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Investigation of minor psychiatric symptoms in adult patients hospitalized in a general hospital

Investigação de sintomas psiquiátricos menores em pacientes adultos internados no hospital geral

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ABSTRACT

The present study proposed to investigate the presence of minor psychiatric symptoms of anxiety and depression in patients during hospitalization for various clinical and surgical treatments at the General Hospital in Marília, SP, Brazil. It is characterized as a descriptive, cross-sectional and quantitative study. Eligible patients were those admitted to the institution through the emergency room in urgent and emergency situations, from the age of 18, and who were able to understand the objectives of the study and to answer the used evaluation instruments, such as the Identification Questionnaire for Sociodemographic and Clinical Characteristics, and the Hospital Anxiety and Depression Scale. Pearson's chi-square test, Fisher's test or its extension were used in inferential analyzes to compare categorical variables. Student's t test was used for independent samples. In all inferential analyzes, a significance level of α equal to 5% was used. There was a statistical significance in the association between patient satisfaction with the team, and the absence of symptoms of depression and anxiety. A statistically significant correlation was also identified between satisfaction with communication of care and the absence of symptoms of depression.

Keywords: Inpatients; Depression; Anxiety; Health Communication; Patient Assistance Team.

RESUMO

O presente estudo propõe a investigar a presença de sintomas psiquiátricos menores de ansiedade e depressão em pacientes durante a internação hospitalar para diversos tratamentos clínicos e cirúrgicos no hospital geral. Caracteriza-se como um estudo de natureza descritiva, transversal e quantitativa. Os pacientes elegíveis foram aqueles internados que deram entrada na instituição por meio do pronto socorro em situação de urgência e emergência, a partir de 18 anos, e que possuíam condições de compreender os objetivos da pesquisa e de responder os instrumentos avaliativos utilizados, como: Questionário de Identificação das Características Sociodemográficas e Clínica, e a Escala Hospitalar de Ansiedade e Depressão. Foram utilizados nas análises inferenciais o Teste de Qui-quadrado de Pearson, teste Exato de Fisher ou sua extensão para comparação das variáveis categóricas e o teste t de student. Em todas as análises inferenciais foi utilizado o nível de significância α igual a 5%. Houve significância estatística na associação entre a satisfação do paciente com a equipe, e a ausência de sintomas de depressão e ansiedade. Também foi identificada uma correlação estatisticamente significante entre a satisfação com a comunicação dos cuidados e a ausência de sintomas de depressão.

Palavras-chave: Pacientes Internados; Depressão; Ansiedade; Comunicação em Saúde; Equipe de Assistência ao Paciente.

INTRODUCTION

According to the World Health Organization (WHO), the hospital's main function is to provide the community with comprehensive health care, both curative and preventive. Based on the principle of equity, one of the guidelines of the Unified Health System (SUS), it is important to know and characterize the users of the system, as well as the profile of hospital admissions, in order to structure it in a way to optimize the application of the economic resources (WHO, 2010).

The National Health Survey (NHS) carried out in 2013 and published in 2014 shows that approximately 12.1 million Brazilians were hospitalized for a period equal to or longer than twenty-four (24) hours in the last 12 months. Mostly women (7.1%), and people aged 60 years (10.2%) or older. Of these, 8.0 million were served by SUS (Brasil, 2013).

In the town of Marilia, in the state of São Paulo, context of this study, where the General Hospital is located, some patients go through long periods of hospitalization. The general high complexity hospital is a reference for hospitalizations of several medical specialties, and it serves the units that belong to the Regional Health Directorate IX - Marília (DRS IX), which comprises a total of sixty-two (62) towns in the region (São Paulo, 2019). According to a survey by the Ministry of Health 2008, the municipality shows that the main causes of admissions to a general hospital are due to diseases of the circulatory system, injuries from external causes, mental disorders and neoplasms. These

hospitalizations have the long stay in hospital units as a common feature, totaling 22.718 hospitalizations in Marília, in 2007 (Brasil, 2008).

