

DEPRESSION: KNOWLEDGE OF ELDERLY ATTENDED IN UNITS OF FAMILY HEALTH OF THE CITY OF LIMOEIRO – PE*

DEPRESSÃO: CONHECIMENTO DE IDOSOS ATENDIDOS EM UNIDADES DE SAÚDE DA FAMÍLIA NO MUNICÍPIO DE LIMOEIRO – PE

DEPRESIÓN: CONOCIMIENTO DE PERSONAS MAYORES ATENDIDAS EN UNIDADES DE SALUD DE LA FAMILIA EN LA CIUDAD DE LIMOEIRO – PE

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ABSTRACT

This study focused on the analyses of the comprehension of elderly patients about depression in units of family health. It is a descriptive and qualitative study, whereby interviews were realized with the elderly registered in the units of family health, using the technique of discourse analysis. It was verified that these elderly patients are, most of the time, women, between 65 and 86 years old, married and widowed, retired and housewives. The analysis of the empirical material revealed a comprehension about depression linked to sadness and discouragement, this perception was obtained by familiar and personal experiences, highlighting that the staff of the unit of family health do not approach this theme in their actions. In the context of a multidisciplinary health staff, nurses must be able to develop effective actions related to the health of the elderly in order to solve, attenuate and slow some problems such as depression, which is very present at this age. In this context, it is evident that it is necessary to implant or effectively implement good practices in mental care of the elderly in primary healthcare centers, such as an integral nursing assistance on the health of elderly.

Keywords: Depression; Elderly; Primary Health Care.

RESUMO

Este estudo tem como objetivo analisar a compreensão sobre depressão dos idosos atendidos em unidades de saúde da família. Trata-se de um estudo descritivo, qualitativo, realizado por meio de entrevistas aos idosos cadastrados nas Unidades de Saúde, com questionário semiestruturado, fazendo-se uso da técnica de análise de discurso. Verificou-se que os idosos atendidos são, em sua maioria, mulheres, pertencentes à faixa etária entre 65 e 86 anos de idade, casadas e viúvas, aposentadas e donas de casa. A análise do material empírico revelou uma compreensão da depressão relacionada a tristeza e desânimo, percepção obtida por meio de experiências pessoais e familiares, destacando-se que as equipes de saúde da família não abordam esta temática em suas ações. A enfermagem, dentro da equipe multidisciplinar de saúde, deve estar apta a desenvolver ações efetivas em relação à saúde do idoso, para solucionar, amenizar ou retardar os problemas, como depressão apresentados nessa faixa etária. Contudo, evidencia-se a necessidade da implantação ou efetiva implementação das práticas de saúde mental na rede de cuidados primários à saúde, como uma assistência integral da enfermagem com a saúde do idoso.

Palavras-chave: Depressão; Idoso; Atenção Primária à Saúde.

RESUMEN

El presente trabajo tiene como objetivo analizar la percepción sobre la depresión de los ancianos atendidos en unidades de salud de la familia. Se trata de un estudio descriptivo cualitativo realizado a través de entrevistas con personas mayores inscritas en las unidades de salud. Se utilizaron un cuestionario semiestructurado y la técnica de análisis del discurso. Se observó que los pacientes mayores son, en su mayoría, mujeres pertenecientes al grupo de edad entre los 65 y 86 años, casadas y viudas, jubiladas y amas de casa. El análisis empírico revela una comprensión de la depresión relacionada a la tristeza y desánimo, percepción obtenida a través de experiencias personales y familiares, haciendo hincapié en que los equipos de salud de la familia no enfocan este asunto en sus acciones. La enfermería, dentro del equipo multidisciplinario de salud, debe estar preparada para

llevar a cabo acciones efectivas relacionadas con la salud de la gente mayor, para resolver, suavizar o retardar problemas, como la depresión, en este grupo de edad. Ello pone de relieve la necesidad de crear o de implementar prácticas de salud mental en el sistema de atención primaria de la salud, tal como el cuidado integral de enfermería de la salud de las personas mayores.

Palabras clave: Depresión; Ancianos; Atención Primaria de Salud.

