Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

SECONDARY OR REACTIVE DEPRESSIVE SYMPTOMS IN ADULT PATIENTS WITH LEPROSY

SINTOMAS DEPRESSIVOS SECUNDÁRIO OU REATIVO EM ADULTOS DOENTES COM HANSENÍASE

SÍNTOMAS DEPRESIVOS SECUNDARIOS O REACTIVOS EN PACIENTES ADULTOS CON LEPRA

Vanessa Virginia Lopes Ericeira[1], Manoel Ramos Costa Filho[2], Dorlene Maria Cardoso Aquino[3], Maria de Fátima Lires Paiva[4], Rita da Graça Carvalhal Frazão Corrêa[5], Larissa Di Leo Nogueira Costa[6]

ABSTRACT

Objective: to investigate the presence of depressive symptoms in adult patients with leprosy. ***Method:*** descriptive study with a quantitative approach, performed in two leprosy control programs, in São Luís (MA), Brazil, with 47 people with leprosy, reported and in the active record. Data collection was performed using a questionnaire (CES-D Scale) for evaluation of depressive symptoms. The data were then stored in the Epi-Info version 7.0 software, analyzed, presented in tables and discussed with the literature. ***Results:*** the majority of the participants were in the transition phase between mania and depression, with predominance in the depressive phase and a discreet presence of suicidal ideation. ***Conclusion:*** secondary depressive symptoms were common in the study population, demonstrating the need for further studies, especially with regard to the emergence and development of a multidisciplinary approach, optimizing health promotion and education. ***Descriptors:*** Leprosy; ReactiveDepression; Depressive Symptoms.

RESUMO

Objetivo: investigar a presença dos sintomas depressivos em adultos doentes com hanseníase. ***Método:*** estudo descritivo, com abordagem quantitativa, realizado em dois programas de controle de hanseníase, em São Luís (MA), Brasil,com 47 pessoas com hanseníase, notificadas e em registro ativo. A coleta de dados foi realizada com um questionário (Escala CES-D) para avaliação de sintomas depressivos. Em seguida, os dados foram armazenados no software Epi-info versão 7.0, analisados, apresentados em tabelas e discutidos com a literatura. ***Resultados:***a maioria dos participantes estava na fase de transição entre mania e depressão, com predominância da fase depressiva e presença discreta da ideação suicida. ***Conclusão:*** os sintomas depressivos secundários foram frequentes na população de estudo, havendo necessidade de novas pesquisas, principalmente no que se refere ao surgimento e desenvolvimento de abordagem multiprofissional, otimização de promoção e educação a saúde. ***Descritores:*** Hanseníase; Depressão Reativa; Sintomas Depressivos.

RESUMEN

Objetivo: investigar la presencia de síntomas depresivos en pacientes adultos con lepra. *Método*: estudio descriptivo con un enfoque cuantitativo, realizado en dos programas de control de la lepra en São Luís (MA), Brasil, con 47 personas con lepra, y se informó en el registro activo. La recolección de datos se realizó con un cuestionario (escala CES-D) para la evaluación de los síntomas depresivos. Em seguida, datos eran armazenados no software Epi-info version 7.0, bem analisado e discutido apresentados em tabelas com literatura. ***Resultados***: la mayoría de los participantes estaban en transición entre la manía y la depresión, con un predominio de la fase depresiva y discreta presencia de ideación suicida. ***Conclusión***: los síntomas depresivos secundarios fueron comunes en la población de estudio, existe la necesidad de una mayor investigación, especialmente en relación con la aparición y el desarrollo de un enfoque multidisciplinario, la optimización de la promoción y educación para la salud. ***Descriptores***: Lepra; La Depresión Reactiva; Los Síntomas Depresivos.

[1]Regirered Nurse, Master's student, Graduate Nursing Program, Federal University of Maranhão/PPGENF/UFMA. São Luís (MA), Brazil. E-mail: vanessavirginia4@yahoo.com.br; [2]Registered Nurse. Professor in Community Health Nursing, Nursing Department, Federal University of Maranhão/UFMA. São Luís (MA), Brazil. Email: costa.ramos@ibest.com.br; [3]Registered Nurse, Professor in Human Pathology, Nursing Department / Graduate Program in Adult and Child Health / MSc in Nursing / Professional MSc in Family Health, Federal University of Maranhão / UFMA. São Luís (MA), Brazil. E-mail: dmcaquino@gmail.com; [4]Registered Nurse, Professor in Clinical and Experimental Pathophysiology, Nursing Department, Federal University of Maranhão/UFMA. São Luís (MA), Brazil. Email: fatimalires@gmail.com; [5]Registered Nurse, Professor in Biotechnology - Renorbio, Nursing Department, Graduate Program in Nursing, Federal University of Maranhão/UFMA. São Luís (MA), Brazil. Email: ritacarvalhal@hotmail.com; [6]Regirered Nurse, Master's student, Graduate Nursing Program, Federal University of Maranhão/ UFMA. São Luís (MA), Brazil. E-mail: larissadileonc@hotmail.com

