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Perceptions of hospitalized people in psychological distress about their families

Percepções de pessoas em sofrimento psíquico hospitalizadas sobre suas famílias

Percepciones de personas hospitalizadas con trastornos psíquicos sobre sus familias

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Abstract:
Objective: to understand the perceptions of hospitalized people in psychological distress about their families. **Methods:** a qualitative study based on Alfred Schutz's phenomenology as a theoretical and methodological framework. Data were collected through interviews from November 2024 to March 2025 in a Psychiatric Inpatient Unit of a university hospital in the interior of the state of São Paulo, Brazil. Data analysis was conducted with the theoretical framework of social phenomenology**. Results:** the participants were 12 hospitalized people experiencing psychological distress. The reported experiences were organized into two categories: one highlighting the "reasons why," titled "*Perception of the hospitalized person in psychological distress about their family and family relationships*," and another addressing the "reasons for," titled "*Intentionalities of the hospitalized person in psychological distress toward their family*." **Conclusion:** the idea that the family is a source of support and assistance, especially during hospitalization, demonstrates how family functioning is essential for psychological development and treatment support. On the other hand, understanding the family from a non-idealized perspective allows us to understand that conflicts are inevitable for the emergence of uniqueness; however, when these conflicts are intense and persistent, they can contribute to the emergence and worsening of psychological distress.
Keywords: Mental health; Psychological distress; Hospitalization; Family.

Resumo:
Objetivo: compreender as percepções de pessoas em sofrimento psíquico hospitalizadas sobre suas famílias. **Método:** estudo qualitativo com referencial teórico-metodológico da fenomenologia de Alfred Schutz. Os dados foram coletados por meio de entrevistas de novembro de 2024 a março de 2025, em uma Unidade de Internação Psiquiátrica de um hospital universitário do interior paulista. A análise de dados foi realizada a partir do referencial teórico da fenomenologia social. **Resultados:** participaram doze pessoas em sofrimento psíquico hospitalizadas. As experiências relatadas foram organizadas em duas categorias; uma evidenciando os "motivos porque", nomeada: *Percepção da pessoa em sofrimento psíquico hospitalizada sobre sua família e relações familiares*, e outra que remete aos "motivos para", intitulada *Intencionalidades da pessoa em sofrimento psíquico hospitalizada em relação à sua família*. **Conclusão:** a ideia de que a família é fonte de apoio e suporte, especialmente durante a hospitalização, demonstra como a funcionalidade familiar é imprescindível para o desenvolvimento psíquico e para apoio ao tratamento. Por outro lado, entender a família de maneira não idealizada permite compreender que conflitos são inevitáveis para a emersão da singularidade, contudo, quando estes conflitos são intensos e persistentes, podem contribuir para o surgimento e agravamento do sofrimento psíquico.
Palavras chaves: Saúde mental; Angústia psicológica; Hospitalização; Família.

Resumen:
Objetivo: comprender las percepciones de las personas hospitalizadas con trastornos psíquicos sobre sus familias. **Método**: estudio cualitativo con referencia teórico-metodológica de la fenomenología de Alfred Schutz. Los datos se recopilaron mediante entrevistas realizadas entre noviembre de 2024 y marzo de 2025 en una unidad de hospitalización psiquiátrica de un hospital universitario del interior del estado de São Paulo. El análisis de los datos se realizó a partir del marco teórico de la fenomenología social. **Resultados:** participaron doce personas hospitalizadas con trastornos psíquicos. Las experiencias relatadas se organizaron en dos categorías: una que evidenciaba los "motivos por los que", denominada: *Percepción de la persona con trastornos psíquicos hospitalizada sobre su familia y sus relaciones familiares,* y otra que se refiere a los "motivos para", titulada *Intencionalidades de la persona con trastornos psíquicos hospitalizada en relación con su familia.* **Conclusión:** la idea de que la familia es una fuente de apoyo y respaldo, especialmente durante la hospitalización, demuestra cómo la funcionalidad familiar es imprescindible para el desarrollo psíquico y para el apoyo al tratamiento. Por otro lado, entender a la familia de una manera no idealizada permite comprender que los conflictos son inevitables para la emergencia de la singularidad; sin embargo, cuando estos conflictos son intensos y persistentes, pueden contribuir a la aparición y agravamiento del sufrimiento psíquico.
Palabras claves: Salud mental; Distrés psicológico; Hospitalización; Familia.

