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CONCEPTIONS OF ELDERLY PEOPLE WITH HYPERTENSION AND/OR DIABETES ABOUT QUALITY OF LIFE

Kalina de Lima Santos[1 2]**,** Orcid: http://orcid.org/0000-0003-1789-199X
Edivan Gonçalves da Silva Júnior[1 3]**,** Orcid: http://orcid.org/0000-0001-6890-7870
Maria do Carmo Eulálio[1 4]**,** Orcid: http://orcid.org/0000-0002-5596-8428

ABSTRACT. The aim of this study was to understand the quality of life concepts in elderly people who suffers from arterial hypertension and diabetes mellitus. It is a descriptive and exploratory study with qualitative approach, the data collection strategy was Focus Group Interviews. The software QDA Miner was used for qualitative data analysis and the Content Analysis Method proposed by Bardin was used for data interpretation. The data had disclosed two categories: 'concepts of quality of life', pointing to the elements that go through the understanding that the elderly have of the quality of life, and 'relation between quality of life andchronic illness' - how the experience of chronic disease is associated with quality of life. Data had indicated that the quality of life concepts in this population are related to the way they live with the chronic illness. The subjective factors are very important concerning the elderly people life with the chronic illness, mainly their psychological and social resources, that help them to fight the negative effects of chronic illness conditions in the quality of life.
Keywords: Quality of life; chronic diseases; aging.

CONCEPÇÕES DE IDOSOS COM HIPERTENSÃO E/OU DIABETES SOBRE QUALIDADE DE VIDA

RESUMO. O objetivo deste estudo foi compreender as concepções de qualidade de vida de idosos portadores de hipertensão arterial sistêmica e *diabetes mellitus* tipo II. Trata-se de um estudo exploratório-descritivo de abordagem qualitativa, e a estratégia de coleta de dados foi a técnica de Grupo Focal. Os dados foram analisados usando o programa de análise qualitativa – QDA miner e interpretados através da análise de conteúdo, proposta por Bardin. Os dados revelaram duas categorias: 'Concepções de Qualidade de Vida', que aponta para os elementos que atravessam a compreensão que os idosos têm da qualidade de vida e 'Relação entre Qualidade de vida e doença crônica', como a vivência da doença crônica está associada à qualidade de vida. Os dados indicam que as concepções de qualidade de vida de idosos com hipertensão arterial e *diabetes mellitus* passam pelo processo de convivência com a doença crônica, enfatizando a importância de fatores subjetivos, especialmente os recursos psicológicos e sociais dos idosos, que auxiliam no enfrentamento dos efeitos negativos das condições crônicas que interferem na qualidade de vida.
Palavras-chave: Qualidade de vida; doenças crônicas; envelhecimento.

[1] Universidade Estadual da Paraíba, Campina Grande-PB, Brazil.
[2] E-mail: kalinalima17@hotmail.com
[3] E-mail: edivangoncalves.junior@gmail.com
[4] E-mail: carmitaeulalio@terra.com

CONCEPCIONES DE LAS PERSONAS MAYORES CON HIPERTENSIÓN Y/O DIABETES SOBRE LA CALIDAD DE VIDA

RESUMEN. El objetivo de este estudio fue comprender las concepciones de cualidad de vida de ancianos con hipertensión arterial y diabetes mellitus. Se trata de un estudio exploratorio-descriptivo de enfoque cual itativo y la estrategia para la recolección de datos fue la técnica de Grupo Focal. Los datos se analizaron usando el programa de análisis cualitativo-QDA miner e interpretados a través del análisis de contenidos propuesta por Bardin. Los datos revelaron dos categorías: "'concepciones de calidad de vida", ', que señala los elementos que pasan por la comprensión que los ancianos tienen de calidad de vida y "'la relación calidad de vida y enfermedad crónica" ' - cómo la experiencia de la enfermedad crónicas se asocia con la calidad de vida. Los datos indicaron que las concepciones de cualidad de vida de ancianos con hipertensión arterial y diabetes mellitus pasan por el proceso de convivencia con la enfermedad crónica enfatizando la importancia de factores subjetivos especialmente los recursos psicológicos y sociales de los ancianos que ayudan en el enfrentamiento de los efectos negativos de las condiciones crónicas que interfieren en la cualidad de vida.

