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Functional capacity and family dysfunction of the elderly in the family health strategy program in Ceará, Brazil: a cross-sectional study

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Abstract

Factors related to aging may interfere with functional capacity and family dysfunction among the elderly population. This has implications for the care provided and directs care planning to the most dependent elderly. Thus, the objective of this study was to analyze the functional capacity and family dysfunction of elderly people assisted in the Family Health Strategy in Fortaleza, Ceará. A quantitative, cross-sectional, descriptive study was carried out with 99 elderly people from a Primary Health Care Unit in Fortaleza, CE. Data collection took place between December 2015 and February 2016. The functional capacity and family relationships of the elderly were evaluated using the scales of Basic Activities of Daily Living and Instrumental Activities of Daily Living scales, as well as the APGAR Family Index. Descriptive statistics, chi-squared tests and Fisher's exact tests were used. It was observed that 82 (82.8%) of the elderly demonstrated independence for all basic activities of daily living and 59 (59.6%) were classified as independent in the assessment of instrumental activities of daily living. The application of the APGAR Family Index showed that 67 (67.6%) of the participants had a perception of good family functionality. Thus, assessing family functionality showed that most elderly people had families considered to be functional, which is a positive factor for their well-being.

Keywords: Nursing. Elderly. Primary health care. Family Health Strategy.

INTRODUCTION

Aging is linked to the interaction of several factors that involve physical health, autonomy and family support. Support and living with the family are essential elements for active aging and can be stimulated by the participation of the elderly in daily life. Failures in this process can impact the balance and harmony existing in the family relationship, affecting its functionality[1].

Family functionality is understood as the way the family is able to organize and fulfill essential functions, adapting them to the identity and trends of its members[2]. A family is considered functional when there is a definition of tasks that are clear and accepted by its components. In the opposite situation, the dysfunctional family is one in which there is disrespect, overlap in the hierarchy, noises

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in communication and there is no joining of forces to solve problems[3].

In this context, family functionality must be assessed in order to improve the planning and execution of care for the elderly. For this, the performance of the professionals of the Family Health Strategy (FHS) is essential, especially the nurse. This professional must be aware of family functionality, directing care to the real needs of the family[4].

Identifying factors of poor family functionality require health professionals to plan actions aimed at preventing or reintegrating the balance of intrafamily bonds to promote the well-being of the elderly and their family[4]. The commitment of the multiprofessional team must be focused on complete care, involving all the participants in this care, of which the elderly and their family must necessarily be a part[2].

It is noteworthy that the family is important in all vital cycles, as it favors the maintenance of the individual's integrity in its various aspects. The changes inherent to aging increase the need for care, whether physical or psychological. The existence of family dysfunction hinders the capacity for assistance and care[5].

To assess family functionality, it is necessary to use models that assist in data collection and in identifying the relationships and functions performed by the family. One of the tools that can be used for this purpose is the Family APGAR tool. It is a questionnaire developed by Gabriel Smilkstein, in 1978. After its translation, adaptation and validation, it started to be called APGAR de Familia[3,6].

Through this questionnaire, it is possible to assess the subjective satisfaction of the care received from the family member. Therefore, five items are addressed, which refer to the acronym APGAR, namely: Adaptation, Partnership, Growth, Affection and Resolve[3,6].

Although there are some studies with a similar focus[1,2,6], none were developed to assess the functional capacity and family dysfunction of elderly people monitored by the Primary Health Care Unit (UAPS), so far. Thus, the question that guided this study was: "what factors are related to functional capacity and family dysfunction in the elderly in the Family Health Strategy Program? "

In view of the above, the objective was to analyze the functional capacity and family dysfunction of elderly people assisted in the Family Health Strategy Program in Fortaleza, Ceará.

METHODOLOGY

This was a descriptive and cross-sectional study, with a quantitative approach, carried out in the city of Fortaleza, Ceará. The base population of the sutdy consisted of elderly people registered in a Primary Health Care Unit (UAPS) of the V Regional Health Department of Fortaleza. The unit served a general population of 37 thousand inhabitants. Of these, only 1,667 were elderly registered and accompanied by the UAPS team.

However, to elaborate the sampling plan, those registered in the electronic medical record system FASTMEDIC, in which 389 elderly people were registered, were considered. This electronic medical record is a tool developed to organize the work processes in the UAPS and contains the users' health history.

