REPERCUSSIONS OF CHRONIC DISEASES ON THE MENTAL HEALTH OF ELDERLY PEOPLE

REPERCUSSÕES DO ADOECIMENTO CRÔNICO NA SAÚDE MENTAL DE PESSOAS IDOSAS REPERCUSIONES DE ENFERMEDADES CRÓNICAS EN LA SALUD DE PERSONAS ANCIANAS

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ABSTRACT

Objective: to understand the conceptions of elderly people about the repercussions of chronic diseases on their mental health. **Method:** qualitative, descriptive study with 13 elderly people diagnosed with chronic diseases registered in a Family Health Unit. The information was collected through the application of a form of a semi-structured interview script. The interviews were analyzed according to the content analysis technique. **Results:** the analysis of the content of the descriptions collected in the interviews resulted in four thematic categories: << Feelings related to the chronic disease >>; << Changes in life habits after the discovery of the chronic disease >>; << Difficulty to accept the chronic disease >> and << Search for spirituality for acceptance of the chronic disease >>. **Conclusion:** in order to reach the objective of the study, it was noticed the need to qualify professionals working in Primary Care to assist the elderly people, not only for the resolution of their demands at the moment, but also to know how to listen and identify possible repercussions that this disease brings to the lives of these individuals and to their mental health. **Descriptors:** Mental Health; Chronic disease; Elderly; Aging; Feelings; Psychosocial Impact.

RESUMO

Objetivo: compreender as concepções de pessoas idosas acerca das repercussões do adoecimento crônico na sua saúde mental. **Método:** trata-se de estudo qualitativo, descritivo, realizado com 13 pessoas idosas com diagnóstico de doenças crônicas cadastradas em uma Unidade de Saúde da Família. Coletaram-se as informações a partir da aplicação de um formulário de um roteiro de entrevista semiestruturada. Analisaram-se as entrevistas conforme a técnica de análise de conteúdo. **Resultados:** a partir da análise do conteúdo das descrições originárias das entrevistas, emergiram quatro categorias temáticas: << Sentimentos relacionados à doença crônica >>; << Mudanças nos hábitos de vida após a descoberta da doença crônica >>; << Dificuldade para aceitação da doença crônica >>; e << A busca pela espiritualidade para aceitação da doença crônica >>. **Conclusão:** percebeu-se, com o alcance do objetivo do estudo, a necessidade de qualificação dos profissionais atuantes da Atenção Básica para assistir o ser idoso, não apenas para a resolutividade de suas demandas no momento, mas também para saber ouvir e identificar as possíveis repercussões que esse adoecimento traz para a vida desses indivíduos e sua saúde mental. **Descritores:** Saúde Mental; Doença Crônica; Idoso; Envelhecimento; Sentimentos; Impacto Psicossocial.

RESUMEN

Objetivo: comprender las concepciones de personas ancianas acerca de las repercusiones de enfermedades crónicas en su salud mental. **Método:** estudio cualitativo, descriptivo, realizado con 13 personas ancianas con diagnóstico de enfermedades crónicas registradas en una Unidad de Salud de la Familia. Las informaciones fueron recogidas a partir de la aplicación de un formulario de una guía de entrevista semi-estructurada. Se analizaron entrevistas conforme a la técnica de análisis de contenido. **Resultados:** a partir del análisis de contenido de las descripciones originarias de las entrevistas, surgieron cuatro categorías temáticas: << Sentimientos relacionados a la enfermedad crónica >>; << Cambios en los hábitos de vida después de descubrir la enfermedad crónica >>; << Dificultad para aceptación de la enfermedad crónica >> y << La búsqueda por la espiritualidad para aceptación de la enfermedad crónica >>. **Conclusión:** con el alcance del objetivo del estudio, se percibió la necesidad de calificación de los profesionales actuantes de la Atención Básica para asistir el ser anciano, no apenas para la resolutividad de sus demandas en el momento, pero también para saber oír e identificar las posibles repercusiones que esa enfermedad trae para la vida de estos individuos y su salud mental. **Descriptores:** Salud mental; Enfermedad crónica; Ancianos; Envejecimiento; Sentimientos; Impacto Psicossocial.

