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LIVED EXPERIENCE NARRATIVE

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It's the way you treat me that makes me angry, it's not a question of madness: Good and bad practice in dealing with violence in the mental health services

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Accessible Summary

What is known on the subject:

- The first access to a mental health service is sometimes marked by aggressive behaviours and anger. Forced hospitalization is frequently an occasion for resistance and hostility to the service, which should not be mistaken for psychotic symptoms.
- If this situation is not dealt with effectively, it can jeopardize the quality of the relationship with staff and compliance with the treatment programme.

What the paper adds to existing knowledge:

- The narrator presents his experience in undergoing voluntary psychiatric treatment, casting light on nurses' good and bad practices: those that increased resistance, and those that helped de-escalate the uncontrolled reaction at the time of access, as well as during the recovery period.

What are the implications for mental health nursing:

- Practitioners should be able to put in place listening techniques and ways of personalizing the relationship with the patient.
- When such measures become part of the patient's meaning system, the vicious circle of misunderstood anger that creates more anger may be interrupted and the patient can invest in relationships of trust.

KEYWORDS

aggressive behaviour, forced psychiatric treatment, nursing, strategies in relationships

1 | INTRODUCTION

1.1 | How to deal with aggressive behaviour? The dilemma of whether to consider it a symptom

Dealing with violence and aggression is a source of uncertainty for health professionals. Hostile or provocative behaviours put the team in a quandary, as important decisions must be made quickly: Is it necessary to involve the police? To physically force the patient? To give him calming drugs? Would it be appropriate to try to reduce the aggression and restore the person's self-control?

Before deciding any of these questions, how should the manifestation be considered? Is it the effect of an anti-social personality behaviour? The symptom of a mental health or emotional problem? An acute psychotic episode? The intoxication effect of drug or alcohol misuse?

The situation is far from easy to understand.

The literature has shown that environmental and contextual factors (such as noise, crowding, bad food, lack of privacy, lack of outlets, excessive use of restraint), as well as relational conditions (conflicts between staff and patients, the imposition of limits), are more influential in the development of aggressive

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behaviours than internal factors such as diagnosed psychopathology or personality traits (Gadon et al., 2006; Iudici, Salvini, Faccio & Castelnuovo, 2015). The availability of routinely shared daily activities, greater autonomy and a strong institutional openness to the outside world are variables that play an important role in reducing episodes of violence (Bensley et al., 2009). In most cases, aggressive behaviour reflects others' behaviour and can rarely be separated from the vicious circle that maintains it: aggression generates a decrease in sensitivity on the part of nurses, who are more likely to use forms of punishment, which in turn generate more aggressive behaviour by patients (Ros et al., 2013). According to McKeown et al. (2019), violence in psychiatric services is the result of the interaction between three actors: an oppressive system, staff and users. For the patient, experiencing the coercive character of the psychiatric institution may result in aggressive behaviours as a reaction to the service's institutional regime and a challenge to its power asymmetries. Aggressive behaviour may emerge from the perception that the user's demands are continually unmet, or because of the user's resistance to the policies of the service, such as its assignment of a diagnostic label that he or she does not feel is appropriate, or in reaction to the staff's control of the user's habits (McKeown, et al., 2019). In addition to the asymmetry in power relations, Holmes et al. (2012) argue that a culture of silence around the reporting of violence in psychiatric services should also be considered, as it makes it difficult to collect the accurate data needed to understand the extent of the phenomenon. Violence in the healthcare sector, as Holmes notes, is omnipresent but often imperceptible, and is not exercised, as is usually believed, exclusively by users, but also by employers and healthcare providers towards both patients and other healthcare providers. Furthermore, violence means more than inflicting harm or injury (in all their forms) to individuals. Violence also manifests itself in the way the user is viewed and constructed and in the way the environment is structured in psychiatric services (Holmes et al., 2012).

What is important to recall here is that the perceptions that nurses and patients have about the factors precipitating episodes of violence seem to be reversed: nurses tend to attribute such episodes to the alleged mental illness, while patients ascribe them to the "imprisonment"—which makes the psychiatric hospital a sort of total institution (Goffman, 1961)—to the absence of communication with the staff, and in general to negative interactions with the health practitioners (Duxbury & Whittington, 2005). As a result, the two actors propose different treatments for aggressive conduct: medical staff tend to see changes in medication as the main strategy (Iudici, Castelnuovo & Faccio, 2015), while users suggest that staff–patient communication be improved (Ilkiw-Lavalle & Grenyer, 2003).

