LIVED EXPERIENCES OF MENTAL HEALTHCARE PROFESSIONALS FACING PATIENTS IN CRISIS WITH CHALLENGING BEHAVIORS: A PHENOMENOLOGICAL STUDY

VIVÊNCIAS DE PROFISSIONAIS DE SAÚDE MENTAL DIANTE DE PACIENTES EM CRISE COM COMPORTAMENTO CONFLITUOSO: ESTUDO FENOMENOLÓGICO

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Abstract: this study aimed to describe mental healthcare professionals' lived experiences in the face of psychiatric crises marked by challenging or aggressive behaviors. Drawing on Amedeo Giorgi's phenomenological method, 12 professionals from a Psychosocial Care Center III in Brazil were interviewed. The findings reveal six essential constituents of the experience: Disruption of daily life; immediate affect; words as ethical gestures; questioning of a caregiver's humanity; inflection in the bond; and tension between vocation and exhaustion. The analysis revealed that the crisis is not merely a clinical event, but an affective and ethical experience that permeates professionals in their corporeality, affectivity, and identity. The study emphasizes the affective, ethical, and existential dimensions of psychiatric crisis care, reaffirming that mental healthcare is also burdensome for those who provide it, and underscoring the importance of caring for caregivers.

Keywords: Coercion; Violence; Psychiatry; Mental Health Care; Phenomenology.

Resumo: este estudo fenomenológico investigou as vivências de profissionais de saúde mental diante de pacientes em crise com comportamento conflituoso. Utilizando o método de Amedeo Giorgi, foram analisados os relatos de 12 trabalhadores de Centro de Atenção Psicossocial III, revelando seis constituintes essenciais da experiência: ruptura do cotidiano; afeto imediato; palavra como gesto ético; interpelação da humanidade do cuidador; inflexão no vínculo; e tensão entre vocação e exaustão. A análise evidenciou que a crise não é apenas um evento clínico, mas uma vivência afetiva e ética que atravessa profissionais em sua corporeidade, afetividade e identidade. A tradição fenomenológica, especialmente em Husserl, Merleau-Ponty e Levinas, ofereceu fundamentos teóricos para compreender essa exposição radical ao sofrimento do outro. Os resultados reforçam a necessidade de reconhecer e acolher o impacto subjetivo da crise sobre quem cuida, propondo que o cuidado ético só se sustenta quando também inclui o cuidador como sujeito do processo.

Palavras-chave: Coerção; Violência; Psiquiatria; Cuidado em Saúde Mental; Fenomenologia.

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1 Introduction

Mental healthcare is neither a neutral profession nor merely a technical task. There is something raw and intimate—almost visceral—in professionals' daily lives. At stake is not just crisis management, but also the slow, cumulative impact of continually facing crises. For some reason, this escapes—not the practices themselves, but rather the narrative surrounding them.

In this field, the crisis scene radically exposes the vulnerability of caregivers. It is not just about managing symptoms or following protocols; it is about maintaining a presence amid human distress in its most chaotic and challenging form. Understanding mental healthcare as a way of being-in-the-world and not just the absence of disorders implies recognizing that psychological distress reconfigures existential structures by disrupting relationships with time, space, the body, and others. In this context, the crisis is not merely an intensification of symptoms, but rather a rupture in the continuity of existence and a collapse of language and bonds (Ferigato; Campos; Ballarin, 2007). Therefore, crisis care requires more than just technique. It also demands active listening, presence of mind, and a willingness to embrace the unexpected (Dell'Acqua; Mezzina, 2005).

However, crisis scenes are often characterized by conflicting behaviors, episodes of verbal or physical aggression, and extreme situations that test professionals' ethical and emotional limits (Bowers, 2014). The conflict is not just the patient's; it permeates the patient-caregiver relationship. Restraint—whether physical, chemical, or symbolic—sometimes emerges as a last resort, but implementing it carries profound ethical implications. Even when justified, restraint can be experienced as a rupture of the bond and a source of distress (Bigwood; Crowe, 2008). Drach-Zahavy *et al*. (2011) proposed that encounters between professionals and patients in crisis oscillate between power struggles, therapeutic encounters, and even double victimization. This depends on the perception of control and recognition of the other's humanity.

Within this context, the Brazilian Psychiatric Reform proposed a new paradigm that shifted the focus of crises from hospitals to communities and from containment to active listening. The critique of the asylum is both architectural and epistemic, calling for a clinical approach centered on connection, individuality, and freedom (Amarante; Nunes, 2018). The Psychosocial Care Center (In Portuguese, *Centro de Atenção Psicossocial* - CAPS) is a space that addresses the intensity of distress within the

community. It acknowledges the unpredictability of clinical settings and the institutional and human limitations of those providing care.

However, few studies focus on the experiences of professionals at the center of the crisis. Literature typically focuses on containment strategies, risk management, and safety protocols, which renders the emotional, ethical, and existential impact of the crisis on workers invisible (Gooding; McSherry; Roper, 2020). Studies by Needham *et al*. (2005), Husum *et al*. (2020), and Jalil and Dickens (2018) show that professionals often experience feelings of helplessness, fear, anger, guilt, and burnout. However, they often lack institutional spaces to process this distress. For workers, the crisis is not merely a situation to be managed; it is an experience that affects them as individuals, wounding, transforming, and sometimes silencing them.

Given this gap, it is necessary to access experience as it occurs—in all its concrete details, ambivalence, and emotional intensity. Understanding lived experience in crisis situations requires an immersion in the phenomenological tradition as a philosophy of consciousness and existence. At the heart of this approach is Husserl's concept of *Erlebnis*, or lived experience, as the way in which the subject becomes aware of something, i.e., how consciousness intentionally relates to the world. All lived experience is directed toward something, even when that something is confusing, threatening, or ambiguous (Husserl, 2006).

According to Husserl (2006), merely describing what happens is not enough; it is also necessary to investigate how it happens for subjects and how reality is constituted through conscious experience. A crisis is an abrupt disruption of meaning that shatters the normal order of lived experience, requiring a new configuration of consciousness. When faced with this donation, professionals update not only their practice but also their position in the world, which is marked by exposure, risk, and emotional connection.

