Original article
Gallina K, Leite MT, Ilha S, Tisott ZL, Centenaro APFC.
Therapeutic itineraries experienced by older adults with depressive disorder and/or anxiety disorder.
Rev Gaúcha Enferm. 2026;47:e20250175.
https://doi.org/10.1590/1983-1447.2026.20250175.en

Therapeutic itineraries experienced by older adults with depressive disorder and/or anxiety disorder

Itinerários terapêuticos vivenciados por pessoas idosas que possuem transtorno depressivo e/ou de ansiedade

Itinerarios terapéuticos vividos por personas mayores que tienen trastorno depresivo y/o de ansiedad

Kaliandra Gallina[a] https://orcid.org/0000-0003-1460-7041
Marinês Tambara Leite[b] https://orcid.org/0000-0003-3280-337X
Silomar Ilha[b] https://orcid.org/0000-0002-2132-9505
Zaira Letícia Tisott[c] https://orcid.org/ 0000-0001-9489-3951
Alexa Pupiara Flores Coelho Centenaro[b] https://orcid.org/ 0000-0002-9117-5847

[a]Secretaria Municipal de Saúde de Maravilha, SC, Brasil.
[b] Universidade Federal de Santa Maria/campus Palmeira das Missões, Programa de Pós-Graduação em Saúde Ruralidade, Palmeira das Missões, RS, Brasil.
[c] Universidade Regional Integrada do Alto Uruguai e das Missões(URI)/campus Santo Ângelo, RS, Brasil

How to cite this article:

Gallina K, Leite MT, Ilha S, Tisott ZL, Centenaro APFC. Therapeutic itineraries experienced by older adults with depressive disorder and/or anxiety disorder. Rev Gaúcha Enferm. 2026;47:e20250175. https://doi.org/10.1590/1983-1447.2026.20250175.en

ABSTRACT

Objective: to understand the therapeutic itineraries experienced by older adults with depressive and/or anxiety disorders.

Method: a qualitative study involving 27 older adults with a diagnosis and/or symptoms of depression and/or anxiety, linked to the Family Health Strategy units in the urban area of a municipality in northwestern Rio Grande do Sul, Brazil. Data were collected between August and September 2024 through interviews. Operative thematic analysis was used, grounded by the theoretical framework of Therapeutic Itineraries guided the deduction of categories.

Results: three deductive categories were constructed: the folk sector, which includes family, community, and social support networks; the popular sector, consisting of popular knowledge; and the professional sector, represented by the bond and interaction with healthcare services and professionals. From these, nine inductive categories emerged.

Conclusion: the therapeutic itinerary of older adults with depressive and/or anxiety disorders was

predominantly based on natural and popular resources. Several factors contribute to mental health issues not being recognized, diagnosed, or treated. These include the lack of follow-up of health conditions by the healthcare team, difficulties in accessing health services due to clinical, financial, and transportation barriers, and limited access to specialized services.
Descriptors: Aged; Primary health care; Depression; Anxiety; Therapeutic itinerary.

RESUMO
Objetivo: conhecer os itinerários terapêuticos vivenciados por pessoas idosas que possuem transtornos depressivos e/ou de ansiedade.
Método: pesquisa qualitativa, da qual participaram 27 pessoas idosas com diagnóstico e/ou sintomas de depressão e/ou de ansiedade, vinculadas às Estratégias de Saúde da Família da área urbana de um município do noroeste do Rio Grande do Sul, Brasil. A produção de dados ocorreu entre agosto e setembro de 2024, por meio de entrevista. Foi utilizada a análise temática operativa, em que o referencial teórico de Itinerários Terapêuticos balizou a dedução de categorias.
Resultados: construíram-se três categorias dedutivas: subsistema popular (*folk sector*), que inclui família, comunidade e redes de apoio sociais; subsistema informal (*popular sector*), que consiste no conhecimento popular; subsistema profissional (*professional sector*), representado por vínculo e interação com serviços e profissionais de saúde. Destas, resultaram nove categorias indutivas.
Conclusão: o itinerário terapêutico das pessoas idosas com transtornos depressivos e/ou de ansiedade baseou-se majoritariamente em recursos naturais e populares. Alguns fatores contribuem para que as questões de saúde mental não sejam reconhecidas, diagnosticadas e tratadas. Destaca-se a ausência de acompanhamento da situação de saúde por parte da equipe, dificuldade no acesso ao serviço de saúde por condições clínicas, financeiras e de transporte e falta de acesso a serviço especializado.
Descritores: Idoso; Atenção Primária à Saúde; Depressão; Ansiedade; Itinerário Terapêutico.

RESUMEN
Objetivo: conocer los itinerarios terapéuticos vivenciados por personas mayores que tienen trastornos depresivos y/o de ansiedad.
Método: investigación cualitativa, en la que participaron 27 personas mayores con diagnóstico y/o síntomas de depresión y/o ansiedad, vinculadas a las Estrategias de Salud de la Familia del área urbana de un municipio del noroeste de Rio Grande do Sul, Brasil. La producción de datos se llevó a cabo entre agosto y septiembre de 2024, mediante entrevistas. Se utilizó el análisis temático operativo, en el cual el marco teórico de los Itinerarios Terapéuticos guió la deducción de las categorías.
Resultados: se construyeron tres categorías deductivas: el subsistema popular (*folk sector*), que incluye a la familia, la comunidad y las redes de apoyo social; el subsistema informal (*popular sector*), que consiste en el conocimiento popular; y el subsistema profesional (*professional sector*), que abarca el vínculo y la interacción con los servicios y profesionales de la salud. De estas surgieron nueve categorías inductivas.
Conclusión: el itinerario terapéutico de las personas mayores con trastornos depresivos y/o de ansiedad se basó mayoritariamente en recursos naturales y populares. Algunos factores contribuyen a que las cuestiones de salud mental no sean reconocidas, diagnosticadas ni tratadas, destacándose la ausencia de seguimiento de la situación de salud por parte del equipo, las dificultades de acceso a los servicios de salud por condiciones clínicas, financieras y de transporte, y la falta de acceso a servicios especializados.
Descriptores: Persona mayor; Atención primaria de salud; Depresión; Ansiedad; Ruta terapéutica.

