

RESEARCH REPORT

Health Psychology

Editors

Sônia Regina Fiorim Enumo  
Raquel Souza Lobo Guzzo

Conflict of interest

The authors declare they have no conflicts of interest.

Received

January 19, 2022

Final version


December 20, 2022

Approved

June 1, 2023

# Psychology in the hospital context: Experiences of patients with non-communicable chronic diseases

## *Psicologia em contexto hospitalar: vivências de pacientes com doenças crônicas não transmissíveis*

Tânia Maria Cemin<sup>1</sup> , Rossane Frizzo de Godoy<sup>1</sup> , William Macedo Fiuza<sup>2</sup> 

<sup>1</sup> Universidade de Caxias do Sul, Centro de Humanidades, Programa de Pós-Graduação em Psicologia. Caxias do Sul, RS, Brasil. Correspondence to: R.F. GODOY. E-mail: <rfgodoy@ucs.br>.

<sup>2</sup> Autonomous Research. Caxias do Sul, RS, Brasil.

**How to cite this article:** Cemin, T. M., Godoy, R. S., & Fiuza, W. M. (2024). Psychology in the hospital context: Experiences of patients with non-communicable chronic diseases. *Estudos de Psicologia (Campinas)*, 41, e210184. <https://doi.org/10.1590/1982-0275202441e210184>

### Abstract

#### Objective

To identify the factors involved in the experience of Chronic Non-Communicable Diseases in patients of a hospital institution, based on electronic medical records documented by the psychology service.

#### Method

A documental-qualitative-exploratory study, carried out with 69 participants. The data were submitted to an open model content analysis with pairing strategy.

#### Results

Four categories were created: Diagnosis assimilation and adaptation to treatment; Death: fear and longing; Symptoms of anxiety and depression; Acceptance of the disease and hope.

#### Conclusion

The study underscores the importance of understanding the unique coping strategies and individual experiences of patients facing pain and suffering resulting from chronic diseases. Qualified listening was crucial in this process, enabling the understanding of what is normative and what is pathological. However, further investigations regarding this theme should be promoted with medical records covering other aspects and categories not included in this study.

**Keywords:** Chronic disease; Health psychology; Psychology, medical.

## Resumo

### Objetivo

Identificar fatores envolvidos na vivência de Doenças Crônicas não Transmissíveis em pacientes de uma instituição hospitalar, a partir de registros em prontuários eletrônicos realizados pelo serviço de psicologia.

### Método

Estudo documental-qualitativo-exploratório, realizado com 69 participantes. Os dados foram submetidos à análise de conteúdo de modelo aberto com estratégia de emparelhamento.

### Resultados

Foram criadas 4 categorias: Assimilação do diagnóstico e adaptação ao tratamento; Morte: temor e anseio; Sintomas de ansiedade e depressão; Aceitação da doença e esperança.

### Conclusão

Evidenciou-se a necessidade de compreensão da singularidade e modos de enfrentamento apresentados pelos pacientes diante de contextos permeados pela dor e sofrimento ocasionados pela vivência de uma doença crônica. A escuta qualificada foi crucial nesse processo, possibilitando a compreensão do que é normativo e do que é patológico. No entanto, sinaliza-se para a necessidade de realização de novas investigações com prontuários abrangendo outros aspectos e categorias não inseridas no presente estudo.

**Palavras-chave:** Doença crônica; Psicologia da saúde; Psicologia hospitalar.

Chronic Non-Communicable diseases (NCDs) are the leading cause of death worldwide and are considered the greatest health challenge of the 21st century. The NCDs accounted for about 70% of all deaths worldwide in 2015. More than 80% of these premature deaths occurred in low- and middle-income people (World Health Organization [WHO], 2018a). In 2017, it accounted for 73.4% of all deaths worldwide (Global Burden of Disease Study, 2017). In Brazil, NCDs accounted for 75.0% of total deaths in 2015, whose main groups of causes were: diseases of the circulatory system; cancer; chronic respiratory disease; and diabetes (Malta et al., 2014). In 2016, the total number of associated deaths was 74%, with cardiovascular diseases (28%), neoplasms (18%), respiratory diseases (6%), and diabetes (5%) being the main causes (Ministério da Saúde, 2019). The increase in the prevalence of risk factors and chronic diseases themselves is a worrisome reality, not only in Brazil, but worldwide. In 2019 alone, 54.7% of deaths recorded in Brazil were caused by NCDs (Ministério da Saúde, 2019).

