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Original Article

Adolescents, mental health and crisis: the story told by relatives[1]

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Abstract: Introduction: Several studies indicate that adolescents are more vulnerable to the development of mental health problems. However, there is a lack of researches on the experience of psychic suffering and attention to mental health for adolescents and their families, including the experience of the mental health crisis. Objective: The objective of this study was to identify the understanding of family members of adolescents of a Center for Psychosocial Child and Adolescent Care (*CAPSij*) about the crisis situations experienced by adolescents and the trajectory covered in the search for care. Method: Five family members of adolescents linked to a *CAPSij* interviewed gave open interviews based on oral history, whose products were later worked through thematic analysis. Results: The results indicate that the experience of the adolescent crisis causes feelings of fear, perplexity and guilt to the family. However, this experience is also pointed out as a reason for greater bonding between them. There were reports that relate the adolescent's crisis to the experience of family adversities and, besides, although they indicate the absence of psychiatric hospitalizations in the care process, they reveal difficulties in the exchanges with professionals and services, which could facilitate the understanding of the situation, even though they recognize their support in critical moments as positive. Conclusion: The study contributes presenting the crisis understanding by the voice of the relatives of adolescents, and it also identifies the perceptions of care experience in the services, reinforcing the family importance in the attention to the mental health of adolescents.

Keywords: *Mental Health, Adolescent, Family.*

Adolescências, saúde mental e crise: a história contada por familiares[1]

Resumo: Introdução: Estudos apontam que adolescentes têm apresentado maior vulnerabilidade para o desenvolvimento de problemas relacionados à saúde mental. Observa-se, no entanto, uma escassez de pesquisas que tratam da experiência do sofrimento psíquico nessa população, bem como da atenção à saúde mental direcionada aos adolescentes e seus familiares, incluindo a vivência da crise. Objetivo: O objetivo do estudo foi identificar a compreensão de familiares de adolescentes usuários de um Centro de Atenção Psicossocial Infantojuvenil (CAPSij) sobre as situações de crise vivenciadas pelos adolescentes e sobre a trajetória percorrida em busca de cuidados. Método: Participaram cinco familiares de adolescentes vinculados a um CAPSij, que concederam entrevistas abertas com base no método de história oral, cujos produtos foram posteriormente trabalhados por meio de análise temática. Resultados: Os resultados indicam que a vivência da crise do adolescente faz emergir sentimentos de medo, perplexidade e culpa nos familiares. Entretanto, tal experiência também é apontada como motivo de maior vínculo entre ambos. Observou-se relatos que relacionam a crise do adolescente à vivência de adversidades familiares e, além disso, embora indiquem a ausência de internações psiquiátricas no processo de cuidado, revelam dificuldades nas trocas com os profissionais e serviços, que facilitem a compreensão da situação, ainda que reconheçam como positivo o apoio dos mesmos nos momentos críticos. Conclusão: O estudo contribui apresentando a compreensão da crise pela voz dos familiares de adolescentes e identifica as percepções da experiência de cuidado nos serviços, reforçando a importância do lugar da família na atenção à saúde mental de adolescentes.

Palavras-chave: *Saúde Mental, Adolescência, Família.*

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1 Introduction

The World Health Organization (WORLD, 2014) divides the period of early adolescence in initial phase, from 10 to 14 years and final phase, from 15 to 19 years. However, in the intention to analyze this period beyond the ages matched by the biological transformations present, authors such as Freitas (2005) and Moreira et. Al (2011) argue that the concept of adolescence changes, accompanying the transformations of society, from an interaction between the maturation in the structure of thought and in the ways in which the person understands their social context and the pressures and expectations arising from the context. Thus, the understandings, expectations and meanings attributed by society to the different possible realities support the subjects' constitution, making possible to experience several adolescences, in the plural (MOREIRA et al., 2011).

In view of the complexity of adolescence, some studies have signaled that this is a vulnerable period for the development of problems related to mental health (SILVA et al., 2018; MOREIRA et al., 2011). The data published in the *Prevención de la Conducta suicida* (ORGANIZACIÓN, 2016) by the Pan American Health Organization/PAHO in partnership with the WHO, indicate suicide as the second cause of death among young people from 15 to 19 years old worldwide which reinforce this understanding. They draw attention to the growth of this index over the past few years and point out suicide because of experiencing intense psychic suffering, especially depression.