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INTRODUCTION

During the last decades, Brazil has undergone some changes in the profile of diseases prevalent in the population. In this period of changes, two types of transition have impacted and will impact the age profile and epidemiological profile of the Brazilian population.

The demographic transition shows a decrease in birth and fertility rates, leading to an increase of the number of elderly people and of life expectancy, so that an inversion of the age pyramid takes place.¹⁻² Data from the Brazilian Institute of Geography and Statistics (IBGE) showed that by the end of the 2030s, people aged 65 and over will be more than individuals aged 0 to 15.³

The epidemiological transition, on the other hand, shows a change in the conjuncture of the most prevalent pathologies in society. The demographic transition, with the narrowing of the base and widening of the apex of the age pyramid, has as one of its consequences a greater number of chronic and degenerative diseases in the populations. Thus, there is a change characterized by the decrease of the prevalence of diseases resulting from acute conditions and which have cure or death as prognosis, and their replacement by a profile of chronic processes that last many years.⁴

Thus, chronic non-communicable diseases (CNCs) have become a public health problem, ranking first in the causes of death, which include cardiovascular pathologies, respiratory diseases and neoplasias, followed by infectious diseases. In this sense, there is an increase in social and health care costs.²

Aging is a natural process that involves progressive and inevitable changes. This process happens gradually and causes organic deterioration, as well as social, cultural and emotional transformations.⁵ As a consequence of the changes brought about by increased longevity, there is an increase in the prevalence of chronic diseases, as well as impacts on the physical, psychological and mental state of the affected individuals.¹

Chronic diseases are defined as non-communicable pathologies that rarely have cure, that is, diseases that are manifested for a prolonged time and require continuous treatment.⁶ Such diseases interfere in the quality of life of people, causing various levels of disabilities and limitations, mainly motor and mental disorders.⁷ Mental health, in turn, is affected by anxiety, depression and dementia, these being the most mentioned in studies on mental comorbidities among the elderly population. Such studies highlight

difficulties in the care for these individuals due to poor diagnosis of mental illnesses.¹ Therefore, longevity has as one of its consequences the appearance of chronic multimorbidities, because the elderly population is the most affected by these conditions and is responsible for the high number of diagnoses of chronic diseases associated with some type of psychic suffering.⁸⁻⁹ However, mental disorders go unnoticed because physicians routinely focus only on identifying clinical signs and symptoms.¹

Based on the concepts above mentioned, it is evident that aging is a process that brings loss of independence and autonomy, especially when accompanied by chronic diseases. Therefore, the object of this study is the mental health of elderly people with chronic diseases, since it is possible to perceive that chronic diseases can interfere directly in the mental health of these people. Furthermore, researches in databases showed a small number of national studies relating chronic diseases to the mental health of elderly people.

In this context, the following guiding question was established for the research: what are the repercussions of chronic diseases on the mental health of elderly people?

We believe that the results of this study may alert health professionals, especially nurses, about the importance of health care for elderly people in their wholeness, broadening the view beyond medical diagnoses, in the perspective of not relating psychic suffering as something inherent in human aging. They also will contribute to help fill a knowledge gap.

OBJECTIVE

- To understand the conceptions of elderly people about the repercussions of chronic diseases on their mental health.

METHOD

This is a qualitative and descriptive study, which is considered the most adequate to achieve of the proposed objective. The qualitative approach goes deep with respect to the meanings of human actions and relationships, becoming a meaning that cannot be captured in numbers, equations or statistics.¹⁰

The scenario was a Family Health Unit (FHU) located in the municipality of Guanambi-BA. This municipality had a total territorial area of 1,272.367 km², in 2015 and it is located 686 kilometers from the capital Salvador, with an estimated population of 86,808 inhabitants by 2016.¹¹ This FHU was chosen due to the high

number of old people registered with chronic diseases, evidenced after a survey of the amount of the elderly people of all FHUs in urban area.

Because these FHUs only have the program for the treatment and follow-up of hypertension and diabetes, the HIPERDIA, Community Health Agents (CHAs) were used as guiding informants to indicate the elderly enrolled who also had other chronic diseases, such as Alzheimer's disease, Parkinson's disease, Chronic Kidney Disease, Neoplasms etc.

