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ORIGINAL ARTICLE

# LIMITATIONS AND POSSIBILITIES OF COMMUNITY HEALTH WORKERS IN IDENTIFYING DEPRESSIVE SYMPTOMS

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## ABSTRACT

**Objective:** to evaluate the knowledge of community health workers about the identification of depressive symptoms in the community. **Method:** this is a qualitative research, conducted in a Primary Health Care Unit in Teresina, Piauí, Brazil, with 15 community health workers. We used the Action-Research method. Data production took place in January and February 2019, through two thematic seminars, guided by the Creative Sensitive Method.The speeches were submitted to thematic analysis. **Results:** community health workers recognize the depressive symptoms by means of sadness, crying, isolation, anhedonia and loneliness, manifested by individuals. The limitations to this identification, reported by professionals, were difficulty of access to users and families, as well as stigma and prejudice against depression. As for the possibilities, access to information about the theme through the media, dialogue/conversation established between users and professionals, besides access to a support network, were highlighted. **Final considerations:** we conclude that the recognition, limitations and possibilities of identification of depressive symptoms by these professionals are reflected in the diagnosis, planning and implementation of actions in mental health care in an early and safe way.

**Keywords:** Community Health Workers. Depression. Primary Health Care. Mental Health. Qualitative Research.

## INTRODUCTION

With the Psychiatric Reform, the evils that affect the mental health of the Brazilian population received anew logistics for care. We started to value care interventions with a territorial and community nature, based on the promotion of biopsychosocial well-being, which enable mental health care different from that portrayed by the historical scenario of non-assistance and mistreatment[1].

Therefore, it is in Primary Health Care (PHC) that such logistics start to happen in an integrated way with the care network of the Brazilian Unified Health System (SUS, as per its Portuguese). In this new context of mental health care, through the Family Health Strategy (FHS) as an organizational and access model to SUS, where individuals requiring mental health care need to find welcoming, incorporation and structuring of appropriate spaces for the identification of symptoms of mental illness[1].

The World Health Organization (WHO) states that the identification of individuals with mental disorders by the professionals that make up the FHS teams ranges from low to moderate, where failures in terms of symptom detection are frequent[2]. In view of this reality, it is necessary to discuss this problem by FHS professionals, since they are the first opportunity in the perception of depressive symptoms in the community.

As part of the team, we can mention the Community Health Workers (CHW), who, theoretically, live in their own territory and know the problems that affect the daily lives of individuals, families and communities. Thus, they must be trained to identify early on

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individuals in need of health care; and, among these, those with mental disorders, as well as directing them to the continuity of care [3].

Despite being important, the literature points out that the knowledge of CHW about mental disorders is still sometimes precarious. This weakness can generate implications that hinder the assistance, where the lack of training of these professionals is portrayed as an obstacle in the care process[3]. Undoubtedly, this reality applies to the context where this study is inserted.

Therefore, it is necessary to know how CHW identify depressive symptoms, what are the limitations and possibilities in terms of identifying the people followed-up in their territory of work. In this context, we defined the research question as: what is the knowledge of community health workers about the identification of depressive symptoms in the community?

In order to answer this question, we outlined the objective of this research in the sense ofevaluating the knowledge of community health workers about the identification of depressive symptoms in the community.

## METHODS

This is a qualitative research, typified as intervention, which used the methodological strategy of Action-Research[4]. In order to guide the methodological conduct, we used the *Consolidated criteria for reporting qualitative research* (COREQ) as a support tool.

The study was conducted in a Primary Health Care Unit (PHCU) located in the city of Teresina, Piauí, Brazil, with 15 CHW. The inclusion criterion was to have a permanent work contract, with a minimum of 1 year of professional linkage and registration in the National Register of Health Establishments (CNES, as per its Portuguese acronym) of that PHCU. We excluded those CHW who, during the period of data production, were on vacation or away for legal reasons.

In order to carry out the research, we followed three phases of Action-Research: the exploratory one, where the survey of the problem situation and the negotiation with the research participants was held; the development, which consisted of the seminars; and, finally, the conclusion, where the analysis, the argumentation and the interpretation were performed, besides the disclosure of the results[4].