Palabras clave: Calidad de vida; enfermedad crónica; envejecimiento.

Introduction

Population aging is a worldwide reality, which occurred as a result of increased life expectancy, as a result of decreased birth and death rates (Silva et al., 2021). Estimates indicate that in Brazil by 2060, 25.5% population will be over 65 years old. In addition, the data points to a reduction in the number of individuals under 15 years of age, which also represents a change in the patterns of population growth in the country (Instituto Brasileiro de Geografia e Estatística [IBGE], 2018).

This scenario implies challenges for the State, especially about demands for health and social security systems. Regarding health, challenges of resolute interventions with elderly people with chronic diseases (CD) stand out, since this population is the most affected by this type of illness. Among these challenges is the provision of assistance based on the performance of health care service networks; production of information in Epidemiological Surveillance and carrying out health promotion and prevention actions in multidisciplinary activities (Barreto, Carreira, & Marcon, 2015).

The development of actions aimed at coping with cases of systemic arterial hypertension (SAH) and type II diabetes mellitus (DM) is one of the health policy agendas in Brazil. SAH is among the cardiovascular diseases with the highest incidence and prevalence among the elderly and can be identified as an important risk factor for complications in the cardiovascular system and trigger cerebrovascular disease, coronary artery disease, peripheral artery disease, heart failure or chronic renal failure (Silva, Leal, & Bruno, 2019). DM has a silent character and lower prevalence compared to other morbidities, but it is a highly limiting disease. As Maeyama, Pollheim, Wippel, Machado and Veiga (2020) point out, diabetes has a relevant economic impact and on health systems, due to the greater use of health services, loss of productivity and prolonged care required to treat its chronic complications, such as renal failure, blindness, heart problems and diabetic foot, among other problems that impair the individual's functional capacity, autonomy, and quality of life.

Considering these demands, there is concern about the QoL of this age group, which is more susceptible to the onset of such diseases and which, among other issues arising from the aging process, needs to live with a chronic disease. For Minayo (2013), quality of life is an eminently human, subjective and polysemic notion that refers to the well-being that individuals and the community find in family, love, social and environmental life. It can also be defined as the standard that a society determines and mobilizes to conquer. The concept therefore comprises aspects related to physical health, psychological state, independence, social relationships, personal beliefs and the relationship with significant aspects of the environment.

Studies on aging and quality of life (Fernandes, 2018; Tomé & Formiga, 2020) support the perspective that QoL is associated with several factors in constant interaction throughout the individual's existence, such as objective conditions (physical environment, social context, social support network, friendship and kinship relationships and functional capacity) and subjective conditions (linked to affective aspects linked to well-being).

Cunha (2018) points to the importance of studies discussing the quality of life of elderly people with chronic diseases, especially considering the individual's perception of their condition. For the author, the relevance of the theme lies in the social, complex, multidimensional and subjective character of the construct, which considers the personal perception of each individual in a given context. According to Azevedo (2015), QoL is an important measure of health impact, and therefore has been widely used by professionals in the area, it represents a health indicator, both in clinical practice and in scientific research, and directs interventions.

In view of the above, the relevance of the study in question is observed, whose objective was to understand the conceptions of quality of life of elderly people with SAH and/or DM, considering the need to know how these elderly people express their feelings and experiences in relation to these chronic diseases, which despite being common, interfere with the ways of seeing and experiencing life.

Method

This was an exploratory, descriptive, qualitative research.