INTRODUCTION

Technological advances over the last decades have driven development in the health field, providing better quality of life (QoL) and increased life expectancy for the population, resulting in important social, economic and health transformations[1,2]. Among older adults (60 years or older in developing countries and 65 years or older in developed countries), physical, psychological, social, and spiritual changes inherent to aging occur, increasing the risk and prevalence of Noncommunicable

Chronic Diseases (NCDs) and contributing to psychological distress. In Brazil, depression is the most common mental disorder among older adults, and 31.74% of older adults with depression also present anxiety symptoms which, when untreated, increase morbidity and mortality and negatively impact QoL, aggravate preexisting diseases, and reduce independence and autonomy[2].

According to the World Health Organization (WHO), in 2022, depressive and anxiety disorders were the most frequent mental health conditions at both global and regional levels, and most affected individuals did not receive any treatment. Estimates indicate that Brazil is the country with the highest prevalence of anxiety disorders[3]. A study found a prevalence of depressive and anxiety symptoms of 20.95% and 21.90% among people aged 60-79 years and in those aged 80 years or older, the percentage was 35.90% and 23.08%, respectively. Overall, the prevalence of depressive symptoms in older people was 23.29% and of anxious symptoms was 22.09%[4].

Given this scenario, the greater susceptibility of older adults to developing depressive and/or anxiety disorders is noteworthy. A study aimed at identifying the association between social isolation and depressive and anxiety symptoms among older adults in a Chinese community observed that advanced age, sleep disorders (which are common in older age), physical inactivity, social isolation, multimorbidities, and a greater number of chronic diseases were significantly associated with depression and anxiety. In addition, widowhood, the death of loved ones, and being female are factors that contribute to changes in mental health[5].

Another epidemiological study conducted in Bahia, Brazil, identified an association between mental disorders among older adults and reduced socioeconomic conditions, which increase social vulnerability, as well as lifestyle and habits such as smoking, alcohol consumption, and physical inactivity[6].

As highlighted in a review study, health promotion and disease prevention actions are present in a limited number of services and are only partially implemented. Although their importance is recognized, practices remain centered on care for noncommunicable chronic diseases. Furthermore, the same study aimed to analyze mental health promotion and protection actions for older adults developed within Primary Health Care (PHC) and demonstrated the contribution of group activities, health education, and actions aimed at strengthening socialization spaces in reducing depressive symptoms. The study emphasized the need to expand these care interventions offered to older adults experiencing psychological distress[7].

It should be noted that mental disorders among the older adults are often underrecognized, underreported and undertreated. The stigma surrounding these conditions can make them reluctant to seek help. However, some factors can hinder adherence to effective treatment of mental disorders, such as poor quality of services, lack of access to information, discrimination and, sometimes, inaccessibility[8]. Although public mental health care policies for the population within primary care settings are in place, gaps remain in the care provided for depressive and anxiety disorders among older adults.

In this context, in the search for solutions to their health problems, people move through Therapeutic Itineraries (TI), understood as the paths outlined and followed in the search for health care with actions based on choices and decisions that enable the sharing of popular, religious and scientific

knowledge and practices. Such choices mobilize various health care systems, associated with the cultural network of the individuals involved[9]. The use of TIs enables an effective understanding of the experience of illness and the search for care, while also considering that treatment is influenced by individual, sociocultural, and economic contexts. Furthermore, it allows understanding of how users relate to health services, identifying barriers and facilitators in access to and comprehensiveness of care, thereby enabling actions to be centered on the needs of the population[10].

Although there has been an expansion in scientific production on human aging and Therapeutic Itineraries (TI) of older adults undergoing treatment for depressive and/or anxiety disorders, further investigations are still needed, since gaps remain in the understanding of care trajectories, especially regarding the articulation between services, continuity of follow-up, and barriers to access. Such disorders negatively impact quality of life, and the search for care is often complex, fragmented, and poorly resolutive. Investigating these trajectories and formal and informal support networks makes it possible to identify weaknesses in care and support improvements in healthcare practices and policies.

It should also be emphasized that the topic is aligned with the third objective of the United Nations 2030 Agenda - "Ensure healthy lives and promote well-being for all at all ages"[11]. Furthermore, research aimed at investigating the health of older adults is necessary and is considered a priority area by the Brazilian National Research Agenda, under item 6 - "Health of Older Adults", which highlights in subitem 6.1.3 the relevance of investigating the "Determinants of older adults' living conditions, with emphasis on environmental, family, nutritional, physical, and psychosocial aspects"[12].

Given the above, the following question emerged: what are the therapeutic itineraries experienced by older adults with depressive and/or anxiety disorders? To answer this question, the study aimed to describe the therapeutic itineraries experienced by older adults with depressive and/or anxiety disorders.

METHOD

This is a qualitative study carried out in nine Family Health Strategy (FHS) units in the urban area located in a municipality in the northwest region of Rio Grande do Sul, Brazil. To guide the clarity and writing of this report, the Consolidated Criteria for Reporting Qualitative Research® (COREQ) checklist was used[13].