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INTRODUCTION

The Brazilian Psychiatric Reform (BPR) emerged from a critique of the mental health care subsystem, the private nature of health policies, and classical knowledge about psychiatry. It initiated processes that operate across various dimensions of the country's social and political context, potentially impacting the lives of people with mental illness by seeking to establish a new social context for madness[1-2]. As a result, people who were previously labeled "mad" for not fitting into societal standards are no longer excluded and segregated in mental hospitals[1-2].

The BPR sparks liberation movements from oppressive and confined situations, provides experiences of empowerment and social reintegration, and stimulates cultural transformations toward acceptance of difference[2]. In 2001, Law 10.216, known as the Psychiatric Reform Law, was enacted. This created a favorable outlook for mental health in Brazil, guaranteeing the protection and rights of people with mental illness, including families in treatment, and redirecting the current care model[3-4].

The Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS) was created as an organizational proposal for mental health services, aiming to integrate care through the coordination of territorially based services at the various strategic levels of the Unified Health System (*Sistema Único de Saúde* - SUS)[5]. The hospital component of the RAPS consists of psychiatric beds in general hospitals, day hospitals, and psychiatric hospitals[5].

During hospitalization, family-related issues arise, given that approximately 70% of people with mental illness live with family members who are responsible for their care[6]. It is known that mental symptoms are strongly associated with the family environment, having a direct relationship with number of suicide attempts, severity of symptoms, and number of years of psychological distress[7].

The psychological distress of hospitalized individuals also affects family functioning, mainly due to the need for changes in daily routines, emotional, social, and financial impacts, lack of social support, and conflicts[8]. Given the importance of the family in the rehabilitation process of individuals with mental illness, it is essential that healthcare professionals recognize the particularities of the family environment in mental health care to offer individualized care that involves not only the individual but also their collective and family support network[8].

Family members' perceptions of the hospitalization of individuals in psychological distress are marked by a dialectic of emotions, in which they consider the support of the hospital service to be positive, while the fact of being in a new and unfamiliar place to be negative and distressing[8]. Publications on the perception of hospitalized individuals in psychological distress regarding their families are scarce, which reinforces the social stigma of

exclusion associated with madness. The justification of this study lies in the redirection of mental health based on the RPB, which values the empowerment of people with psychological distress in care, and by the need to consider, in the context of hospitalization, family dynamics as central to the rehabilitative process and psychological symptoms[1-2,7-8]. Therefore, it aims to understand the perceptions of people with psychological distress hospitalized about their families in a Psychiatric Inpatient Unit (UIP) of a university hospital in the interior of the state of São Paulo.

METHODS

This is a qualitative study using the theoretical and methodological framework of Alfred Schutz's phenomenology[9]. This approach aims to understand the meanings of the phenomenon in the person's lifeworld, which is defined as the space in which humans act and interact with each other, living and coexisting naturally[9-10].

The lifeworld is permeated by face-to-face intersubjective relationships, and people are guided regarding their motivations, ways of thinking, and acting in the social environment based on their biographical situation, which aggregates their body of knowledge from their lived experiences[9-10]. The recommendations of the COnsolidated criteria for REporting Qualitative research - COREQ[11] were followed.

Data collection took place in a Psychiatric Inpatient Unit of a university hospital located in the city of Campinas, in the interior of the state of São Paulo, Brazil, from November 2024 to March 2025.

