



Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

ORIGINAL ARTICLE

QUALITY OF LIFE OF ELDERLY PEOPLE OF THE COMMUNITY AND ASSOCIATED FACTORS

QUALIDADE DE VIDA DE IDOSOS COMUNITÁRIOS E FATORES ASSOCIADOS

CALIDAD DE VIDA DE LA COMUNIDAD DE ANCIANOS Y FACTORES ASOCIADOS

Leiner Resende Rodrigues¹, Daniela Santos Tavares², Flavia Aparecida Dias³, Maycon Sousa Pegorari⁴, Gianna Fiori Marchiori⁵, Darlene Mara dos Santos Tavares⁶

RESUMO

Objetivo: verificar os fatores socioeconômicos e de saúde associados à qualidade de vida (QV) de idosos comunitários. **Método:** estudo analítico, transversal e observacional de abordagem quantitativa, conduzido com 1.691 idosos. Foram utilizados instrumento estruturado referente aos dados socioeconômicos e de saúde, escalas de Katz, Lawton e Brody e Depressão Geriátrica Abreviada, *World Health Organization Quality of Life-bref* (WHOQOL-BREF) e *World Health Organization Quality of Life Olders* (WHOQOL-OLD). Realizaram-se análise estatística descritiva e regressão linear ($p < 0,05$). **Resultados:** o maior preditor de menores escores de QV no domínio físico ($B = -0,375$) e facetas funcionamento dos sentidos ($B = -0,212$) e morte e morrer ($B = -0,132$) foi o maior número de morbidades. Nos domínios psicológico ($B = -0,498$), de relações sociais ($B = -0,309$), meio ambiente ($B = -0,360$) e facetas autonomia ($B = -0,151$), atividades passadas, presentes e futuras ($B = -0,200$), participação social ($B = -0,291$) e intimidade ($B = -0,149$), o principal preditor foi o indicativo de depressão. **Conclusão:** o maior número de morbidades e o indicativo de depressão associaram-se aos menores escores de QV. **Descritores:** Idoso; Qualidade de Vida; Morbidade; Saúde do idoso.

ABSTRACT

Objective: to verify the socioeconomic and health factors associated with the quality of life (QoL) of the community elderly. **Method:** an analytical, transversal and observational study, with a quantitative approach, conducted with 1,691 elderly. Structured instruments referring to socioeconomic and health data were used, Katz, Lawton and Brody scales, and Geriatric Abridged Depression, WHOQOL-BREF and WHOQOL-BREF and the WHOQOL-OLD. A descriptive statistical analysis and linear regression were carried out ($p < 0.05$). **Results:** the highest predictor of lower QoL scores in the physical domain ($B = -0.375$) and functioning facets of the senses ($B = -0.212$) and death and dying ($B = -0.132$) was the highest number of morbidities. In the psychological domains ($B = -0.498$), of social relations ($B = -0.309$), environment ($B = -0.360$) and autonomy facets ($B = -0.151$), past, present and future activities ($B = -0.200$), social participation ($B = -0.291$) and intimacy ($B = -0.149$), the main predictor was the indicative of depression. **Conclusion:** The higher number of morbidities and the indicative of depression were associated with the lower QoL scores.

Descriptors: Aged; Quality of life; Health of Elderly.

RESUMEN

Objetivo: verificar los factores socio-económicos y de salud asociados con la calidad de vida (CV) de ancianos comunitarios. **Método:** estudio analítico, transversal y observacional de enfoque cuantitativo, conducido con 1.691 ancianos. Fueron utilizados Instrumentos estructurados referentes a los datos socio-económicos y de salud, escalas de Katz, Lawton y Brody y Depresión Geriátrica Abreviada, *World Health Organization Quality of Life-bref* (WHOQOL-BREF) e *World Health Organization Quality of Life Olders* (WHOQOL-OLD). Se realizó análisis estadístico descriptivo y de regresión lineal ($p < 0.05$). **Resultados:** el mayor preditor de menores escores de CV en el dominio físico ($B = -0.375$) y facetas funcionamiento de los sentidos ($B = -0.212$) y la muerte y el morir ($B = -0.132$) fue el mayor número de morbilidades. En los dominios psicológicos ($B = -0.498$), las relaciones sociales ($B = -0.309$), el medio-ambiente ($B = -0.360$) y facetas autonomía ($B = -0.151$), actividades pasadas, presentes y futuras ($B = -0.200$), participación social ($B = -0.291$) e intimidad ($B = -0.149$), el Predictor principal fue el Identificativo de la depresión. **Conclusión:** el mayor número de morbilidad e indicativo de depresión se asociaron a los menores escores de puntuaciones de CV. **Descriptor:** Anciano; Calidad de vida; Salud del Anciano.