INTRODUCTION

Leprosy is a chronic infectious disease, of slow evolution, caused by the Mycobacterium leprae. It is a serious public health problem in Brazil and worldwide, having the unique property of peripheral nervous system and skin invasion.[1-3]

Depending on the prognosis of the disease, patients may present complications related to physical changes, with their aesthetic conditions undergoing major alterations, leading the individuals to believe themselves to be people who do not have rights or the possibility of being accepted in society due to this condition.[3-5]

This stigma and/or prejudice, consequently occurs because leprosy has a terrible historical image, being a global phenomenon that is still observed in both endemic and non-endemic countries. Its consequences affect the individual (psychological, family, social, professional and economic problems) and the efficacy of leprosy control measures.[6-8] In addition, the clinical aspects of leprosy present a strict correlation with the typical psychological factors of chronic diseases, where there are increasing stress levels and high frequencies of depressive symptoms. [9,10]

Despite being a public health problem that generates high costs, the disease is still treated with contempt by the political authorities of public health. Depression is highly prevalent, this being the most common psychiatric complaint in primary care services, with a prevalence of 10% to 20%, and can affect any age group. [11]

According to the diagnostic criteria of the major depressive episode in the DSM-IV, the presence of depressed mood or anhedonia for at least two weeks is necessary for a diagnosis of depression, with other related symptoms, such as psychomotor and sleep disturbances, agitation, reduction in the degree of concentration, body weight change, loss of energy and feelings of guilt.[11] It has multifactorial causes involving biological, historical, environmental and psychological factors. [12] When it arises primarily in response to an identifiable stress, such as loss (grief reactions, disease, stigma, etc.), a serious physical illness (brain tumors, stroke, hypo- or hyper-thyroidism, SLE, etc.) or the use of drugs (reserpine, clonidine, methyldopa, propranolol, promazine, thyroid hormones, etc.), it is classified as secondary depression.[13]

Leprosy can no longer be understood only in terms of the bacillus, even though the knowledge of the microbiology is extremely important. It is necessary to understand the human being as a whole.[6,8]

From the premise of the conflicts and emotional state faced by the patients[10,14], the central question of the study is based on the identification of their possible depressive symptoms. Therefore, the aim was to investigate the presence of depressive symptoms in adult leprosy patients, as well as to specifically identify the percentage of depressive aspects in relation to gender, age, origin and skin color and to check the percentage of depressive symptoms presented among the clinical forms, operational classification and degree of incapacity of the disease. These being aspects that constitute an important focus regarding the pharmacological therapy. Constant attention to this situation in which the patient lives is paramount for therapeutic adherence, a good response to this and favorable outcomes, guaranteeing.[10,14]

METHOD

This descriptive study had a quantitative approach and was performed in the municipality of São Luís, which covers an area of 835 km^2 and has a population of 1,014,837 inhabitants. The municipal service network has three federal, 16 state, 52 municipal and 212 private health establishments. [15]

The study was conducted in the leprosy control program (PCH, of the University Hospital of the Federal University of Maranhão (HUUFMA) and the Dr. Genésio Rêgo Health Center.

The population consisted of all cases of patients, aged between 18 and 59 years, with leprosy that were diagnosed and reported by the Dermatology Service of the Presidente Dutra University Hospital (HUPD) and Dr. Genésio Rêgo Health Center, in the period from January 2012 to June 2013. The selection of participants was made by convenience, that is, the members of the population who were more available were chosen to constitute the sample.

The sample inclusion criteria were: to be a patient of the PCH of the Presidente Dutra University Hospital (HUPD) or Dr. Genésio Rêgo Health Center aged between 18 and 59 years, regardless of gender, skin color, origin, clinical form, operational classification or degree of incapacity. The exclusion criteria used were: illiteracy, being depressed or having undergone treatment for depression.