From the perspective of mental health, in a space of micromanagement, the impact of illness and the need for hospitalization can cause emotional changes in patients, especially when they have to leave the family environment (Camon, 2010). Botega (2002) states that during illness and hospitalization, frustration is exhibited in relation to unmet needs, the intensification of intrapsychic conflicts, loss of self-esteem, etc. It is observed that generally, hospitalized patients become known no longer by their names and personalities, but by their bed numbers and/or diagnosis. Thus, they are no longer considered as individuals with autonomy of their own life; they are depersonalized, and a condition of stigma and anguish is generated (Botega, 2002). These emotional sufferings can lead to the emergence of anxiety, depression, aggressiveness, among others, as triggers for the experience of illness and the environmental and procedural implications, which are sometimes embarrassing (Macena; Lange, 2008). This experience during hospitalization presents itself as a break in their life histories, separating them from their family and imposing rules, and deepening the dependence on care (Botega, 2002).

Assertive and efficient communication, as well as the patient's bond with the health team directly affects their involvement in their recovery process, through the understanding of their needs and limitations, helping in their recovery process (Boissy *et al*., 2016; Berger; Boss; Beach, 2017; Gebhardt *et al*., 2017; Paternotte *et al*., 2017; Scotten *et al*., 2015). This assertion allows us to reflect on the possibilities of a multi-professional team in comprehensive health care for these patients, aiming to reduce the effects of suffering that the hospitalization period promotes.

Currently, the proportion of the world population with anxiety disorders is 3.8%, and depression 3.4%, and in Brazil, it is estimated that approximately 7.6% of Brazilians were diagnosed with depression, and 9.3% with anxiety (Ritchie;Roser, 2020; WHO, 2018). The worldwide depression and anxiety rates show that around 300 million people suffer from the symptoms, in which depression alone affects 264 million people, most of them women, and in Brazil, 11,2 million people, causing the consideration of anxiety and depression as Public Health issues (WHO,2019; WHO; 2017; Brasil, 2013).

Studies have shown that, in the hospital environment, patients may experience anxiety and depression during hospitalization, as no significant differences relate these mood changes to medical specificities (Lima *et al.*, 2005). Thus, the specialized literature

reveals that minor symptoms of anxiety and depression may present in hospitalized patients (Gullich *et al.*, 2003; Polikandrioti *et al*., 2015; Saravay *et al*., 1991).

However, emotions and feelings associated with fear, helplessness and depersonalization are related to minor psychiatric symptoms of anxiety and depression in patients who undergo long hospitalizations (Kuhlmann; Raquel, 2008). For example, patients who have heart failure, with the longest duration of illness and hospital treatment may be more likely to develop depressive symptoms (Polikandrioti *et al.*, 2015). The present study proposes to investigate the presence of minor psychiatric symptoms of anxiety and depression in patients during hospitalization for various clinical and surgical treatments at the general hospital in Marília, SP.

METHOD

The research design is characterized as a descriptive, cross-sectional and quantitative study. The data collection of the population was carried out from May to November, 2019 in patients exclusively hospitalized by the Unified Health System (SUS) in the Hospitalization Unit General Hospital I, the school hospital, linked to the Marilia School of Medicine (FAMEMA). The town of Marília is located 443 km from the capital of the state of São Paulo, belonging to health region DRS IX, whose coverage area includes 62 municipalities, grouped into five microregions, totaling an estimated population of 1,200,000 inhabitants.

The research was approved by the Research Ethics Committee under number 15362119.9.0000.5413. Eligible patients were those admitted to the institution through the Emergency Room in urgent and emergency situations, from the age of 18, and who were able to understand the research objectives and answer the assessment instruments: Identification Questionnaire for Sociodemographic and Clinical Characteristics, and also the Hospital Anxiety and Depression Scale (HADS) - the scale has been used to assess mood disorders in patients with physical pathologies, considered one of the most used instruments in the world literature. The global score in each subscale ranges from 0 to 21 points and with an 8/9 cutoff point. For anxious symptoms, sensitivity was 93.7%, and specificity 72.6%; and for depressive symptoms, 84.6% and 90.3% (Botega *et al*., 1995). The data were analyzed using the IBM SPSS Statistics 26.0 software. Quantitative variables were presented in descriptive form as mean, median, standard deviation and minimum and maximum values. Qualitative variables were analyzed by calculating

absolute and relative frequencies. Pearson's chi-square test, Fisher's test or its extension were used in inferential analyzes to compare categorical variables. Student's t test for independent samples was used to compare the mean age according to sex and its corresponding (Mann-Whitney U test) to compare depression and anxiety scores according to sex. In all inferential analyzes, a significance level of α equal to 5% was used.