The sample size resulted from the calculation for the proportion in a finite population. For this, the following was considered: n=number of individuals in the sample; $Z_{\alpha/2}$ = critical value that corresponds to the desired degree of confidence (1.96); p = proportion of individuals in the population belonging to the study's category of interest, considering that the proportion of high family dysfunction at 8.8%[6]; q = population proportion of individuals that do not belong to the category of interest (q = 1 - p); E = margin of error or maximum error of the estimate (e =

0.05 - 95% confidence).

It was considered a representative sample of 99 elderly people distributed among the five family health teams present in the examined health center. To allocate them, stratified probabilistic sampling was used. Thus, from the health teams, a lottery was carried for the selection of the elderly.

The following inclusion criteria were adopted: those who were 60 years of age or older; reside in the coverage area of the chosen UAPS; were registered in the electronic medical record FASTMEDIC and were able to answer the questionnaire. Elderly people with communication difficulties and those with cognitive deficits that made the response to the instruments applied during data collection impossible were excluded from the study.

In order to experience and test the data collection instruments used, a pilot test was carried out in November 2015 with five elderly people living in other areas. The data collection itself occurred from December 2015 to February 2016, at the home of the selected elderly and was carried out by the researcher, who is a nurse at UAPS where the study was developed. The elderly participants were recruited through an invitation letter delivered by community health workers.

During the visits, the elderly who consented to participate in the research signed the informed consent form. Then, a form was applied containing data on sociodemographic identification, lifestyle habits and self-reported health conditions. An assessment of functional capacity was also carried out through the Basic Activities of Daily Living (BADL), Instrumental Activities of Daily Living (IADL) self-assessment scales and the assessment of family functionality through APGAR de *Família* tool.

For the assessment of functional capacity, two instruments widely used in research and which are suggested by the Ministry of Health were used to assess the elderly in Primary Health Care, namely: the BADL and IADL6,7 scales.

The BADL scale assesses independence in the performance of six functions: bathing; dressing; go to the bathroom; transferring; continence; eating. The scale is identified in letters, in a variation from A to G and 'other'. The letter A represents independence for all activities, the others indicate some type of dependency and G implies dependency in all activities6,7.

The IADL Scale measures the autonomy of the elderly to carry out the activities necessary to live independently in the community: using the phone, shopping, preparing meals, housework, washing clothes, using means of transport, handling medication and responsibility for financial matters. The scores vary from 9 to 27 points, in which, for each activity, the elderly person will be classified as totally dependent, partially dependent or independent. Questions 4 to 7 can vary according to sex and can be adapted for activities such as climbing stairs or taking care of a garden7.

Regarding the evaluation of family relationships, the APGAR Family Index was applied, which represents an acronym - word, formed by the first letter of each item - derived from: Adaptation, Partnership, Growth, Affection and Resolve. Its evaluation is made using a scale of 0 - 10. Possible results are: 0-4 = high family dysfunction, 5 and 6 = moderate family dysfunction, 7-10 = good family functionality.

High APGAR indices demonstrate a greater capacity to adapt the family to the new situation and possible and probable changes in roles, while a low index represents a stressful environment, of low adaptability to the new situation, requiring appropriate and urgent interventions[6].

The independent variables analyzed by this study were: sex, age, marital status, lives with children, family income, smoking history, physical activity, self-perceived health, chronic illness, medication use, independence or dependence. As for the dependent variables, they were: APGAR, IADL and BADL.

The collected data were tabulated in an Excel spreadsheet for Windows® 2013 and processed using Epi Info software, version 7. Initially, descriptive statistical procedures were applied, including frequency distribution for qualitative variables and measures of central tendency and deviation-standard (SD). For the analysis of association between independent and dependent variables, the Chi-squared test $(X)^2$ or Fisher's exact test was used, considering a significance level of 0.05.

It is valid to consider that the project was submitted to the Human Research Ethics Committee of the University of International Integration of Afro-Brazilian Lusophony (UNILAB) and obtained a favorable opinion (CEP No. 1.269.652).

RESULTS

The study sample consisted of 99 elderly people registered in a Primary Health Care Unit belonging to V regional health department of Fortaleza, CE. With regard to the sociodemographic profile, it was observed that 56 (56.5%) of the participants were female. The mean age corresponded to 70.4 years (SD = 8.0). The educational level was 3.9 years (SD = 3.3). The most observed marital status was married (n=60; 60.6%), followed by widowed (n=24; 24.2%). Regarding the number of children, the elderly participants reported an average of 4.7 children (SD = 3.1). The family income reported had an average of 1.6 minimum wages, where 73 (73.7%) elderly people claimed to be retired.

