Journal of Nursing
Revista de Enfermagem
UFPE On Line
ISSN: 1981-8963

ORIGINAL ARTICLE

SELF-ASSESSMENT OF PHYSICAL HEALTH AMONG USERS OF PSYCHOSOCIAL CARE NETWORK

AUTOAVALIAÇÃO DE SAÚDE FÍSICA ENTRE USUÁRIOS DA REDE DE ATENÇÃO PSICOSSOCIAL

AUTOEVALUACIÓN DE SALUD FÍSICA ENTRE USUARIOS DE LA RED DE ATENCIÓN PSICOSOCIAL

Vanda Maria da Rosa Jardim[1], Michele Mandagrá de Oliveira[2], Luciane Prado Kantorski[3], Mariana Luchese Vasem[4], Elitiele Ortiz dos Santos[5], Adriane Domingues Eslabão[6]

ABSTRACT

Objective: to analyze the self-evaluation of physical health among users of the psychosocial care network of Southern Brazil. ***Method:*** cross-sectional study, cut from the REDESUL research. The sample was composed of 392 members of SRT and CAPS (health services). To assess the users' perception of physical health, researchers used a question divided in scale of five categories (excellent, very good, good, fair or poor). The self-assessment fair or poor was seen as the outcome. ***Results:*** the self-assessment of physical health as fair or poor featured a prevalence of 41.65%. Gross analysis indicated the association of this evaluation with variables of sociodemographic aspects, morbidity conditions, type of service and support. ***Conclusion:*** self-assessment of health is closely linked to health services that the individual attends. ***Descriptors:*** Self-Assessment; Mental Health; Mental Health Services.

RESUMO

Objetivo: analisar a autoavaliação de saúde física entre usuários da rede de atenção psicossocial da região Sul do Brasil. ***Método:*** estudo transversal, recorte da pesquisa REDESUL. A amostra foi composta por 392 usuários de SRT e CAPS. Para avaliar a percepção dos usuários sobre a saúde física, utilizou-se uma pergunta dividida em escala de cinco categorias (excelente, muito bom, bom, regular ou ruim). Assumiu-se como desfecho a autoavaliação regular ou ruim. ***Resultados:*** a autoavaliação de saúde física regular ou ruim caracterizou uma prevalência de 41,65%. A análise bruta indicou a associação dessa avaliação com variáveis de aspectos sociodemográficos, condições de morbidade, tipo de serviço e apoio. ***Conclusão:*** a autoavaliação de saúde está intimamente ligada aos serviços de saúde que o indivíduo frequenta. ***Descritores:*** Autoavaliação; Saúde Mental; Serviços de Saúde Mental.

RESUMEN

Objetivo: analizar la autoevaluación de salud física entre usuarios de la red de atención psicosocial de la región Sur de Brasil. ***Método:*** estudio transversal, recorte de la investigación REDESUL. La muestra fue compuesta por 392 usuarios de SRT y CAPS. Para evaluar la percepción de los usuarios sobre la salud física, se utilizó una pregunta dividida en escala de cinco categorías (excelente, muyo buena, buena, regular o mala). Se mostró como resultado la autoevaluación regular o mala. ***Resultados:*** la autoevaluación de salud física regular o mala caracterizó una prevalencia de 41,65%. El análisis bruto indicó la asociación de esa evaluación con variables de aspectos sociodemográficos, condiciones de morbilidad, tipo de servicio y apoyo. ***Conclusión:*** la autoevaluación de salud está íntimamente ligada a los servicios de salud que el individuo frecuenta. ***Descriptores:*** Autoevaluación; Salud Mental; Servicios de Salud Mental.