¹Nurse, PhD in Psychiatric Nursing, Department of Nursing in Education and Community Health of the Undergraduate Nursing Course, Health Sciences Institute, Federal University of Triangulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: leiner.r.rodrigues@gmail.com;

²Academic of the fifth semester of Medicine, Federal University of Triangulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: dani_tavares193@hotmail.com; ³Nurse, Master in Health Care, Stricto Sensu Post-Graduation Program in Health Care, Federal University of Triangulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: flaviadias_ura@yahoo.com.br; ⁴Physiotherapist, Master in Health Care, Physical Therapy Course, Federal University of Amapá/UNIFAP. Macapá (AP), Brazil. E-mail: mayconpegorari@yahoo.com.br; ⁵Nurse, Master in Health Care, Stricto Sensu Post-Graduation Program in Health Care, Federal University of Triangulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: gianna_fiori@yahoo.com.br; ⁶Nurse, PhD in Nursing, Department of Nursing in Education and Community Health, Undergraduate Nursing Course, Health Sciences Institute, Federal University of Triangulo Mineiro/UFTM. Uberaba (MG), Brazil. E-mail: darlenetavares@enfermagem.uftm.edu.br

INTRODUCTION

The process of population aging, that has been occurring in Brazil in recent years, has evidenced the need for new research in relation to the elderly population of the country, emphasizing, focus on quality of life (QoL) in several surveys.¹

The concept of QoL adopted in this study is that proposed by the World Health Organization (WHO), namely: "perception of the individual's position in life in the context of the culture and value system in which they live and in relation to their goals, Expectations, standards and concerns".²

It is known that several factors can impact the QoL of the elderly, however, research in the community is scarce, especially, using a specific instrument for this age group. Research with the elderly community in India found that they were associated with low QoL scores: advanced age ($p = 0.014$); no schooling ($p = 0.004$); spouse ($p < 0.001$), and nuclear family ($p = 0.039$); musculoskeletal disorder ($p < 0.001$), low vision ($p = 0.049$) and hearing loss ($p = 0.001$).³

In Brazil, a survey carried out among the elderly in São Paulo observed a negative impact of age and number of QoL morbidities using ShortForm 36 items (SF-36).⁴ Another study, in Minas Gerais found, as risk factors for low scores in QoL domains (WHOQOL-BREF), the use of medications, the need for medical care, the absence of coverage by private health insurance, the presence of comorbidities, sleep problems and retirement.⁵

Other research has been carried out with diverse populations, as institutionalized elderly, participants of elderly projects and hypertensives. A study among institutionalized elderly in São Paulo revealed a direct relationship between functional independence and QoL.⁶ Another survey, among elderly participants in old-age programs, found that higher education, advanced age, and absence of illness positively influence QoL.⁷ Among hypertensive elderly people, in Minas Gerais, unmarried / divorced / widowed, evangelicals, spiritists and other religious entities, and illiterates had lower QoL scores.⁸

Information on health and quality of life contributes to delineate the planning of actions in a way that meets the needs identified by the target population. On the other hand, such information becomes larger when demographic, epidemiological changes are experienced and it is intended to broaden the concept of health and focus on health promotion activities. Household surveys have

contributed greatly to the understanding of health events, since secondary source data, although essential, has been insufficient to meet the needs of health management.⁹

Faced with the scarcity of community studies and the use of instruments designed for this population, it is questioned which factors have negatively interfered in the QoL of the elderly. In this perspective, this research intends to contribute to broaden the knowledge about this subject, in order to subsidize the formulation of actions and public policies for the elderly, according to their specificities. Thus, it is intended to help strengthen management by providing equity and improvement in the QoL of this population.

OBJECTIVE

- To verify the socioeconomic and health factors associated with the Quality of Life (QoL) of the community elderly.