To participate in the study, the inclusion criteria were: being hospitalized in the PIU, not being in an acute phase of a mental disorder, being able to share their perceptions, and having the ability to communicate effectively. The exclusion criteria were: being unable to verbalize due to medication effects or mental disorganization. To select participants, the nurse responsible for the PIU shift referred hospitalized individuals who met the inclusion criteria. There was one refusal to participate.

Phenomenological interviews were used to collect data, which allow the person experiencing the phenomenon to describe it and express the meaning attributed to it[9-10]. These were carried out by the main researcher, who was a nursing student at the time and who underwent training to conduct the interviews. The guiding question was: "*Tell me about your family*." Based on this, other questions were developed to allow participants to delve deeper into the topic.

The interviews were conducted in private spaces within the PIU facilities, recorded digitally, and later transcribed. They lasted, on average, 25 minutes. Data collection concluded when the researcher determined that the phenomenon had been uncovered, their concerns had been addressed, and the study objective had been achieved[12].

To analyze the data with the theoretical framework of social phenomenology, the interviews were first carefully read and reread to understand the overall meaning of the phenomenon[10]. Subsequently, units of meaning were developed, identified through the common meanings of the interviewees' experiences.

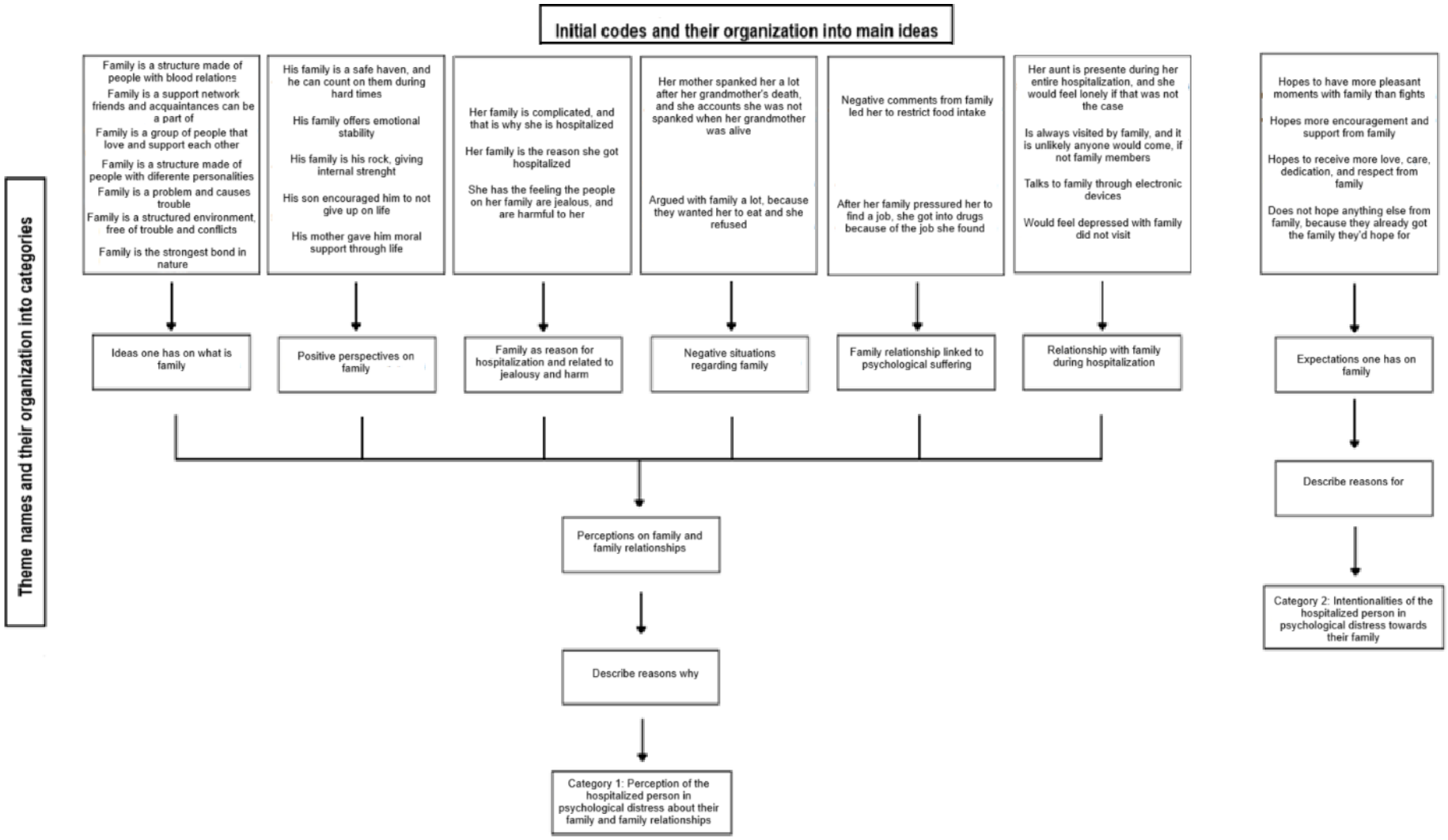
From these, thematic categories were constructed, indicating the "reasons why" and "reasons for" what was experienced, through the synthesis of the meanings of action that emerged from the reported experiences[10]. To discuss the results, a theoretical framework was developed based on social phenomenology and research on the topic[10].

