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Original Articles

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Prevalence of psychic suffering in old people: a community-based study

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Abstract

Objectives: To verify the prevalence of psychic suffering in an old population in the community and analyze its correlation with age, years of education, socioeconomic level, gender, reported morbidity, self-perceived health, visual self-perception, self-perception of hearing, and geriatric syndromes (frailty, fear of falling, functional capacity, and falls). *Method:* A cross-sectional study with 315 non-institutionalized old people living in Juiz de Fora, Minas Gerais, Brazil, in 2015. Data were collected through a household survey, and the psychic suffering can be observed in that old population with the use of the Patient Health Questionnaire (PHQ-4). The Pearson's chi-square test (χ^2) was used to verify the association between the outcome variable and the explanatory variables. The level of significance adopted in the study was 5%. Results: The prevalence of psychic suffering among the old people was 41.8% (95% CI 36.5–47.4%). There was an association between the *PHQ*-4 and gender ($\varrho=0.001$), reported morbidity ($\varrho=0.020$), self-perceived health ($\varrho < 0.001$), visual self-perception ($\varrho=0.001$), self-perception of hearing ($\varrho=0.034$), functional capacity ($\varrho=0.003$), and fragility ($\varrho=0.000$). Conclusions: psychic suffering is a common condition among old people. Knowledge of the factors associated with this event can contribute to a health care model that encourages active and healthy aging.

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INTRODUCTION

Human aging should not mean precarious living and health conditions. Numerous health problems of the old person tend to be chronic, and it is known that they are susceptible to early detection with effective control and monitoring, postponement, and prevention through the encouragement of healthy habits related to strategies and actions based on the paradigm of health production that, in addition to the absence of diseases, aims at guaranteeing the healthy aging of the old person[1,2].

However, longevity is not always congruent with healthy aging, especially in countries with high levels of income distribution such as Brazil, showing the social inequality that creates situations of social vulnerability such as precarious socioeconomic conditions, low self-esteem, and social esteem, and can affect a subject in different age groups, but they intensify with aging and worsening of health condition[3,4].

Social inequality is a serious social phenomenon responsible for processes of deprivation of rights and access to social goods and services, social exclusion, and precarious quality of life, and is considered an undoubted risk factor for triggering psychic suffering and mental disorders, a current possible relation as a result of the acceptance of the expanded concept of health and the notion of multidimensionality and social determination of the health-disease process in agreement with the principle of integrality recommended in the current public policy[5,6].

Thus, social suffering is the result of social inequality and inequity coupled with perverse experiments that can happen concomitantly with the aging process, bringing social isolation, loneliness, separation, loss, humiliation, stress, and physical pain, and contributing to the outbreak of psychic suffering. It is necessary to understand that it does not have a strict biological origin, a claim of the biomedical ideal that underlies the asylum model. In fact, it presents a complex biopsychosocial development concerning the perspective of the Psychiatric Reform[7-9].

It is essential to consider that psychic suffering is not a condition for aging. However, in this process, old people with greater frailty and less access to social resources and apparatus in their context may be more susceptible to mental disorders, susceptible to the onset of mild, moderate, or severe and persistent disorders, and responsible for important disruptions in their daily life, in sociality and their productive life[6,10].

Therefore, the present study aims to verify the prevalence of psychic suffering in an old population in the community and analyze its correlation with age, years of education, socioeconomic level, gender, reported morbidity, self-perceived health, visual self-perception, self-perception of hearing, and geriatric syndromes (frailty, fear of falling, functional capacity, and falls).

METHOD

The present study is part of an umbrella project entitled Health Survey of the Population of Juiz de Fora, Minas Gerais (ISPI-JF) which was designed to investigate the health profile, socioeconomic characteristics, and the determinants of the health-illness process of old people aged 60 or over of both genders and not institutionalized in the North Zone. Thus, to understand this research, it is essential to review the strategies and the methodological path of the macro project.

