

Narratives of emotional distress in Primary Care in Brazil: contributions to a comprehensive and culturally sensitive Global Mental Health approach

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Global Mental Health authors advocate on the one hand, for increased access to mental health care, including the use of standardized interventions. On the other, patients' symptomatic expression of emotional distress hampers its identification by Primary Care professionals in Brazil. This affects the provision of care and demands culturally sensitive approaches. In order to understand patients' perception of their emotional distress and of the care provided in Primary Health Care, a narrative qualitative method was adopted, involving data collection in groups in waiting rooms and the use of a script based on the *McGill Illness Narrative Interview*. We performed content analysis and found out that restricting communication of distress is associated with limited access to care. To face this limitation, strategies are suggested to guide the structuring of care that is both comprehensive and culturally sensitive.

Keywords: Access. Care. Emotional distress. Global mental health. Primary Care.



“A health problem plus the nervous system, combines the useless with the unpleasant.” (Participant 1, Group 1)

Introduction

Emotional distress (ED)^{1,2} is a prevalent demand in primary care (PC). In their narratives, individuals often claim they “suffer from nerves” and present diffuse, non-specific somatic complaints with no medical explanation, such as: fatigue, chest pressure, palpitations, multiple, incessant pains, shortness of breath, trembling, insomnia, agitations and other symptoms of anxiety and depression¹.

Epidemiological studies use the nomenclature Common Mental Disorder (CMD)^{2,3} to designate these manifestations that encompass issues from ED (which does not fulfill criteria for mental disorder) to cases of depression and anxiety and somatizations, which, though they may spontaneously remit, still require care. In the care process, the complexity of the somatological presentation appears as an important component of ED⁴, and its ambiguity challenges biomedical rationality, requiring broadened approaches that take patients’ experiences into account⁵.

Both globally and nationally, the frequency of CMD in PC is high and, if not cared for, they may compromise individuals’ lives⁶. In the 1990s, a World Health Organization (WHO) study on general health units⁷ in several countries found CMD prevalences between 12.25% and 51%. In Brazil, studies have found prevalences ranging from 52% to 64%^{1,2,7}. Although international studies have highlighted the importance of the PC physician in diagnosing, treating and handling patients⁷⁻⁹, 30% to 60% of psychiatric morbidities are not recognized¹⁰. In Brazil, rates of detection by general practitioners in PC units vary between 21% and 78%¹¹ and they have difficulty in handling emotional problems, psychosocial issues and mental disorders¹².

Considering the burden of mental disorders for society, the WHO and authors linked to the Global Mental Health¹³ field state that “*There is no health without mental health*” and advocate for an increased access to mental health care services and a reduction in treatment gaps¹⁴. They thus suggest the integration of mental health into PC^{6,15}, as well as the dissemination of care packages, especially in low- and middle-income countries (LMIC^(f))^{16,17}. However, one of the challenges faced in this process is how to avoid the indiscriminate expansion of standardized, decontextualized biomedical interventions. In order to do so, health care must be culturally sensitive and socially relevant and, therefore, it becomes indispensable to consider the patient’s psychosocial dimension¹⁸⁻²⁰.

The difference between physicians’ and patients’ understanding of the health-disease process, summarized in the notions of disease and illness²¹, causes disruptions in the physician-patient relationship (PPR). After all, while patients express experiences of illness, subjectively immersed in their sociocultural context, including traditions, beliefs and values, most professionals are still trained to act based on a biomedical rationality focused on disease.

The discrepancy between physicians’ training and patients’ needs justifies broadening our knowledge of this demand and of therapeutic resources⁴. Among the aspects that hamper ED identification, some studies emphasize the predominantly

^(f) In the Portuguese version we used the English acronym LMIC, commonly employed in the literature.

physical symptomatological presentation⁴, the disease-centered training model⁵, and structural problems in the health system⁹. Of the aspects that interfere in the PPR, studies highlight: insipid communication²²; patients choosing their own physicians²³; vulnerability of the population receiving care²⁴; stigma²⁵; treatment decision process²⁶; processes that shape the therapeutic alliance²⁷, which involve receptiveness, listening, and providing support and clarification about the patient's health condition; the population's trust on public health institutions identified as representatives of the State²⁸.