The research was approved by the Research Ethics Committee of the Universidade Estadual de Campinas, in compliance with the ethical principles outlined in Resolution No. 466/12, which regulates research involving human subjects, under opinion No. 4,403,089. Individuals who agreed to participate in the study signed the Informed Consent Form. To ensure anonymity, participants were identified by the letter I, for interviewee, followed by an Arabic number.

RESULTS

Twelve people hospitalized with mental distress participated in this study. Based on the "we" relationship, the reported experiences were organized into two categories, one highlighting the "reasons why," titled: *Perception of the hospitalized person in psychological distress about their family and family relationships*, and another addressing the participants' "reasons for," titled: *Intentionalities of the hospitalized person in psychological distress towards their family*. Figure 1 presents the construction of the units of meaning and categories.

Figure 1. Perceptions of hospitalized people in psychological distress on family. Campinas/SP, Brazil, 2025.



Perception of the hospitalized person in psychological distress about their family and family relationships

Participants described what they consider to be family structure, consisting of people who are blood-related, such as father, mother, and distant relatives, and also those who make up a support network, such as friends and acquaintances:

My father, my mother, my ex-wife, my son, my siblings too. Family is everyone involved in daily life. (I10)

I think family isn't just blood, just father, brother, and mother. People who don't have a blood related family often look for family in friends and acquaintances. So I think it's important for everyone to have a family, whether blood related or not, to have that support network. (I1)

The idea of family was also seen as a group of people who love each other and try their best. Participants used symbolism to describe how mutual support among family members makes them strong, unbreakable, and difficult to tear down, as they see family as the root of everything:

Family is everything. Family is a group of people who love each other, who are there to give their best to each other. (I5)

A tree branch breaks easily, but if you add two branches, it's harder to break. You have to break it with your knee. Now, if you add three branches, it won't break even if you put four branches, and it's really stiff. So, that would be a family. If the father helps the son, the sister, and the mother, the four of them are a hell of a branch, no one can break it. (I6)

For me, family is the root of everything, the strongest bond in nature. Every family with roots is difficult to tear down. You can cut the leaves off trees, but if you don't cut the roots, they won't die. (I12)

They cited positive perspectives regarding family, which is seen as a safe haven and "an extra foot in the door," where family members are present in difficult times to keep the person stable and as a foundation that provides inner strength:

I see my family as my safe haven, where I can count on them in difficult times. (I4)

My family is like an extra foot to keep me stable. (I8)

It's my world, my rock, my foundation, it's what keeps me from falling. When I'm on the ground, I remember I'm part of something much bigger. It gives me an inner strength that I can't put into words, it's so good to be part of it. (I9)

