Original article

Coexistence groups and mental health of the elderly: a quantitative study

Grupos de convivência e saúde mental da pessoa idosa: um estudo quantitativo

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ABSTRACT | OBJECTIVE: Describe the clinical profile and mental health aspects of elderly people who participate in social groups. **METHODS:** Quantitative study carried out with 30 women at the Centro Social Urbano, in Salvador. To collect data, validated questionnaires and scales were applied and descriptive analysis was carried out. **RESULTS:** There was a predominance of people self-identified as Black (70%), between 70 and 79 years old (40%), widows (40%), perform physical activity (90%), undergo medical follow-up (97%), do not receive psychological follow-up (90%) and hypertensive (80%). Regarding the cognitive deficit, geriatric depression and functional dependence scales, with mild and/or moderate cognitive deficit (80%), without depression (83.3%) and semi-dependence (76.67%), respectively. In the social context, they have participated for more than 20 years (30%), receive family support (60%), have a group of friends (75%), support network (85%), ability to carry out daily and leisure activities (100%), take care of their health (95%), believe that their physical health does not affect mental health (55%), reported good mental health (65%), pleasure in living their lives (85%), express their feelings (55%), would not change their lives (60%) and feel that they have lived and are living a good life (80%). **CONCLUSION:** The participation of elderly people in a social groups contributes to improving functional capacity, social relationships, and mental health.

KEYWORDS: Mental Health. Elderly Health. Coexistence Groups.

RESUMO | OBJETIVO: Descrever o perfil clínico e aspectos da saúde mental de pessoas idosas que participam de grupos de convivência. **METODOLOGIA:** Estudo quantitativo realizado com 30 mulheres no Centro Social Urbano, em Salvador. Para a coleta de dados foram aplicados questionários e escalas validadas e realizada análise descritiva. **RESULTADOS:** Observou-se predomínio da cor preta (70%), entre 70 e 79 anos (40%), viúvas (40%), realizam atividade física (90%), fazem acompanhamento médico (97%), não fazem acompanhamento psicológico (90%) e hipertensas (80%). Quanto às escalas de déficit cognitivo, depressão geriátrica e dependência-funcional, apresentam déficit cognitivo leve e/ou moderado (80%), sem depressão (83,3%) e semidependência (76,67%), respectivamente. No contexto social, participam há mais de 20 anos (30%), recebem apoio familiar (60%), possuem grupo de amigos (75%), rede de apoio (85%), capacidade de realizar atividades diárias e de lazer (100%), cuidam da saúde (95%), creem que a sua saúde física não implica a saúde mental (55%), boa saúde mental (65%), prazer em viver as suas vidas (85%), expressam seus sentimentos (55%), não mudariam sua vida (60%) e sentem que viveram e vivem uma boa vida (80%). **CONCLUSÃO:** A participação da pessoa idosa em grupo de convivência contribui para a melhoria da capacidade funcional, relacional e saúde mental.

PALAVRAS-CHAVE: Saúde Mental. Saúde do Idoso. Grupos de Convivência.

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1. Introduction

The Brazilian population is undergoing continuous and rapid demographic change. The age group that is currently expanding the most is the elderly, with growth rates of over 4% per year. Projections indicate that, by 2030, the number of elderly people will exceed that of children and adolescents aged 0 to 14 by approximately 2.28 million in the country. It is estimated that, by 2050, the elderly will represent approximately 30% of the Brazilian population[1].

The World Health Organization (WHO) defines healthy aging as "the process of developing and maintaining functional capacity that allows for well-being in old age"[1]. It also defines functional capacity based on the interactions between an individual's physical and mental resources (in this case, their intrinsic capacity) and the environments (social and physical) in which that individual lives, in order to perform activities considered important for themselves and their survival. In other words, functional capacity is linked to the adaptations, developments, and experiences of the individual as a whole[2].

There are several life changes that occur with the aging process, such as physical, physiological, and mental changes[3]. The elderly population, an increasingly significant group, is at greater risk for developing mood disorders, such as depression, which is one of the most common psychiatric disorders in this age group[4].