These four referred diseases: cardiovascular, neoplasms, respiratory, and diabetes, are associated with behavioral risk factors considered preventable. Among them are tobacco use, harmful alcohol use, sedentary lifestyle, and unhealthy diet (WHO, 2018b).

Chronic diseases comprise a set of conditions considered chronic, related to multiple causes. Often with gradual onset, with long or indefinite duration. Their course changes over time, at times presenting aggravations and generating disabilities. In addition to mortality, they have a strong relationship with comorbidities. Chronic diseases are also responsible for a large number of hospitalizations and are recognized as the main causes of amputations, loss of mobility, and neurological problems. In line with this, the disease significantly impairs the quality of life as it progresses (Ministério da Saúde, 2013). The NCDs affect all nations and social classes, and most deaths attributed to them are concentrated in middle- and low-income populations.

This scenario requires a collective effort – managers, health professionals, and civil society – and intersectoral, involving all levels of care and prevention. Only a broad set of policies is capable of satisfactorily impacting on this scenario. Considering this context, in 2021 Brazil launched the “Strategic Action Plan for Combating Non-Communicable Diseases and Injuries in Brazil 2021-2030” with the objective of “strengthening the agenda for the confrontation of NCDs, violence, and accidents in the federal, state, municipal, and Federal District spheres, as well as to guide

health promotion in health actions. It should be noted that the plan in question is in line with global recommendations and adopts a bold system for monitoring indicators (Santos et al., 2021).

The experience of falling ill is unique. It can be understood as a moment of crisis, as it causes significant emotional ruptures and mobilizations, generating implications and repercussions in the person's existence (Conselho Federal de Psicologia [CFP], 2019). The impacts of a chronic disease can be very debilitating. Therefore, understanding the factors involved in experiencing a non-communicable chronic disease facilitates the process of patient awareness regarding the management of the disease, treatment, disease progression, and stages of its development.

For this reason, some key concepts will be contextualized below. It is important to highlight that Freud (1926/1976) developed two connotations of the term anxiety: as an affective state that signals a situation of danger/worry; and another, that can be considered harmful to the individual, preventing him from performing his routine activities and, therefore, presenting a pathological nature. An equally important concept is that of denial, since it is often linked to the difficulty in psychically processing what is happening organically, and may be related to something traumatic. Another fundamental conceptual aspect concerns thinking about death and finitude as issues that are part of human nature. Yet, the proximity of death can be a primary source of anxiety, with variations in intensity. Therefore, it becomes necessary to explore the implications brought by the perspective of death, which can be seen as possibilities for transformation, but also as a source of deep sense of helplessness and hopelessness (Yalom, 1980).

Regarding depressive symptoms, we begin by discriminating that, in this study, these symptoms do not refer to a depressive state, nor to depressive disorders, but refer to the verbalization and/or manifestation of behaviors that may indicate this mood in the participants. Aligned to this aspect, Kehl (2009) considers that the contemporary man is particularly prone to depression. It is also evident that, according to data from the WHO (2014), it is estimated that more than 350 million people worldwide suffer from depression. Based on what has been discussed, one can reflect on how people with NCDs are psychologically, as it may be an important factor for the presence of depressive symptoms. It is also emphasized that the present investigation does not focus on any specific chronic disease, but refers to diseases that fall under chronic non-communicable diseases. The objective of the study is to identify factors involved in the experience of NCDs in patients of a hospital institution, based on electronic medical records documented by the psychology service.