Procedures

Procedures and instruments

Data for this study came from a larger research entitled 'Resiliência, qualidade de vida e fragilidade em idosos adscritos na Rede de Atenção Básica de Saúde' in a municipality in the state of Paraíba and subsidized by the Office of the Pro-Dean for Research - PROPESQ/UEPB. The research complied with Resolução nº 466 (2012), of the Conselho Nacional de Saúde, which regulates research involving human beings, under parecer nº 1.675.115 of the Comitê de Ética em Pesquisa (CEP).

Among the measures used in this larger study, the WHOQOL-BREF Quality of Life Scale was applied, which assessed the participants' quality of life. Composed of 26 questions, the scale is a reduced version of the original WHOQOL-100 instrument and assesses the physical domain, such as pain, sleep, rest and mobility; the psychological domain, which involves positive feelings and self-esteem; the domain of social relationships, such as social support and sexual activity; the domain related to the environment, which concerns physical security, protection and financial resources (Fleck, 2007). In addition, a

sociodemographic questionnaire was used to characterize the participants, a question that investigated whether the elderly person had SAH and DM, and the mini-mental state examination (MMSE), prepared by Folstein, Folstein and McHugh (1975), which is a cognitive screening test for choosing participants with preserved cognition to obtain qualitative data.

Qualitative data were generated using the focus group technique, a non-directive qualitative research technique that gathers data through group interactions when discussing a topic suggested by the researcher. It occupies, as a technique, an intermediate position between participant observation and in-depth interview (Trad, 2009). To participate in the qualitative strategy, two elderly people from each health district were invited, whose analyses of the WHOQOL-BREF indicated a high evaluation (average overall QoL greater than 50) and a low evaluation (average overall QoL less than or equal to 50) of the QoL.

The final sample was defined by the accessibility criterion, and the focus groups were composed of 13 elderly people, who were invited to go to the university (UEPB) on the date, time and place the meetings were held. From there, two groups were formed, which met only once, and each meeting lasted 02 hours. The resources used for developing the FG were: room in neutral territory and with easy access to the participants, with water, coffee and snacks; a moderator (responsible for introducing and supervising the discussion); two observers (responsible for observing non-verbal communications and collaborating with the process); a script and images, used to guide and promote discussion in the groups.

Participants

A total of 24 elderly people were invited, of whom 11 did not meet the convenience and accessibility criteria and were excluded. Therefore, participants in this study were 13 elderly, aged 60 years and over, with SAH and/or DM, divided into two focus groups, in group 1 (G1), seven elderly people attended, who presented a high evaluation of QoL. Table 1, below, lists the characterization of the sample. One elderly male and six female, between 63 and 74 years old. Most are widowed (n=5), literate (n=6), Catholics (n=6) and live alone (n=3), or with a child (n=3). Regarding the socioeconomic profile of the group, the participants' income was divided into three groups: (3 receive) ≤ 1 minimum wage; (1 receives) ≤ 2 minimum wages; (3 receive) > 3 minimum wages. In group 2 (G2), six elderly people, with low QoL assessment, according to analyses performed with the WHOQOL-BREF, two males and four females, aged between 61 and 79 years. Regarding marital status, most correspond to married (n=2) and divorced (n=2), half of the group is illiterate (n=3). Most evangelicals (n=5), and live with a family member (n=6). And in relation to the socioeconomic factor, all participants (6 receive) ≤ 1 minimum wage, it is worth noting that the income of half of the members of this group does not even reach a minimum wage. The data consider the value of the minimum wage at the time of the interview, equivalent to R$ 937.00 reais.

Table 1 - Sample characterization

Variables		Group 1 (n=7)	Group 2 (n=6)
Gender	Female	06	04
	Male	01	02
Marital status	Married or living with a partner	02	02
	Single	0	01
	Widowed	05	01
Schooling	Not literate or did not complete the 1st grade	02	03
	Complete Elementary I	01	01
	Complete Elementary II	01	01
	Complete High School	02	01
	Complete Higher Education	01	00
	Catholic	06	01
Religion	Evangelical	00	05
	Spiritist	01	00
Housing arrangement	With child or stepchild	03	04
	With spouse	01	02
	Alone	03	00
	With grandchild	01	02
Retired	Sim	07	05
	No	00	01
Family income	≤1 minimum wage	01	06
	≤2 minimum wages	02	00
	≥ 3 minimum wages	03	00

Source: Research data (2017).

