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Exploring the emotional distress of women who attend primary health care units in Mexico City. A qualitative study

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SUMMARY

Emotional distress is the subjective sensation of diminishment in well-being which manifests itself in a number of non-specific symptoms. It might be a risk factor for the development of mental illness, especially among individuals with psychosocial or biological vulnerability. Recent studies show that primary healthcare services receive a growing number of patients who suffer distress, but do not fulfill the diagnostic criteria of a mental or physical illness. This phenomenon is more frequent among women. The objective of this paper is to analyze the emotional distress experienced by a group of women who attended primary healthcare institutions in Mexico City, as well as their perceptions and experiences around the care received, in order to identify their treatment needs. Data was gathered through techniques and instruments pertaining to qualitative methodology. The information was coded and analyzed according to the meaning categorization method developed by Kvale. The results show that the main triggers of emotional distress are associated with daily life worries (lack of money, problems with children, and domestic violence, among others). In some cases, it is also associated with traumatic events, such as past or present violence and sexual abuse. Data also suggests that women do not talk about emotional distress directly during medical appointments and that healthcare professionals minimize the importance of distress or do not recognize it at all. These aspects are related to the current characteristics of the service, which lacks a comprehensive approach and a psychosocial perspective.

Key words: Emotional distress, mental health, gender, primary healthcare.

RESUMEN

La presencia de malestar emocional –que se define como el conjunto de sensaciones subjetivas que percibe una persona de que su bienestar sufre una merma y que se manifiesta por síntomas inespecíficos– puede constituir un factor de riesgo para la aparición de enfermedades mentales, sobre todo en personas con vulnerabilidades biológicas y psicosociales. Estudios recientes señalan que los servicios de atención primaria reciben un número, cada vez mayor, de personas con malestares que no cubren los criterios diagnósticos de una enfermedad, ya sea mental o física, fenómeno que es más frecuente en las mujeres.

El objetivo de este trabajo es analizar los malestares emocionales de un grupo de mujeres que acude a instituciones de atención primaria de la Ciudad de México, así como sus percepciones y vivencias sobre la atención recibida, con el propósito de identificar necesidades de atención. Para recopilar la información se utilizaron técnicas e instrumentos propios de la metodología cualitativa.

La información se codificó y analizó conforme al método de "categorización de significados" propuesto por Kvale. Los resultados mostraron que los principales detonantes de los malestares emocionales en las participantes se asocian con las preocupaciones que enfrentan cotidianamente (como falta de dinero, problemas con los hijos y violencia intrafamiliar) y, en otros casos, con la vivencia de experiencias traumáticas de violencia y abuso sexual, pasadas y presentes. Los datos demuestran también que las mujeres no hablan directamente de su malestar emocional, pero que tampoco lo detecta el personal de salud o que, cuando lo hace, le resta importancia. Lo anterior se relaciona con las condiciones actuales del servicio, que no ofrece una atención integral y adolece de una visión psicosocial.

Palabras clave: Malestar emocional, salud mental, género, primer nivel de atención.

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INTRODUCTION

The construct of emotional distress has been widely used in medical and social research.[1] It partly stems from questioning carried out in the biomedical field, where it has been observed that many emotional and physical manifestations do not meet the requirements for a clinical diagnosis.[2] But it also stems from more critical and interpretive positions, which emphasize the feelings and manifestations of distress in daily life, and the importance of sociocultural variables in the construction of the same.[3-5]

Emotional distress is a subjective sensation relative to diminished wellbeing. It arises as unease, discomfort, or "feeling bad", and appears as a set of poorly-defined symptoms with no demonstrable cause.[6] It is a response to various life situations and social contexts, such as family, work, community, and activities in daily life. Some of the symptoms and sensations associated with emotional distress are sadness, feelings of emptiness, muscular pains/headaches or both, insomnia, fatigue, worry, nervousness, and irritability.[7]

It is worth noting that the presence of emotional distress is not synonymous with, nor is it a direct cause of, mental illness. However, it can increase the risk of such an illness presenting itself in those with biological and psychosocial vulnerabilities.[8] Coupled with the above, emotional distress generates important costs to the health and wellbeing of the population, and therefore, work on delineating its field becomes especially relevant to detecting it and intervening in a suitable and timely manner.[6]

Recent studies coincide in indicating that primary healthcare services receive an ever greater number of people with complaints similar to those set out in the definition of emotional distress.[9-11]

As such, it is estimated that between 30% and 60% of all visits seeking primary healthcare are associated with symptoms that do not necessarily cover the diagnostic conditions for an illness, whether mental or physical. Nor can they be confirmed by means of laboratory or clinical examinations.[10,12]

These types of distressing sensations are most frequently mentioned in the female population. Authors such as Velasco,[4] Muñoz et al.[13] indicate that in Spain, more than 70% of people who present with this type of problem are women. As such, they proposed the concept of "women's distress syndrome" as a construct that included the determinant of gender in the subjective and psychosocial approach to emotional distress.