Thus, the development of strategies for promoting and caring for mental health in adolescences is relevant and urgent (FERNANDES; MATSUKURA, 2015; GALHARDI; MATSUKURA, 2018). However, the interest in deepening issues related to child-juvenile mental health is relatively recent, so that studies addressing the experience of psychic suffering in this population. Although they have had a growth after the Statute of the Child and Adolescent (ECA) and the Centers for Psychosocial Care for Children (*CAPSij*), are still incipient, especially considering the adolescent population (GALHARDI; MATSUKURA, 2018).

Moreover, it is worth noting that studies related to mental health involving adolescents, may tend to be based on psychiatric symptomatology and individualizing care strategies, without taking into account the complexity of social phenomena, variables that configure the different expressions of adolescence in contemporaneity (TAÑO, 2017; VICENTIN; GRAMKOV, 2010).

In this sense, the possibility of experiencing the crisis as a complex existential situation (DELL'ACQUA; MEZZINA, 2005; FERIGATO et al., 2007) that can be triggered by the experience of psychic suffering in adolescence, demands for policies and services directed to the child-juvenile public, to develop strategies that can expand the possibilities of approaching this population and make the interventions earlier (DELL'ACQUA; MEZZINA, 2005).

Ferigato et al. (2010), reflecting on the crisis in the context of mental health, indicate that this experience is related to daily intercurrences and the way in which each individual deals with them, affecting the routine and social participation of those who are suffering Psychic, as well as the people of his conviviality.

For Jardim and Dimenstein (2007), the crisis is an urgency when it directly affects the routine of those who experience it and their family, so culture and moral values come into play to configure a psychiatric emergency, and the moment of crisis determines the demands and interventions in mental health services.

Some national and international studies have focused on the processes of experience and attention to the mental health crisis of adolescents, noting the prevalence of psychiatric hospitalizations as a priority intervention in these contexts, as well as difficulties in implementing community and territorial alternatives. In addition, such studies point to the scarce research that focus on the experience of the crisis during adolescence, considering their own voices and specificities (LAMB, 2009; PEREIRA, 2013; BRAGA; D'OLIVEIRA, 2015).

Another point raised refers to the impact, often devastating, that experiencing the crisis related to the experience of psychic suffering in adolescence generates in the family context what, in turn, demands actions of care services. However, there are also gaps that indicate the need for further studies and productions that consider the participation of families to produce data on the mental health of adolescents. They may include the understanding of these actors about the experience of psychological distress and the crisis, as well as on the care process offered in mental health services (TANSKANEN et al., 2011; BRAGA; D'OLIVEIRA, 2015).

In this perspective, occupational therapy, as a profession and a field of knowledge, with mental health as one of its contexts of intervention and study, has the potential to mediate the reinvention of the person in intense psychic suffering daily life, including the experience of the crisis, understanding

the individual through his history, subjectivity, social context, expressiveness and communicability. Expanding the possibilities of intervention, insofar as "human doing" potentiates rehabilitation, it will contribute to the care process, as well as producing new ways of thinking and exercising the profession in this context (COSTA; ALMEIDA; ASSIS, 2015; CONSTANTINIDES; CUNHA, 2016).

Furthermore, focusing on the crisis situation, Kawashima (2013) points out that occupational therapy can develop strategies that assist the interdisciplinary team with the demands of the subjects who are experiencing the crisis in the context of mental health, favoring care in understanding the complexity, singularity and daily life, including family.

Thus, even though occupational therapy is not the focus of this paper, we believe that is important to carry out studies in this field that try to understand realities crossed by the crisis in the sphere of mental health from the perspective of the actors who experience the process. It may contribute to broaden and provide care more effectively, produce new ways of looking to and dealing with this reality.

In view of the above, the present study aimed to identify the comprehension of family members of adolescent users of a Center for Psychosocial Child and Adolescent Care (*CAPSij*) about the crises experienced by adolescents and on the process of looking for care.

2 Method

The study is a qualitative research that adopted the methodology of oral history to meet the objectives proposed.

