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Assessing quality of life and readmission rates among women in psychiatric care: a mixed-method study

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Abstract

Background The mental health of women is significantly shaped by gender-related issues stemming from social and cultural disparities, which intensify female susceptibility and culminate in mental disorders. Despite a plethora of studies delineating the effects of gender on mental health, there exists a conspicuous deficiency in research investigating women's viewpoints regarding their own experiences of rehospitalization. Therefore, the principal aim of our investigation was to assess the relationship between rehospitalization and the Quality of Life (QoL) among women undergoing treatment at a psychiatric care institution.

Methods We employed a mixed-methods research framework to examine the QoL and the variables pertinent to the readmission of twenty women from a public psychiatric hospital situated in the interior region of Espírito Santo, Brazil. The quantitative aspect evaluated QoL using the scores and analytical guidelines established by the World Health Organization Quality of Life Brief Version (WHOQOL-BREF) questionnaire. The results from this phase were subjected to descriptive statistical analysis. The qualitative data were derived from semi-structured interviews aimed at exploring the factors associated with readmission; the insights obtained underwent narrative analysis. This study was approved by the ethics committee. The interviews were only carried out after the patients were medically discharged.

Results Women who are readmitted do not have their problems viewed objectively and, consequently, are not having them resolved, as the factors contributing to the mental health of these patients are complex and span across the domains of physical, psychological, social relationships, and environment. There is a notably low overall QoL (M = 47.78) in the study population, with particularly poor scores in the environment (44.49), psychological (47.71) and social relationships (48.54) domains. These findings align with participants' testimonies, which emphasize the role of unstable living conditions, financial insecurity, social isolation, and family dysfunction in their ongoing struggles with mental health.

Conclusions The mental health outcomes of women are shaped by a multitude of factors, encompassing social support, access to resources, and individual coping strategies. Approaches to mental health care that are humanized and that address these factors are imperative for enhancing QoL and mitigating readmission rates.

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Keywords Quality of life, Readmission rates, Women, Psychiatric care, Patient outcomes, Brazil

Background

Women represent more than half of the Brazilian population [1], yet they continue to face systemic prejudice and discrimination, which significantly affects their mental health [2]. Mental health disorders are among the most pressing challenges in the modern world, driven by a complex interplay of individual, social, and structural factors that can either support or undermine well-being. These determinants, ranging from physical health conditions and psychological resilience to social support networks and environmental influences, directly impact a person's quality of life [3].

One critical factor in mental health care is hospital readmission, particularly in psychiatric settings. Evidence suggests that a decline in QoL scores following hospital discharge is associated with an increased risk of rehospitalization [4], a trend observed among psychiatric patients as well [5]. Therefore, understanding the key factors influencing QoL is essential to developing personalized and effective prevention strategies that enhance patient outcomes and reduce hospital readmissions [4].

Despite the availability of accessible and effective mental health interventions, there remains an urgent need to strengthen humanized, integrated, and multidisciplinary approaches that provide sustained improvements in mental health and QoL [3]. Recognizing this, the World Health Organization (WHO) launched the Comprehensive Mental Health Action Plan 2013–2030 to improve global mental health care. However, preliminary reports in 2020 revealed that progress has been insufficient in meeting the plan's objectives [3]. The COVID-19 pandemic further worsened this scenario [6], disproportionately impacting women and exacerbating existing vulnerabilities [7, 8].

The female population needs to be aware of their rights, as this awareness can foster empowerment and enhance the quality of life across various domains, ultimately benefiting mental health [9].

Women's lived experiences are shaped by social, economic, and structural inequalities [10]. Gender disparities affect multiple aspects of life, from restricted access to employment and healthcare to stigma, social exclusion, and violence, all of which contribute to poor mental health outcomes [10, 11]. Women are also more prone to internalizing disorders such as anxiety and depression [11], and they bear greater burdens of domestic and caregiving responsibilities, which further strain their well-being [12]. Additionally, restrictive social roles, limited educational opportunities, and gendered expectations regarding motherhood negatively impact women's mental health [13]. For young mothers and those with low incomes, these challenges are amplified, leading to higher stress, anxiety, and depression rates, which highlight the mental health burden associated with motherhood [14].

Although gender-related disadvantages in mental health have been widely recognized, there remains a gap in research on how these factors contribute to psychiatric rehospitalization in women [10]. Notably, few studies explore women's own perceptions of the factors influencing hospital readmission. Understanding these experiences is crucial for developing public policies and interventions that address gender disparities in mental health care and hospital readmission prevention.

Thus, this study aimed to assess the relationship between psychiatric rehospitalization and QoL among women receiving treatment at a psychiatric care center.

Methods

Study design and setting

A mixed-method research design was employed to analyze the quality of life and factors associated with readmission in women at a public psychiatric hospital in the interior of Espírito Santo, Brazil. This study utilized a quantitative cross-sectional approach to assess quality of life and a qualitative approach to explore readmission-related factors. By integrating both numerical data and personal stories, this study can capture the multifaceted nature of mental health issues, including the emotional, social, and psychological dimensions that are often missed in purely quantitative studies.

The study was conducted at the Aristides Alexandre Campos Psychiatric Care Center (CAPAAC), part of the Public Health Network of the State of Espírito Santo, located in Cachoeiro de Itapemirim, Brazil. This facility serves as a regional reference for psychiatric emergency care and short-term hospitalizations, supporting 26 municipalities within the Southern Region's Psychosocial Care Network and handling referrals from the Special Internment Regulation Nucleus for eight municipalities in the Metropolitan Region.

The study involved 20 women, there were no participants who refused to participate in the study. The data saturation process was also considered; during the interviews, no new information or differing perceptions emerged, indicating a saturation point where additional data collection would not significantly enhance the research.

Participants and eligibility criteria

A total of 20 women participated in both the quantitative and qualitative stages of the study, with no refusals. Participants were women over 18 years old who had been

discharged from the hospital with authorization from the attending physician and had a history of psychiatric readmission. Women with significant communication difficulties that could impair their ability to understand and respond to the interview or questionnaire were excluded.