The ability on the part of the healthcare staff to look at critical behaviours from the patient's point of view, to grasp their meaning, seems to be a fundamental skill for overcoming misunderstandings and avoiding escalation. In the absence of this skill, the staff is more concerned with correcting than with understanding the problematic conduct, and this, as mentioned, spawns further violence (Secker et al., 2004). Rather than concentrating on correction, the therapeutic alliance must be restored after an aggressive incident through emotional support, critical reflection and learning, and the pursuit of accountability (Secker et al., 2004).

Support from nurses seems to be negatively associated with aggressive incidents and has also been found to mediate the relation between growth and aggressive incidents (Ros et al., 2013). As the literature notes, patients believe that a number of factors can prevent aggressive behaviours: the staff's willingness to accept and negotiate user requests (Lantta et al., 2016; Secker et al., 2004), to become familiar with each person's life story (McKeown, et al., 2019) or, simply, to spend more time with patients (Kontio et al., 2014). Thus, a greater willingness on the part of the staff to understand hostile behaviour once it has occurred, rather than trying to correct it, is crucial in preventing an escalation of aggression. The review conducted by Gudde et al. (2015) found that aggressive behaviour is more likely to occur when users perceive a sense of control or indifference in their relationship with staff, rather than a supportive relationship. Patients associate violence against nursing staff with attitudes and styles of interaction such as poor communication or lack of listening by staff (Greenwood & Braham, 2018). In this connection, Berring (Berring et al., 2015) emphasizes the tendency on the part of nursing staff to blame patients for aggressive behaviour, as they are considered dangerous and unable to understand what is good for themselves. Such a representation of the patient is thought to justify corrective action. Fear has proved to be a powerful catalyst in the decision to implement restrictive practices (Power et al., 2020).

1.2 | The relevance of reflexivity

Research into patients' experiences before, during and after a restraint has found that patients report that increased communication with staff could have prevented restraint, which is never perceived as therapeutic. Debriefing and confrontation should be used to re-establish the therapeutic relationship and to inform plans of care that reflect the patient's perspective (Ling et al., 2015). Paying attention to improving the emotional climate through specific strategies seems to be even more effective when it involves all the protagonists of the psychiatric scene: when supervised and trained in strategies for preventing seclusion-restraint, high security wards, staff, nurses and doctors as well as patients with schizophrenia and violent behaviour can significantly reduce aggressive episodes (Putkonen et al., 2013).

This literature suggests that it is import to increase staff awareness of their working methods; in fact, change seems possible where reflexivity is exercised about one's role (Faccio et al., 2019; Willig, 2019). Reflexivity calls for listening to others, as a mirror through which staff behaviours and their effects can be observed, and Alex's story provides a very effective mirror for rethinking the impact of one's conduct.

"Alex" is the fictitious name chosen by the protagonist of the story presented here. He contributed to the paper by narrating

autobiographical events with the collaboration of the other authors and agreed to its publication in the hope that others may benefit from his experiences by enhancing reflexivity about practices whose painful effect should not be passed over in silence or underestimated.

1.3 | Alex's story

The story of Alex, a 21-year-old Italian man who had struggled with substance misuse and with his family since he was a teenager, brings us straight to the crux of the dilemma involved in understanding the aggressive conduct of an angry young man: What can be done in such a situation to reduce tension and increase collaboration?

We will find out through its opposite, analysing what absolutely did not work. The conflict shifts from Alex's home to the psychiatric service, as the family involved the police against our protagonist's will, and the tension mounted steadily as a result. Alex recalls events that took place two years earlier thanks to the help of the psychologist in charge of the community for people who have used substances where he currently lives (MR). The psychologist assisted Alex in reconstructing the autobiographical events and in transcribing the story, and also added a number of comments on the narrative. Alex is a co-author and has approved all of the comments.

The story is introduced and analysed by EF in order to present practical implications for the clinical setting.