[1]Nurse, PhD Professor, Undergraduate / Graduate Nursing Program, Federal University of Pelotas /PPGENF/UFPel. Pelotas (RS), Brazil. Email: vandamrjardim@gmail.com; [2] Nurse, PhD Professor, Undergraduate / Graduate Nursing Program, Federal University of Pelotas /PPGENF/UFPel. Pelotas (RS), Brazil. Email: mandagara@hotmail.com; [3] Nurse, PhD Professor, Undergraduate / Graduate Nursing Program, Federal University of Pelotas /PPGENF/UFPel. Pelotas (RS), Brazil. Email: kantorski@uol.com.br; [4]Nurse, Graduated by the Federal University of Pelotas / UFPel. Pelotas (RS). Nurse in the City of São José do Ouro / RS, Brazil. Email: ma.luchesevasem@hotmail.com; [5]Nurse, PhD student by the Graduate Program in Nursing, Policies and Practices in Health and Nursing, Federal University of Rio Grande do Sul / UFRGS. Porto Alegre (RS), Brazil. Email: elitiele_ortiz@hotmail.com; [6]Nurse, Master Student by the Graduate Program in Nursing, Policies and Practices in Health and Nursing, Federal University of Rio Grande do Sul / UFRGS. Porto Alegre (RS), Brazil. Email: adrianeeslabao@hotmail.com

INTRODUCTION

Mental health care in Brazil, historically marked by madhouse practices, has undergone enormous changes since the 80s, with the proposal of replacing the hospital-centered model by a network of alternative services that allow them to regain dignity and autonomy of individuals with mental disorder[1]. Among these devices there are the Psychosocial Care Centers (CAPS) and Therapeutic Residential Services (SRT).

The CAPS are institutions designed to accommodate people with mental disorders, encourage their social and family integration, support the pursuit of their own autonomy and offer multidisciplinary and interdisciplinary care. The SRT are therapeutic residences inserted in the community aimed at accommodating people coming from long hospital stays and at meeting the needs of housing and social reintegration.[1] However, people suffering psychological distress have other health needs, in addition to mental health needs. Like the general population, they are also exposed and vulnerable to other diseases.

The World Health Organization (WHO) recommends a number of indicators to assess the health of populations, among which the self-assessment of health status stands out, being one of the predictors that allows evaluating public health policies and investment needs.[2] In Brazil, the results of the Health Supplement for the National Survey by Household Sampling (PNAD), conducted in 2003, indicated that approximately 25.6% of the population aged 14 years or more (22.5% of men and 28.5% of women) self-rated their health as fair, poor or very poor. This perception of health is characteristic of people who are at increased risk of mortality from all causes compared to those who reported having very good health.[3]

The self-assessment of health, despite being a subjective estimate that combines physical, psychological and social aspects, has been more effective than other measurements of health status, since the integration of these aspects directly influences the individual's quality of life and welfare.[4] This is a health measurement that reflects the general state of the person, regardless of illness, but focused on features that might interfere with their health satisfaction.

Considering the CAPS and the SRT as strategic devices in changing the situation of mental health care in the country and that the physical and mental state of people may suffer direct influence of the context in which they live, we believe that research specifically aimed at self-assessment of physical health are potentially generators of support to consolidate interdisciplinary care strategies, given the lack of studies to examine the association between these variables in a representative sample of CAPS and SRT users. In this perspective, this research aims at analyze the self-assessment of physical health of users of psychosocial care network in Southern Brazil.

METHOD

This is a cross-sectional study, cut from the quantitative analysis of the research "Networks that rehabilitate - evaluating innovative experiences in the composition of psychosocial care networks - (REDESUL)". The project received funding from the National Council for Scientific and Technological Development, under announcement No. 33/2008 and approved by the Ethics Committee of the School of Dentistry, Federal University of Pelotas, under opinion No. 073/2009.

For the definition of the sample the existence of Therapeutic Residential Services (SRT) in the municipality was assumed as network marker of mental health services. So, five municipalities of Rio Grande do Sul were identified (Alegrete, Bagé, Caxias do Sul, Porto Alegre and Viamão).

The sample consisted of 392 users of Therapeutic Residential Services and Psychosocial Care Centers who agreed to participate in the study and subsequently signed an Informed Consent Form. The collection of quantitative data was carried out by 23 interviewers in five selected municipalities in the period from September to December 2009.