Family support was frequently cited at key moments throughout these people's lives, with some phrases spoken by family members helping them choose to not take their own lives and giving them a sense of morale:

He never let go of me. I hugged him often, saying, "Today I'm going to kill myself," I hugged him and cried without him realizing, I imagined, "Today I'm going to end my life." But he said, "Dad, take care of yourself." His message was beautiful, "Dad, take care of yourself." (I3)

My mother always encouraged me throughout my life. Whenever I did something and got it right, I would be happy and say, "I'm the best." And my mother would cheer along, saying, "That's right, you're the best, that's why you're my son," and laugh, saying I was the best because I was part of her genetics. So that gave me confidence. (I6)

During hospitalization, family members interacted with them through visits or mobile phone calls, when authorized by the healthcare team. These moments were viewed positively, as the absence of family members is associated with feelings of loneliness and depression:

I'm almost never away from her, only sometimes here when she goes to buy lunch, that's when we're most distant, but other than that she's always here with me. [...] *And then I feel empty because I have no one to talk to, no one to speak to.* (I4)

I depend heavily on my family. They even come to visit me often. If it weren't for someone from my family coming to visit me here, I doubt anyone else would come. (I8)

If she can't come one day, it's no problem, because since I have my phone, they gave me access to mine, so I end up talking to them every day. [...] *At least these two days she came, today she's coming too.* (I11)

Depressed, huh? Imagine you in my shoes. And the visit goes by so quickly... (I3)

On the other hand, they reported that within the family context, there are people with different personalities and behaviors, which directly influences the family's overall structure. Furthermore, they recognized that a structured family is one free of problems and conflicts, but they acknowledge that such a family does not exist:

There are pleasant, welcoming family members, but there are also more hostile, prejudiced, and exclusionary family members. [...] *Because each person has a different personality and behavior, this will influence and directly change how your family is as a whole.* (I7)

Family is a problem; it creates problems and difficulties. [...] *There are often conflicts, financial interests, and a series of things that involve the family concept that can disrupt it.* [...] *Any kind of situation can disrupt a family. So, for me, a structured family is one that doesn't have any of these problems. But that doesn't exist for me.* (I10)

They also identified family fights and episodes of violence as situations that have a negative impact on family relationships, which can generate feelings such as anger and revolt:

My family's relationship got much worse at that time, we fought all the time because they wanted me to eat, and I didn't want to eat, so we argued and it was a bad time. (I1)

After my grandmother died, I was spanked a lot; my mother beat me a lot. And I became angry, rebellious. I said, "But man, when my grandmother was alive, no one hit me." (I12)

Sometimes, they associated family with the reason for hospitalization and, also through symbolism, this was related to envy and feelings of destruction:

My family is very complicated, that's why I'm here [laughs]. (I2)

My family has a lot of issues. That's why I'm in the hospital. (I12)

My family [...] *seems like everyone is jealous and it gives me this feeling. I'm running, and then just as I'm about to hand over the baton, someone kicks me in the back, so I have to run away, and just as I'm coming back, someone else comes and kicks me in the chest, so I have to pick up the baton, then my mother arrives, I have to push my mother, then I elbow my sister in the face, I run away, my father arrives, pushes my father aside, I get there at the end, I throw the baton on the ground, I said "I won, congratulations to me", because my own family destroys me.* (I6)

Family relationships were associated with the psychological distress of hospitalized individuals, such as when family comments led to a participant restricting her diet or when family pressure for a person to study and work led to drug use:

I used to hear comments like, "You have to stop eating junk food," because I always ate a lot of junk food, so "You have to stop eating sweets, because now you're turning into a teenager, your metabolism won't be as fast and you'll end up gaining weight." I heard this from my family, from my mother, grandmother, from everyone. [...] *And I still remember when I started to restrict certain foods.* (I1)

