



AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION

Sara Almeida Oliveira¹, André Akira Ramos Takahashi², Luiz Vinícius de Alcântara Sousa³

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ABSTRACT

Introduction: Affective mood disorder addresses affective manifestations considered as inappropriate for its intensity, frequency and duration. **Objective:** The theme is important for the assessment of public health measures in order to avoid an economic burden to the country and to reduce future aggravating factors on social well-being, in addition to analysing the correlation between social vulnerability and affective mood disorder. The data collection was performed by using the DATASUS from 01st January, 2010 to 31st December, 2015. Summary about how social vulnerability influences this mood disorder. **Method:** It is an observational study of ecological nature carried out by secondary data collection in the 5 Brazilian regions from 01st January, 2010 to 31st December, 2015. Men and women over 10 years old from the 5 Brazilian regions who were hospitalized due to affective mood disorder participated in this study. The data on hospitalization due to affective mood disorder were obtained under ICD-10 F-39 by using the SUS Hospital Information System on Hospital Mortality (SIH/SUS) from the IT department official website of the Unified Public Health System - DATASUS. The Gini and the IDH (HDI) indexes were collected by the Instituto de Pesquisa Econômica Aplicada (Institute of Applied Economic Research) (Ipea). **Result:** According to Figure 1 and 2, there is a decrease in the hospitalization rates in the 5 regions in both sexes. In Table 1, when comparing the five regions, a significant hospitalization rate regression due to affective mood disorder is observed in the Northeast, Southeast and South regions in both sexes; in the North region, it is present only in the female sex and no significant regression or increase in the Mid-West region. In Table 2, the results were interpreted with a detailed analysis and significant regressions or increases of hospitalization rate due to affective mood disorder were recorded. **Conclusion:** According to these studies, it is possible to notice the significant relationship between social vulnerability and the jeopardized mental health issue and, therefore, financial stability difficulties that ends up affecting not only the individual, but also an entire population.

KEYWORDS: Affective mood disorder. Social vulnerability. Epidemiology. Economic burden

INTRODUCTION

Affective mood disorder addresses affective manifestations considered as inappropriate for its intensity, frequency and duration (Piccoloto et al., 2000). Among such manifestations, the most common one is the generically called depression that is characterized by sadness, anguish and hopelessness feelings; low self-esteem; inability to experience pleasure; guilt, ruin and worthlessness ideas; pessimistic future visions and recurring thoughts about death, together with

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AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

somatic changes including sleep, appetite, psychomotor activity and sexual function (Araújo & Lotufo Neto, 2013). At the other end of the mood disorders, the manic pictures determined by an open, euphoric and irritable affection are found, in addition to thought acceleration with flight of ideas; exacerbated self-esteem and reduced sleep change, among other changes (AMERICAN PSYCHIATRIC ASSOCIATION, 2014).

In such a context, the affective mood disorder impact on the population quality of life plays a relevant role (Elliott et al., 2003; Fleck et al., 2002; Rubio, 2022). For example, some studies report a cognitive and labor force decrease in the population with depressive disorder (Shanafelt et al., 2015). Thus, the theme is important for public health measure assessment in order to avoid an economic burden to the country and to reduce future aggravating factors on social well-being.

It is still unclear up to now whether the relationship with social vulnerability would be treated as cause or effect of the affective mood disorders. This is because the lack of jobs and the social vulnerability would affect the individual insecurity and mood or this would lead to his/her professional activity loss and consequently to a greater psychosocial loss (Stranieri & Carabetta, 2015). The fact is that these factors can impact the Brazilian society; hence, its study in the vulnerable population is a matter of paramount importance to be discussed.

In the study design, several countries were considered for the analysis. Nonetheless, Brazil had an outstanding position due to its large population, its unified health system and its great social dichotomies, which has made it perfect for such a study that aims to analyse the correlation between social vulnerability and affective mood disorder.

