http://www.periodicos.uem.br/ojs/index.php/CiencCuidSaude
ISSN on-line1984-7513
DOI 10.4025/cienccuidsaude.v19i0.50072

ORIGINAL ARTICLE

COMMON MENTAL DISORDER IN ELDERLY PEOPLE WITH CHRONIC NON-COMMUNICABLE DISEASES IN PRIMARY HEALTH CARE

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ABSTRACT

Objective: To identify the risk of Common Mental Disorder in elderly people with Chronic Non-communicable Diseases and identify its relationship with sociodemographic characteristics. **Methods:** Cross-sectional, exploratory and descriptive study with quantitative approach, developed in the Family Health Strategy of the Municipality of São Vicente/RN, with a sample of 99 elderly people. The collection took place in September and October 2018 through a structured interview at the participants' homes using the Self-Reporting Questionnaire-20. Descriptive and inferential statistical analyses were performed. **Results:** It was found that 28.28% of the elderly had high risk for Common Mental Disorder and most (71.72%) had low risk. There was no significant association of this risk with Chronic Non-communicable Diseases and sociodemographic characteristics. C**onclusion:** Although no statistical association was identified, the presence of psychological distress in elderly people with chronic diseases is a source of concern, considering the possible impairment of their quality of life. Thus, the study stresses the importance of developing strategies for detection and monitoring of elderly people with Common Mental Disorder in this context of health care.

Keywords: Mental Disorders. Health of the elderly.ChronicDiseases.

INTRODUCTION

The number of elderly people aged 60 years or older with some type of Chronic Non-Communicable Disease (CNCD) is increasing and also the concern about the loss of autonomy and independence of this public. This is because the very condition of old age causes vulnerability to the emergence of disabilities, becoming even more worrying when associated with an unhealthy lifestyle[1]. Greater dependence in the elderly may be associated with sadness and social isolation and, consequently, with psychological distress at this stage of life[2].

In this sense, it is understood that mental illness is followed by repercussions in biological, cultural, social, economic and political dimensions, with Common Mental Disorder (CMD) being the most prevalent in the entire world population[3].

Common mental disorder, also classified as a nonpsychotic mental disorder, is characterized by depressive symptoms, states of anxiety, irritability, fatigue, insomnia, reduced concentration, and somatic complaints, expressed as a mixture of somatic, anxious, and depressive symptoms[3]. It may represent an important public health problem due to its high prevalence and serious effects on personal, family, professional well-being and on the use of health services[4].

A study of elderly people in the countryside of Bahia, in a municipality with a Human Development Index (HDI) and population similar to those of the municipality of the present study, found a general prevalence of CMD of 55.8%. The prevalence was higher in

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elderly women, people over 80 years of age, and people with low education[4].

Considering that Primary Health Care (PHC) is the preferred gateway to the Unified Health System (SUS), it is at this level of care that elderly patients seek treatment and monitoring for their health, especially for CNCDs, especially becausethere are consolidated programs such as Hiperdia for monitoring of systemic arterial hypertension (SAH) and Diabetes Mellitus (DM). The teams that work in these services have the opportunity to identify changes in the mental state of the patients and, thus, assist and/or refer them to receive comprehensive and comprehensive care. Therefore, it is necessary that the team be aware of the various aspects of life that affect the mental health of elderly individuals with CNCDs.

Given all the conditions experienced by elderly people with CNCDs and their greater vulnerability to develop CMD, as previously mentioned, it is considered important to investigate the following question: What is the risk of elderly people with CNCDs to be affected by CMD?

This study aims to identify the risk of CMD in elderly people with CNCDs, and identify the relationship between CMD, CNCDs and sociodemographic characteristics in the elderly of a city in the countryside of Rio Grande do Norte.

METHODS

This study is characterized as a cross-sectional, exploratory and descriptive survey of quantitative nature, developed in the city of São Vicente, in the state of Rio Grande do Norte. The Municipality of São Vicente is located in the microregion known as Serra de Santana, with a population of 6,028 inhabitants. The Family Health Strategy (FHS) of São Vicente is organized into three units, with three teams that serve the urban and rural population.