Sampling was conducted based on the data saturation principle for the qualitative component interviews continued until no new information or differing perceptions emerged, ensuring that further data collection would not significantly enhance the findings.

Recruitment and data collection

Eligible participants were personally invited to participate in the study. Once they accepted, an individual meeting was scheduled. At the beginning of the meeting, the researcher explained the study's objectives, scope, and ethical considerations, including confidentiality and voluntary participation. After receiving this information, participants signed a free and informed consent form.

The data collection process of the study consisted of two main components: Quantitative Component and Qualitative Component.

The quantitative component involved the assessment of Quality of Life (QoL). Participants first completed the WHOQOL-BREF questionnaire, which evaluates four QoL domains: physical health, psychological well-being, social relationships and environmental factors [15]. The WHOQOL-BREF is a validated instrument widely used to assess QoL in individuals with mental illness. It is a valuable tool for analyzing quality of life and contributes to a better understanding of the subjective experiences of individuals with mental illness regarding their well-being. WHOQOL-BREF has demonstrated strong psychometric properties, including construct validity, predictive validity, and internal consistency. Its applicability to both inpatients and outpatients reinforces its utility in diverse mental health care contexts [16].

The instrument has also been validated for use in the Brazilian population and has satisfactory characteristics of internal consistency, discriminant validity, criterion validity, concurrent validity, and test-retest reliability. It has good psychometric performance and is practical to administer, making it a useful option for studies assessing quality of life in Brazil [17]. It is also a robust instrument for assessing quality of life in women with various psychiatric diagnoses. It is sensitive to capturing the subjective dimensions related to QoL, and is thus capable of reflecting the multifaceted impact of these disorders on the daily functioning and general well-being of these women, including aspects such as functional impairment and deficits in social support [18].

The qualitative component involved a semi-structured interview. Following the questionnaire, participants engaged in a semi-structured interview to explore their lived experiences, perceptions of psychiatric readmission, and factors influencing their QoL. The COREQ framework was used to structure the qualitative phase, ensuring methodological rigor in study design, data collection, analysis, and reporting [19].

The interviews were conducted by a male researcher, a master's student in Public Policies and Local Development, with prior training in qualitative research methods and interview techniques. He had no prior relationship with the participants, ensuring minimal bias. The researcher communicated his background, motivations, and study objectives before conducting interviews. Emphasized confidentiality to ensure participants felt comfortable sharing their experiences.

Each interview lasted approximately 60 min, was audio-recorded, and was followed by field notes to document relevant observations. To ensure consistency while allowing participants to express their experiences freely, a semi-structured interview guide was used. The topics covered were selected based on scientific evidence [4, 9, 10, 13, 15, 19, 20] and are available as Supplementary File 1. These topics included: factors influencing QoL post-hospitalization; sources of mental health support; perceived reasons for readmission; differences between first and subsequent hospitalizations; experience with medical treatment and medication use; personal goals and desires at the time of the interview.

Data collection took place between July and December 2022 in a private and neutral setting within the hospital, outside the hospitalization area, to foster trust, security, and serenity.

Before data collection, a pilot test was conducted with three participants to assess the clarity, relevance, and applicability of the semi-structured interview guide and WHOQOL-BREF questionnaire. No major modifications were required, confirming their suitability for the study.

Data analysis

Data analysis was conducted using methods appropriate to the nature of the variables. The data were tabulated and presented in graphs and tables using Microsoft Excel® software. Descriptive statistics were applied to analyze categorical variables, with results reported as absolute frequencies (n) and relative frequencies (%).

For the analysis of WHOQOL-BREF scores, the validated tool developed by Pedroso et al. [21] was utilized within Microsoft Excel® software. This tool facilitated the calculation of scores for the physical, psychological, social relationships, environment, self-assessment of QoL, and total domains. The mean scores of the WHOQOL-BREF questionnaire were transformed into a scale ranging from 0 to 100, with higher scores indicating a better quality of life.

The responses to open-ended questions were transcribed and analyzed qualitatively using narrative analysis. This approach followed a structured process [22], including: Transcribing all interviews verbatim and thoroughly reading them for a comprehensive understanding;

- Identification of core themes and subcategories, allowing themes to emerge from participants' narratives rather than being predetermined.
- Interpretation and contextualization of participants' perspectives, to ensure that the identified themes accurately reflected their social and experiential contexts.

The coding process was conducted manually by two researchers and underwent an iterative review to enhance accuracy and consistency. The categorized data were then analyzed and interpreted in relation to the study objectives.

Table 1 Sociodemographic characterization of patients readmitted to a psychiatric hospital in Espírito Santo according to age, ethnicity, marital status, level of education, municipality of residence, and occupation

Sociodemographic variables	Absolute frequencies (*n*)	Relative frequencies (%)
Age group		
18 a 29	6	30
30 a 39	7	35
40 a 49	3	15
50 a 59	1	5
60 or more	3	15
Ethnicity		
White	10	50
Mixed race	9	45
Black	1	5
Marital status		
Single	11	55
Married	4	20
Divorced	5	25
Education level		
Incomplete elementary school	8	40
Complete elementary school	7	35
Incomplete high school	2	10
Complete high school	3	15
Municipality of residence		
Local residents	6	30
Non-local residents	14	70
Works outside the home		
No	9	45
Yes	10	50
N/A	1	5

Ethical aspects

This study was conducted in accordance with the ethical standards of the 1964 Declaration of Helsinki and its later amendments, as well as the guidelines of the Brazilian National Health Council (CNS) Resolutions 466/2012 and 510/2016. The Research Ethics Committee with Human Subjects at the Escola de Ensino Superior de Ciências da Santa Casa de Misericórdia de Vitória-EMESCAM approved study under Certificate of Presentation for Ethical Consideration protocol number 57700422.7.0000.5065.

