

# Prevalence of depressive and anxious disorders in an area of the Family Health Strategy in the Southern Region of Tocantins

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**Abstract—Introduction:** Mental disorders are among the main causes of morbidity today and represent 22 to 25% of the care provided by the Family Health Strategy. Among them, depressive and anxious disorders are emphasized. **Objective:** To verify the prevalence and clinical-epidemiological profile of patients with depressive and anxious disorders and to analyze access to the mental health care network in an area of the Family Health Strategy in the southern region of Tocantins. **Methodology:** This is an analytical, observational, cross-sectional research of patients with anxious and depressive disorders of the Seville Basic Health Unit in Gurupi-TO, from August to October 2018. Through a form completed by the physician during consultations, with variables: epidemiological, chronic diseases, life habits, psychiatric disorder, non-pharmacological and pharmacological treatments. Descriptive analysis of the data with the help of Microsoft Excel. **Results and Discussion:** 141 patients participated in the study, with a prevalence of 5.59% of depression and anxiety. Mostly with anxiety, women, brown race, age group from 18 to 29 years and 50 to 59 years, occupation of the home, with incomplete second degree, and with partner. Presenting systemic arterial hypertension and diabetes mellitus as comorbidities, they did not adopt physical and pleasurable activities such as non-pharmacological treatment, on regular use of antidepressants and/or anxiolytic, and follow-up only in the basic health unit. **Conclusion:** the prevalence of patients with anxiety and depression was 5.59%, the study contributed to the characterization of these patients, providing information that can be used to improve mental health care.

**Keywords—Family Health Strategy. Primary Health Care. Research on Health Services. Mental Disorders.**

## I. INTRODUCTION

The perception of behavior went through several classifications during history. Currently, the term "mental disorder" or "mental disorder" is used in order to reduce the stigma of psychological conditions [1].

Mental disorders are considered one of the main causes of morbidity in current societies [2], represent four of the top ten causes of disability [3]. They reach biological, cultural, social, economic and political dimensions [4], contemplating the whole biopsychosocial landscape, and still very neglected [5].

According to the World Health Organization (WHO), one in four people in the world will be affected by a mental disturbance at a given stage of life [5]. Studies show that there are millions of patients with mental illness in the world, there is also a progressive increase in [6] [7] [8].

Among mental disorders and behavior, depressive and anxious disorders stand out, which in turn many people are diagnosed simultaneously with both conditions [7]. The current criteria for the diagnosis of mental disorders are characterized by the 5th edition of

the Diagnostic and Statistical Manual of Mental Disorders [9].

Depressed mood, loss of interest or pleasure, feelings of guilt or low self-esteem, feelings of uselessness, change in sleep pattern or appetite may be present in those diagnosed with depressive disorders. While anxious disorders refer to feelings of fear and anxiety, being classified into disorders: generalized anxiety, panic, phobias, posttraumatic stress and others [10].

In 2015, there were 322 million people in the world living with depression, with a prevalence of females and peak age group between 60 and 64 years, and of these, approximately 15% were in the Americas. In Brazil, it reached 11.548.577 people, which corresponded to 5,8% of the population [7]. By 2020, depression is estimated to reach second place in the Disability Adjusted Life Years ranking after cardiac ischemic diseases [6] [8].

Regarding anxiety disorders, while 264 million of the world's population had these disorders, 21% of them belonged to the Americas and 18.657.943 were Brazilian in 2015 [7].

Mental disorders are of paramount importance to public health, due to their chronic and disabling nature, and because they are related to increased risk for communicable and non-communicable diseases, and also these patients are more likely not to adhere to treatment, which negatively affects their health [4] [11].

Borges [12] and collaborators point out that "current public policies in mental health in Brazil recommend that people with mental disorders be followed concomitantly in primary health care and in specialized units".

The integration of the health network occurs through the reference and counter-reference process between the different levels of complexity of the services. However, it is emphasized that there is a failure in this process among the services of the network [13].