The planning for access to the histories considered elements of the thematic oral history (MEIHY; HOLANDA, 2015), as it focused on the apprehension of a specific experience of participants and characteristics of oral life history (MEIHY; HOLANDA, 2015). We favored narratives that brought data from the personal histories involved, as experiences that culminated with the event in question and the arrival of adolescents to *CAPSij*.

The research project was submitted and approved by the *Secretaria Municipal de Saúde* of the city involved and by the Ethics Committee on Human Research of the *Universidade Federal de São Carlos*, with process number 2.030.75. All participants signed a free consent form and a letter of assignment, to validate and allow the use and publication of the texts produced.

Five relatives participated in the study as responsible for adolescents linked to CAPSij of a medium-sized city in the countryside of São Paulo state, who experienced at least one crisis related to the experience of psychic suffering. We should note that the selection of participants follows suggestions of the care service professionals, considering they know the possibilities the adolescents have to participate.

Table 1 presents the general characteristics of the participants. For ethical reasons, we adopted fictitious names.

We can verify from the table, that the group of participants consists of three mothers, one grandfather and one grandmother. The adolescents were 16 and 17 years old, and two of them periods of crisis coincide with the initiation of treatment in *CAPSij*, two others were undergoing treatment when they experienced the last crisis, and one girl started the treatment one month after the crisis.

The collection of the stories occurred during the months of April and May of 2017, through a meeting with each participant at their homes or in the *CAPSij*. The interviews had an open script based on the objectives of the present study.

Table 1. Characteristics of participants.

Participant	Relationship with the adolescent	Age	Schooling	Focus teenager age	Link Time with *CAPSij*	How long has teenager experienced the last crisis
Karen	Mother	32	Full High School	17	4 years	1 month
Keila	Mother	35	Incomplete higher education	17	3 months	3 months
Alessandra	Mother	43	Full High School	17	3 months	4 months
Donato	Grandfather	56	Incomplete elementary school	16	1 year	1 years
Joana	Grandmother	59	Incomplete higher education	17	4 years	1 month

The interviews recorded, transcribed in full, textualized, were treated in a process called transcreation, used to convey more reliably the meanings and intentions of the speeches based on the perceptions of the interviewer (MEIHY; HOLANDA, 2015). We subsequently presented the texts produced to each participant to read them, propose changes and authorize the use of the stories.

Data analysis follow a careful and exhaustive reading of the textualizations by the researchers involved, in order to search common thematic that could emerge from the stories related in the speeches (BARDIN, 2009).

3 Results and Discussion

The process of analyzing the contents covered in the stories told by the relatives allowed the identification of three main themes: a) The crisis as potential transformer of the relationship with the adolescent; b) The family and their relational contexts in understanding the crisis; c) The crisis care.

3.1 The crisis as transformative potential in the relationship with the adolescent

The relatives, when they related the crises experienced by the adolescents, reported that they carried out intense episodes of self and hetero aggression, suicide attempts and expressed feelings of devalue, demotivation, panic, in addition to delusional thoughts and hallucinations. Those situations ended up searching for help in health services.

In the face of such events, the participants of the present study reveal that they experienced feelings of surprise, perplexity, sadness, guilt, concern, fear, doubt and highlight the transformation produced in their relationship with the adolescents after this situation, to the extent that they perceive themselves to be affectively closer to them. The following are excerpts from two stories illustrating some of these results:

> *His first crisis was a surprise, it caught us in feart! When we realized it had already happened* [...] *I came home and he had taken a lot of medicine. He was drowsy, sleeping a lot. He didn't say anything, but I saw the blue saliva on the bathroom sink, due to a urine infection remedy he had. We rushed to the hospital* [...] *Then, after that he started talking about wanting to die, that he wanted to die... Because until then I didn't realize anything* [...] *Then it was over, and he was good for a while. But now, at the beginning of the year, there was a new crisis.* [...] *I came home and found a glass of rat poison under his bed table. He wasn't home, so I dug in his stuff and found a farewell letter. Then I called him, but he wouldn't answer. I got nervous, I started crying. He later phoned, saying he was at a friend's house. When he arrived, he went to his room. He just cried. I laid him on my lap, he didn't want to, he tried to resist, because we're not that much of a contact* [...] *But he ended up lying down* [...] *Now I'm always watching!* (Karen, mother).

