DOI: 10.1590/1413-81232017223.27982015

Psychological assistance provided to patients diagnosed with depression in primary care

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Abstract *The scope of this research was to understand the assistance provided by psychologists to patients diagnosed with depression in the municipal health care network. In this study, the phenomenon is examined from its broader perspective, taking the psychosocial dimensions of health into account. A group of 22 psychologists participated in this study of a qualitative nature. Data collection began with participant in-field observation of the institutional context followed by semi-structured interviews. Grounded theory methodology was used to analyze information, thereby facilitating its integration and categorization.The results revealed that in the primary care network the treatment of depression is essentially restricted to its biological aspect; the choice of individual psychotherapy as the main form of treatment refers to traditional practices of psychological care for depression; the use of institutional and community methods as part of the therapeutic approach suggests mental health interventions that address the psychosocial dimension. The findings indicate that transcending the traditional models of care for patients with depression and the construction of forms of treatment using psychosocial resources are ongoing, indicating that comprehensive care needs to be further consolidated in primary care.*

Key words *Psychologists, Depression, Mental health, Primary care*

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Introduction

This study encompasses a broadspectrum of depression, which brings together a set of signs and symptoms recognized as constituting depressive states, which vary in intensity of effects on the individual. This approach is based on psychosocial and biological dimensions, which influence each other in a recursive manner. Considered one of the main and most common mental health problems, with prevalence rates affectingup to 20% of the world population, depression is a significant contributor to the global burden of disease with an important social and economic impact. The burden of comorbidity of depressive disorders alsoimpacts chronic ailments, making them ever more difficult to treat.

When considering this scenario, care for depression is identified as a challenge for public health. The 2013-2020 Global Action Plan for Mental Health of the WHO[1] consolidates the concept that care for mental health should be provided in community healthcare centers.

A decade ago, Brazil incorporatedhealth assistancewith the actions of primary health care – PHC[2-4], ensuring a favorable outcome for care of depression, as it enabledgreater access to treatment forpatientssuffering fromthis kind of psychic distress. Currently, the demand for care fordepressive symptoms corresponds to 23.9% of PHC users, being characterized as predominant in mental health care in the public system[5].

In primary care, assistancefor depression is supported by a set of policies that makes it possible to create a model of care that seeks to provide comprehensive assistance to users. In this respect, the sociocultural aspects of the ailment gain impetus and care of health reacquires contextual and institutional perspective, such that the psychosocial dimension can be acknowledged in the construction of health and diseaseprocesses[6]. In this line of reasoning, the intervention processes of professionals call for action on a broader scale, interacting with different fields of knowledge in the development of the therapeutic project[7].

In this context, the psychologist's work is based on guiding principles of the institutional context, such as that of expanded and shared clinical practice[8], and the inclusion of guidelines for actions inmental health[3] in primary care, the latter being developed on the tenets of Psychiatric Reform. Thus, the psychologist must workfrom a generalist perspective on curative care and develop prevention and health promotion activities with a focus on the family and the community[9]. This institutional structure is linked to the practice of psychologists in the clinical care of mental health, the intervention processes of which occur through listeningcarefully to the symptoms[10], considering the circumstances involved in order to elaborate therapeutic projects that enable the comprehensive care of the patient diagnosed with depression.

The psychosocial and community dimensions of psychological care are administered through the set of technical/care actions that sustain the practices of professionals. Psychotherapy, both individual and in groups, is an instrument that is known to represent these practices.Individualpsychotherapy is widely recommended to treat depression by national and international health agencies[11,12] and has acknowledged efficacy in different theoretical approaches[13]. For Ferreira Neto and Kind[14], individualized care enables personalized and targeted attention, though at the same time it focuses on the pathological process. On the other hand, group therapy represents atherapeutic strategy that prioritizes mental health actions[15]. The potential of this form of intervention is based on strengthening or building social networks, which constitutes a health factor[14]. With respect to treatment for depression, group psychotherapy is considered a mechanism that is just as effective as individual care[13]and is also recommended by health bodies[11,16]. Psychological care for depression also includes psychoeducational actions seeking to bolster theautonomy process of the health system user diagnosed with depression by means of information[17,18].

