http://dx.doi.org/10.1590/0104-07072017000280016

PERCEPTIONS OF INDIVIDUALS HOSPITALIZED IN PSYCHIATRIC UNITS ABOUT LIVING WITH A MENTAL DISORDER[1]

Gabriela Zenatti Ely[2], *Marlene Gomes Terra*[3], *Adão Ademir da Silva*[4], *Fernanda Franceschi de Freitas*[5], *Marinês Tambara Leite*[6], *Bruna de Nicol Brum*[7]

[1] Article extracted from the thesis – Perceptions of the human being admitted in psychiatric unit abut living with mental disease, presented to the Nursing Graduate Program, *Universidade Federal de Santa Maria* (UFSM) in 2015.

[2] M.Sc. in Nursing. Substitute professor, Nursing Department, UFSM. Santa Maria, Rio Grande do Sul, Brazil. E-mail: gabii_ely@yahoo.com.br

[3] Ph.D. in Nursing. Professor, Nursing Postgraduate Program, Nursing Department, UFSM. Santa Maria, Rio Grande do Sul, Brazil. E-mail: martesm@hotmail.com.br

[4] M.Sc. in Nursing. Doctoral student in Psychology, *Pontifícia Universidade Católica Rio Grande do Sul*, Porto Alegre, Rio Grande do Sul, Brazil. E-mail: aaspsiadao@gmail.com

[5] M.Sc. in Nursing. Nurse at the Psychiatric Unit of the University Hospital, UFSM. Santa Maria, Rio Grande do Sul, Brazil. E-mail: fe_franceschi@yahoo.com.br

[6] Ph.D. in Biomedical Gerontology. Professor, UFSM. Palmeira das Missões, Rio Grande do Sul, Brazil. E-mail: tambaraleite@yahoo.com.br

[7] Student of the Nursing Course, UFSM. Santa Maria, Rio Grande do Sul, Brazil. E-mail: brunanicol@hotmail.com

ABSTRACT

Objective: to reveal the perception of individuals hospitalized in psychiatric units about living with a mental disorder.

Method: study with phenomenological approach with data obtained through interviews with ten adult individuals hospitalized in a psychiatric unit of a teaching hospital in the southern region of Brazil between January and March 2014. The steps of Paul Ricoeur's hermeneutic phenomenology were used, and Maurice Merleau-Ponty's theoretical-philosophical reference was used for data understanding and interpretation.

Results: three themes were revealed: the world of individuals that experience a mental disorder; perception on the mental disorder for the individual that experiences psychiatric hospitalization; and the being in the ambiguity relation: the movement of freedom.

Conclusion: the health care team, particularly nurses, need to incorporate the critical reflective view of the care practice, the scientific bases, and the legislation in force in the area of health, especially mental health, to enable autonomy of choice focused on the human being experiencing a mental disorder, as well as promote a warm network of individualized care that values the reception and incites the self-care through the education in health in the perspective of comprehensive actions. Therefore it is critical to promote health, autonomy, and freedom by listening to the individuals that experiences the phenomenon of a mental disorder in relation to their life desires and clinical perspectives.

DESCRIPTORS: Mental health. Adult. Stress, psychological. Perception. Hospitalization. Nursing.

PERCEPÇÕES DO SER HUMANO INTERNADO EM UNIDADE PSIQUIÁTRICA SOBRE O VIVER COM DOENÇA MENTAL

RESUMO

Objetivo: desvelar a percepção do ser humano internado em unidade psiquiátrica sobre o viver com doença mental.

Método: trata-se de estudo de abordagem fenomenológica, cujos dados foram obtidos por meio de entrevistas com dez adultos internados em uma unidade psiquiátrica de um hospital de ensino do sul do Brasil, no período de janeiro a março de 2014. Utilizaram-se os passos da fenomenologia-hermenêutica de Paul Ricoeur e, para compreensão e interpretação das informações, o referencial teórico-filosófico de Maurice Merleau-Ponty.

Resultados: revelaram três temas: o mundo do ser humano que vivencia a doença mental; percepção da doença mental para o ser humano que vivencia a internação psiquiátrica; e o ser na relação de ambiguidade: o movimento de liberdade.

Conclusão: a equipe de saúde, em especial o enfermeiro, necessita incorporar a visão crítica reflexiva da prática assistencial, as bases científicas e a legislação vigente na área da saúde, em especial a saúde mental, as quais visam à autonomia de escolha centrada no ser humano que vivencia a doença mental. Também promover uma rede quente de cuidado singularizado que preze pelo acolhimento e instigue o autocuidado do ser humano por meio da educação em saúde na perspectiva de ações de integralidade. Logo, é fundamental a promoção de saúde, autonomia e liberdade pela escuta do ser humano que vivencia o fenômeno da doença mental, em seus desejos de vida e perspectivas clínicas.

DESCRITORES: Saúde mental. Adulto. Estresse psicológico. Percepção. Internação hospitalar. Enfermagem.

PERCEPCIONES DEL SER HUMANO INTERNADO EN LA UNIDAD PSIQUIATRICA SOBRE EL VIVIR CON ENFERMEDAD MENTAL

RESUMEN

Objetivo: revelar la percepción del ser humano internado en una unidad psiquiátrica sobre el vivir con enfermedad mental.