## Method

This is a documental study with a qualitative-exploratory design. To carry out this research, we used some of the information already collected in a larger research, from a university located in the south of Brazil, entitled "Interventions in Clinical Psychology: integration, teaching - service and innovation" (INOVAPSI). This larger research compiled information from 402 medical records. For this study, 69 participants (P) were selected, 35 males and 34 females. The predominant education level was Elementary School (incomplete or complete); most were married, white, non-working, and Catholic. All presented NCDs as a problematic issue. The main diagnoses presented by the participants were chronic kidney disease (72.5%), various neoplasms (18.8%), and diabetes *Mellitus* (8.7%). It is important to point out that 66.7% of the patients had two or more NCDs, hypertension being the most prevalent comorbidity (56.5%), followed by diabetes mellitus (36.2%).

Inclusion criteria were having a NCDs, over 18 years old, having been treated by the psychology service. Exclusion criteria: participants with chronic infectious diseases and seeking non-NCDs related

psychology care. To carry out the present study, only the progressions registered in the patients' electronic medical records were considered. The information of this larger study was collected in 2019, from the electronic medical records of patients treated by the psychology service during the year 2018 in a teaching hospital and with a record in the TASY system. A waiver was obtained from the Research Ethics Committee of the General Hospital (COEDI). Specifically, since the research involves data from electronic medical records, a Confidentiality Agreement was sufficient to meet privacy requirements, which was duly signed by the two responsible researchers. The information in the medical records was filled out by psychologists and psychology interns who'd provided care to this specific population. Clinical and sociodemographic data, as well as characteristics about the care provided, were addressed.

Besides the presentation of this brief profile, we carried out a content analysis according to Laville and Dionne (1999), recommending a qualitative treatment of this information. The open model was used, especially for this being an exploratory study. In this type of model, the analytical categories are not determined at the beginning, but emerge a posteriori, during the analysis itself, based on an inductive approach. The qualitative strategy employed for data analysis was data pairing, which consists of pairing the data collected, comparing them to other previously proposed studies.

Thus, after reading and analyzing the records, the following analytical categories were defined: Category 1 – Diagnosis assimilation and adaptation to treatment; Category 2 – Death: fear and longing; Category 3 – Anxiety and depression symptoms; Category 4 – Acceptance of the disease and hope.

## Results and Discussion

### Category 1 – Diagnosis Assimilation and Adaptation to Treatment

Receiving the diagnosis of a chronic disease can be a difficult moment, forcing the subject to face the idea of terminality and the real possibility of death, in addition to a series of adaptations and social changes resulting from the condition and the ongoing treatment (Pires & Castro, 2020). Thus, the first unit of analysis identified in this category regarded the assimilation difficulties in relation to NCDs.

A study conducted by Menezes (2018) reinforces that how a chronic disease is experienced is very personal and is related to one's personality, tolerance to frustration, favorable and unfavorable conditions, as well as the relationship with the doctor and the health team. In the present study, a variation was identified in relation to the ways of dealing with a NCDs, from not being able to name the disease, not questioning the team about their diagnosis/disease, to denying it. The difficulty in naming the disease was found in only four participants. Such as: "Patient says he is fearful that it might be 'a bad disease' [sic], not being able to name the disease and, by thinking about it, the patient visibly mobilized" (P1). "Difficulty in naming cancer, using the term only once and during the second appointment. Receives information from the medical team" (P8). The lack of questioning the health team has as records: "It is noticeable that the patient has difficulties in expressing their doubts regarding the treatment, such as how long it will have to continue" (P52). "Has doubts about prognosis, records indicate they were encouraged to question the doctors, but it seems that the patient has not done this" (P7). "Expressed a number of doubts about their diet" (P54). It can be considered that these difficulties may be related to the stigma of a chronic disease, being important to resume psychological care, stimulating a break of taboos and prejudices regarding

chronic diseases, as well as assisting in the development of their capabilities (Menezes, 2018). This moment of assimilation of a diagnosis of chronic disease can be experienced as one of the most difficult experiences in life, both for patients and their families, due to feelings of despair, anguish, and fear of the unknown, as well as thoughts about death (Coutinho & Costa, 2015).