Vargas et al.[14] found similar results in healthcare centers in Mexico City. Their study reflected that 67% of the people interviewed experienced emotional distress, and that this was more frequent in women (70.6%) than in men (52.5%).

The differences in the presentation of emotional distress between genders seems to be related to a different ways of getting ill, different ways of expressing distress, and with a greater tendency for women to attend healthcare centers, which makes their sensations and ailments more recordable.[15]

Furthermore, various investigations carried out in Mexico coincide by indicating that in the female population, emotional distress is associated with a greater number of responsibilities and obligations related to their gender, such as being a mother, wife, daughter, carer, and in many cases, breadwinner - in other words, in meeting the needs of others before their own. It goes without saying that these situations cause a great deal of worry, tension, and stress.[16-19]

Despite this information demonstrating the presence of emotional distress in the female population attending primary level healthcare centers, in the majority of cases, this distress is not detected or taken into account by staff working in these institutions. In any case, care is oriented towards symptoms and pains, rather than their causes.

This way of approaching the problem responds to certain aspects linked with the current functioning of primary healthcare in Mexico, such as the priority given to interventions focused on physical complaints, the lack of programs oriented towards the diagnosis and care of emotional problems, and the insufficient staff training around these matters.[20]

Furthermore, the short length of consultancies and high bureaucratic and administrative workloads impede further depth into subjects related to the daily life of each patient.[20-22]

Authors such as Nimnuan,[12] Aiarzaguena,[10] and Velasco[4] propose that women with emotional distress who do not receive adequate care will go back for appointments again and again, complaining of the same symptoms and/or other new ones, because their needs have not been met. This "overuse of services" generates suffering for patients, frustration among healthcare staff, and an important economic impact on the healthcare system.[23]

In light of the above, the object of this work was to explore the emotional distress of a group of women and their perceptions and experiences of the care they received from primary healthcare institutions, with the aim of identifying their care needs.

MATERIAL AND METHODS

The study was carried out in eight primary healthcare centers located in three areas of Mexico City. A qualitative investigation was carried out, which included observations and individual semi-structured interviews with staff working in those centers (35 people) and service users (eight men and nine women). This work presents only the information provided by center users. The field work was completed between April 2012 and September 2013.

The interviewees were selected by means of a theoretical or purposive sample,[24,25] in which the most important aspect is not the number of people; rather, the information that each one can provide for interpreting the subject of interest.

The process finishes at the point of saturation; that is, when interviews with additional people do not provide any new or relevant information for understanding the phenomenon. We are mindful that no saturation was reached with this work due to the age range of the women interviewed, among other things. Even so, the information gathered constitutes an increase in the understanding of this phenomenon.

This document presents an analysis of the information provided by nine women who attended as patients of one of the primary healthcare centers where the research was carried out.

Participants

The interviewees ranged in ages from 17 through 70 years. Four of the participants had an elementary level of education, two went to middle school, two went to high school, and one had completed technical studies. All participants referred to having a low socioeconomic level and living in neighbourhoods with high levels of marginalization, violence, and drug consumption (Table 1).

The inclusion criteria for the women were as follows: a) 15 years of age or more, b) regular attendance of the healthcare center to be able to share experiences in terms of the care received, and c) acceptance of participation in the study.

Procedures for gathering and analysis of data

Semi-structured interviews were carried out through the social research interview technique, which favors the production of continued discourse and has a line of argument about a certain theme.[26]

In order to collect the information, an interview guide was prepared, which included the following key points: 1. Use and experience of health services; 2. Mental health, which only included information related to emotional distress and care needs within the health center; 3. Sociodemographic data.

Contact with service users was carried out in two ways: through the nurses and/or social workers in the centers, or by direct invitation while people waited to be seen for their appointments. The interviews were conducted in the healthcare center waiting rooms at dates and times set by the interviewees. They were completed in one or two sessions, depending on the participants' availability, and they lasted approximately 90 minutes. The interviews were conducted by a Master in Public Mental Health and a doctoral student.

