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RESEARCH

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SOCIODEMOGRAPHIC AND EPIDEMIOLOGICAL PROFILE OF WOMEN USERS OF A PSYCHOSOCIAL ATTENTION CENTER

Perfil sociodemográfico e epidemiológico das mulheres usuárias de um centro de atenção psicossocial

Perfil sociodemográfico y epidemiológico de las mujeres usuarias de un centro de atención psicosocial

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ABSTRACT

Objective: This study aimed to analyze the sociodemographic and epidemiological profile of women with mental disorders, emphasizing the gynecological, reproductive and sexual aspects. **Method:** A cross-sectional study, carried out at the Psychosocial Attention Center, with 31 women, aged 18 years or more, undergoing regular treatment. A data collection instrument in a structured format was used and data were analyzed using the SPSS software, version 18.0. This project was approved by one Research Ethics Committee under registration CAAE 56546216.0.0000.5195. **Results:** There was a predominance of women in drug therapy (96.8%), low sexual activity (61.3%), high adherence to cervical cancer screening test (74.2%) and low adherence to family planning (77.4%). **Conclusion:** An integral care provided to women with mental disorders, users of the Psychosocial Attention Care, requires an alignment among the policies of integral attention to women's health and mental health, through matrix support with primary health care.
Descriptors: Delivery of health care, Nursing care, Deisntitutionalization, Women`s health, Mental Health.

RESUMO

Objetivo: Analisar o perfil sociodemográfico e epidemiológico das mulheres com transtornos mentais, com ênfase aos aspectos ginecológicos, reprodutivos e sexuais. **Método:** Estudo transversal, realizado no Centro de Atenção Psicossocial, com 31 mulheres, com

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idade igual ou superior a 18 anos e em tratamento regular. Utilizou-se instrumento de coleta estruturado, os dados foram analisados no SPSS versão 18.0. Esse protocolo foi aprovado por Comitê de Ética em Pesquisa sob o CAAE 56546216.0.0000.5195. **Resultados:** Houve predominância de mulheres em terapia medicamentosa (96,8%), baixa atividade sexual (61,3%), alta adesão ao exame preventivo de câncer de colo do útero (74,2%) e baixa adesão ao planejamento familiar (77,4%). **Conclusão:** Para a integralidade do cuidado prestado às mulheres com transtorno mental, usuárias do Centro de Atenção Psicossocial, é necessário um alinhamento entre as políticas de atenção integral a saúde da mulher e saúde mental, via apoio matricial com a atenção primária de saúde.

Descritores: Assistência à saúde, Cuidados de enfermagem, Desinstitucionalização, Saúde da mulher, Saúde mental.

RESUMÉN

Objetivo: Analizar el perfil sociodemográfico y epidemiológico de las mujeres con trastornos mentales, con énfasis en los aspectos ginecológicos, reproductivos y sexuales. **Método:** Estudio transversal, realizado en el Centro de Atención Psicosocial, con 31 mujeres, con edad igual o superior a 18 años y en tratamiento regular. Se utilizó instrumento de recolección estructurado, los datos fueron analizados en el SPSS versión 18.0. Esta investigación fue aprobada en el Comité de Ética bajo el CAAE 56546216.0.00.00.5195. **Resultados:** Hubo predominio de mujeres en terapia medicamentosa (96,8%), baja actividad sexual (61,3%), alta adhesión al examen preventivo de cáncer de cuello de útero (74,2%) y baja adhesión a la planificación familiar (74,2%) 77,4%). **Conclusión:** Para la integralidad del cuidado prestado a las mujeres con trastorno mental usuarias del Centro de Atención Psicosocial es necesario un alineamiento entre las políticas de atención integral a la salud de la mujer y de salud mental, a través del apoyo matricial con la atención primaria de salud.

Descriptores: Prestación de atención de salud, Atención de enfermaria, Desinstitucionalización, Salud de la mujer, Salud mental.