The study was conducted in one of the three units of the FHS. This unit was chosen because it is the oldest in the city and it has the majority of users enrolled in the program, besides presence of the Extended Family Health Center (EFHC) located in the same facility, facilitating the access ofresearch participants who need this service.

The surveyed population consisted of all elderly users enrolled in the Hiperdia program of theFHS. It is noteworthy that, to be part of the program, users need to have at least one diagnosed CNCD. The inclusion criteria were: being 60 years and older, and being enrolled in the Hiperdia program of the FHS I. Considering these requirements, the population adopted for sample calculation was 144 elderly.

A prevalence of 29.7% was considered to calculate the sample, which corresponds to the percentage of elderly identified with CMD in a study by other authors[5]. Based on the 95% confidence interval and the data mentioned above,and usingthe EpiInfo software version 7.0, a sample of 99 elderly individuals was obtained. The simple random sampling technique was adopted to select the elderly and the place of data collection was the home of each elderly. All participants had access to the Informed Consent Form (ICF), so that the interviews only took place after the participants read and agreed with the conditions of the study and signed the term.

Elderly people who did not have cognitive conditions to answer the instrument were excluded. The cognitive condition was checked by the Verbal Fluency Test (VFT), which consists of evaluating in one minute the largest number of words verbalized by the patient, according to a certain category; the category of animal names was adopted in this study. The cutoff point adopted in this study was nine correct answers for the participants who were illiterate or had up to eight years of schooling (non-full), and 13correct answers for those with eight or more years of schooling[6]. Thus, 102 elderly people were enrolled - all had access and agreed to the informed consent form. Of these, three were excluded in the criterion on cognitive condition, leaving 99 elderly who composed the sample.

Data collection took place from September to October 2018 and was performed at the participants' homes, using the technique of structured interviews by applying the Self-Reporting Questionnaire (SRQ), besides questions covering sociodemographic characterization and self-reported diseases. An adapted version of this questionnaire (SRQ-20)

already validated in several countries, including Brazil, was used. This version has been recommended by the World Health Organization (WHO) for community studies and in the context of PHC, due to its ease of use and low cost.

The SRQ-20 has 20questions that have been used for tracking CMD. The answers can be yes or no. Each affirmative answer corresponds to a value of 1 point and negative answers, to a value of 0. The sum of affirmative answers makes up the final score. The scores obtained are related to the likelihood of presenting CMD, which may range from 0 (no probability) to 20 (extremely high probability). Regardless of sex, people who score from 7 points upwards are considered as at risk for CMD. The cutoff point adopted in this study follows the same parameter adopted by the authors who validated the SRQ-20 in Brazil[7].

The dependent variable of the study was CMD. The independent variables analyzed were divided into two blocks: sociodemographic data and diseases mentioned. The sociodemographic characteristics of the participants investigated were: sex, age, schooling, marital status and monthly income. The comorbidities analyzed were: SAH, DM, osteoarticular, cardiac, respiratory and cancer diseases. Self-reported diseases with multiple or no responses were considered, as many participants had more than one disease.

The database was built using the Excel® software version 2017 and the Statistical Package for the Social Sciences® (SPSS) version 25.0 was used for the descriptive statistical analyses and statistical tests. In the quantitative variables evaluated in the study, descriptive statistics of trend measures and data dispersion were analyzed, namely: minimum and maximum values, means and standard deviations. In the qualitative variables, a descriptive analysis was made through absolute and relative frequency distributions (%).

The internal consistency of the data in the SRQ-20 was also evaluated using the Kuder-Richardson model, which verifies the reliability of dichotomous data, where indices above 0.70 indicate satisfactory data consistency. All items evaluated had indices above 0.70, confirming the consistency of the data, which was classified as satisfactory in the research instrument.

To observe the association between the risk of CMD and the general profile of the population and the categorized variables, the Pearson's chi-square teste or Fischer's exact test were applied when necessary. For all statistical tests applied, the p-value <0.05 was considered to indicate significance.

