

Users' psychological characterization of the *Birigui* Mental Health Clinic

Caracterização dos usuários do atendimento psicológico do Ambulatório de Saúde Mental de Birigui

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Abstract

To improve mental health services, the World Health Organization proposes an "epidemiological approach" based on the constant screening of existing research, and aimed at continuous improvement of psychological treatment rather than strict application of prescribed techniques. This study provides an epidemiological survey conducted at the psychology ward of the municipal *Ambulatório de Saúde Mental* in *Birigui, São Paulo*, Brazil. Data from 180 patients in psychotherapeutic care were collected, and subsequent descriptive analysis showed that the population consisted predominantly of adults (82.8% of total) and females (81.0%). Depressive disorder was the most common symptom (61.1%), and the majority of the participants (72.2%) received psychological treatment for the first time. The data presented in this paper can assist mental health professionals in selecting appropriate treatment by creating a profile of patients.

Keywords: Depression; Gender identity; Health profile; Mental health; Psychic symptoms.

Resumo

Segundo a Organização Mundial de Saúde, a fim de se aprimorarem os serviços de saúde mental, são necessários investimentos na produção de dados concretos sobre os serviços e os recursos existentes. Para cumprir essa orientação, é imprescindível uma "atitude epidemiológica", de forma a não permitir que o trabalho se restrinja apenas à aplicação de técnicas, mas imponha uma postura de invenção permanente ao lidar com o sofrimento psíquico. Este estudo, que traça o perfil epidemiológico da população que utiliza o serviço de psicologia do Ambulatório de Saúde Mental de

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Birigui São Paulo, foi realizado através de coleta de dados dos prontuários dos pacientes em atendimento psicoterapêutico. Foram pesquisados: idade, gênero, queixa, realização e duração de tratamento psicológico anterior, período do atual tratamento psicológico, forma de encaminhamento ao ambulatório e tipo de tratamento. Segundo os dados, a população atendida foi predominantemente de adultos (82,8%) do gênero feminino (81,0%). O sintoma mais comum relatado foi o transtorno depressivo (61,1%), e a maioria (72,2%) estava em tratamento psicológico pela primeira vez. Os dados analisados nos permitem concluir que a caracterização dos pacientes auxilia no esboço de um perfil de usuários para orientar e propor atendimentos dos serviços de saúde mental.

Palavras-chave: Depressão; Identidade de gênero; Perfil de saúde; Saúde mental; Sintomas psíquicos.

A municipal *Ambulatório de Saúde Mental* (ASM, Mental Health Clinic) is a specialised outpatient facility aimed at providing treatment, rehabilitation and social insertion, as well as promoting mental health. It generally targets the whole population, including children and adolescents.

The Mental Health Clinic in *Birigui* (SP) opened on 18 August 1990, in the period of psychiatric reform. At the moment this study was conducted, the unit had a total of 15,000 patients on file, of which 2,500 active. A specific service exists for the treatment of children, which means that the Mental Health Clinic mainly attends adults and adolescents (Birigui, 2009; Hirdes, 2009).

Various studies have researched the characteristics of treatment of adolescents (Barbosa, 1992; Schoen-Ferreira, Silva, Farias, & Silves, 2002), considering the transformations that this phase involves. Studies with adult subjects, on the other hand, point mainly to personal conflicts as a result of physical and/or emotional transformations (Mori & Coelho, 2003, 2004; Mori, Coelho, & Estrella 2006). However, few of these private experiences appear to reach public health services. Knowledge in the public health sector seems to be based for the most part on practical work experience of the professionals involved, and is therefore imprecise and not generalisable. It was verified that the development of services lacks parameters and systemisation, and that incentives and investments in research to improve offered services are scarce (Arcaro, 1991). Mental health services in municipal clinics have, according to official reports, a low success rate and limited impact on the larger mental health network (Brasil, 2010a).