RESULTS

The sample selected in this research was composed of 80 patients with a mean age of 55.38 ± 16.56 years admitted to the hospital (Table 1). There was no statistically significant difference in age according to sex.

Table 1 - Mean, median, standard deviation and minimum and maximum age values of hospitalized patients according to sex.

Age	Sex		Total
	Male	Female	
n	45	35	80
Mean	54,27	56,80	55,38
SD	16,88	16,28	16,56
Median	58,00	57,00	58,00
Minimum	20	18	18
Maximum	78	81	81

Source: by the author

A higher proportion of patients were aged between 52 and 67 and years and 68 and 83 years. In this sample, 45 (52.3%) were men. Regarding marital status, 41 (51.3%) had no partners. Seventy-five patients (78.5%) declared to have a religion; 33 (41.3%) of the patients declared to be economically active. Most of the patients in this study (78.8%) had hospitalization time between 7 to 20 days and most patients, 55 (68.8%), had a companion during hospitalization (Table 2). An important object of investigation in this research was the relationship between the classification of depression and anxiety with several variables measured in these patients. Table 2 shows that there is no association between cases and non-cases of depression and anxiety regarding gender, age group, marital status, religion, being economically active, length of hospital stay and having the presence of a companion ($p > 0.05$).

Table 2 - Distribution of sociodemographic and clinical characteristics of hospitalized patients, according to the classification of cases and non-cases of depression and anxiety.

Variable	HADS depression		*P*	HADS anxiety		Total (n=80)	*p*
	Non-cases	Cases		Non-cases	Cases		
Gender							
Male	39 60,0%	6 40,0%	.159	25 51.0%	20 64,5%	45 56,3%	.236
Female	26 40,0%	9 60,0%		24 49.0%	11 35,5%	35 43,8%	
Age range							
18≥35yrs	8 12.3%	4 26.7%		5 10.2%	7 22.6%	12 15.0%	
36≥51 yrs	12 18.5%	2 13.3%	.465	9 18.4%	5 16.1%	14 17.5%	.103
52≥67 yrs	29 44.6%	7 46.7%		20 40.8%	16 51.6%	36 45.0%	
68≥83 yrs	16 24.6%	2 13.3%		15 30.6%	3 9.7%	18 22.5%	
Civil status							
With partner	29 44.6%	10 66.7%	.157[a]	22 44.9 %	17 54.8%	39 48.8%	.492[a]
Without partner	36 55.4%	5 33.3%		27 55.1%	14 45.2%	41 51.3 %	
Religion							
Yes	60 92.3%	15 100%	.578[a]	45 91.8%	30 96.8%	75 93.8%	.644[a]
No	5 7.7%	0 0,0%		4 8.2%	1 3.2%	5 6.3%	
Eco. active							
Yes	28 43.1%	5 33.3%	.570[a]	24 49.0 %	9 29.0 %	33 41.3%	.104[a]
No	37 56.9%	10 66.7%		25 51.0%	22 71.0%	47 58.8%	
Hospital stay							
7≥20 days	50 76.9%	13 86.7%	.558	40 81.6%	23 74.2%	63 78.8%	.724
21≥49 days	11 16.9%	2 13.3%		7 14.3%	6 19.4%	13 16.3%	
≥50 days	4 6.2%	0 0.0%		2 4.1%	2 6.5%	4 5.0%	
Companion during hospitalization							
Yes	42 64.6%	13 86.7%	.128[a]	34 69.4%	21 67.7%	55 68.8%	1,000[a]
No	23 35.4%	2 13.3%		15 30.6%	10 32.3%	25 31.3%	

Source: by the author. [a] Fisher's exact test.

Table 3 shows the scores obtained on the depression and anxiety scales. On average, patients had scores of 4.89 ± 4.07 on the depression scale and 7.83 ± 4.92 for anxiety. There was no statistically significant difference between the patients' gender (p> 0.05).