INTRODUCTION

The aging process is followed by physical, social and psychological changes, which lead to anxiety, fear, insecurity, conflicts and feelings of loneliness. In Brazil, the population above 60 years of age accounted for about 8% of the Brazilian population in 2000, equivalent to 15 million people. In 2010, this proportion increased to 12%, approximately 18 million people. It is estimated that in 2020, the elderly will account for 15% of the national population.¹

It is verified through epidemiological data that growth of the elderly population is a consequence of decreasing mortality and a decline in fertility, which enhances health and socioeconomic problems, due to the specific existential circumstances of the aging process.²

Diseases contracted during this phase of life, along with loss of emotional bonds, loneliness, loss of a relative or friend, retirement or social inactivation, among others, are important factors for the individual to be vulnerable to mental disorders such as depression.³

Depression consists of a mental disorder that involves biological and psychosocial factors and, in the elderly, it presents particular characteristics and has a frequent occurrence. It is much more than merely a period of sadness, pessimism, low self-esteem or dejection for a loss of drastic change in life; those are often seen and can be combined with each other.

The main characteristics associated with the incidence of this disorder are: older age, female gender, chronic diseases, financial condition and mental state. It can be affirmed that this disease is an emotional disorder, which is related to high risk of morbidity and mortality.²

In the elderly, depression is often misdiagnosed and even ignored because, in general, health professionals perceive depressive symptoms as manifestations resulting from the aging process.²

The disorder is difficult to quantify, since depressive signals reflect states and feelings that vary strongly. In Brazil, the prevalence among the elderly of depression ranges from 4.7% to 36.8%.²

An elderly patient is diagnosed with depression when symptoms of this disorder for at least two weeks are present and they cause significant impairment in social and/or occupational life of the individual.⁴ In this context, depression becomes common in the aging process and has strong impact among the elderly and their caregivers.

In turn, the primary health care units (USF) offer assistance and basic support, in which the professionals involved need to be capable of performing activities of promotion, prevention and health assistance to all people in the community, including the elderly, who due their condition deserve more attention in all their psychophysiological aspects.⁵ It is necessary to incorporate scientific and specialized background knowledge in order to assist them, which require great skills to make decisions and implement them in a timely manner, aiming to reduce the risks that threaten the health of these people.

Treatment of depression is primarily carried out by antidepressant drugs, which should be linked to family support and psychotherapy that help in the psychological restructuring of the individual, increasing their level of knowledge about the disorder and facilitate self-care related to treatment and recovery.⁶

Depression and aging are currently discussed issues, however it is observed that there's a lack of knowledge produced, due to the few studies that examine knowledge of the elderly of the referred to disorder. Moreover, it was perceived that a high prevalence exists of older people with depression, as well as a lack of information about this disorder and its treatment provided in primary health care units.

However, the reflection of the elderly about their health status is relevant to their welfare, being useful to assess their health needs. Therefore, there is a significant relationship between depressive symptoms and health self-evaluation, which reveals necessity for a systematically designed monitoring of the elderly in the primary health care unit of all the health team, especially nursing staff.²

This study aimed to analyze the knowledge of the elderly registered in primary health care units on depression.

METHODS

We worked supported by the presuppositions of a descriptive study with qualitative approach. This method was chosen because it is believed that through the same, the aims of the study would be met.

The study was developed in primary health care units. The population consisted of elderly people monitored by the health-care team. Inclusion criteria for sample selection comprised of: being 60 years old or more; being registered and regularly at-

tended to in the primary health care unit (USF). The exclusion criterion was presenting some difficulty in understanding the interview. Evaluation of this understanding was determined by the perception and cognitive evaluation of the participant by the interviewer. We used the criterion of saturation in definition of sample, i.e. when new data brought repeated information.⁷ Thus, 12 seniors participated as research subjects.

To collect empirical data, the interview technique was used, using as an instrument the semistructured interview script and field journal. Elderly people were asked to participate in the study after receiving nursing care. At that moment, if they chose to participate in the study, interviews were scheduled to be held in environments in which the participants who agreed with the Informed Consent chose.

The interview had the assistance of a voice recorder and was performed upon request for consent from the elderly to participate in the study. The interview script consisted of questions related to identification of the participant such as age, contact address, gender, marital status, occupation and education level, in order to establish the sociodemographic characteristics, and consisted also of the guiding question: what is your understanding about depression? Furthermore, the field journal was used, in which observations regarding the status of the research, such as interviews and impressions related to encounters with the participants, were registered.