The World Health Organization urges that investments in research on existing services and resources are necessary in order to improve mental health services. In this context, it is important to adopt an epidemiological attitude, consisting of constant assessment of the mental health state of the population, its evolution and what it is affected by. This approach ensures that services aren't restricted to the application of techniques, but involve a posture of permanent intervention in dealing with psychic suffering (Brasil, 2010b; Paraná, 2010; Santa Catarina, 2004). Knowledge of patients' complaints and demands also assists in improving the planning and organisation of preventive and curative action (Gatti & Beres, 2004; Peres, Santos, & Coelho, 2004; Romaro & Capitão, 2003).

The objective of this study is to propose an epidemiological characterisation of the patients of a mental health centre in *Birigui*, a medium-sized city in the state of *São Paulo*, thus contributing to the implementation of new strategies aimed at serving users of mental health services in a more effective way.

Method

Participants

This study is based on the collection of data from patient files of 180 patients receiving psychotherapeutic care at the *Birigui* mental health centre in the period 2009-2010. All participants gave informed consent, after which the data were collected by the psychologists responsible for the treatment. Doctor-patient confidentiality was observed, considering that the study is about

documenting differential activities (Franco & Mota, 2003).

Instruments

Following approval by the Human Ethics Committee of the *Faculdade de Odontologia de Araçatuba* (FOA, Dentistry School of Araçatuba) (Process nº 00885/2010), the following data were recorded: age, gender, complaint (reason for the patient seeking assistance), prior psychological treatment and its duration, present treatment time and referral path to the facility.

Proceedings

Data about medical complaints were collected from patients' intake charts, where the results of screening interviews are recorded. As such, this study does not aim to present full diagnoses, but rather the reasons for which the patients sought assistance. Medical diagnoses were only used in cases where those were present on the intake charts.

In order to facilitate systemisation and interpretation of data and avoid fragmentation of the patient group in many different categories, complaints were grouped according to criteria defined by the Diagnostic and Statistical Manual of Mental Disorders - DSM-IV-TR, without the pretention of making diagnostics, as applied in earlier work (Jorge, 2002). In addition, the following categories better fit into criteria established by Campezzatto and Nunes (2007), Louzada (2003), and Romaro and Capitão (2003):

- *Symptoms of depressive disorder*: Sadness/anguish, forgetfulness, irritability, insecurity/low self-esteem, sleep disorder, increase or loss of appetite, headache, compulsive crying, weariness, desire to disappear, suicidal tendency, suicide attempt and psychotic symptoms (Jorge, 2002).

- *Symptoms of anxiety disorder*: Anxiety, shortness of breath, perspiration, trembling, concern with physical health, tingling sensation, cold hands, pressure on the chest, faintish feeling,

tachycardia, changes in blood pressure, xerostomia, fear and phobia; among which fear of being alone, going up stairs, using lifts, driving, or dying (Jorge, 2002; National Institute of Mental Health, 1991; Silva, 2006), obsessive compulsive disorder, ritualism, recurring negative thoughts, compulsion towards certain behaviours, post-traumatic stress symptoms related to anguish, anger, despair, crying, physical symptoms, insomnia and delusions of persecution related to a traumatic event (Jorge, 2002; Torres & Smaira, 2001).

- *Difficulties in interpersonal relationships*: Family and marital conflicts, difficulty with interpersonal relationships in general, shyness, jealousy, aggression, impulsivity and guilt (Cerchiari, Caetano, & Faccenda, 2005; Louzada, 2003; Portugal, 2008; Romaro & Capitão, 2003).

- *Physical disease*: Heart problems, hypertension, diabetes, lupus, cancer, obesity and headaches (Campezatto & Nunes, 2007).

- *Grief*: Loss by death or separation (Louzada, 2003).

- Alcohol and/or drug abuse

- *Others*: Less common complaints and disorders, such as: bipolar affective disorder (medically diagnosed), smoking, sexual abuse and sexual dysfunction.

Registered adolescent-specific complaints were: Indiscipline, learning difficulties, distractedness, stealing, enuresis, and stuttering (Schoen-Ferreira, et al., 2002).

After the data from the medical records were grouped according to the above parameters, a descriptive analysis was performed in order to obtain group percentages and enable comparison.

Discussion

The patient's characterisation with regard to gender, it was observed that a majority of 81% of all patients were female, with 19% male patients (Table 1).