Thus, 13 elderly people enrolled in this FHU participated in this study. As inclusion criteria for the participation of these individuals, the following were adopted: elderly people diagnosed with a chronic disease; who did not present cognitive deficits according to the Mini Mental State Examination (MMSE), because a cognitive impairment would make it difficult to participate in the research; and diagnosed with a chronic disease for at least one year, because we believe that experiencing the disease may be a risk factor for mental disease. Older people who were not found in their residence during three consecutive attempts were excluded.

In order to collect the information, the MMSE was initially applied to verify the existence of any cognitive impairment, and if the elderly person did not present impairment, they would continue in the study. A sociodemographic form was used for characterization of the participants, namely, sex, schooling, religion, occupation, among other information. Then, semi-structured interviews were made using a script prepared by the responsible researchers.

The interviews were recorded using a digital recorder, after the participants' authorization, and later transcribed, maintaining the reliability of the speeches. It should be noted that these transcriptions were made in concomitance with the collection period, so that it was possible to perceive the moment of data saturation to finalize the collection. In order to maintain anonymity, an identification code was chosen for each participant, using the letter "I" followed by a number indicating the order of the interview.

The information was analyzed according to the thematic content analysis technique according to Laurence Bardin. This analysis takes place in three phases, organized chronologically: pre-analysis, which consists of the exploration of the material and treatment of results, inference and interpretation. This is the organizational phase and consists of systematizing the initial ideas that will lead to

a precise scheme of the development of successive operations in a plan of analysis. The phase next phase, exploitation of the material, occurs basically in operations of codification, decomposition or enumeration, according to previously formulated rules. In the last phase, the gross results are treated in such a way as to become meaningful and valid.¹²

The collection of information was initiated after approval of the research project by the Research Ethics Committee of the State University of Bahia (UNEB) under Opinion nº 1.933.091 and CAAE: 63697117.1.0000.0057, respecting all the ethical and scientific criteria proposed by resolution Nº 466/2012 of the National Health Council (NHC) which regulates research involving human beings.¹³

Informed Consent Terms (ICT), which contain information about the research, including the objective, purpose, risks and benefits, were read to all the participants, separately, and data were collected only after voluntary acceptance and signing or fingerprinting the ICT.

RESULTS

The study was carried out with 13 (thirteen) elderly people, among which ten were women and three were men, aged between 64 and 88 years, with the majority being in the age group 70 to 79 years old, i.e. 7 (seven) people (53.85%). Regarding marital status, only one elderly woman said she was single; the others were married or widowed. All participants had been diagnosed with chronic diseases more than 05 (five) years ago and some had only one pathology or presence of multimorbidity. These diseases included systemic arterial hypertension (SAH), diabetes mellitus (DM), arthrosis, depression or some form of neoplasia. All the interviewed elderly reported using some type of medication provided by the primary health care network or obtained in drug stores linked to the Unified Health System (SUS), known as popular drug stores.

With regard to chronic diseases, 12 elderly people had SAH, five had DM, two had some type of cancer, one had sores, two had osteoporosis, two had depression, one had arthrosis and two had dyslipidemia, which is not a chronic disease but was mentioned for being associated with the other disease.

The predominance of elderly women among the participants is consistent with the profile of Brazilian aging; this profile shows a feminization of the elderly population in the country. This characterization can be explained by the violence due to external causes that affect for the most part the male sex and which can culminate in death, thus

preventing men to reach the old age. This implies in the smaller number of men among the elderly Brazilian population. In addition, the feminization of aging in the country also occurs due to the advance of medicine to reduce maternal and puerperal deaths, because women seek health services more frequently, and because they are less exposed to situations of risk, such as violence from external causes.¹⁴⁻¹⁵

Regarding schooling, ten participants stated that they had attended school and were literate. Of these, five stated that they were only literate, three said that they almost finished elementary school, considering at the time the conclusion of the fifth grade. Two said to have completed elementary school and the remaining three reported that they never went to school, and they only learnt how to sign their name.