Although we recently discussed the experiences of ED and care among female patients of a family health clinic in Rio de Janeiro²⁹, user opinion regarding mental health care in Brazilian PC is still understudied. Thus, in line with the previous study and within the context of the research projects "Dilemmas and challenges for implementing Global Mental Health policies in Brazil", led by the Institute for Social Medicine of the State University of Rio de Janeiro (UERJ), and "Evaluating mental health care in primary care services within 2.2 Catchment area of the city of Rio de Janeiro", led by the "Mental Health in Primary Care Research Group" along with the Rio de Janeiro Municipal Health and Civil Defense Secretary, this study seeks to investigate patients' perception regarding ED and its care in PC.

Methods

Study design and setting

We used an exploratory qualitative narrative study methodology³⁰. Qualitative methods are applicable in health research when one wishes to investigate how people attribute meaning to life in the face of a permanently changing sociocultural context³¹. They are used as a strategy for integrating different contexts, needs and demands present in the clinical act. Thus, studying patient narratives enables us to know their perceptions and, in turn, to make this knowledge available to policymakers so they may plan care interventions that are congruent with a PC³² setting.

Field research took place in the Rio de Janeiro 2.2 Catchment Area, between May and July 2013, while the traditional PC model, organized based on medical specialties, was being progressively substituted by Family Health teams centered on patient bonds and comprehensiveness³³. We selected services from eight units, three of which were undergoing a phase of care transition.

Data instrument and collection

We chose the McGill Illness Narrative Interview (MINI)³⁰ qualitative instrument as our reference because it seeks to investigate patients' illness experiences, in addition to having already been validated, translated³⁴ and used in Brazil³⁵.

Although the MINI is meant for individual interviews, since this is an exploratory study, the use of focal groups³⁶ for data collection enabled us to privilege narrative quantity and variety in order to produce familiarization with the research subject. We chose to recruit participants in waiting rooms because, while people are waiting to be



seen by the physician, they are available in the health unit. This required an adapted, shorter and more focused interview guide. Thus, out of the five MINI sections, we selected questions from the two sections that have the greatest affinity with the study's objectives (titled "Explanatory Model Narrative" and "Services and Response to Treatment") and we formulated a new interview guide with two dimensions of investigation: perception of ED and perception of mental health care (Table 1).

Table 1. Focal group interview guide

FOCAL GROUP INTERVIEW GUIDE	
INTRODUCTION: The object of this study is the health care offered in municipal health units. We want to know if patients receive support for all kinds of suffering they face in life, including, especially, emotional distress. This study was authorized by the Ethics Committees of SMSDC-RJ and of this unit. If you agree to participate in the group discussion, we will request that you sign a consent form.	
EMOTIONAL DISTRESS DIMENSION	When people become ill, is this accompanied by emotional distress? How do you understand this distress? How do you refer to or call this distress? How is this distress related to your physical suffering? When you feel more "X" (<i>use the words mentioned by the patients</i>), does that interfere with your physical problems? Are your physical problems altered? When physical problem is out of control, does that interfere with your "X" (<i>use the words mentioned by the patients</i>)? Is the "X" altered?
MENTAL HEALTH CARE DIMENSION	When you feel "X", do you tell your doctor? <i>If not:</i> If you had emotional problems, would you tell your doctor? Why? What does the doctor say that you have? How does the doctor refer to "X"? How does the doctor help you? What does he do? <i>In the case of a negative answer:</i> How could the doctor help? What would you expect the doctor to do with regard to your "X"? Is there something else you'd like to comment on or suggest?

The invitation was done verbally to all who were awaiting consultations, informing potential participants of the study's objectives and that they would be able to leave the group at any time. Some refused to participate for fear that they might miss their appointment, and those who agreed were invited to gather in a circle in order to form a group that enabled a dialog amidst the circulation of people in the waiting room. Due to the lack of seats at the health unit, two groups remained standing.