The high percentage of female patients in mental health services corresponds with finds in

Table 1Number of patients by gender and age. *Birigui (SP), 2010*

Description	Patient	
	n	%
Female patients	146	81.0
Male patients	34	19.0
Patients aged 40 to 49	44	24.4
Patients aged 50 to 59	32	17.8
Patients aged 60 to 66	14	7.8
Total adult patients	149	82.8
Total adolescent patients	31	17.2

other studies (Cerchiari et al., 2005), and may be interpreted as a manifestation of sociocultural patterns in gender relations. Prevailing behavioural standards dictate, for instance, that women are expected to externalise their emotions, seeking assistance when necessary, whereas men are expected to hide emotions and psychic distress when dealing with the difficulties that arise in daily life, thus cultivating an image of courage, strength and stability (Peres et al., 2004).

It can be observed that patients aged 40 to 49 make up the largest age group (24.4%), followed by patients aged 50 to 59 (17.8%). Both age groups have a female majority. Table 1 also shows a considerable majority of adults in the population (82.8%), compared to 17.2% adolescents. It may be assumed that the predominance of women in the age category of 40 to 59 years is associated to the climacteric period. Although it is beyond the scope of this study to confirm this assumption, it is clear that the climacteric has a profound influence on symptoms of anxiety and depression, which can urge people to seek medical and psychotherapeutic assistance. A study conducted by Pedro, Pinto-Neto, Costa-Paiva, Osis, and Hardi (2002) with female patients aged 45 to 60 revealed a high occurrence of climacteric symptoms, the most frequent of which were considered by the authors to be of psychological nature, including depression, nervous tension and irritability.

Menopause is characterised by biological, psychological and sociocultural aspects, and requires some restructuring in the psychological framework of middle-aged women (Mori & Coelho, 2004). It is

in this context that psychosocial factors act that can intensify emotional reactions. The phase in which menopause occurs often coincides with other big changes, such as retirement, children leaving home, elderly parents, and a worn-out conjugal relationship. These events can in some cases culminate into separation or being widowed (Mori & Coelho, 2003).

In the light of earlier research and the data gathered in this study, the proposal by Mori and Coelho (2003) about the importance of psychological assistance in public health services is considered highly relevant.

Another striking detail that came forward in the present study is the near absence of elderly patients. Patients aged 60-66 corresponded with 7.8% of the total, with the oldest patient being 66 years old (Table 1). The absence of elderly patients in mental health services was also emphasised by Louzada (2003).

Data from Table 2 point out that the largest group of patients, 41.1% of the population, were referred to the mental health facility by medical practitioners at *Unidade Básica de Saúde* (UBS, Basic Public Health Units). Another 15.5% were referred by medical specialists, whereas 12.2% were referred by acting professionals at the mental health centre itself. This distribution reveals that the clinic functions well within the public network, and that it receives patients through referrals by UBS, psychiatric hospitals, schools, courts, tutelary councils, psychotechnic services and other institutions, with the exception of urgent cases and emergencies, which receive immediate attention.

Table 3 below shows patients' history of prior psychological treatment. It can be seen that 72.0% of all patients have no history of psychological treatment. Of the patients that were subjected to treatment (27.8%) before, treatment periods varied from 6 months (26.4%) to one year (24.5%).

Of the patients receiving treatment at the moment the sample was taken, 40.6% had been treated for 1-6 months, whereas 17.8% had been treated for over 1 but less than 2 years. Another 17.8% had been treated for over 2 years.