INTRODUCTION

In 2004, while pursuing improvements in care for women, the Brazilian Ministry of Health presented the National Policy for Women's Health Comprehensive Care.[1] This policy incorporates, in a gender approach, integrality and health promotion as guiding principles and seeks to consolidate advances in the field of sexual and reproductive rights.[1] It also includes combined prevention, in other words, the shared prophylaxis and treatment of Sexually Transmitted Infections (STIs), chronic non-communicable diseases and cancer, especially Breast Cancer (BC) and Cervical Cancer (CC).[2]

The female public is highly vulnerable to mental illness, such as the prevalence of common mental disorder, which ranges from 28.7% to 50%, among females and the elderly.[3] So, women, including those who are cared for in *Centros de Atenção Psicossocial (CAPS)* [Psychosocial Care Centers], they need a comprehensive look at their health.[4]

Depression accounts for 4.3% of the global disease burden and is the leading cause of disability worldwide, representing 11% of all years experienced with disability globally, mainly by women. Due to stigmatization and discrimination, people with mental illness have their human rights violated, in addition to economic losses, social and cultural rights, with restrictions on the rights to work, education, reproductive rights and the best standards of health care.[5]

Care for mental health and women's health are fragmented in the different health facilities, compromising their comprehensiveness.[6] Pointing to the need to know the profile of users to invest in matrix support practices that integrate all levels of health care, but mainly, the *CAPS* teams and those of the Family Health Strategy (FHS).

As suggested by the Ministry of Health, through the National Mental Health Policy (NMHP), mental health actions in Primary Health Care (PHC), must transcend the traditional, biologic and medicalizing model, and invest in health promotion, considering the uniqueness of people and their protagonism.[7]

The health of women bearing Mental Disorders (MD) is a topic little discussed in the scientific literature, reflecting the fragmentation of women's health care, the invisibility of their singularities, and the suppression of their rights.[8] Hence, this study aims to analyze the profile sociodemographic and epidemiological aspects of women attending a *CAPS*, emphasizing their gynecological, reproductive, and sexual aspects.

METHODS

It is a cross-sectional study with a quantitative approach, which was performed at CAPS II in the *Pesqueira* city, *Pernambuco* State, with the favorable legal opinion from the Research Ethics Committee of the Hemotherapy Foundation of Pernambuco, under the *Certificado de Apresentação para Apreciação Ética (CAAE)* [Certificate of Presentation for Ethical Appreciation] No. 56546216.0.0000.5195.

The sample was selected by sampling by criteria. Inclusion criteria were, as follows: being female, being 18 years old or older, being under intensive or semi-intensive regular psychosocial monitoring during the research period. The three types of service provided by mental health services are: intensive treatment (daily attendance at the service), semi-intensive (frequency on alternate days) and non-intensive (frequency every two weeks or monthly in a context of discharge planning).[9]

Exclusion criteria were as follows: not being present during the data collection period and being in acute mental distress that would impair their free decision to participate of this research. The final sample consisted of 31 women who made up 100% of the women population undergoing regular and continuous treatment.

Data collection took place through the application of a structured questionnaire, from Monday to Friday, in the morning shift, from March to July 2017, in a nursing office and individually to ensure the autonomy and privacy of the participants. There was no interference with the *CAPS* routine. The instrument was pre-tested and consisted of sociodemographic variables and related to mental and women's health.

Data were stored and analyzed by the Statistical Package for the Social Sciences-SPSS, version 18.0. The Chi-Square Test ($\chi 2$) was used to find the association between statistically

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significant variables, considering the significance level of 95%, in which α≤0.05.

RESULTS

Table 1 addresses the sociodemographic data of the women in the CAPS. The average age was 42.48 years old, with a minimum age of 19 years old and a maximum of 67 years old. There was a predominance of 22 (70.4%) women of childbearing age.[10] Regarding the race, brown skin color predominated, represented by 19 women (61.3%). In regard to the marital status, 15 (48.4%) were single; as for education, it is observed that none has a college degree, while only 3 (9.7%) completed high school.