The present study was approved by the Research Ethics Committee of the Trairi UFRN/FACISA School of Health Sciences, under Opinion nº 2.715.257/2018, issued on June 15, 2018, in compliance with the provisions of the Resolution of the National Council of Health (CNS) nº 466/2012.

RESULTS

Table 1 presents the general classification of high and low risk for CMD in the interviewed elderly, responding to the general objective of the present study.

Table 1. Classification of risk of presence of common mental disorder (n = 99). São Vicente/RN, Brazil, 2018

Classification	n	%
Low	71	71.72
High	28	28.28
Total	**99**	**100.00**

Source: Research data, São Vicente/RN, 2018.

Among the 99 study participants, more than half were female, married, with up to five years of schooling (average 4.97 years of schooling), received up to one minimum wage, and the average age was 72.05 with standard deviation of 7.93, ranging from 60 to 94 years. Regarding self-reported diseases, most reported having SAH (Table 2).

Table 2. Sociodemographic characteristics and self-reported diseases of elderly participants (n = 99). São Vicente/RN, Brazil, 2018

Characteristics		n	%
Sex	Female	63	63.64
	Male	36	36.36
Age group	Upto 72 years	58	58.59
	Over 72 years	41	41.41
Schooling (years)	Upto 5 years	71	71.72
	Over5 years	28	28.28
Marital status	Married	61	61.62
	Widowed	24	24.24
	Single	12	12.12
	Divorced	2	2.02
Family income	Upto 2minimumwages	85	85.86
	More than 2 minimum wages	14	14.14
Self-reported diseases (Multiple response)	Systemic arterial hypertension	87	87.88
	Osteoarticular diseases	52	52.53
	Diabetes mellitus	49	49.49
	Heartdiseases	27	27.27
	Respiratory diseases	26	26.26
	Cancer	5	5.05
	Others	34	34.34
Total		**99**	**100.00**

Source: Research data, São Vicente/RN, 2018.

Table 3. Risk of common mental disorder according to the characteristics of the elderly (n = 99). São Vicente/RN, Brazil, 2018

General characteristics		Risk				Total		p-value
		Low		High				
		n	%	n	%	n	%	
Sex	Male	26	72.22	10	27.78	36	100%	**0.933** *
	Female	45	71.43	18	28.57	63	100%	
Age group	Upto 72 years	40	68.97	18	31.03	58	100%	**0.470** *
	Over 72 years	31	75.61	10	24.39	41	100%	
Schooling	Up to 5 years	49	69.01	22	30.99	71	100%	**0.342***
	More than 5 years	22	78.57	6	21.43	28	100%	
Marital status	No partner	28	73.68	10	26.32	38	100%	**0.732** *
	With partner	43	70.49	18	29.51	61	100%	
Family income	Up to 2 M.W.	59	69.41	26	30.59	85	100%	**0.338** **
	More than to 2 M.W.	12	85.71	2	14.29	14	100%	
SAH	No	7	58.33	5	41.67	12	100%	**0.312** **
	Yes	64	73.56	23	26.44	87	100%	
Osteoarticular diseases	No	38	80.85	9	19.15	47	100%	**0.055** *
	Yes	33	63.46	19	36.54	52	100%	
Diabetes mellitus	No	39	78.00	11	22.00	50	100%	**0.161** *
	Yes	32	65.31	17	34.69	49	100%	
Heart diseases	No	51	70.83	21	29.17	72	100%	**0.750** *
	Yes	20	74.07	7	25.93	27	100%	
Respiratory diseases	No	54	73.97	9	26.03	73	100%	**0.404** *
	Yes	17	65.38	19	34.62	26	100%	
Cancer	No	69	26.60	25	73.40	94	100%	**0.136** **
	Yes	2	60.00	3	40.00	5	100%	
VFT	Upto 13	39	70.91	16	29.09	55	100%	**0.842** *
	More than 13	32	72.73	12	27.27	44	100%	

Source: Research data, São Vicente/RN, 2018.
p-value: <0.05
* Chi-square test ** Fisher's exact test

The high number of people with hypertension and diabetes was something expected, considering that one of the inclusion criteria of the study was to be enrolled in the Hiperdia Program. Furthermore, the fact that the most frequently reported self-reported diseases were all chronic in nature is noteworthy.

