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The delusional certainty in the psychotic discourse and its crossings in the family context

A certeza delirante no discurso psicótico e seus atravessamentos no contexto familiar

La certeza delirante en el discurso psicótico y sus atravesamientos en el contexto familiar

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Objective: to present a case of paranoia and the interaction between the mental health team and the family. **Methods:** a single case report, with a qualitative and descriptive approach, carried out in early 2021 in a state reference hospital service for psychiatric crisis care. The analysis consisted of an in-depth study of the medical records. **Results:** the patient evaluated was 50 years old at the time of the consultations; resided in the metropolitan region of the city of Belo Horizonte; coming from a Catholic family; married for 30 years; mother of two teenagers; complete high school education; worked for many years as a hairdresser, until taking up a career as photographer, in partnership with her husband. With the interventions, the reduction of affective investment in delusional certainties was achieved, with less impact on the patient's functional performance and family dynamics. **Conclusion:** the performance of the mental health team with the family approach proved to be resolute and promoter in the accountability of the members of the nucleus.
Descriptors: Mental health assistance; Delirium; Family.

Objetivo: apresentar um caso de paranoia e a interação entre a equipe de saúde mental e a família. **Método:** relato de caso único, com abordagem qualitativa e descritiva, realizado no início de 2021 em um serviço hospitalar estadual de referência em atenção à crise psiquiátrica. A análise se constituiu no estudo aprofundado das anotações do prontuário. **Resultados:** a usuária considerada tinha 50 anos à época dos atendimentos; residia na região metropolitana de Belo Horizonte; procedente de família católica; casada há 30 anos; mãe de dois adolescentes; ensino médio completo; trabalhou por muitos anos como cabelereira, até assumir a carreira de fotógrafa, em sociedade com o esposo. Com as intervenções, foi atingida a redução do investimento afetivo nas certezas delirantes, com menor impacto no desempenho funcional e na dinâmica familiar da usuária. **Conclusão:** a atuação da equipe de saúde mental com a abordagem familiar mostrou-se resolutiva e promotora na responsabilização dos integrantes do núcleo.
Descritores: Assistência à saúde mental; Delírio; Família.

Objetivo: presentar un caso de paranoia y la interacción entre el equipo de salud mental y la familia. **Método:** relato de caso único, con abordaje cualitativo y descriptivo, realizado a principios de 2021 en un servicio hospitalario estatal de referencia en atención a la crisis psiquiátrica. El análisis consistió en un estudio en profundidad de las historias clínicas. **Resultados:** la usuaria tenía 50 años en el momento de la atención; vivía en la región metropolitana de Belo Horizonte; de familia católica; casada desde hace 30 años; madre de dos adolescentes; educación secundaria completa; trabajó durante muchos años como peluquera, hasta que emprendió la carrera de fotógrafa, en sociedad con su marido. Con las intervenciones se logró la reducción de la inversión afectiva en certezas delirantes, con menor impacto en el desempeño funcional y en la dinámica familiar de la usuaria. **Conclusión:** la actuación del equipo de salud mental con el enfoque familiar fue resolutiva y promovió la responsabilidad de los miembros del núcleo.
Descriptores: Atención a la salud mental; Delirio; Familia.

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INTRODUCTION

The Brazilian Psychiatric Reform (BPR) is a social and significant movement in the field of public health that aims, through public policies, ministerial laws and ordinances, state and municipal laws, to modify the care provided to patients of mental health services, reformulating the previous hegemonic model, normalizing and hospital-centric psychiatry[1] and was responsible for creating a model that included territorial, psychosocial and family contexts in the construction of health care.

With the gradual implementation of substitutive health services for the psychiatric hospital, such as the Psychosocial Care Centers (CAPS), the responsibility for the care of the individual in mental distress began to be shared between services and families. For the consolidation of the BPR principles, the dimension of intersectoriality is essential, allowing the creation of networks of possibilities for people in mental distress, promoting the achievement of autonomy and participation in the territory, with the full exercise of citizenship. In this sense, the family has gained relevance in mental health care by taking new roles with the Psychosocial Care Network (RAPS), part of the responsibilities[2].