The ISPI-JF was fed with information through two waves of population-based multidimensional household surveys (2010/2011 and 2014/2015). At the beginning of the follow-up in 2010, the national prevalence of old people who suffered falls (30%) according to the literature was considered for the definition of the sample calculation, as it is the main objective of the research. Other parameters adopted for the development of the sampling plan were the confidence level of 95%, maximum desired error of 5%, losses due to refusal around 30%, correction for finite populations, and effect of the sampling plan equal to 1.5 (having the selection procedure adopted and the possible effects of stratification and clustering as a reference)[11,12,13].

The participants were selected by stratified and cluster random sampling in multiple stages. The census sectors configured the primary sampling units, and from a draw, they were grouped into

defined strata according to different types of health care to which the population of the sector was assigned in the territory, with the modalities being subdivided into primary care - whose services are covered or not with the Family Health Strategy (FHS) -, secondary care, or uncovered area. Then, the participants were chosen within each stratum, which took place independently and respecting the probabilities proportional to the size of the stratum and based on the data of the Demographic Census of 2000 for the resident population[11,12].

The population dynamics intrinsic to the four-year time frame between the two waves of the survey forged the need to use a new sample calculation, and the Oversample method was employed to preserve the representativeness of the probabilistic sample based on stratification and conglomeration. The initial parameter of the estimate considered the sample of the first wave and the data of the Census of 2010 from the Brazilian Institute of Geography and Statistics (IBGE) related to the population of the delimited area at the level of disaggregation of the census sector[11,12,14].

Oversample is a tool to allow to equalize the outputs of individuals on the panel without disrespecting the nature of the initial sampling. Therefore, it is necessary to comply with some requirements: (i) knowledge of the initial population; (ii) statistical treatment and different weighting for each group depending on the nature of the panel's withdrawal - the withdrawal groups were categorized into death, change of address without the possibility of identifying the new residence, travel lasting longer than the time to carry out the research, hospitalization according to the same parameter of duration and institutionalization; and (iii) appropriate selection of variables to balance the insertion of new participants. Age, gender, and education level were the variables used. In total, 423 old people comprised the sample of the survey[11,12,14].

Regarding the sample of the present study, it is worth mentioning that it comprised old participants in the second phase of ISPI-JF and who did not present cognitive decline (N=315), as indicated by the Mini-Mental State Examination (MMSE) - the instrument used to screen cognitive ability which

identified 108 subjects with cognitive decline. MMSE was the only exclusion criterion for the sample. Thus, the current research is configured as a cross-section of the second wave of collection of ISPI-JF with a sample comprising 315 old people aged 60 or over of both genders, non-institutionalized, and resident in the North Zone of the city of Juiz de Fora (MG), Brazil[11,12].

For data collection, a semi-structured, standardized, and pre-tested questionnaire was used including scales widely used in research and the clinic practice[11,12]. The dependent variable was investigated by the Patient Health Questionnaire (PHQ-4) to allow tracking the psychic suffering in the last two weeks. It comprises four items scored on a Likert scale from zero (not once) to 3 (almost every day) - the higher the sum, the greater the symptoms. The total score ranges from 0 to 12 and suggests the following analysis to understand psychic suffering: 0 to 2 none; 3 to 5 mild; 6 to 8 moderate; 9 to 12 severe[15,16]. To calculate the prevalence, the dependent variable was dichotomized according to the scores of absent and present psychic suffering, with a cut-off point ≥3 points.

Frailty was assessed using the Edmonton Frailty Scale (EFS) adapted and validated for the Brazilian population. It comprises 11 items to assess the nine domains of cognition, general health, nutrition, mood, functional independence, social support, medication use, continence, and functional performance. The total score can vary from zero to 17 points: no frailty (0 to 4), apparently vulnerable (5 and 6), mild frailty (7 and 8), moderate frailty (9 and 10), and severe frailty (11 points or more)[17]. To assess the fear of falling, the Falls Efficacy Scale - International - Brazil (FES-I-BRAZIL) and the Lawton and Brody Scale were used to measure the functional capacity to perform the Instrumental Activities of Daily Living (IADL).

FES-I-BRASIL verifies the fear of falling based on the definition of perceived low self-efficacy to avoid falls during the activities of daily living. The scale includes sixteen activities with scores between 1 and 4 for each of them, whose lowest value indicates the old person who is not at all concerned about falling, and highest indicates extremely concerned

about the possibility of falling. The total values range from 16 points for individuals without any concern to fall to 64 points for extremely concerned individuals[18]. For the categorical analysis of the variable, the fear of falling was admitted as present (score >16 points) or absent (16 points) [11,12,18,19].

