

Coming to terms with the other's perspective: empathy in the relation between psychiatrists and persons diagnosed with schizophrenia

Mônica Monteiro Peixoto¹
Anna Carolina das Neves Mourão¹
Octavio Domont de Serpa Junior¹

Abstract *This article presents qualitative research into the empathic dimension in the physician-patient relationship. The ways to gain access to the other's perspective and collaborate in clinical management are investigated. The material was researched in Community Mental Health Centers in Rio de Janeiro and Campinas. Focus groups were conducted with psychiatrists and persons diagnosed with schizophrenia and the transcribed material was analyzed using phenomenology and medical anthropology as theoretical frameworks. The narratives studied were organized into five main categories: clinical management; negotiation of medication; diagnosis communication; understanding the user's perspective; and limits of empathy. In these thematic categories the participants developed the following subjects: shared construction of care; the desire to know the diagnosis juxtaposed with hesitation to divulge it; managing the control of symptoms and side effects for the negotiation of medication; the effort to understand the user's experience; and crisis as the limit of empathy.*

Key words *Empathy, Mental health, Schizophrenia, Narrative medicine*

¹Instituto de Psiquiatria, Universidade Federal do Rio de Janeiro. Av. Venceslau Braz 71, Botafogo. 22290-140 Rio de Janeiro RJ Brasil. monicampsic@yahoo.com.br

Introduction

In the profound transformation of Western psychiatric care that has been under way since the mid-twentieth century, the asylum model has gradually been replaced by the model of community mental health care, which understands illness as a process and incorporates users' subjective experience and daily life spheres – leisure, work and family – into treatment¹. The personal and political empowerment of persons with severe mental disorders through the organization of social movements is an important dividend of this change².

The Brazilian psychiatric reform began at the end of the 1970s as a social movement and scientific field. *Centros de Atenção Psicossocial* (CAPS – Community Mental Health Centers) are facilities that organize the mental health network and replace the numerous hospital beds of the asylum model. Territorially and community based, the CAPS assist persons with severe and persistent mental disorders³. In this new care paradigm, it is fundamental that the professional is willing to have contact with the patient's experience, guiding the care he provides by such experience. This approach will produce a new social place to the experience of madness. This poses the challenge of the reformulation of the psychiatry's education, which is still based on the biomedical model of knowledge and on the objectivity of diagnostic classification⁴.

Feeling or representing something similar to the other's experience means *empathizing*. The term derives from the notion of sympathy, which initially referred to an affinity not only among people, but also among things. In the medical context, for example, the term sympathy used to be employed to refer to the relation between a drug and a certain disease. The psychological meaning of sympathy, in turn, encompassed the capacity to feel with the other, sharing feelings and being affected by other people. Although there is still no consensus about the similarities and differences between sympathy and empathy, from the 18th century onwards, the term empathy has been gradually adopted by the psychological literature⁵.

An important ingredient of human relations, empathy can be understood as an interactional process between two people in resonance. Kir-mayer⁶ decomposes it into distinct interactional processes, such as: entering into a sensory-motor synchrony with another person (chameleon effect); feeling the same emotion felt by another

person (emotional contagion); understanding events from the other's point of view, which implies a change in perspective; and imagining and fantasizing scenarios in order to contextualize the other's experience.

In the mental health field, empathy enables a better understanding of the user's experience, favoring the physician-patient relationship and the provision of care. However, diverse forms of psychopathology, as well as differences in culture and social position, represent an obstacle to it. Failure in establishing empathy can weaken the bond with the user, although it can be a clue to the diagnosis of psychopathological processes⁶.

Empathy is considered an instrument to access the patient's subjective experience⁷. According to Jaspers⁸, the empathic immersion in the patients' psychological universe mediated by their reports on their experiences, by the analysis of their behaviors and expressive movements, and by the reading of their writings, was the way to "determine and analyze what patients really experience". The clinician must take off his usual reading of the world to contextualize, both subjectively and culturally, his patient's experience⁶.

Potter⁹ discusses forms in which clinicians can immerse themselves in the patient's experience. The author uses the figure of the tourist as a metaphor to describe the contact with difference that characterizes the clinical encounter. Like a tourist, the physician visits the patient's world as if he were an observer. In this relationship with the other, moral evaluations are also present, characterizing what the author calls *moral tourism*. Therefore, the clinician must avoid hurried and superficial judgments. Nevertheless, the physician's stance as an outsider seems to be insufficient for a broad understanding of the patient's universe.