It is observed that treatment for these patients is usually available for cases of greater severity or requiring hospitalization and that comprehensiveness in meeting the needs of the population and the inequalities of the health and disease process, still need to be improved [6] [14].

So that mental health care will materialize through its strengthening and its articulation with primary care [15]. Primary health care should allow the first access of people who demand mental health care, due to the ease

of access of teams to patients [16].

Therefore, the Family Health Strategy (FHS) is considered one of the gateways for patients with psychological complaints [12]. On average, 22 to 25% of the people assisted by the FHS present mental disorders and require comprehensive and continuing health care [15]. The greater proximity of the FHS, daily and continuous can determine more appropriate management of mental disorders in the long term and also identify the relationship with environmental, family and community factors [17].

Given the various challenges of primary health care, it is necessary to know the profile of depressive mental disorders and anxious in primary care for the identification of the current reality. Since there is a shortage of epidemiological studies of psychiatric disorders, making this research timely.

Thus, the present study describes the prevalence and characterizes the clinical-epidemiological profile of patients with depressive and anxious disorders, as well as analyzes their access to the mental health care network in an area of health strategy of Family from the southern region of Tocantins in order to guide prevention projects, contribute to the health promotion and quality of life of these patients.

## II. MATERIALS AND METHODS

The analytical, observational and cross-sectional research was carried out at the Seville Basic Health Unit in Gurupi – Tocantins, from August to October 2018. This study strictly obeyed Resolution number. 466/2012 of the National Health Council and approved by the Ethics Committee on Research in Human Beings (CEP) of Gurupi University (UNIRG) under opinion number. 2.820.700/ 2018.

Data collection occurred during the medical consultation based on the form containing epidemiological and clinical variables – gender, marital status, skin color, age group, occupation, schooling, residents of the house, family income, housing, chronic diseases, life habits, psychiatric disorder, non-pharmacological treatment and pharmacological treatment, and access to the health network – use of health resources and need for referral to other health levels in the last 12 months. The collection occurred from 8/27/2018 to 31/10/2018.

The sample of this study consisted of 141 patients diagnosed with anxiety disorder and/or depressive disorder confirmed during consultation and/or medical records of both sexes, aged 18 years or older, and who voluntarily signed the Free and Informed Consent Form

(FICF).

Patients with other mental disorders, and disabilities, physical or intellectual disorders were excluded to provide the information requested in data collection, and those who were not in the unit area and who only attend for prescription renewal.

After data collection, the data was transferred to the Google Forms platform form and transposed to a spreadsheet in Microsoft Excel®. The prevalence of anxious and depressive disorders was calculated, considering the population universe of 2.520 patients.

And the absolute and relative frequencies of each variable analyzed were calculated considering the sample of 141 patients. Presented the results descriptively, mentioned in the text and in tables - Table 1 describes the epidemiological profile of anxious and depressive disorders, Table 2 refers to the housing conditions of these patients and Table 3 characterizes the non-treatment pharmacological and pharmacological.

### III. RESULTS AND DISCUSSION

The Seville Basic Health Unit of Gurupi - Tocantins serves approximately 11,500 inhabitants. During the data collection period, 2,520 patients over 18 years of age were treated, where only 141 patients with anxious and depressive disorders signed the FICF fulfilling the inclusion criteria of this study, there were more patients diagnosed with AD and DD, however, because they did not accept, they were excluded from the study.

The prevalence of anxiety and depression disorders was 5,59% in the population studied. It is

noteworthy that the sample consisted of convenience encompassing only patients diagnosed with mental disorders who attended medical consultations in August to October 2018.

The Mental Health Care Protocol states that the overall prevalence of anxiety disorders in the adult Brazilian population is 18% and that in all countries depression reaches up to 11% of the population at a certain time and throughout life, 20%. There is also a relationship of approximately 60% comorbidity between depression and generalized anxiety in primary care [18].

The prevalence rate in this study was lower than expected. The limitations of the results are recognized because it is a cross-sectional study, and the data are measured only once and be delimited to a region of the urban area of a single city and by sampling being for convenience and not active search.