1.4 | Alex's experience with a mental health service

Alex defines the first contact with the mental health service as a real "baptism." It is a very effective metaphor: he has been "known" (but perhaps also recognized) on the basis of his psychic discomfort, and the name he first received (the diagnosis), organizes and filters the entire sequence of events, as if it were his real name, and there was no opportunity to choose another one:

(Alex): Things had been going wrong in the family for a long time, we fought constantly and there was very little desire to understand each other. My parents said I was crazy since I was taking drugs, I lived on the street and I was moving in a different way than they did, not good, but inside, it made sense to me. Usually anger increases more and more if the two sides don't give up, and that's what happened. Since nobody ever compromised, at the time of the umpteenth outburst my parents called the police. I hadn't done anything bad at home that evening. I had only screamed and raved, while the other times I had trashed the whole house, broken a mirror, kicked down the door. The police arrived, and they saw me, a drug addict son, outside the house, in the cold and unable to go in.

He (the policeman) came to me, I was calm, I wasn't delirious, I was nervous, but cold, firm, and he said to me: "You don't have to behave like this."

He came to tell me how I should behave, but what the fuck do you know about the situation, you didn't bother to find out! You only listened to the parents' side, and I'm the one who's wrong. And I: "Listen, I didn't call you, you can't tell me what to do, and you can't throw me out of my own house, I live here." And he said: "But you can't stay here, behaving like this, go away!" You could even talk things over with the policeman, he didn't behave badly, he was just doing his job. My mother, however, came up, she started hounding me again and I immediately lost it: "Fuck off, go away, what the fuck do you want?" (I said to her). He (the policeman) grabbed me, threw me to the ground, locked me in the car and took me to the mental hospital.

Thus began my extremely difficult relationship with the mental health service. Once I arrived, I couldn't speak to the doctor; the policeman was the person who preceded me and told the psychiatrist my story. I did not even hear what they said to each other, but as soon as I entered the room where the doctor was, he spoke to me about the compulsory medical treatment.

My first reaction would have been to get angry, to complain about injustice, to rebel. However, I realized that by doing so, I would run the risk of "proving" exactly what was needed to trigger involuntary psychiatric commitment, i.e., a crisis of anger.

By the time I got to the hospital I had calmed down, and anyway I was handcuffed, immobilized, even a bit frightened by the situation. The doctor did not ask me anything, or greet me, yet I was calm. I thought, now what's going to happen to me? I told the doctor that I was calm, and that there wasn't any reason to put me under an involuntary psychiatric hold, I hadn't hit anyone. I told him "stop, if you order an involuntary hold, you'll have me stoned out of my mind for a month, you'll see me crack, you'll switch me off!"

He took me into the room, the police were there around the bed, the doctors... I felt a little disoriented, nobody talked to me, they looked at me as if I might explode any moment, as if something could snap inside me. I just waited. Then the doctor tried to talk to me, but I wouldn't listen to her, I just wanted to be sent home, set free. I had calmed down, it was all over, what was staying at the hospital going to fix? What else was going to happen? What could being there give me?

(Comment) The narrative takes the form of a dialogue between inner voices. Part of him wants to react, wants to explode and fight, but another part, more cautious and moderate, manages to dominate. This part tries to understand what is happening around him and makes him quiet down. Everyone expects him to react badly, but the strategic voice manages not surrender to emotions, manages to maintain control over himself.

(Alex): They wanted to put me under an involuntary hold anyway; at that point I got angry: doesn't what I say count for a shit? I'm not crazy! How can I prove it? If I try to make you understand it, if I protest, will you treat me as if I were crazy?! I'm calm and you're still giving me a shot (with a sedative)? The doctor said: "Okay, then sign for voluntary hospitalization!"

Somehow I had entered the process.

I was no longer free, I had to pass four days, five days there voluntarily, no way to avoid it. And then, what with the situation I had, that is, I couldn't go home, I didn't feel like living on the street and shooting up, and so I stayed there for twenty-two days.

The psychiatric staff got to know me through the version that the police made of my story, which I could not check or correct. Had I done so, I would have exploded in anger, I would not have been able to control myself emotionally. So I had to pretend. The situation became paradoxical: while not agreeing with the idea of hospitalization, I had to accept it willingly, otherwise I would have shown that I really needed it. The only way to "save myself" was to "betray myself."

Choosing voluntary hospitalization meant choosing the lesser evil: once again, it was done to limit the damage. That deludes people into thinking that some choice is possible, but the reality is different.

Since the police were involved, they said to me: "Look, they're not going to let you go free, they won't let you loose, at least have yourself hospitalized voluntarily! Since it was your parents who called the police, if you don't do it of your own free will, it'll be mandatory."