Table 3 - Mean, median, standard deviation and minimum and maximum values of the score of the depression and anxiety scales according to the sex of the patients.

Score	Sex		Total n=80	*p*
	Male n=45	Female n=35		
HADS depression				
Mean	4.20	5.77	4.89	.161*
Standard Deviation	3.40	4.69	4.07	
Median	4.00	5.00	4.00	

Minimum	0	0	0	
Maximum	14	19	19	
HADS anxiety				
Mean	8.09	7.49	7.83	.318*
Standard Deviation	4.57	5.40	4.92	
Median	8.00	6.00	7.00	
Minimum	0	1	0	
Maximum	18	19	19	

Source: by the author. * Mann-Whitney U test.

The study of the association between cases and non-cases of anxiety and depression and the communication of care, and the relationship of the team with the patient was also an important object of investigation in this research. As shown in Table 4, of the 80 investigated patients, 73 (91.3%) considered the team/patient relationship to be satisfactory. It is worth noting that there is a statistically significant association ($p < 0.05$) between patient satisfaction with the team and the absence of symptoms of depression and anxiety. Regarding the communication of care, most patients, 69 (86.3%), considered this aspect to be satisfactory. For this variable, a more frequent satisfaction trend is observed in patients with absence of anxiety symptoms when compared to patients who have these symptoms ($p = 0.059$). A statistically significant association was observed between satisfaction with the communication of care and the absence of symptoms of depression ($p = 0.001$).

Table 4 - Patient/team relationship and communication of care according to the presence of symptoms of anxiety and depression in hospitalized patients.

Variable	HADS depression		*p*	HADS anxiety		Total (n=80)	*p*
	Non-casos	Cases		Non-cases	Cases		
Patient/team relationship							
Satisfactory	63 96.9%	10 66.7%		49 100.0%	24 77.4%	73 91.3%	
Insatisfactory	1 1.5%	2 13.3%	**.003**[a*]	0 0.0%	3 9.7%	3 3.8%	**.001**[a*]
Irrelevant	1 1.5%	3 20.0%		0 0.0%	4 12.9%	4 5.0%	
Communication of care							
Satisfactory	60 92.3%	9 60.0%		45 91.8%	24 77.4%	69 86.3%	
Insatisfactory	5 7.7%	3 20.0%	**.001**[a*]	4 8.2%	4 12.9%	8 10.0%	.059[a]
Irrelevant	0 0.0%	3 20.0%		0 0.0%	3 9.7%	3 3.8%	

Source: by the author. [a] Fisher's test; * statistically significant difference ($p < 0.05$).

DISCUSSION

In the face of hospitalization and patient turnover in a general hospital, we observed that people who are hospitalized may have difficulties in coping with unknown situations, in addition to impersonal treatment at times, feelings of depersonalization, withdrawal from their family environment, as well as the loss of their autonomy of life (Macena; Lange, 2008). We can then infer the existence of minor symptoms of anxiety and depression due to these experiences during hospitalization.

Our study showed that men had symptoms of anxiety higher than women; and the women, on the other hand, more symptoms of depression. These data differed from the general population, in which anxiety is more common in women, although it is estimated that depression will increase in women in the near future (Bandelow; Michaelis, 2015; WHO, 2019).

In this context, according to data researched by Fiedler (2016), in the perspective by Erik H. Erikson, in the average age of 55.38, the ability to create and face challenges, care for the achieved goods, and maintain affective relationships with responsible attitudes for a new unit based on trust is developed, and it includes the preparation of a place to start a new phase of development, through the division of work and coexistence. That is, the individual who solved the previous steps articulating anguish, joy, victory, defeat and fear in such a way as to maintain the integration of his/her ego, with the feeling of trust. This evolution allows the acceptance of the individual and collective life cycle of humanity, configuring a phase of greater wisdom and acceptance (Prado, 2016).

In this sense, it is important to highlight that most patients had psychological protection factors. These factors strengthen the emotional field so that they have comfort and security during the treatment experience, including those who declared to have a religion, and were economically active and who were accompanied by acquaintances or family members during the hospitalization period. Thus, these factors contribute to greater emotional stability and the absence of the aforementioned symptoms (Splivalo *et al*., 2017; Nery *et al*., 2018; Nunes *et al*., 2017).