Physical, cognitive, and psychological changes suggest that, in order for this elderly person to maintain their balance, it will be necessary to maintain their daily activities and also modify their routine to adjust to their diminished capabilities, thus maintaining their autonomy and independence[2]. However, with the changes that occur in the psychological dimension, it is necessary to pay attention to the care of the elderly, and many forms and alternatives must be created to include these elderly people in social spaces for a better quality of life, recognition, and reintegration into society[4,5].

In the emotional context, leisure should be prioritized and understood as an activity of unique significance for each individual. Thus, leisure becomes increasingly necessary and takes on different forms, especially for the elderly, being a predictor for the maintenance of their autonomy in line with their individualities[5].

Leisure activities, aligned with health promotion actions, bring new alternatives for care and quality of life to the elderly, thus dismantling the exclusivity of a curative (disease-centered) care model[6]. For the authors cited, a welcoming and humanized approach in the development of these health actions has the potential to provide new experiences aligned with the values, desires, aspirations, and beliefs of the elderly.

Another point to highlight in relation to the vulnerability of older adults to mood disorders is the intervention with pleasant activity practice. These practices can help in the prevention, maintenance, or treatment of psychiatric diseases and, consequently, improve mood[4].

Social groups can be considered a fundamental strategy for reintegrating older adults into society, as well as reestablishing their autonomy and independence[7]. When they become regular attendees, older adults can acquire knowledge, engage in social practices, and nurture feelings and sensations that can contribute positively to their quality of life, in addition to improving interpersonal relationships with friends and family, thereby expanding their support network[3].

Studies show that social groups are idealized, socio-culturally, as places of excellence in offering leisure activities, where the participation of older adults in these places changes the public perception of this group, demystifying prejudices and, thus, expanding and offering a better quality of life and reintegration into society[4,7,8].

Actions to promote mental health, which are essential for older adults, will bring about transformative changes in the mood and lifestyle of these individuals, making them feel engaged, included, and socially integrated[8]. In view of the above, it is essential to highlight the relationship between social groups and the maintenance of mental health in older adults.

Based on this, this study aims to describe the clinical profile and mental health aspects of older adults who participate in social groups at a Centro Social Urbano — CSU (Urban Social Center) located in Salvador.

2. Methodology

This is a quantitative descriptive study conducted at the CSU located in the city of Salvador, Bahia, an institution belonging to the Secretaria de Assistência e Desenvolvimento Social (SEADES) do Governo do Estado da Bahia (Secretariat of Social Assistance and Development (SEADES) of the State Government of Bahia)[9].

The study population consisted of 30 elderly women belonging to the social group (Conviver) located at the CSU in the Narandiba neighborhood, where they frequently engage in integrative and social activities. The inclusion criteria were age over 65 and at least two years of membership in the group. Elderly people who had communication difficulties or who did not complete the research protocols were excluded. The two male members of the group refused to participate in the research.

The anonymity of the research participants was ensured, in accordance with Resolução No. 466/2012 of the Conselho Nacional de Saúde (Brazilian National Health Council Resolution No. 466/2012) and the Lei Geral de Proteção de Dados (LGPD) (Brazilian General Data Protection Law). Thus, participants were assigned an identification code, such as ID1 (Participant 1), ID2 (Participant 2), and so on. The research was submitted to and approved by the Research Ethics Committee of the Escola Bahiana de Medicina e Saúde Pública, under CAAE number 74384323.8.0000.5544 and Opinion number 6.579.469.

Data collection took place between December 2023 and February 2024 by convenience sampling of elderly people registered in the CSU social group who attended the center on collection days, with eight visits made on the days when the social group met at the center. It was carried out through a semi-structured interview conducted in a private location, manually, lasting about 30 minutes, on weekdays (Monday and Wednesday) when the elderly person had some activity at the study site and/or availability. For data collection, a questionnaire divided into two parts was applied, one with closed questions and the other with open questions and validated instruments, namely the Mini-Mental State Examination, Geriatric Depression Scale, and Lawton Scale.