Phenomenology recognizes that lived experience is not neutral because it occurs within one's body (*Leib*), which is sensitive and situated. The world reveals itself through the body, and crisis reverberates within it as fear, tension, compassion, or anguish (Merleau-Ponty, 1999). A caregiver's body is not an external instrument. Rather, it is a stage that trembles, protects itself, offers itself, and collapses. This phenomenology of the body is essential for understanding how aggression, threat, and extreme distress impact those who care for others.

Moreover, the crisis demands an ethics of presence. In contexts of extreme distress, others do not appear as objects of technical attention but as faces that demand a

response. They are a radical otherness that precedes any calculation (Levinas, 1980). Even if marked by violence, the encounter with patients in crisis calls upon professionals to recognize the other as a disorganized subject worthy of care.

In light of phenomenology, understanding these experiences implies a methodological shift. This shift involves suspending causal explanations and performing an *epoché*, or reduction of natural judgments. This allows the phenomenon of crisis to reveal itself as it is lived, with its affective density, ambiguity, and transformative potential. The present investigation is guided by this movement and is based on Amedeo Giorgi's phenomenological method. This method proposes rigorously describing the meanings experienced by subjects in the same way they emerge in their reports without reducing them to pre-existing theoretical frameworks (Giorgi; Souza, 2010).

Thus, this analysis seeks to go beyond a clinical description of the crisis by understanding it as an intersubjective experience laden with meaning, emotion, and existential implications — an experience that transforms those who endure it and those who witness it. This study aimed to describe the meanings experienced by mental healthcare professionals when confronted with patients exhibiting conflictual behavior in crisis situations. To achieve this goal, Amedeo Giorgi's phenomenological method was employed.

2 Methodology

In many ways, conducting qualitative research is accepting that one does not know what one is looking for beforehand. Rather than applying a formula, it involves following traces of meaning left by individuals who have experienced something that defies conceptualization. With this in mind, this study was structured as rigorous listening, attentive to the cracks in lived experience and guided by phenomenology as a way of seeing, not merely as a method.

This qualitative, exploratory, descriptive investigation is guided by Amedeo Giorgi's phenomenological method of psychological research (Giorgi; Souza, 2010). This framework aims to understand the constitutive meanings of lived experience as they present themselves to subjects' consciousness, avoiding pre-established frameworks based on theoretical categories external to lived experience. Inspired by Edmund Husserl's philosophical tradition, the method retains the fundamentals of intentionality, *epoché*, and eidetic reduction. Unlike classical Husserl's phenomenology, which seeks to

access the researcher's experience as a transcendental subject, Giorgi's method was developed to investigate the experiences of others in empirical contexts, particularly in psychology and the human sciences. This methodological shift is important because it enables researchers to rigorously describe the experiences of participants while remaining faithful to them without reducing them to pre-existing explanations.

The research was conducted at a Type III CAPS located in a capital city in southeastern Brazil. The CAPS serves a territory of approximately 300,000 people and operates continuously. The city is nationally recognized for its anti-asylum trajectory and the decentralized organization of its Psychosocial Care Network, as well as its consolidated network of alternative mental healthcare services (City Hall of Belo Horizonte, 2018). Twelve CAPS workers participated in the study, including 11 nursing technicians and one psychologist. They were intentionally selected based on their experience caring for patients in crisis with conflictual behavior. The group consisted of ten women and two men, ranging in age from 27 to 54 years old, with experience in mental healthcare ranging from six months to 18 years. The lack of specialized training among participants gave the narratives a practical and experiential character, enriching the understanding of the phenomenon.

The interviews were conducted individually in a private room at the service between September and October of 2022. The script included two open-ended questions: "Describe your experience with an aggressive patient in as much detail as possible" and "What feelings did this moment evoke in you?". The interviews were recorded, transcribed verbatim, and analyzed in their entirety. Data collection interruption was based on sensory saturation, which is not merely the repetition of content, but rather the exhaustion of significant variations in the texture of lived experience—a sensitive saturation, not merely a technical one.

The analysis of reports followed the phenomenological approach proposed by Giorgi and Sousa (2010). This approach is composed of four main stages: a complete reading of the material to grasp the overall experiential field; identification of units of meaning based on perceptible changes in the narrative focus; transformation of these units into psychological language through phenomenological reduction and imaginative variation; delineation of the general structure of essential meanings, with a description of the empirical variations that reveal the phenomenon's multiple expressions in the different reports. This process was not treated as a mechanical procedure, but rather as a

handcrafted exercise in description and interpretation. It was grounded in the suspension of presuppositions and an attention to the nuances and subtleties of language.

Two researchers conducted the analysis independently, holding intersubjective validation meetings to discuss and refine emerging interpretations. The goal was not to force a consensus, but rather to maintain a rigorous dialogue consistent with the phenomenological approach. Participants were assigned alphanumeric codes (P1, P2, ..., P12) to ensure anonymity and ethical confidentiality. The study was approved by two research ethics committees, in accordance with Opinions 5.379.817 and 5.611.848.

3 Results

Dealing with a patient in crisis, especially when their behavior becomes unpredictable, is not just a technical task or an administrative function. There is something that escapes. It demands more than preparation; it demands presence. When immersed in this scene, professionals not only act, but are also affected. Routines break down, protocols falter, and the situation becomes tense, ambiguous, and unpredictable.

Regardless of the episode's objective gravity, what stands out is the mark it leaves: an internal, almost indescribable reverberation that transcends job titles and reaches individuals in their entirety. This experience resonates deeply because it calls upon ethics, exposes fragility, and often undermines what was believed to be solid about the caregiving profession.

3.1 General structure of meanings in the experiences of professionals when dealing with patients exhibiting conflictive behavior

When a crisis looms, daily life is suspended. Time seems to bend, and what were once shifts, schedules, and procedures become scenes where everything shifts. Language fails, the body reacts before reason, and care becomes confused with urgency. Professionals describe the arrival of a crisis as a silent fracture in routine—a sudden absence of predictability that thrusts them into an uncertain reality. However, patients are not the only ones who change; caregivers are also affected. It is impossible to remain intact when the other is fragmented.

The first gesture is usually verbal—an attempt to maintain the connection and make sense of the chaos. Though simple, this gesture reveals the clinic's fundamental

ethical stance, which is to bet on communication even when noise dominates. However, when dialogue fails and risk becomes apparent, the body must act. Restraint, whether physical, chemical, or symbolic, emerges as a last resort, and no professional performs it without consequence. It is never a neutral decision, but rather an ethical dilemma experienced in real time with a racing heart and a divided conscience between preserving and harming, protecting and betraying the ideal of care.