So I was obliged. But it changed a lot in substance, because if it had been mandatory, they would have decided everything for me: I would have entered the same day and I would have left when they decided. But if it's voluntary, you leave after four days, by law. This was a forced hospitalization because, seeing that I'd got worse, a process had started that involved well-defined steps, and beyond that process, a policeman, a doctor would not have taken the responsibility—since my reaction had not been the best—for trusting me. I mean, they could take the responsibility to release me: since the "charge" (the diagnosis) was that I was agitated, I could still be agitated at home and anywhere else. They thought I was an unstable, unpredictable boy, I was going to explode.

They only saw me as a set of symptoms to be monitored, they were there to deal with a patient who as symptoms had a nervous and volatile attitude, of anger. They thought that I could lose patience and do damage, as they say, go out of control, and therefore I could be violent, I could do dangerous things. They did that: they watched to see if I was violent, if I got nervous. I felt under observation. The doctor did her job, checking that I wasn't dangerous. If that was her job, there was nothing I could do about it.

How can they take up another stance?! (in other words, do something other than what their job requires them to do?)

I felt observed because of what I did before entering the hospital, because of the reason I was admitted, because of what the police said, but none of the staff had spoken to me in first person. I woke up in the morning, I was given the depakin immediately, without saying anything.

By the same token, I had to "undergo" drug therapy without complaining. Again, the situation bordered on the absurd: why be forced to take an anticonvulsant? I was not crazy. Why, given that I was trying to do my best and above all to appear calm? I understood that I no longer had any power.

I was upset, and I asked: What do you mean, depakin? How is it possible? How'd you [referring to the doctor] decide on that? You weren't there yesterday, you don't know anything about me, but the doctor prescribed it, and you give me a mood stabilizer. After that, I shut up, that's the doctor, I was going to make a fuss about it? It's not my home. I'm not getting out of there. I did not feel confident enough to take a stand. I was already seen as a danger to people, to society. If I messed up, I would have put myself in the position of being in even more danger.

If I had asked the doctor too many questions, I would have been perceived as a troublemaker. You become the one who's a pain in the ass. What, you find yourself here and you also piss everybody off? You don't have to piss people off! You've got to be well, to be good and doing the things you're supposed to do.

(Comment) There are many conditions that encourage aggressive thoughts: not having been taken into consideration, not having had the opportunity to express oneself from the very beginning, being hospitalized involuntarily, having to take drugs against one's will and without justification, having deliberately assumed a passive position, not asking for clarification or anything else, not even trivial things. All this promotes further anger, which must not be considered a property of the person (or the personality), but as a communication strategy, secondary to these contextual conditions, as a way of denouncing injustice, abuse of power and stigma.

Since the staff had already formed a very negative idea of Alex, he had to be good enough to sway their opinion in his favor. In order to be perceived as "sane," Alex had to be able to do what the staff expected of him, he had to anticipate their moves and meet all of their expectations about him.

(Alex) "I had to be just the way they want me! But how did they want me to be?"

(Comment) A long series of anticipations begins, thanks to which Alex tries to interpret and control the impressions he makes on others and decide what strategies to take as a result: he senses that there is a sort of "invisible behavior code" that all of the staff follows. According to this code, being aggressive, being impulsive, means being "crazy." Alex understands that he must keep calm, feel comfortable at all costs! In addition to being silent, he must commit himself not to creating problems!

(Alex): The doctor who comes is an imposition, a silent imposition: you must comply with that. If you don't comply, it means that you have a problem, and therefore you need medicine. If you understand that, you save yourself and you also feel down, feeling bad where you appreciate that nurse on the shift, who shows you her human side, the human side of looking at a person, who asks you how you are, what's wrong, why are you doing what you do …".

(Comment): The effort of having to "simulate" an accommodating and submissive version of oneself, against one's will, generates frustration and leads to melancholy. Only direct and sincerely interested human relationships can make the oppressive experience more bearable.

Over time Alex, accustomed to concealing his thoughts and bending to others' will, begins to doubt himself and his interpretation of situations.

(Alex): Maybe somebody who goes into the psychiatric ward takes it for granted that the doctor will tell them what to do. But that way, they lose everything inside. Everything that a person has saved up, all the thoughts you have, are lost. You come to think that you really are like that, the way they tell you! Fuck! Then I really have a

problem: the doctor tells me I do, the nurse too, I'm surrounded by crazy people! You see where your life is going and you say: "okay, this is me." No, am I going to get out of here? And how am I going to get out of here? Everything's dark. A lot of people have been put in the psychiatric ward for doing some stupid shit and then got stuck because they couldn't mentally find a way to deal with the situation on their own. That's the danger."