A study carried out with women undergoing cancer treatment, found that social support networks were important to minimize the impacts that anxiety and depression could have on quality of life; this population indicated that religion was second (Kugbey;

Asante; Meyer-weitz, 2019). The same findings were observed in patients and their families in view of the hospitalization impact (Nunes *et al*., 2017).

From the perspective of support networks, in this sample, most patients did not have a partner and presented minor symptoms of anxiety. For Pandey (2019), this condition can harm the general health status of patients, since married people tend to have better health conditions, not only through support and care, but also through a more efficient pattern of health care use (Pandey *et al*., 2019). Mutual support of couples during hospitalization can also contribute to a better-quality adaptive adjustment process (Nunes *et al*., 2017).

According to the HADS, of a total of 80 individuals, 15 were identified as cases of depression and 31 of anxiety, thus corroborating studies carried out with hospitalized patients with injuries (Raghuwanshi; Aggarwal; MadhumatI, 2019). Therefore, it was found that generally the symptoms of anxiety and depression can be associated with greater difficulties in health treatments and worse prognosis, such as, for example, more severe illnesses, longer hospital stays and difficulties in self-care (Guo *et al*.,2019; Stockbridge *et al*., 2019; Davydow *et al*., 2015). However, in our study, we found no statistical significance in the relation between minor symptoms of anxiety and depression at the time of hospitalization. We identified the range of 7≥20 days as the most present, with the highest frequency of cases of anxiety and depression among patients, which refutes the correlation between length of stay and symptoms, as the length of stay varied between 7 and 125 days. In addition to longer hospital stays, it was possible to identify that the symptoms of depression were more present in those patients with higher numbers of hospitalizations (De Fazio *et al*., 2017). However, a meta-analysis study stated that depressive symptoms can be predictors of admission to hospitalization, that is, regardless of longer hospital stay and greater risk of readmission (Prina, 2015).

Regarding religiosity, the patients who declared to have some kind of religious belief, mostly, did not show symptoms of anxiety and depression. However, the identified cases of depression were declared religious, since the same observation was also identified in cases of anxiety. This information from our study is in contrast to other studies, in which there is an association between the most severe depressive symptoms and low religiosity/spirituality (McClintock *et al*., 2029; Walker *et al*., 2018). Religiosity also contributes to social well-being, however there was no correlation between religiosity and depressive symptoms, although it was found that religion would be a support network to allow reduction of vulnerability of living in the hospital environment

(Nery *et al*., 2018). It was evident that a good understanding of the treatment as well as the adherence to it are associated with the presence of religiosity, the support of health professionals and the family, as favorable elements for the quality of medical care (McClintock *et al*., 2029; Walker *et al*., 2018).

However, considering the data collected, no statistical significance was observed between cases and non-cases of depression and anxiety, and sex, and socio-demographic and clinical data. However, in relation to the communication of care, it was possible to identify a higher frequency of satisfaction and the absence of symptoms of anxiety in the interviewed patients. They considered communication as satisfactory, with a statistically significant association between communication of care and the absence of symptoms of depression.

Understanding the involvement of people in their medical treatments depends on the relationship established with the professional. The ways of communicating are important to share responsibility and involve the patients in their healing process. Therefore, the positive or negative experiences felt by the patients affect their clinical results (Boissy *et al*., 2016; Berger; Boss; Beach, 2017; Benham-Hutchins *et al*., 2017; Espinha; Mauro, 2008; Pedro *et al*., 2016). In a broader view, the difficulty in interprofessional communication and collaboration negatively affects the health system as a whole (Bortun; Matei, 2017; Hemesath *et al*., 2019; Kagan, 2019; Didier *et al*., 2017).

Deficits in doctor-patient communication still exist, as they are usually limited to the most basic aspects (such as diagnosis), contributing to the patient's passivity (Benham-Hutchins *et al*., 2017; Espinha; Mauro, 2008; Pedro *et al*., 2016).