It is admitted that it is necessary to contextualize the family role in modern society, which was constituted with the evolution of the concept of private life. The family came to be considered the main instance of social protection, to the detriment of the social functions of the State. This process can be characterized as "*familism*" or "*familiarism*", with the attribution of the greatest responsibilities for the well-being of its members to family units. It can also be said that there is a resumption and appreciation of the protective functions of the family, which can also contribute to family overload, especially of female members, culturally in charge of care functions[2].

Since the end of the colonial period in Brazil, at 19th century, with the support of hygienism, social reproduction and care were built as female activities, as unpaid work. Women were primordial in the social relations of production. The understanding of this process, known as the sexual and social division of labor, points to the role of the family in the construction of care and of the Mental Health policy, given that female figures mostly occupy the central role of caregiver and provider of sustenance in Brazilian families. It is common that domestic work, also performed mostly by women, is still not considered real work, with no remuneration or social recognition. It is this "invisible" work that is imperative for the organization of families and the maintenance of the lives of its members[3-4].

The family is a dynamic and complex organism, as it is constituted as a collective being, but also as a singular being, composed of real individuals and attributed subjectivity. Most of

the time, the family is the first institution that the social being experiences and, even though unique and singular, that context is delineated by life in society[4]. In this perspective, one of the essential dimensions for the construction of new forms of mental health care is the notion of territory.

Care must emancipate users, enabling the protagonism of their own lives and citizen participation in the community. However, the difficulties of carrying out this care in the territory remain, for often not extrapolating health services and/or practices restricted to their limits, maintaining institutional care and not covering the entire relational dimension of people's daily lives[5].

Effective care must be built by expanding the support network of institutions, family and community. When dealing with a network, there is a resizing of the place of the family in the context of mental health, leaving a passive role in the treatment process to assume a role in the consolidation of care guidelines as well as that of mediator in social relationships. For centuries, families delegated to the State the function of "taking care" of their loved ones. However, it is something that is still in the process of consolidation in the country.

The shared care of the person in mental distress can lead the family to the belief that they are unable to deal with the situation. The family learns to care through the interaction with the psychosocial devices and these must provide support so that the group can deal with the resulting overloads and act in the fight against stigma, which can culminate in the rejection of the individual, making it difficult to reintegrate into the community[6].

Paranoia, as a diagnosis, was described in the 19th century by Kahlbaum and later refined by Kraepelin, with the notion of paranoid dementia as a degenerative psychic process. This would be described by an initial depressive period, with subsequent flowering of utopian and constantly changing delusional ideas, built around interpretations and illusions of memory[7].

In 1987, the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)[8] reintroduced the concept of paranoia, similar to that proposed by Kraepelin, but including a variety of disorders in which a long-standing delusion presents itself as the most salient clinical feature. However, the condition was renamed delusional disorder. The diagnostic criteria included non-bizarre delusions and indicated that affect and behavior suffered minimal, if any, damage.

Delusional disorder is strongly characterized by systematic speech of delusional content, and the individual maintains congruent affection to the content of the delusion[9]. In most cases, delusions are persecutory, being in the rest of the cases of reference, control,

grandiosity, hypochondriac, religious, among others. Delusional disorder may also present irritability, social isolation, self-neglect and obsessive ideas.

Phenomenally, in the space of their delusion, the delusional interprets and relates signs. Thought is obscured by the shadow of the delusion, whose certainty is based on the implicit certainty of a precedent and unquestionable essence.

The delusional interpretation consists of taking it as certain, true, and not as probable or plausible, giving it the quality of evidence. There are four defining characteristics: 1) interpretation and non-explanation; 2) taken as true; 3) self-referential character, and 4) systematize until constituting a delusion or delusional speech[10:87]. Thus, this study aimed to present a case of paranoia and the interaction between the mental health team and the family.