Método: estudio con abordaje fenomenológico, cuyos datos fueron obtenidos por medio de entrevistas con diez adultos internados en una unidad psiquiátricos de un hospital de enseñanza del Sur de Brasil, en el periodo de enero a marzo de 2014. Se utilizaron los pasos de la fenomenología-hermenéutica de Paul Ricoeur y, para la comprensión e interpretación de las informaciones, el referencial teórico-filosófico de Merleau-Ponty.

Resultados: se revelaron tres temas: el mundo del ser humano que vive la enfermedad mental; percepción de la enfermedad mental para el ser humano que vive la internación psiquiátrica; y el ser en la relación de ambigüedad: el movimiento de libertad.

Conclusión: el equipo de salud, en especial el enfermero, necesita incorporar la visión critico-reflexiva de la práctica asistencial, las bases científicas y la legislación vigente en el área de la salud, en especial la salud mental, las cuales visan la autonomía de elección centrada en el ser humano que vive la enfermedad mental. También promover una red de cuidado singularizado que preconice la recepción e instigue el autocuidado del ser humano por medio de la educación en salud en la perspectiva de acciones de integralidad. Consecuentemente, es fundamental la promoción de la salud, autonomía y libertad por la escucha del ser humano que vive el fenómeno de la enfermedad mental, en sus deseos de vida y perspectivas clínicas.

DESCRIPTORES: Salud mental. Adulto. Estrés psicológico. Percepción. Hospitalización. Enfermería.

INTRODUCTION

The health/disease process involves cultural and socioeconomic aspects of the human being inserted in a historical and political context of a given society. In terms of mental health, the Brazilian Psychiatric Reform (Law 10,216) promotes a resizing of the purely hospital-centered model into a biopsychosocial model.[1] Therefore it is necessary to deconstruct the psychiatric clinics and develop new apparatus for mental care that consider the social context and, particularly, the human being as the protagonist of this process. It also implies their own life choices, that is, their autonomy as a human being experiencing a mental disorder. One strategy consists in education in health, which enables an understanding on the health/disease process as well actions of joint responsibility of the treatment and health promotion.[2]

Although the Psychiatric Reform is focused on the redirection of the care model from one that is psychiatric hospital-centered into a network of integrated care based on the territory of the individual, such as the Psychosocial Care Centers (CAPSs), hospitalization is still a necessary therapeutic support in certain moments of human life. The determining factor for hospitalization does not consist in the disease in itself, but in the severity status presented as a result of the therapeutic needs exceeding the profile of the extra-hospital services.[3] In the conjuncture of public policies in mental health the care should be considered from a longitudinal perspective. By welcoming individuals experiencing mental disorders, the health reference team invests in the development of the health/disease process and reveals the psychosocial needs. They activate the care apparatus in the health care network in interdisciplinary and intersectoral actions, matrix supports, and education in health, supporting the user flow through the line of mental health care.[4]

As a member of the multiprofessional healthcare team the nurse needs to congregate the management of care into their professional core actions, instigating the potentialities of the human being as an active agent and negotiator of their therapies. In addition, they propose interdisciplinary and intersectoral actions from the perspective of the comprehensiveness of the longitudinal care of the transference between the reference team and the matrix supporters.[5-6] The analysis of the scientific production on the theme evidenced the existence of a gap in relation to studies specifically approaching the perception of individuals hospitalized in psychiatric units about living with a mental disorder according to the phenomenology of Merleau-Ponty.[7]

National studies show the need to explain mental disorders through the concept of what led the individual to become mentally ill. It is expressed in an event (the fact) that triggered the crisis of the patient, negatively affecting their family structure and determining the life history of the individual experiencing a mental disorder.[8-9] In this sense the human being is not mentally ill, but becomes mentally ill as a result of that event and the symptoms of their disease. These symptoms need a scientific classification and explanation to the detriment of the meaning attributed to their life perspective and experience. There is a lack of knowledge of the individual about themselves.[10-11]

It evidences the delusional symptomatology to the use of drugs. It concretizes the mental disorder in the psychiatric hospitalization and in the conception

of social uselessness. It has no responsibility and productive ability to work.[12] The illness is shown as the rupture of routine and course of their life, as well as the loss of perception of sense in the face of their life experiences.[13] This socially stigmatized individual lacks information about the pathology. Individuals experiencing a mental disorder have their space of identity from the conception of the other, in their condition of mentally ill, non-recovery, and social frustration.[14] From this perspective the patient has the conception of the power of the diagnosis.[15]

International studies evidence the fact that this phenomenon of personal experience from the speech of the other may result from various factors. One of them is the "self-stigma," a maladaptive psychosocial phenomenon that affects a substantial number of psychiatric patients. Those presenting high levels of self-stigma accept the social damages associated with people with mental disorders. They are convinced of their inferiority and that their symptoms and disease are not treatable. The effect of self-stigma is directly perceived in the effectiveness of the psychiatric treatment.[16]

Several factors may help us to understand the experience of an involuntary psychiatric hospitalization; they are represented by two forms of care. When the practices were represented by disempowerment and disconnection from the care thought by the patient in terms of power over patients, the representation of the hospitalization was related to horror. There was an easiness of occurrence of human rights abuse. On the other hand, when the practices were focused on care and listening to the individual, respecting their beliefs, the hospitalization was represented as a sanctuary, a place where they could overcome their symptoms and reestablish their health. These results reinforce the importance of a proper proceeding in a psychiatric hospitalization service in which the behavior of the team may define the prognosis of the disease and the quality of life of patients.[17]

In this context, this study asks: How does the human being hospitalized in a psychiatric unit perceive their condition of living with a mental disorder? Intending to obtain an answer, this study aimed to reveal the perception of individuals hospitalized in psychiatric units about living with a mental disorder.