As for life habits, 67 (66.8%) of the elderly reported presently or having a history of smoking and 16 (16%) consumed alcohol. Physical inactivity was reported by 85 (85.8%) of the participants. The most reported motives were a lack of disposition (n=37; 37.3%), motor difficulties (n=25; 25.2%) and lack of time (n=16; 16.1%).

With regard to health perception, the majority of the elderly (66.6%) (n=66) considered their health to be regular. The presence of chronic diseases was reported by 81.8% (n=81) of the participants, where arterial hypertension (60.6%) (n=49), diabetes mellitus (39.3%) (n=32), cataracts (27.2%) (n=22), obesity (25.2%) (n=20) and musculoskeletal diseases (20.2%) (n=16) were the most reported. The drugs reported as the most used among the elderly were cardiovascular drugs (60.6%) (n=60).

According to APGAR Familiar, families were classified as functional or dysfunctional. The results showed that the perception of Good Family Functionality (GFF) was estimated by 67 participants (67.6%). Family Dysfunction (FD) was reported by 32 participants (32.3%), in which 14 (14.1%) had Moderate Family Dysfunction (MFD) and 18 (18.1%) had High Family Dysfunction (HFD).

The dimensions of the APGAR Familiar of elderly are adaptation, companionship, development, affection and resolving capacity, which correspond to satisfaction with the family. In the adaptation dimension, 63 (64.2%) said they were always satisfied; and with regard to the development dimension, 64 (64.6%) responded "always". This latter dimension refers to the family's acceptance of the elderly person's desire to start new activities or modify their lifestyle.

Concerning the resolving capacity dimension, 64 participants (64.6%) said they were always satisfied with the way family members organize themselves to have time to give them attention, listening and dialoging with the elderly. In this dimension, there was a higher frequency of responses "never" (n=10; 16.1%) when compared to the other dimensions. In the companionship dimension, which corresponds to the way issues of interest and reciprocity in family communication are discussed, 29 (29.2%) of the elderly answered, "a few times".

In the evaluation of Basic Activities of Daily Living (BADL), it was observed that 82 (82.8%) of the elderly participants demonstrated independence for all activities and 17.1% (n=17) were dependent in one or more activities. Considering, each of the BADLs individually, the majority of the elderly were classified as independent; the item "Feeding" was the most performed activity carried out with

independence (n=97; 98%). The activity that had the second-best performance was "Use of the toilet" (n=95; 96%).

As for the Instrumental Activities of Daily Living (IADL), it was noticed that 59 participants (59.6%) were classified as independent and 40 (40.4%) self-reported impaired functional capacity with partial dependence. Evaluating each item of the instrument, "handiwork" was the activity that most showed a level of dependency (n=25; 25.5%), followed by the activities "shopping" (n=21; 22.2%) and "washing clothes" (n=20; 20.2%).

In the bivariate analysis, there was a significant association between age and IADL classification (p=0.023). It was noted that in the age group between 60 and 69 years, 40 (40.4%) of the participants were dependent in IADL. Self-perceived health showed a statistically significant association with the APGAR Familiar (p=0.0006), since the elderly who responded with excellent\ good or regular self-perception of their health, had good family functionality.

There was also an association with statistical significance between the BADL and IADL variables (p=0.024), as 82 (82.8%) of the elderly were independent in BADL. However, 64 (64.6%) of them were dependent in at least one activity according to the IADL.

Table 1 – Association between independent and dependent variables of elderly participants in the study at a Health Center in Fortaleza, Ceará, 2019.