METHOD

Analytical, transversal and observational study, of quantitative approach. The sample was elaborated in 2005, in a longitudinal study, considering 95% confidence, 80% of power of the test, margin of error of 4.0%, for the interval estimates, and an estimated proportion of $\pi = 0.5$, for the interest proportions. Therefore, the population sample of the survey, in 2005, consisted of 2,683 elderly people and, in 2008, 2,149, since 534 elderly were excluded, of which: 199 were not found after three visits; 168 refused; 142 were Death and 25 were hospitalized.

The inclusion criteria of this study were: to be 60 years old or over; Living in the urban area of the city of Uberaba (MG), Brazil; Obtain a minimum score in the cognitive assessment according to schooling and agree to participate in the research. In this research, in 2012, 2,116 elderly people participated: 1691 were interviewed and 425, were excluded (265 due to death and 160 due to cognitive decline).

The data collection was carried out between January 2012 and January 2013. However, due to the amount of losses, the sample was recomposed from January 2013 to February 2014.

Before the interview, cognitive evaluation was done, through the Mental State Mini Exam (MMSE), translated and validated in Brazil.¹⁰ The scores range from zero to 30 points, with the cutoff points being 13 for illiterates, 18 for schooling from one to 11 years and 26 for schooling of more than 11 years.¹⁰

For the characterization of socioeconomic data, a structured instrument was used, constructed by the Collective Health Research Group / UFTM.

In order to measure quality of life, the WHOQOL-BREF, validated in Brazil,¹¹ and the World Health Organization Quality of Life of Olders (WHOQOL-OLD), also validated in the country, were used.¹²

The functional capacity was evaluated through the basic daily life activities (BDLAs), using the Scale of Independence in Daily Life Activities (Katz Scale), elaborated by Katz (1963) and adapted to the Brazilian reality.¹³ This scale consists of six items that measure performance in self-care activities.¹³

Instrumental Activities of Daily Living (IADLs) were also evaluated using the Lawton and Brody Scale, adapted in Brazil.¹⁴ This scale is composed of nine items and evaluates the ability of the elderly to perform activities without help, with partial help or if they cannot perform it.¹⁴

The indicative of depression was measured using the Abridged Geriatric Depression Scale. This scale is used for depression screening, and is validated in Brazil¹⁵, and being composed of 15 closed questions with objective answers (yes or no). Positive screening for depression is considered when the score exceeds five points.¹⁵

The interview was chosen, due to possible reading difficulty or comprehension of the items described in the questionnaire and visual problems presented by the elderly.

The variables of the study were: gender, age, marital status, schooling, home arrangement, individual income, QoL, indicative of depression.

As the interviews were carried out, the instruments were filled out and the researchers carried out the reviews. When necessary, the interview sheets were returned to the interviewer to supplement the information.

An electronic database was built on the Excel spreadsheet. The data collected was processed in a microcomputer, by two people, in double entry, for later verification of the existence of duplicate records, as well as different names between the two databases. The fields were consistently checked for wrong typing. When there was inconsistent data, it was verified, in the original interview, and its correction was carried out.

Statistical analysis was performed in the software "Statistical Package for Social

Sciences" (SPSS), version 17.0, by means of simple frequency distribution, for the categorical variables, and measures of centrality (mean) and dispersion (standard deviation), for the numerical variables.

Multivariate analysis was carried out, using linear regression, preceded by bivariate analysis, using Student's t-test and Pearson's correlation. Only the variables that obtained p value <0.10, in the bivariate analysis, were included in the regression model with reverse staggering (Backward method). Nominal variables were recategorized to become dichotomous. It was considered as a dependent variable the scores of each domain and facet of the QoL, individually, and as predictors: sex, age (in years), schooling (in years), income (without and with), number of morbidity and functional disability and the indication of depression. The tests were considered significant when p <0.05.

The research project was approved by the Research Ethics Committee of the Federal University of Triângulo Mineiro, under opinion nº 2265. The subjects of this research were contacted in their homes and after the presented the objectives, the Free and Informed Consent Term and provided the pertinent information. Only after the consent of the interviewee and signature of said Term, was the interview conducted.

RESULTS

Prevalence of female elderly (63.7%), aged 70-80 years (43.5%), married (43.1%), with 4,8 years of schooling (35.7%), income from a monthly minimum wage (47.8%) and living with the children (40.7%).

The highest percentage of the elderly considered their QoL as good (51.8%) and were satisfied with their health (47.0%).