Groups were led by a moderator who posed participants discussion-triggering questions based on the interview guide. Focal group discussions were recorded in audio-recordings that were later transcribed along with the field notes taken by the moderator and the observer. We carried out eight groups, with three to nine members, for a total of 54 participants. Each group lasted in average 30 to 40 minutes. Since the two pilot groups did not lead to significant changes to the interview guide, they were included in the eight groups we analyzed.

Content Analysis

Narratives were treated through the thematic Content Analysis method³⁷, following the phases pre-analysis; material exploration; treatment of results, inference and interpretation. Initially, the document corpus comprising the transcriptions and observations was systematized and organized according to rules of exhaustiveness, representativeness, homogeneity and pertinence. From reading the narratives following the dimensions of the interview guide (perception of ED and perception of care), the

related contents that emerged were grouped in thematic categories. In the excerpts we present, participants are identified in the following manner: “P” (participant) + participant’s number + “G” (group) + group number.

Ethical aspects and funding

This study was approved by the Ethics Committees of UERJ and of the Rio de Janeiro Municipal Health Secretary. Each participant signed, and was given a copy of, an Informed Consent Form, and their anonymity was guaranteed. We received support from the CNPq Universal Grant (no.43137/2014-5), from FAPERJ (TCT-5 E-26/102.610/2012; CNE 2016. E-26/202.992/2016) and CNPq student grants (PhD 140379/2014-2).

Results

The following general categories emerged from our analysis of patients’ perception of ED and its care: 1) “Explaining Distress”; 2) “Communicating Distress to a Physician”; 3) “Communicating regarding Structuring Care”; 4) “Communicating Distress within the Service Context”. A fifth transversal category, termed “Facilitators and Barriers to Care”, permeated categories 2, 3 and 4 and, therefore, will be presented alongside them.

Explaining Distress

The most common way patients’ explained ED consisted of utterances recounting everyday situations and psychosocial experiences in which the causes of ED were attributed to difficult circumstances (diseases, conflicts, unemployment, financial problems and losses):

Everyone has high blood pressure, diabetes, the symptoms I have, everybody has them, why? Because life is very complicated, financially everyone has problems. It’s a child who’s unemployed, a child who’s sick [...] my head’s racing [...], you don’t know what you’ll do. I feel weak out of nowhere, I fell down. It’s all this running around in life. (P1G7)

A striking feature of the narratives were accounts that interwove organic symptoms, mental state and psychosocial problems and that reiterated the connection between physical and emotional distress:

I can’t sleep at all. The problems I have in my life, with children, grandchildren, finances, got worse. And I can’t sleep and I take rivotril [tranquilizer pills]. (P1G7)

They go together. If you’re sick, that interferes with your emotional state. That, or the other way around. (P1G1)



When discussing ED, patients automatically cited coping strategies for dealing with their problems. Work, family and friend networks, which had already been cited as causes of ED, were equally characterized as protective factors:

You have to have an occupation and also a family with structure, that understands you. It's incredibly important, family, true friendship [...] helps a great deal! Because out there you have to have friends who listen to you. All of that is part of the treatment. It's not just going to a doctor and him giving you medication. (P1G1)

Communicating Distress to a Physician

Although they were able to explain their ED, patients found barriers and facilitators to communicating it to physicians, which involved perceptions related to patient beliefs, physician attitudes and the service context. Among factors that make communication difficult were patient beliefs regarding the appropriateness of discussing ED and the conviction that physicians are unable to help:

I don't know if we can occupy the doctor's time with all these things we feel. (P3G2)

[The doctor] Can't do anything [about the issue of fear]! Forgive my language, but I'm the one who's fucked! No doctor, no psychologist, no psychiatrist. I'm the one who needs to lose this fear. (P5G2)

The belief that exams and medications are the only subjects that should be discussed with a physician is another obstacle to communication:

I don't talk much with doctors, that's a problem. Because I come to discuss something specific: exams, medications. Problems at work that affect me, that wear me down, I don't mention, because I don't bring my personal problems to a specific person. But because he's a doctor, I could open up. (P4G4)