Tied to this, it is believed the short period of time of data collection; the great demand only for renewal of prescriptions rather than new consultations for clinical evaluation; refusal to participate in research for fear and prejudice; not every population in the studied area attends the basic health unit; and the stigma and ignorance of mental disorders; all this influenced the results. Regarding the epidemiological profile of patients with anxious and depressive disorders in this area of FHS in the southern region of Tocantins it was observed that the majority were: women, brown race, age group from 18 to 29 years and 50 to 59 years, occupation of the home, second degree marital status with partner (Table 1).

Table 1. Epidemiological profile of patients with anxious and depressive disorders in an area of Family Health Strategy in the Southern Region of Tocantins, 2018.

SEX	n	Relative frequency (%)
Female	113	80,1
Male	28	19,9
AGE GROUP	n	%
18 the 29 years	35	24,82
30 the 39 years	18	12,77
40 the 49 years	24	17
50 the 59 years	35	24,82
60 the 69 years	15	10,64
70 years or more	14	9,93
SKIN COLOR	n	%
Yellow	5	3,55
White	21	14,9
Black	33	23,4

Brown	82	58,2
<b>OCCUPATION</b>	<b>n</b>	<b>%</b>
Student	25	17,0
Signed wallet	21	14,0
Standalone (a)	13	9,22
From home	50	35,0
Unemployed	13	9,22
Retired (a) / Pensioner	19	13,0
<b>SCHOOLING</b>	<b>n</b>	<b>%</b>
Illiterate (a)	5	3,55
Incomplete first degree	48	34
Full first grade	11	7,8
Incomplete second degree	11	7,8
Full second degree	33	23,4
Incomplete higher education	21	14,9
Complete higher education	12	8,51
<b>MARITAL SITUATION</b>	<b>n</b>	<b>%</b>
Single (a)	42	29,8
With companion (a)	67	47,5
Divorced/Separated (a)	15	10,6
Widower (a)	17	12,1
<b>RESIDENTS IN THE HOUSE</b>	<b>n</b>	<b>%</b>
1 person	16	11,35
2 or 3 people	80	56,74
4 people or more	45	31,91
<b>FAMILY INCOME</b>	<b>n</b>	<b>%</b>
≤ 1 minimum wage	57	40,4
1 to 2 minimum wages	2	1,42
2 to 3 minimum wages	61	43,3
4 to 6 minimum wages	14	9,93
≥ 7 minimum wages	7	4,96
<b>HOUSING</b>	<b>n</b>	<b>%</b>
Own	111	78,7
Rented	25	17,7
Borrowed/donated	5	3,55

Legend: n = number of patients.

In this study, most individuals with mental disorders belonged to females (80,1%), 51,1% (n = 72) diagnosed with anxious disorders, 12% (n = 17) with depressive disorders and 18% (n = 25) with both. Only 14,9% (n = 21) males had anxious disorders and 4,3% (n = 6) depressive.

Females are considered a predictor factor of greater search for health care [19]. Studies show that in Brazil, but women seek health services more than men [20] [21]. Mental disorders are present in up to 20% of women and mood and anxiety disorders are more common, [22] corroborating the findings of this study.

As well as depression, which is also more

common among women, white race, adults with shorter school education time and people who do not have a stable marital relationship, causing a negative impact for their patients and family members [6] [11]. Regarding age group, there was a predominance of anxiety and depressive disorders between 18 and 29 years and 50 years; followed from 40 to 49 years (17%); 30 to 39 years (12,77%); 60 to 69 years (10,64%); and 9,93% in those aged 70 years or older. Regarding race, there was a predominance of brown with 58,2%, followed by 23,4% black patients, 14,9% of the white race and only 3,55% yellow.

In a medium-sized municipality in the Midwest region of Brazil, the highest prevalence of common

mental disorder was in women, divorced or separated, yellow race, age group from 18 to 59 years, occupation of the home, with 4 to 7 years of study, monthly income of up to 1 salary of minimum and who lived in borrowed or donated housing [4].