(Comment) When the person surrenders the power to define their identity (the answer to the question: who am I?) to someone else, at a certain point they may no longer be sure about what kind of person they were before hospitalization, dominated by the pursuit of such different attributions.

Another strategy for guiding the impression one makes on other people is that of personalizing the relationship in order to demonstrate being "normal." This worked with the nursing staff and the social workers, who are more willing to refrain from generating a biographical career starting from the psychopathology. With the psychiatrist, who categorizes, preventing change, the best strategy is probably to adapt to the specialist's preconceived requests and visions of "how to behave like a healthy person" and avoid looking for rapport or closeness.

(Alex): When I was with a social worker, I tried to show him that I was a person. But their eyes, working inside that type of facility, couldn't see me, they saw a patient. The meanings they took from you, the confirmations, they based them only on that. You're lucky if you find someone who understands you there.

The psychiatrist is not called to look at what problems the person has, he doesn't care who you are. He simplifies: "he had a psychotic crisis, he had a moment of anger, and so he's impulsive." The next day you're agitated and the doctor asks you: "how's it going? well?" "How should it go?"—I say—a little agitated. And the doctor: "Perfect, blood and urine test." There is no personal care, like let's go for a walk, let's go have coffee.

With some social and health workers I received real moral support. For example, she (S.) came, opened the window a little, made me feel a little fresh air, played cards with me. She asked me how I was, she brought me a pastry, simple things, which she didn't even have to try too hard to do. I managed to get her on my side. Like, you couldn't have coffee outside, so I would collect money from all the "crazy people" there, for hot chocolate or whatever, and then I would buy things for everyone. I "won her over" on my side, the side where I'm a person, who needs to smoke a cigarette or whatever.

(Comment) What Alex considers "true moral support" is the genuine willingness to have a different kind of relationship, closer to the person's needs. He is aware that he is running a risk: the practitioner may or may not be willing; however, Alex's goal is precisely that of "getting the social worker on his side" (the patients' side). This is the proof of being considered "normal," being observed not for his symptoms, but for his real needs.

(Alex): They (the nurses) allowed themselves to be themselves, to share with me, to listen, to be curious, asking questions and telling me how they saw my situation. They didn't consider me crazy.

I was able to make my situation clear, because it bothered me to be misunderstood, I felt constrained. With them, though, I felt free to say what the truth was.

(Comment) It is precisely the closeness Alex thus experienced that made it possible for him to maintain reciprocity and trust in the relationship. It was as if a sort of "moral duty" was triggered, aimed at returning the benevolent gaze received with an equally benevolent attitude.

(Alex): The fact of having known them in person, made even the idea of behaving badly with them impossible. I knew him, I'd talked to him, what am I going to do? Am I going to behave badly with him? No, why should I behave badly?

At the end they too understood my situation. What they let me know in turn was: "Okay, now accept the situation and try to get better, do what you have to do!"

But we had decided together which was best, and I liked this, what did "best" mean? Best, as in: "Live the day as it comes, try to keep smiling, don't let it get you down." And in fact, in the end I had fun, at first I didn't, but then I had fun with the patients and the nurses.

(Comment) In all this, there is also an important relationship with other patients, to whom the same things that Alex says to himself also apply: by being close to someone different, you realize that you share more similarities than differences.

Healthcare practitioners can also play an important role in the emergence of relationships between patients. According to Alex, in fact, some nurses were looking for reasons to separate patients, to keep them away from each other. They feared that by joining together, patients could create problems, while other nurses appreciated Alex's attempt to "form a group," and treated him as a leader, as he was able to create aggregation, warmth and sympathy.

1.5 | Issues of importance

Alex's story provides ideas and insights for rethinking operating practices in mental health services. Two main themes run through the narrative: the first concerns the disparities in power between the parties involved (Alex and the staff), and emerges from the following elements of the story, where the staff has:

- The power to who decide which information about to the person will be considered legitimate and which will not—ignoring the person's own experience and his version of the facts.
- The power to force a person towards a choice he would not want to make: voluntary hospitalization just because it is the lesser evil.
- The power to decide on the patient's pharmacological treatment, without seeking input of any kind from the patient, and also failing to communicate the reasons for the therapy, its benefits for the patient or its side effects.