METHOD

This is a phenomenological study based on the theoretical-philosophical reference of Maurice Merleau-Ponty, which seeks an understanding of the life experiences of human beings. The philosopher understands phenomenology as an ambiguous experience that enables the perception of several profiles on a given theme. For him, phenomenology is the study of the essences; it enables an understanding of the individual from their facticity. It is a philosophy that replaces the essences in the existence; it is the own experience in the search for a sense that seeks to understand it in its existential totality. It is a direct descriptive approach of the experience as an incarnated body, as a lived body located in the circumstantial time and space of the lived world.[7] The philosopher proposes the perception as a means of the concrete existence in the description of the human experience, and it occurs through the body that is related to temporality, what happens to us at that moment. The body is the foundation for knowledge; it is its essence developed over history, making up the expressiveness and its subjectivity as a being in the world.[18]

The study site was a psychiatric hospitalization unit of a teaching hospital in the southern region of Brazil. It was developed with adult individuals that were hospitalized at the moment of data collection and that voluntarily agreed to participate in the study, signing a Free and Informed Consent Form. The following inclusion criteria were selected: adult individuals, which according to the Brazilian Institute of Geography and Statistics (IBGE) comprises the age range between 15 and 59 years; of both genders; that had already passed through the acute stage of the disease. Exclusion criteria were: adults in acute crisis; presenting cognitive limitations or incapacitating neurological sequelae that restricted their participation at the time of the study.

Phenomenological interviews recorded by digital device were used for data production. This type of interview aims at accessing the phenomenon questioned by understanding the events experienced by the individual, as it promotes openness to listening to the other, availability, and concern in relation to not inducing their speeches. It occurs in a singular meeting between the interviewer and each participant of the study. As the interview refers to the subjective meeting between two human beings, there is no recipe for the elaboration of the phenomenological interview, but it is necessary that the researcher intends it for the object of study. Also, researchers need to develop empathy for the other, paying attention to how the individual behaves, respecting their manners, silence, and gestures, and capturing other forms of communication with the world.[19]

An mp3 audio recorder device was used to record the interviews in order to ensure the reliability of the speeches. A field diary was kept where the perceptions of the researchers in relation to gestures, actions, and interactions were recorded. The interviews were conducted between January and March 2014 in a room of the hospitalization unit, preserving the privacy of the participant. The following question was introduced: How do you feel having a mental disorder? The number of participants in the study was not predetermined. Data production and understanding and interpretation of the speeches occurred concomitantly. The total of ten participants enabled the researchers to reach the proposed aim and revealed the phenomenon in its essence, as a structure of meanings.[20] Time in phenomenology is not chronologically demarcated, but the shortest interview lasted three minutes and 44 seconds, while the longest one lasted 69 minutes and 35 seconds.

The hermeneutic phenomenology of the French philosopher Paul Ricoeur was used in this study as its goal is the interpretation of the being through the thought of the human being and elaborates the analysis on their will. It seeks to reveal the hidden meaning of what is apparent in order to rediscover the genuine meaning of the language. The hermeneutics of Ricoeur has three stages: simple reading, critical reading, and appropriation, seeking to understand the human existence through the experience expressed in the meaning of the written speech, revealing the reality in its entirety. Therefore the reader needs to understand the intentionality of the text in revealing the truths of the phenomenon in order to understand the meaning of the text.[21]

The interpretation of the findings was carried out text by text, as the reader needs to go beyond the literal meaning of the words in a sentence to understand it. The search for meanings happened through the understanding of the text from situations of the reality learned from the experience of the other (simple reading). Chromatic analysis was used to evidence the theoretical-philosophical foundations of Merleau-Ponty in which the themes were structured from the segments of the written speech comprehended in the text that, in turn, formed a unit of meaning (critical reading).[21]

From this perspective, in view of the themes it was necessary to have an ability to understand the meanings and images projected before the text or, as Ricoeur explains, the metaphor (appropriation). This reveals something new in view of the reality and enables the understanding of the text from an enhancement of the meaning that emerges from the conflict between words and encompasses a new meaning in the sentence.[21] The metaphor in the study was understood as Man on the Sea from the perspective of the human being (man and woman). It invites us as readers to participate in the adventure and show ourselves in perspectives as the movement of the waves of the sea and the man in the world. Three themes emerged: the world of human beings that experience a mental disorder; the perception of the mental disorder for the individual that experiences psychiatric hospitalization; and, the being in the ambiguity relation: the movement of freedom.

The research project was based on the principles of Resolution 466/12 of the National Health Council and was approved by the Human Research Ethics Committee of the *Universidade Federal de Santa Maria* under Protocol 512.085/2014 and CAAE: 26153713.1.0000.5346. The participation of the subjects occurred on a voluntary basis, and after clarifications they signed the Free and Informed Consent Form. In addition, the participants were identified with the letter "H" (Man) followed by Arabic numerals according to the increasing order of the interviews (H1 to H10).