The SRQ-20 global average score was 5.10 points, with a standard deviation of 3.55, and the score ranged from zero to 18 points. The Chi-square or Fisher's exact test showed no association between CMD and sociodemographic characteristics and self-reported diseases of the elderly, as shown in Table 3.

Despite absence of a significant association, a tendency of osteoarticular diseases to be related to the risk of CMD was observed, considering that these were the variables with closest to the p-value adopted according to the Chi-square test.

Table 4 shows the frequency distribution of items evaluated in the SRQ-20. It is noteworthy that 82.83% of the participants said they felt nervous, tense or worried, and almost half of the participants said they felt sad.

Table 4. Frequency distribution of items assessed in the SRQ-20 (n = 99). São Vicente/RN, Brazil, 2018

Items	No		Yes		Total	
	n	%	n	%	n	%
Do you often have headaches?	83	83.84	16	16.16	**99**	**100.00**
Is your appetite poor?	77	77.78	22	22.22	**99**	**100.00**
Do yousleepbadly?	73	73.74	26	26.26	**99**	**100.00**
Are youeasilyfrightened?	76	76.77	23	23.23	**99**	**100.00**
Do yourhandsshake?	82	82.83	17	17.17	**99**	**100.00**
Do you feel nervous, tense, or worried?	17	17.17	82	82.83	**99**	**100.00**
Isyourdigestionpoor?	72	72.73	27	27.27	**99**	**100.00**
Do you have trouble thinking clearly?	67	67.68	32	32.32	**99**	**100.00**
Do youfeelunhappy?	54	54.55	45	45.45	**99**	**100.00**
Do you cry more than usual?	86	86.87	13	13.13	**99**	**100.00**
Do you find it difficult to enjoy your daily activities?	80	80.81	19	19.19	**99**	**100.00**
Do you find it difficult to make decisions?	63	63.64	36	36.36	**99**	**100.00**
Is your daily work causing you suffering?	81	81.82	18	18.18	**99**	**100.00**
Are you unable to play a useful part in life?	87	87.88	12	12.12	**99**	**100.00**
Have you lost interest in things?	58	58.59	41	41.41	**99**	**100.00**
Do you feel that you are a worthless person?	87	87.88	12	12.12	**99**	**100.00**
Has the thought of ending your life been on your mind?	94	94.95	5	5.05	**99**	**100.00**
Do you feel tired all the time?	89	89.90	10	10.10	**99**	**100.00**
Do you have uncomfortable feelings in your stomach?	72	72.73	27	27.27	**99**	**100.00**
Are youeasilytired?	77	77.78	22	22.22	**99**	**100.00**

Source: Research data, São Vicente/RN 2018.

It was still possible to see that about 1/3 of the elderly reported losing interest in things and having difficulty making decisions. Overall, the responses to the SRQ-20 showed that the respondents seemed to deal positively with issues related to their mental health.

DISCUSSION

In the present study, although no statistically significant association was found between CMD, CNCDs and other sociodemographic characteristics, it is worrying that approximately one in three elderly people was at high risk for CMD. A study conducted with elderly people in the city of Campinas/São Paulo also showed a similar prevalence of CMD (29.7%), which was considered high[5]. In addition, the study had high rates of positive answers to questions about feeling nervous, tense or worried, feeling sad in the last days, and losing interest in things.

Although not as severe as psychotic disorders, difficulties arising from mental illness can represent a major public health problem, even when the illness is non-pathological, due to their serious effects on personal, family, professional well-being, and use of health care services. They may lead to situations such as social isolation and impairment of the quality of life of these elderly and their families, besidesgreaterexposure to psychic morbidities[4].

The fact that most participants showed a low risk for CMD also calls attention to the need for further studies investigating the possible protective factors of the mental health of people living in this place, because studies by other authors conducted in small towns usually show evidence of the opposite: high prevalence of CMD[8].

These disorders in most of cases require family care. In this context, the family needs to be guided and included in the therapeutic plan and sometimes, the family itself also needs care. Such need comes from the physical, emotional and financial stresses resulting from these conditions[9].