In this sense, it is noted that the participants of this research have little or no schooling. This situation can be explained by the fact that some of them lived in rural areas during school age and also because of the difficulty of continuing their studies, due to the need to work, because all the elderly in the study had low economic status.

As for occupation, six interviewees stated that they were housewives, two practiced the profession of farmer, two worked as seamstresses, one said he was a retired driver and now helped the wife in a trade, and one claimed to be a seamstress and a retired traveling merchant. Regarding family income, 12 said they were retired, but two needed help to provide for their family, and only one declared not to receive a pension, thus surviving with the income from the trade on her own. This economic profile contributes to the frailty in the health of the elderly.

All participants reported having religion; 10 were Catholic and three were evangelicals. Studies show that individuals who have a religion tend to have a healthier psychosocial life because of the insertion in a common environment, avoiding isolation and giving meaning to their lives.¹⁶⁻¹⁷

As for leisure, eight interviewees reported having some kind of leisure, including walking, farming activities, planting vegetables, dancing forró or sewing. In contrast, the other five said they did not engage in any kind of leisure activity. In this context, a study about the leisure and mental health of hypertensive individuals showed that the practice of some type of leisure activity causes a decrease in stress as well as influences the feeling of well-being of individuals.¹⁸

The thematic content analysis of the descriptions in the interviews resulted in four thematic categories, namely: feelings related to the chronic disease; changes in life habits after the discovery of the chronic disease; difficulty in accepting chronic disease; and the search for spirituality for acceptance of the chronic disease.

DISCUSSION

◆ Feelings related to the chronic disease

As a consequence of daily living with chronic diseases, continuous and invasive treatment, depending on the disease, and which degrade the physical and psychological condition of the elderly, these patients normally experience feelings of sadness, fear and worry. However, some reported feeling joy after finding a disease that has treatment, because they have the chance of treating it, although the disease has no cure.

During the interviews, when asked what feelings emerged after the discovery of the chronic disease, the participant described feelings sadness, fear, discouragement, worry, joy, acceptance, and contentment, and there were still those who said that no feelings aroused. It is thus evident that individuals who live with some kind of disease are more likely to develop feelings that may influence the maintenance of well-being and self-esteem, as evidenced in the following statements:

[...] I was more sad [...] It was only sadness". (I1)

[...] after I took the pills and I got well, I felt joy [...]" (I2)

[...] a fear of killing me, not living anymore [...] It was only the fear that arose". (I3)

[...] sadness, because who wants to have diabetes? [...]" (I4)

[...] I got worried like that [...] I only worried in those days that the physician told me that I had high blood pressure and told me to take the pills correctly [...]. (I11)

[...] I was a little sad [...]. (I12)

The process of aging is related to several physical, social and psychological changes that can cause a multitude of feelings, such as fear, insecurity and internal conflicts that can be intensified when aging is accompanied by some kind of chronic disease. In this sense, these pathologies associated with loss of affective bonds and fear of death due to age and diseases cause greater vulnerability to mental suffering, as for example, to depression.¹⁹⁻²⁰

There is no doubt that the elderly, by the age factor, tends to experience more often situations of loss, be it from people living with them, or damage to autonomy or physical independence. These losses can in most cases

cause feelings of discouragement, sadness and fear that tend to generate the known depressive syndromes, which go unnoticed because they are considered typical emotions of elderly people.²¹ In addition, experiencing losses of loved ones can cause the feeling of approaching their own finitude, especially when it comes to an elderly person with chronic diseases.

The lifestyle that the elderly population feels obliged to adopt with the advance of age, the chronic disease, its treatment or the physical, economic and social condition that the disease incurs can cause fear, anguish, sadness, conformism, anger and insecurity. These feelings end up influencing a continued resistance to treatment, as well as the worsening of the clinical picture¹⁶. This reality resonates in the following speech:

[...] Taking medicine is bad [...] is not good no. But what can I do? I have to take it. (I7)

In the process of aging, the feeling of finitude of life can be present in the thought and cause fear in many elderly people when they relate their disease to the possibility of its cure. This type of fear is one of the most common negative sensations during the treatment phases that may lead to a transient or progressive depressive state, also causing feelings of worthlessness, lack of motivation, impotence, loss of autonomy and increased physical, emotional and financial dependence, as we can see in the following statements:

I felt so much, very sad, I was afraid, I was very afraid [...] I mean, to face the disease, the treatment. (I13)

In this way, it is noticed that the fear of the unknown, fear of death, is one of the feelings reported by the participants, thus showing that when physicians diagnose elderly people with a chronic disease, these patients tend to be afraid of what can happen, and they think always the worst, the end of life.