Regarding the domains of QoL in the WHOQOL-BREF the highest score was for social relations, while the lowest, was for the environment. In WHOQOL-OLD, the highest score was in the death and dying facet and the lowest, social participation (Table 1).

Table 1 shows the distribution of QoL scores of the WHOQOL-BREF domains and WHOQOL-OLD facets of the elderly.

Table 1. Distribution of QOL scores of the WHOQOL-BREF domains and WHOQOL-OLD facets of the elderly. Uberaba (MG), Brazil, 2012.

Variables	Average	SD
WHOQOL-BREF		
Physical	61.74	18.08
Psychological	65.87	15.94
Social relations	71.20	14.65
Environment	60.40	14.28
WHOQOL-OLD		
Functioning of senses	70.75	23.39
Autonomy	65.85	30.00
Past, present and future activities	68.07	28.96
Social participation	63.41	21.96
Death and dying	74.65	29.22
Intimacy	70.04	29.32

*SD: Standard deviation.

In the bivariate analysis, they remained related to QoL in the domains: physical - gender (p <0.001), age (p <0.001), schooling (p <0.001), number of functional disability in BADL (p <0.001), number of functional disability in IADL (p <0.001), number of morbidities (p <0.001) and indicative of depression (p <0.001); psychological - gender (p<0.001), education(p <0.001), income (p = 0.033), number of functional disability in BADL (p <0.001), number of functional disability in IADL (p <0.001), number of morbidities (p <0.001) and indicative of depression (p <0.001); social relations - gender (p=0.017), age (p = 0.031), educational level (p = 0.007), number of functional disability in the BADL(p = 0.003), number of functional disability in the IADL (p <0.001), number of morbidities (p <0.001) and indicative of depression (p <0.001); environment - gender (p<0.001), education (p <0.001), number of functional disabilities in the BADL (p <0.001), number of functional disability in the IADL (p <0.001), number of morbidities (p <0.001), and indicative of depression (p <0.001); facets of functioning of senses - age (p<0.001), education (p<0.001), number of functional disabilities in the BADL (p <0.001), number of functional disability in the IADL(p <0.001), number of morbidities (p <0.001) 0.001) and indicative of depression (p <0.001); autonomy - gender (p+0,089), age (p = 0.028), educational level (p = 0.011), number of functional disability in BADL (p = 0.004), number of functional disability in IADL

(p <0.001), number of morbidities (p <0.001) and indicative of depression (p <0.001); past, present and future activities - education (P = 0.043), number of functional disability in the BADL (p <0.001), number of functional disability in the IADL (p = 0.029), number of morbidities (p = 0.056) and indicative of depression (p<0.001); social participation - gender (p=0.038), education (p = 0.026), number of functional disability in BADL (p <0.001), number of functional disability in the IADL (p <0.001), number of morbidities (p <0.001) and indicative of depression (p <0.001); death and dying - gender (p=0,001) income (p = 0.012), number of functional disability in BADL (p = 0.078), number of morbidities (p <0.001) and indicative of depression (p <0.001); intimacy - gender (p = 0.011), schooling (p = 0.007), number of morbidities (p <0.001) and indicative of depression (p <0.001).

In the multivariate model, the number of morbidities was the highest predictor of lower scores in the physical domain (B = -0.375) and facets (B = -0.212) and death and dying (B = -0,132), Tables 2 and 3.

In the psychological domains (B = -0.498), social relations (B = -0,309) and environment (B = -0.360), and; (B = -0,291), and intimacy (B = -0,149), the indicative of depression was the main predictor of lower scores, Tables 2 and 3.

Tables 2 and 3 show the factors associated with the QoL scores of the studied population.

Tabela 2. Regression model of factors associated with QoL scores, WHOQOL-BREF, of the study population. Uberaba (MG), Brazil, 2012.