When I turned 18, my father left me more alone, more abandoned, to fend for myself. Then he said, "Go study, find a scholarship," "Go work, earn your own money." He didn't say it like that, but he pressured me, my whole family pressured me, so I had to leave my bubble and go to various places with people I didn't know to work, until I ended up at the kiosk, and at the kiosk, I fell into drugs. (I7)

Intentionalities of the hospitalized person in psychological distress towards their family

Participants expect to receive love, affection, dedication, respect, and encouragement from their family, in order to support and unite each other:

I hope to receive the greatest love and affection from my family, the greatest dedication, the greatest respect. (I5)

What would I expect my family to be like? I think more encouraging, more supportive... More supportive, really. (I7)

In some cases, they understand that family isn't perfect and that there will be arguments, but they recognize that family members meet their expectations and don't expect anything different. They mention positive and harmonious moments with family members, as well as actions that contribute to gaining autonomy:

I hope for a family like the one I have now. For example, I went on leave on Sunday and spent time with my family. I went to Mass with them. Then in the afternoon, we went to the pool, listened to some music, and talked. It was a really great time. Everyone enjoyed it, my mom, my dad, and me. There was harmony. But I understand that families aren't

perfect like in TV commercials. There will be times when things aren't going well and there will be fights. But I expect there to be more good times than fights. (I1)

I don't know what I expect from my family, because I'm already fine with my family the way it is, so I can't think of anything to change it. (I4)

I think my expectations of my family, they've already met them. Because, like my mother, she furnished a house for me [...] *Regardless of circumstances or anything, I'll have more autonomy for myself, right. Because before I didn't have that, because I lived in her and my father's house, right. And now I'll have more autonomy. So, what I expected of my family, they've already done.* (I10)

DISCUSSION

The results of this research allowed us to categorize the interviewees' experiences with their families, based on their hospitalization experiences and in-person relationships in the world[9].

Participants argue that the family structure is composed of people related by blood, as well as friends and acquaintances. The concept of family can be defined objectively through legislation that provides social and legal recognition, and/or through biological connection[13]. The definition of family is changeable and influenced by multiple factors, such as historical, cultural, social, and temporal contexts[14-15].

Therefore, defining a family structure today is challenging. It can be considered a social unit consisting of two people who consider themselves family, formed by different arrangements, with the presence of mutual feelings of emotional attachment, forming a support network with similar interests. It can be composed of spouses with or without children, grandparents, siblings, a group of friends, neighbors, among other diverse possibilities[13-17]. Each person's experiences constitute their body of knowledge, a fundamental aspect of their life biography and the organization of social and family relationships[9].

Regarding the interviewees' positive perceptions of their families, they argue that they are made up of people who love, support, and strengthen each other, providing a foundation and safe haven, especially in difficult times. Relationships between people occur in face-to-face encounters, moments with others that allow for intersubjective exchanges in the life-world that constitute the body of knowledge[9].

The family is the first contact with the world, being the stage for initial experiences, which are extremely important for the development of physical, mental, emotional, and interpersonal capacities. They also impact personality, behavior, values, social adaptability, emotions, feelings, and ways of thinking, resulting in the structuring of subjectivity[17-19]. The

family should also be a provider of care and of a safe, affectionate, and respectful environment[15,17].

A healthy family functioning is based on quality interactions, dialogue, understanding, harmony, commitment, communication, expression of feelings, positive emotional exchanges, problem-solving ability, and emotional support[17,20]. Furthermore, aspects attributed to good family functioning can be described as people's social actions in the world, characterized by individual motivations; that is, what drives them to achieve family balance and directly influences established subjective relationships[9].

Sufficiently good characteristics in the family context are necessary for healthy psychological development, and to achieve this, it is necessary to consider the quality of family relationships[17,21]. These impact each member and are intrinsically related to family-emotional closeness, in which support and mutual acceptance facilitate the expression of emotions, enabling emotional companionship, resilience, and a sense of security in facing difficulties[13,22].