Analysis of information

The audio-recorded interviews were transcribed, and the transcriptions coded and analyzed using the "categorization of meanings" method set out by Kvale.[27] With this method, each interview is codified into a series of mutually exclusive categories, which allows for the accounts to be structured into units of information that facilitate understanding of the subject of interest, as well as their occurrence throughout the discourse.

Two members of the research team, a Doctor of Anthropology and a Master in Public Mental Health, codified the interviews separately and any discrepancies were resolved through joint discussion and review of the original accounts. Initially, the categories were defined from the objectives of the study and the subjects covered by the interview guide. The interviews were later reread to extract relevant new information that may prompt addition or modification of the categories already identified.

In this work, the results will be presented in the following three categories:

1. *Emotional distress*. This category dealt with the sensations and manifestations perceived by the interviewees that make them "feel bad", "uncomfortable", "unsettled", or "bothered", and which do not fall into a specific clinical 'box'. This category was formed by analyzing the bodily reactions and emotional sensations associated with the problem or experience that triggered the distress.

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Table 1. Characteristics of the participants

Pseudonym	Age	Civil status	Children	Scholarship	Occupation	Chronic disease	Psychological treatment
Reyna	45	Married	Yes	Middle school	Housewife	No	No
Juana	49	Married	Yes	Elementary school	Housewife	No	No
Susana	20	Common law marriage	No	Incomplete high school	Helps her mother at home	No	Yes
Socorro	70	Widowed	Yes	Elementary school	Housewife	Diabetes and hypertension	No
Ema	17	Single	No	Middle school	Student	No	Yes
Berenice	39	Separated	Yes	Technical course	Beauty salon	No	No
Lucila	65	Married	Yes	Elementary school	Housewife	Hypertension	Yes
Érica	60	Married	Yes	Elementary school - 4th grade	Housewife	Diabetes	No
Eréndira	18	Single	No	High school	Student	No	No

2. *Perceptions and experiences of women in primary healthcare*. The women's perceptions of the care they receive or have received in healthcare centers were analyzed in this category.
3. *Care needs*. This category explores the care and support needs, both implicit and explicit, that are identified in the interviewees' accounts.

Ethical considerations

The project from which the information in this document was gleaned was approved by the Ethics Committee of the National Institute of Psychiatry Ramón de la Fuente Muñiz.

Given that it was considered a study with minimal risk, informed consent was only obtained verbally. This involved providing detailed information about the objectives and characteristics of the research. Participants were also informed about their rights to withdraw their consent at any time, and to leave the project without any repercussions on the care they receive at the healthcare center. Permission was also sought to audio-record the interviews. Pseudonyms were used in order to protect the privacy of the interviewees.

RESULTS

It is important to mention that the women interviewed had attended the healthcare centers for various reasons, such as bringing their children to an appointment, monthly check-ups during pregnancy, intestinal infections, and sore throats/coughs/colds. Middle-aged and older women also attended a chronic-degenerative group.* Although none of the participants referred to emotional distress as the reason for their appointment, it appeared during the various topics covered in the interview.

Emotional distress

The participants spoke about feeling unsettled, nervous, irritable, desperate, and/or with constant mood swings. There were frequent phrases such as: "I feel different because of my nerves, I am afraid, I feel anxious" and "I have the urge to run away".

Some women presented physical complaints, such as persistent pain throughout the body, feeling physically and mentally drained, headaches, "hot flashes", memory lapses, insomnia, shaky hands, and high blood pressure. They associated these feelings of distress with various concerns; for example, problems at home, excessive responsibilities, lack of economic resources, and substance abuse, whether their own or that of a close family member. They also indicated distress being triggered by experiencing violence in the home, sexual abuse, or living in insecure environments.

The following account exemplifies how physical complaints, causes or triggers of worry, and emotional sensation are interwoven:

Lucila is a 65 year old woman who frequently attends the healthcare center because she has high blood pressure, nausea, chest pains, and "a horrible heat in the head". She relates her hypertension and "feeling bad" with being constantly worried. Her main sources of worry are: her husband is out of work and so she sees it as "very hard to be able to survive"; her son's alcoholism and her perception that he lives in a dangerous area because "they take drugs outside his door and they are sometimes there all night long".

Even if it is clear that feelings of emotional distress can manifest themselves in women regardless of age, it was also identified that some of these sensations are associated with a specific time of life. For example, adolescents relate distress primarily with problems at school, disputes with their parents, drug and/or alcohol consumption, and unwanted pregnancy.