Variables	Initial model		Final model	
WHOQOL-BREF	B	p	B	p
	standard		standard	
Physical				
Gender	-0.001	0.952	-	-
Age	-0.032	0.090	-	-
Education	0.087	<0.001	0.092	<0.001
BADL disability	-0.053	0.007	-0.053	0.007
Disability IADL	-0.184	<0.001	-0.192	<0.001
Morbidities	-0.374	<0.001	-0.375	<0.001
Indicative of depression	0.323	<0.001	0.322	<0.001
Psychological				
Gender	-0.086	<0.001	-0.089	<0.001
Education	0.087	<0.001	0.088	<0.001
Income	0.004	0.857	-	-
BADL disability	-0.024	0.247	-	-
Disability IADL	-0.082	<0.001	-0.089	<0.001
Morbidities	-0.120	<0.001	-0.121	<0.001
Indicative of depression	0.497	<0.001	0.498	<0.001
Social relationships				
Gender	-0.024	0.323	-	-
Age	0.092	<0.001	0.070	0.002
Education	0.035	0.130	-	-
BADL disability	-0.010	0.691	-	-
Disability IADL	-0.065	0.012	-	-
Morbidities	-0.069	0.005	-0.082	0.001
Indicative of depression	0.294	<0.001	0.309	<0.001
Environment				
Gender	-0.046	0.040	-0.046	0.040
Education	0.143	<0.001	0.143	<0.001
BADL disability	0.005	0.837	-	-
Disability IADL	-0.105	<0.001	-0.104	<0.001
Morbidities	-0.112	<0.001	-0.112	<0.001
Indicative of depression	0.360	<0.001	0.360	<0.001

Tabela 3. Regression model of factors associated with QoL scores, WHOQOL-OLD, of the study population. Uberaba (MG), Brazil, 2012.

Variables	Initial model		Final model	
WHOQOL-OLD	B	p	B	p
	standard		standard	
Functioning of the senses				
Age	-0.083	<0.001	-0.083	<0.001
Education	0.083	<0.001	0.083	<0.001
BADL disability	-0.057	0.017	-0.057	0.017
Disability IADL	-0.110	<0.001	-0.110	<0.001
Morbidities	-0.212	<0.001	-0.212	<0.001
Indicative of depression	0.187	<0.001	0.187	<0.001
Autonomy				
Gender	-0.015	0.561	-	-
Age	-0.026	0.295	-	-
Education	0.032	0.196	-	-
BADL disability	-0.026	0.314	-	-
Disability IADL	-0.042	0.124	-	-
Morbidities	-0.070	0.007	-0.083	0.001
Indicative of depression	0.138	<0.001	0.151	<0.001
Past, present and future activities				
Education	0.028	0.248	-	-
BADL disability	0.144	<0.001	0.144	<0.001
Disability IADL	-0.059	0.021	-0.062	0.015
Morbidities	<0.001	0.977	-	-
Indicative of depression	0.197	<0.001	0.200	<0.001
Social participation				
Sex	-0.031	0.197	-	-
Education	0.006	0.789	-	-
BADL disability	-0.049	0.044	-0.055	0.023
Disability IADL	-0.115	<0.001	-0.112	<0.001
Morbidities	-0.036	0.148	-	-
Indicative of depression	0.277	<0.001	0.291	<0.001
Death and Dying				
Sex	-0.039	0.118	-	-
Income	0.050	0.039	0.056	0.019
BADL disability	-0.013	0.586	-	-
Morbidities	-0.120	<0.001	-0.132	<0.001
Indicative of depression	0.077	0.002	0.078	0.002
Intimacy				
Sex	-0.020	0.408	-	-
Education	0.043	0.071	-	-
Morbidities	-0.081	0.002	-0.089	<0.001
Indicative of depression	0.145	<0.001	0.149	<0.001

DISCUSSION

Regarding the prevalence of the socioeconomic and demographic variables of the elderly in this study, consistent results were identified in the national scientific literature.¹⁶⁻⁷

Similar data with health self-perception and QoL were obtained among elderly people enrolled in basic health units in Belo Horizonte, in which 56.3% evaluated the quality of life as good and 52.4% were satisfied with their health.¹⁷

A survey conducted with community elders in Rio Grande do Sul identified 75 (75.10) and the lowest scores (65.09) in the WHOQOL-BREF similar to that of this study.¹⁶ A divergent result was obtained among elderly people in India, in which the highest score was for the

physical domain (55,17) and smaller social relations (36,68).³ It is inferred that the lower environmental score may be related to the limitations imposed by income considering that, in this study, those with incomes of a minimum wage prevailed, this aspect was evaluated by the respective domain.¹¹

The lower score in social participation indicates that the elderly in this study are less likely to participate in community activities. Thus, it is necessary for the health services to identify the options of community activities in the community, as well as the interests of the elderly, in order to minimize the impact in this area.