The third difficulty in understanding NCDs identified in this study refers to denial, which is identified as a lack of awareness, and in some cases, the discourse may be more severe among patients. This was observed in nine participants, as follows: “The patient refers that he does not understand why he needs to perform it being that he feels good. The patient refers that he has been told that his kidneys are not working properly and that he takes medication for this, but that he is fine now and would not like the treatment to last for a long time” (P52). Non-adherence to necessary care also refers to an aspect observed in the reports of P2, P5, P18, and P65 who express wanting to give up treatment. While P67 says he feels hopeless towards positive changes, P68 often fails to take their medication as prescribed.

There are some studies that report manifestations like these, associated with the “denial” unit and often represented by symptoms of insomnia, crying, and agitation (Coutinho et al., 2003). It is noteworthy that, currently, we live in a supposed dictatorship of happiness, consuming and reproducing life models without questioning, in which there is no room for experiences of suffering and weakness (Roos & Munhoz, 2020). Therefore, it is crucial to consider the impact of this concept on chronic diseases, as it perpetuates negative narratives of suffering and subscribes to manuals that prescribe the “secret of happiness,” leaving little room for expressing distress.

The diagnosis comes carried with symptoms and discomforts already perceived by the subject and that motivated him/her to seek help and discover the chronic disease (Ferreira & Pereira, 2020). P25 and P35 expressed that they had difficulties adapting at the beginning of the treatment, but that now they are used to it. On the other hand, P66 said that at the time of diagnosis he had no idea of the “extent” [*sic*] to which the disease would impact, while P41 says he was taken “by surprise” [*sic*] and that it was something difficult to accept. In this way, understanding the difficulties regarding the adaptation to treatment is also necessary.

During the illness, the subject will experience different losses and hindrances that may modify relationships and bring social, psychological, and physical losses that can trigger conflicts of self-image and sexuality (Pires & Castro, 2020). In this regard, P32, P36, P37, and P42 express, respectively, difficulty in looking themselves in the mirror and recognizing themselves in the reflected image, they do not like to be “treated as sick or incapable and to be pitied” [*sic*], the perception that people have prejudice and no longer call them to go out. This denotes the discomfort and dissatisfaction with the limits imposed by chronicity that are different from the previous lifestyle (Ferreira & Pereira, 2020). Thus, leisure activities, distraction, and enjoyment that can help cope with the disease are often interrupted or limited due to the symptoms and weekly treatment (Viegas et al., 2018). Missing going for walks, traveling, caring for children, living in the same city as their daughters are examples of changes verbalized by P13, P53, P21, and P34, respectively. The physical impacts will depend on each type of treatment adopted, in addition to the progression of the chronic disease itself (Ferreira & Pereira, 2020). Some examples are leg pain and fatigue (P50), the wound on the foot, preventing putting on shoes (P40), difficulty sleeping (P44), feeling weak (P43), and headaches (P27).

The dependence on other people to perform some activities is another triggering factor of discomfort and fear (Viegas et al., 2018). The concern about being a nuisance in some way was verbalized by P17 and P32, as well as P23 who cannot walk, feed, or bathe himself; even relating to life

adaptations, such as P46, who moved in with his daughter to perform the treatment. Concerns about finances due to the interruption or reduction of work were expressed by P19, P38, and P58. For the young adult, in particular, this experience can mean a disruption of social expectations, generating exclusion (Viegas et al., 2018), as perceived in the report of P24 and P57. Thus, the socioeconomic context of each individual must be taken into account for this impact to be understood (Fernandes et al., 2018). As examples, there are P52 (worried about his son's expenses), P68 (wanting to quit treatment due to difficulties with transportation), and P21 (who pays for transportation).