The first part of the questionnaire consisted of closed questions about sociodemographics (race, place of birth, age, marital status, children, education level, employment status, salary range, dependents, religion, and housing conditions), lifestyle (diet, physical activity, smoking, and alcohol consumption), and clinical profile and health care (medical follow-up, use of medications, vaccines, psychological therapy, and most frequent comorbidities).

The second part of the questionnaire, which assessed the elderly person's participation in the group in a social context, consisted of open-ended questions and was only administered after the scales had been applied. During this part of the interviews, the responses were recorded with prior informed consent, and only 20 participants agreed to answer the questions. Its content consisted of the following questions: 1) How long have you been participating in the Conviver Group? 2) Do you receive any family support to participate in the social group? 3) Do you have a group of close friends? 4) Do you believe you have a support network you can count on? 5) Do you feel capable of performing your daily and leisure activities? 6) Do you like to take care of your health? 7) Do you consider that your physical health affects your mental health? 8) Do you feel that you have good mental health? 9) Do you enjoy living your life today? 10) Do you express your feelings often? 11) What would you change in your life today? 12) Would you like to do something that you believe could change your life right now? and 13) Do you feel that you have lived and are living a good life?

The cognitive assessment and quality of life scales were: Mini-Mental State Examination — MMSE to assess cognitive function, recent memory, time and space orientation, attention, calculation, and language. The MMSE has a total score of thirty points that include assessment of orientation, memory, attention, naming, language, and comprehension. Higher scores indicate better cognitive performance, and the cutoff points are according to the educational level of the interviewee[10].

The Geriatric Depression Scale (GDS/EDG) to screen for the existence or level of depression in older adults has a score between zero and fifteen points, with zero to five considered no depression, six to ten mild depression, and eleven to fifteen points severe depression[11].

The Lawton Instrumental Activities of Daily Living Scale (Lawton IADL) assesses seven types of daily activities and the functional independence of elderly people when performing them. This scale assesses seven instrumental activities of daily living, and the scores for each item range from one to three, with three alternatives, each with a score. A score of three means independence; two suggests semi-dependence, indicating that the elderly person needs help with certain activities; and a score of one means total dependence in performing instrumental activities of daily living. At the end of the test, the points for each item are added up; the maximum score is twenty-one, which indicates total independence, and the minimum score is seven, which shows that the person assessed is totally dependent[11].

The data collected were grouped and analyzed in an Excel for Windows spreadsheet using descriptive statistics, with absolute (*n*) and relative (%) frequencies.

3. Results

The study population consisted of 30 women. Table 1 shows the sociodemographic profile, composed mainly of elderly black women (70%) from the countryside of Bahia (60%), aged 70 to 79 years (40%), widows (40%), with children (93%), Catholic (77%), with incomplete elementary education (46.7%), retired (83.3%), with an income range of 1 to 2 minimum wages (87%), without dependents (70%), living with family members (63%), and in their own homes (87%).

Table 1. Sociodemographic profile of study participants. Salvador, Bahia, Brazil, 2024. (*n* = 30) (to be continued)

Variables	*N*	%
Race		
Black	21	70
Mixed/Multiracial	9	30
Place of birth		
Salvador	11	37
Rural areas of Bahia	18	60
Rural areas of another state	1	3
Age		
65 to 69 years old	7	23
70 to 79 years old	12	40
80 to 89 years old	8	27
90 to 99 years old	3	10
Marital status		
Single	6	20
Married	5	17
Widowed	12	40
Divorced	6	20
Common-law marriage	1	3
Children		
Yes	28	93
No	2	7
Level of education		
Illiterate	4	13.3
Incomplete elementary education	14	46.7
Complete elementary education	3	10
Incomplete secondary education	1	3
High school graduate	7	23.3
Complete higher education	1	3

Table 1. Sociodemographic profile of study participants. Salvador, Bahia, Brazil, 2024. (*n* = 30) (conclusion)

Variables	*N*	%
Employment status		
Retired	25	83.3
Pensioner	4	13.3
Unemployed	1	3.3
Salary range		
Less than 1 minimum wage	2	7
1 to 2 minimum wages	26	87
3 to 4 minimum wages	1	3
More than 4 minimum wages	1	3
Dependents		
None	21	70
1 to 2	9	30
Religion		
Catholic	23	77
Evangelical	4	13
Candomblé practitioner	1	3
Other	2	7
Housing situation		
Lives alone	11	37
Lives with a family member	19	63
Housing		
Own	26	87
Rented	4	13

Source: authors (2024).