However, the crisis does not end with the moment of restraint. It lingers, reverberating in the body and mind. It extends into the next shift, reconfiguring relationships. Some professionals report unexpected gestures of reconciliation, such as a thank you, a look, or a return to dialogue. The violent episode becomes a turning point where patients and caregivers alike reposition themselves. Violence leaves a trace, as does care. Amid this tense interplay, professionals wonder who they were in that moment, what they lost, what remained, and what transformed.

These experiences are not just technical, but also existential. Being touched by another's distress also implies recognizing one's own limitations. Many professionals report persistent fatigue, insomnia, and a body that remains on high alert outside of work. Others claim to remain in the profession out of faith—faith in care, in others, or in something they may not even know how to name. They persist, even when exhausted, because they believe their presence makes a difference. However, this persistence comes with cracks; the line between continuing and protecting oneself is never clear. Each new crisis reopens the question of how far one can go.

In short, professionals who deal with patients in crisis exhibiting conflictual behavior have an ethical, emotional, and physical experience that requires presence and responsibility towards others. It is a way of being in the world in which care transcends technique and becomes a radical exposure to distress, risk, and humanity itself.

3.2 Description of the empirical variations of experiences

The following presents the six essential constituents identified through a phenomenological analysis of interviews with 12 mental healthcare professionals. Each constituent expresses a core meaning of dealing with patients in crisis who exhibit conflictual behavior. There are also illustrative empirical variations. The statements were coded to ensure anonymity, and proper names were omitted to maintain confidentiality.

3.2.1 Experiencing crisis as a disruption of daily life and an exposure of the self

Professionals experience the eruption of a psychiatric crisis as an event that abruptly disrupts the institutional routine. It is not gradual or predictable, but rather an emergency that forces caregivers to face total physical, emotional, and technical exposure. The usual space of care becomes a risky scenario, demanding an immediate presence and urgent action. In these situations, technique gives way to instinct, and the body becomes the primary coping mechanism.

In several reports, this rupture is strongly evident. A professional recalls:

> *"Then he started complaining about the scrubs, and he began banging on the furniture in the medication room* […], *I tried to leave the medication room, and the patient pushed me onto the oxygen tanks* […], *at that point, I got up, tried to leave again until he grabbed my trachea and started squeezing. At that point, I had to defend myself, so I grabbed him in a way that also defended me* […]. *He came back with two knives and wanted to enter the ward, and said they were for me".* (P1)

The intensity of episodes transforms work environments into a space of conflict, as another participant reports:

> *"He came in disrupting the service, throwing everything, threatening employees. The patient is very strong,* [...] *on the day of his restraint, there were actually three restraints in quick succession at the same time. He was in one place, and other patients were in another* [...], *the patient assaulted the employees, the employees were injured. And there was an employee who had to leave early because he was injured* [...], *we restrained the patient on the floor. It was an even more brutal and heavy restraint. Several professionals were on top of him, he was kicking and fighting against the team that was present, and we had to take the already restrained patient to the bed".* (P2)

Even when a situation begins seemingly mildly, a crisis can suddenly escalate and disrupt the scene:

> *"She suddenly freaked out in the courtyard and wanted to escape, so when I realized what was happening, I called the* (professional). *Then she went all out for the* (professional's) *neck. I tried to hold her arms to protect my colleague and stop her from continuing the aggression. Then the* (professional) *came and we finished restraining her. But the* (professional) *had to throw himself to the ground to hold her down, because she was furious".* (P7)

The need to mobilize the support network highlights the limits of the service's internal containment capacity:

> *"*[...] *there wasn't time to reach an agreement. We had to intervene, make several interventions, call the police for help, because he was very aggressive and threatening. That's when we had to call the municipal guard. We also had to call the team from (*another mental healthcare service in the network) *to intervene. When we saw that the situation was already out of control, we sought help from the Municipal Guard".* (P6)

Situations in which professionals are alone increase feelings of vulnerability and urgency:

> *"[...] last week, there was a disturbance with this patient. I was alone in the office. He came in, I was surrounded at the table, there was no way to jump over him, although I quickly thought, 'I'll go under the table or I'll jump over the table,' but it was no use: he grabbed the trash can and started hitting me, but the trash can fell to the floor, and he quickly went to pick it up, I grabbed a chair to put in front of him to defend myself. And then I yelled for the staff to come into the room; he came in and closed the door".* (P4)

The crisis is intensifying, and verbal mediation is proving ineffective:

> *"He went into the kitchen for dinner, and right away he started saying he wasn't going to take his medication. He was talking to another patient, and then his mood started to change. He was also becoming persecutory with the staff. He started saying he wasn't going to take his medicine, that it was pointless to even touch him, because otherwise he would attack. And we went to talk to him. But then he got agitated and threw a table up in the air, and we went to stop him [...]. The patient became agitated, freaked out, and started breaking things in the kitchen, and we didn't want to get in touch [...] when we arrived, he had already wrecked the kitchen. It was quite a mess".* (P5)

The reports reveal that, for professionals, the crisis disrupts daily life and establishes a time of exception. Predictability and technique are temporarily suspended and replaced by emergency physical and emotional responses. The service, usually a place dedicated to care, transforms into a threatening space, demanding quick decisions and improvised actions. The crisis belongs not only to patients but also to the team. It instills chaos and redefines caregivers' way of being in the world, even if temporarily. By exposing professionals to risk, the crisis calls upon them to act with their entire being: body, emotion, intuition, and humanity.

3.2.2 Experiencing affection as an immediate and inevitable response

The experiences reported show that the crisis immediately and uncontrollably mobilizes emotions. Even before a technical assessment or the definition of management or containment, intense emotions have already touched the body of professionals. Reactions such as fear, anguish, fright, pity, sadness, compassion, and exhaustion emerge, independent of will or protocol. These reactions are modes of presence in the face of another's disorganization.