Having completed the recording, the oral report was fully transcribed and typed, and the names of interviewees were replaced with fictitious names of flowers to ensure anonymity. The statements of the participants were analyzed according to discourse analysis, establishing a dialogue with the relevant literature.

The technique of discourse analysis is usually indicated for qualitative studies, because it allows interaction of materials that encompass values, judgments and arguments or as means leading to a simulation in the totality of the social-historical context.⁸

In discourse analysis, the basic principal is to recognize the most abstract level (thematic) that gives coherence, when receiving a text that everything seems to be dispersed. Materialization of the information enables identifying the social position of the subject interviewed, taking into account that, from the discursive elements, it is revealed the worldview of the subject and what determined that vision. The category of intentionality is not assessed as part of the discourse, i.e., it is not analyzed the intention of the subject interviewed, but his or her knowledge in the emerged context.⁸

The analysis of the empirical material began with transcription of the records, reading the texts produced, identifying major subthemes, regrouping subthemes from the interviewed elderly's speeches and, finally, construction of remaining empirical categories.

The study was submitted to the Ethics in Research Committee (CEP) of the Otavio Freitas General Hospital of Pernambuco, and approved by it, registry: CEP 0.16.08.2010 / CAEE: 3955.0.000.344-10. It is noteworthy that the study took into consideration the ethical standards of the National Health Council (NHC), which regulates research conducted with humans, being secured to the interviewee total anonymity, privacy and the possibility of withdrawal at any stage of the research.

RESULTS AND DISCUSSION

PARTICIPANTS' SOCIODEMOGRAPHIC CHARACTERISTICS

In terms of sociodemographic characteristics, the subjects interviewed were predominantly age ranged from 65 to 86 years, female, secondary education degree, retired and housewife. The relationship between widows and married women was proportional.

Women, for having a longer life than men, are more likely to be widowed, besides being seen as responsible for the structure of their family by the society and, along with the aging process, have twice more chance than men of developing depression.⁹

In this study, it was identified that the majority of the elderly had a low level of education, which may influence their understanding of depression. Education is a prominent factor, considering that the higher the educational level, the lower the psychosomatic symptoms. Study has demonstrated a relationship between low educational level and high number of depressed elderly.⁹

Therefore, it was found that education plays a fundamental role for the understanding of depressive symptoms and their expression. From the data above, the need for implementation of educational policies that meet this clientele demand is observed.

The analysis of the empirical material allowed the identification of two categories. The first, named "depression: sadness and dismay", portray the perception of elderly on depression; and the second, named "strategies used by healthcare team for the knowledge about depression", in which strategies are discussed that can be used by healthcare teams to assist the elderly to better understand depression.

DEPRESSION: SADNESS AND DISMAY

For the quantitative analysis, the various readings of the recorded material and observations were taken as references to be made. It was found that the perception of the elderly on depression is related to sadness and discouragement. It refers to a simplistic view of the disorder, but also reproduces the popular conception, as identified in the statements:

It is a very bad, very horrible thing, you feel like disappearing from the world, you live locked, run and want to kill yourself. It is all that builds up in the mind (Rose).

The person is unwilling to do anything, isolated, without mood for anything (Daisy).

Annoying, problem, family, disease, talks alone, gets mad, sees things, keeps crying ... (Poppy).

I don't know, don't know... because I studied just little [...] No, I see things about it but I don't know what it is [...] Nobody never told me, it was a thing never told to me (Tulip).

Depression is a common mental illness in the population, especially for the elderly, intensely affecting their quality of life, being considered a risk factor for health, since it affects the biological, psychological and social states, and its development is related to intrinsic and extrinsic factors.²

A study reported that with aging there is a tendency for the occurrence of more frequent and longer lasting episodes, with higher progression to chronicity of the disease, due to the fact that for the elderly the aging process is a major aggravator that for itself, presents signs and symptoms that can be mistaken with depression. It was found in the referred study that the higher number of depressive symptoms in old age are: deterioration of physical health and of activities of daily living, and the poor social support, identifying the aggravating factor of these depressive symptoms, physical illness and the onset of cognitive impairment in elderly.¹⁰