> *One day he arrived at the professionalizing institution he goes very upset, saying that he had stayed in front of the cars on the avenue. They called me urgently and said they were forwarding him to go to the CAPS. I had realized that he was even more aggressive and explosive. There was an episode that he started attack me, with words; he said things I didn't even imagine. It was too heavy. He was in such an absurd way that I was shocked. I've had a bad time because of this situation. He defines this episode as an outbreak* [...] *That same week he walked in front of the cars on the boulevard. At the same time, he began to say that he was hearing things in his head, and that sometimes he did things without understanding the reason* [...] *Once he got so nervous, he broke his own hand punching a pole.* [...] *Nowadays, after these situations, we talked about everything. Now he's putting me as if I were a pillar, so we're talking a lot more than before. He calls when he's in school, complains if I don't pick him up, if I don't pay attention* (Keila, mother).

Among the results presented in this theme, we highlight the suicide, evident in the stories told and in the current discussion about public policies directed to the young population, considering that, globally, the suicide of young people 15 to 29 is the second cause of death among this population. In this context, we know that for each committed suicide, there are countless attempts not recorded in epidemiological studies (ORGANIZACIÓN, 2016).

The literature around adolescence has been signaling depression as the clinical condition most commonly linked to suicide, pointing out, as risk factors related to its causality: the experience of violence, precarious family support, contemporary culture expressions and psychic changes inherent to this phase of life (BRAGA; DELL'AGLIO, 2013; BENETTI et al., 2007).

Such notes, and the results of the present study, reinforce the urgent need to implement effective public policies to promote mental health and prevent suicide in the adolescent population.

Taking into account that the crisis experience affects the individual and collective spheres (FERIGATO et al., 2007), from the results, we could verify, also, the extension of the suffering experienced by the adolescent to the life of the participating relatives. This finding resembles what Moura (2018) found when investigating the demands and daily life of the families of adolescents experiencing crisis.

On the other hand, the stories also address the moment of the crisis have the power to provide an opportunity to modify the relations between adolescents and relatives and how these are established, of reconstruction (DELL'ACQUA; MEZZINA, 2005; FERIGATO et al., 2007), revealed by the discourses that discuss dialogue increase, as well as affection and attention dispensed to adolescents.

These findings strengthen the understanding about the essential place of the family in the mental health care process of adolescents both as an active participant and as a focus of care actions. Looking together to develop strategies that, in addition to foster, can broaden the tools for strengthening and coping with the situation (MOURA, 2018). Thus agreeing with the notes coming from some studies that have focused on the processes of occupational therapy care in the field of mental health (CONSTANTINIDES; CUNHA, 2016; COSTA; ALMEIDA; ASSIS, 2015).

3.2 The family and their relational contexts in understanding the crisis

The family narratives presented elements related to the life histories of adolescents and their families, highlighting characteristics and events that could relate to the adolescent's psychic distress and, consequently, contributed to the manifestation of crises.

We addressed situations of violence experienced by adolescents, constant ruptures in their relationships with family members throughout their lives and situations of psychic illness of relatives, as illustrated in the excerpts of the stories above:

> *He lived with his grandmother before he came here, in another town. One day she went away and he ended up alone there, because his mother had traveled too. Then he phoned here, his grandmother, and she passed me the problem. So I got the ticket money for her to go and get him and bring him to live here with me. I'm his mother's father* [...] *At the beginning of last year he came here. Before that I don't know, because he lived with his grandmother more, and stayed with his mother. I guess that's why he started having trouble, sometimes he was one, sometimes with another, so I couldn't keep up. We were a little distant. My ex-wife told me that his mother also had these mind problems* [...] *Today I could say that this disease is complicated* [...] *And if the parents don't care, if they leave their children at ease, it's complicated to be able to keep up* [...] *Not knowing what's going on, if they're taking their medicine* [...] *That's complicated, too. Some time ago, he came to tell me that sometimes he wants to live with his father, and I was worried because of it, because his father until today never bothered to give things to him, he was never a present father* (Donato, grandfather).