RESULTS AND DISCUSSION

The world of the human being that experiences a mental disorder

Individuals experiencing a mental disorder reveal their perceptions in perspectives before the living world. This is the lived world, rooted by the human experience in a range of singular meanings in which each one perceives a given circumstantial moment. The essence of the individual remains as a background figure in its meanings as life, but these are not static. There is the movement of the consciousness before themselves, of the time for new experiences and meanings of the lived world. When a human being needs to initiate their thoughts, they need to move before themselves, immerse themselves in their body, making up their world without denying it before the uncertainties of the sensitive world.[21-22] By allowing themselves to think about experiencing the phenomenon of mental health the human being revealed their desire to show themselves as the man on the sea. This apprehends experiences, perceptions, and behaviors, and gradually recognizes themselves as being their own actions in the world, of their body in the world, becoming an incarnated consciousness.[18,21-23]

The world of mental health is imposed on the human being in the discovery of the psychiatric diagnosis. They are surprised by a scientificity that shows that their behavior reflects a mental disorder. Conformism occurs when a human being perceives that they are before a situation of illness and acceptance of the speech of the other, as expressed in the following speeches: *how will you form an opinion* [gestures with the hands] *about someone through other people's mouths? On what will the psychiatrist be able to tell whether or not an individual is sick? In conversations with family and friends* (H3); *Ah! I didn't want to believe. I thought, and I still think, that the doctors might be wrong. But they are not; it's true. They found something wrong* [lowering the voice] *and really wrong if I do not take my medicine. He* [doctor] *said the diagnosis in the presence of my mother: bipolar disorder. I remember that he said that, but I didn't understand* (H6).

There is a chronic disease, we cannot deny it nor assume that the human being will not have limitations in view of their clinical symptoms. They will possibly need therapeutic adaptations to their daily life, as denying the treatment is also a form of exclusion.[21] However, as the human being finds out that they have a mental disorder, they become the mental disorder in itself through the speech of the other (doctor, social worker), incorporating to themselves: I am mentally ill in a tone of generality.[22] The man on the sea expresses ambiguity in their speech, in a relation of coexistence of the speech of one and the other.[23] Thus, they recognize in the other something veiled, they perceive the world of the other, supporting the recognition of their world:[7,21-23] *having bipolar disorder is like water and wine, that's how I feel in relation to myself and in relation to other people* (H5).

Experiences of each human being are singular and expressed through the language (verbal and non-verbal) in relations with the world and in the interaction with the other in the spoken speech (routine dialogue) and in the speaking speech (permeated by creativity and meaning of the experiences).[7,23-26] The man on the sea reveals a spoken speech of a being in the middle of the crowd alienated to the environment of the social life that binds them to the disease and limits them to their clinical condition. They may accept the passive condition of being mentally ill in a non-reflexive process. Imprisoned by the disease, they retake the experiences presented under a background, the habit, the forms of treatment, and the stigma. This happens without deliberation or planning, and always in a modified manner.

By rethinking their actions and attitudes before life they reveal a feeling of surprise and enthusiasm towards the possibility of talking about themselves, by their speaking speech, revealing their being in the world with meanings in the face of the perceived reality.[23] As an embodied subject,[7,18,21-23] the man on the sea becomes the expressive means of their experiences, appearing and hiding in the middle of the waves from the perspective of a being in the world, in the movement of the waves in the recognition of themselves: *It has been so hard, because I want to keep being like I have always been, I used to be happy that way, before I find out about the disease* (H2); *It is like hell, because I want to live my life but I never can* [...]. *For me there is nothing worse than being considered mentally ill* (H3); *About my disease, I don't know, how could I know about my disease? I think it is bad, really bad. I cannot tell you about the disease* (H9).

This historical rescue of their lives brings to the present the mental disorder experiences: the discovery of the diagnosis; the difficulties of living with the signs and symptoms; the fear of themselves and others; the treatment. Sometimes, when a scenario of improvement is visualized, there is the idea of a temporary cure and the masked possibility of freedom when not requiring a treatment. In this movement it ends up attached to the mental suffering or to the exclusion in the asylum logic, as they have no access to the treatment to enable their improvement, violating the principles of the Unified Health System. Or, still, by the treatment, the removal of the characteristics of their way of being, causing strangeness before themselves and the memories that made up their identity as a human being.

In this context, despite the advances in the political conjuncture in mental health and the struggle for its implementation, instigating the autonomy of the individual and the valorization of citizenship,[24-25] it is possible to perceive in the speeches that this clinical condition is limited and reduced in the world of mental health, regardless of the place it inhabits. However, mental disorders are configured in a world in which the characters are labeled. A mask (professional, social) is used to dictate the rules that brings them back to human normality at the same time that it proposes parallel worlds to their existence. The fact that the person is not given the choice of treatment is also a form of exclusion and withdrawal of their rights in relation to their own life.[27]

In the conformation of the Singular Therapeutic Projects (STP), autonomy based only on the range of possibilities of the professionals rather than the human being as a source of their desire, a modality of treatment and promotion of life is an example of a

masked idea. The construction of the STP needs to be jointly performed with the human being that experiences the mental disorder, the clinical perspectives and life desires, enabling the rescue of their history and leveraging their autonomy.[28-29] By virtue of this, it is not the place that attaches the human being to their disease, but the asylum model that persists in the human mentality.[30]

Perception of mental disorder for the human being that experiences a psychiatric hospitalization

The perception of the human being before the world in this moment is imbricated in the facticity of the existence in a network of intentionalities. It permeates the essence of the human being, of the experienced events and their meanings in relation to the world-life from the perspective of a temporal relation between the past, present, and future. The process of temporality is made up in a subjective way; the consciousness is the form of all times:[7,22,31] *It's been a month and 11 days; it is hard, tense, you know, and I complain every day. It is very tense in here. If you were not here, I think I would have lost my mind* (H2); *I feel isolated. Locked. Imprisoned* [wide eyes]. *It is bad to be here; we are not allowed to go outside. Sometimes we go out* [sighs]. [...] *they treat us well, but it is not like being outside. Outside you have to get by on your own* (H9).