Given the sensitive nature of the study, certain measures were taken to ensure participant well-being: Follow-up for transcript validation was not conducted, as it could impose an additional burden on participants. Confidentiality was strictly maintained throughout the study. Data collected included admission/discharge dates, hospitalization history, diagnosis, sociodemographic data, QoL measures, and perceptions of mental health and readmission.

Results

Quantitative data: sociodemographic, clinical, and QoL characteristics of participant

Most of the interviewed women (65%) were aged 18 to 39 years old, did not live with their partner (80%), self-identified as white (50%), had incomplete elementary education (40%), and self-identified as 'housewives' (45%) (Table 1).

The clinical variables related to the participants' last hospitalization are illustrated in Table 2.

Most of the interviewees (45%) had bipolar affective disorder, followed by depressive episodes (25%), and were hospitalized (75%) for less than 30 days (Table 2).

The readmitted women had a total QoL score of 47.78, presenting the lowest scores in the studied population (Table 3).

Figure 1 describes the average score of each facet investigated on a scale from 0 to 100.

It was found that the facet of financial resources (score = 27.50), dependence on medication or treatment (score = 31.25), and sleep and rest (score = 36.25) had the lowest reported scores. The self-assessment of QoL reported by the interviewees had a score of 49.84, meaning approximately half of the maximum total on the evaluated scale (Fig. 1).

Qualitative data: women's perceptions of mental health, experiences, and aspirations

The topic under analysis presents multiple nuances, requiring careful consideration given the vulnerability of the interviewed participants. After a thorough examination of the narratives obtained from the in-depth, semi-structured interviews, and following a consensus among

Table 2 Diagnostic hypothesis and length of hospitalization

Clinical variables	Absolute frequencies (*n*)	Relative frequencies (%)
CID 10		
Mental and behavioral disorders due to multiple drug use and use of other psychoactive substances – dependence syndrome	1	5
Paranoid schizophrenia	1	5
Acute psychotic disorders	1	5
Mania without psychotic symptoms	1	5
Bipolar affective disorder	9	45
Depressive episodes	5	25
Recurrent depressive disorder	1	5
Mild intellectual disability	1	5
Current length of hospitalization (in days)		
Less than 30 days	15	75
30 days or more	5	25

Table 3 Average self-reported QoL scores by women readmitted to a psychiatric hospital distributed across physical, psychological, social relationships, environment, and total domains

DOMAIN	Score (0-100) *
Physical	50.48
Psychological	47.71
Social relationships	48.54
Environmental	44.49
Total	47.78

*Score converted on a scale from 0 to 100.

the research team, four core concepts and their corresponding subcategories emerged. These findings are summarized in Fig. 2a. Additionally, Fig. 2 (b) illustrates how these subcategories align with the WHOQOL domains—Physical, Psychological, Social Relationships, and Environmental—providing a clearer integration between the qualitative themes and the quantitative findings.

Regarding the perceptions of the interviewees, when women were asked about the conditions that could contribute to improving their mental health and QoL, it was observed that improving relationships with family members was the perception reported by 40% of the interviewees.

Overall, it was possible to observe in the women's reports that there is a practical desire for better family interactions, but it also reveals deeper layers of meaning-making associated with emotional support, stability, and identity reconstruction within family dynamics, as represented by Regulus's statement:

> *"My family, my family doesn't have structure, my father is someone who curses a lot, very rude, ignorant, and there's a lot of fighting between my mother and my father at home, you know? And before my mother had had depression for five years, and hers is real depression. But she took a long time to seek help; she saw that she couldn't handle it anymore and went to see a doctor. Because back then she wasn't retired yet, and you know, I'm from the rural area, and everything depends on the husband's money for the woman to survive. Unfortunately, that's how it is at my house. So, after she managed to retire, she started taking care of herself, and now she's more stable. And all the fights, everything that happened there influenced me to end up here at CAPAAC, to try to commit suicide eight times, like I said that lady who brought me here. I don't know if I'll leave here and get better because my mind isn't right. What I need to get better is to have a more united, peaceful family. Do you understand, Doctor? To have a united, peaceful family, a family that understands what you're feeling. Do you understand me, Doctor?"*

Regulus's testimony demonstrates how ongoing family conflict, domestic hostility, and economic dependence shaped her subjective experience of mental distress and directly contributed to feelings of despair. Her narrative suggests that a supportive and understanding family environment is perceived as fundamental to emotional stabilization, as well as a basis for reconstructing a coherent and meaningful personal narrative after psychiatric crises. Thus, family unity and peaceful relationships become symbolic of recovery, autonomy, and restored self-esteem, transcending merely practical considerations and pointing to deeper existential and social dimensions of mental health recovery processes.

Observing the narratives of women who emphasized the significance of family in their QoL and mental well-being, a common theme emerged: the challenge