METHOD

This is an observational study of ecological nature, carried out by secondary data collection in the 5 Brazilian regions from 01st January, 2010 to 31st December, 2015. Men and women over 10 years old from the 5 Brazilian regions who were hospitalized due to affective mood disorder participated in this study. Brazil is considered a vast country and of average income, divided into five administrative regions: North, Northeast, Southeast, South and Mid-West. These regions show population differences depending on each area. The data on hospitalization due to affective mood disorder were obtained under the ICD-10 F-39 by using the SUS Hospital Information System on Hospital Mortality (SIH/SUS) from the IT department official website of the Unified Public Health System – DATASUS. DATASUS is the IT department of the Unified Public Health System of Brazil. It is a Participatory Management Secretariat body of the Ministry of Health with responsibility of collecting, processing and disseminating information on health. This database can be consulted freely and unrestrictedly on Datasus portal (BRAZIL, 2012).

The data concerning social vulnerability count on the Gini and the HDI indexes, collected by the Instituto de Pesquisa Econômica Aplicada (Institute of Applied Economic Research) (Ipea).



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

These data concern social, work, education and income characteristics. Ipea is a federal public federation under the Ministry of Economy. Its research activities provide technical and institutional support to government actions in order to the formulate and to reformulate public policies and development programs. The Ipea aims at carrying out researches and socioeconomic studies. (IPEA, 2019).

As this study is based on secondary data, not being able to identify the individual and with the data freely and unrestrictedly available on the internet, there is no need for this project to be sent to the Comitê de Ética em Pesquisa (Research Ethics Committee) for its evaluation, as stated in the 466/2012 resolution.

RESULT

As this study was carried out by secondary data collection on TabNet, the number of men and women who participated in this sample in each region has not been recorded.

According to Figure 1 and 2, there is a decrease in the hospitalization in the 5 regions in both sexes - except for some small variables during the period represented in Figure 1 (male sex), Mid-West, between 2013 and 2015 approximately. In addition to some minimal oscillations in Figure 2 (female sex) in the Mid-West region.

In Table 1, when comparing the five regions, a significant regression in hospitalization rate due to affective mood disorder is noticed in the regions: **Northeast** (p male= 0,002, β = -0,88 and p female<0,001, β = -0,97), **Southeast** (p male<0,001, β = -1,01 and p female= 0,001 and β = -1,51) and **South** (p male= 0,006, β = -1,44 and p female= 0,027, β = -2,44) in both sexes; in the **North region**, it is noticed only in the female sex (p =0,008, β = -0,45) and no significant regression or increase in the Mid-West region was found.

In Table 2, the results were interpreted with a detailed analysis and the following regressions (negative β) or increases (positive β) (p <0,05) of the hospitalization rate due to affective mood disorder were recorded.

Male – North - 20 to 24 years (p =0,031 and β = -9,23); 25 to 29 years (p =0,023 and β = -4,42); 35 to 39 years (p =0,047 and β = **5,32**). **Northeast** – 10 to 14 years (p =0,026 and β = -0,85); 25 to 29 years (p =0,005 and β = -8,20); 30 to 34 years (p =0,020 and β = -7,33); 35 to 39 years (p =0,003 and β = -13,72); 40 to 44 years (p =0,016 and β = -10,92); 45 to 49 years (p =0,007 and β = -11,86); 50 to 54 years (p =0,016 and β = -12,80); 55 to 59 years (p =0,008 and β = -10,42); 60 to 64 years (p =0,021 and β = -5,12); 75 to 79 years (p =0,002 and β = -1,71). **Southeast** – 10 to 14 years (p =0,036 and β = -2,13); 20 to 24 years (p =0,002 and β = -7,00); 25 to 29 years (p =0,001 and β = -7,21); 30 to 34 years (p =0,001 and β = -9,971); 35 to 39 years (p =0,020 and β = -12,74); 40 to 44 years (p =0,001 and β = -17,95); 45 to 49



