until all the interview transcripts are exhausted); exploration of the material: highlighting in the body of the text the most frequent themes that emerge in the transcriptions; then, the marked excerpts are analyzed and inserted in the passages that fit the emerging themes; and, finally, interpretation of the results: the themes that emerged were separated into three thematic axes and discussed throughout the text[10].

This study was carried out in a public institute that is a reference for the care of mental health crises in Minas Gerais, Brazil. The research was previously submitted to and approved by the institutional Ethics Committee, obtaining opinion No. 3,566,943, of 09/11/2019. The principles for research with human beings provided for in CNS Resolution 466/2012 were followed, maintaining secrecy and data confidentiality and preserving the participants' identity.

Results

The participants of this research study were 12 men aged between 18 and 29 years old, with the following schooling levels: one illiterate user, three with incomplete elementary school, three with incomplete high school, three with complete high school, one with complete technical education, and one with incomplete higher education. All were diagnosed as psychotic by the framework of the medical psychopathological approach, according to the medical records.

The results of the interviews were organized, grouped and presented from three main thematic axes, defined after the descriptive analysis of the data. The results also allowed for the interpretation of the users' initial perceptions about the credibility of their speech and what happens during the treatment, that is, from hospitalization at the critical moment to discharge, and how having their statements listened by the team represents or not an autonomy gain. The thematic axes were established as follows: the moment of crisis and the arrival at the service; stabilization: the credibility of the users' speech in the treatment; and institutional routines, autonomy and discharge.

The moment of crisis and the arrival at the service

The users' statements during the interviews about the crisis experience showed that this moment was experienced in a particular way by each individual and that the most recurrent manifestations recorded in the medical chart and which justified the hospitalization, characterized by prejudice to the criticism and judgment of the reality and the denial of being evaluated, medicated and/or hospitalized, could be perceived in their statements: *I don't really know the reason, because I was working and they brought me here. How was that? It was bad, because I had to come tied up, as if I was dizzy, if […] then I put my hand on my conscience and thought about not doing anything and I agreed to be tied up and brought here. You know they wanted to apply an injection on me, but they couldn't because I had drunk alcohol...* (P09); *Because I'm fine, I'm not addicted to anything, I'm not addicted to drugs, I'm not addicted to cigarettes, I'm not addicted to anything. I'm hospitalized here because […] family quarrel* (P12); *I'm hospitalized because… I assaulted my mother, I was arrested in the NAPS (CAPS). [...] The NAPS people went to the judge and the judge ordered to put me here, then I came here* (P08).

Arrival at the institution was associated with a moment of tension and disruption, where the speeches tend to be replaced by attitudes, which are classified as psychomotor agitation, aggressiveness with family members and third parties and/or self-extermination attempts, as revealed in the following statements: *Then the moment of my hospitalization? I remember that I was in the*

ambulance, then I got out because I wanted to leave, I wasn't tied up or anything... my mother was at the reception and then I went towards the doorway wanting to leave, but then I saw the men from the ambulance behind me, surrounding me. So, instead of proving to them that I was right, that I wasn't having an outbreak or anything, I fell into the trap and got mad and punched... I ended up being aggressive with them and then they tied me up and forced me in here (P04); *Because I took poison to kill myself, [...] they caught me, put a hose in my mouth, removed the hydrogen liquid* (P05).

A moment identified by the user as one of disregard for his speech and even of incomprehension regarding lack of credibility was the decision-making process regarding hospitalization; the statements showed the enormous difficulties in arguing and being able to propose other strategies for the treatment, as in: *I know that [...] any doctor you see, the doctor always says, "if you're drinking you can't receive medication", as it was medication, I spoke and didn't want to accept. They took me by force [...] I would've preferred to have taken a pill but [...] that was it, I surrendered. I took one, then I took another and another, I took two or three injections* (P09); *Hospitalized... I don't have the information because I wasn't supposed to be hospitalized, it was to try to have a phimosis surgery, then I came here, they left me for a week, they said that I had to stay* (P10).

The research showed that, after admission to the service and over time, the user's position in relation to the other changed, as well as his psychological organization and discursive abilities. It was identified that he started to realize that his statements have repercussions in the meetings with the different professionals, during hospitalization. With evolution of the treatment and stabilization of the condition, it was noticed that most of the participants expanded their contact with the professionals, in order to express what they were feeling and their interests.

Stabilization: the credibility of the users' speech in the treatment

It was observed that the treatment during hospitalization included all the professional categories and the work took place from a multidisciplinary perspective. However, for the users, the distinction of functions or the complementarity of the professionals' collective work was not clear, as can be noticed in the statements: *Then, the three doctors discuss my case and they talk all Monday, everybody in the team together, then they talk about what is happening, how I'm feeling, that [...]* (P03); *I'm not making decisions like that. On the very paper that the staff has administered, then throughout my treatment, in a way it's more... psychiatric, not true that I say so, I'm not having much attention, do you understand?* (P02).