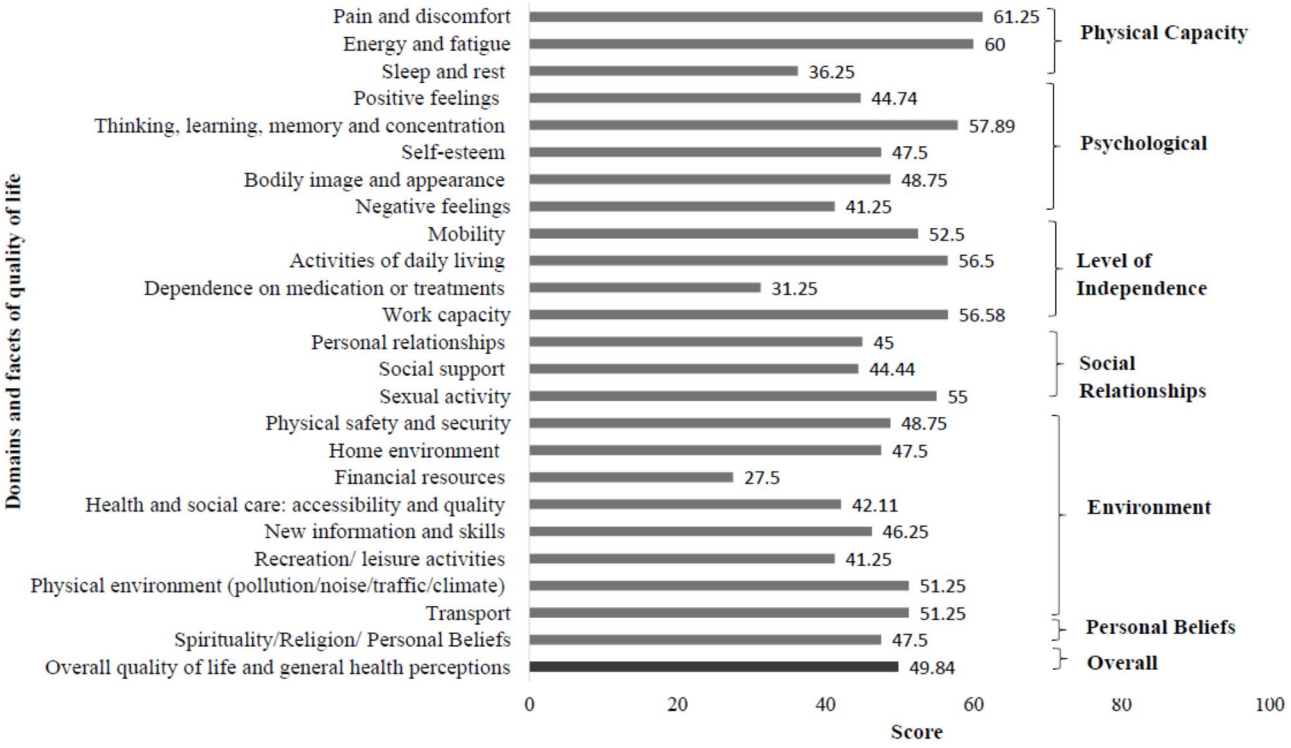


Fig. 1 Average QoL score of women readmitted to a psychiatric hospital distributed according to facets related to the physical domain, psychological domain, social relationships, and environment

of relating to one or more family members. In two instances, the desire to live alone was expressed, echoing Betelgeuse's sentiment:

> *"At the moment, I live with my family, so I don't have the right to be alone, and I'd like to be alone in my calm home. I don't have any benefits, nothing, no income, so I can pay rent and live by myself. Thus, I depend on people".*

Further highlighted in Rigel's account:

> *"My mental health would be very little if not for my children. I love my children dearly, but if I didn't have them, it would help me a lot. Another thing is living with my mother. I think I'm not fit to live together. I'm more suited to living isolated in my own space. Although I get along very well in groups, I feel better alone".*

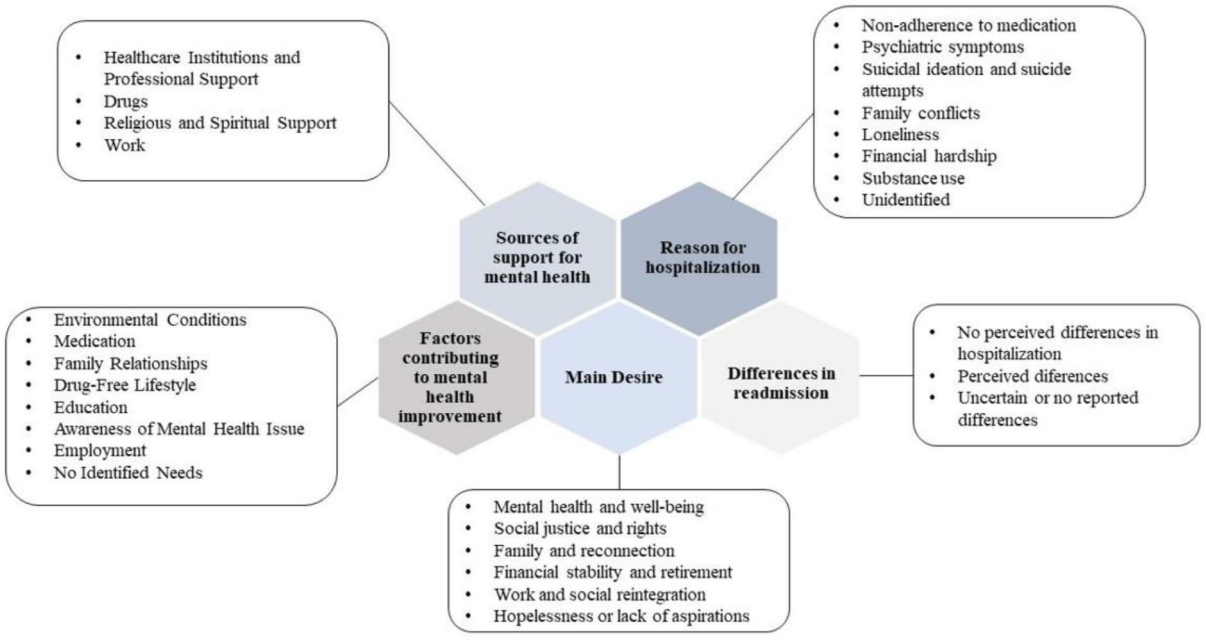
Betelgeuse's expression of a desire to live alone reflects not only economic dependence but also an underlying need for autonomy and emotional control over her personal environment. Similarly, Rigel's narrative reveals a complex internal conflict, where love and responsibility toward her children coexist with a profound need for isolation as a means of preserving her mental health. These narratives suggest that solitude, rather than merely representing isolation, symbolizes for these women a pathway toward regaining stability, independence, and a sense of identity often compromised within family relationships.

When individuals need to seek space to achieve balance in mental health and QoL, the options for seeking help reveal many perceptions. The narratives presented by participants about seeking help reflect deeper meanings attributed to healthcare services, drug use, freedom, and spirituality. Rather than mere coping mechanisms, their choices represent complex symbolic processes through which they attempt to manage distress, regain autonomy, or find existential comfort in their pursuit of mental balance and improved quality of life.