We understand, in view of the possible communication deficits, the population of this study may have little autonomy in the search for information, and participation in their health condition and care planning. Thus, they may present a greater dependence on the medical team, in which the regressive aspects make up for passive behavior, configuring as a protection that favors the absence of symptoms of anxiety and depression related to hospitalization. Generally, patients want to participate in discussions about their health and feel frustrated when communication fails (Benham-Hutchins *et al*., 2017). When the frustration emerges, there may be feelings that prevent them from leaving the condition of dependence. In hospitalization there is a range of feelings in which the dependence on the other, whether from family support or from the health team that assists them, can be present (Damion; Moreira, 2018). It is worth mentioning the importance of

the individual to seek control over health determinants to improve their heath and thus have greater autonomy over himself/herself (Carrapato; Correia: Garcia, 2017).

Improving communication skills leads to reductions in errors and readmissions, which can decrease the length of hospital stay and improve the satisfaction of patients and companions with the care provided by the health team (Scotten, 2015). In this aspect, we were able to observe the length of hospital stay for our sample, up to 20 days, a relatively average length of stay.

Our study also showed statistical significance in the relation between patient satisfaction with the health team and the absence of symptoms of depression and anxiety. This satisfactory relationship perceived by patients with the health team may indicate benefits in the emotional state, as they did not have symptoms of anxiety and depression. Studies from different countries and varied cultural forms point out to the bond as the center of the health treatments as important for the reestablishment of inpatients, regardless of their diagnosis or prognosis (Scotten, 2015; Gebhardt *et al.*, 2017; Paternotte *et al*., 2017; Nunes *et al*.,2027; Benham-Hutchins *et al*., 2017; Pedro *et al*., 2016).

The presence of anxiety in newly hospitalized patients may be related to the fact that they are in a strange and unknown environment to their routine, but that it tends to reduce in up to 24 hours, due to the bond and trust that can be established in this period with the health team (Delfini; Roque; Peres, 2009). This also corroborates with another study that concluded that patients, when they feel more respected and understood, they also start to feel more confident when treated in their individuality, welcomed, listened to, and having their doubts and difficulties valued by the health team. Even when there are cultural barriers, the bond is identified as a central point in the professional-patient relationship (Paternotte *et al.,* 2017). Patients with ties to the health team and who participate in the decision-making processes for their treatment tend to have less feelings of anxiety and uncertainty, and have better self-care both in the hospitalization period and after discharge (Benham-Hutchins *et al*., 2017).

The National Humanization Policy (Brasil, 2013) defines the bond as the process that generates an affective and ethical relationship between professional and patient in a coexistence of mutual help and respect. The strengthening of these bonds occurs through the expansion of communication, as a therapeutic action. The policy also advocates the establishment of multi-professional reference teams for patients, family members and other support networks, composed of doctors, nurses, psychologists, social workers, occupational therapists, pharmacists, nutritionists and other professionals according to the

need; promoting the transversality and comprehensiveness of care through communication and bonding, as in the proposal of the expanded clinic, which seeks to integrate several health professionals to enable an adequate and expanded management of the patient's care needs (Brasil, 2013; Almeida *et al*., 2019; Fereeira; Artmann, 2018; Brasil, 2010). Thus, we were able to identify that the population of the present study felt welcomed by the multi-professional team and considered the communication of care as satisfactory in view of their needs for understanding, as these factors can correlate with the reduction of minor symptoms of anxiety and depression. However, in anxious individuals, satisfaction with communication may be lower, possibly due to the need for more concrete and in-depth information. For Pedro et al. (2016), the teams communicate only the superficial and, in this way, can favor dependency and accommodation. Thus, possibly indicating the satisfaction results found in our study.

This study had limitations regarding the number of studied patients, and the use of only one instrument for investigation. It is worth pointing out that data collection was carried out at the bedside and was sometimes affected by noise and traffic interference from other people.

CONCLUSION

In view of the discussed results, the scope of the study strengthens the importance of communication as a way of encouraging patients' autonomy and strengthening their participation in treatment planning, which can be shared with family members and other members of the health team, in which the bond of trust and human relationships can be the guiding axis for an outcome of comprehensive care and the appreciation of the subject, in addition to mitigating the possible symptoms of anxiety and depression throughout hospitalization. Further studies should be carried out, expanding the investigation of minor symptoms of anxiety and depression, with scales that assess the doctor-patient relationship and in-hospital quality of life, in order to contribute to comprehensive patient and family care during hospitalization.

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