METHODS

This is a single case report, with a qualitative and descriptive approach, carried out with a patient of a hospital service, which is a state reference in psychiatric crisis care for individuals from municipalities in the state of Minas Gerais, Brazil, that do not provide a specialized service of the CAPS type in your network or that the existing service does not have full-time assistance.

Data collection was carried out between January and February 2021 and the analysis consisted of an in-depth study of the medical records. The research was previously submitted and approved by the institutional Ethics Committee, obtaining opinion 4,576,528, of 03/06/2021, under CAAE 43041421.7.0000.5119 and the patient considered received a fictitious name, aiming at her protection.

RESULTS

The user considered was named Beatriz; 50 years old at the time of the consultations; resided in the metropolitan region of the city of Belo Horizonte; coming from a Catholic family; married for 30 years; mother of two teenagers, an 18-year-old daughter and a 13-year-old son; complete high school education; worked for many years as a hairdresser, until taking up the career as a photographer, in partnership with her husband.

Beatriz was referred to emergency care by the mental health team of her municipality. She said she was being persecuted by family members, such as her husband, siblings and her mother, who would be involved in criminal activities in the territory where they lived. She stated that the municipal service team would ally with her family members, and that she had started the process of divorce from her husband, without notifying him.

The patient claimed that her husband offered gifts and fatty and sugary snacks to the couple's son, in order to gain the teenager's support. For her, body and health care were significant and stood out in her speech. She performed physical activities daily, studied about food education and valued physical well-being. Without being asked, she spoke confidently: "*I am totally healthy, there is no disease or problem in my body. That's why I don't allow anyone to put any medicine in it.*"

Beatriz's husband and brother reported that about a year ago, the situation began, marked by persecutory ideas, intense psychomotor activity, and excessively altruistic behavior, when she got rid of assets needed by her family, using religious justifications. Beatriz had sleep restriction, as she spent nights in prayer, and was involved in risky situations in the territory. The episodes of aggression became frequent, with threats to family members, with the use of bladed weapons, and announcing that she would poison the family's food.

The report from the service of origin corroborated the picture pointed out by the family members. Beatriz had been seen a few times in that establishment and had persistent refusal to use the prescribed medication, in addition to an episode of psychomotor agitation and aggression towards the professional who attended her. Then, they referred Beatriz for crisis management, moment when they claimed that it was not possible to attend to her due to her persecution with the service. The patient was then admitted by the emergency physician, when hospitalization was decided, accompanied by two TRs: a multiprofessional mental health resident and a psychiatry resident.

Beatriz was not opposed to the service proposals, even though, after a few minutes of dialogue, her speech was already self-referential. In her speech content, there were several tension points related to her sex life. The patient also spoke about the decision to break off family relations with her mother and brother, since she "*discovered that they were also involved with crimes.*"

Despite not opposing the dialogue, Beatriz resisted the medications and other resources of the proposed treatment. The patient was oriented about the service and invited to participate in the care, seeking to (re)elaborate her story and understand the context that had been causing crossings in her daily life and that of her family. Regarding the mental state examination, Beatriz kept most of her psychic functions preserved, she presented impairment of her judgment of reality, but there were no sensory-perceptual alterations. The team understood that it was, therefore, an interpretive delusion.

The patient did not accept medication, expressed a taste for physical activities and therapeutic workshops. The religious character in the speech was still very prominent. Beatriz

expressed regrets about her children, who were to some extent resistant and withdrawn in the face of her changes in behavior.

Beatriz claimed to be a mystical, sanctified figure, with a function of benevolence and charity as principles. She tried to help other patients of the service by defining actions that she considered most suitable for them. There were frequent meetings between the family and the team, aiming at listening, raising awareness and accountability between the parties.

Listening and family management were maintained, but despite the series of meetings and guidance on the care process, family members continued to present behaviors that reinforced the affective investment of the patient in her delusional certainties. These behaviors often generated secondary gains.