Then, Potter⁹ adapts to the clinical context what Lugones¹⁰ calls *world traveling*, in which the world is a type of experience constructed by means of concepts, norms, language and interpersonal relations. World traveling goes beyond "moral tourism", as it requires a literal immersion in the other's community and culture, and demands that the traveler be flexible. This process engenders a transformation of the self and requires learning new forms of perceiving, allowing to understand a little of what it means to be the other person and how we are seen by him.

The clinician must be aware of the influence of his cognitive, normative, theoretical and ideological schemes on the formation of his perceptions, interpretations, diagnoses and plans of

treatment, so that his reading of the world does not dominate the clinical process and does not hinder the understanding of the situation⁹. The profound ontological insecurity experienced in schizophrenia challenges the modern Western conception according to which the healthy person must be unified, delimited and integrated¹¹.

Still inspired by Lugones¹⁰, Potter⁹ proposes that the clinician should keep a playful attitude with his patients, leaving aside his pre-conceived ideas about mental illness and about the composition of his patients' daily routine, and allowing himself to know the other in his own terms.

The clinician who proposes to undertake "world traveling" gets close to the double perspective of participant/observer. At the same time in which he integrates himself into the patient's "culture", he engages in a continuous and critical self-evaluation and retains his therapeutic identity. Although this playful posture loosens the frontiers between clinicians and patients and promotes a relation of greater trust between the parties, this does not mean that we must abandon them totally. Even within the ethical and legal limits of clinical practice, some patients may experience the practice of "world traveling" as intrusive and the professional must be aware of this.

The clinical encounter reveals that facts do not speak for themselves; it is through narrative that they acquire meaning. When we tell a story, we process our experiences and communicate them to other people. We make connections among events, express emotions and appraise parts as good and bad. Therefore, there is a kind of narrative contract¹² that legitimates and makes deviations from documental reality become acceptable, deviations that are performed by the inferences and connections of the narrative. It is a permanent construction, as new events are introduced all the time. However, experiences of suffering challenge our capacity to narrate, as they are not easily accommodated in some plot that gives them meaning. The individuals search for meaning in the midst of the chaos installed by the disorder^{12,13}.

The narrative work requires time and patience, as it is produced together with the interlocutor. By recognizing and respecting his patient's narrative, the clinician gives up the presumption that he understands the patient better than the patient himself does. An empathic hearing that is not targeted only at symptoms enables a relationship of trust between clinician and patient beyond the presupposed differences in power and knowledge¹².

In this paper, we examine the empathic dimension in the physician-patient relationship based on narratives of psychiatrists and users of mental health services. Our aim is to investigate in what way having access to the other's perspective can collaborate with their clinical encounter.

Methodology

Our study made two options in accordance with the clinical approach that views empathy as a skill that constitutes the physician-patient relationship: the choice of the CAPS as the place of investigation and the use of narratives.

The action of CAPS articulated with the territory enables a closer contact with the user's universe and a smaller distance between professionals and patients. The health care team faces the challenge of creating bridges between distinct worlds, undertaking an action that does not colonize; rather, it must include the user's point of view.

This article is part of the multicenter qualitative research *Experiência, Narrativa e Conhecimento: A Perspectiva do Psiquiatra e a do Usuário* (Experience, Narrative and Knowledge: The Psychiatrist's and the User's Perspective), carried out between 2009 and 2011 at CAPS units located in the Brazilian cities of Rio de Janeiro, Campinas and Salvador. The research investigated how the experience of the person with schizophrenia can illuminate the technical knowledge of the psychiatrist and vice-versa¹⁴.

The narratives were produced in focus groups conducted in three periods. In the first one, the users discussed the following themes: antecedents of the disorder, moment of crisis and recovery/post-crisis; the psychiatrists, in turn, talked about the diagnosis, treatment and prognosis of schizophrenia. In the second period, the narratives were crossed, that is, fragments from the psychiatrists were presented to the users and vice-versa. In the first and second periods, psychiatrists and users participated in distinct groups. In the third period, users and psychiatrists together discussed the narratives produced in the previous periods. In the first two periods, we held 24 meetings with users and 4 with psychiatrists, and in the third one, 2.