It's noted that the majority (75%) turned to healthcare institutions, underscoring the importance of the Psychosocial Care Network and its facilities, such as the psychosocial care.

> *"I am undergoing treatment at the Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD) because I am a former user and wanted to quit. I undergo treatment there and here. At "CAPS AD", I seek help when... this time I came because I was having suicidal thoughts and didn't want to die, you know? I didn't want to die. So, I knew that here*

(a)



(b)

WHOQOL-BREF Domains			
Physical	**Psychological**	**Social relationships**	**Environmental**
• Medication • Non-adherence to medication • Psychiatric symptoms	• Awareness of Mental Health Issue • Psychiatric symptoms, • Suicidal ideation and suicide attempts • Loneliness • Hopelessness or lack of aspirations • Mental health and well-being	• Family Relationships • Religious and Spiritual Support • Family conflicts • Social justice and rights • Family and reconnection	• Environmental Conditions • Financial hardship • Work • Employment • Education • Substance use • Drugs • Drug-Free Lifestyle • Work and social reintegration • Financial stability and retirement • Healthcare Institutions and Professional Support

Fig. 2 Main Core Concepts and Sub-Categories Emerged from the Semi-Structured Interviews (**a**), and Distribution of Sub-Categories According to WHOQOL Domains: Physical, Psychological, Social Relationships, and Environmental (**b**)

I wouldn't die, and I would get treatment. There was something wrong".

Drugs were also reported as a source of support for mental health, as described by Shaula:

"My son is 17 years old; I've known drugs for 17 years. I came to know drugs as an escape in my life, and from this escape valve, I stopped, relapsed, was hospitalized, returned, stopped. This is the fourth time, the fourth hospitalization. And from here, I was transferred twice to other clinics, where I stay

longer, because of a three-day relapse, I'll have to pay a very high price. I've been here for about three weeks, and from here, I'm going to another clinic. The escape valve I found in my life".

In the description of another interviewed woman, it was observed that the fear of losing freedom scares her, facing the possibility of being hospitalized, and expressed by Canopus:

"Actually, I don't like to seek help because I don't like being hospitalized. I'm afraid, like, of those people who help me improve. Because I need to have my freedom because I know that in that life there, using drugs, they will catch me sooner or later. I feel afraid because they take away my freedom, and I like my freedom. I might even stop using, right…? But I want my freedom. I may try to get better out there, but I want my freedom. I seek help when I'm feeling short of breath, feeling like I'm almost losing it; I seek to use drugs because when I use drugs, I feel satisfied, I feel good, and that's it".

Religion also demonstrated importance, as 10% of the interviewees emphasized "God" as the main source of support, as reported by Sirius:

"First of all, you think about God, so you already enter solving the problem. The second is the doctor who will prescribe me the medication".

When asked about the reasons that led to the need for rehospitalization, it was observed that suicide attempts (30%), family conflicts (20%), and depression (15%) represented most of the reasons that required hospitalization. These triggers for rehospitalization also reflect deeper existential and symbolic dimensions related to their subjective experiences, serving as manifestations of underlying struggles for autonomy, validation, identity, and purpose amidst persistent emotional distress, as illustrated by the participants' narratives below.

Suicidal ideation and suicide attempts were present in Fomalhaut's description:

"I can't explain how. But I had a breakdown, and when you have a breakdown, you have some flashes; you don't have the notion of what you're doing. Understand? I'm here why? Because I tried to kill myself. I stepped in front of the car, threw myself, broke my teeth. Now, what does it mean? With the accident, I get even more depressed until I finish the treatment. And it goes on like this".

Family conflicts were present in Capella's and Hadar's statements, who described their perceptions of relationships with their partners:

"Sadness. Very sad. Living with my husband is not going very well. I was working, and he was getting very lonely because I needed to work to help him because we were building our little house, which also helped. So, I came here. (cries)
I wanted to come because my husband was complaining that I was disturbing him. I woke up at 5 a.m., and then I wanted to go out, and he wouldn't let me. I wanted to do things, and he wouldn't let me, and then he said I was bothering him. So, that's what was happening, Doctor. He wouldn't let me take care of the house. He thought I wanted to boss him around and be the man of the house".

In the reports of perceptions regarding the main reason for rehospitalizations, it was observed that there were problems with medication adherence, as described by Rigel:

"This is a complex question that involves a lot of things. I was in a crisis, and I was refusing to take the medications. Another doctor indicated to meditate, but I continued to refuse and thus I was hospitalized. But I might not have come if I had agreed to take the medications at home. This time I was forced to be hospitalized, but on the way, I had an outburst, and I wanted to break the ambulance, so the police car came, the EMS came, and everyone gathered, so what happened during transportation was what made me stay hospitalized".
Have you been hospitalized at another time? Do you remember the reason for the first hospitalization? The interviewer asked. "Yes, refusal of treatment. I just wanted to die, to commit suicide. So why would I undergo treatment? It didn't make sense to me[a].

Financial issues were also reported by Arcturus:

"Let's say it was the lack of money. It was the tightness of things missing and I wasn't having dreams, plans, projects for my life because I didn't have the means to have money to carry them out, that was the biggest issue".

Regarding the experience of several hospitalizations, it was observed that they are perceived by women in very diverse ways. Rather than being mere repetitions, subsequent hospitalizations represent deeper layers of emotional complexity, awareness, frustration, and intensified vulnerability, reflecting an ongoing and increasingly

critical process of self-reflection about treatment expectations, personal failure, and familial bonds. The vast majority (65%) perceive it to be different if they reiterate other times and justify it as follows:

Rigel

[...] the first time you don't know, you're completely lost, the despair is ... absurd, right? You're going to a place you don't know what it's like, what kind of person you'll meet, especially when it comes to a psychiatric hospital, the second time you know.