The severity of ED is a facilitator of spontaneous communication. On the other hand, the belief that a patient should only mention ED if questioned by the physician is a barrier:

I don't [mention it]. Unless it's something very serious that led you to an extreme. If not, you don't mention these things. You want to arrive, you want to hear what the doctor has to offer you for you to get better, and not talk about problems [...] unless you were called upon to talk about it. I don't see it as, you come in and then open up to the doctor about it. (P3G5)

As to the barriers attributed to physician attitudes, patients mentioned a lack of openness to listening to ED:



Because the disease already leaves you in a complicated situation, the medication also leaves you emotionally with a bunch of sequelae, you are affected. Sometimes, you don't have anyone to talk to [...] But here [at the health service] I still haven't felt this openness to talk about it. (P1G1)

Being ironic, changing the subject, prescribing something or suggesting a consultation with a psychologist are physician attitudes perceived as a means to avoiding communication:

I don't [talk about it], when you try to talk about it, they change the subject: "Go home, child". (P7G3)

The first thing they do is prescribe a tranquilizer, so you calm down, relax. I've had heard from a doctor: "don't you wanna talk? Schedule an appointment with a psychologist". (P4G8)

The attitude of devaluing physical complaints is another barrier, perceived as a sign that the doctor is unwilling to discuss ED:

If when we get to a consultation and refer something serious, like a strong headache, body aches, they look at you like, they [health professionals] already try to imagine something, they think the person is even deceiving them. Can you imagine, if we arrive like that, he'll [the physician] simply think: "Here I am, full of people to see in a serious condition, and here comes a patient to talk about distress". (P2G3)

Communicating regarding Structuring Care

The way treatments are proposed either stimulates or inhibits communication. Combined with pharmacological interventions, psychosocial recommendations, such as engaging in pleasurable activities and strengthening social bonds, were perceived by patients as helpful:

He tells me to go for walks, talk to people, gives me medications. (P5G1)

She [the doctor] helps me with many things, telling me to go out, to talk, because I spend a lot of time inside the house [...] She tells me to go out, see the street, talk to people, chat, exchange ideas, even at home with my husband and daughter. (P6G1)

On the other hand, patients complained when drug interventions were not accompanied by a dialog about the circumstances of ED:



When I'm very anxious, agitated, nervous, the doctor [says]: "Oh, I'll give you a tranquilizer". Except he doesn't give you the space to ask you why you're nervous, what is making you feel this way... They don't give you this space because, if they did, we would even get better, right? Then it would be a set. (P4G8)

The expectation of dialog, of being heard by the physician, was expressed as an ideal of care:

What he [the doctor] can do, and generally does, is to prescribe medication that attempts to relieve the emotional pressure that the person is experiencing. [...] doctors can do more, but they usually don't have time for that, they can play the role of a father, provide counseling. (P5G4)

Lastly, patients, simultaneously noting the importance and limits of medical care for ED, pointed to specialist referrals as part of medical care:

After some time goes by, and the doctor, having followed that patient, notices the wound [emotional distress] doesn't close, doesn't heal, in addition to a medical prescription, there should also be a referral, he should also refer the patient to a psychoanalyst, a psychologist. (P3G3)

Communicating Distress within the Service Context

When stating their perception of medical care, patients spontaneously commented on the service context. Problems related to working conditions, such as a lack of professionals and overcrowded services, represent barriers both to physicians' ability to listen adequately and to patients' ability to expose their ED:

[I don't mention it] because there's already a line with fifty people out there. It's a small number of doctors for a significant larger number of people. (P3G3)

The professional won't want to listen. I think this listening thing is good, but often the doctor doesn't have time to give you this attention. He sees you quickly because sometimes there's only one doctor. (P2G3)

Physicians' work overload constitutes a barrier that leads patients to question whether they should communicate their ED:

I arrived at 11am, the doctor saw me at 5:30pm, she was already tired. I saw the doctor complain that she was seeing too many people, she was worn out. If the doctor herself was complaining, how am I, as a patient, going to talk about my problems? (P3G5)