Data collection was conducted through structured, validated questionnaires, however, one, with quantitative variables, was not validated. The questionnaire was

chosen as the instrument as it presented considerable advantages for researchers, such as: obtaining responses in less time and with greater accuracy, saving time and obtaining large amounts of data, application at times favorable for the participant and guaranteeing the anonymity. Initially, the patients aged between 18 and 59 years were identified from the leprosy case registration book. Next, the interviews were conducted during the provision of the medication to each participant identified. Data were collected from July to September 2013, from the following instruments:

a) Data collection form;

b) Center for Epidemiologic Studies Depression Scale (CES-D);

The first is a non-validated instrument used to obtain the characteristics: sociodemographic and clinical aspects; including the following variables: gender, age, skin color, origin, clinical form, operational classification, degree of incapacity at the beginning of treatment, adherence or not to the treatment for depression. The information on skin color, adherence or not to the treatment for depression were obtained through interviews with the participant. The rest of the information related to the other variables was obtained from the medical records.

The population screening scale for depression of the Center for Epidemiologic Studies (CES-D) is a self-administered instrument, of 20 items, developed by Radlof in 1977 with the purpose of detecting depressive symptoms in adult populations. The scale includes items related to mood, behavior and perception that were considered relevant in clinical studies on depression. The characterization of depressed mood is determined by the responses related to the symptoms in the period corresponding to the week preceding the application. Much of the contribution to the development of this instrument stemmed from other scales of depressive symptoms, such as the Zung depression scale, the Beck's depression inventory, the self-reported Raskin depression rating scale, the depression scale of the Minnesota Multiphasic Personality Inventory - MMPI and the depression scale of Gardner. The CES-D has been widely used in clinical and population studies.[16]

Responses to each question are given according to the frequency with which each symptom was present in the week prior to the application of the instrument: "rarely or never" corresponding to a score of 0 (zero); "for a short time or some time" a score of 1 (one); "occasionally or for a moderate time" a score of 2 (two); and "most of the time" corresponding to a score of 3 (three). The score ranges from 0 (for those who respond "nothing or less than one day" to all 20 questions) to 60 (for those who respond "5 -7 days or almost every day for two weeks" to all 20 questions).[16]

The 20 items of the CESD scale cover the following symptoms, defined by the American Psychiatric Association Diagnostic and Statistical Manual (Fourth Edition), with their respective questions: dysphoria (2,4,6), anhedonia (8,10), appetite (1.18), sleep (5,11,19), thinking / concentration (3, 20), uselessness (9,17), fatigue (7,16), agitation (12), suicidal ideation (14,15). [16]

The cutoff point of 16 or more was used, i.e., the presence of depressive symptoms was considered in the cases where patients achieved a score of at least 16 (sixteen). The validation of the cutoff point of 16 or more was verified through studies of the sensitivity and specificity in comparison with established diagnostic criteria. Validation of the scale for Brazil was performed by Dartiu Xavier da Silveira and Miguel R. Jorge.[17]

The study was conducted from July 2013 to November 2013 and the data was digitalized into the EPIINFO (version 7. 0) program, where the percentage of the presence of depressive symptoms for each variable and not were calculated for the total number of participants in general and with depressive symptoms. With regard to the calculation of the percentage of the presence of depressive symptoms, the sum of the score of the selected option in each item of the CES-D questionnaire was calculated and participants that obtained a score higher or equal to 16 were considered to present depressive symptoms. Regarding the percentage of each of the depressive symptoms, the calculation was made from the total number of participants with depressive symptoms, and the number of each increasingly frequent question of the CES-D questionnaire.

To understand the characteristics of the depression the participants had and the symptoms that afflicted them, they were organized into 2 (two) groups, according to the frequency of each symptom: A and B, where Group A consisted of the most frequent depressive symptoms and B of those less frequent; based on the 20 items in the CES-D scale, defined by the American Psychiatric Association Diagnostic and Statistical Manual. In the analysis, the absolute numbers and percentages were considered. The results were presented in tables.

In compliance with Resolution CNS/145 No. 466/12, the project was approved by the Research Ethics Committee of the University Hospital of the Federal University of Maranhão - HUUFMA (CEP - HUUFMA), with authorization No. 326. 352, CAAE: 16439313.2.0000.5086, dated: 21/06/2013.