We believe that the organization of the focus groups in periods served as a research procedure. However, we verified that, in the third period, the participants were not open to the other's perspective. In addition, some users preferred not to par-

ticipate, as they do not feel at ease in a meeting with psychiatrists, possibly because they perceive that they have less contractual power compared to the latter, and also due to the particularities of their own psychological organization. Thus, in this study, we decided to use only the narratives produced in the first and second periods.

The criteria for the inclusion of participants were, in the case of the psychiatrists, working in the public network of mental health care and accepting to participate in the study, and in the case of users, self-attribution of the psychotic experience based on identification with situations broadcast by a video produced with this purpose. Furthermore, users should be undergoing treatment at the CAPS and accept to participate in the study. It is important to highlight that the recruited psychiatrists did not compose the team that provided care for the users who participated in the study. This investigation had 27 participants: 18 users (12 men and 6 women) and 9 psychiatrists (3 men and 6 women)¹⁴.

The recruitment of psychiatrists was hindered by factors like work overload, precarization of employment relationships, and scarcity of these professionals in the mental health network. In Salvador, these obstacles prevented the recruitment of psychiatrists.

The material was audio-recorded and transcribed. Afterwards, it was submitted to interpretation and analysis and was categorized by two researchers separately and validated by a third. Phenomenology and medical anthropology were used as theoretical frameworks. All names were replaced by pseudonyms. As it was not possible to develop focus groups with psychiatrists in Salvador, the material of this field was not used in this article.

The study was approved by the Research Ethics Committee of the Psychiatry Institute of *Universidade Federal do Rio de Janeiro* (UFRJ), by the Ethics Committee of *Universidade Estadual de Campinas* (UNICAMP) and by the Municipal Health Department of Rio de Janeiro.

Analysis of the narratives

We organized, in the topics below, the themes associated with the therapeutic relationship, in which empathy can function as a facilitating agent. Likewise, we approached situations in which empathy was constrained.

We verified that there was a greater production of narratives about the physician-patient relationship in the second period of the research,

especially in the group of psychiatrists. We believe that this is due to the study's methodology, which enabled them to be affected by the users' narratives. During the focus groups, the psychiatrists reflected on their clinical practices and showed a greater inclination towards a change in perspective – a result that is coherent with the fact that the concern for maintaining an empathic posture must belong to the person who provides care. In addition, they revisited cases they had assisted in their trajectories, offering them as examples of the themes under discussion.

Clinical management

The psychiatrists listed some clinical management strategies. They defended the importance of respecting the *specificity* of each case, which would reduce the importance of the diagnosis. *I don't treat the disorder, I treat you* (Raimundo, psychiatrist). Schizophrenia was pointed as a diagnosis that encompasses different clinical presentations and deserves greater care.

When users do not mention spontaneously the difficulties they face, mainly regarding medication, this creates a challenge to the psychiatrists. Terms like *investigate*, *dig*, *empower*, *produce demand* and *protagonism* illustrate their attempts to stimulate the user to speak about himself. The psychiatrists highlighted that the social and family contexts, associated with a remaining *asylum culture*, produce passivity in the schizophrenic user. The shared construction of the therapeutic project by the psychiatrist and the other mental health professionals must include users and their families in the decisions about the treatment.

The psychiatrists argue that crises do not mean a retrocession in the treatment. This corroborates the concept of *recovery* - a term that does not have a canonic translation into Portuguese. It means a process of recuperation through which a new way of dealing with the consequences of the disorder is constituted, favoring a full life, in a continuous, nonlinear process that goes beyond the remission of symptoms and encompasses sense of hope, autonomy, empowerment, and the capacity to deal with the symptoms and possible adversities of the situation¹⁵.

From the users' point of view, factors like the sensation of being invaded by the doctor, medical consultations that are distant in time from one another, high turnover of professionals in the service and the psychiatrist's lack of attention affect the therapeutic relationship and can make it break up. [...] *How can a person who is a psychi-*

atrist and doesn't even look at your face prescribe a medicine to you? [...] (Regina, user).