The data were double entered by independent digitizers in Epi-Info 6.04 software, and subsequently analyzed using Stata 9.0 software. The cleaning of the data occurred by comparing the two files and evaluating amplitude and consistency errors. The quality control included the replication of 10% of the questionnaires.

To evaluate the perception of physical health among users, the following question was used: "How do you assess your physical health in the last four weeks?", which measures the self-assessment of health status in five scale categories (excellent, very good, good, fair or poor). It was assumed as an outcome the evaluation of a negative health status, and the variable was dichotomized in positive rating (excellent, very good, good) and negative rating (fair or poor).

Demographic exposure variables were selected: age (up to 40 years, 41 years or older), gender (male and female), color (black / other, brown and white), marital status (single, married / with partner, separated / widowed) and education (no schooling, incomplete primary education, high school / higher education) - and morbidity conditions: (first diagnosis, psychiatric crisis in the last year, smoking (yes or no, ex-smoker), alcohol consumption (no, yes), other non-psychiatric health problems (yes or no) - type of service (CAPS, SRT) and support (yes or no).

In the bivariate analysis, the significance level adopted was p <0.25. The analysis, initially bivariate, selected variables for logistic regression considering a p-value of 0.25, maintaining the model.

RESULTS

The self-assessment of physical health as fair or poor reported by 392 users of SRT and CAPS featured a prevalence of 41.65%. Gross analysis indicated the results presented in Tables 1 and 2, which shows the combination of this assessment with variables of sociodemographic aspects, morbidity conditions, type of service and support.

According to Table 1, the prevalence of self-assessment of health as fair or poor was higher in people who are aged older than 41 years (52.53%) and in female (48.39%), being 2.63 and 1.70 times more likely to occur, respectively. The same evaluation predominates in self-declared brown individuals (53.13%), among married / with partner (54.22%) and among the separated / widowed (61.40%). Regarding education, this assessment was higher among the group of people who have not completed primary school, presenting odds ratio (OR) 3.08 times higher compared to individuals with no schooling.

Table 1. Prevalence and odds ratio (OR) of self-assessment of health as fair or poor among SRT and CAPS users, according to sociodemographic variables. REDESUL, RS, 2009.

Variable	n*	Prevalence (%)	Gross OR and Confidence interval (95%)	p-value
Age				
Up to 40 years old	142	29.58	1	<0.0001
41 years old or older	217	52.53	2.63 (1.70 – 4.12)	
Gender				
Male	203	35.47	1	
Female	186	48.39	1.70 (1.13 – 2.56)	0.009
Color				
Black/other	107	29.91	1	
Brown	64	53.13	2.66 (1.40 – 5.05)	
White	214	44.86	1.91 (1.16 – 3.12)	0.005
Marital status				
Single	249	32.93	1	
Married/w.partner	83	54.22	2.41 (1.45 – 4.00)	
Separated/widowed	53	61.40	3.24 (1.79 – 5.87)	<0.0001
Education				
No schooling	81	23.46	1	
Incomplete primary school	171	48.54	3.08 (1.70 – 5.58)	0.0004
High School/Higher Education	126	45.24	2.69 (1.45 – 5.02)	

* The sample differs because of the number of unknown answers.

Table 2. Prevalence and odds ratio (OR) self-assessment of health as fair or poor among SRT and CAPS users according to morbidity conditions, type of service and support. REDESUL, RS, 2009.

Variable	n*	Prevalence (%)	Gross OR and Confidence interval (95%)	p-value
1st diagnosis				
Schizophrenia	71	33.80	1	0.0048
Major Depressive Disorder	64	62.50	3.26 (1.61 – 6.61)	
Bipolar	38	57.89	2.69 (1.20 – 6.05)	
Other	34	44.12	1.55 (0.67 – 3.57)	
Crisis				
No	130	24.62	1	< 0.0001
Yes	258	50.00	3.06 (1.92 – 4.89)	
Smoking				
No	197	40.10	1	0.69
Yes	163	42.33	1.10 (0.72 – 1.67)	
Ex-smoker	29	48.28	1.39 (0.64 – 3.05)	
Alcohol				
No	361	41.83	1	0.79
Yes	22	39.29	0.90 (0.41 – 1.98)	
Health problem				
No	197	26.90	1	< 0.0001
Yes	191	56.54	3.53 (2.31 – 5.41)	
Type of service				
CAPS	247	51.42	1	< 0.0001
SRT	142	24.65	0.31 (0.19 –0.49)	
Support				
No	113	49.52	1	0.04
Yes	276	38.41	1.57 (1.01 – 2.45)	

* The sample differs because of the number of unknown answers.