The assistance centrality occupied by the physician was perceived by the user as concurrent with the interventions by the professional in charge of the

Technical Reference (TR) in this case, which reflected in the development of the STP to be compromised, because he did not recognize the work of the TR as relevant to the treatment, as can be seen in the statements: *Yes, I talk every day with doctor E. but with F., who is really the reference, I'm not having much contact with her. Yeah, it's a bit like that [...] she talks to me once a week, then there's not much space for me to talk [...] things that should have been talked with her a while ago, right?* (P02); *Always telling the truth to my doctor and he's always advising me and we see what the means is, let's say... of medication, if that medication isn't working very well with me, he changes it and puts another* (P01).

In relation to the way in which the users reported their perception about participation in the construction of the STP and what they understood or not about this experience, when asked about their statements being considered by the professionals, it was possible to verify that the interviewees did not perceive the legitimacy of their statements and active participation in the treatment, or that third parties spoke for them. The statements indicated the devaluation of their participation, as seen in: *Oh yes, some yes, but some they don't agree. Sometimes you say something or ask for something, many times they don't agree, got it? [...] since they don't solve it, then there's no point in insisting, right? There are even times when some people here are upset and don't like it, got it? So we prefer not to insist, go back to the room and go to bed, that's it* (P11); *Well, I don't understand that much because my mother is the one who talks at meetings and... ends up deciding more for me, that's why* (P07).

At some moments, the users reported the need for authorization and/or validation from the team regarding the indications that they made during the case discussions and alignments, even for the users who apparently showed greater clarity about their treatment responsibilities. The power delegated to the team by the users was identified, as can be seen in the statements: *I try not to hide anything, not to be afraid of not being discharged; if I'm fine, then I deserve to be discharged, if I'm not, I have to stay here* (P03); *They're giving me the medicine and I'm taking it correctly and then I'm helping a lot too, if I don't take the medicine and don't contribute to them too, then it's bad for me* (P11).

With advancement of the treatment and improvement of the condition, concomitant with the expected stabilization, the resumption movement and the emergence of plans for life, as well as the return to daily life and society, were perceived as a challenge. The interviewees expressed the desire to be able to live with others and to access the trivial modes of satisfaction made possible by social interaction, as can be perceived in the statements: *To get out of here... well... to work... What am I wishing for? Work and study, much more study. (Long period of silence) I'm trying to understand myself and I'm getting it and... only* (P07); *My perspective is to get out of here, being able to*

live with all the people, be able to raise a family, work... that's it, I want... to get out of here well (P01).

Although the expression *being able to live with all the people* raises questions about what the impediments would be to this coexistence, the statements indicated the interviewees' desire to resume their social role, when it already existed, or to build a bond with society, although they do not know how to do it.

Institutional routines, autonomy and discharge

Aiming at understanding how the users perceived the entire hospitalization process and the context in which it occurred, it was found that the way the institution is organized did not favor the users' effective participation in their treatment and implied a position of passivity, such as in the following statements: *This is in general what I can contribute, do what they say, because here we have to do what they say [...] Ah, it's like, I want the light turned off, I go there and ask and they turn off the light, yeah... I can ask for a free patio and they allow it* (P06); *Because what they say to me I'll have to accept [...] what they say to me I'll accept, got it? There's no other way* (P12).

For the participants, hospitalization was perceived as an immediate and definitive solution and, when asked about their responsibilities in the treatment itself, they replied: *It's because... the staff here, the doctor plus the technician, they aren't helping me in some parts, right? That would be like, a place for me to stay. Yes, I want to move to a place further away and I'm not getting this help* (P02); *Oh, about that (being included in the treatment) I don't understand, only when I'm going to take the medicine; sometimes, the medicine is already there (on the table) already, then I don't know. So I really don't know how they solve it* (P10).

It was possible to see how the institution was perceived by the participants in terms of bureaucracy, leaving little space for each one to express their individualities, as in the statements: *I think it would be the bureaucracy that... both the nurses and the doctors have to deal with because of the hospital, which is very regulated, right? Both during medication and meal times, I think this is the greatest difficulty* (P04); *[...] the lack of power... the lack of space... I feel very trapped in here, got it? Sometimes I go [...] to the free patio [...] and it was even nice, but Dr. B and Dr. M said that they were going to take me there today (but) I don't know if they will [...]* (P09); *[...] I'm just waiting now to do a medical test, this Friday, God willing, and then after the medical examination, the doctor will discharge me so I can leave, God willing! It's being the biggest anxiety I'm in* (P05).

According to the users' speeches, the service was perceived as a bureaucratic place, with power concentrated in the professionals and with little space for expressing opinions. For most of the participants, passivity towards the rules was associated with a greater chance of being discharged.