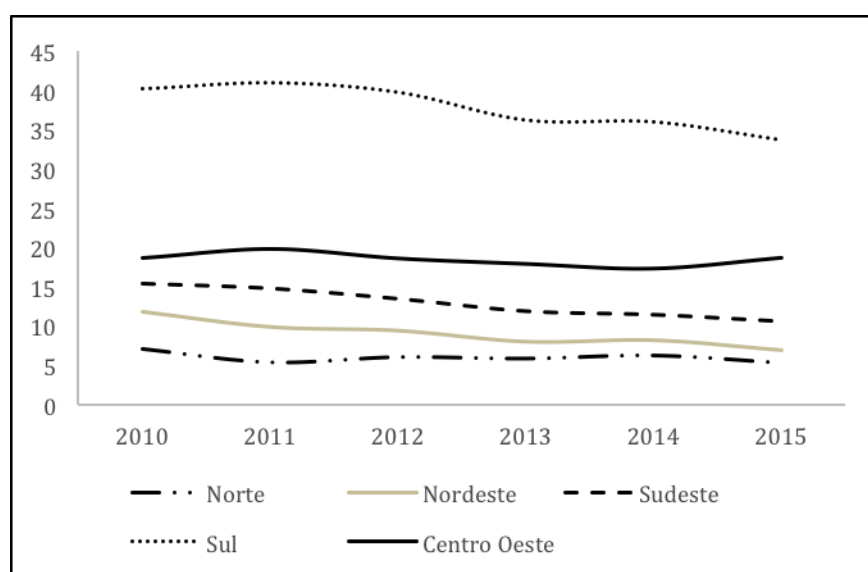
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AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

years ($p=0,001$ and $\beta=-12,43$); 50 to 54 years ($p=0,012$ and $\beta=-9,33$); 55 to 59 years ($p=0,005$ and $\beta=-9,66$); 60 to 64 years ($p=0,003$ and $\beta=-5,43$); 70 to 74 years ($p=0,003$ and $\beta=-4,15$); 80+ ($p=0,045$ and $\beta=-0,54$). **South** – 25 to 29 years ($p=0,003$ and $\beta=-16,00$); 30 to 34 years ($p=0,046$ and $\beta=-14,07$); 35 to 39 years ($p=0,001$ and $\beta=-38,02$); 40 to 44 years ($p=0,029$ and $\beta=-27,89$); 45 to 49 years ($p=0,003$ and $\beta=-35,22$). **Mid-West** – 15 to 19 years ($p=0,002$ and $\beta=30,67$); 25 to 29 years ($p=0,003$ and $\beta=-16,00$); 40 to 44 years ($p=0,018$ and $\beta=-15,12$); 65 to 69 years ($p=0,031$ and $\beta=-11,94$).

Female – North – 35 to 39 years ($p=0,019$ and $\beta=-10,83$); 80+ ($p=0,029$ and $\beta=0,94$). **Northeast** – 30 to 34 years ($p=0,001$ and $\beta=-8,04$); 35 to 39 years ($p=0,003$ and $\beta=-12,89$); 40 to 44 years ($p=0,002$ and $\beta=-18,76$); 45 to 49 years ($p=0,002$ and $\beta=-20,04$); 50 to 54 years ($p=0,004$ and $\beta=-14,07$); 55 to 59 years ($p=0,007$ and $\beta=-10,92$). **Southeast** – 20 to 24 years ($p=0,001$ and $\beta=-7,45$); 25 to 29 years ($p=0,001$ and $\beta=-14,53$); 30 to 34 years ($p=0,000$ and $\beta=-18,59$); 35 to 39 years ($p=0,007$ and $\beta=-22,26$); 40 to 44 years ($p=0,000$ and $\beta=-25,61$); 45 to 49 years ($p=0,006$ and $\beta=-26,91$); 50 to 54 years ($p=0,001$ and $\beta=-21,77$); 70 to 74 years: ($p=0,025$ and $\beta=-3,61$); 75 to 79 years ($p=0,047$ and $\beta=1,18$). **South** – 10 to 14 years ($p=0,009$ and $\beta=11,91$); 15 to 19 years ($p=0,007$ and $\beta=16,48$); 25 to 29 years ($p=0,002$ and $\beta=-39,12$); 35 to 39 years ($p=0,021$ and $\beta=-53,40$), 40 to 44 years ($p=0,000$ and $\beta=-52,62$); 45 to 49 years ($p=0,009$ and $\beta=-40,20$). **Mid-West** – 10 to 14 years ($p=0,022$ and $\beta=12,16$); 15 to 19 years ($p=0,045$ and $\beta=17,03$); 65 to 69 years ($p=0,039$ and $\beta=-12,14$).