These features, along with the mental health care policies, represent the tools that allow the psychology professional to provide care to patients with depression from the psychosocial perspective, which contributes to comprehensive care to patients, seeking to transcend traditional mental healthcaremodels. In this respect, investigating how professionals develop their actions makes it possible to understand the impact of the guidelines of public policies on the proposals of intervention of those working in the public health system.

The scientific literature on the practices of mental health professionals in public care for depression, from the standpoint of health professionals is, however, scantly explored. On the international scene, the bibliographic production, mostly related to the medical professional, focuseson the analysis of the processes of clinical management of patients both with regard to the prescription of medication[19] and to the recom-

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mendation of psychotherapy[20]. The perspective of other mental health professionals is addressed in productions that deal with shared care[21,22]. Within the scope of public policies for care, there is a need to (re)consider new methods of intervention thatbroaden the forms of care to render treatment more comprehensive and effective[23].

On the national scene, the production of the last five years in indexed journals about depression in the context of PHC is strongly related to epidemiological prevalence data, revealing the absence of publications on professional practices and intervention processes in depression[5,24]. This may be connected to the fact that mental health treatment in primary care is a recent and ongoing phenomenon.

Based on these ideas, this work belongs to the field of professional practices in conjunction with the public policies that orient the work processes. The study then aims to understand the practice of psychologists in assisting users with a diagnosis of depression in the municipal health network.

Method

The research is qualitative and seeks to understand the meanings, beliefs and values manifested by the participants within their social and everyday reality[25]. Conducted from the perspective of epistemological assumptions of Complex Thinking[26], this study is grounded on the dialogical principles in order to contemplate the vast network of interacting elements that comprise mental health care.

The study was conducted in a municipal mental health network, which consisted of teams of psychologists and psychiatrists, who attended via matrix support and NASF (Family Health Support Center) teams in health centers, aiming to offer full coverage in terms of primary care in the municipality.

Psychologists who assist patients in the mental health care network participated in the research. From a group of 28 professionals operating in the network, 24 were invited, namely 15 from Primary Care, 5 from CAPS (Psychosocial Care Centers) II and 4 from Child CAPS. Of the professionals invited, 22 psychologists agreed to participate in the survey.

The description of the group of participants showed that the majority of the respondents had between 3 and 7 years of experience as a psychologist. With respect to the time worked in the municipal mental health network, 12 were active between 10 months and 3 years, and the rest ranged up to 13 years.

In terms of specialization in the theoretical approach, the 12 participants had completed the course in Psychoanalysis, Gestalt and Systemic Family Therapy; 10 had incomplete specializationor no experience in any theoretical approach. In addition, 13 had postgraduate degrees, 10 of which with specialization in areas related to psychology or health. Regarding participation in training courses, only 4 psychologists declared that they had taken a specific course onmood disorders.

Data gathering, which was conducted from 2009 to 2010, was organized in two stages: the first was characterized by the "in-field participant observation" process in the monthly meetings of mental health teams and matrix support meetings of CAPS with mental health teams, with a total of 30 events. This stagemade it possible to understand the research field and identify the work processes of the mental health team. The data collected in this phase were recorded in field diaries and formed part of the analysis, revealing the configuration of the institutional context and how depression was discussed and dealt with in this situation.

The second stage was carried out through semi-structured interviews applied after the "in-field participant observation" period. The guiding thematic aspects of the interview were: a) training and qualification process; b) characterization of the diagnostic process; c) identification of the clinical management principles; d) issues relating to working in a mental health network; the latteraspect was also supported by data garnered from observation. The interviews recorded on audio tape were conducted individually at a previouslyagreed time and place.

Data analysis was performed using Grounded Theory developed by Strauss and Corbin[27], which enabledsystematic grouping, linking and comparisonof the data from the transcripts of the semi-structured interviews and the notes in the field diaries. When considering the scope of the study, analysis was performed using the following steps: a) immersion in the data from the reading of the material collected; b) division of the data into incidents, ideas or events and relabeling them with a conceptual code that represented them, namely a step called "open coding"; c) classification of the codes in such a way as to create nucleiof similar properties or show singularities –a step called "axial coding"; d) listing,

based on the main categories of the respective subcategories of analysis, namely the phase called "selective coding", where codes are refined and integrated in order to describe and understand the main categories.