♦ Changes in life habits after the discovery of the chronic disease

During the interviews, elderly people listed some changes in their lives related to the disease, as we noted in the following statements:

[...] I used to walk a lot in the house of my friends, nowadays I cannot go there, for me to go has to be by car [...] I left, these physical exercises that I did [...]. (I6)

[...] I did a lot of walking, but now I cannot do it, I cannot walk. Because I go, after a while my legs drop me there [...] I fell in the door, you see, I am all wounded. Here at the door I fell". (I8)

[...] I used to sew. I stopped sewing [...]. (I10)

[...] I stopped sweeping the yard, because it is makes me bad. (I11)

After I discovered the diseases, I changed [...] if we had not taken some importance we were already dead. (I2)

It is possible to perceive that to be an elderly person means to be at a state that goes beyond the age. It has a relation with limitations within the daily situations that with the advance of years may impose emotional disorders, either slight or more serious, depending on the importance that the individuals give to their pathology.

Individuals who face some type of chronic disease see their daily habits change, being forced to face changes in their routines, body image, social and financial life, food restrictions and, depending on the pathology, liquid restrictions. Thus, the presence of the disease starts to dictate all the rules that must be followed, often affecting their relatives, such as food exceptions²³. This reality is corroborated by the following statements:

[...] I stopped drinking cachaça and eating sugar. (I5)

[...] because of the diet, I cannot eat everything. Everything I used to eat, I cannot eat anymore. Cakes, that from time to time I used to make a little cake, nowadays I do not make it anymore, because if I do I eat and I can't. So these things changed. The feeding. (I6)

The elderly population that lives with chronic diseases, for the most part, understands the need to change some eating habits that were previously common, but these people experience these transformations as a negative process of the disease. The development of feelings related to anger and revolt are expected at the first moment.

In this sense, this negativity may not be present only when the non-medicinal treatment begins, because living with a routine based on taking medicines and restricted food, or limited amount of water to be ingested in case of renal impairment, in addition to physical limitations, can influence the elderly in the decision to abandon treatment.²⁴ These barriers to mobility can be seen in the following statements:

[...] going for a walk, I do not do it anymore, because of the arthrosis [...] I stopped walking. I liked to walk, I liked to do things, to solve my things, it was all me. (I3)

[...] I used to go very often at my friends' house, nowadays I cannot go there, if I go, I have to drive there [...] I stopped, those physical exercises that I used to do. Going to church, I used to go a lot but I'm not going anymore". (I6)

[...] I have no leisure because the doctor forbade [...]. (I7)

[...] I can barely walk. I have not been able to go the fair again [...] It was every day, every day I used to go to the fair [...] I used to walk a lot, but now I can't, I am not able to walk [...] I stopped going for a walk [...]. (I8)

[...] Yes, I left it because I used to sew, I stopped sewing. I sewed for others, I used to sew". (I10)

[...] I stopped doing this, sweeping the yard [...]. (I11)

Therefore, the changes experienced by the elderly at their advanced age bring consequences to the development of activities that give pleasure and well-being. These consequences limit their autonomy, and the deprivation of work, food, leisure, and daily activities cause recurrent doubts, fear, discouragement, anguish and suffering in relation to the frustrated desire of healing and the meaning of life, which for many elderly people ends at the moment they are restricted in their daily life, different from what they were used to live.²⁰⁻¹⁸

However, besides all the changes in the life habits of this population, there is also the need to attend health services, such as family health units, not to mention the need to search for medications. Therefore, the National Policy on the Health of the Elderly makes it clear that the path to be followed within the health services, encompassing low, medium and high complexity, must start in primary care, that is, in basic health units,¹⁷ as observed in the course of the interviews in several lines, as shown below:

[...] No, I go to the health center, when they do not have it (the medicine) there, I go and get it in the drug store. (I9)

[...] I get them (the medicines) in the drug store, I am enrolled in the one there [...] I go from month to month. (I10)

[...] Because I go there in the health center; if they do not have it (the medicine), I'll pick it up in the other drug store there. (I11)

[...] Then I go [...] I get it (the medicine) there in the health center; this girl gives me, and sometimes I go to get it down there. (I12)

The health of individuals is associated with factors such as independence and autonomy to develop their activities of daily living. Dependence, diverse restrictions and the inability to perform the most basic tasks often bring to elderly people emotional disorders that can be perceived in physical health and that lead to the development of mental disorders, such as depression.¹⁹

◆ Difficulty accepting the chronic disease

Chronic conditions are considered non-communicable diseases, that is, diseases that cannot be passed from person to person through contact or through any other means, and which rarely have cure. Thus, this type of diseases have their action for an indeterminate time and require continuous treatment.⁶ Because of the need for uninterrupted care and attention, this type of diseases tends to interfere with people's quality of life and may result in varied levels of limitation and incapacity.⁷

In this context, the consequences of living with a disease that has no cure and that requires daily and often medicinal treatment can culminate in moments of denial of the diagnosis. This denial is reported by many scholars as being one of the five stages from the perspective of death. This usually happens at the time of diagnosis of the disease and is considered a moment similar to a "bumper" for unexpected news.²³

Thus, when the participants were questioned about the diseases with which they have to deal, two denied having any disease, although the diagnosis had already been informed to the patient, or they did not agree to live with this pathology, as we can observe in the following statements:

[...] I did not want to find out that I had this disease [...]. (I4)

[...] I only have high blood pressure; this is the disease I have. (I12)

The 72-year-old man interviewed has a medical diagnosis of depression, but he only claims to have hypertension, either because he does not accept/believe that he has been affected by psychic suffering, or because of the influence of the biomedical model or because of the stigma that society has created over the years against people who have some kind of mental suffering.

Two participants in the study had a diagnosis of depression, but did not report this diagnosis at the time of the interview. This diagnosis was informed by the CHA, who knew the clinical history of the participant and accompanied us, or by a family member present at the moment of the interview.

[...] What I have is a gas that goes through my whole gut [...]. (I10)

[...] Depression I felt a few days, but then it was gone. (I12)

Therefore, we noticed that when the diagnosis is related to psychological symptoms, elderly patients tend to deny the existence of the illness, because many of them feel ashamed that they are mentally ill and this is

due to the social prejudice that exists in relation to depression. Moreover, depressive symptoms are often erroneously considered to be typical of people over 60.²⁵

Because they deny the existence of depression in their life, many elderly people also reject treatment, favoring the chronic state of the mental disease, going beyond resistance to psychotropic drugs. It is a fact that relatives and those who live with elderly people start not giving importance to the complaints and manifestations of sadness and melancholy, associating them with advanced age and relating these manifestations to affective, social losses and with chronic diseases.²¹ Below is the speech of a participant who denies making use of drugs for depression.

[...] The day I do not take it (the medicine), this goes up (blood pressure) [...] I take medicine every day [...] no, I do not take drugs for depression (I12)

It was possible to perceive that the majority of the interviewed elderly live and does not deny having some type of chronic disease, except for mental disorders. The denial of mental disorders is linked to a smaller portion of the elderly people.

Another factor that may influence the denial of presenting some chronic diseases is the food and water restrictions imposed by some pathologies, mainly, among the elderly population. This is due to being forced to excluding foods from their diet that were once considered essential.