The Lawton and Brody Scale investigates nine instrumental activities: using the telephone, shopping, laundry, cooking their meal, taking care of the money, cleaning the house, doing housework, taking medication, and going to distant places, using some type of transportation - scores vary from 9 to 27 points, and the lower the score, the greater the degree of dependence[19]. For categorization purposes, this variable was dichotomized into dependent (<18 points) and independent (≥19 points)[11,12,19,20].

The Kappa index was used to verify the degree of intra- and inter-examiner agreement before the beginning of the survey. The coefficient observed was greater than 75%, being considered substantial or excellent. To guarantee the quality of the data collected, the field researchers were carefully monitored and evaluated during the development of the research. Another strategy used for this purpose was to reevaluate 10% of production using a new partial interview after the end of the collection.

Data were inserted by two researchers independently and subsequently confronted to reduce failures and inconsistencies. The characteristics of the sampling plan were considered for the development of the statistical analysis, including the categorization of explanatory variables, description of absolute and relative frequencies, the prevalence of the outcome with the respective confidence interval, and application of the Pearson chi-square test (χ^2) to analyze the association between independent variables and outcome. The level of significance adopted was 5%.

The research was approved by the Ethics Committee of Universidade Federal de Juiz de Fora under opinion No. 771/916. All Regulatory Guidelines and Rules for Research Involving Human Beings were followed in compliance with Resolution No. 466/2012 of the National Health Council. All old people participating in the present study signed the Informed Consent Form.

RESULTS

The sample comprised 66.3% women. The average age was 72.2 years (sd ± 7.3), and education was 4.3 years of study (sd ± 3.5). Among the survey participants, 46% declared themselves black or brown, 58.4% belonged to socioeconomic class C, 58.4% were married or lived in a common-law marriage, and 87.9% had a roommate. Morbidity was reported by 88.3% of old people, poor or regular perception of health by 43.5% of old people, 54.9% reported regular or poor sight, and 28.6% poor hearing. Table 1 presents the characterization of the sample.

The prevalence of psychic suffering was 41.8% (95% CI 36.5–47.4%), 22.2% at a mild level, 13.3% moderate, and 6.3% severe. Regarding geriatric syndromes, 24.3% presented frailty, functional disability was observed in 6.3%, fear of falling in 95.2%, 34.3% had falls in the year before the interview, and 31.5% of these reported having suffered more than one fall (Table 1).

The Pearson's chi-square test (χ^2) showed significant results ($p<0.05$) between psychic suffering and gender ($\varrho=0.001$), reported morbidity ($\varrho=0.020$), self-perceived health ($\varrho <0.001$), visual self-perception ($\varrho=0.001$), self-perception of hearing ($\varrho=0.034$), functional capacity ($\varrho=0.003$), and frailty ($\varrho=0.000$) - Table 2.

Table 1. Sociodemographic characteristics, general health profile, and geriatric syndromes (N=315). Juiz de Fora (MG), 2015.

Variable	Absolute Frequency (N)	Relative Frequency (%)
Sociodemographic Profile		
Gender		
Male	106	33.7
Female	209	66.3
Age (years)		
60 – 70	136	43.2
71 – 80	124	39.4
Over 80	55	17.5
Education (in years)		
Illiterate	29	9.2
1 – 4	196	62.2
5 or more	90	28.6
Race/skin color		
White	143	45.4
Black/brown	145	46
Yellow/indigenous	27	8.6
Socioeconomic status		
A or B	89	28.3
C	184	58.4
D or E	42	13.3
Marital status		
Married or common-law marriage	176	55.9
Widow/ed, separated, divorced, or single	139	44.1
Home arrangement		
Lives alone	38	12.1
Lives with a roommate	277	87.9
General Health Profile		
Referred morbidity		
No	37	11.7
Yes	278	88.3
Self-perceived health		
Excellent/Very good/Good	178	56.5
Regular/Bad	137	43.5
Visual self-perception		
Excellent/Very good/Good	142	45.1
Regular/Bad	173	54.9
Self-perception of hearing		
Excellent/Very good/Good	225	71.4
Regular/Bad	90	28.6