On the other hand, when the subject feels that the physician listens to him, he tends to explain his symptoms in a more complete way, which may influence the diagnosis and the proposed care. The physician's attention and engagement are translated into the patient's greater satisfaction and adherence to treatment.

I think that what we lack is just love, because medicines we have. Why does everyone here remember Dr. C.? Because it seemed that she [...] that one day she was crazy, too; in her other life she was a patient like us. Then, in this life, she returned as a doctor. [...] That's why she understood us so well. When I was afraid of the rain, she went outside to get wet. She didn't have this thing that she's a doctor and we're poor and mentally ill. (Roberta, user)

The therapeutic bond allows the psychiatrist to settle with the user what measures to take during the crisis, being available to him. Moreover, it is an important factor to be considered when a medicine is introduced or changed¹⁶.

Situations like referring the patient to another place when the service is no longer capable of meeting the demand or when the user cannot bear the costs of private assistance break the therapeutic bond with the professional and, sometimes, the user wants to return to the previous place of treatment.

I was assisted there for a long time... then she [the doctor] said that [...] it is very crowded, there are no available dates for appointments and they could not take care of me properly. But, sometimes, I want to go back there. [...] but when I call her, she says [...] that I have to be treated here. (Cleuza, user)

Negotiation of medication

According to Staring et al.¹⁷, the use of medication in schizophrenic patients points to the following dilemma: on the one hand, it reduces symptoms; on the other hand, it produces adverse side effects. Due to this, users have opposed and ambivalent perceptions about the impact of medication on their quality of life, which makes their adherence be particularly difficult.

Negotiation of medication is constant in the psychiatrists' daily routine. They recognize a mismatch between what they prescribe and the way in which the user takes the medication. Expressions like *invisible little balance* and *a rather subjective calculation* reveal the necessary

arrangement among symptom, side effect and user's choice - aspects to be considered in the administration of the medication. [...] *how far can we let the symptom manifest itself without dominating her [user] and causing trouble in her life and in the life of the people who are beside her?* [...] (Raimundo, psychiatrist). Depending on the clinical presentation, negotiation may be limited: [...] *With the schizophrenic patient, I negotiate less about medication. I think for him much more, even with the side effects [...]* (Carolina, psychiatrist).

The psychiatrists narrated that they often compare the periods of highest stability with the moments of crisis caused by the interruption in the medication, with the aim of rescuing the user's adherence to treatment. However, sometimes this strategy does not produce the expected effect.

In the users' narratives, negotiation of medication also emerges as a recurrent theme. Telling the psychiatrist about being bothered by the side effects shows an active attitude on the part of the user. The material also indicated a kind of self-monitoring that makes the user look for assistance when he does not feel well: [...] *I asked her to increase my medication ... 'cause I'm having hallucinations [...]* (Cleuza, user). Such conducts indicate that the user feels responsible for his own treatment.

Sometimes, the interest in sharing decisions in relation to treatment seems to come from the psychiatrist and not from the patient: [...] *'I'll give you some options, I'll tell you the pros and cons [of the medication] and we'll decide'. And some people get a little scared: 'what do you mean, Doctor? The doctor is you! You have to decide!'* (Carmen, psychiatrist).

This narrative allows to infer that these professionals' principles match some practices of shared management of medication, which have been recently adapted to the Brazilian scenario¹⁸.

The users highlighted that the physician must stress the clinical need of the medication, which indicates the weight attributed to the psychiatrist's words, as we will see below in a narrative.

The psychiatrists are reluctant to inform the user that the medication must be taken throughout his life. When they are questioned about it, they try to highlight the need of the medication and the possible reduction in the dose according to the evolution of the case. Analogies with diseases like diabetes and hypertension are used to explain the chronic character of schizophrenia. Thus, the psychiatrist strives to be understood by the user and the family, which demands adopting

their perspective. This strategy also functions as a way of mitigating the *taboo* involving mental disorders. [...] *diabetes is something that is very close to them* [users], *everybody knows someone who has diabetes and [...] sometimes take an injection every day [...] it's diabetes, it's not taboo, because madness is taboo and they feel this.* [...] (Carla, psychiatrist).