In the first phase, the negotiation meeting took place after prior scheduling through a group on the *WhatsApp* application, in January 2019. This meeting lasted 1 hour, during which clarifications and consensus were made among people belonging to the group of participants and the research team. On this occasion, it was agreed how the seminars would take place, the frequency of the seminars (biweekly), and the data collection technique that would be used[4].

In order to carry out the workshops, we made use ofthe Creative Sensitive Method (CSM) [5], adopting the brainstorming dynamics (adapted to written form) and cutting and collage, both added to the use of one or more specific trigger questions[6]. These had an average length of 1 hour and 30 minutes, being held in January and February 2019, in the meeting room of PHCU, since it enabled easy access for the participants. All seminars were recorded in meeting minutes and the speeches recorded in an application for IoS.

Action-Research is a methodology that proposes the implementation of an action. Accordingly, at the end of each thematic seminar, formal knowledge was given back to the participants through the development of a mini-exhibition[4].

Subsequently, the data produced were transcribed, mapped and categorized. These were submitted to thematic analysis, interpretation, argumentation and discussion[7], thus articulating them with concepts and conceptions about the investigated phenomenon.

The study was authorized by the Research Ethics Committee (REC) of the Federal University of Piauí (UFPI, as per its Portuguese acronym), under opinion nº 2.975.812 (CAAE nº. 00318818.0.0000.5214). All participants signed the Free and Informed Consent Form (FICF). In order to preserve the anonymity of the participants involved in the study, we used the letter "I" (I1, I2, I3 [...])throughout the results, due to the fact that it starts the word interviewee.

## RESULTS AND DISCUSSION

The following themes were raised in the analysis of the produced data: (Ac)knowledge of depressive symptomatology; Limitations in terms of identifying depressive symptoms; and Possibilities in terms of identifying depressive symptoms.

### *(Ac)knowledge of depressive symptomatology*

In this category,we observed that CHW identify users with depressive symptoms in their area of operation based on characteristics manifested by the individuals, especially sadness, crying, isolation, loss of interest in activities previously performed with pleasure and loneliness.These symptoms translate the (ac)knowledge acquired by these professionals from their experiences, cultural knowledge and popular imaginary of depressive symptoms.

It is not surprising to find other depressive manifestations in the speeches; however, the ones that most call the attention of these professionals in their home visits (HV) and remind them of the need to take care of these individuals and their relatives were the ones pointed out, as noted in the statement issued by I1 and also reported by I9:

> It's the spontaneous crying, for everything, out of nowhere, it's the lack of sleep, lack of appetite, it's the desire to always be alone, it's the anguish and sadness, these are the symptoms we identify the most on a daily basis**.(I1)**

> It's isolation, extreme negativity, deep sadness, very great sadness. To feel that somehow the world is against you, nothing you do is welcome, is accepted. **(I9)**

A study conducted in Recife, Pernambuco, Brazil, which investigated the CHW's perception in relation to mental health problems in the community, showed that, although depression is one of the most frequent diseases, they have difficulties in recognizing it, but demonstrated to welcome individuals during HV[8]. On the other hand, a research developed in Ribeirão Preto, São Paulo, Brazil, pointed out that CHW were able to identify mental health demands. Nonetheless, these demands were perceived by most of them as complex situations in need of intersectoral actions, and not only of health services[9].

As for the (ac) knowledge of depressive symptoms, the work practices experienced by CHW have a significant participation in the construction of their knowledge about mental health. These professionals learn what is asked of them to develop their work, relating it to their previous set of experiences in facing the problems that have been presented. Therefore, the knowledge of these professionals in mental health is still based on the popular imaginary, little understood and overlapped in the daily practices[8].

Depression is a heterogeneous syndrome, with a great variation in symptoms, which has made early identification of the disease more difficult. The main depressive symptoms manifested by individuals are decreased mood, reduced activities, capacity for fun, self-esteem, self-confidence and libido, reduced concentration, ideas of guilt and uselessness, somatic symptoms, feelings of tiredness, psychomotor retardation or agitation, changes concerning eating and sleeping patterns, in addition to loss of interest[10].