to be continued

Continuation of Table 1

Variable	Absolute Frequency (N)	Relative Frequency (%)
Geriatric Syndromes		
Falls		
No	207	65.7
Yes	108	34.3
Fear of falling		
No	15	4.8
Yes	300	95.2
Functional capacity to carry out IADL		
Independent	295	93.7
Dependent	20	6.3
Frailty*		
Does not present frailty	130	51%
Apparently vulnerable	61	23.9%
Mild frailty	42	16.5%
Moderate to severe frailty	22	8.7%
Psychic suffering		
None	183	58.1%
Mild	70	22.2%
Moderate	42	13.3%
Severe	20	6.3%

Source: Table prepared by the authors themselves. *Variable not investigated in the case of disapproved old people n=60 (19.05%) with significant errors in the first item of EFS and who did not have a caregiver.

Table 2. Association between explanatory variables and psychic suffering (N=315). Juiz de Fora (MG), 2015.

Independent variables	Patient Health Questionnaire (PHQ-4)				
	None n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	p-value
Gender					0.001
Male	183 (42.1)	70 (25.7)	42 (21.4)	20 (10.0)	
Female	106 (57.9)	52 (74.3)	33 (78.6)	18 (90.0)	
Age (years)					0.732
60 – 70	183 (39.3)	70 (50.0)	42 (47.6)	20 (45.0)	
71 – 80	72 (41.0)	35 (37.1)	20 (38.1)	9 (35.0)	
Over 80	36 (19.7)	9 (12.9)	6 (14.3)	4 (20.0)	
Education (in years)					0.145
Illiterate	15 (8.2)	7 (10.0)	4 (9.5)	3 (15.0)	
1 – 4	106 (57.9)	45 (64.3)	29 (69.0)	16 (80.0)	
5 or more	62 (33.9)	18 (25.7)	9 (21.4)	1 (5.0)	
Race/skin color					0.236
White	183 (43.2)	70 (55.7)	42 (45.2)	20 (30.0)	
Black/brown	87 (47.5)	29 (41.4)	18 (42.9)	11 (55.0)	
Yellow/indigenous	17 (9.3)	2 (2.9)	5 (11.9)	3 (15.0)	

to be continued

Continuation of Table 2

Independent variables	Patient Health Questionnaire (PHQ-4)				
	None n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	p-value
Socioeconomic status					0.623
A or B	52 (28.4)	21 (30.0)	12 (28.6)	4 (20.0)	
C	107 (58.5)	43 (61.4)	23 (54.8)	11 (55.0)	
D or E	24 (13.1)	6 (8.6)	7 (16.7)	5 (25.0)	
Marital status					0.235
Married or common-law marriage	106 (57.9)	41 (58.6)	22 (52.4)	7 (35.0)	
Widow/ed, separated, divorced, or single	77 (42.1)	29 (41.4)	20 (47.6)	13 (65.0)	
Home arrangement					0.101
Lives alone	18 (9.8)	7 (10.0)	8 (19.0)	5 (25.0)	
Lives with a roommate	165 (90.2)	63 (90.0)	34 (81.0)	15 (75.0)	
Referred morbidity					0.020
No	30 (16.4)	5 (7.1)	2 (4.8)	0 (0.0)	
Yes	153 (83.6)	65 (92.9)	40 (95.2)	20 (100.0)	
Self-perceived health					<0.001
Excellent/Very good/Good	126 (68.9)	34 (48.6)	14 (33.3)	4 (20.0)	
Regular/Bad	57 (31.1)	36 (51.4)	28 (66.7)1	16 (80.0)	
Visual self-perception					0.001
Excellent/Very good/Good	94 (51.4)	27 (38.6)	20 (47.6)	1 (5.0)	
Regular/Bad	89 (48.6)	43 (61.4)	22 (52.4)	19 (95.0)	
Self-perception of hearing					0.034
Excellent/Very good/Good	141 (77.0)	48 (68.6)	25 (59.5)	11 (55.0)	
Regular/Bad	42 (23.0)	22 (31.4)	17 (40.5)	9 (45.0)	
Falls					0.919
No	120 (65.6)	46 (65.7)	29 (69.0)	12 (60.0)	
Yes	63 (34.4)	24 (34.3)	13 (31.0)	8 (40.0)	
Fear of falling					0.276
No	11 (6.0)	4 (5.7)	0 (0)	0 (0)	
Yes	172 (94.0)	66 (94.3)	42 (100.0)	20 (100.0)	
Functional capacity to carry out IADL					0.003
Independent	178 (97.3)	60 (85.7)	40 (95.2)	17 (85.0)	
Dependent	5 (2.7)	10 (14.3)	2 (4.8)	3 (15.0)	
Frailty*					0.000
Does not present frailty	100 (64.9)	23 (39.0)	6 (20.0)	1 (8.3)	
Apparently vulnerable	33 (21.4)	13 (22.0)	11 (36.7)	4 (33.3)	
Mild frailty	12 (7.8)	15 (25.4)	11 (36.7)	4 (33.3)	
Moderate to severe frailty	9 (5.8)	8 (13.6)	2 (6.7)	3 (25.0)	