The psychiatrist's intervention is not limited to the prescription of medicines. Encouraging socialization and *stimulating* the user in his daily routine are considered *therapeutic actions*. However, users may view these incentives as demands; thus, the psychiatrists recognize that there is a limit to what they can demand.

Even though some users receive the psychiatrist's orientations well and put them into practice, they argue that there is a limit to medical orientations.

He told me to take the medicine and I'm taking the medicine. He told me to sleep early [...] beer, I don't drink it. So, I'm following the scheme as he demands. If he tells me to do more than this, then he wants me to be like a baby, right? (Rogério, user)

Diagnosis communication

The psychiatrists resist and hesitate to communicate the diagnosis of schizophrenia. Expressions like *it labels the person and a stamp that can't be removed* reveal the social stigma related to the disorder. Even so, they tend to answer the questions asked by users and relatives, as they recognize that they have the right to know. The form of announcing the diagnosis has implications in its reception by the user.

I never hide it. If they ask 'What do I have?', I say 'What you have is called schizophrenia,' [...] because if we feel uncomfortable to say it, they will think that it is something terrible [...] if you say it in a natural way, I think that it is easier for them, too [...] (Carla, psychiatrist)

Some psychiatrists are reticent regarding the diagnosis because they believe that it would cut the possibility of constructing meaning about the psychotic experience, even though this construction occurs in a delirious way:

In the case of the schizophrenic, I feel that, with this, we can cut a possibility [...] of a delirious elaboration later. [...] To me, a schizophrenic who has a systematized delirium is much better, no matter if it's about what happens to him or about the onset of his disease. This guy remains much more preserved over time than a guy who doesn't have it (Rita, psychiatrist)

Users, in turn, point to the importance of being informed about the diagnosis and prognosis of cure, and argue that the psychiatrist must pick an appropriate moment to supply this information.

Depending on the patient, I think that the diagnosis cannot be hidden, but it can be omitted for the sake of the patient himself, until he acquires greater maturity to understand exactly what he has, or when he can understand only what is convenient to him, due to his problems (Railson, user).

The discussion about diagnosis communication stole the show in the focus groups. The participants frequently approached the team of researchers and asked for information about their diagnoses. Although some of them were ignorant of their diagnosis, at some moments it was necessary to inform that the schizophrenia spectrum disorder constituted our theme of study. We were worried that this information would influence the production of discourses guided by the common sense understanding of schizophrenia, and not by the participants' subjective experience.

Other knowledge sources, in addition to that offered by the physician, can be used in favor of the treatment. For example, there was a case of diagnostic uncertainty in which the user searched for information in the internet and could verify which category fitted her best. This characterized an active posture of diagnostic self-attribution.

Many patients ask [...] the name [of the diagnosis], as they have more access to information and talk to others. Sometimes they consult the internet [...] Some patients come to me and say 'I've read it there...' I remember that I had said that I was in doubt, I wasn't sure, but the hypotheses were such and such, and she [user]: 'Oh, I thought I matched one of them better and the other wasn't a perfect match...' (Carmen, psychiatrist)

On the other hand, the psychiatrists fear that the users will find information about the prognosis of schizophrenia, which is considered bad. The following narrative illustrates the handling of information sources that are external to the clinical encounter:

[...] then, I said: 'your daughter has schizophrenia and, if you don't give her the medicine, she will gradually get worse. [...] Bring the Kaplan [compendium of psychiatry] here, I've heard that you've bought the book, [...] and we'll read it together. I'll explain to you what it is, what is happening, I'll show you the page of the medicine that I'm giving her' [...] (Carla, psychiatrist)

We observed that the content addressed to the physician is different from the one directed

to other professionals of the healthcare team. *I'll tell what I feel, what I have, to her, the psychologist. He [psychiatrist] is pharmacological. He prescribes medicines. He is not for conversation* (Regina, user). The user makes a selection of facts that he supposes are relevant to each situation and interlocutor. Presuppositions concerning what interests the psychiatrist may lead to a report on symptoms isolated from their social and emotional context. This is related to the study carried out by Csordas et al.¹⁹. The authors compared a semi-structured ethnographic interview with a structured interview targeted at clinical investigation, and found that the format of the interview shapes the interactional context between interviewer and interviewee, influencing the way in which patients articulate their experiences of illness (and cure) and how they evaluate what is adequate to say.