Table 2 describes the lifestyle and clinical profile of the interviewees. It can be observed that 16 (53%) consider their diet to be sufficient, but could be healthier, 27 (90%) engage in physical activity, 27 (90%) have never smoked, 20 (67%) are not alcoholics, 29 (97%) reported receiving medical care, 20 (66%) reported taking one to four medications per day, 27 (90%) are up to date with their vaccinations, and 27 (90%) do not receive psychological therapy. Regarding comorbidities, the highest prevalence is systemic arterial hypertension (*n* = 24, 80%).

Table 2. Lifestyle and clinical profile of study participants. Salvador, Bahia, Brazil 2024. (*n* = 30) (to be continued)

Variables	*n*	%
Diet		
Insufficient	2	7
Sufficient, but could be healthier	16	53
Sufficient and healthy	12	40
Physical activity		
Yes	27	90
No	3	10
Smoker		
No	27	90
Former smoker	3	10
Alcoholic		
Yes	10	33
No	20	67

Table 2. Lifestyle and clinical profile of study participants. Salvador, Bahia, Brazil 2024. (*n* = 30) (conclusion)

Variables	*n*	%
Medical follow-up		
Yes	29	97
No	1	3
Number of medications per day		
1 to 4	20	66
5 or more	10	34
Vaccines		
Up to date	27	90
Outdated	3	10
Receives psychological counseling		
Yes	3	10
No	27	90
Comorbidities and pathological events		
Hypertension	24	80
Dyslipidemia	16	53
Diabetes Mellitus	13	43
Osteoporosis	8	27
Heart attack	4	13

Source: authors (2024).

Table 3 shows data related to cognitive impairment, signs of depression, and level of dependence, based on scores on the Mini-Mental State Examination (MMSE), Geriatric Depression Scale, and Lawton Scale, respectively. Regarding cognitive impairment, it was found that 6 (20%) elderly people had no cognitive impairment, 12 (40%) had mild cognitive impairment, and 12 (40%) had moderate cognitive impairment. Regarding the scores on the Geriatric Depression Scale, there was a predominance of elderly people without depression (25, or 83.3%). Regarding the Lawton Scale scores, the majority (23, or 76.67%) reported semi-dependence (score of 8 to 20), and no elderly person evaluated reached the minimum score of seven, which indicates total dependence in performing their activities of daily living.

Table 3. Distribution of participants according to cognitive deficit, signs of depression, and level of dependence. Salvador, Bahia, Brazil, 2024. (*n* = 30)

Variables	*n*	%
Cognitive impairment according to the MEEM		
No cognitive impairment	6	20.0
Mild cognitive impairment (MCI)	12	40.0
Moderate cognitive impairment (MCI)	12	40,0
Severe cognitive impairment (SCI)	0	0.0
Geriatric Depression Scale (GDS) scores		
No depression (score from 0 to 5)	25	83.3
Signs of mild depression (score of 6 to 10)	5	16.7
Signs of severe depression (score of 11 to 15)	0	0.0
Lawton Scale scores		
Total dependence (score of 7)	0	0.0
Semi-dependence (score of 8 to 20)	23	76.7
Independence (score of 21)	7	23.3

Source: authors (2024).

Table 4 describes the data from the questionnaire on the participation of older adults in a group in a social context. It was found that 6 (30%) of the interviewees have been participating in the group for more than 20 years, 12 (60%) receive family support to participate in the group, 15 (75%) have a close group of friends, 17 (85%) have a support network, 20 (100%) feel capable of performing their daily and leisure activities, 19 (95%) like to take care of their own health, 11 (55%) believe that their physical health does not affect their mental health, 13 (65%) feel they have good mental health, 17 (85%) enjoy living their lives today, 11 (55%) express their feelings frequently, 12 (60%) would not change anything in their lives today, and 16 (80%) feel they have lived and are living a good life.