In addition to classic depressive symptoms, the severe symptomatology related to suicide and thoughts of death was mentioned by some CHW, referring to be a manifestation identified during HV and that integrates the knowledge of these professionals, as observed in the following speech:

> It's sadness, anguish, apathy, carelessness, loneliness. And so, somatization of the whole, the only way the person has to feel better is to commit suicide**. (I11)**

The depressive disorder can evolve as a triggering factor for suicidal behavior[11]. Individuals with suicidal behavior can be identified by several professionals of the FHS team, including CHW, because, through HV, they constitute the link between the community and otherprofessionals. Their performance in the community allows proximity with the user and favors the recognition of depressive symptoms and suicidal behavior more frequently and earlier[12].

Depressed individuals who present suicidal behavior need multidisciplinary care. In this scenario, CHW are in a privileged situation, since they have a link with the individual and the community, thus enabling them to perform an early situational diagnosis of mental health

needs, share and develop comprehensive health care plans with the other team members[13].

In order to achieve a comprehensive health care plan, PHC must be articulated to the Psychosocial Care Network (RAPS, as per its Portuguese acronym) [14], seeking to overcome biomedical models focused on the disease and that have medication as the main form of treatment[14,15].

### *Limitations in terms of identifying depressive symptoms*

The position that CHW occupy within the community allows them to know it more closely than other health professionals and, therefore, to notice behavioral changes in individuals early. However, in order to make that possible, the continuity of care to the individual is necessary, a process limited by the difficulty of access tousers, as demonstrated in the statement issued by I15:

> The difficulties we face are related to the fact that some people open up to us, there are other families that are locked in and sometimes don't even want to receive. **(I15)**

It could be inferred that there is resistance from some users in carrying out HV, not allowing CHW to put their work strategy into practice.

A study conducted in Quixadá, Ceará, Brazil, which analyzed the work of CHW in the territory, showed that the difficulty of access is a reality in the daily work of these professionals, since many homes are inaccessible. This situation brings up feelings of frustration, sadness and anguish[16].

The urban violence and the different conflicts present in the communities and outskirts of the cities constitute another situation that has also been observed and that hasmade the performance of CHW and PHC limited, thus implying other essential assumptions for its strengthening, such as the comprehensiveness of care, the return of the biomedical model, punctual and fragile in the promotion of rights; and the reduction of social healthinequalities [17].

Furthermore, the literature shows that health insurance plans are a limiting factor to the access of CHW to homes. Due to the fact of having such service, some families deny their access to register with FHS, using only occasional services without continuity[18]. Entering the home and, consequently, the family's privacy, requires responsibility, ethics, commitment and respect for its configurations, beliefs, wishes and dynamics. By understanding the dynamics of each family, CHW broaden their view and plan care strategies based on the needs and individuality of each family group[19].

Another limitation observed in this study was the stigma of depression. Even after years of the Psychiatric Reform, the new care model for mental health care, the welcoming of mental health problems by the FHS team, as well as the works in the field of health education to demystify mental illness, there are still perceptions laden with prejudice, linked to a state of madness, and not a disease that needs health care, as well expressed in the following statement:

> There is a very big prejudice in relation to this disease, as people don't want you to know that you'll seek a psychiatrist, that you'll seek a psychologist, because psychiatrist is a doctor for crazy people. **(I12)**

The stigma and prejudice cause individuals to develop a posture of distrust in sharing their depressive symptoms, in addition to hiding consultations with a psychiatrist or psychologist, due to the fear of being associated with madness, thus limiting the identification of depressive symptoms by CHW.

CHW observe that the rejection of the person who has become ill due to a mental problem is often a reaction of shame, accompanied by prejudice and discrimination, thus segregating him/her from society. The individual is no longer identified by name. In some situations, he/she loses his/her identity because he/she no longer produces his/her daily activities; and, by no longer contributing socially and economically, he/she becomes meaningless to society. There is devaluation of his/her desires, losing even the right to exercise his/her citizenship[20]. Therefore, besides identifying depressive symptoms, CHW should demystify such behaviors and work for acceptance and adequate treatment.