There were advances in the therapeutic proposals to manage the patient and the family and to promote awareness and responsibility for the clinical condition, but the delusional construction still stood out in the scenario. Despite the intense identification she maintained between her life story and the "*mission*" she carried, Beatriz referred to a certain fatigue for such a responsibility and said: "*I am 'The Saint', people need me to be saved.*" The team's interventions referred to the dimension of humanity common to all, seeking to appease it of such a grandiose responsibility. Afterwards, Beatriz said: "*you are careful and human with us, who are human too."*

Meetings and case discussions were held with the municipal team. The need for embracing the family was highlighted, as family relationships were markedly impacted by the situation. The team proposed to call the patient's husband for a conversation. In subsequent consultations, Beatriz complained of having suffered injustices in that service, proving to be persecutory with the reference technique that was initiating the construction of the case, thus signaling some of the managements that the service should build for the continuity of its therapeutic project.

The patient always remembered the difficulty of returning to her home, saying "*I want another family, this is God's plan. I no longer have a family, they are all drug dealers.*" Residents continued to hold meetings with family members, discussing the prognosis, welcoming demands and doubts and advising on family support, seeking preservation in relation to overload and emotional exhaustion. The patient's mother, quite elderly, questioned whether her daughter would recover. Therapeutic proposals were clarified. It was emphasized that the intention was Beatriz's autonomy and performance, even if some aspects of the delusional thinking did not cease.

Over time, Beatriz observed that her thoughts of grandeur, supremacy and holiness did not materialize in the way she expected. She presented lowering of mood and speech of hopelessness. The patient said she did not understand why she had received so many missions and revelations, which in fact did not materialize and said she was helpless. This process triggered emptying and affective distancing of the patient from her certainties. An intervention was planned in which Beatriz would write a letter of suggestions and considerations for the service, for her home and for the people she wanted. In this intervention, it was delimited that these were proposals and observations that were understandable and shared by all. The aim was to displace the grandiose and centralized character of the "missions" that the patient believed she had to fulfill. The patient showed greater tolerance for staying at home with her family.

The welcoming, management and educational interventions were carried out with the family, providing guidance on the clinical scenario and on the return to daily life. Some collective meetings caused hostility among the members, with accusations and offenses, inflamed by Beatriz's delusional interpretations. Eventually, professionals chose to interrupt the meetings to avoid further emotional damage. The aim was to favor social ties based on family approaches.

With the sequence of consultations, a reduction in affective investment in delusional certainties was already observed, with less impact on functional performance. The team considered that it would be an opportune moment for discharge, with outpatient follow-up. The return to the real context of life would be an ally in the continuity of care. However, despite the articulations of the case built with the reference service, Beatriz did not accept to return for treatment at this location.

We discussed with the manager and the service team about the approach strategies extended to the family members, who were also oriented to seek support to deal with the confrontations inaugurated by Beatriz in each period. The patient chose to continue the outpatient care with the psychiatric resident at the present institution. At the first follow-up appointment, she attended with her mother and husband. Family members confirmed good acceptance of oral medication and return to professional activities as a photographer.

DISCUSSION

Interpretive delusion refers to false reasoning that starts from a real sensation. From associations of ideas, inductions and affective tendencies, such reasoning assumes an irreducible personal meaning for the subject, to whom everything is related[11]. The described

true paranoia, which includes interpretive delusions in its clinical phenotype, arises from an unfavorable development of a paranoid personality. Delusions are structured from interpretation mechanisms, and subjects may not show bizarre behavioral changes[12].

In the case of Beatriz, it was observed as a process of association and interpretation of delusional ideas that shaped a belief system and intensely affected the daily life of the patient and her family. Despite keeping herself preserved in several psychic functions, such as humor, affection and felt perception, Beatriz had an altered judgment of reality, impacting her pragmatism and prospection, eventually generating risk to herself and her family. Her delirious production emerged from a feminine and maternal universe, mainly.