Patients perceive this work overload to be a practically unsurmountable barrier and, consequently, state they expect that other professionals offer them the possibility to discuss their ED:

I think, like, a doctor, or someone who wants to listen to you, or a professional who wants to listen to it. Not the general practitioner. It would be the psychologist, the social service worker, someone like that, who is prepared to listen to you. Not the doctor, who's too overloaded, you know, who had to eat lunch in a hurry in order to see me. This doctor isn't prepared to listen to our problems. (P3G5)

As for the impact of health service conditions, the lack of consultations is a barrier to communicating ED that worsens the already-present emotional distress:

It really gets in the way because of my work [...] disease gets in the way of everything. The immune system is shaken. You stay home, you become irritated, you don't work, you become irritated. If you go to see a doctor and you don't get a consultation, you can't see the doctor, you become even more irritated. (P1G2)

On the other hand, gaining access to medical attention is a facilitator of care that generates a highly positive emotional impact:

It messes with my emotional state, the diabetes, and I've lost vision and I'm worried at the same time, like, I don't know. But here I'm being very well cared for, thank God. Here I'm being very well cared for and this is improving my self-esteem. (P3G2)

Discussion

These accounts show that patients have singular discursive modes of explaining their experiences that configure illness narratives³⁸, and in which the category "Explaining Distress" stands out. In this category, patients presented explanatory models²⁸ which are not limited to mentioning symptoms, but correlate them with biological, psychological, social, cultural and even spiritual issues that permeate their lives. This condensing of multiple dimensions of existence into a single experience confers a totalizing biopsychosocial character to human life, blurring the lines between body-mind. Thus, accounts of experiences that involved *pathos*, that is, "the direct and concrete feeling of suffering and impotence, the feeling of life gone wrong"³⁹ (p. 96), show that ED affects vital normativity³⁹, restricting patients' ability to confront their unease and to create new forms of living. This phenomenon helps us to understand the complexity of ED's symptomatic presentation, which often includes physical complaints⁴ overlapped with psychosocial problems and which, therefore, require comprehensive³³ care that is sensitive to patients' life contexts.

While the category "Explaining Distress" showed that patients are able to explain their ED in their own manner, the categories "Communicating Distress to

a Physician”, “Communicating regarding Structuring Care” and “Communicating Distress within the Service Context” showed that there are factors that interfere in the possibility of communicating ED and in getting physicians to listen – facilitating or obstructing ED communication.

The narratives have shown that the severity of ED is a condition that leads patients to express it spontaneously. Physician attitudes which put patients at ease to discuss the problems that cause distress, in particular, also stimulate communication. Obtaining access to medical care in the face of precarious service conditions, in addition to being a facilitator, also generates a positive emotional impact on patient self-esteem. Thus, offering patients space to discuss psychosocial aspects and displaying a welcoming, counseling attitude are factors that enable ED communication.

As to the barriers to communication, narratives indicated that patients have preconceived thoughts regarding what to inform physicians in PC and the latter’s role in ED care. Constrained by these beliefs not to expose their ED, especially when there are psychosocial problems, patients carry out their own selection process and communicate only what they understand physicians to be able to address, which is usually associated with physical symptoms.

Certain physician attitudes also do not favor communication, such as: showing themselves to be unavailable and unwilling to discuss, or actively inquire into, ED, or, if patients mention it, dodging the subject, giving them a prescription or referring them to specialists. Given this semantic distance and the asymmetry of the PPR, the embarrassment patients feel when exposing their problems is added to the difficulty of being listened to by the professional. The narratives suggest that, beyond treating disease, physicians are not prepared to offer a broadened attention to ED and to commit themselves to addressing illness²¹, and, consequently, to offer a comprehensive care as established in the Unified Health System (SUS) and National Primary Care Policy guidelines⁴⁰.