RESULTS

A total of 47 patients were interviewed, from July to September 2013, diagnosed and reported by the Dermatology Service of the Presidente Dutra University Hospital (HUPD) and by the Dr. Genésio Rêgo Health Center, with 18 (38.29%) presenting depressive symptoms, according to Table 1.

Age, gender, skin color and origin were analyzed according to the quantity of each variable (T), where the presence of depressive symptoms (F) was observed in all groups, with the more frequent symptoms of depression being in patients aged 18-25 years, male, of brown skin color and coming from the municipality of São Luís, according to the data presented in Table 1.

Table 1. Demographic characteristics of leprosy patients who presented symptoms of depression.

Variable	T	F	%
Age			
18 to 25 years	10	05	50.00%
26 to 35 years	10	04	40.00%
36 to 45 years	11	05	45. 45%
46 to 59 years	16	04	25.00%
Gender			
Male	26	10	38.46%
Female	21	08	38.09%
Skin Color			
Black	11	04	36.36%
Brown	29	12	41.37%
White	07	02	28.57%
Origin			
São. Luis	42	15	35.71%
Other municipalities of Maranhão	05	03	60.00%
Total	47	18	38,29%

Considering the clinical variables, Table 2 shows that, participants who presented depressive symptoms were those that had the tuberculoid, borderline and lepromatous forms, with the tuberculoid form showing the highest percentage. The largest number of cases presented the borderline form.

The operational form and degree of incapacity were also analyzed in accordance with the quantity of each variable (T), where there was the presence of these symptoms (F) in all groups; with those that presented the highest percentage for their respective variable being paucibacillary operational classification and degree one of physical incapacity. The highest number of cases presented multibacillary operational classification and degree zero of physical incapacity, with these data presented in Table 2.

Table 2. Demographic characteristics of leprosy patients who presented symptoms of significant depression.

Variable	T	F	%
Clinical Form			
Intermediate	02	00	00%
Tuberculoid	06	04	66.67%
Borderline	28	11	39.28%
Lepromatous	10	03	30.00%
Operational Classification			
Multibacillary	39	14	35.89%
Paucibacillary	08	04	50.00%
Degree of Incapacity			
Zero	24	09	37.50%
One	14	06	42.85%
Two	09	03	33.33%
Total	47	18	38.29%

Group A consisted of the following symptoms: anhedonia, fatigue, agitation, worthlessness and sadness, with this group being the more frequent among the patients, where fatigue had the highest frequency, demonstrating the transition phase between mania and depression, as shown in Table 3. Group B consisted of the following symptoms:

changes in sleep, appetite, thought, concentration, and suicidal ideation. Although these characteristics were less frequent, they obtained relevant frequencies, as shown by the data presented in Table 3.

Table 3. Depressive Symptoms of the leprosy patients.

Variable	T	F	%
Group A			
Fatigue	18	13	72,22%
Anhedonia	18	11	61,11%
Uselessness	18	11	61,11%
Movement (agitation)	18	11	61,11%
Dysphoria	18	10	55,55%
Group B			
Appetite	18	09	50,00%
Thinking and Concentration	18	08	44,44%
Sleep	18	09	50,00%
Suicidal Ideation	18	07	38,88%

DISCUSSION

Leprosy is a chronic disease of slow and insidious onset, which may cause limitations, cognitive and emotional problems and impaired social relationships for the patient. The emotional problems are closely linked to self-esteem, control of the body, interpersonal relationships, with the possibility of triggering complications such as depression.[18] From this premise, the present study was designed to investigate the presence of depressive symptoms in a sample of 47 patients with leprosy. In this study, the presence of depressive symptoms was found in 18 patients, representing 38.29% of the sample, similar to that found in the study by Junqueira.[10]

This can be explained by the fact that approximately 30% of skin diseases are associated with psychiatric disorders that may have various manifestations, including depression, with depression being the most common psychiatric disorder in leprosy. In addition to the chronicity there are important aggravating factors, such as stigma and types of disability, which together trigger or intensify the depressive condition.[10]

With regard to age, gender, skin color and origin, depressive symptoms were found in all groups. This result is in agreement with the study conducted in Minas Gerais[19], which reported that depression can occur in both men and women, of all ages in adulthood, independent of skin color and origin, and in any social class, although the incidence is twice as high in women than in men. With regard to gender, despite the prevalence of depression being higher in women, the presence of depressive symptoms in both genders of the participants in this study can be explained mainly by the fact that, in women, the requirements of beauty standards make them more vulnerable to depression due to disorders that impair the appearance. In men, because they are affected by occupational restrictions or financial constraints, a sense of impotency arises, although there are other multifactorial causes that could influence the onset of these symptoms in both genders.[13]