The data presented in Table 2 show that most participants were female, which is in line with the scientific literature[5,10]. This reflects the phenomenon of feminization of old age, in which women represent the largest percentage of the elderly in Brazil, a fact believed to be associated with the better care of women concerning their bodies, eating and adherence to the guidelines of health professionals[11].

Most of the elderly in the present study had low income, a condition that may have implications for access to health and treatment resources. Individuals with lower incomes often tend to adopt harmful habits to health, because they have less access to information and live in conditions that facilitate unhealthy behaviors[12].

The level of education is a favorable factor for the social, political and economic development of all citizens. When individuals have little or no education, this may affectvarious aspects of their lives, including health[1]. In this study, 2/3 of the elderly had up to five years of schooling, a reason of concern because it directly influences their understanding and perception of health.

The most frequent diseases reported by the elderly were hypertension, followed by osteoarticular diseases and DM. The appearance of hypertension and DM with greater representation is due to the fact that these diseases are part of the Hiperdia program.

Osteoarticular diseases are also among the most prevalent in elderly subjects worldwide, and in Brazil they are responsible for decreased physical performance and increased number of falls and fractures, thus contributing to the loss of autonomy and greater dependence on the elderly in activities of daily living (ADLs)[13]. In addition, elderly people who have a health problem usually present impairment in the performance of basic activities of daily living[14]. In turn, this may be associated with the onset of suffering. It is noteworthy that, although the direct correlation between the variables could not be confirmed, osteoarticular diseases presented a p-value of 0.055, that is, a valuethat approached statistical significance.

In the elderly, the discovery of a chronic disease may be accompanied by feelings of sadness, fear, discouragement and worry, but also acceptance. Thus, the maintenance of well-being, self-esteem and quality of life of these people may be impaired[15].

Consideration should be given to the fact that having a chronic disease in itself often leads to changes in eating habits, continued use of medications, and sometimes the need to adapt to routine activities, especially when these diseases worsen and lead to complications. All these changes and restrictions can affect the quality of life of the elderly, their socialization and mental health.

Regarding access to mental health care in PHC - scenario of this research - it is emphasized that there is still a large gap regarding the ability of teams to adequately meet the needs in their territories. Although health professionals identify the social vulnerability of the elderly caused by the perspective of family and affective disability, there are actions that do not consider this perspective[16]. This is due to the great complexity of this attention together with the fragile public policies in the area that cause a great distance between the theory and the reality of services[10], making it difficult to perform interventions in this population to prevent the worsening of their condition.

These interventions include measures common to all PHC professionals, such as providing the user with moments to think/reflect, exercise good communication, exercise empathy, and provide support. The measures should be focused on promoting new possibilities for modifying and qualifying conditions and lifestyles, as well as for promoting attitudes that provide emotional support to people in distress, aiming at the production of life and health and not merelythe cure of diseases[17].

It can be seen that this population lives under silent suffering. The presence of depressive symptoms is a risk factor for the development of dependence in ADLs. Thus, detecting signs of suffering is important for early interventions to be implemented, considering the modifiable risk factors, such as social support and psychic functioning[10].

In PHC, the work of nurses is characterized by the bond between people and respect for the territory. These characteristics are strongly in tune with the Psychiatric Reform precepts of overcoming the logic of social exclusion, giving attention to the need of social inclusion of people in their territory, and stimulating subjects to exercise theirautonomy[17]. In this light, the role of nurses in PHC should occur in a holistic, welcoming manner, and with co-responsibility in care.

Knowing that the mental health care of the elderly can be performed essentially in services linked to PHC, the fact that these distressed people do not have their problems identified and treated at this level of care is a cause of concern. Thus, the importance of developing strategies to detect these cases in this portion of the population - elderly with chronic disease - is reaffirmed, so as to better understand the serious problems that these findings may cause.

A limitation of the study was that the use of psychotropic was not investigated, since they are consumed in high proportions today, an aspect that, in this reality, could had been associated with mental disorders. Further studies are needed to verify the protective factors of mental health in elderly people living in small Brazilian municipalities, since there was a low prevalence of risk forCMD in this scenario.