In Table 2, the self-assessment of health as fair or poor was also higher among users who reported the first diagnosis as Major Depressive Disorder (62.50%). Those who referred psychiatric crisis in the last year showed a prevalence of 50% and were 3.6 times more likely to rate their physical health status as negative when compared to those who reported no crisis.

Smoking and alcohol consumption were not statistically significant in this study, however, there was a higher prevalence of negative self-assessment among former smokers, followed by smokers, compared to nonsmokers. The fact of having other non-psychiatric health problems is an important finding, and among those who have other health problems the prevalence was 56.54% and the odds ratio for individuals who do not have other problems was 3.53 (95% CI 2.31 to 5.41).

Regarding the type of service, the majority of respondents who reported negative assessment of health status was not resident of SRT (51.42%). There was worsening in the assessment of health status in relation to the negative statement of support (49.56%).

Tabela 3. Odds ratio (OR) of the self-assessment of physical health as fair or poor among SRT and CAPS users according to sociodemographic variables. REDESUL, RS, 2009.

Variable	Adjusted OR and Confidence interval (95%)	p-value
Age		
Up to 40 years old	1	0.0005
41 years old or older	2.32 (1.43 – 3.76)	
Gender		
Male	1	
Female	1.60 (1.00 – 2.57)	0.19
Color		
Black/other	1	
Brown	1.97 (1.14 – 3.42)	0.0018
White	3.45 (1.69 – 7.03)	
Marital status		
Single	1	
Married/ w.partner	2.00 (1.15 – 3.49)	0.0041
Separated/widowed	2.62 (1.32 – 5.20)	
Education		
No schooling	1	
Incomplete primary school	2.39 (1.19 – 4.80)	< 0.0001
High School/Higher Education	2.18 (1.06 – 4.50)	
1st diagnosis		
Schizophrenia	1	
Major depressive disorder	2.52 (1.01 – 6.25)	
Bipolar	1.82 (0.68 – 4.85)	0.23
Other	1.28 (0.47 – 3.47)	
Crisis		
No	1	
Yes	3.91 (1.63 – 9.42)	0.0014
Health problem		
No	1	
Yes	3.31 (1.66 – 6.60)	0.0005
Type of servisse		
CAPS	1	
SRT	0.20 (0.07 – 0.56)	0.0009
Support		
No	1	
Yes	5.08 (1.88 – 13.73)	0.0006

The self-assessment of health as fair or poor, according to Table 3, was significantly associated with individuals over 41 years old, white, separated / widowed and with incomplete primary education. There were also significant values when associated with the presence of psychiatric crisis in the last year, and other non-psychiatric health problems and type of service. That fact of not living in SRT and not receiving support demonstrated a highly significant value as for the self-evaluation of physical health as fair or poor.

In the bivariate analysis, with the exception of smoking and drinking, all variables were associated with fair or poor self-reported physical health among the population studied. However, after adjustment for confounding variables, through hierarchical logistic regression (Table 3), the findings differed regarding the skin color, which now has the highest prevalence in whites, and also in relation to gender and first diagnosis, who failed to show statistical significance, being kept in the model for confounder control.

DISCUSSION

In general, the studies on self-assessment of health refer people with mental disorders, Therapeutic Residential Service and Psychosocial Care Center users. The approaches, in most cases, include the elderly population,[5-7] people developing specific chronic diseases [2,8] and the general population.[3,4,8-12] Most of these studies found negative self-assessment of health, regardless of the type of sample and the country of research.