Considering the clinical data related to the leprosy, there was the presence of depressive symptoms in all groups except that of the indeterminate clinical form, in agreement with the finding of a study conducted in the city of Belo Horizonte/MG[6]. Therefore, these psychological changes may be related or not to the development of the condition of leprosy, the aesthetic conditions of the person, the self-image or the limitations that the disease can cause, depending on the characteristics of the individual.

The study in the city of Belo Horizonte - MG[6] highlights the comprehension that self-image is the image that individuals have of themselves, how they considers themselves, in that this consideration can cause determinations in their lives, in both the conditions of socialization and the characterization of their personalities. This, in turn, tends to lead leprosy patients to their own exclusion, especially if the self-image is unfavorable, when, for example, the patients find themselves physically unpleasant, cripples, "lepers", preventing them from satisfactorily using their relationship potential. Individuals may start to believe that they are people who do not have rights or the possibility of being accepted in society due to their aesthetic conditions, with the memory of living in a society that values the preconceived aesthetic conditions. In this case, depending on the characterization of the condition, leprosy has many factors, such as the presentation of spots on the body, facial alterations and/or muscular disorders of the feet and hands, that almost always cause a negative self-evaluation in the subjects. [6]

Patients that present the need, due to the evolution of the disease, for behavioral changes in their activities of daily living (ADLs) and practical life activities (PLAs) have to cope with new schemes for performing tasks, which are often simple for others, but that, due to the leprosy, become difficult or even impossible tasks for these patients.[6]

Regarding the characteristics of the depressive symptoms it was observed that there was predominance of the Group A symptoms, showing a transition between the manic phase (agitation) and depression (anhedonia, fatigue, worthlessness, sadness), with predominance of the depressive phase, with the fatigue symptom (72.00%) being present, representing the overall inhibition triad of this psychiatric disorder.[1,13]

The manic phase, represented by the symptom of agitation, can be explained simply by the fear that the patients present when confronted with the disease, which can lead to the dissimulation of the problems that leprosy causes. They, therefore, present behaviors of denial of the disease and their disabilities.[1]

With regard to the depressive phase, where there is awareness about the disease, in which the negative impact of this disease and emotional distress cause subjects to develop the characteristics of this psychiatric disorder. The predominance of the fatigue symptom, which is part of one of the triads of this disorder, causes overall inhibition of the body, which manifests itself as a kind of brake or slowing of the physical and mental processes in their entirety. In varying degrees, this general inhibition makes the individual apathetic, uninterested, sluggish and unmotivated, causing difficulty in performing the basic tasks of daily life and great loss in the ability to take initiatives.[13-4]

Anhedonia fits into the triad of Existential Narrowing, which represents the most appropriate expression for the progressive loss of pleasure that depressed people experience. With this the range of interest and pleasure in the things of life become increasingly smaller and more restricted, with only concern for themselves and their pain existing. Nothing can give them pleasure anymore and nothing can motivate them. In this case, the range of the existential field is so narrow that only the patients themselves fit into it, with their depression, the rest that life can offer is of no more interest, life itself seems to hold no interest anymore.[13-4,20]

The feeling of guilt fits into the triad of moral suffering or feeling of worthlessness and is considered an outstanding and unpleasant phenomenon in the depressive trajectory. It includes a sense of self-deprecation, self-accusation, inferiority, incompetence, sinfulness, guilt and rejection, ugliness, weakness, fragility and any number of other pejorative adjectives, and is considered the feeling most responsible for the suicide outcome of severe depression.[13-4,20]

Feelings of worthlessness, fatigue, dysphoria and anhedonia were perceived among the respondents, being related to the inability to continue working or get a new job due, to some extent, to the complications of the disease - “loss of strength and sensitivity” “intense pain”. Although this and other studies have identified several implications of the psychosocial effects of leprosy, this aspect is rarely considered in the leprosy care programs and in its educational materials.[21]

In relation to the various conditions presented, it was realized that the presence of this symptomatology can affect the medication adherence and quality of life, negatively affecting the course of the disease. When the treatment for leprosy is carried out incorrectly, it tends to worsen the conditions of this disease, worsening the depressive symptoms in extreme situations, which can lead to suicidal thoughts, with it not being uncommon for patients to yield to these impulses. In this study, there was a discreet presence of suicidal ideation (38.88%) among the 18 participants, drawing attention to the importance of monitoring the evolution of these depressive characteristics.