In the evaluation of individuals with mental disorders of a reference unit for family health program in Santa Cruz do Sul, Rio Grande do Sul, it was found that 69,4% were female, with an average age of 37,96 years, and 62,9% attended the first degree incomplete, and 94,6% had monthly income of up to three minimum wages [23].

A higher relationship between mental disorders in this study was observed with the occupation of the home 35% (n = 50), followed by 17% (n = 25) of students, 14% (n = 21) with signed portfolio, 13% (n = 19) retired (a) or pensioner, 9,22% (n = 13) of self-employed (a) and 9,22% unemployed (a).

In another study conducted in primary care, the predominant categories among patients with Common Mental Disorders were "from home" and self-employed. The authors explain that this tendency to mental disorders is related to the fact that women who perform domestic activities, isolate themselves at home and give up the consequent socialization of a professional environment. While those so-called self-employed, that is, informal workers experience situations such as uncertainty about the work situation [4].

The level of education found in this study was the second incomplete grade corresponding to 34% of the total, followed by that with a complete second degree (23,4%), incomplete higher education (14,9%), and complete higher education (8,51%). Those with complete first grade and incomplete second grade represented 7,8% each, and only 3,5% illiterate.

In Lucchese study [4] and collaborators found that respondents who were less likely to have common mental disorders reported having four to seven years of studies, and that the lower the number of years of study, the lower the number of years of study, the more than a factor related to the presence of no due to the difficulty of insertion in the labor market. As Silva says [24] et al. that as the level of education decreases, the probability of presenting higher levels of depressive symptoms increases.

Regarding marital status, it was observed that the majority had a partner (a) representing 47,5% of the 141 patients, 29,8% were single, 10,6% divorced/separated (as), and 12,1% widowed (as). Like most patients with anxious disorders in another psychiatric outpatient study,

she was married or living with someone as if married (63,1%) [25].

For some authors, marital dissatisfaction is related to depression in women and dysthymia in men. Therefore, married women would have a higher risk of depression than single women, as well as divorced women [24].

In this study, it was verified how much family and housing conditions, that patients with mental disorders lived with 1 or 2 more people, mostly with family income of 2 to 3 minimum wages (43,3%) and who lived in their own home (78,7%).

Patients with anxious and depressive disorders describe the number of residents in the house in 56,74% as 2 or 3 people, followed by 31,91% as 4 people or more, and only 11,35% reside alone. Most patients in this study have their own home (78,7%), and the others live in rented homes (17,7%) and borrowed or donated (3,55%).

Family income corresponds to 2 to 3 minimum wages in 43,3% of patients; followed by 40,4% living on less or 1 minimum wage; 9,93% with 4 to 6 minimum wages; 4,96% with 7 or more; and 1,42% between 1 and 2 minimum wages. It is believed that individuals with incomes of up to one minimum wage were more likely to develop Common Mental Disorder [4].

Among the 141 patients, the prevalence of patients with anxious disorders was 66% (n = 93), depressive disorders 16% (n = 23) and 18% (n = 25) had both diagnoses.

It was found in this study that 39% (n = 55) of patients with depressive and anxious disorders practiced physical activity, 16% (n = 22) used alcoholic beverages, 13% (n = 18) smoked and 3% (n = 4) used illicit drugs. Authors state that smoking is directly related to anxiety disorders, especially in females, and also with depressive disorders, especially major depressive disorder [26].

In a study with patients with depressive disorders, 23% stated that they used tobacco and 2% of alcoholic beverages. Smoking interferes with neurotransmitter metabolism and alters cytochrome P450 enzyme activity [24]. In another study, it was noted that 26,3% patients with anxiety or depressive disorders were smokers [25].

Regarding the comorbidities of this study, 38% (n = 53) have systemic arterial hypertension (SAH), 12% (n = 17) diabetes mellitus (DM), 10% (n = 14) hypothyroidism and none of the patients reported the diagnosis of dementias. While in Machado study [27] and collaborators, clinical data from elderly people with anxious disorders showed that 31% reported presenting SAH.