As inclusion criteria, the following were considered: older adults registered in FHS located in the urban area of the municipality; having a diagnosis or presenting symptoms of depression and/or anxiety, based on indications provided by the FHS healthcare team. It should be noted that the FHS units did not maintain records or control of users presenting such disorders. Indications were based on the professionals' knowledge of individuals linked to the FHS who showed manifestations of these conditions. It is important to highlight that, in the municipality where the study was conducted, there are no records that would allow estimation of the eligible population for participation in the research. Thus, at least three individuals were requested from each FHS unit, and these individuals were contacted. Older adults who were not found at home after three visit attempts by the

researcher/interviewer were replaced by another potential participant indicated by the FHS professionals. Individuals living in collective housing, such as Long-Term Care Institutions for Older Adults (LTCI), were excluded from the study because they present care dynamics and access to healthcare services mediated institutionally, differing from those experienced by older adults living in private households, which could compromise the comparability of the therapeutic itineraries analyzed.

After identifying older adults with a diagnosis or symptoms of depression and/or anxiety through data collected from the FHS units, a convenience sample was selected with the assistance of Community Health Agents (CHA), since these professionals know the older adults linked to the FHS. All older adults approached agreed to participate in the study, with no refusals or withdrawals. To encompass the municipality's entire geographic area, sequential interviews were conducted, in which participants were selected through simple random sampling until three participants per FHS unit were reached. Interviews were discontinued when data saturation occurred, that is, when the researcher identified that no new information was being added to the content already collected. Following this protocol, 27 participants were interviewed, with no repeated interviews. Data were collected between August and September 2024 through a single, individual, face-to-face interview in a private setting, at the participant's residence. This task was conducted by one of the researchers (the main author, female), a 9th semester nursing student, previously trained by her advisor (a nurse with a doctorate in Gerontology and expertise in qualitative research). The research was conducted with the purpose of producing a final paper for the undergraduate nursing course.

The interview script was specifically designed by the researchers for this study and consisted of two parts: the first contained questions regarding the participants' sociodemographic data, and the second contained open-ended questions aimed at determine whether the participant received home visits from the Community Health Agent (CHA) or another healthcare professional (physician, nurse, or other); how they perceived their health and whether they had any illnesses; how they sought care from the FHS; how they perceived the care received with a focus on mental health; how they experienced symptoms of depressive and/or anxiety disorders; and what self-care measures they took to alleviate them and improve their psychological condition. The average duration of each interview was 36 minutes. The interviews were audio-recorded, fully transcribed, and typed by the researchers using Microsoft Word® (version 16.31). Field notes were also taken regarding the interviewer's perceptions of gestures and other forms of emotional expression that were not captured by the recordings or verbally expressed by the participants. These notes served to facilitate analysis but were not included in the analyzed database. It should be noted that, after transcription, the interviews were not returned to participants for comments and/or corrections, nor was the interview guide provided to them.

The adequacy of the script was verified through a pilot test with three interviews, in order to assist the researcher to become familiar with the instrument and identify possible inconsistencies. These interviews were recorded, transcribed, and analyzed. It was necessary to adapt the way the questions were formulated to facilitate the participant's understanding. However, it was not necessary to modify the content of the script, and therefore, these participants were included, and the interviews comprise the corpus of the research.

The data were subjected to the operative thematic analysis technique, based on its three phases:

ordering and organization of the material; categorization: search for units of meaning; Second-order analysis and interpretation[14]. The theoretical framework of Therapeutic Itineraries (TIs) guided the construction of categories based on the healthcare system model, which suggests that, in the analysis of a complex society, three healthcare subsystems can be identified: the informal, the popular, and the professional subsystems[10]. The folk subsystem (folk sector) includes family, community, and all types of activities and social support networks. The informal subsystem (popular sector) includes nonprofessional healing specialists, such as those linked to religious and secular groups. The professional subsystem (professional sector) consists of professionals practicing scientific medicine or traditional medicine systems (such as Chinese medicine). These subsystems are widely used in overlapping and nonexclusive ways, interacting according to individuals' search for healthcare[10].

Thus, during the ordering and organization of the material, the researchers conducted an initial contact with the documents in order to become familiar with and understand the audio recordings, followed by the organization and preparation of the material through transcription, organization, and floating reading. Subsequently, categorization was carried out by extracting recording units, such as small segments of content, words, and phrases with specific meanings relevant to the research; contextual elements, through broader segments of the message, such as complete sentences and paragraphs; and, finally, thematic categories. Based on the adopted theoretical framework, three deductive categories were initially established through predefined codes or themes derived from the framework: folk subsystem (folk sector); informal subsystem (popular sector) – popular knowledge as a healthcare practice; and professional subsystem (professional sector) – bonding and interaction with healthcare services and professionals. To achieve this, recording and contextual elements were identified and inserted into the categories. Subsequently, the categorization process was conducted after analyzing each recording and contextual element, leading to the formation of inductive categories, which emerged directly from the data and were not predefined. As a final phase, second-order analysis and interpretation were performed so that the data became meaningful and valid, enabling the identification of potentially emerging categories.

The ethical and legal aspects involved in research with human beings were respected, in compliance with Resolution 466/2012 of the National Health Council. The research project was registered under number CAAE: 80316624.3.0000.5346 and approved by the Institutional Research Ethics Committee, under opinion number 6,899,368 of June 20, 2024. No artificial intelligence (AI) tools were used in any stage of the research. Participants signed the Informed Consent Form (ICF) in writing, in two copies, one copy for the participant and the other for the researchers. The anonymity of the participants was maintained, identifying them by the acronym OA (Older Adult), followed by a number, according to the order of the interview (OA1, OA2…OA27).

RESULTS

Of the 27 older adults participating in the study, 20 were female and 7 were male, aged between 61 and 90 years, with a mean age of 72.6 years and a standard deviation of ±8.43. Regarding marital status, 15 were married, eight widowed, three divorced, and one single. Of these, 13 lived with their spouses; six lived alone; four lived with a child and other family members (grandchildren,

daughters-in-law, sons-in-law); two lived with a child; and two lived with their spouse and child. Regarding income, 13 participants received up to one minimum wage; 12 received between one and three minimum wages; two received more than three minimum wages; and one participant had no income. Concerning education, four participants were unable to answer; two were illiterate; 17 had incomplete elementary education; one had completed elementary education; one had incomplete high school education; and four had completed high school education.