Face-to-face relationships, which allow one to be aware of the other in this encounter, are a form of interaction that allows for understanding intersubjectivity and the emotions of others, leading to the construction of meanings in the life-world[9]. Healthy family relationships provide the possibility for the emergence of self-esteem, autonomy, independence, and healthy relationships. They also provide the store of knowledge that enables individuals to face the problems that will arise throughout life through adaptive and functional behaviors[9,17,21].

Good family functioning, based on positive family relationships, is an important resource for the mental health of its members[13]. One of the most important factors in the quality of life of people experiencing psychological distress is the presence of social support, which refers to the resources obtained from support networks, especially family, to cope with stressful situations[23].

The coexistence of people in the social sphere demonstrates that individual actions influence their life histories, as the life-world is shaped by social interactions[9]. Family ties can directly and positively impact emotional development, contributing to the prevention and recovery of biopsychosocial health, in addition to reducing the chances of involvement in situations that generate further psychological distress[24].

This way of thinking about family may be related to contemporary family reconfiguration, in which family relationship dynamics are less hierarchical and roles are more flexible[15]. On the other hand, the idea of maintaining an intact family legacy is also evident, even if relationships are unhealthy[15].

In the specific context of hospitalization, participants also identified positive aspects of the presence of family members, such as not feeling alone or depressed. Family involvement in psychiatric treatment can positively impact the outcome of hospitalization, with effects on recovery, which is driven by support networks that contribute to better health outcomes, greater therapeutic adherence, and reduced relapses, hospitalization, and mortality rates[20,25-27].

The experience of hospitalization becomes an important record in the life biography, as it involves new experiences that become a store of knowledge for actions in the life-world[9]. Given the importance of the individual's participation in therapeutic decisions, family involvement is considered valuable and patient-centered. Psychiatric professionals are satisfied with mental health services that encourage family inclusion in treatment[16].

However, it is important to consider that caring for a person with mental illness can also cause symptoms of distress for family members, especially those associated with feeling overwhelming, depression, and anxiety, which can affect family functioning[20,26]. Therefore, healthcare professionals, especially during hospitalizations, must consider family relationships and those who make up the person's support network, involving them in the care[25].

Families of people with mental illness often do not feel prepared or lack the skills to provide the necessary care and, therefore, require help to sustain their roles as caregivers[16]. In the life-world, the experience of mental illness permeates existing relationships, as the need for care is shared in the encounter with another family member, which impacts the meanings attributed to individual experiences, creating expectations of action as a response to the encounter with the other[9].

Professionals should offer support and strategies to family members or caregivers, such as providing easy-to-understand reading material, information about the mental disorder and available resources, professional opinions, and guidance on skills for coping with the role of caregiver, in addition to identifying and highlighting strengths[16,20,27].

They can also encourage family members to listen to each other's concerns and feelings, as well as build support networks among people experiencing similar situations, as valuable strategies to help cope with the emotions triggered by psychological distress and reframe the mental disorder[16,20,27].

One possible assistance option is family-centered care, a service approach that emphasizes a therapeutic alliance with family members to recognize their roles in care, strengthening their functioning[20]. In Brazil, the Family Health Strategy is a strategic point of the RAPS, through which mental health care finds opportunities for support and the development

of interventions based on comprehensive health care[18]. This form of care as a social action, considering the family, can reduce the risk of illness of its members, strengthening family members as a unit[9,18,20].

On the other hand, participants also identified that there is no family without problems and conflicts, associating them with the reason for hospitalization, psychological distress, and negative feelings. This is because the family is permeated by a shared social meaning in the life-world, that is, it is integrated into the culture and social group to which it belongs, having its own identity and positive and negative characteristics[9,15].

Parenthood, early life experiences, and family functioning as a whole can have lasting impacts on each person's mental health and life history, given that the family is considered a place for the construction of individuals[9,13,17].