> "*I'm telling you, I had the urge to drop out of school, run away, hit somebody. In fact, I didn't even want to eat, I wanted to cry, I don't know, I didn't want to do anything, anything […] and being at home I felt bad; actually, it was even worse there. I feel like all of it was because of seeing my parents fighting all the time. Before, the fighting was even worse, now they don't even talk to each other; but before, they threw things, they fought, they hit each other.*" [Ema, 17 years].

The demands of daily life in and out of the home, conflicts with children and partners, and in some cases, taking care of parents are the most frequent causes of distress among adult women. The above is expressed as "feeling overwhelmed" or "to the limit".

> "*There are always problems at home, with one thing or another. I have three children, and each one has their own problems and is living them day to day […] My 14 year old daughter got pregnant, she just had her baby and it had a huge impact on us. I am the one who takes care of my dad. Sometimes I get stressed out […] like my daughter's baby just got sick, we had to go to the hospital; I was there all day and I was worried about my dad who doesn't have anyone to take him food, and if I don't do it, he just stays lying down and doesn't eat. So there are lots of things, I feel really pressured.*" [Reyna, 45 years]

Finally, mature women feel worried due to their "ailments", whether typical of growing older, or associated with chronic illnesses such as diabetes. Feelings of loneliness and abandonment are also common at this stage of life.

* The forming of these groups follows a program with the objectives of promoting healthy lifestyles (exercise and change of diet) and ongoing monitoring of weight, blood sugar levels, and blood pressure in patients. Specific steps are also taken such as checking the back of the eyes and the feet of diabetics, among others. All of the above is followed in patients diagnosed with diabetes and/or hypertension. The patients are invited to the healthcare center on a certain day of the week to perform exercises and receive advice on various aspects of these illnesses. The groups vary in number; the majority of participants are middle-aged and older women. The dynamic of each group depends on the cohesion and interests of the participants, such that there are groups that meet more frequently than others and do other activities, such as walks and spending time together.

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"*Now, because I have been ill, it makes me very unsettled, I think 'Oh, I'm all alone and no one can see me'. I have diabetes, hypertension - I was fine, but lately lots of things have gotten more complicated. Now I have colitis, high cholesterol, triglycerides, I get a lot of throat problems too. It all makes me feel bad, feeling unwell, because I mean, I do worry about being alone and I am always so careful because I am afraid of falling down, I say, 'Oh no', I am going to break something, and then…[…].*" [Socorro, 70 years]

Perceptions and experiences of primary healthcare

The women interviewed were very clear about the range of services and resources on offer at the healthcare centers, so using them was very convenient. They sought diagnosis for bodily pains or physical illnesses and expected to receive a (primarily medical) treatment; they also brought their children to be vaccinated, or they wanted to join Seguro Popular* or the Programa de Gratuidad.**

The participants considered that a medical appointment is not the appropriate place to discuss what is bothering them in daily life, given that appointment times are very short and they believe that the doctors do not have the necessary skills and knowledge to give them adequate care.

Furthermore, they prefer not to speak about their worries and suffering, either because they feel ashamed, ("*I shouldn't talk about my family - vent about family business*"), or they are afraid of being scolded and/or judged.

Even if these women do not speak directly about their distress, it is also the case that healthcare staff do not always ask about daily life, their concerns, or their mood. They perceive that staff are more interested in diagnosing and treating physical symptoms and ending the appointment quickly, than in knowing their life stories.

As such, it would seem that primary healthcare professionals only recognize emotional distress when the problems are very evident and/or their association with physical symptoms is very clear.

Susana is 20 years old and attends the healthcare center because she is pregnant. She comments that whenever she visits the center, the nurse records her weight and blood pressure and that once, she noticed that Susana's hands were covered in scars. When the nurse asked her why this was, Susana told her that she cut herself when she was feeling desperate and felt that she had not done things right. She mentioned that after hearing this, the nurse said that pregnancy in adolescents could cause depression and that it would be a good idea to make an appointment with the doctor, referring her to the center psychologist.

On the other hand, in cases where the interviewees confided in doctors that they were feeling tense, stressed, nervous, or sad, the most frequent response they received was to be prescribed some sort of medication, ranging from antacids, analgesics, or relaxants to drugs for "sleeping" or "depression".

"*He [the doctor] started to control my blood pressure with medication and he gave me some sleeping pills because he told me I had 'a strong depression', he said 'it will go up with these', and yes, I mean, I am still taking them now […].*" [Lucila, 65 years]

Another frequent recommendation by medical staff when they recognized the presence of emotional distress in women, especially mature women, was to incorporate them into chronic-degenerative groups.