The data analysis, linked to the theoretical framework, resulted in three deductive categories: Popular subsystem (folk sector), which includes family, community, and social support networks; Informal subsystem (popular sector) – popular knowledge as a healthcare practice; Professional subsystem (professional sector) – bond and interaction with healthcare services and professionals. From these, nine inductive categories emerged, as can be observed in Chart 1.

Chart 1 – Synthesis of the interconnection between the deductive and inductive categories of analysis. Palmeira das Missões, Rio Grande do Sul, Brazil, 2025.

Deductive categories	Themes	Inductive categories
Folk Sector	Religious beliefs	Religion as support for anxiety and depression symptoms
	Physical Activity Respiratory Activity	Physical activity and breathing exercises in reducing anxiety/depression
	Teas	Use of teas as a nonpharmacological measure for anxiety/depression symptoms
Popular Sector	Medication	Use of medication: lack of knowledge about its effects
	(Mis)information	(Lack of) knowledge about anxiety and depression symptoms
	Treatment	(Mis)understanding of and resistance to adherence to drug/non-drug treatment
Professional Sector	Access to healthcare services	Factors that hinder access to healthcare services
	Consultation at the FHS	(Lack of) knowledge about consultations with nurses
	Health follow-up Home visits.	Deficit in monitoring health conditions

Source: the authors, 2025.

Religion as support for anxiety and depression symptoms

Among the natural resources that can be linked to the folk sector, used by older adults in coping with/living alongside symptoms of anxiety and depression, issues related to faith and religiosity stood out, expressed through church attendance, prayers, and religious practices, as illustrated in the following reports:

> *I like going to church, it makes me feel good, I go there and it seems to fill the emptiness, you know? So I'm always trying to keep myself busy, I fill my day with things to do.* (OA8)

> *But I pray, girl, I pray! Look, I think I am still holding on, still standing because of the faith I have, because of how much I pray. I attend Mass, pray the rosary; if it were not for that, I do not know*. (OA25)

Physical activity and breathing exercises in reducing anxiety/depression

The TI of older adults linked to the folk sector leads them to seek strategies to alleviate symptoms of anxiety and depression. Among these, breathing exercises and walking stood out, as shown in the following reports:

> *I do the cup exercise. I put water in a cup with a straw and blow. And then there's that essential lavender oil. That helps me a lot.* (OA3)

> *I go outside. I go for a walk. I walk up the street a bit and then come back, and that helps! I cry, and that helps a lot too.* (OA6)

> *And then I take it, I breathe. I breathe deeply, you know? I try to think, I try to breathe deeply, I drink some cold water*. (OA21)

Use of teas as a nonpharmacological measure for anxiety/depression symptoms

The use of teas also stood out among the strategies adopted by older adults during their TI regarding the folk sector:

> *I make it, there's a little herb in the garden, I pick some leaves and make it. I drink lemon balm water. Yes, it helps. You have to live like that*. [Speaks in a low voice and with a discouraged facial expression]. (OA20)

> *Then I drink a little chamomile tea*. (OAI3)

> *I also drink water with lemon.* (OAI21)

Use of medication: lack of knowledge about its effects

During the TI of older adults with symptoms of anxiety and depression, their lay knowledge, linked to the popular sector, was observed. This issue becomes evident when they expressed a lack of

knowledge about why they were using certain medications.

> *Well, I take the* [medication]. *Because we feel anxious. Just from the passing of the days. I was thinking, 'We get old, we don't have children, just us*. (OA2)

> *I take this medicine to sleep at night.* (OA24)]

> *[...] they suddenly gave me medication to help me concentrate more because I worry too much, you know? If I have a lot of things to do tomorrow, I already start worrying today*. (OA16)

(Lack of) knowledge about anxiety and depression symptoms

From some statements, it was possible to note the lay knowledge, analyzed from the perspective of the popular sector, that the older adults participating in this study had regarding symptoms of anxiety and depression. This knowledge contributes to older adults sometimes being unable to identify, or uncertain about, the effects of depressive and/or anxiety disorders on their own bodies.

> *One day, in the middle of the night, something came over me, a trembling, my mouth was locked, I couldn't speak. But I was nervous, really nervous, I think that's why it happened.* (OA2)

> *And then sometimes it passes, I calm down, calm down, and suddenly I get that feeling again, sometimes that fear, you know? Panic, panic syndrome, I think. That anxiety, you know? I do not know if it is normal for mothers or if it is just me. I lose sleep. I wonder, am I pessimistic or is it my nervous system?* (OA7)

> *Then later, when I started to get that acceleration, you know? I already knew that it was going to happen (anxiety attack).* (OA21)

(Mis)understanding of and resistance to adherence to drug/non-drug treatment

Still within the evaluation of the popular sector, it was observed that the lack of monitoring regarding mental health conditions led some older adults to demonstrate misunderstanding of and resistance to pharmacological and nonpharmacological treatment, resulting in treatment abandonment, self-medication practices, and failure to seek psychological care.

> *Then I started feeling like I was becoming more and more nervous, my mind kind of weak, confused. And I started becoming dependent on that medicine. One day I thought: 'I am not taking this anymore.' Then I threw the bottle away. After that, I stopped taking it.* (OA7)

> *I stopped taking my medications on my own. I am trying another one now. My daughter is taking it, so I started taking it too. The doctor does not even know.* (OA1)

> *She wanted to prescribe me a controlled medication so I could just lie down and sleep. I said, "No, doctor, I do not want that because controlled medication is addictive".* (OA12)

> *No, there is no need to see a psychologist. Just the medication (speaks rigidly).* (OA4)

However, it was possible to observe that some participants recognized the importance of receiving specialized treatment, such as psychological counseling, in order to improve their mental

health condition.