The study included the elderly who freely agreed to participate; presented preserved cognition according to the MMSE; had diabetes and/or hypertension and were enrolled in the UBS of each health district. The names of the participants referred to in some statements described throughout the work are fictitious to maintain the confidentiality agreed with the groups and protected by the Informed Consent.

Data analysis

The analyses of the study were carried out using the content analysis method according to Bardin (2016). The Focus Group meetings were recorded, the audios transcribed forming the research corpus, pre-analysis state. Then, floating reading was performed, providing initial impressions and then the material was organized for

categorization. The created categories were inserted, along with the research corpus in the QDA software, and the corresponding codes were assigned to each category.

According to Costa, Silva and Pereira, (2016), the creation of categories and their ramifications, called codes in the software, allows grouping the participants' speeches that refer to the same theme (category), and allows these relationships to be more easily found and demonstrated, giving greater reliability to the researcher, favoring the process of systematization and exposition of the data. In this sense, tools used for content analysis, from the software, were the coding frequency report that allowed the visualization of the codes used, as well as numerical information related to these codes, such as the coding frequency and the number of words in the segments (Provalis Research, 2009). In addition, a similarity analysis was performed between the cases, case 1 and case 2, focus groups 1 and 2, respectively.

Results and discussion

The development of the focus group with the elderly enabled their good interaction and participation, with agreement and divergence of ideas. This study corroborates Horta et al. (2016), who points out that interaction is one of the most important elements of the group, since the synergy between participants favors greater diversity and depth of responses, eliciting information with greater detail than just the sum of individual responses. In this way, the focus group allowed apprehending the experiences lived and expressed by the study participants, their feelings, attitudes and ideas alluding to the topic addressed.

With regard to chronic diseases, as can be seen in Table 2, the number of hypertensive patients is greater than diabetics. For Tortorella, Corso, Gonzáles-Chica and Melhen (2017), hypertension is in fact the most frequent chronic non-communicable disease (NCD), despite the increased incidence of cases, both of hypertension and diabetes separately, as well as of these combined diseases in recent years. In this study, only hypertensive elderly people were observed; however, there were not only diabetic elderly, those who were diabetic were also hypertensive. In G1, five participants had only hypertension and two had associated pathologies. In G2, out of the six elderly people, four had only hypertension and two had associated pathologies.

Table 2 - Occurrence of chronic diseases (SAH: systemic arterial hypertension; DM: Type II diabetes mellitus) by focus group

Focus group	Chronic disease	N	%
G1	SAH	5	71.4
	SAH + DM	2	28.6
	Total G1	**7**	**100.0**
G2	SAH	4	66.7
	SAH + DM	2	33.3
	Total G2	**6**	**100.0**

Source: Research data (2017).

Using the QDA miner, an analysis of case similarity was performed - the closer to 1, the more similar the responses of the groups, which made it possible to visualize the

proximity of responses between the participating groups. In the study in question, the similarity was 0.897. This is important, as it indicates that despite the scale capturing different means, signaling a group that would have a better quality of life compared to the other, the participants' speeches regarding the QoL concept of the two groups were very similar, a fact observed in the direction of the groups, organization and analysis of the material. The most significant differences detected between the groups, in addition to the differences in the assessment of QoL, indicated by the instrument, were questions related to the characterization of the groups: the socioeconomic factor, education and religious belief.