Fear emerges as the initial emotion:

> *"At first, it's frightening. The young man speaks louder, and there's a growth in his stature, as if the man becomes a giant in front of you. And we become fearful because we don't know the outcome, what will happen. Initially, when we come into contact with these hostile situations, we get used to it [...], we're*

usually afraid, which is normal, and we start to wonder if that's really what we want". (P10)

This fear can escalate into panic:

"Initially, it's tense, it's scary. Then comes the reaction. Once the team is together, we gain more courage, but initially, it's really tense [...]. We're afraid, because [...] even more so when it's a man. Men have more strength than women, so panic sets in". (P12)

There are times when fear prevents initiative, requiring another professional to intervene:

"It was a patient I'd felt very intimidated by (patient's name). *Several [...] times he restrained me; I didn't have the courage to approach him first. Someone else had to approach him so I could go in afterward, because of my fear of him".* (P12)

At other times, the emotion mobilized is the instinctive need for defense:

"Because, at the moment you are attacked, you are also a human being, so you become braver, you don't care if the person comes in, if they do something [...] because, at the moment when people have this outburst of anger, you think, 'If I don't defend myself, they will do something worse'". (P1)

Despite the harshness of the scene, feelings of care and compassion also emerge:

"Actually, I feel sorry for her acting that way. Not for hitting [...], but for begging for attention, because for someone to get to the point of self-harm, hurting themselves, it's because things aren't going well". (P7)

"Look [...] the first feeling is really one of care. This attention that we have to have to care. This care is very broad. It's both in the sense of observing to anticipate agitation, hostility, and trying to handle the situation in the best way possible". (P10)

In other situations, the predominant feelings are anguish, frustration, and emotional exhaustion:

"I feel anguish. There's this anguish, and I keep thinking about it, it makes me sad. I get distressed by these things [...] that come. Why so much rudeness, so much disrespect?" (P9)

"Now, I've had a feeling of tiredness for a long time, of thinking, like, 'I should have put a stop to it already'. Because now I'm finding that I'm more tired, you know, psychologically". (P8)

Affection can be ambivalent, mixing fear and ethical responsibility:

"So, we have that feeling of fear, but at the same time, the feeling that I need to help [...]". (P2)

Finally, some acknowledge that anger can arise momentarily, especially when professionals feel personally affected:

"Sometimes, at first, people take it personally and get irritated, especially if there's aggression. I think that's just a normal human thing. It's difficult, depending on the situation, to have the composure to understand the patient's side, to [...] understand everything that's involved". (P5)

The reports reveal that emotion is a structural aspect of the professional experience during a crisis. Fear is almost always the initial reaction and is accompanied by a range of emotions that challenge clinical rationality. When confronted with the disorganization of others, caregivers are flooded with destabilizing yet propelling affects. Anguish, compassion, exhaustion, and sadness illustrate the depth of this subjective exposure. Affect is more than a secondary factor; it is the very foundation of the experience, preceding words, conditioning action, and marking the memory of the scene. Recognizing this dimension acknowledges that care is not neutral but always involves an encounter between vulnerabilities.

3.2.3 Experiencing the word as the first ethical gesture and its exhaustion

In times of crisis, force and shouting are not the first recourse; words are. Even if they are trembling and tinged with fear, professionals launch themselves with words—a gesture that is both technical and existential. Speaking is not just an intervention; it is an affirmation that, despite the imminent chaos, a relationship is still possible and the other person, no matter how disorganized, is still a subject who can be heard. In this scenario, listening arises less from protocol and more from ethical intuition—a fragile thread that attempts to contain the collapse, sustain the bond, and delay violence.

> *"Our approach is usually to try to calm them down, but they can't. We try a verbal approach and then move on to a restraint approach, both with medication and physical means".* (P2)

> *"Initially, trying to talk is a service that heavily involves the psychological aspect* [...] *the first attitude is to try to approach them in some way through dialogue, and then it depends on patients' reaction. Depending on the reaction, we will see what the next steps are".* (P4)

Some people transform the attempt at dialogue into an almost therapeutic gesture, inventing shelters of words in the midst of a storm:

> *"And* [...] *we try our best through words and listening. And I've even had patients I brought to the office to act as a kind of on-call therapist, to talk, to start writing, to write down everything they're saying, to say they're venting* [...]. *There are some you can just keep talking* [...]. *Now, others, no, others unfortunately go all the way to the point of containment, and sometimes you need to restrain them* [...]*".* (P8)

Emphasis on dialogue also appears as an explicit strategy to avoid escalation:

> *"First, I approach it gently. They even say I'm kind of sweet when I talk to them, and I think that sometimes dialogue is, initially, the best way rather than going straight to medication or restraint".* (P7)

However, words do not always sustain the scene. When verbal appeal fails and risk becomes the norm, the situation changes rapidly, and caution turns into restraint:

> *"We went to approach him to talk. But then he got upset and threw a table up in the air, and we went to stop him* [...]. *The patient became agitated, freaked out, and started breaking things in the kitchen* [...]*". (P5)*

> *"My attitude. I, personally, tried to approach the patient at first, and* [...] *I tried to talk, but there, at that moment, I think it wouldn't have been possible and it might have come to the point where I would have had to be restrained".* (P5)

When dialogue breaks down, containment emerges as an extreme measure and is often painful for those who implement it:

> *"Personally, I detest patients being restrained. I suffer greatly seeing them restrained, and I do my best to avoid it. Whatever I can do to help them relax during my shift, I do, only when there's absolutely no other way".* (P8)

On other occasions, contact is suspended and will be resumed when listening conditions improve:

> *"My approach with this patient is to try to calm them down in that moment. However, I can, in whatever way I can, otherwise we step away, give it some time, then come back and try to understand why, to find out what led to that behavior. Often, they even tell me what happened".* (P3)

In extreme cases, there is no room for subtlety: the transition is direct and urgent:

> *"He came at the employees and there was no way to handle it. There wasn't time to talk,* [...] *there wasn't time to reach an agreement. We had to intervene* [...]*". (P6)*

Even so, many efforts seek to preserve some dignity in the act of restraint:

> *"We took the correct action and, in the end, he was restrained, but calmly. He lay down on the bed himself, and we restrained him to finish controlling the situation, and he was also medicated".* (P5)

In short, words are the initial ethical gesture of care in a crisis because they attempt to sustain the bond, affirm the dignity of others, and prevent violence. When the crisis makes listening impossible, exhausting words is experienced as a fracture in communication and the ethical project of care itself. Although restraint is necessary, it carries the moral distress of a person performing it because it exposes the limits of dialogical reason in the face of extreme disorganization. For many, the silence that remains after words are insufficient can be more distressing than the act of restraint.