Shaula

[...] the first time we think we're going to get cured, right? That it will be... but unfortunately, it's not the hospitalization that will be worth it. It's your mind, psychology, being, and you who will change that. The first time, there is this expectation. I'll go there and get out of this...? [...] Yes, now that I've been hospitalized, I'll never go back there again, but it's a mistake! Pure mistake! Illusion of the mind of those who think that way. That's the fact of the first time. And what's the difference between the second, third or fourth time here? I just regret it because I made a mistake again. I wasn't supposed to have made a mistake.

Canopus

[...] there's a reason why every time you're hospitalized... you're worse than the last time. And this time, I got worse. This time, I entered worse and got even worse because I missed my family more than the other times.

The treatments reported in all interviews included consultations with a psychiatrist, psychologist, and general practitioner and participation in occupational workshops and pharmacological therapy. Considering the focus of this study on understanding, from each woman's perspective, the real reasons for her rehospitalization, it was observed that more than half of them were not undergoing treatment at the time of their rehospitalization.

Archenar described what she was doing in terms of treatment at the time:

[...] I wasn't doing anything, doctor. They were forcing me to take the medicine. I don't need to take medicine, because I don't feel anything. I'm fine.

Breastfeeding and taking care of the child at night, and household chores were reasons for not using the medications, as reported by Capella:

[...] none. When the medicine ran out, I saw that I was feeling better, so I stopped on my own. I went to the doctor, and he asked me if I was taking the medicines properly, and I said yes, but in reality, I was afraid he would scold me. Because when I take the medicine at night I feel very sleepy and I can't take care of my child. I felt like sleeping all the time, during the day and at night. I had to stop breastfeeding because the medicine was too strong. My husband was also pressuring me because I couldn't take care of my children. He didn't have much patience with me and when I came back from the hospitalization, I wasn't 100% yet. I had difficulty walking and washing dishes.

The reduction in the use of prescribed medications, consequent to their absence in the popular pharmacy, and the impossibility of buying them, was reported by Arcturus:

[...] I was taking the right medicine, but as it was running out and the popular pharmacy didn't have it. I couldn't afford to keep buying until the next appointment, so that's when I came to the point where instead of taking five medications, I was only taking one.

Regarding the treatments being done at the time of rehospitalization, some patients were using the prescribed medication; however, they had not returned to the prescriber for months, as reported by Betelgeuse:

"I was only using the medications. I just wasn't going to the doctor's appointment. How long have you been without a medical appointment? Nine months".

After another hospitalization, already discharged and authorized to return to their "modus vivendi", each interviewed woman could express her greatest desire at that moment. Thus, we observed the intensity in the expression of various dreams, returns from detours or changes in their realities, some of which were possible and others that seemed to depend less on each of them in their words and more on others for their goals to be achieved. The interviewees' narratives reflected symbolic aspirations, conveying deeper existential needs such as belonging, normality, autonomy, and recognition.

It was observed that the greatest desire at that moment was to return home (40%) and to have good mental health (30%). These wishes symbolize an attempt to reconstruct disrupted personal identities, restore social connections, and regain emotional stability.

Leaving, being at home with my husband, seeing my children, missing home, having my family's love, living

with them were some of the desires expressed with emotion and sometimes tears. That's how Procyon's account went:

> *"Today, it would be to see my daughter. She's 13 years old. She'll be 14 in December. And it's been a year since I last saw her".*

Arcturus's perception was narrated as follows:

> *[...] my greatest desire is to be well psychologically, mentally, and at home, doing my tasks as a wife, mother, daughter, and taking my correct medications so I don't have to come back, because I miss it a lot here, sometimes it makes me sad. So I want to do everything I can to not have to come back and be well for them and especially for myself. For them to be well, I need to be well.*

Procyon's yearning to reconnect with her daughter and Arcturus's wish to reclaim her role within the family illustrates how these desires represent deeper processes of identity reconstruction and emotional healing.

Among the reports of the desire to have good mental health, the expression "to be a normal person" was described by Shaula as follows:

> *[...] ah... to never have experienced this crap, to have a normal life, to be a normal person, to live without this amount of medication that I take, because I use a lot of medication. I wake up and it's medication, ten and a bit more is medication, an hour is medication, all day long, my life is summed up in taking medication. For me to have a dignified life, how difficult it is, how sad it is for me, very sad! (cries).*

In the interviews, several topics were spontaneously raised by the women, such as racial discrimination, social injustice, having the physical and mental condition to return to work, equal rights for all, social security, and retirement. These elements reflect how these women's aspirations encapsulate broader struggles for meaningful existence, acceptance, and social reintegration beyond psychiatric hospitalization. Adhara said:

> *[...] my greatest desire is to go back home, build my history, my structure, continue my work out there, because I'm a micro-entrepreneur, I work for myself, I have education, I'm very hardworking, my biggest dream is to go home.*

Pólux described her desires as follows:

> *[...] there's no going back, doctor! There's no going back! I wish so much that God would take me, because I don't like living here on Earth. (cries...) Because it seems that nobody likes me back home. And to tell the truth, I don't think even the psychiatrist cares about me anymore.*

Discussion

The experiences of readmitted women reflect the complex and multidimensional nature of mental health challenges, as evidenced by both the quantitative QoL scores and the qualitative narratives gathered through interviews. The QoL results indicate a notably low overall QoL (47.78), with particularly poor scores in the environment (44.49) and psychological (47.71) domains. These findings align with participants' testimonies, which emphasize the role of unstable living conditions, financial insecurity, and social isolation in their ongoing struggles with mental health.

The core concepts that emerged from the interviews emphasize the importance of addressing both immediate clinical needs and broader structural issues, such as financial stability, family dynamics, and access to mental health care. The following sections provide a comprehensive perspective on psychiatric readmission in women and underscore the interconnected nature of psychiatric readmission in women.

Reasons for hospitalization and readmission: the complexity of psychiatric readmission

Women who experience readmission to psychiatric hospitals often face unresolved underlying issues, as their problems are not fully addressed in a structured and objective manner. The factors influencing their mental health are complex, spanning across the physical, psychological, social, and environmental domains.