The concept of family based on the bourgeois nuclear model produces an idealized expectation of family, which often generates frustration and a feeling of inadequacy for people who do not have or do not live with a corresponding family group[13]. Families are socially produced, marked by specific contradictions and conflicts, associated with historical time. It is necessary to deconstruct that idealized model, in order to legitimize other possible family configurations. Understanding that Beatriz's family nucleus was composed mainly of her marital relationship, in addition to her nucleus of origin - mother and brother - an intervention plan was drawn up that legitimized and included such actors, using the relationship and the resignification of roles as strategies. therapies[14].

Welcoming Beatriz's family was a crucial point for the construction of the case, since the family members had potential as partners and care agents. The family can be understood as a basic unit of care, in which the subjects influence each other. Therefore, it is important that mental health professionals identify resources that this group has, both the potential of the context and the vulnerability factors that make it difficult or prevent performance in the care function[15]. The patient's notions of identity and self-esteem were strongly associated with her roles as a woman, mother and wife, and with the meanings she attributed to these roles[16]. Her delusional production positioned her in the dimension of a superior-maternal being, associated with the notion of purity and wholeness. Beatriz believed that all looks, messages, functions were directed at her, as she occupied a purified space of great responsibility.

In general terms, the individual in mental distress often assumes the role of a crystallized representative of the family's symptoms. The family environment can contribute to exacerbate their suffering. The mental health team is faced with the challenge of dealing not only with issues of suffering itself, but also with their dysfunctional family environment[15]. It is important to know about the stories that make up that family, as these can be important bets for the team to produce care that legitimizes the family space as a potentiator of experiences[5,17].

Commonly, the religious theme presents itself in paranoid delusions. The individual, when delusional, produces individual symbols and beliefs, an ideological system of their own, even if such beliefs contest their social fabric. The subject starts to live under such an individual and non-shareable production, that is, not understood or experienced by the community, which can lead to losses in occupational performance and ruptures in their social bonds. In this sense, the work of mental health teams and care institutions is done both in the management of clinical symptoms, based on qualified listening seeking to systematize delusions, and in the role of secretariat, optimizing participation in areas of life, including participation in the community, involvement in meaningful activities and in managing their own life care[18].

As evidenced by the participation of Beatriz's family in the interventions proposed by the team, the family starts to be recognized as a resource in the implementation of community care, in a conception of division of care with public policies and services. It is also understood as a place of identity construction and bonds, through which its presence influences the formulation of public policies based on the announced demands and claims for rights. Welcoming the family in the process of accountability for the person in psychological distress, from educational, psychosocial, restorative and adaptive interventions favors the approach of the subject in crisis[19].

In this research, the integrality of mental health services was evidenced as an issue to be problematized and resolved. Despite the advances and the permanent construction of a network of strong and resolute services, the municipality where Beatriz lives used an exclusive therapeutic strategy for very particular cases, which is hospitalization in a crisis care service in a hospital environment. It is advocated the importance that mental health care is territorialized, as recommended in the current model, and that municipalities are able to offer services to their inhabitants, avoiding not only displacements, but also their impacts on social ties and family members of patients.

CONCLUSION

From the construction of this case, it was possible to demonstrate to the team and the mental health service and to the patient's family the importance of articulating everyone, in harmony, in the elaboration of care. Without the family approach, promoting the responsibility of the members of the nucleus, the interventions of professionals have a great chance of being of little resoluteness.

Care still remains centralized in the health service, not covering the extent of the real life contexts and occupational roles of the patients served. It remains important to point out that

the maintenance of social ties and participation in the community must be included as central proposals.

It is essential to overcome the challenges of institutional routine and bureaucracy to access patients' real-life contexts, since there is no way to help them understand and deal with contradictions without knowing them. The case researched showed that the technical reference and the team chose appropriate strategies when they promoted articulation with the family and the existing network points, including the service in which the user was referred.

The single case report, aligned with the principles of BPR, favors the theoretical production in the field of mental health and increases the clinic in the elaboration and conduct of care strategies, in approaches that prioritize the individual's knowledge and their exercise of citizenship. On the other hand, as it deals with a singular individual, with subjective characteristics and particular social reality, this study presented as its main limitation the impossibility of generalization, which did not compromise its viability and importance.

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