Depression has a wide range of clinical manifestations, such as deep feelings of sadness, anxiety, loneliness, low self-esteem, pessimistic views, thoughts of death, loss of interest, decrease in concentration, loss of pleasure in the activities of daily living, besides insomnia or hypersomnia.⁹

The study associated health with independence; autonomy to develop diverse activities, a seeking and fully living behavior. In turn, the disease was associated with physical or emotional dependency, with disabilities or restrictions, which may lead to depressive state.¹¹

The knowledge about depression is important, because the way elderly people will comprise the disease will influence in the treatment, rehabilitation, recovery and prevention of other mental disorders. It can be stated that the majority reflect a deficit in knowledge regarding mental health, thus slowing their rehabilitation in the health-disease process.

It is noteworthy that several issues may interfere in the identification of depressive symptoms in the elderly, highlighting the insidious onset of symptoms, the tendency to express

these symptoms in the form of physical complaints, as well as the reluctance to report psychiatric manifestations. Moreover, a lot of times depressive symptoms, for example change of mood, are considered physiological in old age or expected reactions in the presence of physical illness.³

Through the statements of the interviewees, it is observed that, in most cases, the acquisition of information about depression occurred by means of family and personal experiences:

Nothing, they explained nothing, didn't do any lecture and nobody never came here at home. What I know I've seen in a girl that has depression for 5 years, and what people say. But the healthcare team never talk about it and don't come to my house [...] The care center does nothing (Poppy).

None. They never explain to me when I come (Carnation).

What I know about depression I didn't learn in the primary health care center, but from outsiders (Orchid).

Although some participants have reported not having doubts about the issue, during the course of the interviews some questions appeared:

I have no doubt, because what people say it is true. I would like to know if it is a severe disease. How does it start and how to take care of depression. Its symptoms... (Daisy).

[...] I have no doubt [...] would like to know more, but there is nobody to explain it (Chrysanthemum).

If depression is right? To know the treatment of depression? Where this problem begins? (Orchid).

The analysis of the elderly's discourse aimed to compact the themes, showing a contradiction in the studied phenomenon, namely, the knowledge of older people on depression and the absence of contribution of the Family Health Strategy (ESF). The elderly have a superficial understanding about depression, presenting questions about care, not being provided, according to themselves, orientations by the healthcare team responsible for the integral health care. Knowledge, information and doubt of the elderly, who are questioning, reflective and critical of the depression does not come from guiding of the health care team, being necessary integration and implementation of ESF strategies for mental health and elderly. Thus, from the elderly people's testimony, a second category emerged, which will be discussed below.

STRATEGIES USED BY HEALTHCARE TEAM FOR THE KNOWLEDGE ABOUT DEPRESSION

The discourse analysis revealed that health care teams do not use strategies such as lectures, meetings, discussions, groups, home visits to explain information about depression: “No strategy (lectures, meetings, discussions, groups, home visits) was used by PSF to explain to us what depression is” (Rose).

It is estimated that the majority of elderly patients with depression are not identified by health professionals, including nurses, due to weaknesses in professional training on this phenomenon in older people. The rate of recognition of depression and consequent effective treatment for the problem is relatively low in the context of primary health care. It is identified that there are a considerable number of elderly people with depressive symptoms, such as anxiety, low self-esteem, loneliness, insomnia, helplessness and anhedonia, but without any established therapeutic approach.¹²

These aspects highlight the non-involvement of primary health care services in the mental health of elderly patients. The user is damaged and needs to seek other services for the prevention and achieving diagnosis and treatment of depression. These are some factors that problematize the discussions about promotion, recovery, rehabilitation and prevention of mental health in old age.²

In this sense, the analysis of the empirical material allowed to identify strategies suggested by participants for addressing the theme, as lectures, meetings, home visits.

To work the depression topic. If they made a meeting for us to talk about depression, to people who are starting depression and who knows someone with depression, to learn about depression (Rose).

They could come to our houses... Working, right?... Counseling, speaking things that should be spoken (Violet).

If [...] a couple of them came here [at home] and did what you are doing, the question, and explained what it is, then [...] myself would know what it is, but if they don't come, don't explain [...], it means that I can't know. Because, today, if I was invited to go to the primary health care center [...] I would go, but my wife couldn't [...]. (Chrysanthemum).