Understanding the user's perspective

Mood changes, thought disorders and psychotic organization are complex experiences that cannot be correlated with daily events and, due to their radicalness, are hard to imagine and bring some complications to the establishment of empathic bridges between users and psychiatrists⁶. To overcome this gap, there is the idea that an immersion in the psychotic experience would promote a better understanding. [...] *every person who works with mental health should become psychotic during a couple of days to understand this dissociation* [...] (Carla, psychiatrist). Nevertheless, even though the experience of psychosis produced by the use of hallucinogens is a recurrent theme in the history of psychiatry²⁰, the distress, lack of control and discomfort that resemble a psychotic break would only work as a model of knowledge if the subject were unaware of having ingested the drug⁶.

The quality of the physician-patient relationship seems to be directly related to the possibility of a change in perspectives. Because they have a function of care, psychiatrists are willing to understand the user's experience. Thinking of themselves as patients of the treatment they offer and taking the side effect of the medication they prescribe into account are examples of this: [...] *our medication is not cookies; they are medications that detonate* [...] (Cléber, psychiatrist).

The psychiatrists also imagine the impact of the diagnosis of schizophrenia on the user, for at the same time that it "holds and supports" suffering, it may produce distress in those who understand the limitations inherent in the disorder.

Through the empathic effort, the psychiatrists mention a gap, which is apparently insurmountable, between different perspectives.

[...] although we study a lot of things, it's very difficult to understand what they are experiencing. You're able to rationalize it, you try to explain some things briefly, but I doubt that, to them, this is an explanation [...] (Carmen, psychiatrist)

In some situations, like the prognosis of schizophrenia, the difference between perspectives stands out.

But, sometimes, the patient says: 'But will I be all right?' Many times, what they imagine about being all right is being free from medication [...] going to the doctor and everything gets fine. And our all right is: 'With this you'll be able to work...' Even when it's very good, it's bad! It supposes care, medication... (Carolina, psychiatrist)

Dr. Y told me I was all right: 'You're all right. You're really fine.' We're not going to be all right. We have to take medication. Today, I know it. [...] The doctor must always say to the patient that he must take the medication. Even if he is all right. [...] We're all right, but this all right is not like yours. (Roberta, user)

However, this does not mean that the attempt to understand the other is in vain. The psychiatrists presented strategies to facilitate communication: they talk about the disorder using the same terms with which the user talks about himself and employ a simple and direct language: [...] *I don't go much into details about neurotransmitters because it's not the case, but then I explain that each head functions in its own way* [...] (Carmen, psychiatrist)

Lack of correspondence between the user's understanding of his problem and the physician's explanation does not prevent the user from adhering to treatment.

They said it was bipolar disorder. [...] This doesn't mean anything to me. To me, what matters is what I am thinking. I'm not disrespecting the doctor, you see? He told me to take the medicine and I'm taking the medicine. (Rogério, user)

It is through the therapeutic bond that is established that the user can expound his understanding of the problem to the psychiatrist. His construction can be used to enable the maintenance of the treatment. Therefore, it is a work proposal that takes advantage of the user's perspective: [...] *the doctor said that I had gastritis because of too many cigarettes, but I don't have any problem in the head* [...] *The injection is for gastritis, not for the head* [...] (Caio, user)

Limits of empathy

The psychiatrists also discussed what prevents them from being open to the other's experience. Crises are considered a situation in which there is no possibility of dialog, demanding an imposing stance of the psychiatrist, who must decide for the user and, sometimes, in partnership with the relatives. Physical restraint or drug intervention are viewed as resources that are necessary sometimes, but are unpleasant and distressing: *It's terrible, I don't like it, [...] you having to restrain someone is the bad part of psychiatry.* (Carla, psychiatrist).

Intervention during a crisis may interfere in the subsequent bond with the user. [...] *for some time, he became a little withdrawn. He didn't tell me things anymore, it was perceptible, because what if I lock him in again and hold him in the hospital [...]* (Carmen, psychiatrist). Even if the bond is shaken, it is possible to re-establish a good relationship.