Although the psychosocial dimension of ED is constitutive of patients’ explanatory models, there was no reference to other PC professionals (nurses, technicians or community agents), which suggests that care is physician-centered. If, on the one hand, the perception of the centrality of medical care may indicate a medicalizing perspective in legitimating ED, on the other, this highlights physicians’ responsibility in developing the comprehensiveness of ED care.

Although the care process basically involves two people – patient and physician –, a third agent interferes in that relationship: the health service. The narratives show that the perception of ED care does not depend only on what happens in the PPR microcosm, but also involves the perception of the institutional context. To paraphrase the psychoanalyst D.W. Winnicott⁴¹, narratives signal that the service setting does not constitute a “good enough environment”. In other words, working conditions put pressure on professionals, who restrict themselves to examining physical symptoms, without investigating their association with subjective affects, and who carry out consultations within the biomedical mold, that is, strictly focused on diseases and symptoms, in the offer of pharmacological interventions and in specialist referrals (when available in the service network). Since it is unfavorable to communication, this environment does not offer a space for dialog and safety that supports the development of a salutary therapeutic alliance between physicians and patients, based

on which patients are able to express themselves and find new ways of confronting their ED²⁷. On the contrary, this tumultuous context undermines patients' trust on their physicians and disturbs the PPR^{28,29}. This restricts physicians' ability to listen to patients and inhibits the expression of ED, reiterating patients' conviction that physicians are not there to discuss ED and that it is not worthy of being shared, which may accentuate the stigma²⁵ surrounding mental health and even worsen patients' illnesses. Under these conditions, the service context itself is an obstacle to the full use of services and becomes a barrier to the access it should enable.

Given their importance, factors that intervene in the perception of care are summarized in Table 2.

Table 2. Facilitators and barriers to care

FACILITATORS AND BARRIERS TO CARE		
DIMENSION	FACILITATORS	BARRIERS
Patient beliefs	<ul style="list-style-type: none"> - severity of distress - being invited to speak 	<ul style="list-style-type: none"> - doubts concerning demanding physician's time - physician cannot help with ED - one only talks to physicians about exams and medications - emotional problems should not be talked about
Physician attitudes	<ul style="list-style-type: none"> - welcoming and counseling attitudes - addressing psychosocial aspects when proposing treatment 	<ul style="list-style-type: none"> - lack of openness to talking about ED - being too overburdened to listen - undervaluing emotional grievances - not exploring the context of ED when proposing treatment - avoiding dealing with ED through medication prescriptions or referrals
Health service context	<ul style="list-style-type: none"> - positive emotional impact of receiving medical care 	<ul style="list-style-type: none"> - services over capacity and with long waiting lines - lack of professionals - work overload - excessively short consultation times - negative emotional impact of not receiving medical care

According to the treatment decision stages (symptom presentation, physician request for information and offer of intervention), communicating problems to the physician is the basis from which the care process will be established²⁶. However, the narratives have shown that the interaction between the embarrassment patients feel when expressing themselves, physicians' lack of training for addressing ED and the context of overloaded health services creates a dynamic that obscures ED communication at the seminal moment of consultation. As they feedback on and intensify each other in a vicious cycle, these barriers form an anti-therapeutic loop (Figure 1) that is extremely pernicious to health and, as a result, the potential of access to comprehensive care^{33,42} is unfulfilled.