The popular education in health can contribute to the transformation of social reality, playing a key role, since it takes relevant information to improve the quality of life, using simplified themes. Therefore, the lack of educational activities in health contributes to the deficit of knowledge of the population, which confirms the alienation of the population about

the common health problems nowadays, and delay or absence of demand for treatment and subsequent recovery.

I think it could, but no one explains it, not even the doctor himself never explained to me [...] I think they could explain this theme to us, right? [...] so we can take more care of ourselves, but the doctor only says what you say you're suffering, he doesn't explain [...] They are doctors, but the nurses are the ones who should [...] explain to us [...] (Tulip).

It was also observed the approach of a theme that is of utmost importance, and that comprises one of the doctrinal principles of the Health System, the integrality. As can be seen in the discourse above, it is evident the lack of integrality.

Integrality is one of the guidelines of the Unified Health System (SUS), established by the 1988 Constitution. However, it is not only one of the SUS guidelines defined constitutionally, it is a goal of fighting, that tries to talk and seek a set of values that are worth fighting for, because they relate to an ideal of a more fair, more caring and equal society.¹³

The individual is a human being, social, citizen who is susceptible to risks of death and illness in the biological, social and psychological sphere. Consequently, care should be provided for his or her health, and not for his or her illness. This requires that the service is done holistically, in order to eradicate the causes and mitigate risks, besides treating damages, targeting the valuation of the subject as a whole.¹³

It is crucial to join actions of popular education in health and integrality as elements that produce collective knowledge, stimulating the individual's autonomy and empowerment for self-care, of family and community.

Due to the fragility in actions to promote mental health by the professionals of primary health care units, it is clear why the delay in identification of depression by the population itself exist; the search for diagnosis and consequent treatment and rehabilitation.⁶

The reality of mental health problems seen in the population served by the primary health care team needs a qualified hearing and interventions relevant at this level of care. This is a powerful marker that indicates the incorporation into everyday practice of the expanded concept of the health-disease process. This way, it is possible to enhance the ability of health-care teams to leave the conduct based on complaints, a curative model, and generate competence and ability to articulate community and intersectoral resources.⁶

Thus, the results suggest that healthcare professionals monitor the clientele studied in an integral way, as the principle of SUS emphasizes, highlighting the promotion of mental health through lectures, meetings, orientations, discussions,

groups, home visits, individual consultations, training for the professionals, aiming to stimulate self-care of the elderly.

Considering that the main objective of the ESF is act in the prevention of diseases in the community assisted, through features of continuous monitoring of social, environmental and vital conditions of the client, a qualified team who participates in the service has the responsibility to develop strategies that minimize the feelings related to depression presented by the elderly. It is in this context that the need of dealing with emotional distress arises, taking an ethical position of respect for others, love, touch and attention as instruments for care.

Caring for the elderly, therefore, involves looking at their physical conditions, without placing in second place their psychosocial aspects, aiming at preventing or reducing the emotional distress and mental illness.

FINAL CONSIDERATIONS

Through that analysis of the interviews with elderly, it was possible to verify their knowledge of depression and the healthcare team's contribution to the same. Thus, it is required from health professionals of primary health care units, especially nurses, awareness and sensitization in order to produce information, actions and strategies on depression among the elderly, in the community and primary health care spheres, achieving identification and treatment of the problem, increasing the chance of a healthy old age.

However, it is necessary that the team, including the nurse, who is closer to the individual, develop a systematic and integral view of the elderly, family and community; that assumes in practice the inclusion of mental health activities in the Family Health Strategy, contributing to real progress in the reconstruction and reorientation of the work process in primary care, working with creativity and critical thinking through a humane, competent and solving practice, involving health promotion, prevention and rehabilitation of individuals involved in their care process.

The study highlighted the need to effectively embed the actions to prevent mental illness, specifically depression, in primary health care units, so it can be possible to develop an in-

tegral care to the elderly, family and community. It is pointed out as limitation of this study, the number of the sample participants, being relevant the development of new studies with a larger sample.

From this study, it is expected to encourage professionals to implement the policy of mental health care in primary care network, especially in family health units, reducing costs and increasing the resolution of the system.

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