## Category 2 – Death: Fear and Longing

This category encompasses different nuances perceived in the participants' reports. Expected aspects of experiences faced with the situation of finitude, up to serious situations that encompass suicide ideation and attempts.

When a person is diagnosed with a chronic disease, his/her reactions to their illness become crucial. The subject must construct a new meaning for the new existential situation experienced (Junges & Bagatini, 2010). Physiological changes are perceived and have an impact on how the patient perceives themselves and is perceived by their family. Moreover, they experience loss of roles, of control over their destiny and their lives for fear of becoming dependent. In view of all this, it is common to have feelings of frustration, anger, sadness, and suffering, since the fantasy of immortality is broken, since death is considered a real possibility (Melo et al., 2013).

Faced with chronic illness, the fear of what might happen is commonly observed in patients. This fear was the first unit of analysis identified in this category. As an example, we can see the reports: P10, when they say that they are afraid of dying, as they relate to family members who have already had cancer; P42 says he/she is "afraid that some complication will happen, because he/she would like to see the construction of his/her house materialize" [sic]; P46 comments that they are afraid of having an unsuccessful transplant and causing suffering to themselves and family members.

The perception of finitude, fear of dying, and not being able to accomplish their projects, as well as causing suffering to the family members, are evidenced in the clippings presented above. In researches cited by Yalom (1980), these aspects were observed in the general population. A certain degree of anguish in the face of death arises from a primary, existential anguish, that is inseparable from the experience of existence.

Other aspects identified in the participants' statements concern the perception of suffering and fear of not getting better (P54); fear of staying in a vegetative state (P69). P22 reports getting sad when seeing people getting sick or dying because of hemodialysis. Given these discourses, it is possible to perceive suffering reactions to the unknown, death, and fear of the consequences and limitations that the disease can bring in their lives, depending on the severity of each case.

In some situations, as identified in the "thinking about dying" unit of analysis, P21 says: "I feel like dying, but I don't have the courage, and he/she says that their two uncles have committed suicide" [sic]. Both suicide and NCDs are considered global public health issues. Chronic diseases are associated with decreased quality of life and a range of functional, psychological, and social problems, including increased risk of suicidal thoughts, attempts, and deaths by suicide (Rogers et al., 2021).

In a study by Huh et al. (2021), thoughts of suicide were present in 5.2% of participants with NCDs. In the present research, P63 reported feeling very sad and unwilling to live in recent days, saying, "if my daughter didn't keep my medicines with her, I would take them all at once" [sic]. P53 verbalized that they would rather provoke their own death than die due to the disease. P23

and P34 expressed a desire to die at the hands of the medical team. P23 asked the team for a lethal injection and P34 reported that he/she “would like to go to the cemetery” [*sic*], having suggested to a team member that they “turn off the machines” [*sic*].

In the face of incapacitating scenarios, NCDs stand out for causing a sense of deep anguish, worthlessness, lack of prospects, and intense suffering, which when added to the lack of emotional support, can lead the patient to see suicide as a possibility (Magalhães & Figueiredo, 2019). P11 reports attempting suicide in the morning with the use of a knife and attempting to jump off the building; P13, P15, P23, P61, and P68 had suicide attempts prior to hospitalization.

Although there were important differences in the participants’ reports, suicide attempts appeared related to the experience of NCDs. Participants who had suicide attempts, or suicidal ideation, had three or more NCDs. One study found that the presence of multiple chronic conditions was associated with an almost twofold increased risk of suicide, demonstrating that there is interference of diagnosis and time since diagnosis, in increasing suicide risk (Rogers et al., 2021).

In addition to the aspects presented, it is important to note that almost half of the participants who reported suicidal ideation had had previous suicide attempts or had had suicide attempts and suicides in the family. Symptoms of depression were also perceived in a large part of the patients who had suicidal ideation or attempted suicide. Knowledge of these aspects becomes crucial because previous attempts, death by suicide in the family, mental disorders, and the presence of symptoms of depression and hopelessness are considered important risk factors for suicide (WHO, 2014).