Source: Table prepared by the authors themselves. *Variable not investigated in the case of disapproved old people n=60 (19.05%) with significant errors in the first item of EFS and who did not have a caregiver.

DISCUSSION

The main findings of the study related to the variables gender, referred morbidity, self-perceived health, visual self-perception, self-perception of hearing, functional capacity, and frailty which were associated with psychic suffering in community old people will be discussed herein. Among the variables mentioned above, frailty (ϱ=0.000), self-perceived health (ϱ <0.001), gender (ϱ=0.001), and visual self-perception (ϱ=0.001) presented a greater association with psychic suffering in the present study.

In the sample studied, 66.3% of participants are women. This can be related to the phenomenon known as the feminization of aging, resulting in a greater number of old women than men. This is because the female life expectancy is higher than that of men both in Brazil and in the world, as well as the greater demand for primary healthcare services by women[21]. Thus, it is necessary to consider some gender issues to discuss the prevalence of psychic suffering in old age.

Sales et. al.[22] found a strong connection between the female gender and depression resulting from the cultural dynamics that conditions women to the situation of vulnerability when compared to men during life. In addition to this data, Maximiano-Barreto and Fermoseli[23] found a higher prevalence of depression and anxiety symptoms in old women when compared to old men, which corroborates the findings of the present study.

Gender is an important social determinant of health inequities related to socio-cultural standards and values of a given society. Thus, the patriarchal, sexist, and misogynistic structure of society ends up imposing differences in the pattern of health and aging between women and men. When comparing active aging between both genders, Campos et. al.[24] note that it is worse for women because they have a higher degree of functional dependence, cognitive deficit, depression, worse family functioning, and a more negative perception of their health when compared to men.

Furthermore, although women live longer, they often experience old age in social isolation and precarious economic conditions resulting from a second-rate experience compared to men on which many depend financially and/or emotionally. To guarantee an independent and autonomous old age to old women, measures such as ensuring financial stability in old age, improving social inclusion, and ensuring care for old women seem to be effective to restore their psychological well-being[25].

The fast demographic and epidemiological transition in Brazil has led to an increase in chronic non-communicable diseases and functional and cognitive losses. Having that said, there is an epidemiological profile of multimorbidities associated with some type of psychic suffering that is not usually noticed in the healthcare routine[26].

The prevalence of psychic suffering in the studied population was 41.8%. Although the measurement of this outcome is of great relevance, there are still few studies assessing it in community old people. There is also a variety of screening instruments that limits comparisons between studies. In the present study, the PHQ-4 was used because it has some advantages such as easy application, low cost, and fast performance[15]. These characteristics are compatible with the conditions of the present study.

In another study also carried out with old community members in Recife (PE), 47.8% of them presented depressive symptoms in the assessment with the Geriatric Depression Scale (GDS)[27]. Fernandes et. al.[28] found a prevalence of 40% of depressive symptoms among the old people investigated using the same instrument in Teresina (PI). Anxiety symptoms were assessed in the study by Menta et. al.[29] in Porto Alegre (RS), with a prevalence of 9% from the use of the Mini International Neuropsychiatric Interview plus (MINIplus). When combined, depression and anxiety symptoms are directly related to psychic suffering[15,23,27] which were assessed using the PHQ-4 instrument in the present study.