The data from this study made it possible to list two categories, namely 'conception of QoL' and 'The relationship between QoL and CD', which will be discussed below, and allow to apprehend some elements regarding what the groups understand by quality of life, and what the relationship they have between QoL and their chronic disease. Box 1 deals with an analysis carried out from the QDA miner, allows viewing the frequency of categories, highlighting the frequency of codes in each category, and indicates that the data refer to the evocations of the two cases (groups):

Category 1: Conception of QoL				
	Count	**% Codes**	**Cases**	**% Cases**
Quality of life _ conception				
Social relationships	9	3.8%	2	100.0%
Lifestyle	6	2.6%	1	50.0%
God	6	2.6%	2	100.0%
Doing what you like/pleasure	4	1.7%	2	100.0%
Health	4	1.7%	2	100.0%
Economic fator	2	0.9%	1	50.0%
Category 2: Relationship between QoL and CD.				
	Count	**% Codes**	**Cases**	**% Cases**
QoL and CD				
Control	9	4.0%	2	100.0%
Food	7	3.1%	2	100.0%
Emotional	3	1.3%	2	100.0%

Box 1 - Distribution of categories by frequency of codes (qualitative analysis - QDA miner). Source: Research data – qualitative analysis – QDA miner (2017).

In category 1 – the conception of quality of life of elderly people with SAH and/or DM showed that QoL is related to: 'social relationships', which involve family/community life and groups with people in the same age range, as well as solidarity/helping others; 'God', who appears in the speeches as a support for living well; 'do what you like'; QoL as a 'synonym for health'; and it is worth highlighting a distinction between case 1 that reveals the importance of taking care of themselves, highlighting issues related to a healthy lifestyle,

and case 2 the financial issue is seen as an essential element for dignity and consequent quality of life. These elements will be presented and discussed below.

Social relationships

QoL is a multidimensional and multidetermined phenomenon, which is characterized by a social representation created from subjective and objective parameters. Considering that QoL is a subjective concept implies saying that it is influenced by factors inherent to human existence, linked to the physical, psychological and social condition of the individual, in addition to external elements (Cunha, 2018).

In this study, the subjective character is highlighted, which is directly related to the way the elderly live, and the tools they have in their existence. For Dawalibi, Anacleto, Witter, Goulart and Aquino (2013), quality of life in old age is related to the self-esteem and personal well-being of the elderly, comprising aspects ranging from functional capacity, socioeconomic status, emotional state, social interaction, intellectual activity, self-care, family support, health status, cultural values, religiosity, lifestyle, job satisfaction and/or with activities of daily living, to the environment where one lives.

The code ‘social relationships’ was the most expressive report by both groups, in the conception of quality of life. As revealed by Mota, Oliveira and Batista (2017), individuals who maintain greater contact with friends and family, possibly live longer than those who do not have these relationships. As these relationships promote physical, social, cultural, economic and psychological support for the elderly, it allows them to feel valued and belonging to a social network, which will have positive implications on their health and, consequently, on the way they evaluate their quality of life. In addition, as stated by Braga, Braga, Oliveira and Guedes (2015), social relationships represent an important aspect to maintain the autonomy and living conditions of the elderly, relating to the ability to remain active, since it enables contact with different people and environments, in addition to the possibility of the elderly feeling useful, when they feel part of this network.

God

The aspect of the religious dimension is something present in the speeches, and all participants reported that they have a religion. God appears as a support and even his health condition is attributed to Him, as can be illustrated in the speech of one of the participants: “God is in control of everything in our life then. I’m sick today? I am. But it is God’s will” (Marilene, 65 years old). For Braga et al. (2015), there is a direct relationship between aging, quality of life, and religiosity, since in the face of difficulties, changes and everyday stresses, religion emerges as a support that helps them overcome the tendency to social isolation as well as overcome everyday problems. Moreover, religiosity is a phenomenon related to man’s quest to answer existential questions and gives meaning to life. It is also one of the strategies used to cope with adverse situations, such as physical illnesses, mental disorders or grief, and is therefore shown to be an aid to coping, a defense mechanism or even resignation. For Melo, Sampaio, Souza and Pinto (2015), religiosity is a very important dimension for the elderly, in which the belief in a just God, who watches over everyone, and who knows all things, helps them to live well in this phase of life.