Figure 1. Hospitalization rates due to male affective mood disorder according to Brazilian regions. Norte = North; Sul = South; Nordeste = Northeast; Centro oeste = Mid-West.



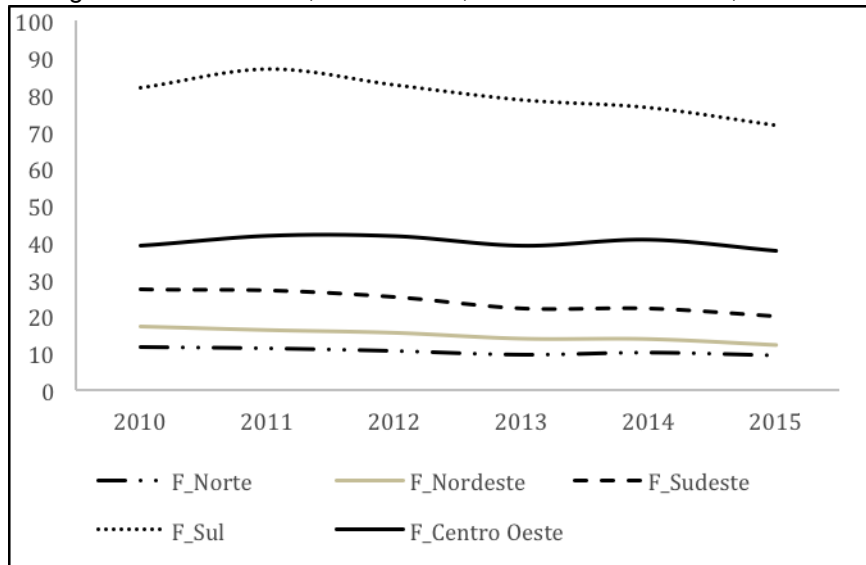
SOURCE: DATASUS, SIH/SUS e IBGE, 2020



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

Figure 2. Hospitalization rates due to female affective mood disorder according to Brazilian regions. Norte = North; Sul = South; Nordeste = Northeast; Centro oeste = Mid-West.



SOURCE: DATASUS, SIH/SUS e IBGE, 2020

Table 1. Hospitalization regression rate according to regions.

Regions	Male		Female	
	β	p	β	p
North	- 0,18	0,281	- 0,45	0,008
Northeast	- 0,88	0,002	- 0,97	<0,001
Southeast	- 1,01	<0,001	- 1,51	0,001
South	- 1,44	0,006	- 2,44	0,027
Mid-West	- 0,22	0,319	- 0,33	0,468

SOURCE: DATASUS, SIH/SUS e IBGE, 2020

Table 2. Hospitalization regression rate due to affective mood disorder of the Brazilian regions according to sex.

REGIONS	MALE		FEMALE	
	β	p	β	p
NORTH				
10 -14	- 0,42	0,305	-0,18	0,762
15-19	0,92	0,640	-2,79	0,303
20-24	-9,23	0,031	-1,68	0,568
25-29	-4,42	0,023	-2,90	0,602
30-34	-6,85	0,126	-6,88	0,264
35-39	5,32	0,047	-10,83	0,019



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR
ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
 Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