### *Possibilities in terms ofidentifying depressive symptoms*

The sensitivity of FHS professionals to the mental health demand is a result of the strengthening of policies implemented in the country and the new way of caring for [10]. From this perspective, the identification of depressive symptoms in users of the FHS servicesshould be incorporated into the routine of these professionals, whether in clinical care or during HV, as a form of early screening and establishment of appropriate therapy.

To this end, access to information represents an important possibility in the process of identifying depressive symptoms, even if by informal means, such as television programs, books, internet and radio:

> Currently, you turn on the television, you see a program. These mid-morning or mid-afternoon programs talking about the topic, you listen to a radio, you hear a specialist talking about the topic.**(I4)**

> The media are there for us to use, they are like new alternatives to this challenge. There is a lot about depression if we have the interest to search in books and on the internet. **(I3)**

Given the expansion of access to technologies, many people have internet, social media and mass media as their main source to obtain information. Accordingly, these media represent a relevant tool to support the teaching-learning process and the dissemination of information, thus providing the opportunity to be used not only for the promotion of services and products, but also for information literacy[21].

Another possibility expressed by CHW in this study was the dialogue/conversation established through the contact between users and professionals. In the statements, we can note that CHW is perceived by the community as a welcoming professional who is prepared to listen and dialog. Through this dialogue, bonds are strengthened, vulnerabilities can be detected and possible depressive symptoms identified:

> It is fundamental when the person is willing to talk, to expose what he/she feels inside, to put it out there, to expose it, we find it easier to know what the person is feeling. **(I8)**

The conversation is, therefore, a common strategy within the work routine of CHW in the field of mental health. Counseling is a way of carrying out the work and has therapeutic effects[22]. Furthermore, it is underlined that conversation and qualified listening are work tools that have positive effects on health care.

In this space of conversations, dialogues and advice offered by CHW, important information is passed on to the community, thus ensuring exchange between popular health knowledge and scientific knowledge, due to the position they occupy – mediators between the community and other health professionals[10]. Through these tools, a link is established, considered to be one of the most important attributes in the FHS context [23]. Its construction is necessary in the scope of public health and is often highlighted in theNational Primary Health Care Policy (PNAB, as per its Portuguese acronym) guidelines[24].

Dialogue/conversation, bonding, listening and embracement are soft technologies that the CHW use to develop their work. These are shown as important strategies in the professional exercise to meet the mental health demand, established during HV, and that can enable the identification of depressive symptoms[10,18].

CHW highlighted the access to the family and the presence of the support network as another possibility in terms of identifying depressive symptoms, whether users' relatives or FHS professionals. Through the statement issued by I5, we can note that this professional is in a favorable position to access the family in the FHS context because of the opportunity to enter the house, access the family and interact with everything that permeates the individual:

> If you have access to the family as a health worker, it becomes a facilitator. **(I5)**

Occasionally, when noticing mental health demands, CHW may find themselves in situations they do not understand very well, but simultaneously seek support from FHS members who can clarify their uncertainties and guide their actions:

> When I arrive and see that the person wants to talk a lot, but he/she wants to talk a lot and is running away from my area, so I bring him/her to the UBS (PHCU), I bring him/her to our nurse, so I believe that SUS gives me this access and I put it as easiness. **(I14)**

Therefore, we can see that the support network among professionals, even if it seems simple and informal, as it occurs in daily

meetings, can be a way of improving the procedures of those involved and still ensure multidisciplinary and comprehensive care[25]. Recognizing their possibilities brought us a greater understanding of their professional practice in the field of mental health and identification of depressive symptoms, thus providing the opportunity to help planning actions to improve the performance of CHW.

In view of the findings and this interlocution with the literature, we believe that this study offers contributions to public health and mental health. The limitation of this research is related to the fact that it was carried out in only one PHCU and with a reduced number of interviewees; however, it is the possibility given by the chosen method.Accordingly, aligned with the method, we believe that this work reveals a local overview that can serve as a basis for future comparisons, in addition to suggesting new investigations that address this theme in a broader scenario, articulating it with all levels of the Health Care Network (HCN).