Table 1 - Sociodemographic profile of women assisted at the *CAPS, Pesqueira* city, *Pernambuco* State, 2017.

Variable	Avg.[a]	X (SD)[b]	Min-Max[c]	(N)	(%)
Age (full years)	42.48	11.975	19 / 67	31	100
Race					
Brown				19	61.3
White				7	22.6
Indian				3	9.7
Black				2	6.5
Total				31	100
Marital status					
Single				15	48.4
Married				9	29
Divorced				5	16.1
Widow				2	6.5
Total				31	100
Education					
Incomplete Elementary School				13	41.9
Complete Elementary School				13	41.9
Complete High School				3	9.7
Illiterate				2	6.5
College				0	0
Total				31	100

Superscript: a. Average b. Standard deviation c. Minimum - Maximum

Table 2 shows the characterization of sexual life, treatment, and self-reported diagnosis of the disease, in order to show the interference of this diagnosis in the affective and sexual lives. There were found 37 answers for self-reported diagnosis since more than one answer was given per woman. Only 1 woman (3.2%) did not undergo pharmacological treatment, 9 (24.3%) reported depression, and 11 (35.5%) stated that their diagnosis has interference in sexual life.

Among the changes in sexual life, 8 women (25.8%) feel an either absence or decreased libido and 9 (29%) have an altered sexual function. Only 7 women (22.6%) reported a satisfactory affective relationship with their partner and 19 women (61.3%) do not have an active sex life. The altered sexual function is related to the presence of some discomfort during sexual intercourse that makes the sexual act impossible, such as dyspareunia and burning. As for the number of partners during the entire affective life, there is an average of 2.44 partners and the average age of the coitarche was 16.32 years old.

Table 2 - Characterization of drug therapy, self-reported diagnosis and sexual life of women assisted at the *CAPS, Pesqueira* city, *Pernambuco* State, 2017.

Variable	(N)	(%)
Pharmacological treatment		
Yes	30	96.8
No	1	3.2
Total	31	100
Self-reported diagnosis		
Depression	9	24.3
Anxiety/Unrest	8	21.6
Mental disease	7	18.9
Unknown disease	4	10.8
Chronic disease	2	5.4
Different of everything	2	5.4
Aggressiveness	2	5.4
Complex disease	2	5.4
Shame	1	2.7
Total	37	100

Variable	(N)	(%)
Interference of the diagnosis in sex life		
Yes	11	35.5
No	20	64.5
Total	31	100
Interference of the diagnosis		
Do not know/Not applicable	19	61.3
Absence or decreased libido	8	25.8
Abandon	2	6.4
Do not feel pleasure in having sex	2	6.4
Fear	0	0
Total	31	100
Active sex life		
No	19	61.3
Yes	12	38.7
Total	31	100
Affective relationship with the partner		
Do not know/Not applicable	19	61.3
Good	7	22.6
Regular	3	9.7
Bad	2	6.4
Total	31	100
Sexual function		
Unaltered	16	51.6
Altered	9	29
Do not know/Not applicable	4	12.9
Inexistent	2	6.5
Total	31	100

Concerning the reproductive health, it was observed that 20 women (64.5%) have children, with an average of 4.35 pregnancies, 3.40 births, and 1.86 abortions. With regard to family planning, only 7 (22.6%) used any contraceptive method, 4 (12.8%) underwent a surgery to occlude the Fallopian tubes, 1 (3.2%) using the male condom, 1 (3.2%) used oral contraceptives and 1 (3.2%) used injectable contraceptives. Observing the health care during pregnancy, 18 (58.1%) had prenatal consultations, with an average of 6.46 consultations, and 8 (25.8%) had some complications during the pregnancy period.