Due to the observed aspects, identifying symptoms of depression and anxiety become necessary to think about preventive interventions.

### **Category 3 – Anxiety and Depression Symptoms**

Anxiety and depression are highly prevalent neuropsychiatric disorders and are associated with chronic diseases, pain, loss of autonomy, dependence to perform routine activities, and loneliness (Aragão et al., 2019). In this study, we considered symptoms of anxiety and depression, referring to the characteristics of constant sadness, discouragement, loss of interest in routine matters, without identifying their pathological nature, i.e., not evidencing a disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM V) criteria.

This way, it is understood that in the presence of a chronic disease, it is expected that the individual may present anxiety symptoms, mainly due to chronicity; however, it can also present itself at a harmful level, characterizing a disorder. Thus, the need to identify the severity of a given situation is emphasized, providing guidance, or not, about a specific treatment (Machado et al., 2016). According to Kinrys and Wygant (2005), women have a higher risk of developing anxiety disorders throughout life. Data published by the WHO in 2017 show that the worldwide prevalence of anxiety disorder is approximately 3.6%, with a higher rate for women, reaching 7.7%, and for men, 3.6% (WHO, 2017). These data correlate with the study of Costa et al. (2019), in which they verified the prevalence in females and that the presence of a chronic disease showed a higher prevalence of anxiety ( $p < 0.001$ ).

In this study, we focused solely on symptoms of anxiety and depression and did not assess whether they meet the diagnostic criteria for a disorder. This decision was made due to the need for additional information and direct contact with the patient to make such a determination. Thus, we identified 12 participants who manifested, verbally or through behavior, the presence of anxiety symptoms. The speeches can be illustrated with the following reports: “Verbalized that



he feels despair during treatment, due to the anxiety of it ending" (P66); "They said that they had several episodes of anxiety crisis, insomnia, and that they were not feeding themselves. In process of adaptation to psychiatric treatment" (P69); "Intense anxiety, difficulty in remaining seated" (P13); "Has a history of panic syndrome. Excessive fear of surgical procedure. Shows anxiety in appointments" (P10).

As for depressive symptoms, the present study evidenced 21 participants who verbally or behaviorally manifested them, and it is important to emphasize that seven participants already had a history of depression. Here are some examples: "history of depression, shows anxiety in the consultations, presents intense crying, depressed mood, anger" (P10); "depressed after baby's death (due to hypertension)" (P12); "Reports using medication as to 'Not get sad'" (P18); "History of depression, mood changed after diagnosis and starting medication (after that, reports feeling well)" (P20); "Reports a period of being quite sad some time ago and was able to improve due to the help of his/her three children" (P43); "He/she has already faced a depressive period and underwent therapy. Nowadays, maintains drug treatment for depressive symptoms" (P45).

One can see that there are different speeches and some with a history of depression prior to seeking care for NCDs and others with drug treatment for such. Therefore, it is important to emphasize that quality of life is inversely proportional to the prevalence of anxiety and depression (Muñoz et al., 2006). This prevalence can represent an increase in morbidity and mortality of patients with some kind of chronic disease, as well as interfere with treatment adherence, both by presenting symptoms of depression or anxiety, and also by possible associated symptoms, such as decrease or loss of the ability to concentrate, decrease or loss of motivation intensity, sleep disorders, significant fatigue, and difficulty in understanding information (Barros et al., 2011).

#### **Category 4 – Acceptance of the Disease and Hope**

Acceptance of illness and hope was the last category identified. Acceptance of the disease appears to be directly related to its control, the development of strategies to overcome and/or cope with the new chronic condition, and the family or social support received. Acceptance of the disease was observed in the reports of 31 study participants.