Table 2Referral path to the Mental Health Clinic. *Birigui (SP), 2010*

Description	Patient's referred	
	n	%
Referred by UBS	74	41.1
Referred by medical specialists	27	15.5
Referred by the Clinic's own personnel	22	12.2

Note: UBS: *Unidade Básica de Saúde*.**Table 3**History of psychological treatment. *Birigui (SP), 2010*

Description	Prior treatment number	
	n	%
Never had psychological treatment	130	72.0
Had psychological treatment	50	27.8
Duration of treatment 6 months	13	26.4
Duration of treatment 1 year	12	24.5
Patients in treatment 1-6 months	73	40.6
Patients in treatment 1<2 years	32	17.8
Patients in treatment >2 years	32	17.8

Table 4Number of cases per type of complaint. *Birigui (SP), 2010*

Description	Patient's symptoms	
	n	%
Symptoms of Depressive Disorder	110	61.1
Difficulty in interpersonal relationships	97	53.8
Symptoms of Anxiety Disorder	84	46.6

This result may be related to a commonly held belief that the Ministry of Health established a maximum of 6 months for the duration of psychological treatment in the public sector. However, there is no official document present at the institution confirming this norm. From this, it can be inferred that the cases with treatment for more than two years involve grave mental disorders that cannot be resolved in a shorter period.

As is demonstrated in Table 4, 61.1% of the sample population sought psychological assistance as a result of symptoms related to depressive disorder. Furthermore, 53.8% suffered from difficulties in interpersonal relationships, and another 46.6% had symptoms of anxiety disorder.

Relating gender with complaints, it was observed that in both genders the prevalence of depressive disorders was the highest, followed by difficulty in interpersonal relationships and anxiety disorder, with equivalent percentages of approximately 36.0% on the two variables for female and 5.0% for male patients. This complaint is characterised by: sadness/anguish, forgetfulness, anger, irritability, insecurity/low self-esteem, sleep disorder, increase or loss of appetite, headache, compulsive crying, weariness, desire to disappear, suicidal tendency, suicide attempt and psychotic symptoms.

Analysing the profile of complaints of adolescent patients separately, a particularly high prevalence of difficulty in interpersonal relationships stood out (43.1%). This category includes: family and marital conflicts, difficulty with interpersonal relationships in general, shyness, jealousy, aggressiveness, impulsivity and guilt. The presence rate of adolescents (17.2%) in the patient group points to the importance of adopting a group-specific psychological approach that takes the critical transformations that occur during adolescence into account (Schoen-Ferreira et al., 2002).

The second most frequent complaint in adolescent patients involved symptoms of anxiety disorder, followed by depressive disorder and learning difficulties, equally distributed.

Research by Romaro & Capitão (2003) provided similar results; adolescents in their sample predominantly had difficulties in interpersonal relationships (25.4%), family relations (22.5%), learning problems (9.8%), sleep disorder, eating disorder, enuresis and difficulty in dealing with loss (8.8% cumulative).

Then, the characterisation of the epidemiological profile found in the studied population is composed, in majority, of female adults aged 40 to 59 years, referred by practitioners from a UBS, and receiving psychological treatment for the first time, the duration of which varied from 1 to 6 months. Predominant complaints related to

symptoms of depressive disorder and, in the case of adolescents, difficulty in interpersonal relationships.

The relatively high representation of middle-aged women in the Mental Health Clinic's patient file points to the importance of developing programmes that attend to the specific needs of this group. As mentioned before, it is in this phase of life that several psychosocial factors appear that can contribute to emotional problems, such as feeling of abandonment when children leave home, ageing parents, retirement and a worn-out conjugal relationship (Mori & Coelho, 2003).

For this reason, Mori and Coelho (2003) propose the inclusion of group specific psychological assistance, aimed at improving the quality of life of middle-aged women by helping them redefine their social relations, deal with losses, and redirect time and energy to new goals and pastimes.

This study revealed the necessity to revise and standardise the instruments used at the institution, considering that several variables relevant for research like marital status, occupation, education and address were either unrecorded or recorded in a non-systemised manner. It was also noted that there is a need to improve the files kept on the work and activities of psychologists. At present there is no demand by authoritative organs to provide documentation about anything other than individual and groups consults, which means that no registers are kept on extra activities like waiting room activities and sociocultural activities. Information about this was therefore collected verbally from the clinic's staff members, but if documented systematically it could make an interesting contribution to new research.

Respecting the limitations of this study and considering its context, it can be concluded that information systemisation at mental health clinics is a fundamental factor in generating reliable data needed for the implementation of improvements in mental health care. This way, the visibility and impact of projects is increased, which in turn leads to more recognition by the government and society at large.

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