40-44	0,65	0,783	-3,93	0,412
45-49	-0,39	0,846	-12,16	0,069
50-54	-2,70	0,453	1,67	0,372
55-59	0,21	0,911	-5,01	0,056
60-64	-0,79	0,541	-1,48	0,430
65-69	-1,53	0,422	0,51	0,442
70-74	1,01	0,451	-1,89	0,298
75-79	0,25	0,717	1,42	0,172
80 and over	-0,31	0,506	0,94	0,029
NORTHEAST				
10 -14	-0,85	0,026	0,23	0,422
15-19	-0,01	0,988	-1,12	0,367
20-24	-2,92	0,187	-2,41	0,166
25-29	-8,20	0,005	-1,67	0,621
30-34	-7,33	0,020	-8,04	0,001
35-39	-13,72	0,003	-12,89	0,003
40-44	-10,92	0,016	-18,76	0,002
45-49	-11,86	0,007	-20,04	0,002
50-54	-12,80	0,016	-14,07	0,004
55-59	-10,42	0,008	-10,92	0,007
60-64	-5,12	0,021	-3,11	0,163
65-69	-1,08	0,538	-2,92	0,094
70-74	-1,25	0,198	-0,28	0,704
75-79	-1,71	0,002	-0,96	0,092
80 and over	-0,08	0,559	-0,11	0,328
SOUTHEAST				
10 -14	-2,13	0,036	-0,71	0,286
15-19	-1,65	0,241	0,31	0,818
20-24	-7,00	0,002	-7,45	0,001
25-29	-7,21	0,001	-14,53	0,001
30-34	-9,971	0,001	-18,59	0,000
35-39	-12,74	0,020	-22,26	0,007
40-44	-17,95	0,001	-25,61	0,000
45-49	-12,43	0,001	-26,91	0,006
50-54	-9,33	0,012	-21,77	0,001
55-59	-9,66	0,005	-4,94	0,133
60-64	-5,43	0,003	-5,15	0,110
65-69	-2,00	0,305	-1,93	0,504
70-74	-4,15	0,003	-3,61	0,025
75-79	0,38	0,354	1,18	0,047



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR
ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
 Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

80 and over	-0,54	0,045	0,19	0,386
SOUTH				
10 -14	-1,27	0,507	11,91	0,009
15-19	6,81	0,154	16,48	0,007
20-24	-0,26	0,844	-18,70	0,150
25-29	-16,00	0,003	-39,12	0,002
30-34	-14,07	0,046	-44,10	0,114
35-39	-38,02	0,001	-53,40	0,021
40-44	-27,89	0,029	-52,62	0,000
45-49	-35,22	0,003	-40,20	0,009
50-54	-17,55	0,057	-25,48	0,063
55-59	-5,84	0,148	-10,30	0,120
60-64	2,11	0,552	5,43	0,309
65-69	0,56	0,880	1,84	0,391
70-74	-1,43	0,384	2,24	0,439
75-79	2,10	0,235	1,49	0,146
80 and over	1,54	0,122	0,14	0,870
MID-WEST				
10 -14	14,20	0,085	12,16	0,022
15-19	30,67	0,002	17,03	0,045
20-24	0,87	0,788	-2,11	0,195
25-29	-16,00	0,003	7,24	0,327
30-34	-3,16	0,367	-16,60	0,067
35-39	-4,92	0,406	-16,41	0,153
40-44	-15,12	0,018	0,91	0,857
45-49	-12,57	0,178	-10,38	0,594
50-54	-3,69	0,254	11,00	0,249
55-59	-2,43	0,618	-13,56	0,144
60-64	-5,87	0,300	-3,55	0,360
65-69	-11,94	0,031	-12,14	0,039
70-74	4,10	0,342	-5,17	0,111
75-79	-2,05	0,124	-0,93	0,567
80 and over	-0,36	0,685	-0,60	0,258

SOURCE: THE AUTOR HIMSELF, 2020

DISCUSSION

This is the first population based work carried out in Brazil that analyses Affective mood disorder with social vulnerability.



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

Thus, the discussion is based on articles that approach the theme on Affective mood disorder and social vulnerability isolated from population base in Brazil.