3.2.4 Experiencing the crisis as a challenge to caregivers' humanity

It is not always the blow that hurts the most. Sometimes it is the word that pierces like a sentence, dismantling certainties and the individual, not the one that heals. When a crisis hits, it affects more than just patients in pain. It also reaches caregivers, destabilizing institutional security and the professional identity they had built for themselves—the one that says, "I can handle this". It is not just about applying a protocol or intervening according to guidelines because it becomes evident that professionals are affected in their own humanity. They react as people who feel, fear, and suffer. Yet, they are still called upon to be present for others.

> *"[...] the end of the story is that I left crying uncontrollably. I arrived home crying; I couldn't stop crying. [...] I felt very attacked, I was returning from maternity leave, and then you arrive somewhere, in the first week, and they call you a slut, a whore, and I don't know what else. I found it very harsh; it was very difficult".* (P9)

There is no manual that anticipates this. No technical sheet guides you on what to do when what is attacked is not the body, but dignity. The pain that follows is not only emotional, but ethical, a kind of silent collapse of belief in one's own worth.

> *"When we are attacked, we go home with a feeling of nothingness. You think, 'Wow, I'm worth nothing, nothing'* (crying)*".* (P9)

The impact is not episodic, but accumulates, becoming overload and, over time, persistent distress, loneliness in the role, and burnout that is not alleviated by rest.

> *"But until a few years ago, no, I was just holding on normally, you know? 'It's all good like this,' but now, I'm starting to feel anxious, I don't know if it's sometimes loneliness, just tiredness, I'm".* (P8)

There are scenes that cannot be erased, remaining as a shared scar. Not only for those who lived through it, but for everyone who was nearby, and the team is consumed by the same grief. The scene is repeated in the discourse as if it still needs to be digested or simply shared so as not to suffocate.

> *"What we witnessed, you know, here inside. Our colleagues, when we arrived, everyone was overwhelmed, crying a lot, our manager, you know, [...], everyone was very overwhelmed by what had happened. And even today, we still talk about it, you know. [...] it's a job I really enjoy doing. I really like mental healthcare, I've learned to like it, and these things really affect me, you know, they really affect me".* (P11)

Still, resentment does not prevail. In many reports, what emerges is compassion—not as a formula, but as a refusal to dehumanize. Even when wounded, caregivers acknowledge others' distress.

> *"[...] I don't think at any point did it provoke anger, nothing like that. Later we even became close; he came to have a very strong connection with me. [...] I feel sorry for the person, for seeing how a human being can reach such extremes".* (P1)

This empathy coexists with the pain of irreparable losses. The death of a patient is not just an event, but a devastating occurrence; grief is present even when the body is not seen and the absence weighs heavily.

> *"I was on duty with her there, with her body, you know, that... I didn't get to see her body. Everyone saw it, but I didn't want to, because I think that if it affected me without me seeing it, if I saw her... I saw the family, you know, very shocked, so you end up feeling that way, you know... a young girl, very young, the family, the mother, so... it was very sad indeed".* (P11)

Nothing is pure: crisis also produces ambivalence. There are times when aggression hurts so much that affection gives way to anger or, at least, irritation. Even when one is aware that the other person is in distress, the emotional response can still become overwhelming.

> *"Sometimes, at first, it becomes personal, you know, and... you get irritated and all that, especially if there's aggression and everything, right? Which I think is actually a normal human thing. It's difficult, depending on the situation, to have the composure to... to understand the patient's side".* (P5)

Even so, they stay. Many professionals remain not because they ignore the pain, but precisely because they do not ignore it. Others' pain calls to them, despite their own. There is a sense of duty, of calling, of silent faith in the value of being there.

> *"I've been thanking and praying a lot to God, asking Him to give me strength to help them, you know. Since I'm retiring, I want to do my best until I finish this task myself, you know? [...] at least I'm not just here to earn money, but to truly help".* (P8)

Everyday recognition sustains small gestures, words that touch, bonds that remain when everything else crumbles.

> *"I always talk about this at home, with my husband and daughters, you know? It's a real feeling they have for us, you know? We can see it! Like she keeps calling me "darling". [...] so, it really affects us, doesn't it?".* (P8)

In this context, the blurring of the boundary between the professional and the personal becomes evident. As the crisis unfolds, it affects not only individuals experiencing the crisis, but also caregivers, weakening their identity and jeopardizing their ability to provide care. Symbolic violence, such as insults, humiliation, and devaluation, can be more damaging than physical aggression because it erodes self-worth. However, it is in this space of pain and questioning that the depth of the ethical gesture becomes apparent. Many caregivers remain not out of technical obligation, but out of affective commitment, faith in care, and the bond they have built with their patients. Thus,

the crisis reveals care as radical exposure and mental healthcare as a field that demands not only competence, but also courage and humanity.

3.2.5 Experiencing crisis as a turning point in relationships and self

The crisis does not end when a patient leaves, nor does it stop at the end of a shift. It lingers as residual noise, a subtle mark, or silent reconfiguration. The critical event reorganizes the relational field, and in many cases, the way caregivers recognize themselves in their role. In some cases, despite how intense the conflict may have been, a new form of closeness emerges: care transforms, the gaze is reassessed, and otherness, previously defined by distrust or fear, is permeated by respect and, sometimes, a strange tenderness.

> *"Later we became very close; he gave me a great deal of encouragement. He would tell everyone who came to work, 'Look, don't mess with her, because she's a good person and all, but if she gets nervous, she'll show that she's just like us, she's human, so… it's best not to mess with her'".* (P1)

Even restraint, when experienced as a last resort, can open space for another type of recognition: patients realize that something was sustained, that the bond endured.

> *"Today, he's not afraid, but he has respect. And even when he's feeling bad, like today, he's there complaining that he's not well, all that stuff. He comes close to me, he talks, he vents. [...] after that time [...] during my shift, he's gotten agitated, he's yelled, he's spoken, but it never came to blows".* (P8)

The memory of the scene does not fade. It becomes part of daily life, shaping future interventions and sharpening our ability to listen for early warning signs.