The characteristics described in this study do not relate to all leprosy patients, as they may have different psychosocial characteristics, manifesting in different ways. The attitude of professionals and people living with such patients can, however, be crucial in order to support them in the protection and guarantee that this degraded condition does not become part of their lives, preventing, guiding and taking into consideration that these are human beings that present psychosocial needs just like anyone else. [6]

CONCLUSION

The presence of a health condition in the non-psychiatric context, especially a chronic disease such as leprosy, could significantly increase the risk of occurrence of depressive symptoms. The presence of stress associated with the impact of illness and the emotional reactions to the physical or aesthetic changes caused by the disease contribute to the incidence of depressive symptoms.

A significant proportion of patients with depressive symptoms was found, with these manifested in varying proportions in each group, with the exception of the indeterminate clinical form, as the clinical conditions, limitations caused, understanding and self-image are the most visible factors for induction or not of the manifestations of the depressive characteristics. Regarding the types of depression, it was observed that in addition to the presence of the triad of symptoms, there was a transition between phases of mania and depression. This showed the departure from the denial phase, where there is a conscious decision in relation to the disease, in which the negative impact of this disease, these emotional afflictions, lead to psychological changes, thus demonstrating the manifestation of the characteristics of depressive phase.

When health professionals do not perceive the manifestation of the depressive phase in patients, physical and emotional stress becomes increasingly present, gradually worsening the situation. With this there may be the emergence of suicidal tendencies and it is not uncommon for patients to give in to these impulses.

The majority of the participants were in the transition phase between mania and depression, with predominance of symptoms of fatigue and a discreet presence of suicidal ideation. The groups that had the highest percentages were: those aged 18 to 25 years, male, with brown skin color, with the tuberculoid form, paucibacillar operational classification and one degree a physical disability. This shows the need for further research with this target public, especially with regard to the emergence and development of a multidisciplinary approach, optimization of health promotion and education, which may contribute to a better prognosis for the leprosy and control the worsening of the depression.

REFERENCES

1. Videres ARN. Trajetória de vida de ex-portadores de hanseníase com histórico asilar [dissertation]. Natal (RN): Programa de Pós-Graduação em Enfermagem, Universidade Federal do Rio Grande do Norte; 2010

2. Martins MVPS, Silva TS. Saúde pública e hanseníase na cidade de Uberlândia. Inst Geog on line [Internet]. 2011 Oct [cited 2013 Jan 20];3(7):38-52. Available from: http://www.observatorium.ig.ufu.br/pdfs/3edicao/n7/3.pdf

3. Ministério da Saúde (Brasil). Secretaria de Vigilância em Saúde. Departamento de Vigilância Epidemiológica. Guia de Vigilância Epidemiológica, Série A, Normas e manuais técnicos. Brasília: Ministério da Saúde; 2010

4. Ministério da Saúde (Brasil). Departamento de Vigilância Epidemiológica. Manual de Prevenção de Incapacidades, Cadernos de prevenção e reabilitação em hanseníase, 3º edição, revista e ampliada. Brasília: Ministério da Saúde; 2008

5. Ministério da Saúde (Brasil). Secretaria de Vigilância da Saúde. Boletim Epidemiológico vol. 44 nº11 de 2013. Situação epidemiológica da hanseníase no Brasil – análise de indicadores selecionados na última década e desafios para eliminação. Brasília: Ministério da Saúde; 2013

6. Garcia JRL, Macário DPAP, Ruiz RB, Siqueira LMS, Cara MRG. Considerações psicossociais sobre a pessoa portadora de hanseníase. In: Opromolla DVA et al. Prevenção de incapacidades e reabilitação em hanseníase. Bauru: Instituto Lauro de Souza Lima; 2003

7. Eidt LM. Ser hanseniano: sentimento e vivências. Rev Hansen Int on line [Internet]. 2004 July [cited 2013 Feb 24];29(1):21-27. Available from: http://periodicos.ses.sp.bvs.br/pdf/hi/v29n1/v29n1a04.pdf