> *Sometimes I think that I would like to go see a psychologist, I would like to go and get medication for this anxiety.* (OA7)

> *This week when I go to the health center, I'm going to see the psychologist.* (OA15)

Factors that hinder access to healthcare services

During the TI of older adults regarding the professional sector, some factors hindering their access to healthcare services could be identified. Among these, the lack of adequate social and economic support stood out. At times, some older adults needed to use extra financial resources to access the FHS. In other situations, the healthcare team traveled to conduct home visits.

> *No, I can't always go to the health center, usually I have to skip buying something else for myself, save some money to take a taxi.* (OA16)

> *I go by taxi then. What else can I do, right? I cannot walk. So, the doctor and the nurse always come here to check blood pressure and bring medication for me and for her.* (OA1)

Another hindering factor involved the physical and clinical conditions resulting from the aging process itself, associated with mobility limitations. In addition, the geographical distance between the FHS location and the user's residence also made access difficult.

> *I have difficulty walking. That's a bit bad. Because then it hurts, right? My God!* (OA8)

> *But look, I hardly ever go to the health center. It's quite far.* (OA11)

> *But I have difficulty walking. Because it's far from here up there. And then you have to go on foot.* (OA12)

(Lack of) knowledge about consultations with nurses

Consultations with healthcare professionals at the FHS emerged as part of the TI of older adults within the professional sector. However, it is noteworthy that few participants mentioned nursing consultations, and one participant stated that they did not know nurses also conducted consultations. Nevertheless, older adults who had consultations with nurses emphasized positive experiences with the care provided.

> *I don't mind consulting with the nurse because she is very intelligent.* (OA9).

> *I like the nurse. I also consult with the doctor. But I like her, she gets my medicine right a lot.* (OA14)

> *With the doctor. I did not even know the nurse also provided consultations. I only found out now.* (OA15)

> *No, I have never had a consultation with the nurse. Always with the doctor.* (OA26)

Deficit in monitoring health conditions

In the following statements, the lack of follow-up regarding health conditions within the Professional sector becomes evident, especially concerning mental health. Most older adults participating in the research did not have routine consultations at the FHS, they only had prescriptions for renewed medications.

> *No, I do not go* [for routine consultations]. *Those people always have to get the prescriptions that they get for us.* (OA2)

> *No, I didn't go. You only need to go to get a prescription, right?* (OA16)

Regarding guidance provided by healthcare professionals to alleviate depressive and/or anxiety symptoms, older adults reported receiving sporadic visits when they were unable to go to the BHU. One participant reported not receiving any guidance, only medication prescriptions to help control symptoms.

> *Nothing, nothing was said. They did not say anything. Just the medication.* (OA22)

> *Once, when we were sick, the doctor came, but afterward no, maybe it was not necessary anymore, right? Then he does not come visit because we can go there. Sometimes he visits people who can't go*. (OA2)

> *For me, no. I do not think I need it. So whenever I need something, I just go to the health center*. (OA21)

The lack of other forms of therapeutic mental healthcare aimed at promoting well-being also stands out. Thus, some interviewees mentioned that they did not engage in any psychological healthcare practices beyond medication use, while others did not even use medication.

> *I don't do anything, no. Just the medication. I don't know, I got comfortable. I became complacent. So for me, it's like this, I always have to be drugged, as I say, right?* (OA23)

> *No, no. The only treatment I do is using this* [medication]. (OA4)

Regarding specialized care, none of the older adults reported receiving follow-up care from a psychologist, and only a small number reported having consulted a psychiatrist to use medication. In addition, two older adults had been referred by the FHS for psychological care but had still not been called for an appointment.

> *No. I was referred that time* [more than 2 years ago], *but they haven't called me yet.* (OA15)

> *I haven't been treated by anyone, I don't think there's one here*. (OA2)

> *But I wanted to be treated for this anxiety! And then they didn't give me a referral here. I talked, I talked to the doctors here. But they didn't say anything. I asked them to refer me* [to a psychologist] *too, right? "Ah, it's crowded, I don't know what." So, I didn't say anything more.* (OA26)

DISCUSSION

In the present study, it became evident that the TI of older adults involves the folk subsystem (folk sector), as it encompasses the search for different strategies such as walking (physical activity), breathing techniques, religious beliefs, and the use of teas. These findings corroborate those of a study that analyzed publications on quality of life, physical exercise, older adults, and mental health, which demonstrated that physical activity contributes to reducing mental disorders among older adults through the production of endorphins (hormones responsible for feelings of pleasure, well-being, and happiness). Thus, regular physical exercise is associated with a decrease in anguish, depression, anxiety and improved mood[15].

Also, regarding religious beliefs, the findings were similar to those of a study conducted in Portugal, which demonstrated that religiosity/spirituality is frequently associated with reduced symptoms of depression and anxiety, greater resilience, and better emotional management of stressful situations[16]. Religiosity and spirituality are used as a coping strategy for suffering, exerting a positive influence on health and directly related to mental well-being, happiness, life satisfaction, high morale, and better mental and physical health. Having a religious belief provides feelings of connection, belonging, and identity, which generates more favorable conditions for coping with mental illness situations[17].

The use of teas, mentioned by participants in the present study is consistent with findings from a study that evaluated the use of Integrative and Complementary Health Practices (ICHP) in supporting depression treatment, highlighting that medicinal plants were among the most frequently reported practices. The authors reinforce that these tools are important as expanded care strategies for individuals experiencing psychological distress[18].

Based on the studies previously presented, it can be stated that the therapeutic itineraries found are aligned with the theoretical framework used in this research, the folk sector, such that the care for older adults with their mental health includes cultural and popular knowledge and beliefs.

The TI of older adults with depressive and anxiety symptoms in this study also takes place within the informal subsystem (popular sector) – popular knowledge as a healthcare practice, in which this population demonstrated lay beliefs and knowledge regarding the health-disease process. This lack of knowledge about mental illness led participants to negative self-perceptions of health, discontinuation of drug therapy or self-medication, and even resistance to therapeutic treatment.