Women's health was characterized by the Cervical Cancer Screening Test (CCST) being performed in variable moments, place and time interval between the performance of the CCST, clinical examination, Breast Self-Examination (BSE), and breast image exams, as well as STI prevention. Considering the total of 31 women, 23 (74.2%) had undergone the CCST. Of these, 21 (67.7%) performed at a PHC unit; 16 (51.6%) did it less than a year ago, 4 (12.9%) did it between one and two years, 2 (6.5%) did it more than two years ago and 9 (29%) did not know how to answer or they didn't. Regarding the breast exam, 13 (51.6%) have already undergone some breast exam; 5 (16.1%) underwent a breast exam less than 1 year ago, 4 (12.9%) between one and two years, and 4 (12.9%) more than two years ago. Among them, 4 (12.9%) underwent BSE, 5 (16.1%) underwent mammography, 4 (12.9%) underwent breast ultrasound and there was no report of clinical breast examination. Concerning the prevention of STIs, 22 (71%) did not use preventive methods and 7 (22.6%) used the male condom as a preventive method.

Table 3 provides data on the associations between the type of self-reported disorder, the use of psychotropic drugs, and the users' sexual activity.

Table 3 - Association between type of disorder and use of psychotropic drugs with sexual activity of women assisted at the *CAPS, Pesqueira* city, *Pernambuco* State, 2017.

Variable	Active sex life		%
Depression	**Yes**	**No**	
Yes	3	6	
No	7	13	0.599
Do not know	0	2	
Total	9	20	
Anxiety	**Yes**	**No**	
Yes	1	7	
No	9	12	0.177
Do not know	0	2	
Total	8	21	
Use of psychotropic drugs	**Yes**	**No**	
Yes	15	15	
No	0	1	0.325
Total	15	16	

It was observed that there was no statistically significant association among all variables.

DISCUSSION

Analysis of sociodemographic data indicates the vulnerability of women according to their strata. When relating the age group to the presence of MD, there is a prevalence among women of childbearing age and economically active, within the age group from 15 to 44 years old (64.55%). This age profile is justified by the association of vulnerability factors for the development of MD such as socioeconomic difficulties, pre-existing comorbidities, social isolation, among others.[12] Furthermore, the development of

the first symptoms of severe MDs treated at *CAPS* occurs when the individual is still a young adult.[4,11]

Marital status has an impact on mental health, as being single has been an important risk factor, especially for depression.[12] Low education is a factor of non-adherence to preventive exams, related to reduced access to information, which has a negative impact on self-care, understanding information and adopting preventive attitudes.[13]

As for pharmacological treatment, a high number of women who use pharmacological therapy persists, corroborating with other studies that point to the persistence of asylum practices, introducing medication overload to treat psychological suffering.[8,14]

The risky sexual behavior, as well as having multiple partners during life and the precocity of the coitarche are risk factors for CC and STIs.[15] Therefore, CC screening should be performed in all women from 25 to 64 years old who initiated sexual activity and, every three years, if the first two annual exams are normal.[16]

Studies describe that women with MD, for the most part, have at least one child.[8,17] Supported by this data, it can be addressed that despite the difficulties to play the role of mother, women bearing MD point to motherhood as an event that adds quality to their lives.[6]

Bearing in mind that MD can compromise autonomy, individualized care in family planning in PHC is essential, recognizing the reproductive right of these women and allowing them to decide whether they want to have children or not.[6,18]

As psychological distress in the perinatal period can enhance non-adherence to prenatal care, making mothers prone to obstetric complications, and can also impair child growth and development and contribute to predisposition to MD in children.[15,19] Hence, multidisciplinary monitoring, systematic and continuous to women with MD in PHC, must obey the minimum number of 8 prenatal consultations, with interim monitoring between doctor and nurse.[20] A joint effort to reduce perinatal mortality and improve the experience of attending women.[21]

CC corresponds to approximately 10% of malignant neoplasms diagnosed in the female population, being the second cause of death in women, surpassed only by BC.[22,23] To reduce female morbidity and mortality, it is necessary to encourage adherence to preventive exams. In women bearing MD the average adherence to CCST varied, in different studies, between 23% to 69%.[10,24]