## FINAL CONSIDERATIONS

The recognition, limitations and possibilities of identification of depressive symptoms by CHW should be seen as a condition that deserves constant attention, because it depends on it to identify, even at an early stage, people in the community who present these symptoms and refer them to the PHC unit for diagnosis, planning and implementation of actions in mental health care.

Stimulating the work of CHW based on the early detection of depressive symptoms is a way of strengthening public policies on mental health and public health, minimizing stigmas, risks and consequences associated with them and contributing to raising the level of the available care and the quality of life of the assisted population.

## LIMITES E POSSIBILIDADES DE AGENTES COMUNITÁRIOS DE SAÚDE NA IDENTIFICAÇÃO DE SINTOMAS DEPRESSIVOS


### RESUMO

**Objetivo:** avaliar o conhecimento de agentes comunitários de saúde sobre identificação de sintomas depressivos na comunidade. **Método:** trata-se de pesquisa qualitativa, realizada em Unidade Básica de Saúde, em Teresina, Piauí, Brasil, com 15 agentes comunitários de saúde. Utilizou-se o método da Pesquisa-Ação. A produção dos dados aconteceu em janeiro e fevereiro de 2019, por meio de dois seminários temáticos, pautados no Método Criativo Sensível. Os discursos foram submetidos à análise temática. **Resultados:** agentes comunitários de saúde reconhecem os sintomas depressivos por tristeza, choro, isolamento, anedonia e solidão, manifestados pelos indivíduos. Os limites para essa identificação, relatados pelos profissionais, foram dificuldade de acesso aos usuários e às famílias e estigma e preconceito com a depressão. Quanto às possibilidades, destacaram-se acesso à informação sobre a temática pela mídia, diálogo/conversa estabelecido entre usuário e profissional e acesso à rede de apoio. **Considerações finais:** conclui-se que o reconhecimento, as limitações e as possibilidades de identificação de sintomas depressivos por esses profissionais refletem no diagnóstico, planejamento e implementação de ações no cuidado em saúde mental de forma precoce e segura.


**Palavras-chave**: Agentes Comunitários de Saúde. Depressão. Atenção Primária à Saúde. Saúde Mental. Pesquisa Qualitativa.

## LÍMITES Y POSIBILIDADES DE LOS AGENTES COMUNITARIOS DE SALUD EN LA IDENTIFICACIÓN DE SÍNTOMAS DEPRESIVOS


### RESUMEN

**Objetivo:** evaluar el conocimiento de agentes comunitarios de salud sobre identificación de síntomas depresivos en la comunidad. **Método:** se trata de investigación cualitativa, realizada en Unidad Básica de Salud, en Teresina, Piauí, Brasil, con 15 agentes comunitarios de salud. Se utilizó el método de Investigación-acción. La producción de los datos tuvo lugar en enero y febrero de 2019, a través de dos seminarios temáticos, de acuerdo con el Método Creativo-sensible. Los discursos fueron sometidos al análisis temático. **Resultados:** Los agentes comunitarios de salud reconocen los síntomas depresivos por tristeza, llanto, aislamiento, anhedonia y soledad, manifestados por los individuos. Los límites para esa identificación, relatados por los profesionales, fueron dificultad de acceso a los usuarios y a las familias y estigma y prejuicio con la depresión. En cuanto a las posibilidades, se destacaron acceso a la información sobre la temática por los medios, diálogo/conversación establecido entre usuario y profesional y acceso a la red de apoyo. **Consideraciones finales:** se concluye que el reconocimiento, las limitaciones y las posibilidades de

identificación de síntomas depresivos por parte de estos profesionales reflejan en el diagnóstico, la planificación e implementación de acciones en el cuidado en salud mental de forma precoz y segura.

**Palabras clave**: Agentes Comunitarios de Salud. Depresión. Atención Primaria de Salud. Salud Mental. Investigación Cualitativa.

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