An analysis developed in Brazil on self-assessment of health with a sample of 285,778 people over 14 years old, based on data from the National Survey by Household Sampling (PNAD) in 2003 showed that the percentage of poor and very poor ratings increases with age both for men and women,[3] which agrees with the present study that shows that assessment in the age group above 41 years old compared to the population under this age.

Older age increases the likelihood of people developing diseases, especially chronic diseases, which are responsible for increasing

the rate of comorbidity and change in lifestyle. [13]

With regard to skin color, there were no statistically significant values among individuals who reported self-assessment of health as fair or poor, according to PNAD data.[3] In the present study, it was observed through bivariate analysis the prevalence of white people among individuals who reported fair or poor health. This result, however, should take into consideration the fact that most of the population declares to be white in the state of Rio Grande do Sul, the location of the research.

The negative self-rated health was higher among separated / widowed individuals. Married people have better self-rated health status than those who remain single forever or those who have lost a spouse through death or separation. Instability caused by divorce or death of the mate has prolonged negative impact on physical and mental aspects of the individual.[12]

The fact of not receiving support was associated with negative self-assessment of health. This variable corresponded to the result of a study of elderly residents of a community who reported not receiving support nor having someone to rely on to prepare meals and / or accompany them to the doctor when they could not go alone.[5]

It is also noteworthy a longitudinal cohort study of Swedish workers. The study showed that a weak social support, such as not receiving support nor even help from colleagues, was one of the factors related to worse self-rated health in the male population.[14] However, the population of our study does not perform paid work, it is a beneficiary population, more prone to have the perception of a worse health status than those with paid employment, according to data from the same survey.

The PNAD 2003 data showed that the negative health assessment stands in individuals who have no education and is inversely proportional to those with 12 or more years of schooling.[3] In our study, the self-assessment of health as fair or poor remained higher in individuals with incomplete primary education, followed by high school / higher education and inversely proportional to individuals with no education.

A survey conducted in 18 state capitals of Brazil demonstrated that the lower the educational level, the greater the percentage of individuals who reported worse health conditions. It was emphasized also that the educational differences in the perception of health can vary in relation to the regions of the country, and the level of schooling can interfere or not.[9] This reflects factors related to socioeconomic status, lifestyle, different environmental exposures and social inequality that guide the low education group.[9] According to a survey conducted in Psychosocial Care Centers in Southern Brazil, unfavorable socioeconomic conditions have been consistently associated with less healthy behaviors. The study showed the characterization of a population with lower socioeconomic status and less educational level compared to the general population.[15]

The Major Depressive Disorder appeared in the bivariate analysis as the first diagnosis reported by users who self-rated their physical health as fair or poor. However, this negative perception may be associated with the mental health status of the person, making them distort the way they see and evaluate themselves.[16] On the other hand, a 2009 study found that subjects with depressive behavior in fact are more likely to develop behavioral health risks, such as strict dietary habits, daily smoking, excess alcohol consumption, and other factors capable to cause comorbidities that affect the perception of health of the person.[17]

The self-assessment of health as fair and poor prevailed in individuals who reported having other non-psychiatric health problems. These results are according to a survey conducted in the United States that followed a group of people for years to analyze the change in the status of self-assessment of health in face of incident diseases. The results showed that the self-assessment of health is different before and after diagnosis, regardless of the disease. In general, the self-assessment of health was good at the beginning but decreased to a poorer evaluation among individuals who developed diseases, compared to healthy members of the cohort study.[8]

Results like these were also observed in studies on self-assessment of health with a representative sample of the male population, in which men with chronic diseases self-rated their health as poor five times more than those who reported no illness.[10]

With regard to smoking and drinking alcohol, a survey conducted by telephone in all Brazilian capitals found that a poor self-reported health featured a group of heavy smokers. Not smoking or being in the condition of former smoker reduces the risk of developing diseases, improves quality of life and promotes an increase in life expectancy.[11] In addition, another study found that the fact of drinking alcohol moderately (one to four

times per month) was associated with improved self-assessment of health compared to abstemious people.[7] However, in the present study, these two variables did not obtain significant values.