CONCLUSION

The results of this study showed that, although most elderly people had a low probability of presenting CMD, one third of the interviewees were at high risk for developing this health condition. The individual responses to the research instrument showed important signs of psychic distress, which can be exemplified by the fact that most participants reported feeling nervous, tense or worried.

There was no association between the risk of CMD and sociodemographic characteristics or with self-reported diseases of the elderly. It is believed that the adoption of other designs or a larger sample may allow a more thorough investigation of such associations in future studies.

Although no significant associations were found, the present surveymet the purposes of an exploratory-descriptive study, as it showed the characteristics of a population that had not yet been studied and, in this case, from the perspective of chronic diseases and common mental disorders.

The importance of taking this information into consideration to support the creation of care plans appropriate to the peculiarities of this population, as well as to strengthen the mental health care network,is stressed.

TRANSTORNO MENTAL COMUM EM IDOSOS COM DOENÇAS CRÔNICAS NÃO TRANSMISSÍVEIS NA ATENÇÃO PRIMÁRIA À SAÚDE

RESUMO

Objetivo: Identificar o risco de Transtorno Mental Comum em idosos com Doenças Crônicas Não Transmissíveis e identificar sua relação com características sociodemográficas. **Métodos:** Estudo transversal, exploratório-descritivo, de abordagem quantitativa, desenvolvido na Estratégia Saúde da Família do Município de São Vicente/RN, com amostra de 99 idosos. A coleta ocorreu em setembro e outubro de 2018 mediante entrevista estruturada com aplicação do *Self-Reporting Questionnaire*-20,no domicílio. Foi realizada análise estatística descritiva e inferencial. **Resultados:** Foi identificado que 28,28% dos idosos apresentaram alto risco para Transtorno Mental Comum e a maioria (71,72%) tinha risco baixo. Não houve associação significativa deste risco com as Doenças Crônicas Não Transmissíveis e com características sociodemográficas. **Conclusão:** Apesar de não ter sido identificada associação estatística, é preocupante a presença de sofrimento psíquico em idosos com doenças crônicas, tendo em vista o possível comprometimento de sua qualidade de vida. Tal fato reafirma a importância de desenvolvimento de estratégias para detecção e acompanhamento de idosos com Transtorno Mental Comum nesse contexto de atenção à saúde.

Palavras-chave: Transtornos Mentais. Saúde do idoso. Doença Crônica.

TRASTORNO MENTAL COMÚN EN LOS ANCIANOS CON ENFERMEDADES CRÓNICAS NO TRANSMISIBLESEN LA ATENCIÓN PRIMARIA DE SALUD

RESUMEN

Objetivo: identificar el riesgo de Trastorno Mental Común en personas mayores con Enfermedades Crónicas No Transmisibles e identificar su relación con características sociodemográficas. **Métodos:** estudio transversal, exploratorio-descriptivo, de abordaje cuantitativo, desarrollado en la Estrategia Salud de la Familia del Municipio de São Vicente/RN, con muestra de 99 ancianos. La recolección ocurrió en septiembrey octubre de 2018 mediante entrevista estructurada con aplicación del*Self-Reporting Questionnaire*-20, en el domicilio. Fue realizado análisis estadístico descriptivo e inferencial. **Resultados:** fue identificado que el 28,28% de los ancianos presentó alto riesgo para Trastorno Mental Común y la mayoría (71,72%) tenía riesgo bajo. No hubo asociación significativa de este riesgo conlas Enfermedades Crónicas No Transmisibles y con características sociodemográficas. **Conclusión:** a pesar de no haber sido identificada asociación estadística, es preocupante la presencia de sufrimiento psíquico en personas mayores con enfermedades crónicas, considerando el posible comprometimiento de su calidad de vida. Tal hecho reafirma la importancia del desarrollo de estrategias para detecciónу acompañamiento de ancianos con Trastorno Mental Común eneste contexto de la atenciónprimaria de salud.

Palabras clave: Trastornos Mentales. Salud del anciano. Enfermedad Crónica.

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Submitted: 26/09/2019
Accepted: 28/11/2019