These findings corroborate those of a study developed with the objective of assessing the level of medication adherence among older adults using polypharmacy in Primary Care. In that study, the authors describe that older adults are more likely to discontinue treatment and experience adherence problems due to comorbidities and the use of multiple medications. Nonadherence to treatment is also associated with lower levels of knowledge about medication prescriptions, resulting from reduced cognitive and memory capacity related to the aging process, dementia, or depressive conditions. Thus, lack of knowledge may lead to inappropriate use of psychotropic drugs, a factor that compromises treatment effectiveness, as well as user's safety[19].

In this regard, research conducted in Canada with 200 older adults revealed complex perceptions and beliefs of older adults about medication that may be related to lack of knowledge or

insecurity about use/benefit/risk[20]. Therefore, the need for healthcare professionals to provide older adults with manifestations of depression and/or anxiety with information regarding pharmacological treatment is emphasized, as well as guidance on mental health care and interventions beyond pharmacological therapy. To achieve this, healthcare teams need to be trained to monitor and track treatment adherence, in addition to developing health education actions capable of making users protagonists of their own therapeutic process[19].

Another finding similar to that of this study was identified in research conducted in South Korea that sought to evaluate the influence of factors on self-rated health among older adults. The presence of chronic diseases, dependence in activities of daily living, and depression contributed to negative self-rated health among older adults living alone[21], since these morbidities may cause limitations and hinder self-care. Moreover, the study highlights that social roles may contribute to improving the health status, well-being, and quality of life of these individuals[21].

In this context, the presence of the theoretical framework of the informal subsystem (popular sector) can be observed, considering the need for older adults to have knowledge regarding medication use and effectiveness, clinical manifestations, and the importance of therapeutic interventions in order to facilitate understanding and promote adherence to treatment whether it is medication-based or not.

The TI of older adults in this study also encompassed the professional subsystem (professional sector), involving bonding and interaction with healthcare services and professionals, addressing how this population relates to the FHS and healthcare professionals in meeting mental health demands. Within this subsystem, impaired bonding with the healthcare team, fragmented care, and difficulties in accessing healthcare services were identified.

From this perspective, the difficulty of the older population in accessing the FHS was evidenced, due to clinical and physical conditions, location of residence in relation to the FHS, and financial difficulties. A study that analyzed factors associated with difficulties in accessing healthcare services among the older population highlighted those older adults without a partner, with low educational levels, transportation difficulties, lack of financial resources, architectural and geographical barriers, negative self-rated health, and those categorized as frail had greater difficulty accessing public services[22]. Limitations in mobility were also identified, as well as sequelae of chronic morbidities and disabilities[22], findings similar to those of the present study.

Fragmentation of continuous care was also observed, as some study participants did not receive frequent home visits and, when such visits occurred, they were mainly performed by CHA. As highlighted in a study conducted with data from Cycle III of the National Program for Improving Access and Quality of Primary Care, home care, including home visits, integrates the principle of comprehensive health care through the development of preventive, curative, and health promotion actions, being of fundamental importance for better user care. Furthermore, the demand for home care is greater than the supply, making it necessary to adjust the number of professionals according to the size of the territory, in order to enable the planning and organization for conducting home visits[23].

Most older adults participating in this study did not have their mental health status monitored, nor did they have access to specialized care with psychologists and psychiatrists. The Brazilian mental health report S20 addresses that many users with mental health problems, including anxiety and

depression, face barriers to accessing adequate public mental healthcare. These barriers hinder efforts to combat mental health-related stigma, promote social support, and establish effective rehabilitation programs, which are essential components in addressing individual social needs and the broader determinants of mental health[24].

It was also noted that there was a lack of certain professionals, such as psychologists and psychiatrists, to meet the specific demand, as drug treatment often prevails, based on consultation with a general practitioner. A study conducted in Australia also reported fragmentation of mental health services, which prevents users' needs from being fully addressed. The study emphasized the importance of multidisciplinary care with a structured care plan involving both pharmacological and nonpharmacological interventions, which could improve mental and physical outcomes for patients with mental disorders. However, this practice of integrated mental healthcare within Primary Care faces numerous challenges[25], similar to those evidenced in the present study.

Furthermore, most participants did not receive continuous care regarding their mental health condition. This study positively associates continuity of care with better management of chronic diseases and improved quality of life. Thus, a continuous and personalized relationship between PHC professionals and older adults promotes proactive and patient-centered care, enabling better health maintenance[26].

In agreement with the findings of this study, research conducted in southern Brazil with FHS professionals highlighted that the physician-centered model still predominates in mental healthcare within PHC. The main care actions are characterized by psychotropic medication prescriptions and prescription renewals, which means that users are not understood in their entirety, as professionals may fail to consider biopsychosocial and spiritual aspects, focusing only on the disease and separating mental health from other healthcare demands[27]. In this context, the lack of a perspective beyond the disease itself leads professionals to fail to provide guidance on mental healthcare practices or information about symptoms of depression and anxiety disorders, making it more difficult to cope with the condition.

Another relevant finding of the study concerns the fact that most older adults have never consulted with a nurse, demonstrating a weak bond with this professional and, consequently, care was centered on consultation with the general practitioner. It should be noted that the nurse is the professional present at all levels of the healthcare network and plays a fundamental role in the mental health care of older adults.

However, although nurse's role is relevant in addressing the psychosocial demands of PHC users, their responsibilities are not clearly defined and are often presented in a generalized manner, which weakens and limits mental health actions. Thus, mental health interventions reveal that nurses restrict care to referring and welcoming patients, delegating care to other professionals and/or services, making it fragmented, bureaucratic, and centered on the medical model[28].