> *"Today, he's seeing another, more agitated patient. He starts, 'I'm not feeling well,' 'I can't stay here'. I sat with both of them and managed one, then the other".* (P8)

This process, however, is not always immediate. There are absences, setbacks, internal timelines that do not keep pace with institutional rhythms. Returning to work sometimes requires the courage to reappear in the same place—now wounded.

> *"I remember I stayed for five days and came back and said, 'Look, I think I'm ready to work'".* (P8)

For some, the crisis acts as forced training—emotional learning in a minefield—in which one moves from paralyzing fear to a more situated know-how.

> *"In the beginning, when I first started here [...], I was scared. I would talk to the patient to say... should I say what I feel? What I felt? Oh, okay! I was scared, I was scared to get close to the patient, to really approach them, to say anything to them. I was very afraid they would yell at me [...]. Then, as time went by, you [...] get smarter, gain more experience, even knowing what to say".* (P9)

In other scenarios, what remains is the trauma, the emptiness, and the powerlessness of those who were wronged—literally or symbolically—and found no reparation:

> *"Especially here, because we get physically assaulted. And nothing happens. I tell the girls, 'We get beaten up here'. What's left for us to do? Go home and cry. The only thing left for us is to go home and cry".* (P9)

The shock can affect one's self-perception of professional worth, touching the core of the self:

> *"[...] when we are attacked, we go home with a feeling of nothingness. You think, 'Wow, I'm worthless'* (crying)". (P9)

Returning after a prolonged absence then becomes more than difficult. At times, it is unbearable to ignore what the experience has opened up as both wounds and clarity.

> *"I had this difficulty now, when I came back after being away for a year, what to say about a patient. Like, a patient was crying there [...] I thought about ignoring it, but I couldn't pretend I didn't see".* (P9)

Still, there are narratives that bear witness to discreet reconstructions: slow rapprochements, threads that reconnect where there seemed to be only rupture.

> *"I remember he also escaped… we managed to get him back here. Over time, he improved… until he stabilized […] today, interestingly, he came to work… he seemed to be doing very well".* (P10)

Rather than a pacifying synthesis, what emerges from this multiplicity of trajectories is a radical realization: crisis marks and disorganizes, but it also reshapes. Within the crisis, bonds can either grow stronger or crumble. It is from this crisis that the clinical subject can either rebuild themselves or collapse. The crisis is more than an event; it acts as an existential inflection point because it erases continuity, demands symbolic reworking, and calls upon professionals to rethink themselves as a caregiver, a body, and an ethical subject. Ultimately, the post-crisis period reveals the clinic as a field of subjectivation for both patients and caregivers.

3.2.6 Experiencing caregiving as a tension between vocation and exhaustion

In the field of mental healthcare, caring means more than performing technical tasks; it means inhabiting a territory of constant exposure. Amidst others' psychological distress, professionals find themselves torn between two extremes: consuming dedication and the need for self-preservation. Repeated and unpredictable crises wear down the body

and corrode the sense of meaning. It is not physical strength that is often exhausted, but rather the symbolic bond with the profession itself.

> *"When I first started here, I remember a colleague telling me, 'Mental healthcare has an expiration date, we can only work for ten years', [...] yeah, ten years maximum, it doesn't go beyond that, you know, because otherwise things get worse, and I'm already over 18, you know, maybe that's it".* (P8)

This silent accumulation leaves deep scars. Yet many remain, sustained by an almost stubborn faith in the possibility of caring—a hope that transcends protocol and resists disillusionment.

> *"I've been thanking and praying a lot to God, asking Him to give me strength to help them, you know? Because I'm retiring, I want to do my best until I finish this task myself, you know? [...] because I've really been thinking about them".* (P8)

For some, the connection to their work is a deeply rooted affection, something that transcends the realm of duty and approaches a vocation built over time.

> *"It's a service I really enjoy doing. I really like mental healthcare, I've learned to like it, and this stuff really affects me, you know, it really affects me".* (P11)

But vocation, far from being a natural gift, is also a field of responsibility and discernment. It requires a willingness to be affected and the courage to recognize when the limit is approaching.

> *"I think this is a moment when we need to reflect a lot, because I think that to be working, whether in a mental healthcare center [...], a CAPS, or a hospital, we have to like the mental healthcare population. So [...] I suggest to people, especially those who are just starting out, to do this self-analysis, to really see if they like working with this population".* (P8)

In this context, liking something acts as a thin line between support and collapse. It gives meaning to daily life, but it does not guarantee immunity to exhaustion.

> *"Enjoying caring for this audience, enjoying working with this audience is fundamental; it makes all the difference. For us to be successful, to be able to work with and care for this audience".* (P8)

In this context, it becomes clear that a vocation is not a cure for distress. Rather, it is an ethical and emotional process that renews with each encounter and exacts a high price from those who sustain it. Here, care is also a negotiation of one's limits, balancing the need to continue with the need to stop, and the need to be present with the need to preserve oneself. Recognizing this tension is perhaps the most ethical gesture possible, acknowledging that caregivers need care, too.

As one can infer from the conversation, mental healthcare is a field of pain and meaning. Remaining in it is an act of courage and a way of insisting on the possibility of remaining human, even when tired.

4 Discussion

The results confirm that mental healthcare professionals' experience when dealing with conflictual behavior in crisis situations extends beyond the technical field of clinical intervention. It is a phenomenologically dense experience in which individuals are affected in their corporeality, their perception of time, their emotions, and the very constitution of the self. In this context, a crisis is not merely an event that requires containment or protocols; rather, it is an abrupt bestowal of meaning that disrupts the intentional continuity of consciousness and transforms caregivers' way of being-in-the-world.

4.1 Experiencing crisis as a disruption of daily life and an exposure of the self

Disruption of daily routine, often described as sudden disorganization, reveals the impact of the crisis on lived temporality. According to Husserl (2006), all experience occurs within a continuous temporal horizon. The suspension of this horizon generates bewilderment, urgency, and exposure. Emerging as an unexpected and threatening event, the crisis breaks the habitual order of experience and establishes another time that is immediate, unpredictable, and liminal.

This disruption to routine requires caregivers' full attention, placing them in a situation of risk and responsibility. They are called upon to act, even when there are no guarantees of effectiveness. Richmond *et al*. (2012) and Chang *et al*. (2022) described this displacement as functional disorganization. Here, however, it also manifests as existential disorganization, affecting the bodies and minds of professionals.