The psychiatrists bet that the therapeutic bond facilitates their clinical action during hospitalizations. Knowing the user guides the psychiatrist in the negotiation of the treatment, that is, to what extent he can succumb to the patient's requests. On the other hand, situations in which the psychiatrist is summoned to act without knowing the user, like in emergency services, are considered harder to manage because there is no previous bond that validates the physician's action.

[...] *I think it's much worse when you don't know the person and the person doesn't know you. For example, in the Emergency Service, the person is a stranger and you have to convince him, or touch him, or hold him, or do something and, suddenly, you're putting yourself at risk. I think it's much harder to deal with this [...]* (Carmen, psychiatrist)

The users who do not adhere to treatment and do not take medication were considered difficult by the psychiatrists, mainly due to the absence of *insight* or *morbidity judgment*. Such users summon a more active posture on the part of the psychiatrist, as it was mentioned above:

[...] *sometimes, they don't recognize that they have a severe or chronic problem, so I think that this is the worst situation to manage. Perhaps we have the sensation that we have more certainty and perhaps we're even more incisive and invasive in the treatment [...]* (Carmen, psychiatrist)

Conclusion

It was interesting to notice how the understanding of the users' perspective stimulated the psychiatrists to reflect on their clinical practices and question their concepts. For example, the narratives showed that the psychiatrists hesitated to communicate the diagnosis of schizophrenia because they feared the stigma that is associated with the disorder, and this contrasted with the users' willingness and right to know.

The importance of clinical management for the maintenance of the treatment became evident, and the main aspect was the negotiation of medication in its difficult balance between symptoms and side effects. However, the narratives show that the psychiatrist's action is not limited to prescribing medicines. The professionals must deal with the alterations that psychological suffering produces in the subject's life as a whole, and must include the participation of the family, of the community and the construction of care networks.

The psychiatrists also narrated that actions targeted at the singularity of each case favor the therapeutic bond. Patients may not want to listen to their doctors, unless they believe their doctors listened to them first. Listening to the patients' anguish generally challenges physicians to use their imagination and feelings to enter into the patient's inner life. However, feeling empathically the patients' pain, confusion, hope and fear can be a threatening and emotionally tiring experience to the clinician²¹. Regarding these aspects, the psychiatrists mentioned their difficulty in understanding complex psychotic experiences because they cannot be compared to their personal experiences. Furthermore, they complained about the routine of intense work demand at the CAPS. Nevertheless, the effort to understand the user's perspective emerges continually in the professionals' narratives.

The patient-centered method, originated from family medicine, is in tune with these concerns because it is a clinical approach that includes the patient's personal illness experience and strives to learn about the ideas, feelings and expectations that are awakened in the person about what affects him^{22,23}. This approach enables that physician and patient reach a satisfactory agreement regarding the definition of the problem; the establishment of the objectives and priorities of the treatment; and the distinction of the roles of each one.

Although the psychiatrists attempted to negotiate the treatment with users, they argued that crises are moments in which it is hard to open themselves to their perspective, and they are summoned to decide for the users. In addition, the importance attributed to the continuity of the treatment, both by psychiatrists and users, for the construction of the therapeutic bond, contrasts with a reality of high turnover of professionals at the CAPS.

How can the physician's education, particularly the psychiatrist's, amplify the empathic capacity? Reducing the intervention to the prescription of medicines would weaken the therapeutic relationship. The psychiatrist must develop therapeutic skills to understand the symbolic meaning of the symptoms and difficulties faced

in the alliance to maintain the treatment^{22,24,25}. The development of the health professionals' narrative competence in accordance with the methodology proposed by Charon²⁶ can be a powerful way of amplifying the empathic capacity in an era in which knowing the patients' inner universe – enabled by phenomenology and psychoanalysis, for example – is being replaced by the DSM's checklist of symptoms²⁷.

We believe that betting on the empathic dimension of the physician-patient relationship means the possibility of including the user as the subject of the knowledge about his illness and care – and not only as the object. The narrative is a pathway to access the perspective of the person who suffers, a way of getting in contact with different worlds.

Collaborations

MM Peixoto collected and transcribed the material, analyzed and interpreted the data, and wrote the article. ACN Mourão collaborated in the collection and transcription of the material and in data analysis and interpretation. OD Serpa Junior participated in the conception and design of the study, in the collection of the material, in data analysis and interpretation, and in the writing of the article.

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