The human being is born in the world and from the world. This already exists when they are born, but it is never completely formed. It is neither determinism nor absolute choice, as there is a relation of coexistence of the human being among things that demands external determination and a consciousness that cannot be pure. The human being coexists in this tangle of things and others, linking the idea of absolute freedom to a situation as it consists in a psychological and historical structure. Being in the world presents a structure of their existence in which only by assuming their social and natural position the human being will be able to be free. Therefore, they are born motivated to discover the world in a field of possibilities. But, at the same time, they are limited by this world in an ambiguous relation of coexistence.[7,18,21-23]

In the speech of hospitalized human beings there are questionings of the recognition of themselves in the face of the mental disorder, as an individual of and in the world in a relation of coexistence, of the signification of the human being that recognizes themselves as being ill. This designates the hospital as a place for recognition of feeling home in a friendly environment and in questioning the withdrawal of their documents, and consequently their citizenship. *It has been hard for me because my way of being has changed. I do not know if it has to do with the drugs. But I'd like to be the way I used to be, but I can't, because that was a disease. So I cannot be that way anymore. So I feel kind of oppressed, kind of sad, but what can I do? They saved me when I tried to commit suicide, but I died at the discovery of the diagnosis* (H2).

The human being perceives a mental disorder as part of their world when they understand that the mental disorder may motivate sensations through their body, changing their behavior in their daily life.[7,21,26] Therefore, besides the fact that the individual is experiencing the psychiatric hospitalization and the hospital-related routines, their speeches refer to the difficulties of living with their own mental disorder. They are often held hostage by the lack of control of the body and its impulses before the signs, symptoms, and treatment as well as by the social, intellectual, institutional, and self imprisonment.

The body reflects this world[21-23] when it incorporates the bars of the asylum logic by the disease in itself, reducing the perceptions of themselves before a pathology of explicative causality, blame, non-control of their actions in the face of the psychiatric crisis and impulses of the body process. Thus, the human being experiences the world of mental health through the marks felt and experienced by their body: [...] *they will never see inside our head. This is something one cannot see. You do not see the mental disorder; you feel it* (H4); *If the individual could control it . . . but they can't* (H6); *Today I do not feel good. But all my exams showed good results, my blood pressure, all good, my heart rate was very good, my liver is very good* (H8); *Since I was a kid I have my head broken* (H10).

Therefore, the world of psychiatric hospitalization is experienced through a mixture of sensations to the own body in the middle of the temporality of the human existence,[7,21-23] or through a feeling of isolation and imprisonment of the body by the institutional walls, or through the feeling of empathy with the place, of identification with the movement of going back home, as the world of hospitalization would be welcoming the human being in a feeling interpreted as friendly. They now experience feelings and memories of difficult moments, with marks in the body under the form of treatment (injections, mechanical restraints, the power of the speech of the professional), or by the possibility of a new meaning to the hospitalization as a process of maturation before their treatment.

Despite that the experience of psychiatric hospitalization by the human being ends, the memories of that experienced world will persist in their minds. In addition, consciousness makes the prospective movement in the speech of the human being referring to the possibility to encourage their choices and the liability to reflect in face of their actions as a man in the world in an emancipative movement.[7,22-23]

The Being in the relation of ambiguity: the movement of freedom

Every human being has a relation of ambiguity in their existence in the world. Ambiguity permeates their relation with themselves and others in the combination of the speech and contradiction, as I perceive myself before the incarnated other, and the other perceives themselves before me. In this relation of coexistence I am materialized as marks of the lived body investing in my usual field. I perceive myself and I am perceived as an existential being before the unfinished world of singular discoveries and significations.[22-23]

In this sense the human being that experiences a mental disorder expresses in their lived body the desire for normality perceived in the other. Sometimes they incorporate in their usual field the speech of the other, of how to live, and acceptable social habits: *It is not easy, you know, because I wanted to be a normal person, you know, just like you, him, just like everyone* (H2); *All I wanted is a normal life. Recovering my life as I used to be, I worked and all, and then I retired and I no longer could do what I liked to do* (H6).

Freedom in the human existence is an achievement from the action of man in the world before a given situation. There is no full freedom or determinism. We are born free in a world that is open to the possibilities of what we desire. However this already-existing world, with its essence, its moorings, is in a continuous movement of construction that enables the desire for freedom.[7] Therefore the human being needs to be constituted in this world, a fact that will affect their desires and choices through the social, cultural, and geographic aspects that may impose limits to their freedom.[22-23] Freedom results from the desire to be free. It is necessary for them to question themselves about in which situation they want to be free. The strength of this desire is not linked to reasons. These are the justifications that usually paralyze them in the face of the actual desires.[21-22,30] Thus the greatest act of freedom provides for the listening to the actual desires of the human being in a given situation.