Pleasant activities

The quality of life related to ‘doing what you like’, highlights the importance of leisure activities or activities that make the elderly feel good about themselves, as can be identified in the following excerpt: “– quality of life for me, is we do what we like, we fulfill ourselves in

some things, right [...]" (Francisco, 63 years old). As Silva (2018) points out, psychic energy has the function of conserving the continuity of pleasure, interest, meaning, the constant flow of investments both in oneself and in others, in activities, ideas and in the outside world. The function of the psyche lies in the ability to invest outside the self, which points to the importance of discovering objects, which the elderly can dedicate themselves to at this stage of life. The participant's statement mentioned above mentions this importance.

The theory of selection, optimization and compensation (SOC) (Baltes, & Baltes, 1990), as highlighted by Tomé and Formiga (2020), is an important theory in the Psychology of Aging. According to this, aging is a continuous process, multidetermined by interactional, dynamic processes and throughout adulthood, people become increasingly aware of the gains and losses related to this phase of life. In this perspective, elderly individuals select the goals that are most important by adopting behaviors that optimize their abilities to achieve their goals. As one ages, short-term social goals tend to focus more on the emotional aspects of relationships and less on informational aspects. Thus, people come to depend more on internal emotional regulation strategies. In this sense, there is a shift in the role of social relationships, but their importance remains for the elderly, insofar as these relationships are essential for maintaining feelings of subjective well-being and social skills.

Health/absence of disease

Although the public in question has a chronic disease, whose characteristic is precisely living with the disease, health, another indicator associated with QoL and shared by the groups, appears in the speeches linked to the absence of diseases "[…] quality of life is primarily health, right... if there is a sick person in the family, it already harms [...]" (Josefa, 72 years old). For Azevedo (2018), health-related quality of life involves the subjective assessment of the individual, and is linked to the impact on the health status. This is linked to the ability of the individual to live fully, considering that the essential dimensions of quality of life related to health include physical, social and emotional functions and, health in this case, involves precisely the ability of the elderly to maintain themselves active and socially involved, which is impacted by illness.

Healthy lifestyle

A healthy lifestyle is another code associated with the participants' understanding of QoL, and appears in one of the groups, associated with the need and importance of taking care of oneself in order to have QoL. Questions related to the practice of physical activity, changing eating habits, following medical guidelines are highlighted, as can be seen in the speech of an elderly woman who defines QoL as: "[...] it's taking care of myself! Now I've changed my whole diet [...] I don't eat fried foods, I don't consume oil [...] Now I have a better quality of life" (Odete, 68 years old). According to Portes (2011), despite evidence that changes in lifestyle have a great impact on individual and population quality of life, it is necessary to rectify the differentiation between the terms 'Lifestyle' and 'Quality of Life', the first, a term associated mainly with healthy ways of living, which interferes with people's physical health, and the second, a broader term involving several dimensions of existence, the author draws attention to the overlap of the physical aspect in understanding QoL by most people.

Regarding this issue, it is necessary to consider what Paulino, Siqueira and Figueiredo (2017) reflect. Often appropriated by the biomedical discourse, the understanding of QoL evidences a view of the individual's responsibility for their health that disregards their cultural, social, and life history context. For the authors, this is a technique

of power, part of the subjectivation process of the subjects, present in the relationship between health professionals and users, when those are instructed to persuade them to have a healthy life, and it is necessary to be careful not to reduce the QoL to this aspect.

It is interesting to highlight that in the data of the present study, the healthy lifestyle also appears, from another perspective. First, these healthy habits often imply changes that alter the life dynamics of these patients with SAH and/or DM, who develop their strategies to live with this reality, sometimes ways of 'circumventing' these rules, especially considering the food, as can be seen in this speech: "I follow the diet very well [...] but also on the day that I want to eat chocolate, there's no one to get in the way, ice cream, there is no diabetes to stop me [...] pork, I love it!" (Marilene, 65 years old), food is among the greatest difficulties presented by the participants, as it is also an element associated with pleasure.