> *His picture I think was caused by several reasons. His gestation that was completely disturbed, my immaturity when he was born, then came the divorce, he stayed with his father from six to fourteen years old, his experience with his stepmother and my distance, the fact that we live far away. In his head all this sounded like neglecting* [...] *And there's his father who was also young when he was born. He's always been very strict with him. If he had any normal tantrum, he'd beat him up* [...] *He didn't tell anyone he was suffering at his father's house* [...] *He spent every vacation of the year with me. One of the times, when he came to a tricky point, he said he didn't want to come back, that he couldn't stay with his father, and he told me a few things. That's when I request to reverse the custody* (Keila, mother).

Experiences of intra family violence, constant ruptures in family relationships during development processes and problems related to parents mental health are considered risk factors for the mental health of children and adolescents (SILVA; CID; MATSUKURA, 2018), which the participants of the present study seem to recognize.

However, according to Carvalho and Costa (2008), faced with the experience of intense psychic suffering of one of its adolescent members, families often face feelings of impotence and guilt. In addition, the fact that family members are not always welcomed in their demands and anxieties regarding the experience of suffering and/or crisis in mental health (CARVALHO; COSTA, 2008), which makes the situation potentially generating more suffering.

On the other hand, the possibility of looking at their own history and the process of the adolescent in the family system may have caused to emerge difficult feelings. However, it also seems to have made them reflect on the history and the possibility of building a future, from then on, in a process of

co-responsibility for their own and the adolescent suffering.

On this, when defending that the clinic of attention to the child and the adolescent should be given in an enlarged way, Vicentin (2006), points out about the fact that children and adolescents with their conflicts and sufferings, reach the entire social field, presenting challenges and questioning adult ideals, involving them. In this way, their conflicts expand to families and institutions, calling the adult world to analyze and permanently evaluate their positioning.

Thus, we agree with the author and understand the importance of welcoming the relatives of adolescents in intense psychological distress and/or in crises in their demands, from an effective listening. It can trigger a movement of more active and effective co-responsibility in the care process, insofar as the transformative potential that such situations carry (FERIGATO et al., 2007) may be towards the production of healthier relationships in the family context and in the mental health care dynamics.

3.3 The crisis care

The family members tell about the course in the health services, during the adolescents' crisis, which obey, according to what four of the participants report, to the circuit *UPA – CAPS III – CAPSij*. One of them was instructed to seek the *CAPSij* in the basic health unit.

On this, it is worth considering the fact that none of the five adolescents were admitted to psychiatric hospitals, which may indicate that, in this medium-sized city in the countryside of São Paulo state, there is are different points of the psychosocial care network and some articulation in terms of the flow of demands for strategic attention. This finding goes against what has been found in some studies focused on adolescent crisis care (JARDIM; DIMENSTEIN, 2007; LAMB, 2009; PEREIRA, 2013; BRAGA; D'OLIVEIRA, 2015), which pointed the practice of hospitalization in psychiatric hospitals as predominant, signaling a challenge for integral care in adolescent mental health and demanding investigations on good practices.

The participants also reported the care processes experienced by them and the adolescents. Through the textualizations, we could verify the reduced number of medical consultations and the absence of exchanges between relatives and professionals to solve the issues regarding diagnosis and treatment, as well as aspects perceived as positive, such as the availability of professionals as a support in times of greater difficulty.

> *I wanted him to go with a psychologist. Hence, in CAPS III, I asked and they indicated that he would have to triage here in the CAPSij first. Then he didn't stay here much, I can't tell how long he stayed* [...] *He passed only once or twice with the psychiatrist, she gave medication too, antidepressant. We cared about the time he will be taking meds. I, as a mother, understood that he was too young for that. But he didn't take much time, because he didn't want it and he doesn't like to come to CAPSij either* [...] *So, there was one time that, worried, I came alone to talk, and they said that if he didn't come, they could go to our house because they understood he needed it* [...] (Karen, mother).