Disorganization is not just external. Many professionals report internal confusion, momentary paralysis, or a feeling of not knowing what to do. According to Chang *et al*. (2022), the immediate emotional impact of a threat to integrity triggers physiological and cognitive reactions that hinder the ability to act in a coordinated manner. This state of suspension, which occurs between shock and the need for a quick response, lies at the heart of the crisis experience.

There is also a symbolic rupture: the therapeutic space stops being a place of listening and becomes a field of containment. This sudden transformation requires the full attention of professionals and often exposes their vulnerability. The daily routine of care then reveals its other side—one of unpredictability, fear, and subjective vulnerability.

Therefore, the crisis is not just another clinical demand; it inaugurates a new scene. This event removes professionals from their previously known script and summons them to respond to something that is not entirely under their control. This rupture gives rise to a distinct form of experience, marked by urgency, uncertainty, and risk.

4.2 Experiencing affection as an immediate and inevitable response

There is not always time to think. Sometimes, the body has already felt and reacted before a name has been given to what is happening. This immediate emotional response demonstrates that the crisis is not merely an external fact, but rather a phenomenon that directly affects the body (*Leib*), as Merleau-Ponty (1999) described. Fear, anguish, compassion, and exhaustion erupt as primary, non-deliberate emotions that shape how the world appears to an affected consciousness. In Levinas' terms, this is radical affectability in the face of the other (Levinas, 1980). Therefore, the crisis affects before it is understood and mobilizes before it is named. It is in this pre-reflective dimension that the ethics of care begins to take shape—being there, even without knowing how.

Haugvaldstad and Husum (2016) demonstrate that exposure to aggression triggers automatic physiological responses such as muscle tension, tachycardia, and hypervigilance. These responses are experienced as a warning and affective compass that guide immediate decisions, such as approaching, containing, or retreating, as a form of care rather than escape. However, emotions do not follow a script. Fear can mix with compassion, anger can give way to sadness, and perplexity can transform into an impulse of presence. Drach-Zahavy *et al.* (2011) identify four affective styles—authoritarian, empathetic, helpless, and symmetrical—and suggest that interpreting others as a threat versus as distress modulates the prevailing affect.

This terrain is evident even in training. According to Avanci, Malaguti, and Pedrão (2002), there are oscillations between authoritarian and paternalistic attitudes. These oscillations are a reflection of poorly processed contradictory emotions that reappear with greater intensity during a crisis. In short, emotion governs the scene; it comes before words and technique. When necessary, restraint is already marked by this turmoil. Recognizing this inevitability means understanding that caring also involves self-restraint—that is, moderating one's own emotions to sustain the connection with another person, rather than neutralizing it, when faced with someone who simultaneously mirrors and weakens us.

4.3 Experiencing the word as the first ethical gesture and its exhaustion

In this field, the word emerges as the initial step in recognizing the other person as a subject—an initial ethical gesture (Levinas, 1980) that aims to maintain the connection through listening and dialogue. We speak not only to contain, but also to reach out and keep the relationship alive when the ground beneath us falters. According to Richmond *et al*. (2012), verbal de-escalation can restore to patients some of what the outbreak disorganizes, such as a sense of control and belonging to the shared world. This is why, before implementing the protocol, the team uses words—an approach that is both a technique and a conviction.

However, in some scenes, words become excessive. Noise dominates, and there is no possible interlocutor. What settles in is not just silence but also an ethical mourning—a lament for an encounter that could not take place. In these cases, restraint is necessary to preserve lives and bonds, but it is also bitter. Bowers *et al.* (2014) describe it as a rupture in the field of care, and Bigwood and Crowe (2008) refer to it as an ethical wound, even when it is legitimized by protocols. Sometimes, containing means remaining silent, which can sound like an involuntary betrayal of a listening project. From a psychopathological perspective, Messas and Fukuda (2018) remind us that a crisis reshapes the fundamental aspects of existence, creating genuine limitations on intersubjectivity that do not negate ethics, but rather test them.

Nevertheless, the word does not die out. Even after containment, speaking to reconnect and mend what has been torn sets the bond in motion again. Bowers *et al*. (2015) demonstrate that empathetic and consistent verbal interventions decrease the likelihood of new containments. The lesson is simple yet demanding. The momentary failure of words does not eliminate their symbolic power; rather, it reveals their centrality. Restraint is experienced as failure precisely because listening matters. Thus, words are not instruments, but ethical stances—a horizon to which one always returns, even when the situation demands the careful use of force.

4.4 Experiencing crisis as a challenge to caregivers' humanity

Sometimes, it is not just the protocol that crumbles, but also the belief that technique alone is enough. A crisis disrupts not only the situation, but also caregivers'

state of mind. Reports show that professionals are confronted with their own humanity in the moment of crisis, experiencing tears, fear, anger, guilt, and loneliness. Technique alone cannot sustain presence; what remains is the exposure—the skin, tears, and exhaustion—of someone who remains in the face of overwhelming pain.

This exposure is not a weakness to be corrected but rather a constitutive element of mental healthcare practice. Bigwood and Crowe (2008) describe it as a rupture in the care project. Even when necessary, restraint is experienced as an ethical defeat because "it is part of the job, but it ruins the job". Husum *et al.* (2020) demonstrate how humiliations and contempt, which have become normalized in daily life, silence workers' distress. Over time, this empties the essence of care. The issue is not only the impact on patients, but also the institutional helplessness that fails to support those who provide care.

Scars do not emerge from a single episode; they accumulate over time. According to Needham *et al.* (2005), successive crises can lead to affective withdrawal, insecurity, loss of empathy, and vocational doubt. In this context, the practical question is how to continue. Data indicate that successful past experiences, genuine connections with patients, and the perception of support from the team help sustain the decision to stay (Bowers *et al.*, 2014). Bowers (2014) notes that many people resort to self-affirmations such as "I have faced this before", "I am trained", and "I am not alone" in the face of aggression.

Therefore, emotional support does not only originate from within; it is also built within a network. Trust among colleagues, consistent procedures, and support during and after a crisis are important. More than technique, care requires moral courage, including the courage to remain present when the bond breaks and to begin again when possible (Bowers, 2014). In these moments, professionals cease to see themselves as merely an executor and becomes someone who is fully involved in the face of others' pain and dignity.