Another point is, even though the elderly people recognize the importance of maintaining a healthy lifestyle, the speeches about the mishaps of this maintenance were recurrent and the way in which the elderly place themselves in relation to the 'healthy lifestyle', as can be illustrated in the following statements:

> "I get jealous [...] I've already suffered a stroke because of that, because I didn't do physical exercises, I didn't do anything...just alcohol, cigarettes [...]" (Chaves, 79 years old).

> "It doesn't work for me [...] because I don't leave the house, I'm vey lazy [...] I feel like it, I just lack the courage" (Odete, 68 years old).

Feelings such as envy and laziness, raised in the exposed statements, reveal negative feelings that affect the elderly for not being able to remain physically active, in relation to the practice of physical activities, including assuming responsibility for their chronic condition. For Azevedo (2018), the concern with living a healthy life is growing every day. We live in an era that exalts individual responsibility, preventive behaviors and the cult of health, accompanied by a growing set of medical recommendations and prescriptions on how to live a healthy life. This need, characteristic of contemporaneity, constitutes an 'ideal of health' to be achieved, even in old age.

Financial conditions

The 'financial conditions' code, appears in one of the groups, and relates the quality of life to the conditions to meet their needs for food, health, medicine, housing, among others, to live with dignity, as can be seen in the statement below: "[...], but you have to have money, even to cure [...] to have your own health [...] If you don't have money, you're screwed" (Chaves, 79 years old). Study carried out by Leite et al. (2015) reveals that financial difficulties, in relation to their own livelihood, purchase of medication, concern for unemployed children, dissatisfaction of the elderly with having to work to support the family, unemployment due to the fact that they are no longer accepted in the labor market and not having their own home, are key elements for the elderly to negatively assess their quality of life. As can be illustrated in the following statement: "[…] we also have dignity, right?! [...] about finances, for us to have coffee, lunch, dinner [...] who doesn't have their own house, but pays the rent, being able to pay for it [...]" (Socorro, 69 years old). The elderly people tend to relate QoL to the financial issue, because this gives them more access to goods and services. Besides that, the financial resource has a compensatory effect on the losses of old age, and is among the main determinants of a satisfied life at this stage of life (Braga et al., 2015). It is important to consider that the economic factor appears precisely in the understanding of QoL for G2, the group that has lower purchasing power (family income ≤ one salary) in relation to G1, as observed in the socioeconomic description.

It is possible to state that the conception of the QoL of the groups is crossed by the way in which the elderly relate QoL and their CD. In this sense, the second category is configured as a synthesis of how they perceive this relationship. From the content, it was possible to list three codes: control, food and emotional, points that say about how it is possible to have QoL with SAH and/or DM, and how CD interferes with quality of life.

The first includes the lifestyle - based on control, complying with the necessary care, it is possible to have quality of life, as illustrated in this statement: "[…] just control your diet, go for walks, use medication, always visiting your physician [...] you can have QoL" (Francisca, 64 years old). An element also incorporated into the biomedical discourse, as pointed out by a study carried out by Braga et al. (2015), in which the elderly absorb the discourses that advocate a more adequate lifestyle, and follow them because they believe they represent alternatives to minimize the effects of aging process. This was a very present factor in speeches of the group in question, precisely because it is one of the premises for living well, having a chronic disease.

Regarding the other two codes, which appear as points that interfere with the participants' quality of life, something that seems to be difficult to deal with, food - is configured as a way of pleasure and at the same time of limitation; this movement is punctuated as something that interferes with the quality of life, the following statement is very significant and says a lot about this issue: "[…] because hypertension takes away our taste of life! Because there is nothing better in life than health and food!" (Josefa, 72 years old). This is data that corroborates Silvia et al. (2019), whose results point to dietary control, arising from the diagnosis of a chronic disease as part of a process of suffering, intertwined with emotions and feelings, anxiety and a grief for losses and changes in behavior patterns, considered a treatment goal difficult to be achieved. In addition, the authors draw attention to the cultural and social meanings attributed to food. Therefore, food restriction goes through all these points, which justifies the significant place of food assigned by the participants.