About anxious and depressive disorders according to non-pharmacological and pharmacological treatment (Table 2), it was noted that 14% (n = 20) of patients with anxious disorders practiced physical activity; and 14,4% (n = 2) of those with depressive disorders practiced physical activity and pleasurable

activity. Among the classes most cited as pharmacological treatment are anxiolytics and antidepressants and although most consider their adherence to regular treatment, they stated only partial improvement.

Table 2. Characterization of the treatment of patients with anxious and depressive disorders in an area of Family Health Strategy in the Southern Region of Tocantins, 2018.

	Anxious disorders		Depressive disorders		Anxious and depressive disorders	
	n	%	n	%	N	%
<b>NON-PHARMACOLOGICAL TREATMENT</b>						
Physical activity	20	14 %	9	6,4 %	7	5 %
Pleasurable activities	14	9,9 %	3	2,1 %	4	2,8 %
Physical and pleasurable activities	7	5 %	2	14,4 %	1	0,7 %
No activity	51	36 %	9	6,4 %	13	9,2 %
They did not report	1	0,7 %	0	0 %	0	0 %
<b>PHARMACOLOGICAL TREATMENT</b>						
Anxiolytics	10	7,1 %	2	1,4 %	1	0,7 %
Antidepressants	25	18 %	9	6,4 %	12	8,5 %
Association and/or other classes of medications	9	6,4 %	9	6,4 %	7	5 %
No medication	49	35 %	3	2,1 %	5	3,5 %
They did not report	0	0 %	0	0 %	0	0 %
<b>ADHERENCE TO PHARMACOLOGICAL TREATMENT</b>						
Regular use	30	21 %	18	13 %	11	7,8 %
Irregular use	9	6,4 %	0	0 %	4	2,8 %
Abandonment or suspension	14	9,9 %	1	1,7 %	5	3,5 %
You're not in treatment	40	28 %	4	2,8 %	5	3,5 %
They did not report	0	0 %	0	0 %	0	0 %
<b>RESPONSE TO PHARMACOLOGICAL TREATMENT</b>						
No improvement	2	1,4 %	0	0 %	1	0,7 %
Partial improvement	23	16 %	7	5 %	13	9,2 %
Total improvement	19	13 %	13	9,2 %	6	4,3 %
You're not in treatment	47	33 %	3	2,1 %	5	3,5 %
They did not report	2	1,4 %	0	0 %	0	0 %

Legend: n = number of patients. % = relative frequency.

Approximately 50% of patients with mental disorders do not perform physical and/or pleasurable

activities, as well as in an- other study in Itapuranga-GO that considered low the practice of physical exercises and



also suggests that physical activity helps in the rehabilitation of patients with psychological disorders, acting as a "catalyst for interpersonal relationships and stimulating the overcoming of small challenges" [24].

Regarding pharmacological treatment, about 40% were not on use of any medication. Most patients with anxious disorders used antidepressants (18%) and anxiolytics (7,1%). Furthermore, 6,4% cited other pharmacological classes and/or drug associations, such as antidepressant with anticonvulsant; anxiolytic, antidepressant and antipsychotic; anxiolytic and antidepressant; anxiolytic and anticonvulsant.

When asked about adherence to pharmacological treatment, 4,8% (n = 59) stated regular use of medications, 9,2% (n = 13) irregular use and 15,1% (n = 20) abandoned or suspended treatment. Some of the justifications for the abandonment of treatment were: fear of prejudice and influence of the family.

Non-adherence to pharmacological treatment is a complex and universal phenomenon, and when it comes to psychiatric therapy, a worsening of diseases with possible relapses and increased time for recovery is noticed [28].

The improvement in pharmacological treatment was considered total in about 26% (n = 38) of patients and partial by 34% (n = 43). In their minority, they reported not getting improvement. Corroborating the interviewees from another study that the highest prevalence occurred among patients who improved (74%) [24].