Given the amount of data generated in the interviews, analysis was performed using ATLAS.ti 5.0 software (Qualitative Research and Solutions). The use of this tool enabled visualization, integration and scrutiny of information in accordance with the principles of the program[28] to permit codification and construction of categories, based on the theoretical reference framework of the researcher.

The research was submitted to the Human Research Ethics Committee, which approved it under protocol (Case No. 147/08 FR-201479), and it had the permission of the participants who signedanInformed Consent Form.Participants were identified by letters and numbers to maintain anonymity.

Results and discussion

From the analysis of the narratives of the professionals, four categories were singled out for this article that showed clinical and institutional aspects of the treatment of the health of patients diagnosed with depression, duly itemized below.

Contextual factors for care for the diagnosis of depression

The links in the relationships and organizational structures in which professional practices are constructed and reproduced represent the contextual factors of care for depression. In this study, two institutional factors are highlighted: the first – *discussion about depression among mental health professionals* – reveals data on in-field participant observation of matrix support meetings between CAPS and mental health teams of PHC. The meetings mainly sought to discuss more complex cases that required a multidisciplinary effort.

In these meetings,most of the time it was observed that depression was presented by health professionals as a symptom of other types of psychic distress, such as borderline, obsessive-compulsive disorder, alcoholism, psychosis, besides being associated with suicidal behavior. It was seen that depression was not a subject of the matrix support meetings. Despite the significant frequency of occurrence, depression was not observed in the narratives of professionals, which suggests the process of normalization of this form of psychic distress, which implies little or no mobilization of professionals to meet the demands and the needs generated by the depressive state of the patients.

The second factor relates to the flow of healthcare users seeking psychotherapeutic assistance, which governs the forms of care for depression. By monitoring the flow, one can understand the assessment and intervention to which the patient is subjected before being assisted by the psychology service. The organization of the flow of mental health care patients results from the model of the Family Health Strategy (FHS), which dictates that the initial assessment must be performed by the FHS team. This procedure is critical to the perception of the depressive state and the therapy prescribed, inasmuch as the majority of patients are attended by the psychologist with prior diagnosis and medication.

The development of work proposed by the matrix support system signified, on the one hand, advances in health care, as it required (and indeed stillrequires) a new outlook on the clinical process marked by interdisciplinarity.This was promoted by the Ministry of Health when it recommended that the Single Therapeutic Project should be the result ofa team effort between members of the healthcare team[7,8]. This was also stated by the interviewees when they stressed the importance of being able to discuss with the team regarding the need for medication for patients with depression.

On the other hand, the promotion of clinical care using the support matrix perspective favors the biomedical approach, since the concepts of health and disease are based on this notion, which focuses on the biological dimension of the phenomenon of depression. Rey[29] confirms this standpoint when he asserts that the representations and practices in relation to health reflect the dominant discourses of society. Thus, the attempt to develop psychosocial resources and strategies from this perspective is linked to this symbolic order, which limits the therapeutic possibilities for treating depression.

Psychotherapeutic care

Therapeutic care addresses the main elements cited by the participants regarding psychological care to patients with a depressive condition. The use of the word psychotherapeutic to define the category relates to the fact that, for psycholo-

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gists, care is focused on individual psychotherapy based on the clinical training of the professionals, as pointed out by the participant: *So, the proposal isshort-term psychotherapy with a predetermined number of six to eight sessions, after which thepatient's health is reevaluated* (P20).

Different therapeutic approaches were presented by the interviewees as the mainstay of psychological carefor depression, highlighting the importance of this perspective in the development of professional practice. Different approaches are considered efficient[13], consolidating the plurality of perspectives in the professional field and in the treatment of depression.

In order to describe psychotherapeutic care, the narratives of the participants presented information and support strategies as one of the therapeutic intervention techniques. These strategies have been identified as an initial approach to the patient with depression.