The presence of psychiatric crisis in the last year was also associated with self-assessment of health as fair or poor in this study. Authors point out that the experience of a crisis causes intense physical manifestations that may remain after complications, such as clinical problems.[18]

The fact of living in Therapeutic Residential Services was a significant protective factor for self-reported physical health as fair or poor. A study in the same type of service identified the SRT living and everyday enable users to change the style and quality of life.[19]

In addition, a survey of elderly residents of public and private geriatric institutions showed that most of those seniors rated their health as very good or good. However, the authors believe that the self-assessment of health implies some comparative evaluations, suggesting that residents in this context should compare their health situation with the others around, a factor that can result in overly positive reviews for people living in institutions.[6]

A study in a SRT in South Brazil identified activities that strengthen social bonds and autonomy of residents through incorporation into social spaces, such as churches, trade, friends, hippotherapy, water aerobics; and also in public mental health services, such as CAPS, Basic Health Unit, general hospital, emergency unit, etc.[20]

Thus, it is believed that the SRT are important tools within the mental health policy and that, by enabling activities for social inclusion and autonomy, they may promote a positive self-assessment of health.

CONCLUSION

The studies analyzed with different subjects as well as the results of this study show that a fair or poor health status tends to increase with the aging of population, reflecting the need for investments in public health in order to improve the quality of people's lives.

The self-assessment of health is closely linked to health services to which the individual attends. Thus, there is need of periodic studies aimed to evaluate services that encourage the qualification of care provided.

It is emphasized the difficulty of finding studies of self-assessment of health involving individuals in psychological distress. Thus, research on this issue need to be valued, since when subjects evaluate their own health they indicate possible paths regarding the improvement of care, financial investment and establishing of public policies.

FUNDING

National Council for Scientific and Technological Development.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Atenção à saúde- DAPE. Coordenação Geral de Saúde Mental. Reforma psiquiátrica e política de saúde mental no Brasil. Documento apresentado à Conferencia Regional de Reforma dos Serviços de Saúde Mental- 15 anos depois de Caracas. Brasília: OPAS/Brasília; 2005.

2. Theme Filha MM, Szwarcwald CL, Souza Júnior PRB. Socio-demographic characteristics, treatment coverage, and self-rated health of individuals who reported six chronic diseases in Brazil, 2003 Cad Saúde Pública. [Internet]. 2005 [cited 2013 May 12];21(1):43-53. Available from: http://www.scielo.br/scielo.php?pid=S0102-311X2005000700006&script=sci_abstract

3. Dachs JNW, Santos APR. Health self-rating in Brazil: analysis of data of the PNAD/2003. Ciênc saúde coletiva [Internet]. 2006 Oct/Dec [cited 2013 May 12];11(4):887-94. Available from: http://www.scielo.br/scielo.php?pid=S1413-81232006000400012&script=sci_arttext

4. Szwarcwald CL, Souza-Júnior PRB, Esteves MAP, Damacena GN, Viacava, Francisco. Socio-demographic determinants of self-rated health in Brazil. Cad Saúde Pública [Internet]. 2005 [cited 2013 May 15];21(supl. 1):54-64. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2005000700007

5. Nunes APN, Barreto SM e Gonçalves L G. Social relations and self- rated health: the ageing and health project. Rev bras Epidemiol [Internet]. 2012 June [cited 2013 May 15];15(2):415-28. Available from: http://www.scielo.br/scielo.php?pid=S1415-790X2012000200019&script=sci_arttext

6. Damián J, Pastor-Barriuso R, Valderrama-Gama E. Factors associated with self-rated health in older people living in institutions. BMC Geriatr [Internet]. 2008 [cited 2013 May 15];27(8):1-5. Available from:

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2291468/

7. Borim FSA, Barros MBA, Neri AL. Self-rated health in the elderly: a population-based study in Campinas, São Paulo, Brazil. Cad Saúde Pública [Internet]. 2012 Apr [cited 2013 May 22];28(4):769-80. Available from: http://www.scielo.br/scielo.php?pid=S0102-311X2012000400016&script=sci_arttext