Some researchers say that 3% of the Brazilian population, that is, 5 million people, needed continuous care for severe and persistent mental disorders, and another 9% need eventual care related to less serious disorders, totaling 20 million Brazilians [28].

Primary health care is the level of the health system responsible for providing the population with the necessary care for their most common health problems, including preventive, curative, rehabilitation and health promotion measures [8].

Data such as these demonstrate the need for a well-structured mental health care network for better monitoring and promotion of quality of life.

Regarding the care network for mental health patients, in the last 12 months 14% (n = 27) required care with psychiatric specialist and 2,83% (n = 4) emergency care.

In the sample of this study 70,92% (n = 100) were followed only in the basic health unit; 23,4% (n = 33) performed psychotherapy; 13,47% (n = 19) attended the

mental health outpatient clinic, and only 2 patients were psychosocial care centers (CAPS).

Since 11,34% (n = 16) claim to have achieved referral to other levels of care by the SUS, 8,51% (n = 12) did not achieve referral, and 68,8% (n = 97) did not require access to other health levels.

Regarding the time of referral for psychiatric specialist, 0,7% (n = 1) was attended from 15 days to 1 month; 1,41% (n = 2) between 1 and 2 months; 3,54% (n = 5) between 2 and 3 months; 4,96% (n = 7) had not yet been attended. And 81,5% (n = 115) were not referred to the psychiatrist.

While the referral time for care with a psychologist was for 0,7% (n = 1) up to 15 days; 1,41% (n = 2) between 15 days and 1 month; 0,7% (n = 2) from 1 to 2 months; 0,7% (n = 1) from 4 to 5 months; 11,3% (n = 16) were not seen and 79,4% (n = 112) were not forwarded.

In a research in the Family Health Program in Santa Cruz do Sul, Rio Grande do Sul, patients with mental disorders presented a higher number of consultations with general practitioners and/or family physicians, specialists and emergency in the last 12 months, as well as schedules for some type of health service [23]. The physician considered general practitioner is the most active in mental health in Brazil and other countries, such as England, USA, and Canada [24].

Despite all impasse, it was observed that most patients performed follow-up only in the basic health unit, demonstrating the resolution of primary care in the southern region of Tocantins. However, it was observed that there is still difficulty in accessing other levels of care that provided specialized care with psychologists and psychiatrists with an average delay of 2 to 5 months.

#### IV. CONCLUSION

Knowledge of the profile of patients and the environment in which they live becomes strategic for planning and improvements in mental health. In this study, there was a prevalence of anxiety and depressive disorders of 5,59%. And the profile of patients with anxious and depressive disorders of a Family Health Strategy area in the southern region of Tocantins was presented, which corresponded to women, of the brown race, aged 18 to 29 years and 50 to 59 years, of the home, with incomplete second degree, and with companion.

Mostly diagnosed as anxious disorder, presenting systemic arterial hypertension and diabetes mellitus as comorbidities, did not adopt physical and pleasurable activities such as non-pharmacological treatment, on

regular use of antidepressants and/or anxiolytic, with clinical improvement considered partial and follow-up only in the basic health unit.

Mental disorders in primary health care are common, it is remarkable in this scenario the non-adherence to treatment, difficulty in referral to specialized care (psychiatrist and psychotherapy) and still family disarrangement due to difficulty in care of these patients. Conferring a great impact on the lives of patients with mental disorders.

The results demonstrated the importance of epidemiological studies in mental health with the identification of risk groups in the studied region, which will allow discussion with the health team in search of strategies for prevention and health promotion. In addition, they revealed the reality of access to specialized care.

The importance of primary care in the studied area as a gateway to and offering health services to the community is emphasized. However, there is a need for articulation to facilitate access to specialized consultations promoting integrality in mental health care.

It is believed that the presence and valorization of professionals with their own training at this level of the health system is a differential in the quality of mental health services. As a suggestion for future research to be conducted, it is necessary to identify the general reality of primary mental health care and also implement instruments for screening mental disorders.

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