The proposal is toinform the patients more to get them to recognize their own condition, what their problem is, what depression isand how treatment is conducted through dialogue [...] (P8)

These cognitive processes develop the personal toolkit that helpsto prevent the deterioration of the condition and assist in the treatment. The information and guidance of psychologists constitute stages of the psychoeducation process, which assuage the symptoms and help to prevent new episodes of depression[17,18].

The report of the professionals on care highlighted qualified listening and the embracement of patient´s demand as the main intervention resourcesfor treating depression. For the interviewees, listening enables the professional to gain the patient's confidence in order to ensure the space foracknowledgement of the other, as pointed out by P17: *So, initially it is a space for listening, to discover how thepatients are, to proceed slowly making the links between what theysay*. [...] *So generally, we do not immediately find an answer, but mainly we gain their confidence and acceptance without making any judgment*.

Thus, in psychological care, these elements are key processes to access the subjectivity of the other and understand their psychic distress. In depression, listening helps to identify the issues underlying the core demand of the patient, based on understanding the context and the social relations that constitute the existence of the subject seeking psychological care. According to Frizzo et al.[30], understanding the relational context through empathic listening makes it possible to build a good therapeutic alliance with the depressive patient, which is a precondition for the progress of the treatment.

The narrative of the intervieweesrevealed that psychotherapeutic work is marked by the effort of making sense of the symptom, as pointed out in the report of P7: *And, I therefore believe that the most important thing is to help the patients to makesense of what is happening to them. The abilityto make sense of it is important, because what the patientssuffer from is the lack of sense, isn't it?*

The reportmakes it clear that making sense of the situation occurs in the relationship between patient and therapist. Making sense of the symptom allows people with depression to understand the psychic dimension of their clinical status. This task becomes a process of understanding and reinterpretation of the psychic distress, generating new meanings that enable the individual to understand the structure of their own life story and the implications for the composition of subjectivity. For the participants, importance is given to the care that enables a new configuration to redeem their personal life history. Thus, for the psychologists, thetherapeutic project should be built upon the demands and possibilities of the patient

The set of features and techniques presented in the narrative of the participants who make up the "psychotherapeutic care" category consolidates the psychological dimension of treatment for depression, when it describes the processes of care. In this sense, it was observed that the techniques used are generalist and do not refer to the treatment of depression itself, but to every form of psychic distress. The core work of the participants lies in listening, understanding the needs and developing person-specific therapy, namely the components of psychological care, recognized and recommended by different health organizations.

When one considers the context of PHC, these results show that psychotherapeutic care still has a privileged space in the development of psychological interventions, reflecting how the construction of professional practices in PHC is still marked by the concept of individual care. The results are consistent with the findings of Ferreira Neto and Kind[14] and indicate that the broaderinterdisciplinary clinical proposal and the extra-clinical interventions coexist with individual care, showing that the changes promoted by the SUS are still ongoing, requiring a continuous review process of practices in psychology in the search for assistance that aims to provide comprehensive health care.

Group therapy

Group therapy brings together elements related to therapeutic work for this type of patient and is one of the strategies of mental health assistance inPHCrecommended by the Ministry of Health[12,15]. All psychologists interviewed reported providinggroup therapy; however, some of them stated that they performed this type of intervention solely on the basis of the work proposal and goals of the municipality in which they worked and declared they did not feel prepared or preferred not to provide group sessions.

Acknowledged[13] as being an effective psychological intervention resource in the care of patientssuffering from depression, in accordance with the reports of participants,group therapy in PHC does not have differentiated proposalsforeach type of psychic distress. In group therapy, the focus is on the individual and not the kind of psychic distress that defines the group. This form of intervention is based on the principles of Psychiatric Reform, which proposes actions in mental health from the standpoint of the concepts of citizenship and autonomy[31,32], altering the focus in accordance with the concept of mental diseases or disorders. The concept of extended clinical practice reinforces this perspective, as it proposes abandoningthe focus on the disease, limits and suffering, and incorporating the concept of the potential of the individual[7,8].

The psychologists pointed out that the users of the health services with depressive symptoms constituted the main demand for group therapy, a result that reflected the data regarding the prevalence of depression in the context of PHC. For them, the structure of groups with the participation of patients with depressionenabled the therapeutic work based on the identification of symptoms, as stated by one of the interviewees:

So it's good for this (group therapy)*, as it has this ability to show that the individual is not the only sufferer in the world, right?* [...] *It showshow others dealt with the situation in the family or elsewhere.* [...] *I think that the group has the very important therapeutic resource, which is to identify and to know that the individual is not the only one and hear how others managed to deal with the situation.* (P13).