Corroborating this research, is a study with elderly people in São Paulo found that the physical aspects presented lower scores related to the greater number of morbidities.⁴ It is believed that the greater number of

morbidities can impact the dependence of medication or treatments and work capacity, evaluated, therefore, the development of intervention strategies and early screening of the elderly with this condition should be a priority in primary care, considering their negative relation and the functional impact on the life of the elderly.

Research in Turkey found consistent data in which the elderly with chronic diseases had a greater impact on the factors' functioning of the senses ($p < 0.01$).¹⁸ The scientific literature has verified the relationship between chronic morbidities and sensorial loss, the need for educational actions, together with the multidisciplinary team, with the objective of transmitting to the elderly information about the sensorial changes due to aging and its relation with chronic diseases, and thus, possible strategies for the promotion, prevention, treatment or adequacy of the loss of sensory abilities in their daily lives.

Regarding the death and dying facet, discordant data was found in Turkey, and no relation was observed between the presence of chronic diseases and impact in this facet.¹⁸ It is inferred that the presence of comorbidities may reflect negatively on the issues related to death, considering its impact on the daily life of the elderly. In this sense, it is important that the health services develop strategies to accompany and monitoring the health conditions of the elderly, especially directed to those with comorbidities, in order to minimize their impact on QoL. The elderly should, also, be screened for possible sensorial losses resulting from comorbidities and activities that favor reflection on the finitude of life.

Regarding the indication of depression as a predictor of lower scores in the psychological domain, research conducted in Spain also observed a greater impact on psychological QOL ($p < 0.01$) related to the presence of an indication of depression.²⁰ Another study showed that the elderly with more serious depression presented more errors in cognitive performance test. These may also present anxiety symptoms, favoring the decline of motor visual coordination, perception, analytical capacity, synthesis, logical reasoning and working memory²¹, being able to explain this result. This result reveals the need for follow-up of the elderly, through screening for the indication of depression, in order to prevent the development of the disease and adverse results to QoL.

The highest impact on social relationships ($p < 0.01$), due to the presence of an indication of depression, was also observed in a study in Spain.²⁰ Research in Portugal, with

institutionalized elderly people, showed a significant negative correlation ($p < 0.01$) between depressive symptomatology and levels of satisfaction, with social support suggesting that social support can attenuate depressive symptoms in the elderly.²² In this sense, it is up to the health team to investigate the elderly support network in order to maximize it.

As for the lower environmental scores, research conducted in Spain also observed a relation with indicative of depression ($p < 0.01$).²⁰ This fact may be related to the lower interest of these elderly people with recreational and leisure activities, aspects evaluated in this field.¹¹

Regarding the relation between depression and autonomy, in research in Rio Grande do Sul, autonomy was related to: non-dependence, decision-making capacity, responsibility, willingness to decide and self-confidence.²³ These aspects may be minimized by the presence of depressive symptoms. In this sense, it is up to the health professional to identify the factors that determine the decision-making capacity of the elderly, with the relatives, in order to propose strategies for their expansion.

Consistent with the data from this study, research in Paraná found that 81.5% of the elderly with depressive symptoms did not present expectations for the future. It should be noted that those in the community reported greater regrets than in previous years.²⁴ The greater impact on this aspect, indicates the need for research on this aspect as well as the need to establish a diagnosis of depression in order to establish the appropriate treatment.

The lower scores on social participation related to the indicative of depression may be due to a lack of interest in community activities. It also adds the advent of negative feelings, also considering the impact on the psychological aspect. A study in Paraná found that 69.9% of community-dwelling elderly people, with depressive symptoms, had feelings of loneliness in the last month.²⁴ The social isolation, associated with depression, denotes the need for encouragement and support for social activities, with the support of a multidisciplinary team, inserting the elderly in actions that make them feel valued and, thus, resulting in improvement of their social relations and self-esteem.

The impact of the indicative of depression on personal relationships, an aspect assessed in the intimacy facet,¹² identifies the need to stimulate this item. It is worth investigating whether the frailty of elderly relationships

could be contributing to the indicative of depression. It is believed that strengthening this network may favor the minimization of depressive symptoms.

CONCLUSION

The number of morbidities was the highest predictor of lower scores in the physical domain and functioning facets of the senses and death and dying, while the indicative of depression was the main predictor of lower scores in the psychological domains, social relations and environment and autonomy facets, past, present and future activities, social participation and intimacy.