The evaluation of self-perceived health has gradually become crucial in studies on aging, as it is considered an indicator of the quality of life and mortality. The old people who reported worse health conditions have a higher risk of mortality due to all causes assessed, such as heart disease and metabolic diseases, when compared to those who say they have

excellent health[30]. In the present study, a correlation was found between psychic suffering and negative self-perceived health, showing the possibility of suffering for those who report poor or regular health.

Communicating is an essential process for human development developed since birth and is relevant at all stages of life. The exchange of information in the face of aging has become a challenge due to the difficulties arising from the means of communication and the constant need for adaptations and readaptations with the advent of new technologies to achieve an effective dialogue. In this sense, the increased incidence of hearing loss and/ or hearing problems in old people is a reality that causes or may cause emotional, social, and quality of life consequences[31].

When assessed in the community, self-perception of hearing has more intense outcomes because it disables, causes sensory deprivation, hinders access to health services, blocks family relationships, and contributes to the onset of signs and symptoms of depression and anxiety, especially when the socioeconomic conditions are unfavorable[31]. The findings of the present study corroborate the literature by showing that negative perception of hearing is related to psychic suffering.

Living and dealing with problems in the sensory system tends to generate anguish and sadness since such limitations change the individual's way of relating to society and the world. Regarding vision, the results show that psychic development is more severe when visual self-perception is classified as regular or poor. So, there are many interconnections; this condition leads to functional disability, frailty, favoring the onset of falls, and consequently psychic suffering. It should also be noted that the quality of life also tends to worsen because visual impairment implies loss of self-esteem, status, and motivation[32], aspects that are intertwined in the causality of psychic suffering.

In the face of so many obstacles, if living in old age is a challenge, this is intensified when a condition of functional disability develops. As for IADL, 6.3% of old people were classified as dependent, and it was found that the greater the degree of functional impairment, the greater the degree of psychic suffering. Functional disability can be a predisposing factor for symptoms such as fear, distress, and anxiety. It is also related to other adverse outcomes such as frailty, morbidity, and social isolation, thus increasing the chances of depression and anxiety[33].

Like other geriatric syndromes, frailty is multifactorial. It is characterized as a frequent syndrome involving psychological, social, and biological aspects related to the life path of the old person bringing consequences to the health conditions and corresponding to the main causes of morbidity[34].

The negative perception of health, functional disability, and history of falls expressly impact the complexity triggered by the frailty that worsens with the association of more determinants of the health-illness process. Similarly, several factors influence psychic suffering and are associated with its onset[19]. Among the variables investigated in the present study, frailty was the one with the highest degree of correlation with the outcome. Carneiro et. al.[35] carried out a study in Montes Claros (MG) and observed similar behavior. Among the old people assessed with frailty syndrome, 37.2% had psychic symptoms.

The development of psychic suffering is related to the aging process since changes in daily life and motor, physical, social, and psychological losses lead the old person to reflect on their role in society. In a study carried out in Várzea Grande (MT) with old people assisted by the FHS, the presence of depressive symptoms also revealed an association with the most fragile and vulnerable ones. Such results are like others in the literature reporting the onset of depressive symptoms in old people with frailty[19,27].

Regarding the aging process and the increased prevalence of psychic suffering among old people, it is necessary that the health care models are reviewed in the apparatuses of the Health Care Network of the Unified Health System's, so that aging with quality of life is ensured by the implementation of public health policies covering not only the health of the old person but above all the mental health of the population at individual and collective levels.

To better contextualize the discussion, it is important to remember that the present study was the result of a larger study - the Health Survey of the Old Population of Juiz de Fora -, with a different objective from this one, although it was carried out based on the methodology proposed for the aforementioned household survey. It is also important to consider that some limitations such as memory bias and information bias (due to self-reported information) may have influenced the inference about its findings.