Furthermore, the narratives of the few participants who had previously consulted with nurses highlighted the value and importance of these professionals in older adults' mental healthcare. Research conducted in the United Kingdom and Australia described the implementation of the Mental Health Nurse Incentive Program, in which these professionals worked in general practice clinics to

facilitate access to mental health services. The program showed several positive outcomes, such as improved coping with illness, reduction of symptoms, and greater community participation, resulting in more effective and integrated clinic[25]. Thus, the importance and necessity of interventions carried out by nurses in addressing the mental health demands of the older population become evident.

From the perspective of the professional sector, it is clear that the TI of the studied population involves aspects related to access to healthcare services, the possibility of consultations with nurses in addition to physicians, and receiving home visits from healthcare professionals, all of which contribute to identifying older adults with manifestations characteristic of depression and/or anxiety, thereby favoring diagnosis, treatment, and follow-up care.

Therefore, it can be observed that the TI of older adults with depressive and/or anxiety disorders is influenced by social, cultural, economic, and individual contexts. As supported by the TI theoretical framework, the study highlights the influence of popular, religious, and scientific knowledge and practices.

The recommendations for conducting and subsequently reporting qualitative research were followed. The fact that this study was conducted with older adults in a single setting may hinder the transferability of knowledge, as the findings are anchored in specific territorial, organizational, and sociocultural conditions. Moreover, the mediation of the Family Health Strategy teams and Community Health Agents in the selection of participants, associated with the use of convenience sampling, as well as the identification of cases based on professional perception, constitute elements that may subtly influence the composition of the investigated group. Added to this is the delimitation of the study to a single municipality and urban household settings, which circumscribes the understanding of therapeutic itineraries to specific care dynamics. In this sense, although at first glance this may appear to limit transferability, individuation reinforces the interpretation of the findings based on the singularity of experiences, which strengthens transferability by enabling an interpretative and critical analysis that allows analogies to be established with other similar contexts in the in-depth understanding of the conditions under which the phenomenon is produced. Furthermore, the analysis and discussion in this study are based on self-reported information provided by participants during the interviews and are therefore subject to memory, communication, and interpretation biases.

FINAL CONSIDERATIONS

This research allowed an approximation of the therapeutic itineraries experienced by older adults with depressive and/or anxiety disorders, highlighting how these pathways are articulated between the popular, informal, and professional subsystems. Regarding the popular subsystem, issues related to the practice of religion, physical activities, breathing exercises, and the use of teas in reducing symptoms of depression and anxiety stood out.

Within the informal subsystem, the lack of knowledge among older adults regarding the effects of medications, the symptoms of anxiety and depression, as well as their misunderstanding and resistance to adherence to drug and/or non-drug treatment, stood out. In the professional subsystem, several factors hindering access to healthcare services were identified, including the lack of social and economic support. Furthermore, the lack of knowledge among most participants regarding

consultations with nurses in the FHS was also evident, as well as deficits in monitoring older adults' health conditions.

REFERENCES

1. Santos EMB, Pimenta CJL, Ferreira GRS, Frazão MCLO, Costa TF, Ribeiro GS, et al. Fatores relacionados aos sintomas depressivos em pessoas idosas com diabetes mellitus. Cogitare Enfermagem. 2022;27:e81965. https://doi.org/10.5380/ce.v27i0.81965

2. Farias WM, Aguiar IM, Martins KC, Santos JB, Barreto MAM, Fermoseli AFO. Sintomas ansiosos e depressivos em idosos na atenção primária à saúde em Maceió – AL. Rev.Med. 2022;101(1):e-188307. https://doi.org/10.11606/issn.1679-9836.v101i1e-188307

3. World Health Organization (WHO). Depression and Other common mental disorders: global health estimates [Internet]. Geneva: WHO. 2017[cited 2025 Dec 17]. Available from: https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2eng.pdf?sequence=1

4. Torres AG, Lima KC, Martins AM, Medeiros AA. Anxious and depressive symptoms in older adults treated by the Family Health Strategy in rural areas of Campo Grande/MS. Rev Bras Geriatr Gerontol. 2024;27:e240028. https://doi.org/10.1590/1981-22562024027.240028.pt

5. Li L, Pan K, Li J, MeiqinJiang, Gao Y, Yang H, et al. The associations of social isolation with depression and anxiety among adults aged 65 years and older in Ningbo, China. Sci Rep. 2024;14:19072. https://doi.org/10.1038/s41598-024-69936-w

6. Valença Neto PF. Prevalence and factors associated with suspicion common mental disorders in older adults: a population study. J Bras Psiquiatr. 2023;72(2). https://doi.org/10.1590/0047-2085000000410

7. Souza AP, Rezende KTA, Marin MJS, Tonhom SFR, Damaceno DG. Ações de promoção e proteção à saúde mental do idoso na atenção primária à saúde: uma revisão integrativa. Ciênc Saude Coletiva. 2022;27(05). https://doi.org/10.1590/1413-81232022275.23112021

8. World Population Prospect (WPP). Release note about major differences in total population estimates for mid-2021 between 2019 and 2022 revisions [Internet]**.** New York: United Nations; 2022 [cited 2024 Nov 20]. Available from: https://population.un.org/wpp/assets/Files/WPP2022_Release-Note-rev1.pdf

9. Kleinman A. Patients and healers in the context of culture an exploration of the borderland between, anthropology, medicine and psychiatric. Berkeley: University of California Press; 1980.

10. Alves PCB, Souza IMA. Escolha e avaliação de tratamento para problemas de saúde: considerações sobre o itinerário terapêutico. Rio de Janeiro, Editora Fiocruz; 1999. p. 264.

11. Organizações das Nações Unidas (ONU). Agenda 2030 para o Desenvolvimento Sustentável [Internet]. 2015 [cited 2024 Nov 20]. Available from: https://brasil.un.org/pt-br/91863-agenda-2030-para-o-desenvolvimento-sustent%C3%A1vel

12. Ministério da Saúde (BR). Agenda Nacional de Prioridades de Pesquisa em Saúde: Brasil. 2018 [citado 07 mar. 2025]. 26 p. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/agenda_prioridades_pesquisa_ms.pdf

13. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349-357.