The quality-of-life scores in this study (47.78) align with findings from similar studies in India and Iran, where scores ranged around 56.47. Notably, psychiatric patients tend to report the lowest scores in the psychological, social, and environmental domains, with relatively better performance in the physical domain, a trend also observed in previous research [17]. These domains with lower scores are also reflected in the testimonies of the women interviewed, who revealed, for example, experiences marked by emotional distress (psychological domain), complex family dynamics (social domain), and socioeconomic vulnerability (environmental domains).

Psychopathology, particularly anxiety and depressive symptoms, has been strongly associated with lower QoL [23]. Factors contributing to poor QoL in the psychological domain were also evident in the interviewees' narratives, which frequently included expressions of hopelessness, mood instability, and suicidal ideation.

Fomalhaut described attempting suicide by stepping in front of a car, while Shaula lamented, "For me to have a dignified life, how difficult it is, how sad it is for me, very sad!" These narratives convey the depth of emotional distress behind the low psychological scores.

Suicidal ideation and psychiatric symptoms have emerged as potential predictors of women's readmission to psychiatric hospitals, due to their profound impact on mental health outcomes.

Studies suggest that factors such as negative affectivity, history of suicide attempts, and depression play pivotal roles in psychiatric readmission [24–26]. Specifically, heightened levels of negative affectivity have been linked to elevated readmission rates in psychiatric patients [27].

The qualitative findings reinforce this, as participants frequently described mood instability, loneliness, and family conflicts as major contributors to their worsening mental health and QoL. Additionally, medication non-adherence emerged as a critical issue, with participants citing side effects, financial barriers, and caregiving responsibilities as reasons for discontinuation. This pattern aligns with evidence indicating that irregular use of prescribed medication is a major predictor of relapses and readmission [28, 29].

Sources of support for mental health: healthcare, family, and religion

Access to mental health services remains essential for these women, yet many rely on informal support networks, such as family, religion, and even substance use. The majority of participants (75%) reported seeking help from healthcare institutions, mirroring findings from a Brazilian study, where 76.2% of patients accessed public mental health services [30]. However, barriers to care persist, including stigma, gender norms, and a lack of psychological support. These barriers are reflected in the low scores for the psychological domain, particularly in aspects related to emotional support and accessibility of mental health services. For instance, while psychologists play a crucial role in mental health maintenance, only one participant explicitly mentioned receiving support from a psychologist.

Adhering to societal gender norms, such as fulfilling caregiving responsibilities, maintaining harmonious relationships, and adhering to fidelity, significantly influences whether women seek psychological support [31]. These dynamics align with participants' narratives and help explain the limited use of formal psychological services, contributing to the low QoL scores in the psychological and social domains.

Additionally, factors such as stigma, pessimism regarding the future, reluctance to discuss emotions, skepticism about healthcare professionals' ability to address psychological issues during consultations [32], psychological costs, as well as intrapersonal and interpersonal threats, act as barriers that deter women from seeking support [33]. These factors collectively contribute to the intricacies surrounding women's access to psychological help, underscoring the significance of addressing these barriers to enhance accessibility to mental health support services. Such difficulties were directly cited by participants and are consistent with the quantitative findings in the environmental domain, where access to healthcare and availability of support services were among the lowest-rated aspects.

Beyond formal healthcare, spirituality and religiosity were commonly cited as sources of mental resilience. Previous studies have found that integrating spiritual and religious considerations into patient-centered mental health care can improve treatment outcomes [34, 35]. Conversely, some participants resorted to substance use as a coping mechanism. This is a well-documented phenomenon where drug use serves as a short-term escape from emotional distress but ultimately exacerbates mental health issues.

Family conflicts were among the most reported reasons for hospitalization. Yet, paradoxically, many participants expressed a strong desire to return home, highlighting the dual role of family as both a source of emotional distress and a foundation of emotional security. This ambivalence mirrors the moderate-to-low scores in the social relationships domain, where participants' lack of stable and supportive interpersonal connections likely contributed to reduced perceptions of quality of life.

Similar findings have been reported in studies on women's empowerment and QoL, where family dynamics emerged as significant predictors of well-being [9]. However, in the present study, many women experienced inconsistent or absent family support, increasing their vulnerability. Notably, 80% of the participants lived without a partner. In this context, existing evidence [36] suggests that single individuals are more likely to experience depressive symptoms compared to those in partnered relationships, whether through cohabitation or marriage.

Factors contributing to mental health improvement: addressing medication adherence, social support, and financial stability

Although the physical domain had relatively higher scores, facets related to "sleep and rest" and "dependence on medication" were among the lowest-rated aspects. Poor sleep quality is common in individuals with mental health disorders, and depressive symptoms are significantly linked to sleep disturbances [37]. These results are supported by participants, which frequently mentioned fatigue, oversedation, and difficulty maintaining daily routines, illustrating how these physical symptoms impair their perceived quality of life. Therefore, incorporating

sleep hygiene strategies into mental health interventions may contribute to improved overall well-being.

Medication adherence was another major concern. As one participant stated: "I stopped taking my medication because it made me too sleepy to care for my child". This narrative exemplifies how the burden of side effects directly impacts medication use, a key issue reflected in the low facet score for "dependence on medication or treatment" within the physical domain. This highlights the conflict between treatment adherence and caregiving responsibilities, which is consistent with research showing that medication non-adherence increases psychiatric relapse and readmission risk [28, 29].

Socioeconomic factors: the impact of financial instability on mental health

Financial insecurity was a dominant theme, with employment challenges, gender-based financial dependence, and poverty acting as major stressors. "I want to work, but my family doesn't let me. They say it's not my place."

Economic hardship has been widely recognized as a risk factor for poor mental health, particularly among unemployed women and those in low-income households [38]. Studies suggest that achieving financial independence improves resilience and QoL [39].

These socioeconomic vulnerabilities were also reflected in the quantitative data, particularly in the environmental domain of the WHOQOL-BREF, which received the lowest average score. Participants' narratives about lack of income, dependence on others, and limited access to essential resources align with the low ratings in facets such as financial resources, opportunities for leisure, and access to health services.