8. Secretaria Municipal de Saúde e Defesa Civil (Brasil). Cuidado e Programas Especiais. Linha de cuidado de Hanseníase. Superintendência de Atenção Primária. Coordenação de Linhas de Cuidado e Programas Especiais. Gerência de Dermatologia Sanitária. Rio de Janeiro; 2010

9. Pereira SVM, Bachion MM, Souza AGC, Vieira SMS. Avaliação da hanseníase: relato de experiência de acadêmicos de enfermagem. Rev bras enfermon line [Internet]. 2008 Nov [cited 2013 Aug 29];61(spe):774-80. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672008000700020

10. Junqueira AV. Aspectos psicopatológicos na hanseníase e nas reações hansênicas [dissertação]. Goiânia (GO): Mestrado em Medicina Tropical, Universidade Federal de Goiás; 2006.

11. Perito MES, Fortunato JJ. Marcadores biológicos da depressão: Uma revisão sobre a expressão de fatores neurotróficos. Revista Neurociências on line [Internet]. 2012 Jul [cited 2013 Apr 02];20(4):597-603. Available from: http://www.revistaneurociencias.com.br/edicoes/2012/RN2004/revisao%2020%2004/730%20revisao.pdf

12. Cade NV, Prates JG. Treinamento em solução de problemas: intervenção em

mulheres com depressão. Rev Esc Enferm on line [Internet]. 2001 Sept [cited 2013 Apr 04]; 53(3):223-9. Available from:http://www.scielo.br/scielo.php?pid=S0080-62342001000300004&script=sci_arttext

13. Figueiró JAB, Júnior, RF. Depressões em Medicina Interna e em outras condições médicas, Depressões secundárias. 2nd ed. São Paulo: Atheneu; 2004

14. Louzã N, Mário R, ELKIS H. Psiquiatria Básica. 2nd ed. Porto Alegre: Artmed; 2011

15. Brasil. Ministério do Planejamento, Orçamento e Gestão [Internet]. Fundação Instituto Brasileiro de Geografia e Estatística; 2000 [cited 2012 May 12]. Available from: http://www.ibge.gov.br

16. Maluf TPG. Avaliação de Sintomas de Depressão e Ansiedade em uma amostra de familiares de usuários de drogas que frequentaram grupos de orientação familiar em um serviço assistencial para dependentes químicos [dissertação]. São Paulo(SP): Mestrado em Ciências da Saúde, Universidade Federal de São Paulo; 2002

17. Myers JK, Weissman MM. Use of a self – report symptom scale to detect depression in a community sample. American Journal of Psychiatry on line [Internet]. 1980 Sept [cited 2013 Aug 28];137(9):1081–1084. Available from:http://www.ncbi.nlm.nih.gov/pubmed/7425160

18. Ministério da Saúde (BRASIL). Secretaria de Políticas Públicas de Saúde. Departamento de Atenção Básica. Guia para o controle da hanseníase. Brasília: Ministério da Saúde; 2002

19. Machado RM, Oliveira SABM, Delgado VG. Características sociodemográficas e clínicas das internações psiquiátricas de mulheres com depressão. Rev EletrEnf on line [Internet]. 2013 Jan-Mar [cited 2013 Aug 25];15(1):223-32. Available from: http://www.fen.ufg.br/revista/v15/n1/pdf/v15n1a26.pdf

20. Campos APF, Silva EBP; Cruz JB, editores. Técnicas comportamentais na Depressão: Fundamentos Teóricos [monografia]. Governador Valadres (MG): Universidade Vale do Rio Doce; 2009

21. Santos AK, Ribeiro APG, Monteiro S. Hanseníase e práticas da comunicação: estudo de recepção de materiais educativos em um serviço de saúde no Rio de Janeiro. Inter Com, Saúde, Educ on line [Internet]. 2012 Jan-Mar [cited 2013 Aug 29];16(40):205-18. Available from: http://www.scielo.br/scielo.php?pid=S1414-32832012000100016&script=sci_arttext

Submission: 2015/11/14
Accepted: 2016/05/08
Publishing: 2016/09/01

Corresponding Address

Vanessa Virginia Lopes Ericeira
Programa de Pós-Graduação em Enfermagem
Mestrado Acadêmico em Enfermagem
Universidade Federal do Maranhão
Cidade Universitária
Av. dos Portugueses, 1966
Bairro Bacanga
CEP 65080-805 — São Luís (MA), Brazil