Therefore, the human being empowered with their health situation will express their desire in relation to their treatment and life possibilities. Thus, the human being is not set free upon discharge from the psychiatric hospitalization unit; above all, it may be possible for them to achieve their freedom by listening to their desire as an ambiguous being in the world. *I don't think I am a disabled person; I don't think I am incapable* [negatively gesticulating with his head and hands]. *I am not out of the picture* [...] *But I am here today. My disease keeps me away from people, from my home, and from following my wishes* (H1); *I could even study if I wanted to do so, but I don't want it, I can do a lot of things, but I don't, I am a prisoner at home, I do not walk too much on the streets* (H5); *It's very difficult when you do not accept the treatment, it becomes more difficult. For example, when my mother started it she began to refuse to take the medicine, and I said: you can pay for the drug, you can have it, you have this chance of taking the medicine. And she did not want to accept it, and now I am at the same point* [laughs euphorically] (H7); *The mental disorder steals your freedom. And you learn more about life* (H8).

It is possible to perceive that the human being is an ambiguous being in existence in the world.[7-21-23] Regarding the human being that experiences a mental disorder there is a relation of ambiguity between the desire for the normality of the other and the identification of the world of insanity, prejudice, and social habits accepted with the movement of their desires in favor of the movement of freedom; of the institutional bars and the bars created by the human mind; the relation of the treatment, often imposed by the certainty of the scientific knowledge and the treatment recommended by the Mental Health Care Policy. But, after all, what is the space for listening to the actual therapeutic desire of the human being for their life?

It is therefore observed that the human being is captured in their own disease, in which their actions reflect the world of insanity in their daily life. It is necessary to work the meanings for their living, their conceptions of life, their losses, supporting the elaboration of daily mourning and celebrating their therapeutic achievements and life wishes. It is possible to institutionalize the human being for the therapeutic possibilities, but health professionals primarily need to open their minds to the reinvention of the individual as a human being in the world.

CONCLUSION

The present study aimed to reveal the perception of individuals hospitalized in psychiatric units about living with a mental disorder. It produced

knowledge through the movement of an investigation into the understanding of the phenomena through the theoretical-practical basis substantiated by the methodological philosophical reference that instigated the intersubjective meeting with the human being that experiences a mental disorder.

The search for an approximation of the understanding of the philosophical contribution of Merleau-Ponty stimulates the perception of the own body shaken by the habitual field of care and teaching daily routines. It promotes the search for meanings for the movement of freedom of the human being in a perspective of the world and the implementation of an comprehensive care. In the context of humanization policy, aiming at implementing the principles and guidelines of the Unified Health System and the expanded clinics, it motivates a being of possibilities rather than reducing the human being to a clinical comorbidity. Moreover, Ricoeur encourages the listening to wishes and desires, valuing the reflection on the actions of the man in the world and their significance, the sense of language, of life, and the being in its entirety. In addition to propelling the mental health care line, education in health empowers the human being in the face of their own therapeutic choices and life possibilities.

In this context, the healthcare team needs to incorporate the critical reflexive view of the care practice, the scientific bases, and the legislation in force in the area of mental health in order to enable autonomy and power of choice for individuals experiencing a mental disorder. This will enable advances in the construction of the care in the line of mental health care from a perspective of care comprehensiveness. However, there are a number of challenges to be overcome, particularly in relation to the professional power over the other and the relation of dependence established around the patient in reference to health services. The nurse needs to assume the welcoming role in face of the human being in relation to what Merleau-Ponty calls *own body*. It is necessary to have technical and clinical knowledge in mental health to recognize the signs and symptoms and anticipate clinical crises, but it is also necessary to promote health and expand this care to the biopsychosocial aspects.

It is imperative to offer means for education in health and empower the human being to the joint responsibility of the treatment and social control. Education in health is a strategy to stimulate the movement of the man on the sea, to self-care, prevention of crises, recognition of the symptoms, and therapeutic choices. In addition, it initiates the human being to the meanings of the mental disorder experienced in a singular manner in the health/disease process. These options may be performed in therapeutic groups and/or through nursing visits, prioritizing health actions through the systematization of care and welcoming in mental health care. Therefore, the nurse needs to delimit their core role in the health team in order to enable the exchange of knowledge and experiences in multidisciplinary works, which is critical to the continuity of the treatment in the perspective of care comprehensiveness.

This continuity of treatment is proposed through the transference of the care between the healthcare teams, the reference team and, if necessary, the matrix team and intersectoral actions. Therefore, in the hospitalization of the patient it is necessary to carry out a hospital discharge plan, develop the network of continuity of the treatment substantiated by the voice of the patient and their clinical conditions. For this purpose, the human being hospitalized in a psychiatric unit needs to have a reference health team that respects their freedom, that is, that does not make them dependent on their therapeutic course, but as a means of support to the health/disease process. Despite the hospital discharge, this service is still jointly responsible for their treatment in the line of mental health care as a matrix support point in the network. Therefore, the communication in and between the health services, as well as the continuous education and awareness of managers, are extremely important to support the applicability of the investments and for the planning of actions related to the health/disease process in its whole conjuncture.

Nursing knowledge in mental health is critical to promote the warm care network that respects the welcoming and transference of the care for the human being in accordance with their actual therapeutic needs and levels of complexity. Thus, it will be possible to carry out health actions from the perspective of comprehensiveness, mental health promotion, and the practice of social nursing.

As it is part of a number of experiences in the context of mental health, the specific context for the care to adults hospitalized in a psychiatric unit is understood as a possible limitation of the study. It is believed that other realities may add evidence to enable the understanding of those experiencing a mental disorder in order to support the health/disease process. Replication of this study in other scenarios of the daily routine of human coexistence and in services of the line of mental health care is suggested.