The process of identification provided by theinterviewabove was singled out as the element based on which the therapeutic work is performed in the group. By means of identification, patients with symptoms of depression can recognize themselves in the experience of others and understand the moment in their life story. For Zimerman[33] and Pombo-de-Barros & Marsden[34], the identification process elicits feelings of belonging and unity, which permits sympathy between the participants, favoring the therapeutic work from this moment onwards.

The psychologists stressed that the process of identification favored what was referred to by one of them as the "Wailing Wall": *So, it is sometimes difficult as you have to steer* [the group] *so as not to become what I call a 'Wailing Wall.' Because, otherwisethe conversationcan become whiney, pessimistic, discouraging and ends up infecting everyone* (P10).

In this case, the identification process plays the opposite role and contributes to the patient maintaining the symptoms of depression. For Zimmerman[33], the identification processes in the group field can hinder the emancipation of the individual and increase the suffering, which reduces the therapeutic potential of group therapy. This can be due to the difficulty of managing this form of therapeutic interventionby exposing limitations in conducting group therapy, as was pointed out by some of the interviewees.

Although the Ministry of Health advocates collective approaches in actions in mental health[15], group therapy for patients with depression is not always possible. One of the main factors to be considered for proposing individual care is the degree of severity of depression. In this sense, according to psychologists, identifying the most serious cases was understood as a criterion for individual care. The non-inclusion of critical patients in group therapy is endorsed by studies of Oei and Dingle[35], indicating that cases of severe depression should not be handled in a group due to the difficulty of engaging them in the group process and the need for more personalized care.

Another factor highlighted by participants is related to difficulties in signing up to this kind of therapy – according to the psychologists, there are patients who do not sign up or have difficulty signing up to group therapy. This difficulty may be linked to embarrassment or inability to participate, given the position of the individual within the community, representing a limiting factor for the use of therapeutic resources available in the Network. Thus, the position of the health user in the social context is a relevant factor in building strategies that enable participation in group therapy.

The response of the participants revealed different elements that show how group therapyfor

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the health patient diagnosed with depression is hampered by limitations in terms ofthe professional practices used by psychologists. Associated with psychosocial limits of the patient or thetraining of professionals, barriers to group therapy restrict psychosocial interventions. The group context is characterized as a space that enables the empowerment of social networks, the link between health users and the institution and enables the development of actions of health prevention and promotion[14]. Group therapy increases social contact, which diminishes the condition of isolation, common to people suffering from depression.

Complementary Resources

The psychosocial dimension of treatment for depression also includescomplementary resources for individual or group psychotherapeutic care. Health actions scheduledwithin the scopeof this include the indication of social and physical activities on a daily basis, the use of the resources of the health unit and the community, as shown in the following interview section:

[...] *so, I always try to keep abreast of things; to know what the resources are in the community; what courses are availablein the social center; what habits people have; what they might be interested in learning; if they have little formal schooling, I always try to know what high school equivalency programs are available in the region; physical activity – where they could begetting exercise ... I end up recommending these things. In short, I try to see how people canchange their lives and anythingnew that appears is good.* (P5)

The report of P5 above shows the different options of activities within the community, which can contribute to treatment for depression. This participant, as well as others, said they seek to keep abreast of the activities and programs developed by community centers, NGOs and public institutions existing in the community of the patient. The use of community resources is one of the guidelines of the process of inclusion of mental health in PHC–backed by the proposal of the Ministry of Health which recommends the relationshipof interchange and building spaces between the health institution and the community that promote mental health[15].

When considering the institutional framework, different actions of prevention and promotion conducted in PHC and mediated by various professionals represent therapeutic resources that the health unit provides to users that contribute to treatment for depression, as pointed out in the following passage:

Ah, yes, yes ... Therapeutic workshops, group therapy ... Which is as follows: in the therapeutic workshop, there is also a time for listening which, of course, will not be psychotherapeutic, but it will be a resource that will also contribute to the process. [...] *Because, isolated individual therapy greatly limits the results that may be achieved.* (P19).