Discussion

The care offered to the person in mental distress and who experiences an exacerbation of the condition can culminate in the decision of hospitalization or temporary isolation and, as found in the research, with or without their active participation, that is, it is sometimes necessary to do so against the individual's will[9,13]. The participants' reports showed the passive position towards the service and professionals at the time of hospitalization and, before that, in the field of family and social relationships. In the same direction, the credibility of the speech expressed was evidenced as very low upon arrival at the service, which ended up exerting a negative influence on their negotiating power and autonomy to make choices[13-14]. In addition to that, the interpretation of the results pointed to the punitive perception of hospitalization, which was directly linked to the scene in which an undesirable behavior occurred, almost always associated with situations of supposed threat or aggressive attitude towards a third party or with the risk of death.

The participants, all diagnosed with psychosis, revealed that they were unaware of the reach of their speeches towards the teams and expressed the feeling that their statements are either not heard or undervalued during the treatment; therefore, they used particular strategies to overcome the institutional barriers and get what they wanted, even though, at certain times, the most effective measure was to remain silent. The important consideration of dealing with utterances of people diagnosed with psychosis is also acknowledged, when some common characteristics were present in the statements regarding the lack of symbolic resources to elaborate what is said, which is associated with the particular way of using language and consequently, words, and with concreteness in the interaction with the other in psychosis[14-15]. In addition to the use of language, the participants revealed strategies closer to acceptance and resilience, which contradicts any guiding principle regarding the users' active participation in their treatment.

The participants reported not knowing the interdisciplinary care offered by the service during hospitalization and highlighted in their answers the drug treatment and the care centered on the figure of the physician[16], indicating the permanence of a traditional model, which has not yet been overcome in the social imagination, despite the advances proposed from the mental health care model sponsored by the RPB. According to the users' perceptions, the discussions of cases in order to align the courses of action towards the construction of the STP would take place first among the physicians and only later would be shared with the other members of the team, users and/or family members.

The research showed that the discharge process was associated with leaving the institution and to the end

of hospitalization, rather than being understood as an improvement and stabilization of the clinical condition[17]. Through the participants' speeches, it was noticed that these individuals wanted to recover or obtain simple and everyday things, such as work, study and family and social relationships. None of the participants indicated that hospitalization promoted any significant change in their lives, which allowed us to infer that this moment worked as an intermediary, as a stop point for recovery from a previous state, but not in the sense of crisis as an opportunity for growth.

From the users' perspective, institutionalization was prominent in the hospitalization routine and they named it bureaucracy; in response to this criticism, it is up to the professionals to create spaces for negotiation, in the sense of opening up to the expression of subjectivities. The ongoing discussion about the organization of mental health services and work processes must include a reflection on how the internal relationships and the different roles occupied by each of the actors in this context reproduce hierarchical and power structures[17-18].

This research revealed some challenges that still exist in the clinical practice, contributing to advances in knowledge in the field of mental health; the study investigated how the service and professionals valued or allowed the expression of speech and the users' participation in the construction of their STP. Complementarily, it brought to light the permanence/resistance of psychiatric hospitalization in the Brazilian reality, despite the undeniable advances in the construction of the network of substitute services in mental health. As for the limitations, this research analyzed the discursive productions of a single group of users and, as this is a qualitative study, which does not aim at data generalization, it does not reflect the totality of the perceptions.

Conclusion

Based on the authors' clinical experiences, in the context of a crisis care service and in the midst of the current conceptions in mental health, this study advocates guaranteeing the legitimacy of the user's speech. The research proved to be relevant when it revealed, through the participants' statements, how the institutional clinical strategies and professional practices are perceived. The research objective was achieved and the results allowed concluding that the users perceive that their speech has little credibility, both during the crisis and during stabilization, and that their statements do not always contribute to the promotion of autonomy during the therapeutic process. The users did not recognize the legitimacy of their speeches before the team and highlighted the frequency of decision-making by third parties.

In their statements, the participants enunciated some weaknesses of the institutional project when they revealed the maintenance of the professionals' exercise of power within a bureaucratic organization. It was concluded that the professionals offer a small margin for negotiation, especially upon arrival, but also throughout the treatment. The users revealed that they did not discern the roles of the professionals, except the physicians, in the set of team interventions, in addition to not clearly understanding their own responsibilities in the development of treatment and in the construction of the STP. The passive or even submissive posture characterized the participants' speeches in several statements.

Although there are specific clinical reasons for defining the isolation of a person in mental distress, configured in this service by hospitalization; the services and professionals must reflect on innovating strategies to address the crisis, given that this moment is rich and crucial for possible rectifications of the users' clinical evolution. With the participants' statements, it was concluded that they perceived hospitalization as an inevitable event, sometimes contrary to their wishes, and attributed the chance of improvement and discharge to adherence to the drug treatment. The research endorsed previous studies in the sense that the institution must adopt permanent self-criticism to review the practices it performs and left open questions to be answered in further research studies, such as: possible strategies for strengthening the user's speech and the power of interdisciplinarity in mental health to consolidate the users' participation in their therapeutic project.

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Author's contribuition

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