4.5 Experiencing crisis as a turning point in relationships and self

The crisis does not end with the episode; rather, it reconfigures relationships and alters professional self-image. Paradoxically, many reports point to subsequent reconciliations, such as gestures of respect and gratitude and renewed conversations. These are not calculated responses, but rather responses that arise before the decision. In

this vein, Marion (cited in Korelc, 2016) speaks of donation as a saturation of meaning that precedes the subject and calls upon them. Care is received before it is chosen. Thus, the bond can be rebuilt through the crisis itself and not in spite of it. Jalil *et al.* (2017) observe that navigating aggression in a certain way can improve patients' perception of the team, thereby strengthening ties.

However, the tipping point is not always positive. For other professionals, what remains is a crack: disbelief in their own actions, a desire to distance themselves, and damage to their identity. Bigwood and Crowe (2008) demonstrate that restraint can have greater implications than merely interrupting a violent act; it can also shatter the ideal of care and touch the core of the professional self. These scars do not disappear on their own. According to Needham *et al.* (2005), repeated violence alters the way we interact with others, leading to withdrawal, excessive caution, and avoidance. Thus, the crisis not only changes the relationship with patients, but also the practice itself, narrowing the boundaries of listening and shifting the limits of empathy.

This essential component indicates that the crisis is an existential event because it reorganizes caregivers' relationships and self-perception. The manner in which the bond is rebuilt or weakened following the episode serves as an indicator of how professionals perceive themselves. Examples include discreet reconstructions, rapprochement after an abyss, protective distancing, and partial rebirth. In this sense, caring is not about repeating techniques, but rather remaking oneself as a caregiver with each encounter with limits.

4.6 Experiencing caregiving as a tension between vocation and exhaustion

Finally, the tension between vocation and exhaustion emerges as an existential axis that structures a caregiver's experience. While caregiving gives meaning to the practice, it takes a heavy toll on the body, mind, and the very essence of being a caregiver. According to Schablon (2018), this is ontological exhaustion—moments when caregivers no longer recognize themselves in what they do or try to do. Jalil and Dickens (2018) show that the demand for constant emotional control favors the defensive use of masks (surface acting), which, although protective, also suffocate, allowing one to function, but by hiding emotions, multiply the pain.

A phenomenological reading adds depth to this conflict. It is not just about providing comfort or control; it is about renegotiating one's own being-in-the-world with each crisis. The reports demonstrate persistence due to ethical commitment, emotional

connections, and a profound understanding of distress. Nevertheless, signs of wear and tear emerge, including insomnia, irritability, accumulated fatigue, a feeling of emptiness, and sometimes a progressive loss of sensitivity to the pain of others. Husum *et al*. (2020) describe the unstable space between hardening and dissolving in which care loses consistency, opening blind spots that are difficult to perceive.

This dilemma is exacerbated by a lack of institutional spaces for processing workers' distress. As Bowers (2014) makes clear, team support mitigates the problem, but one cannot expect emotional support to come solely from individual resilience. Without collective support, workers are forced to make a cruel choice: continue working and risk becoming ill, or withdraw to preserve their psychological well-being. The literature indicates that mutual support, sharing difficult experiences, and reflective practice are crucial to preventing cynicism, apathy, and abandonment in response to pain. According to Jalil and Dickens (2018), constant surface acting depletes the gesture's vitality and dehumanizes care. Thus, affective distancing ceases to be a choice and becomes a defense mechanism.

The findings of this study indicate that mutual recognition within the team, legitimization of caregivers' distress, and shared construction of meaning are conditions that make it possible to remain in caregiving without losing oneself. As Bowers (2014) and Chang *et al*. (2022) emphasize, merely surviving a crisis is insufficient; it is essential to have a support system in place to assist in the aftermath. Ultimately, mental healthcare is a field of ongoing internal decisions: welcoming others without erasing oneself, insisting on bonds while acknowledging limits, and knowing when to be present or step back. Exhaustion is not a moral failing here, but a lived experience. Expressing this tension, even if it is done hesitantly or late, is what enables us to continue providing care in an ethical, sensitive, and truthful manner.

5 Final considerations

Guided by Amedeo Giorgi's phenomenology, this study sought to describe and understand the meanings experienced by mental healthcare professionals in crisis situations involving conflicting behaviors. Such episodes are not merely technical events; they are intense, intentional experiences that affect caregivers' subjectivity in multiple dimensions: bodily, affective, relational, and existential.

The analysis revealed six key components of the experience: (1) the crisis as a rupture of daily life and exposure of the self; (2) affect as an immediate and inevitable response; (3) the word as an inaugural ethical gesture and its limits; (4) the crisis as an interpellation of caregivers' humanity; (5) the critical episode as a turning point in the bond and the self; and (6) care as a tension between vocation and exhaustion. Together, these axes demonstrate that care is not merely a collection of techniques, but rather a way of being in the world that is affected by the presence of another person in distress.

When a crisis erupts, it disrupts the usual order of experience, prompting an ethical repositioning of professionals. According to Husserl (2006), all consciousness is intentional and always directed toward something. In this case, the "something" is a disorganized other that imposes itself as an unavoidable alterity. This encounter demands more than protocol. It requires an ethical presence, emotional availability, and symbolic support. Through this process, professionals recognize their limits, reassess their role, and reconfigure their caregiving identity.

However, institutional reality often silences this dimension. Without spaces for support and reflection, the crisis becomes a chronic source of distress, fostering desensitization, empathic withdrawal, and abandonment. Therefore, an agenda that recognizes the intersubjectivity of the crisis is essential. Caring for mental healthcare means caring for those who care. This requires policies, routines, and mechanisms that legitimize workers' distress and support them in processing it.

Professionals' experience is not peripheral to the crisis scene. Rather, it contributes to the scene's outcome and therapeutic potential. Crises transform not only patients, but also the people who experience them. When listened to and understood in its phenomenological depth, this transformation can lead to subjective re-elaboration, ethical growth, and the development of more compassionate practices.

In short, the findings support a truth rarely mentioned in technical discourse: "Mental healthcare work is painful for those who do it". Therefore, care is only ethically and politically sustainable when it acknowledges shared distress, recognizes that healing is a collaborative process, and understands that the dignity of care is inextricably linked to caregivers' dignity.

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