These results indicate the need of the health teams, to identify the elderly who are more vulnerable to the involvement of these variables and, from that, develop strategies to promote QoL in order to optimize the care provided and adequate support. The importance of improving actions related to more committed domains and facets, is also emphasized, with a multidisciplinary team, identifying possible interventions for the improvement or stability of the QoL of the elderly..

FUNDING

CNPq and FAPEMIG

REFERENCES

1. Vagetti GC, Barbosa Filho VC, Moreira NB, Oliveira V, Mazzardo O, Campos W. Condições de saúde e variáveis sociodemográficas associadas à qualidade de vida em idosos de um programa de atividade física de Curitiba, Paraná, Sul do Brasil. Cad saúde pública [Internet]. 2013 May [cited 2016 Sept 30];29(5):955-69. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2013000500013
2. World Health Organization. The world health organization quality of life assessment (WHOQOL): position paper from the world health organization. Soc Sci Med. 1995;41(10):1403-09.
3. Kumar SG, Maumdar AG. Quality of Life (QOL) and Its Associated Factors Using WHOQOL-BREF Among Elderly in Urban Puducherry, India. J Clin Diagn Res [Internet]. 2014 Jan [cited 2016 Sept 30];2014;8(1):54-7. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939587/pdf/jcdr-8-54.pdf>
4. Campolina AG, Dini PS, Ciconelli RM. Impacto da doença crônica na qualidade de vida de idosos da comunidade em São Paulo (SP, Brasil). Ciênc saúde coletiva [Internet]. 2011 June [cited 2016 Sept 30];16(6):2919-25. Available from: <http://www.scielo.br/pdf/csc/v16n6/29.pdf>
5. Pereira RJ, Cotta RMM, Franceschini SCC, Ribeiro RCL, Sampaio RF, Priore SE, et al. Influência de fatores socio sanitários na qualidade de vida dos idosos de um município do Sudeste do Brasil. Ciênc saúde coletiva [Internet]. 2011 June [cited 2016 Sept 30];16(6):2907-17. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000600028
6. Murakami L, Scattolin F. Avaliação da independência funcional e da qualidade de vida de idosos institucionalizados. Rev méd hered [Internet]. 2010 Jan [cited 2016 Sept 30];(1):18-26. Available from: http://www.scielo.org.pe/scielo.php?script=sci_arttext&pid=S1018-130X2010000100004
7. Dawalibi NW, Goulart RMM, Prearo LC. Fatores relacionados à qualidade de vida de idosos em programas para a terceira idade. Ciênc saúde coletiva [Internet]. 2014 Aug [cited 2016 Sept 30];19(8):3505-12. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232014000803505
8. Andrade JMO, Rios LR, Teixeira LS, Vieira FS, Mendes DC, Vieira MA, et al. Influência de fatores socioeconômicos na qualidade de vida de idosos hipertensos. Ciênc saúde coletiva [Internet]. 2014 Aug [cited 2016 Sept 30];19(8):3497-504. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232014000803497
9. Malta DC, Leal MC, Leal MC, Costa MFL, Moraes Neto OL. Inquéritos Nacionais de Saúde: experiência acumulada e proposta para o inquérito de saúde brasileiro. Rev bras epidemiol [Internet]. 2008 May [cited 2016 Sept 30];11(supl.1):159-67. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1415-790X2008000500017
10. Bertolucci PHF, Brucki SMD, Campacci SR, Juliano Y. O mini-exame do estado mental em uma população geral: impacto da escolaridade. Arq neuropsiquiatr [Internet]. 1994 Mar [cited 2016 Sept 30];52(1):1-7. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-282X1994000100001
11. Fleck MPA, Louzada S, Xavier M, Chachamovich E, Vieira G, Santos L, et al. Aplicação da versão em português do instrumento abreviado de avaliação da qualidade de vida "WHOQOL-bref". Rev saúde pública [Internet]. 2000 Apr [cited 2016 Sept 30];34(2):178-83. Available from:

http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-8910200000200012

12. Fleck MPA, Chachamovich E, Trentini C. Development and validation of the Portuguese version of the WHOQOL-OLD module. *Rev saúde pública* [Internet]. 2006 Oct [cited 2016 Sept 30];40(5):785-91. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102006000600007