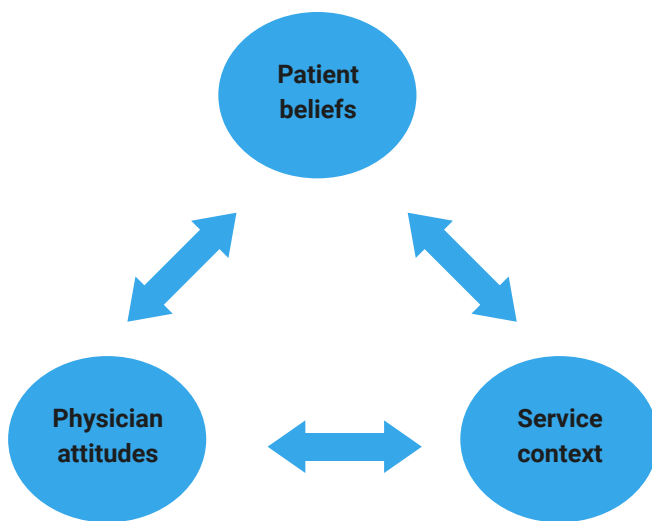


Figure 1. Barrier dynamics within an anti-therapeutic loop

Implications for access to care

According to WHO and Global Mental Health recommendations¹³, the integration of mental health actions within PC is a guideline for increasing care for CMD⁶, including ED. However, the narratives we have analyzed in this article point to barriers that still hamper this access. On the other hand, knowledge of these obstacles provides subsidies to guide strategies directed at the many dimensions of care⁴³.

In review, the narratives indicated that enabling ED communication is paramount, which requires a clinical-service space that facilitates PPR. An indispensable strategy in ensuring that PC is a safe environment for this is the improvement of working conditions. This may be done by addressing both the organizational dimension⁴³ (related to services' capacity to establish flows and processes; regulate vacancies and articulate service network in order to meet patient demands); and the political and socioeconomic dimensions of access⁴³ (i.e., those that guarantee pacts and investments according to levels of service complexity).

Another factor indicated by the narratives to increase care resoluteness was the need to negotiate therapeutics that are congruent with patient perspectives, incorporating the comprehensiveness of the ED experience and the hermeneutic understanding of the meaning they attribute to ED⁴². Thus, another strategy is to act upon the symbolic dimension of access⁴³, including patients' views and the characteristics of their context within clinical care, in order to enable care that is culturally sensitive and socially relevant¹⁸, and to avoid the spread, in LMIC countries such as Brazil, of standardized intervention packages that exclusively use biomedical approaches which ignore local contexts¹⁹.

Another essential strategy for Brazilian PC is to act on the technical dimension of access⁴³, ensuring the construction of practices based on the comprehensiveness of care and to intensify therapeutics based on 'soft technologies'⁴⁴. These therapeutics are commonly used in psychosocial interventions^{45,46} and involve relational and communicative approaches, which, without ruling out medication interventions,



when needed, emphasize dialog and strengthening of the PPR, which is in and of itself a therapeutic action²⁷. They thus enable physicians to explore the complexity of patient experiences and to incorporate it into the act of care.

Strengths and limitations

The study's greatest strength is that it is an exploratory investigation that produced a set of narrative evidences regarding ED and barriers to its care in PC. Another virtue is that it informs on cultural perspectives and local discursive modes of understanding ED in order to enrich Global Mental Health approaches¹⁴. Another highlight is that the study exemplifies that the narrative approach may be used both as a research strategy and as an instrument for improving actions of clinical care.

Among its limitations, there is the fact that conducting research in the waiting room, immediately before medical consultations may have biased some of the information provided by participants. Additionally, the interruption of participation, when patients went into their consultations, made data collection difficult.

Final thoughts

This study explored patient narratives regarding their perception of ED and of the mental health care offered in PC in Brazil and concluded that patients present a comprehensive view of ED and face barriers to communicating it which limit its care. This shows that PC is not totally prepared to contemplate the amount of individuals with ED who often turn to this sector. To deny ED communication is to deny the full use of services and, therefore, to deny access to health.

Seeking to reduce human suffering, this study, by establishing a dialog with the field of Global Mental Health, pointed out strategic institutional actions to guide the structuring of comprehensive, culturally sensitive and socially relevant PC in Brazil.

Authors' contributions

Alice Lopes do Amaral Menezes worked on study and manuscript conception, data collection, analysis and interpretation, article composition and critical revision, and on the approval of the final version. Karen Athie worked on study conception, data analysis and interpretation, article revision and on the approval of the final version. Cesar Augusto Favoreto worked on study and manuscript conception, data analysis and interpretation, article revision, and on the approval of the final version. Francisco Javier Guerrero Ortega worked on article revision, and on the approval of the final version. Sandra Fortes worked on study and manuscript conception, data analysis and interpretation, article revision, and on the approval of the final version.

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