When declaring that the use of complementary resources broadens the possibilities for care, the words of P19 suggest the recognition of this tool as being inherent to the treatment of the health patient diagnosed with depression. The use of these resources develops comprehensive care, which assimilates the possibilities of the context and consolidates the psychosocial dimension of treatment.

Another resource mentioned by the participants was the practice of physical activity, indicated by more than half of those interviewed, which confirms the results of studies that show the positive impact of exercise in treatment for depression[36]. The recommendation of physical exercise is viable in the PHC units, thanks to the actions of physical education professionals in the teams of the Support Nucleus for Family Health – NASF. Based on the tenets of Physical Activity and Body Practices[37], the intervention of this professional should be performed from the perspective of the concept of health as social production. Thus, physical activities represent a "space" for comprehensive health care, in which social relations preserve the essence of health care. For the patient with depressive symptoms, being able to join groups of this typemakes it possible to enjoy both the benefits of physical activity and the strengthening of coexistence networks.

The complementary resources listed by the psychologists reveal a multiplicity of scenarios that increase the optionsfor treatment and consolidate the relevance of the psychosocial dimension in the development of therapeutic interventions in cases of depression. The use of these resources assists in the treatment and minimizes the recurrence of depression. For Moos[38] and Moré and Macedo[39], the more social inclusion and more meaningful the network of relationships, the more the chances of success are in the post-treatment stage. In this sense, the recommendation of these resources strengthens the network of social relationships of the health user and is characterized as action that promotes health.

Final considerations

This study sought to evaluate the practices of the psychologists inassisting patients diagnosed with depression in primary care, sinceitrepresents a challenge in the treatment of this psychic distress.

The survey results reveal that psychological care for depression is subordinated to the work processes proposed in theHealth Network, to such an extent thatwhen patients arereferred, in most cases they have already been prescribed medication by the Family Health Team. In this sense, the treatment of the underlying depressionin clinical care is predominantly based on a biomedical standpoint– which prioritizes the biological dimension of the depression phenomenon – establishing a proposal for intervention consistent with this approach. Thus, the proposal of actions that underscore the potential of the health users is faced with barriers inherent to the work processes proposed by the Network.

With respect to the methods of psychological intervention to treat depression, the choice of individual psychotherapy as the main form of treatment also reflects professional practice centered around the individual. The barriers related to group therapy confirm this trend and suggest that the intervention proposals for the health user diagnosed with depression are in a process of transition to meet the shortcomings of the psychosocial dimension, since this type of care is configured as an effective device for treating depression and enables the construction of social networksbythe health user.

In turn, the use of complementary resources points to the exercise of broadened clinical practice, as it encourages the use of institutional and community resources as an active part of the treatment for depression. The use of these resources qualifies as a health practice that provides comprehensive care and contributes to the adoption of actions to promote the health of patients diagnosed with depression.

Since the inclusion of mental health in primary care, progress in broadening the service to provide care for depression has been significant by virtue of the coverage and working strategies which led tobroadened access by users to mental health professionals. However, transcending the traditional models of care for patients with depression and the construction of forms of care using psychosocial resources in the pursuit of comprehensive care are still ongoing; the health user diagnosed with depression can count onmeasures acknowledged to be effective, but which only partially meet the demands generated by the complexity of the phenomenon.

In this manner, reflections on the forms of carefor depression in the light of the public policies for the area will make it possible to develop a new approach to the phenomenon and build effective tools that can be combinedwithtried and testedmethods. Conducting research with this in mind can contribute to the development of this new gamut of options, thereby confirming the importance of ongoing studies in the area.

Collaborations

CCL Motta, CLOO Morée and CHSS Nunes participated in the design and delineation of the article; CCL Motta performed the data collection, CCL Motta and CLOO Moré performed the analysis and interpretation of the data; CCL Motta wrote the manuscript; CLOO Moré and CHSS Nunes made the critical review. All authors approved the final version of the manuscript.

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Article submitted 25/09/2015
Approved 14/04/2016
Final version submitted 16/04/2016