Since these episodes throw light on a highly asymmetric power relationship between the parties, where one party has the institutional

power to say whether the second is sane or insane, and the second must simply abide by the other's impositions, without even being able to exercise the power to rebuttal. This story offers an excellent example of what the current literature has called the epistemic violence and injustices of psychiatry and mental health services, thus confirming the legitimacy of anger and resistance (or even violence) on the part of service users subjected to compulsion and coercion (Holmes et al., 2012; Lieggo, 2013; McKeown, et al., 2019).

The second theme running through Alex's account is more closely related to identity and the influences of the setting in limiting the individual's free expression. The situation in which he finds himself is described as a sort of dead-end road and presupposes a willingness to conform to presumed expectations of normality.

- The person is forced to set aside authentic experiences and feelings to "act the part" in order to "pass as normal" (the Goffmanian "passage," linked to the control of information about the self and to the coverage of emotions, Faccio & Costa, 2013; Goffman, 1963).
- As such situations are repeated, the person tends to give more credit to the diagnostic theory about the self than to his own idea of himself, leading to discouragement and insecurity.

Being able to personalize relationships and interact with other patients on the basis of how they define their identity rather than on the basis of their symptoms is, according to Alex, the antidote that prevents the role as a patient from saturating one's entire identity.

As is also emphasized by the literature discussed in the introduction (Lantta et al., 2016; McKeown, et al., 2019; Secker et al., 2004), it was precisely the interaction with the nurse that enabled Alex to demonstrate his effective "normality" through a different strategy: with those who observed him only in terms of the diagnosis, the only possible solution was to show that he abided by the rules of place, that is to appear calm and adapt. In this way, he could demonstrate that he was not aggressive or dangerous, the elements on which the diagnosis was based.

Although this had not been feasible with psychiatrists, it proved possible with social workers and nurses, who established a personal relationship, enabling him to show he was "normal," in that he was many other things in addition to his past bad behaviour.

(Alex): When I left, I knew that I would take a different direction, despite all my difficulties, different from the guy I had been that evening.

I was the guy who had shouted and yelled at my mom, but I was also the one who had tried to live in that place (the mental health center) serenely, the one who had collected money to get chocolate for everyone, the one who had made himself known to them, I had told him what I had done in my life.

At the beginning it didn't happen that much, but later I would say to the nurses, "you know, today I feel a little down, I'm getting bored, let's put on some TV." They had learned everything about me, and this had allowed more parts of me to exist, and that all of them were equally true.

That was the only thing I needed, for there to be multiple Alex's.

And I wanted the others to be seen as the people they were at that moment there, but also for them it was important to know that more than one part of them existed.

For example, the lady who was sleeping next to me, she had a job, children, grandchildren, a family who came to visit her; the mother who cut herself was not only the mother who cut herself, who cried and was depressed, but she was the mother who loved her children, who had married young, who had fallen in love with that man, she was also the woman who had had difficulties, and who was full of life. Where had they put all these other things? They had thrown them away!

2 | CONCLUSION

Alex's story can be translated into an operational objective: deploying all the strategies that make it possible to admit, not just the patient, but also the person, to the mental health centre.

This can be achieved from the first contact thanks to a stratagem, viz. by asking ourselves: what would I do differently, as a practitioner or social worker (or in any other possible role, including that of a volunteer), if I thought that what I am hearing are not just symptoms, but the person's actual intentions, based on the meanings they assign to the events and those they meet on their path?

The key lies in deciding whether to consider the person as a victim of their symptoms, or to consider the latter as poor communication strategies, which only when accepted and managed can induce the person to form alliances with the practitioners rather than oppose them (MASKED FOR REVIEW; MASKED FOR REVIEW).

In addition, it is essential to consider the physical space of the service as a setting which can accommodate all the roles that the person has gone through and is currently going through, from the most uncomfortable (including that of being a patient), to the most favourable. People who are brought to the service find themselves living through a moment of great uncertainty and instability, and the most effective way to generate positive images of themselves is to start from something that has worked successfully in the past. All the experiences that allow them to maintain an active and participatory role with respect to the service, including the choices about the treatment that concern them, can contribute to making them feel "at home" even in that setting. All of this can prevent the psychopathological aspect from dominating over any other possible self-narration.

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