REFERENCES

1. Brasil. Lei 10.216 de 06 de abril de 2001: Dispõe sobre a proteção e os direitos das pessoas portadoras de transtornos mentais e redireciona o modelo assistencial em saúde mental. Brasília (DF): Diário Oficial; 2011 abr 06.
2. Botti NCL, Torrézio MCS. Significados do Festival da Loucura: a perspectiva de profissionais do Centro de Atenção Psicossocial. Rev Enferm UERJ [Internet]. 2013 [cited 2016 Aug 08]; 21:307-11. Available from: http://www.epublicacoes.uerj.br/index.php/enfermagemuerj/article/view/7455
3. Brischiliari A, Bessa JB, Waidman MP, Marcon SS. Concepção de familiares de pessoas com transtorno mental sobre os grupos de autoajuda. Rev Gaúcha Enferm [Internet]. 2014 [cited 2016 Aug 08]; 35(3):29-35. Available from:http://seer.ufrgs.br/index.php/RevistaGauchadeEnfermagem/article/view/41015
4. Wetzel C, Pinho LB, Olschowsky A, Guedes AC, Camatta MW, Schneider JF. A rede de atenção à saúde mental a partir da Estratégia Saúde da Família. Rev Gaúcha Enferm [Internet]. 2014 [cited 2016 Aug 08]; 35(2):27-32. Available from: http://seer.ufrgs.br/index.php/RevistaGauchadeEnfermagem/article/view/43052
5. Azevedo EB, Carvalho RN, Cordeiro RC, Costa LFP, Silva PMC, Filha MOF. Tecendo práticas intersetoriais em saúde mental para pessoas em sofrimento psíquico. Rev Enferm UFSM [Internet]. 2014 [cited 2016 Aug 08]; 4(3):612-23. Available from: https://www.researchgate.net/publication/272565256
6. Almeida ANS, Feitosa RMM, Boesmans EF, Silveira LC. Cuidado clínico de enfermagem em saúde mental: reflexões sobre a prática do enfermeiro. Rev Pesq: Cuidado Fund Online [Internet]. 2014 [cited 2016 Aug 08]; 6(1):213-34. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/viewFile/2819/pdf_110
7. Merleau-Ponty M. Fenomenologia da percepção. 3ª ed. São Paulo: Martins Fontes, 2011.
8. Furegato ARF, Silva EC. A doença mental vivida por um paciente psiquiátrico: suas percepções. Esc Anna Nery [Internet]. 2006 [cited 2016 Aug 08]; 10(4):652-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452006000400006
9. Miranda FAN, Dutra SVO, Pessoa Júnior JM, Rangel CT. The opinion of family members in the family health strategy about the mental illness, the patient and the family. Rev Pesq: Cuidado é Fundamental Online [Internet]. 2012 [cited 2016 Aug 08]; 4(4):2901-8. Available from: http://www.seer.unirio.br/index.php/cuidadofundamental/article/view/2026
10. Maciel SC, Maciel CNC, Barros DB, Sá RCN, Camino LF. Exclusão social do doente mental: discursos e representações no contexto da reforma psiquiátrica. Psico-USF [Internet]. 2008 [cited 2016 Aug 08]; 13(1):115-24. Available from: http://www.scielo.br/pdf/pusf/v13n1/v13n1a14.pdf
11. Assad FB, Pedrão LJ. O significado de ser portador de transtorno mental: contribuições do teatro espontâneo do cotidiano. SMAD, Rev Eletr Saúde Mental Álcool Drog [Internet]. 2011 [cited 2016 Aug 08]; 7(2):92-7. Available from: http://www.revistas.usp.br/smad/article/view/49578
12. Colvero LA, Ide CAC, Rolim MA. Família e doença mental: a difícil convivência com a diferença. Rev Esc Enferm USP [Internet]. 2004 [cited 2016 Aug 08]; 38(2):197-205. Available from: http://www.scielo.br/pdf/reeusp/v38n2/11.pdf
13. Ferreira MSC, Pereira MAO. Cuidado em saúde mental: a escuta de pacientes egressos de um hospital-dia. Rev Bras Enferm [Internet]. 2013 [cited 2016 Aug 08]; 65(2):317-23. Available from: http://www.scielo.br/pdf/reben/v65n2/v65n2a18.pdf
14. Nunes M, Torrenté M. Estigma e violências no trato com a loucura: narrativas de Centros de Atenção Psicossocial, Bahia e Sergipe. Rev Saúde Pública [Internet]. [cited 2016 Aug 08]43(1):101-8. Availablefrom://www.scielo.br/scielo.php?script=sci_arttext&pid=S0348910200900800015&lng=em
15. Salles MM, Barros S. Vida cotidiana após adoecimento mental: desafio para atenção em saúde mental. Acta Paul Enferm [Internet]. 2009 [cited 2016 Aug 08]; 22(1):11-6. Available from: http://www.scielo.br/pdf/ape/v22n1/a02v22n1.pdf
16. Holubova M, Prasko J, Latalova K, Ociskova M, Grambal A, Kamaradova D, et al. Are self-stigma, quality of life, and clinical data interrelated in schizophrenia spectrum patients? A cross-sectional outpatient study. Dove Press J [Internet]. 2016 [cited 2016 Aug 08]; 10:265-74. Available from: https://www.dovepress.com/are-self-stigma-quality-of-life-and-clinical-data-interrelated-in-schi-peer-reviewed-article-PPA
17. Seed T, Fox JRE, Berry, K. The experience of involuntary detention in acute psychiatric care. A review and synthesis of qualitative studies. Inter J Nurs Stud [Internet]. 2016 [cited 2016 Aug 08];61:82-94 Available from: http://www.sciencedirect.com/science/article/pii/S0020748916300633
18. Oliveira PP, Viegas SMF, Santos WJ, Silveira EAA, Elias SC. Women victims of domestic violence: a phenomenological approach. Texto Contexto Enferm [Internet]. 2015 [cited 2016 Aug 08]; 24(1):196-203. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072015000100196
19. Paula CC, Padoin SMM, Terra MG, Souza IEO, CabraL IE. Modos de condução da entrevista em pesquisa fenomenológica: relato de experiência. Rev Bras Enferm [Internet]. 2014 [cited 2016 Aug 08]; 67(3):468-72. Available from: http://www.scielo.br/pdf/reben/v67n3/0034-7167-reben-67-03-0468.pdf
20. Paula CC, Cabral IE, Souza IEO, Padoin SMM. Movimento analítico-hermenêutico heideggeriano:

possibilidades metodológicas para a pesquisa em enfermagem. Acta Paul Enferm [Internet]. 2012 [cited 2016 Aug 08]; 25(9):984-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002012000600025

21. Freitas FF, Terra MG, Silva AA, Ely GZ, Girardon-Perlini NMO, Leite MT. Alta hospitalar da pessoa com transtorno mental: significados atribuídos pelo familiar. Rev Enferm UFPE on line [Internet]. 2013 [cited 2016 Aug 08]; 7:6477-87. Available from: doi:10.5205/reuol.3794-32322-1-ED.0711201322
22. Matthews E. Compreender Merleau-Ponty. São Paulo: Vozes, 2010.
23. Silva AAS, Terra MG, Freita FF, Ely GZ, Mostardeiro SCTS. Cuidado de si sob a percepção dos profissionais de enfermagem em saúde mental. Rev Rene [Internet]. 2013 [cited 2016 Aug 08]; 14(6):1092-102. Available from: http://www.periodicos.ufc.br/index.php/rene/article/view/3717
24. Salles MM, Barros S. The social exclusion/inclusion of users of a psychosocial care center in everyday life. Texto contexto Enferm [Internet]. 2013 [cited 2016 Aug 08]; 22(3):704-12. Available from http://www.scielo.br/scielo.php?pid=S010407072013000300017&script=sci_arttext&tlng=en
25. Andrade LM, Sena ELS, Jesus IS. A experiência do outro e o vir a ser cidadão idoso. Rev Gaúcha Enferm [Internet]. 2014 [cited 2016 Aug 08]; 35(2):14-9. Available from: http://seer.ufrgs.br/index.php/RevistaGauchadeEnfermagem/article/view/41792
26. Silva AA, Terra MG, Motta MGC, Leite MT, Padoin SMM. Enfermagem e cuidado de si: percepção de si como corpo existencial no mundo. Rev Enferm UERJ [Internet]. 2013 [cited 2016 Aug 08]; 21:366-370. Available from: http://www.facenf.uerj.br/v21n3/v21n3a15.pdf
27. Pinho LB, Kantorski LP, Olschowsky A, Schneider JF, Lacchini AJB. Ideology and mental health: analysis of the discourse of workers in the psychosocial area. Texto Contexto Enferm [Internet]. 2014 [cited 2016 Aug 08]; 23(1)65-73. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072014000100065
28. Scholz DCS, Duarte MLC, Correa MM, Torres OM, Balk RS, Strack EM. Construction project of a therapeutic CAPS in Southern Brazil. Texto Contexto Enferm [Internet]. 2014 [cited 2016 Aug 08]; 14(27):65-69. Available from: http://www.lume.ufrgs.br/handle/10183/116241?locale=en
29. Schimith MD, Brêtas ACP, Budó MLD, Chiesa AM, Alberti GF. Colonialismo nas relações entre trabalhadores e usuários durante as práticas de cuidado: implicações para a integralidade da atenção. Esc Anna Nery [Internet]. 2013 [cited 2016 Aug 08]; 17(4):788-95. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1414-81452013000400788
30. Ely GZ, Terra MG, Silva AA, Freitas FF, Padoin SMM, Lara MP. Internação psiquiátrica: significados para usuários de um centro de atenção psicossocial. SMAD, Rev Eletr Saúde Mental Álcool Drog [Internet]. 2014 [cited 2016 Aug 08]; 10(1):23-8. Available from: http://www.revistas.usp.br/smad/article/view/86760
31. Sena ELS, Helca THF, Carvalho PAL, Souza VS. A intersubjetividade do cuidar e o conhecimento na perspectiva fenomenológica. Rev Rene [Internet]. 2011 [cited 2016 Aug 08]; 12(1):181-8. Available from: http://www.revistarene.ufc.br/vol12n1_pdf/a24v12n1.pdf

Correspondence: Gabriela Zenatti Ely
Rua Vale Machado, 1605, ap. 106
97110-530 – Centro, Santa Maria, RS, Brasil
E-mail: gabii_ely@yahoo.com.br

Recived: march 14, 2016
Approved: september 19, 2016