Addressing these barriers requires accessible financial counseling programs and public health interventions aimed at reducing economic stressors for vulnerable populations [38, 40].

Main desires and future aspirations: hopes, barriers, and the path forward

Despite their challenges, many participants expressed strong aspirations for the future, with family reintegration, mental health stability, and financial independence emerging as primary goals.

40% of women cited returning home as their greatest wish, while 30% hoped for improved mental stability. However, some participants expressed hopelessness, feeling that their circumstances would never change. "I don't belong anywhere anymore. I don't even think my psychiatrist cares about me."

These contrasting narratives, ranging from hope to despair, are consistent with the low scores observed in the psychological domain of the WHOQOL-BREF (47.71), which includes facets such as self-esteem, negative feelings, and outlook. The participants' longing for family reconnection and emotional security also reflects the challenges captured in the social relationships domain (48.54), where lack of social support and personal relationships contributes to reduced quality of life.

This highlights the mental toll of chronic psychiatric illness, where prolonged hospitalizations and repeated relapses erode self-efficacy and hope.

Additionally, aspirations for financial independence and the frustrations caused by economic dependence align with the environmental domain's low score, particularly in areas related to financial resources and opportunities for daily life improvement.

Beyond personal aspirations, participants also discussed broader social issues, including gender roles, stigma, and the difficulty of reintegrating into society after hospitalization. These findings emphasize the need for targeted mental health interventions that address the intersection of psychological, social, and economic challenges faced by women experiencing recurrent hospitalizations.

Study limitations and implications for public policy

The main limitation of the study is related to the sample size, particularly in the analysis of factors related to QoL, which limits the generalizability of the data and extrapolation of the findings to other regions. The small number of participants compromises the generalizability of the findings, making the quantitative analysis descriptive and limited. Thus, the quantitative data should be interpreted as descriptive rather than inferential, as they only reflect the characteristics of the population studied. Although the WHOQOL-BREF is a well-validated and widely used tool for assessing quality of life, its application in a small sample reduces the statistical power of the findings. However, it was chosen because it is a valuable tool that can be incorporated as part of the routine clinical evaluation, monitoring and an important indicator of treatment outcome and research [16]. Future studies with larger samples are essential to confirm these results, allowing for more robust statistical analyses and the identification of specific sociodemographic and clinical factors that influence quality of life and readmission rates.

Given the complex factors involving QoL and mental health, the findings of this study highlight the urgent need for public policies that go beyond the immediate clinical management of psychiatric crises.

Readmission to psychiatric hospitals is a recurring event because it merely removes the woman from the crisis that led to hospitalization and, after discharge, places her back into the same routine. We cannot expect different results by doing the same things repeatedly. Drug treatment alone is insufficient to prevent readmission. Without a deliberate intervention in the quality of

life of these women, the outcomes are likely to remain unchanged. Interventions must not be limited to pharmacological treatment or short-term hospitalization but should prioritize actions centered on family support, spirituality, personal development that promote education and employment, and social integration.

Strategies should include the implementation of Women's Mental Health Reference Centers, capable of offering multidisciplinary support, therapeutic services, and assistance in areas such as employment, education, access to medication, and family support. These services should be integrated into primary care and tailored to the specific needs of women in situations of vulnerability.

In this context, QoL assessment can serve as a strategic tool to guide targeted interventions in the most affected domains, particularly the psychological, social relationships, and environmental domains. Intervening in these areas may improve long-term outcomes, promote social reintegration, and ultimately contribute to more inclusive and effective mental health policies.

By addressing the complex intersection between rehospitalization and QoL among women readmitted to psychiatric hospitals, this study contributes to a deeper understanding of their needs and challenges. Exploring the nuances of this relationship generates results with the potential to inform more comprehensive and compassionate social and public policies aimed at improving mental health care.

Conclusions

Being a woman already carries a strong stigma, as they struggle to fit into a macho social and cultural model, and prejudice is even greater when mental health hospitalization is needed. After rehospitalization, readjustment becomes necessary to cope with suffering, as plans for the future and the stigmas associated with continuing work, motherhood, and other everyday responsibilities can be impactful.

Enhancing mental health outcomes for women requires collaboration across multiple sectors to get improvements in the physical, psychological, social relationships, and environmental domains. Intersectoral partnerships can address the social determinants of mental health and improve access to comprehensive care.

This study highlights significant challenges in the provision of mental health care for women, including the disarticulation of services that fail to provide adequate support. Women need consistent tools to address the main challenges related to the hospital readmission process, especially issues related to family conflicts, which could be better addressed with increased access to psychological monitoring.

Women's mental health outcomes are influenced by various factors, including social support, access to resources, and individual coping mechanisms. Holistic approaches to mental health care that address these factors are essential for improving QoL and reducing readmission rates.

Abbreviations

CAPAAC	Aristides Alexandre Campos Psychiatric Care Center
COVID-19	Coronavirus Disease 2019
CAPS AD	Psychosocial Care Center for Alcohol and Other Drugs.
QoL	Quality of Life
WHO	World Health Organization
WHOQOL-BREF	World Health Organization QoL-BREF

Supplementary Information

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Supplementary Material 1

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Author contributions
CGA was involved in conceptualizing, designing the study, collecting the data, writing the paper, and performing data analysis. BEGD, J de AP, and EPE were involved in data tabulation, data analysis, and the review process. IMPB and CES were involved in data analysis and the review process. TCM was involved in project supervision, writing the paper, data analysis, and the review process. All authors read and approved the final manuscript.

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Data availability
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
The study was approved by the Research Ethics Committee with Human Subjects at the Escola de Ensino Superior de Ciências da Santa Casa de Misericórdia de Vitória – EMESCAM, Espírito Santo, Brazil, study under Certificate of Presentation for Ethical Consideration protocol number 57700422.7.0000.5065. The participants signed the free and informed consent form.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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