A training course on mental health, held by UNASUS/UFMA, by the authors Frederico Navas Demétrio and Taís Michele Minatogawa-Chang. – São Luís, 2013, addresses the Mood Disorder theme. Three dimensions for such disorder are reported: biological, psychological and sociocultural, considering that the psychological ones such as stress and trauma contribute to this disorder; however, only stressful situations such as job loss are not enough to cause depression according to these authors. As for the sociocultural dimensions, it is perceived that women are more prone to depression due to hormone issues and socioeconomic factors, because they are poverty preferred victims; hence, they are more vulnerable to depression causing agents, mainly the divorcees. In order to justify Mood Disorder, these three dimensions have to be integrated ones and not isolated ones. Hence, it can be noticed that social vulnerability is a cause for a possible mood disorder to occur (DEMETRIO & CHANG, 2013).

According to Bellenzani and Malfitano, it is possible to address the vulnerability concept in two other dimensions: social and psychological. The latter seems pertinent due to the possibility to consider potential factors so that, synergistically, they comprise driving conditions to suffering or to psychological illness. These factors would be related to both social, historical and cultural universe, hence the social vulnerability dimension, and also to the experience of unique lives which, being combined, would be the raw material for the development of subjectivities (Bellenzani & Malfitano, 2006, p. 122). That is, the cultural, historical and social environment influences the psychological state of the individual illness by including him/her within the vulnerability term that interferes in his/her life quality and well-being (SCOTT ET AL., 2018).

Yet, a cross-sectional study that investigated the relationship between common mental disorder (CMD) and the socioeconomic condition in Brazilian adolescents from 12 to 17 years old concluded that the socioeconomic variables that were associated to CMD were suggestive of higher economic class, whereas the unpaid labor favored the adolescent mental health, results that are contrary to literature on socioeconomic condition and CMD. Such literatures with contrary results to this study show an association between social inequality and CMD, in which individuals with worse socioeconomic condition feel insecurity, lack of hope and violence risk. Moreover, CMD was associated to stress producing events, nonexistence of social support, precarious work conditions, unemployment, low schooling and income in Brazil and in several parts of the world (RIBEIRO & CORREA, 2020).

A systematic review of the scientific literature evaluates the relationship between mental disorders and the poverty context in Brazil. Some factors such as low schooling and female gender increase the CMD prevalence when associated to poverty. These disorders affect persons of all ages from the whole world, which cause socioeconomic impacts and fall in quality of life. The current review quotes some examples of how mental disorders can affect the global impact:



RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

“human capital losses, qualified and educated labor reduction, health weakening and children global development, work force loss, violence, criminality, homeless persons and poverty, premature death, vulnerable health, unemployment and expenses for the family members”. Additionally, it shows areas affected by poverty that result in consequences for the country economy: physical, health, emotional, education, productivity and family interaction. Therefore, one can perceive that the income inequalities have disseminated psychosocial effects and the mood disorders jeopardize the social logistics in the economic scope, i.e., social vulnerability implies a CMD, and the contrary is also true, but to a lesser extent (SILVA & SANTANA, 2012).

In an article published by Fiocruz, the most common mental disorder rate such as anxiety and depression related to sociodemographic characteristics in some Brazilian capitals indicated that mental health problems are higher in women, unemployed persons and those with low schooling and income. Researchers affirm that mental disorders are possible risk factors for the development of more severe disorders; thus, the need for public policies that promote improvements for mental health (MOEHLECKE, 2014).

CONCLUSION

According to these studies, it is feasible to notice a significant relationship between social vulnerability and the issue of jeopardized mental health and, therefore, some financial stability difficulties that end up affecting not only the individual but also an entire population.

Hence, the aim to discuss this subject matter is an attempt to draw attention to public policies in favor of improving life quality for these persons, to keep SUS hospitalizations due to affective mood disorder low according to place of residence and to decrease social inequalities, which consequently would also avoid an economic burden to the country.

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RECIMA21 - REVISTA CIENTÍFICA MULTIDISCIPLINAR ISSN 2675-6218

AFFECTIVE MOOD DISORDERS OF THE BRAZILIAN VULNERABLE POPULATION
Sara Almeida Oliveira, André Akira Ramos Takahashi, Luiz Vinicius de Alcântara Sousa

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