8. Foraker RE, Rose KM, Chang PP, McNeill AM, Suchindran CM, Selvin E, et al. Socioeconomic status and the trajectory of self-rated health. Age Ageing [Internet]. 2011 [cited 2013 May 22];40(6):706-11. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21737460

9. Souza MC, Otero UB, Almeida LM, Turci, SRB, Figueiredo, VC, Lozana JA. Self-rated health and physical disabilities due to heath problems. Rev Saúde Públ [Internet]. 2008 [cited 2013 May 22];42(4):741-9. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102008000400022

10. Barreto SM, Figueiredo RC. Chronic diseases, self-perceived health status and health risk behaviors:gender differences. Rev Saúde Públ [Internet]. 2009 [cited 2013 May 22];43(2):38-47. Available from: http://www.scielo.br/scielo.php?pid=S0034-89102009000900006&script=sci_arttext&tlng=en

11. Barros MBA, Zanchetta LM, Moura ECD, Deborah CM. Auto-evaluación de la salud y factores asociados, Brasil, 2006. Rev Saúde Pública [Internet]. 2009 [cited 2011 May 12];43(supl. 2):27-37. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102009000900005

12. Hughes ME; Waite LJ. Marital Biography and Health at Mid-Life. J Health Social Behavior [Internet]. 2009 [cited 2011 May 12];50(3):344-58. Available from: http://hsb.sagepub.com/content/50/3/344.abstract

13. Brasil. Ministério da Saúde. Secretaria de Gestão Estratégica e Participativa. Vigitel Brasil 2010: vigilância de fatores de risco e proteção para doenças crônicas por inquérito telefônico. Brasília (DF): Secretaria de Vigilância em Saúde; 2011.

14. Wulff C, Lindfors P, Sverke M. Childhood general mental ability and midlife psychosocial work characteristics as related to mental distress, neck/shoulder pain and self-rated health in working women and men. J Occup Health [Internet]. 2011 [cited 2011 May 12];53(6):439-46. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22001596

15. Adamoli NA, Azevedo MR. Patterns of physical activity of people with chronic mental and behavioral disorders. Ciênc saúde coletiva [Internet]. 2009 Jan/Feb [cited 2011 May 12];14(1):243-51. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232009000100030

16. American Medical Association-APAS. Guia Essencial da Depressão. O atendimento a crise em saúde mental: ampliando os conceitos. São Paulo: Aquariana; 2002.

17. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. Prev Chronic Dis [Internet]. 2005 Jan [cited 2013 May 25];2(1):1-12. Available from: http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm

18. Ferigato SH, Campos RO, Ballarin ML. The attendance the crisis in Mental Health: Extending Concepts. Rev Psicol UNESP [Internet]. 2007 [cited 2013 May 25];6(1):31-44. Available from: http://186.217.160.122/revpsico//index.php/revista/article/viewArticle/44/83.

19. Silva DS, Azevedo DM. New practices in mental health and work in therapeutic residential service . Esc Anna Nery [Internet]. 2011 [cited 2013 May 25];15(3):602-9. Available from: http://www.scielo.br/pdf/ean/v15n3/a23v15n3.pdf

20. Cortes JM, Kantorski LP, Barros S, Antonacci MH, Magni CT, Guedes AC. Social ties of individuals in psychic distress: contributions for psychiatric nursing. J Nurs UFPE on line [Internet]. 2015 Apr [cited 2015 Nov 12];9(4):7322-9. Available from: http://www.revista.ufpe.br/revistaenfermagem/index.php/revista/article/view/7343/pdf_7519

Submission: 2015/10/11
Accepted: 2016/05/27
Publishing: 2016/07/01

Corresponding Address

Elitiele Ortiz dos Santos
Rua Lobo da Costa, 398, Ap. 23
Bairro Azenha
CEP 90050110 — Porto Alegre (RS), Brazil