CONCLUSION

The present study identified a prevalence of psychic suffering of 41.8% among old community members, and an association between the outcome and the variables gender, referred morbidity, self-perceived health, visual self-perception, self-perception of

hearing, functional capacity, and frailty. The growing process of the Brazilian population aging with an evident prevalence of psychic suffering in the old population requires the understanding of this as a public health problem.

Thus, interventions are essential to ensure the healthy and active aging of old people. It is necessary to undertake intersectoral transformations with the initiative of the public authorities responsible for ensuring protection and social well-being aimed at valuing the old person and fostering their active participation in society. Said interventions will greatly serve to optimize strategies and actions of the management of healthcare models consistent with coping with the main problems affecting the old person.

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REFERENCES

1. Belasco AGS, Okuno MFP. Realidade e desafios para o envelhecimento. Rev Bras Enferm. 2019;72(Supl 2):1-2.

2. Matud MP, García MC. Psychological distress and social functioning in spanish people: a gender analysis. Int J Environ Res Public Health. 2019;16(3):1-10.

3. Barros MBA, Goldbaum M. Desafios do envelhecimento em contexto de desigualdade social. Rev Saúde Pública. 2018;52(Supl 2):1-3.

4. Jesus ITM, Orlandi AAS, Grazziano ES, Zazzetta MS. Fragilidade de idosos em vulnerabilidade social. Acta Paul Enferm. 2017;30(6):614-20.

5. Garbois JA, Sodré F, Dalbello-Araujo M. Da noção de determinação social à de determinantes sociais da saúde. Saúde Debate. 2017;41(112):63-76.

6. Tonin CF, Barbosa TM. A interface entre saúde mental e vulnerabilidade social. Tempus, Actas Saúde Colet. 2018;11(3):50-68.

7. Dimenstein M, Siqueira K, Macedo JP, Leite J, Dantas C. Determinação social da saúde mental: contribuições à psicologia no cuidado territorial. Arq Bras Psicol. 2017;69(2):72-87.

8. Manna RE. A experiência vivida por mulheres idosas como sofrimento social [tese]. São Paulo: Universidade de São Paulo, Instituto de Psicologia; 2018.

9. Trajano MP, Bernardes SM, Zurba MC. O cuidado em saúde mental: caminhos possíveis na rede de atenção psicossocial. Cad Bras Saúde Ment. 2018;10(25):20-37.

10. Silva PAS, Rocha SV, Santos LB, Santos CA, Amorim CR, Vilela ABA. Prevalência de transtornos mentais comuns e fatores associados entre idosos de um município do Brasil. Ciênc Saúde Colet. 2018;23(2):639-46.

11. Cruz DT, Duque RO, Leite ICG. Prevalence of fear of falling, in a sample of elderly adults in the community. Rev Bras Geriatr Gerontol. 2017;20(3):309-18.

12. Cruz DT, Leite ICG. Quedas e fatores associados em idosos residentes na comunidade. Rev Bras Geriatr Gerontol. 2018;21(5):532-41.

13. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Manual para utilização da Caderneta de Saúde da Pessoa Idosa. Brasília, DF:MS; 2018.

14. Rahman MM, Davis DN. Addressing the class imbalance problem in medical datasets. Int J Mach Learn Comput. 2013;3(2):224-8.

15. Kroenke K, Spitzer RL, Williams JBW, Lowe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4. Psychosomatics. 2009;50(6):613-21.

16. Lowe B, Rose IWM, Spitzer C, Glaesmer H, Schneider KWA, Brahler E. A 4-item measure of depression and anxiety: validation and standardization of the Patient Health Questionnaire-4 (PHQ-4) in the general population. J Affect Dis. 2010;122(1):86-95.

17. Fabrício-Wehbe SCC, Schiaveto FV, Vendrusculo TRP, Haas VJ, Dantas RAS, Rodrigues RAP. Adaptação cultural e validade da Edmonton Frail Scale - EFS em uma amostra de idosos brasileiros. Rev Latinoam Enferm. 2009;17(6):1043-9.

18. Camargos FFO, Dias RC, Dias JMD, Freire MTF. Adaptação transcultural e avaliação das propriedades psicométricas da Falls Efficacy Scale – International em idosos brasileiros (FESI-Brasil). Rev Bras Fisioter. 2010;14(3):237-43.