[...] I did not want to have it (the disease), not at all. (I4)

[...] Yes, many (limitations). (laughs) It was a lot. (I7)

Thus, the successful treatment of some diseases requires that these dietary restrictions be respected, but the discontentment and non-acceptance is notorious because the elderly people feel deprived of eating what they like and what was formerly part of their eating routine. The act of eating is related to values linked to the past, to family and habits. Thus, when these habits must change, this has repercussions on the meaning of life of these individuals.²⁰

♦ Search for spirituality/religiosity for acceptance of the chronic disease

Throughout the interviews, we observed that in some speeches spirituality was associated with the desire and hope of healing or with the feeling of confidence that nothing worse, such as death, could happen. This belief in God is demonstrated in the speeches of several interviewees as a feeling of conformism for acceptance of their condition, as follows:

[...] I get it is pleased to God, so I said: Oh my God, I have this problem, but behind me there is so much worse, because I at least still can walk a little, while many are bedridden". (I6)

[...] We must accept everything [...] I stick to God, because without God we are nothing". (I8)

[...] Yeah, what can we do, right? We give up for God's sake (laughs). All for the love of God. God knows what he does [...]. (I10)

[...] But God gave me the strength, and I got it (healing). (I13)

More than half of the elderly claimed to believe in God and such spirituality increases with age. This belief is often associated with the sense of well-being and with a source for emotional support, with repercussions on physical and psychological health. The practice of religiosity contributes to the balance of biopsychosocial well-being before the different demands that old age brings about.¹⁷⁻²⁶

The relationship between disease and death with support of religion brings to patients and families a feeling of strength to face and accept all the processes and obstacles related to disease. Thus, belief in God is seen as an instrument of explanation and meaning for those who live with chronic pathologies. Both religiosity and spirituality are strategies for family and patients to accept the process of disease and death as a natural and godly determined process.²³

[...] I leave it in God's hands. (I6)

[...] my leisure is to go to church". (I9)

Religion ends up providing a social connection, bringing to these patients the feeling of being part of a group, having a leisure activity, a place where people can meet, talk and exchange affections and continuous social and emotional relations, and the building of friendship ties, promoting personal satisfaction among the elderly. Religiousness brings well-being, a sense of security and comfort in relation to accepting the conditions arising from the disease and from treatment.¹⁷

Therefore, we noticed that religiosity/spirituality works for elderly people as a support for the acceptance and coping with the chronic disease, imparting a feeling of well-being and interaction in religious groups.

CONCLUSION

The exploratory research made it possible through interviews to observe the experiences of elderly people living with chronic diseases, identifying the repercussions in their lives according to the type of pathology that affects them. Based on the issues addressed in the

course of this research, the importance of the challenges experienced during this phase of life was highlighted.

According to the results obtained, it was possible to perceive that chronic diseases that require physical and food limitations and whose treatment is invasive tend to have a greater repercussion in the life and, consequently, in the mental health of the elderly. However, those who cling to religiousness/spirituality face the demands brought about by the disease as something from God and that conformism derives from understanding that it is His will.

However, when the subject is chronic pathologies, that is, diseases without cure, fear and sadness are inevitable feelings, especially at the moment of diagnosis and of implementing the first restrictions or losses, such as autonomy and independence. Therefore, these elderly people need attention from all health care areas to help them achieve health in a comprehensive way.

When isolation and sadness are mentioned among the elderly, these factors should not and cannot be seen as the natural circumstances of these people. The physical changes and the need to cope with limitations attributed only in old age, the incidence and probability of mental disorders such as depression are greater than in young adults.

Basic health units are the place these elderly people tend to attend more frequently when they search for medical prescriptions and/or medicines. In this sense, it is of the utmost importance that health professionals working in these environments be able to receive the elderly people, not only for the resolution of their demands at the moment, but also, to be able to hear and identify the possible repercussions that the disease brings to the life these individuals and to their mental health.

It is also important to emphasize the role of nursing professionals who work in primary care, because these professionals have a wide range of duties in the territory and they need to be trained and constantly updated to provide comprehensive health care for the elderly patients.

As a limitation of this study, the interviews need to be conducted only in the presence of CHAs as a request from the coordinator of the unit. There was also a difficulty in the understanding of some professionals within the health services regarding the importance of conducting research in this area.

Finally, we believe that this study may contribute to the understanding of health professionals regarding care for elderly people,

aiming not only their physical health, clinical signs and symptoms, but also their psychic health, not regarding suffering as something inherent in human aging.

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