Herein, 26% of women with MD had not undergone CCST. Among the factors that influence non-adherence to preventive exams, we can mention limited autonomy related to cognitive difficulties arising from MD; difficulty in accessing exams, or even, the unpreparedness of professionals to deal with these women. It should be noted that the stigma and denial of rights to these users are related to their double vulnerability: being a woman and having a MD.[25]

Given the 65% coverage for CCST, it is estimated that, in Brazil, between 12% and 20% of Brazilian women between 25 and 64 years old never underwent CCST.[26] The main risk factors related to non-adherence to exams preventive measures were: being over 40 years old, having a low level of education and being single.[27]

Considering the aforesaid, the transversality of policies must provide care for women in the psychosocial care network, surpassing the model of homogenization of care provided to men and women. It is about ensuring care that embraces its singularities linked to gender issues.[28]

In Brazil, BC is the second most prevalent type in the female population. Although this type of cancer is diagnosed in the early stages, the Brazilian health network offers only 47% coverage for mammography, compromising early diagnosis and reducing the survival of diagnosed people, compared to developed countries (50%-60% against 85%).[26,29]

BSE is a useful tool for detecting BC, when associated with mammography and clinical examination.[30] In this study, only 12.9% of women performed it.

Considering the prevention of STIs, adherence to preventive methods was observed by only 22.6% of women, in addition to the exclusive use of male condoms, which characterizes gaps in knowledge regarding available contraceptive methods. It appears that health education is a primary strategy to reduce barriers to access services and their strategies for protecting this population.

Herein, it was found that the variables of self-reported diagnosis and use of psychotropic drugs did not influence the sexual life of women, with no significance in the association between these variables. The experience of sexuality by women bearing MD did not suffer any interference from their health condition and/or the self-perception of their disease, although the sexuality of women with MD is treated as a controversial topic and is often related to the symptomatologic characteristics of the disorder.

Although the vast majority of respondents do not have an active sex life, it is important to recognize that sexuality is still present with representativeness similar to that of those without MD. Women with MD "have feelings, fall in love and love like anyone else, then wanting to express themselves sexually".[6:4] It follows from this fact that people with MD have conditions and rights to live their sexuality fully, although there is a significant path to be followed in the search for respect for their individuality and uniqueness and satisfactory health care.[8,24,25] It is therefore necessary to reestablish the right to femininity, enabling women to have a better quality of life and greater autonomy over their bodies.[20]

This study enabled the observance of the need for the empowerment of femininity, of being a woman with her singularities, on the part of women with MD, given that they still face many difficulties for this full experience, with autonomy and freedom for the choices and actions that will influence their ways to live, your health and your completeness. Despite advances in the fields of health and access, they have partial and fragmented access to health, since they are still unable to experience their sexuality free from prejudice, stigma and access to all preventive methods against STIs and contraceptives, as well as not all

the necessary information is available for them to make their decisions based on current health knowledge.

The limitations of this study are linked to the cross-sectional design and the literary scarcity about the interface between women's health and mental health.

CONCLUSION

Bearing in mind the aforementioned, it is concluded that there was a prevalence of women of childbearing age, single, brown skin color, undergoing drug therapy, without active sex life, multiple partners, early coitarche and with children. There was high adherence to the CCST and low adherence to family planning, breast examination and STI prevention. Association tests revealed that neither drug treatment nor self-reported diagnosis interferes with women's sexual lives. Nevertheless, the vast majority do not have an active sex life, which opens the way for new research to seek the understanding of the causes that interfere in the non-experience of this dimension of the life of these women.

The results of this study will contribute to improving the quality and access to assistance towards women bearing MD who use local, regional and State and national psychosocial care networks, as well as intending to align the National Policy for Women's Health Comprehensive Care with NMHP, promoting real health integrality. This knowledge is useful for health planning, in addition to providing subsidies to researchers and health professionals in the construction of longitudinal care strategies.

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