Poor family relationships can be marked by negative communication, daily problems, marital disputes, criticism, hostility, excessive emotional involvement, unstable employment, rigidity, frequent changes in family dynamics, insensitivity, rejection, excessive demands, incongruence, unpredictable behavior, corporal punishment, and, most importantly, conflict[17,19-21]. When these characteristics are present in childhood and adolescence, they can be reflected in adulthood, considering that a person's development is a product of the interaction between their characteristics and those of those around them[17].

Mental disorders, such as depression, anxiety, and alcohol abuse, are directly related to the family environment[19]. Therefore, the intersubjective space of family relationships is formed from the actions of each person in their encounters with others. The meaning of an action is only revealed after its completion, demonstrating the impact of negative attitudes on the mental health of people in such environments[9].

The presence of conflicts in the family environment results in the accumulation of stressors and constitutes a risk factor for the development or worsening of emotional, psychological, cognitive, social, and behavioral issues[17,19-21].

As a result of recurring conflicts, family members may become distant and fail to communicate and express their feelings, which can lead to further conflicts and difficulties with emotional regulation and psychosocial development[17,19-21]. Often, people living in a conflict-ridden environment may feel guilty about the events or even abandoned, which can compromise their relational and social skills, in addition to allowing feelings of worthlessness, dissatisfaction, and insignificance to emerge[17,20-21].

When a conflict is not properly addressed, transforming it into an opportunity to improve family relationships, it can cause irreparable damage to one's life history[9,21]. This

results in a family environment lacking in safety, responsibility, and entertainment, riddled with conflict, difficulty obtaining support, and a lack of emotional expression, which can exacerbate mental health issues[19].

Family members sometimes use verbal pressure strategies and contingency agreements, popularly known as "setting limits," generally motivated by increased medication adherence and the prevention of problematic behaviors. These practices have been associated with conflict and family violence, and often precede aggression[25]. It is necessary to understand people's motivations, as intersubjective relationships involve an encounter with one another, sharing knowledge built on lived experiences. Each action can have a significant impact on the life-world of those within this family environment[9].

The presence of severe and persistent mental disorders can negatively impact the perception of family functioning among people with mental illness, especially in psychotic conditions[20]. However, the presence of mental illness is not necessarily associated with negative family dynamics, given that severe mental disorders also occur in people with positive family dynamics, even with the presence of aspects such as gratification in caregiving and closeness in interpersonal relationships[25].

Family resilience, which concerns the family's ability to successfully cope with crisis situations, such as the exacerbation of mental illness during hospitalization, is an important action to overcome conflict situations[28]. In resilience, family interactions are used to establish connections between members and improve the integration of resources to cope with adversity[28].

Participants expect feelings of love, respect, encouragement, and autonomy from their family in their life-world, which encourages them to unite, or they claim that their family members already fulfill what is expected. This finding corroborates the idealized conception of family, in which family relationships are expected to be healthy and provide a safe and affectionate environment, based on communication and support, which represents an action projected into the future, as a starting point for acting in the world, disregarding that the family context is a place of stable and typical complexes, permeated by conflicts and contradictions that permeate everyday life and enable the emergence of a unique person[9,15,17-18,20].

CONCLUSION

The perception of hospitalized individuals in psychological distress regarding their family and family relationships encompasses both positive and negative aspects. The former relate to the idea that family is a source of support, especially during acute moments of mental

illness, such as hospitalization, demonstrating how healthy family functioning is essential for mental development and favorable treatment outcomes.

The negative aspects highlighted the presence of conflicts in the family environment, associating them with the cause of mental illness and the reason for hospitalization. These aspects contribute to a non-idealized view of the family, with conflicts being inevitable for the emergence of uniqueness, although, when intense and persistent, they can contribute to the onset and worsening of mental illness.

The limitations of the study lie in the context in which it was conducted within a single mental health facility and from the perspective of a specific group of individuals. Therefore, it is timely to develop future research that investigates this topic in other RAPS care settings and the perceptions of other stakeholders, such as family members. Despite this, it is worth noting that giving a voice to people experiencing mental distress is a differentiator, given that they have historically been stigmatized, and their perceptions are rarely considered, in this case, in publications.

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