Considering the emotional aspect, the chronic disease affects the elderly, in the sense of awakening the need to control even emotions, as we can see in the following statement: "I think it's a very bad disease [...] you get agitated when you talk, you can't be angry with a boy, you know? I get stressed [...] I tend to keep to myself, then I go somewhere to cry [...] I get sad, I have to control everything" (Josefa, 72 years old). Living with a chronic disease implies living with emotional and psychological changes, as shown by Leite et al. (2015), in which patients diagnosed with chronic diseases are more likely to develop pathological forms of stress, anxiety and depression, as individuals are exposed to aversive situations, and many have difficulties in managing the disease, in addition to compromising adherence to treatment and consequently their quality of life.

In this sense, it is important to consider the individual demands, and the characterization of the experience of living with the disease, which will determine a better understanding not only of the disease, but of the patient's relationship with it (Leite et al., 2015). In addition, as Pinto and Neri (2017) state, psychological and social resources play a key role in the way individuals face their losses in physical functions and social roles, and in relation to negative effects of chronic conditions on quality of life. For the authors, in old age there is a socio-emotional selectivity, which proposes changes in the composition of the social network, in the family structure, in work and leisure relationships, indicating that social needs of this stage of life are different and the practice of social activities in the community configure the social behavior that influences the health and well-being of the elderly. Factors that are also reported by participants in this study, thus confirming the importance given by

the elderly, the subjective issues that are linked to the conception and experience of a satisfying quality life, which are configured as an essential way to be worked together with this audience.

Furthermore, it is important to understand that, as Silva (2018) points out, in the face of helplessness, each subject seeks to create a unique form of existence and their own way of inhabiting their inner world, through their desire, inventing a style, (re)discovering their capacity in the face of adversity.

Final considerations

The study allowed understanding about the conception of quality of life of elderly people with systemic arterial hypertension and diabetes mellitus. Indicating that this conception goes through the process of living with a chronic disease and points to the relevance of subjective issues, highlighting that, above all, the psychological and social resources available to the elderly represent a way through which they face the negative effects of chronic conditions that interfere with their quality of life and the way they deal with the illness they have to live with. Among these resources, social support stands out, an essential element for experiencing this phase, to which the elderly will attribute a sense of social participation and of an affective nature, for interpersonal relationships; religiosity as a tool to help in this experience; and the maintenance of pleasure activities.

The results draw attention to the relationship between CD and QoL, highlighting the issue of lifestyle, which appears as one of the dilemmas for the elderly with CD, considering that this is the ‘recipe’ for living longer, but also imposes the deprivation of primordial pleasures, such as eating what one likes and the difficulties of maintaining healthy lifestyle habits. In addition, the elderly point to the influence of emotional aspects in the process of living with CD, which is exposed as something that negatively interferes with their quality of life. This emphasizes the relevance of psychological resources as tools that can help in experiencing a quality old age.

Analyzing these questions, it is necessary to consider the importance of characterizing the experience of SAH and DM, as it is from the speeches, perceptions and meanings attributed by the participants that one can understand how they experience the disease they have; as well as the relationships established for coping with their illnesses, especially since it seems essential that individual demands be considered in the guidance and treatment process, as this will produce more assertive interventions, something essential and necessary for coping with this public health problem.

In this sense, it is important to invest in studies that investigate the relationship between the individual and their disease, even if it is established as ‘common’, as is the case of SAH and DM. The disease, especially the chronic one, is a type of event that somehow produces the need to change the experience, and presenting physical pain or not, can produce psychic suffering.

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