A qualitative research conducted in Brazil identified that acceptance of the illness was directly related to its control and the strategies developed by patients to overcome or live with the new chronic condition. In addition, it points out that accepting the chronic condition requires the person to recognize and learn in some way to live with the discomfort. According to the study, the acceptance of disability resulting from the disease was a crucial factor for patients to achieve the necessary psychosocial adjustment (Chiang et al., 2015).

Some participants reported being aware of their condition. Having a good perception of self, illness, and treatment were words described in the medical records of P5 and P62. Support from family and friends appeared in the reports of 13 participants. Having a support network other than the support of family members (wife, children) was an important factor verified in the study; two patients mentioned psychology support. The perception of having someone to count on and share the difficult moments of living with a chronic illness seemed to facilitate coping with the associated difficulties and decrease feelings of isolation. A qualitative study highlights that family support provides emotional balance so that the patient can prepare psychologically for coping with the situation (Florijn & Kaptein, 2013).

Hope, another unit of analysis of the category, encompasses the religious/spiritual support



and the perspective of accomplishing life projects. P15 talks about faith and their baby as motivating factors when confronted with life; P22 says: "I get very attached to God". P45 also mentions religion as a way to keep moving forward. In line with these aspects, a study with chronic patients concluded that religion and spirituality were associated with improved control, highlighting that for many of these patients, developing a closer relationship with God provides more inner peace and hope (Thomas-Purcell et al., 2020).

To the extent that the patient accepts their condition and can adapt to it, one realizes that new ways of looking at life begin to manifest. New possibilities open up. The resumption of old projects and new ones start to be observed in the patients' hopeful reports. P55 says that, in relation to the future, he/she hopes to go back to study radiology and get a new job; P61 mentioned having a perspective for the future, such as wanting to work. P42 expressed feeling better and that "they are no longer caring as much about what others think, as they previously did". They mentioned that they continue to participate as a volunteer for clothes-donation work and that they would start to participate in a mothers' group.

These reports highlight the importance of healthcare professionals understanding the uniqueness of each patient, as it is impossible to separate the disease from the person experiencing it. Patients may have specific ways of coping with pain and the challenges posed by their condition, and thus these need to be considered. Understanding these movements is necessary to be able to assist the subject in their suffering (CFP, 2019).

## Final Considerations

The present study focused on identifying factors involved in the experience of NCDs in patients of a hospital institution, based on electronic medical records documented by the psychology service. While summarizing the results, it was possible to identify that although it is very singular how each individual manages the idea of having some kind of chronic disease, it can be considered a moment of crisis, causing significant ruptures and emotional issues, generating implications and repercussions in the individual's own existence. It is worth mentioning that there are several symptoms, feelings, thoughts that are expected due to what a NCDs represents, many of which were listed in the present study as normative. On the other hand, some situations/conditions that refer to a concern or seriousness regarding the perception/ confrontation of the disease were also evidenced among the participants. In this way, the categories discussed in the study can signal important themes to be investigated by professionals in the area to enable an adequate support for these patients.

As a limitation, it is noteworthy that medical records did not always include all the desired information, such as whether the care occurred in the inpatient or outpatient setting. This characteristic is expected by the type of research, since data analysis naturally raises questions on the part of the researcher. Nevertheless, the investigation of medical records also allows for important information clippings that portray the daily treatment of these individuals.

In this study, we reiterate the importance of psychology as a service present in the hospital context to continue discriminating the expected from the pathological, beyond any support network that the patient himself may have. Conducting clinical listening with an individual with NCDs is fundamental for him to be able to live with his disease in the best possible way. It is important to emphasize that there are patients who don't have this opportunity, either for not being referred or spontaneously requesting the psychology service.

As such, the presence of psychology and studies about the experiences of these patients with NCDs are understood as essential. Thus, additional investigations regarding this theme should be promoted to enhance the expertise of hospital psychology. New studies with medical records that may address and compare characteristics that were not categorized in this article are suggested.

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## Contributors

Writing – review & editing: T. M. CEMIN, R. F. GODOY and W. M. FIUZA.