13. Lino VTS, Pereira SRM, Camacho LAB, Ribeiro Filho ST, Buksman S. Adaptação transcultural da Escala de Independência em Atividades de Vida Diária (Escala de Katz). *Cad saúde pública* [Internet]. 2008 Jan [cited 2016 Sept 30];24(1):103-12. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2008000100010

14. Santos RL, Virtuoso Júnior JS. Confiabilidade da versão brasileira da escala de atividades instrumentais da vida diária. *RBPS* [Internet]. 2008 [cited 2016 Sept 30];21(4):290-96. Available from: <http://www.redalyc.org/articulo.oa?id=40811508010>

15. Almeida OP, Almeida AS. Confiabilidade da versão brasileira da Escala de Depressão em Geriatria (GDS) versão reduzida. *Arq neuropsiquiatr* [Internet]. 1999 June [cited 2016 Sept 30];57(2-B):421-26. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-282X1999000300013&lng=pt&nrm=iso&tlng=pt

16. Vitorino LM, Paskulin LMG, Vianna LAC. Qualidade de vida de idosos da comunidade e de instituições de longa permanência: estudo comparativo. *Rev Latino-Am Enferm* [Internet]. 2013 Jan-Feb [cited 2016 Sept 30];21(9):1-9. Available from: http://www.scielo.br/scielo.php?pid=S0104-11692013000700002&script=sci_arttext&tlng=pt

17. Silva PAB, Soares SM, Santos JFG, Silva LB. Ponto de corte para o WHOQOL-bref como preditor de qualidade de vida de idosos. *Rev saúde pública* [Internet]. 2014 June [cited 2016 Sept 30];48(3):390-97. Available from: http://www.scielo.br/scielo.php?pid=S0034-89102014000300390&script=sci_arttext&tlng=pt

18. Bilgili N, Arpacı F. Quality of life of older adults in Turkey. *Arch Gerontol Geriatr* [Internet]. 2014 Sept/Oct [cited 2016 Sept 30];59(2):415-21.

19. Meneses C, Mário MP, Marchori LLM, Melo JJ, Freitas ERF. Prevalência de perda auditiva e fatores associados na população idosa de Londrina, Paraná: estudo preliminar. *Rev CEFAC* [Internet]. 2010 May/June [cited 2016 Sept 30];12(3):384-92.

Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-18462010000300005

20. Lucas-Carrasco R, Laidlaw K, Power MJ. Suitability of the WHOQOL-BREF and WHOQOL-OLD for Spanish older adults. *Aging Ment Health* [Internet]. 2011 [cited 2016 Sept 30];15(5):595-604. Available from: <http://www.tandfonline.com/doi/abs/10.1080/013607863.2010.548054>

21. Lopes RMF, Nascimento RFL, Esteves CS, Terroso LB, Argimon ILL. Funções executivas de idosos com depressão: um estudo comparativo. *Cuad Neuropsicol* [Internet]. 2013 Dec [cited 2016 Sept 30];7(2):72-86. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0718-41232013000200005

22. Pimentel AF, Afonso RM, Pereira H. Depression and support in old age. *Psicol saúde doenças* [Internet]. 2012 [cited 2016 Sept 30];13(2):311-27. Available from: <http://www.scielo.mec.pt/pdf/psd/v13n2/v13n2a13.pdf>

23. Bredemeier SML, Wolf SH, Santos MRM, Accurso A, Soares AP, Riegel C, et al. Autonomia na velhice: concepções de idosos participantes de um programa de ação social. *Estud Interdiscipl Envelhec* [Internet]. 2011 [cited 2016 Sept 30];16(esp):371-84. Available from: <http://www.seer.ufrgs.br/index.php/RevEnvelhecer/article/view/17920/16302>

24. Teston EF, Carreira L, Marcon SS. Sintomas depressivos em idosos: comparação entre residentes em condomínio específico para idoso e na comunidade. *Rev bras Enferm* [Internet]. 2014 May/June [cited 2016 Sept 30];67(3):450-56. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-71672014000300450

Submission: 2016/09/29

Accepted: 2016/08/14

Publishing: 2017/03/15

Corresponding Address

Darlene Mara dos Santos Tavares
Universidade Federal do Triângulo Mineiro
Avenida Getúlio Guaritá, 159
CEP: 38025-440 - Uberaba (MG), Brazil