14. Minayo MCS, Costa AP. Técnicas que fazem uso da palavra, do olhar e da empatia:

pesquisa qualitativa em ação. Aveiro: Ludomedia; 2019.

15. Oliveira ERP, Chaves LGS, Nascimento EVS. A relevância do exercício físico na qualidade de vida de idosos: nos aspectos da saúde mental. Rev Ibero-Am Human, Ciênc Educ. 2022; 8(05):1003-09. https://doi.org/10.51891/rease.v8i5.5538

16. Brandão T. Religion and Emotion Regulation: A Systematic Review of Quantitative Studies. J Relig Health. 2025;64(3):2083-100. https://doi.org/10.1007/s10943-024-02216-z

17. Martins DA, Coêlho PDLP, Becker SG, Ferreira AA, Oliveira MLC, Monteiro LB. Religiosidade e saúde mental como aspecto da integralidade no cuidado. Rev Bras Enferm. 2022;75(01). https://doi.org/10.1590/0034-7167-2020-1011

18. Schwambach LB, Queiroz LC. Uso de práticas integrativas e complementares em saúde no tratamento da depressão. Physis. 2023;33. https://doi.org/10.1590/S0103-7331202333077

19. Rodrigues MES, Nascimento GS, Medeiros LB, Nogueira MF, Pascoal FFS, Carvalho MAP. Polypharmacy and drug adherence in the elderly in the context of primary health care: cross-sectional study. Online Braz J Nurs. 2023;22:e20236633. https://doi.org/10.17665/1676-4285.20236633

20. Geremie T, Guiguet-Auclair C, Laroche ML, Mely P, Gerbaud L, Blanquet M. Deprescribing in older adults in a French community: a questionnaire study on patients' beliefs and attitudes. BMC Geriatr. 2024;24:562. https://doi.org/10.1186/s12877-024-05165-0

21. Ryu D. The impact of physical functionality and activity level on the self-rated health status of older adults living alone: An analysis of the mediating effect of social engagement. Geriatr Nurs. 2025;63:464-9. https://doi.org/10.1016/j.gerinurse.2025.03.035

22. Figueiredo DSTO, Silva JEGS, Feitosa PYO, Silva MPGPC, Alexandrino A. Fatores associados à dificuldade de acesso aos serviços de saúde pela população idosa: Pesquisa Nacional de Saúde 2019. Ciênc Saúde Coletiva. 2025;30(8). https://doi.org/10.1590/1413-81232025308.00082024

23. Linhares RS, Thumé E, Carrett MLV, Fantinel EJ, Cesar MADC, Tomasi E. Dificuldade de locomoção e necessidade de atendimento no domicílio: estudo transversal. Rev Saúde Pública. 2025;59:e35. https://doi.org/10.11606/s1518-8787.2025059006939

24. MariJJ, Kapczinski F, Brunoni AR, Gadelha A, Baldez DP, Miguel EC, et al. The S20 Brazilian Mental Health Report for building a just world and a sustainable planet: Part II. BJP. 2024;46:e20243707. https://doi.org/10.47626/1516-4446-2024-3707

25. Isaacs, AN, Mitchell, EKL Modelos de atenção integrada à saúde mental na atenção primária e fatores que contribuem para sua implementação efetiva: uma revisão de escopo. Int J Ment Health Syst. 2024;18(5). https://doi.org/10.1186/s13033-024-00625-x

26. Albarqi MN. Continuity and sustainability of care in family medicine: assessing its association with quality of life and health outcomes in older populations: a systematic review. PLoS ONE. 2024;19(12): e0299283. https://doi.org/10.1371/journal.pone.0299283

27. Cardoso LCB, Marcon SS, Rodrigues TFCS, Paiano M, Peruzzo HE, Giacon-Arruda BCC, et al. Mental health assistance in Primary Care: perspective of professionals from the Family Health Strategy. Rev Bras Enferm. 2022;75(Suppl 3):e20190326. https://doi.org/10.1590/0034-7167-2019-0326

28. Gusmão ROM, Viana TM, Araújo DD, Torres JD'ARV, Silva Junior RF. Atuação do enfermeiro em saúde mental na estratégia de saúde da família. J Health Biol Sci. 2022;10(1):1-6. https://doi.org/10.12662/2317-3076jhbs.v10i1.3721.p1-6.2022

DATA AND MATERIAL AVAILABILITY

Access to the dataset is available upon request from the corresponding author.

AUTHORSHIP CONTRIBUTION

Conceptualization: Kaliandra Gallina; Marinês Tambara Leite; Silomar Ilha; Alexa Pupiara Flores Coelho Centenaro

Formal analysis: Kaliandra Gallina; Marinês Tambara Leite; Silomar Ilha; Zaira Letícia Tisott; Alexa Pupiara Flores Coelho Centenaro

Investigation: Kaliandra Gallina; Marinês Tambara Leite

Methodology: Kaliandra Gallina; Marinês Tambara Leite; Silomar Ilha.

Resources: Kaliandra Gallina; Marinês Tambara Leite

Writing-original draft: Kaliandra Gallina; Marinês Tambara Leite; Silomar Ilha.

Writing-review & editing: Kaliandra Gallina; Marinês Tambara Leite; Silomar Ilha; Zaira Letícia Tisott; Alexa Pupiara Flores Coelho Centenaro

The authors declare that there is no conflict of interest.

Corresponding author:
Kaliandra Gallina
kaliandra.gallina@gmail.com

Received: 06.02.2025
Approved: 04.25.2026

Associate editor:
Dagmar Elaine Kaiser

Editor-in-chief:
João Lucas Campos de Oliveira