Table 4. Participation of older adults in the group in the social context. Salvador, Bahia, Brazil, 2024. (*n* = 20)

Variables	*n*	%
How long have you been participating in the Conviver Group?		
Less than 10 years	7	35
10 to 20 years	7	35
Over 20 years	6	30
Do you receive any family support to participate in the social group?		
Yes	12	60
No	8	40
Do you have a close group of friends?		
Yes	15	75
No	5	25
Do you believe you have a support network you can count on?		
Yes	17	85
No	3	15
Do you feel capable of performing your daily and leisure activities?		
Yes	20	100
No	0	0.0
Do you like taking care of your health?		
Yes	19	95
No	1	5
Do you think your physical health affects your mental health?		
Yes	11	55
No	9	45
Do you feel that you have good mental health?		
Yes	13	65
No	7	35
Do you enjoy living your life right now?		
Yes	17	85
No	3	15
Do you express your feelings often?		
Yes	11	55
No	9	45
Would you change anything in your life today?		
Yes	8	40
No	12	60
Would you like to do something that you believe could change your life right now?		
Yes	11	55
No	9	45
Do you feel that you have lived and are living a good life?		
Yes	16	80
No	4	20

Source: authors (2024).

4. Discussion

Given the characterization of the results obtained, there is a considerable prevalence of black elderly women from the interior of Bahia in the social group. This corroborates literature[5,12], emphasizing that women make up this group that continuously seeks leisure, social reintegration, self-care, and engage much more in community activities than the male public, who showed less presence and involvement in actions promoted in the urban social center, in addition to not showing interest in participating in this research.

It also reinforces the fact that, due to these actions, women have a higher life expectancy[5], with the majority being 70 to 79 years old, widows, who attend religious activities inside and outside the study space, share housing with family members, and receive encouragement and care from their children, as presented in the study.

The elderly women in the study population mostly have systemic arterial hypertension and dyslipidemia, undergo regular medical follow-up, and their frequency of participation in the group highlights how much they care about self-care, obtaining essential knowledge and care for maintaining their clinical and mental condition at the CSU. Emotional support and access to up-to-date information on health care make the aging process much healthier[13].

Socialization interventions are important resources for maintaining health, and pleasant activity practices are positively understood as tools for healthy aging[4]. The results obtained through the application of MEEM converge consistently, emphasizing that participation in social groups favors the mental health of older adults. In addition, MEEM is essential for tracking cognitive changes and emotional states in older adults[10], enabling alternatives in the care process[11].

The literature shows that elderly women living in nursing homes have significantly higher depression scores when compared to women who regularly attend a social group[5]. We associate these data with the result obtained in this study through the application of the Geriatric Depression Scale (GDS) where five elderly people among the thirty interviewed showed signs of mild depression.

The CSU, a welcoming space for guidance and care, is extremely important in maintaining the health of the community. The search for this type of space enhances the involvement of older adults in social groups with the aim of reducing their levels of anxiety, stress, and depression, in addition to enabling experiences that contemplate their desires, values, and choices, removing them from social isolation and loneliness[14].

Assessing the scores of the Instrumental Activities of Daily Living (IADL) of the elderly people participating in the Conviver Group was significant for understanding how much participation in a social group also promotes autonomy and independence[11]. Preserving functional capacity, performing basic and enjoyable activities spontaneously, and even performing more complex and decisive tasks related to the condition of the elderly person are essential for promoting quality of life[13]. No elderly person in this study achieved the minimum score of seven, which indicates total dependence in performing activities of daily living.

Studies show that interventions carried out in social groups also improved performance in daily activities, both inside and outside the family environment[15]. In addition, being able to perform daily living activities enhances the dexterity and socialization skills of these individuals, especially outside the social group, thus enabling them to gain confidence and a better perception of their own health, thereby paying attention to their level of ability in their daily activities[13].

Reports on older adults' participation in the group indicate that the length of participation and family encouragement to remain in the group are of great value in strengthening and creating new bonds. Continuous presence in this space also influences social reintegration, awakening a sense of belonging and identification with the other participants[14,15]. Corroborating other studies, these places provide them with a new perspective on the aging process and recognize that these attitudes are positive for a healthy lifestyle and that they directly affect their mental health[7,14,15].