> *After the UPA, we took him to CAPS III, so he could be medicated. Then we went straight to CAPSij, which is this one and we started doing this treatment with him. Since then he's coming only here, taking several medications. And if you ask me what he's got, I don't know what to say, because they didn't gave us a clear diagnosis. At first he did a treatment for that kind of problem* [...] *Schizophrenia! For me, Vinícius doesn't have it, I can't accept it. They explained to me that, in fact, everyone has, depending on the impact it comes to the surface. And if that's what Vinícius turned into, he turned at once, and he won't come back. I don't think he's coming back. But I don't see Vinícius as a schizophrenic* [...] *After all, I just have to thank for the support we have here. About the treatment I don't have anything to talk about. Because at the time of the crisis I run here* (CAPSij) *Yes!* (Joana, grandmother).

The Brazilian child juvenile mental health policy indicates that the success of interventions depends on the work done by the mental health team in crisis is not restricted to the individual and the *CAPS*, but rather, extrapolates this institution, reaching the family and the entire inter sectoral network involved (BRASIL, 2014).

Likewise, Dell'Acqua and Mezzina (2005), reference theorists of the Italian psychiatric reform process affirm that the effective practices of attention to the crisis allow finding the specificity in the singularity of the subject, understanding that they may have all the complexity of their existence from suffering reduced to a symptom. Thus, it is important to reconnect the individual in crisis to their broader context, so that they can overcome the critical moment conserving their existential and historical

continuity, through keeping existing bonds and building new networks of relationship.

Thus, the increase in the support network is also an enriching element of the possibilities of intervention with the family. In addition, the interactions between family, health services and the community become essential for achieving good results of health actions, which depends on the quality of listening and welcoming and encouraging the active participation of relatives in the treatment (BRASIL, 2014).

We should note that, in the stories told by the participants of this study, we do not see a follow-up directed specifically to the family, which only receives guidance or leads the adolescent for assistance. Tańo and Matsukura (2014), who in their study sought to understand the participation of relatives in the *CAPSij*, concluded that they do not feel inserted in the practices of the services. According to the authors, notes made by the professionals indicate that exchanges between families and professionals do not constitute a frequent practice in the daily routine of the services. The authors indicate (and this study reinforces this consideration), the importance of the active participation of relatives in the construction of care, even considering ethical issues regarding health care, especially related to mental health of children and adolescents (TAŃO; MATSUKURA, 2014).

4 Final Considerations

This study adopted the methodology of oral history to identify the comprehension of relatives of adolescent users of a *CAPSij* about the experience of crisis by adolescents and on the course for care. The results show that the manifestation of the adolescent crisis occurs through episodes of intense psychic distress, which make emerging in the participants of this study feeling of surprise, perplexity, sadness, guilt, concern, fear and doubts.

On the other hand, we could also verify that crisis favored the increase in dialogue and affection between family members and adolescents. In addition, the narratives presented elements related to the life histories of adolescents, marked by stressful situations, such as: experience of intra-family violence and relationships breakdowns that, in the participants' view, could be related to the adolescent's psychic suffering and, consequently, contribute to the manifestation of crises.

Regarding the care processes in the moments of crisis, we could verify that there were no episodes of psychiatric hospitalizations, which indicates potentiality of the network to identify situations that require strategic actions. However, the stories told also revealed the absence of exchanges between relatives and professionals to solve issues about the adolescents' diagnosis and treatment, as well as we could verify the lack of reports about follow-ups specifically focused on the family. A positive point identified by family members refers to the availability of *CAPSij* professionals offering support and embracement at critical moments.

Given the above, we considered that the present study achieved its objectives and, based on the methodology used, evidenced the power present in the spaces of listening and participation of those involved. Thus, we believe that, although it has important limitations such as the small number of participants and the cut-off of the study place, this investigation may contribute to future reflections on the mental health care processes of adolescents in different areas of care. Moreover, it has raised other research questions that can be object of future studies to broaden the look and care of adolescence permeated by psychic suffering, such as: In the families' view, what aspects are present in good practices of mental health care for adolescents? What is the comprehension of professionals, relatives and adolescents about the active participation and the co-responsibility of the mental health care of adolescents?

It is also worth pointing out the relevance of the development of participatory investigative processes that recognize and value the voices of the adolescents themselves and their families. We need to understand they have knowledge about their experiences of psychic suffering and the right to participate building collective actions aimed at their own care. Together with strategies of occupational therapy in mental health care can configure a power in the context of production a more democratic, emancipator and coherent knowledge of the profession.

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