19. Cruz DT, Vieira MT, Bastos RR, Leite ICG. Fatores associados à fragilidade em uma população de idosos da comunidade. Rev Saúde Pública. 2017;51(106):1-13.

20. Lawton MP, Brody EM. Assessment of older people: self-maintaining and instrumental activities of daily living. Gerontologist. 1969;9(3):179-86.

21. Almeida AV, Mafra SCT, Silva EP, Kanso S. A feminização da Velhice: em foco as características socioeconômicas, pessoais e familiares das idosas e o risco social. Texto Contexto Enferm. 2015;14(1):115-31.

22. Sales JCS, da Silva Jr. FJG, Vieira CPB, Figueiredo MLF, Luz MHBA, Monteiro CFS. Feminização da velhice e sua interface com a depressão: revisão integrativa. Rev Enferm UFPE. 2016;10(5):1840-6.

23. Maximiano-Barreto MA, Fermoseli AFO. Prevalência de ansiedade e depressão em idosos de baixa escolaridade em Maceió/AL. Psicol Saúde Doenças. 2017;18(3):801-13.

24. Campos ACV, Ferreira EF, Vargas AMD. Determinantes do envelhecimento ativo segundo a qualidade de vida e gênero. Ciênc Saúde Colet. 2015;20(7):2221-37.

25. Rajasi RS, Mathew T, Nujum ZT, Anish TS, Ramachandran R, Lawrence T. Quality of Life and sociodemographic factors associated with poor quality of life in elderly women in Thiruvananthapuram, Kerala. Indian J Public Health. 2016;60(3):210-5.

26. Soares MFN, Maia LC, Costa SM, Caldeira AP. Dependência funcional em idosos assistidos por equipes da Estratégia Saúde da Família. Rev Bras Geriatr Gerontol. 2019;22(5):1-14.

27. Cordeiro RC, Santos RC, Araújo GKN, Nascimento NM, Souto EQ, Ceballos AGC, et al. Perfil de saúde mental de idosos comunitários: um estudo transversal. Rev Bras Enferm. 2020;73(1):1-8.

28. Fernandes MA, Melo DM, Bastos LA, Feitosa CA. Prevalência de depressão geriátrica em uma unidade básica de saúde. Rev Enferm UFPI. 2018;7(3):1-6.

29. Menta C, Bisol LW, Nogueira EL, Engroff P, Neto AC. Prevalence and correlates of generalized anxiety disorder among elderly people in primary health care. J Bras Psiquiatr. 2020;69(2):126-30.

30. Ribeiro EG, Matozinhos FP, Guimarães GL, Couto AM, Azevedo RS, Mendoza IYQ. Autopercepção de saúde e vulnerabilidade clínico-funcional de idosos de Belo Horizonte/Minas Gerais. Rev Bras Enferm. 2018;71(Supl2):914-21.

31. Sousa MGC, Russo ICP. Audição e percepção da perda auditiva em idosos. Rev Soc Bras Fonoaudiol. 2009;14(2):241-46.

32. Bravo Filho VTFB, Ventura RU, Brandt CT, Sarteschi C, Ventura MC. Impacto do déficit visual na qualidade de vida em idosos usuários do Sistema Único de Saúde vivendo no sertão de Pernambuco. Arq Bras Oftalmol. 2012;75(3):161-5.

33. Farías-Antúnez S, Lima NP, Bierhals IO, Gomes AP, Vieira LS, Tomasi E. Incapacidade funcional para atividades básicas e instrumentais da vida diária: um estudo de base populacional com idosos de Pelotas, Rio Grande do Sul, 2014. Epidemiol Serv Saúde. 2018;27(2):1-14.

34. Nascimento PPP, Batistoni SST. Depressão e fragilidade na velhice: uma revisão narrativa das publicações de 2008-2018. Interface. 2019;23(10):1-16.

35. Carneiro JA, Cardoso RR, Durães MS, Guedes MCA, Santos FL, Costa FM, et al. Fragilidade em idosos: prevalência e fatores associados. Rev Bras Enferm. 2017;70(4):747-52.