"*The doctor recommended that I take exercise, go to the [chronic illnesses] group, he said that I would feel better, and yes, I feel really good with exercise; [it helps] with stress more than anything. The ones who go to the group also talk, we do relaxation, we laugh; I feel good, we chat, we relax, and we leave feeling very content […].*" [Érica, 60 years]

From the interviewees' accounts, it was possible to identify that there was also an "informal" level of care occasionally provided by nurses and social workers. Said care is better provided based on life experience and solidarity of gender than on professional knowledge. This dynamic is thanks to friendly and empathic links having been formed, and to the patients feeling confident in talking about their problems.

Care needs

The women explicitly indicated the need to have a specialist in mental health, preferably a psychologist, in each center. For them, mental health professionals are the only ones who have the necessary knowledge to listen and deal with the daily problems facing them. They also perceive that it is necessary to have information on subjects related to childcare, depression, family violence, drugs, and others.

Another need expressed by the women is that these specialized services should be available in the centers in both the morning and afternoon surgeries. This is because it is often difficult to attend in the morning given that they have to prepare food, take children to school, and work, among other things.

As can be observed, the explicit needs are clearly around needing mental health specialists. It is not considered possible for medical, nursing, or social work staff at the primary healthcare level to provide this type of care.

However, analysis of the accounts revealed underlying needs associated with the daily relationship maintained with primary healthcare staff and the functioning of the same.

In the women's accounts, the need for staff to listen to them with greater sensitivity and empathy can be perceived,

* Seguro Popular (SP) ['People's Insurance'] is part of the Social Protection in Health System that came into force in January 2014. If offers financial protection to people who are not beneficiaries of public social security institutions such as IMSS or ISSSTE. It is mainly aimed at unsalaried workers, the unemployed, and their families. SP is coordinated by the Federation and administrated by federal bodies.

** Gratuidad is a Program strategy for free medical services and medication, started in July 2001. In 2006, it was passed as law in the Federal District, and in 2007 it was declared a social program. It is aimed at uninsured families resident in Mexico City.

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especially in the case of doctors. This lack of empathy and sensitivity is associated with staff characteristics such as age (taking into account that if they are very young, they have less training) or with sex (feeling more confident with a woman).

From what is said by the women, the need is also apparent for private spaces, as there is a certain discomfort in speaking about "personal and intimate" subjects in consulting rooms where the door is regularly open, the walls are not soundproof, or people are constantly coming and going.

DISCUSSION

The accounts analyzed here allow for an examination of the patients' perspective in terms of how their ailments, the triggers of their worries, and the feelings of emotional distress are all interlinked, as well as their perceptions and experiences around the care received for the latter.

The results of other investigations[5-7] support the above indications in the sense that emotional distress in women can only be detected and dealt with to the extent of the understanding that various factors converge at its root. These factors are associated with the patients' biography, conditions of gender, and the way in which they experience and have attached significance to sociocultural circumstances.

The information also demonstrates that the women do not directly talk about their emotional distress, but healthcare staff do not detect it either, and when they do, its importance is downplayed. This is perhaps related to the current conditions of the primary healthcare service provided, which does not offer integrated care and lacks a psychosocial vision.

In order to achieve adequate care for emotional distress, it would be necessary to make changes within the first level of care, which would allow for: a) raising awareness and training for authorities and staff about the impact of daily life on health, as well as the importance of dealing with situations different to medical or somatic complaints, and b) integrating the detection of emotional distress and its care as one of the objectives of the mental health program.[28,29]

Carrying out the actions proposed above and hearing what is hidden behind the symptom will allow for a clearer understanding of the demands of women and as such, give them care that is more in line with their needs. This change in care could diminish what has been called "overuse of primary healthcare services".[4] As already mentioned, this causes suffering of the patients, frustration and helplessness in healthcare staff, and an economic impact on the healthcare system, precisely because the demand is not completely resolved.[4,13,23]

The characteristics and demands established in the healthcare centers where this project was completed made it difficult to make first contact with the service users, establish dates and times for the interviews, and develop them optimally. It is necessary to seek better strategies in order to achieve greater participation of women in the study and make them available to give interviews in spaces other than healthcare centers.

In subsequent works, it would be advisable to complement the information presented in this article with the primary healthcare staff's vision in terms of the distress of women and their associated care needs. Finally, it would also be appropriate to conduct further research focused on a more precise analysis of the relationship between the presence of emotional distress, the lack of recognition and care of the same, and the "overuse of primary healthcare services" on the part of the female population.

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