Regarding the results, the interviewees still feel capable of performing all their daily and leisure activities. Frequent visits to the CSU promote autonomy and independence, even though some of the participants need family or community support to get there. This is made clear when most of the elderly people interviewed state that they like to take care of their own health, which is in line with current literature, and that in this space they have access to knowledge and consequently develop increasing self-care skills, which is very favorable for healthy aging[14].

By explicitly stating, for the most part, that they consider physical health to be linked to mental health, that they believe they have good mental health, and that they express their feelings very frequently, it is inevitable to relate the data obtained with various studies on the aging process and the particularities of mental health in older adults[15].

The elderly women who reported forgetfulness during the interview also affirm their pleasure in living life despite the difficulties of the comorbidities that affect them, corroborating studies that show that new experiences are connected to the expression of various positive feelings and keep them away from social isolation, sadness, and vulnerability to mental disorders, reinserting them into safe and welcoming environments that favor quality of life[16].

It is in this context that social groups are increasingly valued by this population, and the CSU becomes an important health facility for the community, as it serves to caring for and socially reintegrating older adults in various spaces[14]. Aging is often associated by society with the loss of abilities and the aggravation of diseases[11]. The participation of older adults in social groups gives new meaning to the aging process[14].

It is clear from this that the benefits of group interaction are indisputable, as it mainly contributes to the delay progression of various diseases that affect the elderly and promotes self-awareness regarding their health, enabling them to treat physical and mental illnesses such as depression and Alzheimer's with greater awareness[11,14,17].

Considering the results found and their interpretation, it is noteworthy that when developing the process of caring for the elderly, the approach of primary care health professionals working in urban social centers should be integrated, also focusing on the mental health of this group. After all, various emotional and psychological problems lead to physical problems, and many physical problems, such as the comorbidities that most affect older adults, impact the mental health of these individuals[17,18].

By developing and implementing strategies capable of understanding older adults and the contexts in which they live, healthcare professionals can more quickly and compassionately detect situations of emotional crisis or signs of psychiatric disorders. Interventions can be designed with or without the assistance of the support network or family, and subsequently, an appropriate referral can be made more appropriately to alleviate any psychological distress and thus promote healthy aging[17,18].

Finally, it should be noted that this study has limitations, including low participant adherence and the fact that the responses given may have been influenced by biases, as the topic involved feelings and experiences that could compromise the health of elderly person, even though the confidentiality of the participants was guaranteed and maintained. However, the study invites other researchers to replicate it, allowing strategies to be identified for maintaining the health of older adults in a social group.

5. Conclusion

The continuous maintenance of physical and mental capacities promotes quality of life and well-being in the process of healthy aging. For this reason, it is essential to understand the many changes involved in this process and to develop actions that positively impact the experience of the elderly. Therefore, public facilities such as the CSU become important elements in the development of beneficial approaches to health, making it possible to combine clinical care with changes in habits and lifestyle linked to the social interactions that are promoted in these environments.

The research highlights that participation in social groups promotes the formation of support networks and reduces social isolation, which contribute positively to improving the mental health, functional capacity, and progression of autonomy and independence of the interviewees. Furthermore, the results substantiate that the perception of health and self-care of the elderly should be dynamized due to the particularities of everyone.

Based on the data obtained, it is expected that this study will support healthcare professionals in caring for the elderly by identifying the profile of social group participants and their needs, and to public agencies by demonstrating that the maintenance of facilities such as the CSU is essential, as they promote improved health and quality of life and reestablish important pillars that promote healthy aging.

Authors' contributions

The authors declared that they made substantial contributions to the work in terms of the conception or design of the research; the acquisition, analysis, or interpretation of data for the work; and the writing or critical revision of relevant intellectual content. All authors approved the final version to be published and agreed to take public responsibility for all aspects of the study.

Competing interest

No financial, legal, or political conflicts involving third parties (government, private companies and foundations, etc.) were declared for any aspect of the submitted work (including, but not limited to, grants and funding, participation in advisory boards, study design, manuscript preparation, statistical analysis, etc.).

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