	APGAR			IADL		BADL	
Variables	E (%)	M (%)	B (%)	I (%)	D (%)	I (%)	D*(%)
Sex							
Male	08 (18.6)	04 (9.3)	31 (72.1)	16 (37.2)	27 (62.8)	33 (76.7)	10 (23.3)
Female	10 (17.9)	10 (17.9)	36 (64.3)	24 (42.9)	32 (57.1)	49 (87.5)	07 (12.5)
		p = 0.4758#		p =0.5703[1]		p = 0.1596[1]	
Age Range							
60 - 69 years	11 (19.6)	05 (8.9)	40 (71.4)	16 (28.6)	40 (71.4)	49 (87.5)	07 (12.5)
70 - 79 years	03 (12.0)	05 (20.0)	17 (68.0)	14 (56.0)	11 (44.0)	18 (72.0)	07 (28.0)
80 years or more	04 (22.2)	04 (22.2)	10 (55.6)	10 (55.6)	08 (44.4)	15 (83.3)	03 (16.7)
		p = 0.4374#		p = 0.0235[1]		p = 0.2318#	
Marital status							
With companion	11 (18.3)	07 (11.7)	42 (70.0)	26 (43.3)	34 (56.7)	51 (85.0)	09 (15.0)
No companion	07 (18.0)	07 (18.0)	25 (64.1)	14 (35.9)	25 (64.1)	31 (79.5)	08 (20.5)
		p = 0.6760[1]		p = 0.4612[1]		p = 0.4772[1]	
Lives with Children							
Yes	08 (16.7)	08 (16.7)	32 (66.6)	21 (43.8)	27 (56.2)	39 (81.2)	09 (18.8)
Not	10 (19.6)	06 (11.8)	35 (68.6)	19 (37.2)	32 (62.8)	43 (84.3)	08 (15.7)
		p = 0.7589[1]		p = 0.5104[1]		p = 0.6862[1]	
Family income							
Up to one salary	07 (13.7)	09 (17.7)	35 (68.6)	20 (39.2)	31 (60.8)	42 (82.4)	09 (17.6)
More than one salary	11 (22.9)	05 (10.4)	32 (66.7)	20 (41.7)	28 (58.3)	40 (83.3)	08 (16.7)
		p = 0.3540[1]		p = 0.8038[1]		p = 0.8971[1]	

to be continued...

continuation table 1...

Variables	E (%)	M (%)	B (%)	I (%)	D (%)	I (%)	D*(%)
Smoking History							
Yes	13 (19.7)	12 (18.2)	41 (62.1)	28 (43.9)	37 (56.1)	52 (78.8)	14 (21.2)
No	05 (15.2)	02 (6.1)	26 (78.8)	11 (33.3)	22 (66.7)	30 (90.9)	03 (9.1)
		p = 0.1792#		p = 0.3106[1]		p = 0.1647[2]	
Physical activity							
Yes	01 (7.1)	01 (7.1)	12 (85.8)	04 (28.6)	10 (71.4)	13 (92.9)	01 (7.1)
No	17 (20.0)	13 (15.3)	55 (64.7)	36 (42.4)	49 (57.6)	69 (81.2)	16 (18.8)
		p = 0.1792#		p = 0.3106[1]		p = 0.1647[2]	
Self-perceived Health							
Great / good	03 (15.0)	02 (10.0)	15 (75.0)	07 (35.0)	13 (65.0)	19 (95.0)	01 (5.0)
Regular	08 (12.1)	08 (12.1)	50 (75.8)	24 (36.4)	42 (63.6)	55 (83.3)	11 (16.7)
Bad / terrible	07 (53.8)	04 (30.8)	02 (15.4)	09 (69.2)	04 (30.8)	08 (61.5)	05 (38.5)
		p = 0.0006#		p = 0.0752#		p = 0.0442#	
Chronic disease							
Yes	16 (19.8)	11 (13.6)	54 (66.7)	36 (44.4)	45 (55.6)	65 (80.2)	16 (19.8)
No	02 (11.1)	03 (16.7)	13 (72.2)	04 (22.2)	14 (77.8)	17 (94.4)	01 (5.6)
		p = 0.6800#		p = 0.1121[2]		p = 0.1868[2]	
Continual Use of Medication							
Yes	16 (20.5)	10 (12.8)	52 (66.7)	35 (44.9)	43 (55.1)	64 (82,1)	14 (17,9)
No	02 (9.5)	04 (19.1)	15 (71.4)	05 (23.8)	16 (76.2)	18 (85,7)	03 (14,3)
		p = 0.4475#		p = 0.0808[1]		p = 0.6927[1]	
BADL							
Independent	13 (15.8)	10 (12.2)	59 (72.0)	29 (35.4)	53 (64.6)		
Dependent*	05 (29.4)	04 (23.5)	08 (47.1)	11 (64.7)	06 (35.3)		
		p = 0.1359#		p = 0.0248[1]			
IADL							
Independent	09 (22.5)	08 (20.0)	23 (57.5)				
Dependent	09 (15.2)	06 (10.2)	44 (74.6)				
		p = 0.1878[1]					

Caption: E - high family dysfunction; M - moderate family dysfunction; B - good family functionality; I - independence; D - partial dependency; D* - dependence in at least one activity;
Nonparametric Statistical Tests: 1Chi-squared test; 2Fisher's Exact Test;
Note: #Expected value less than five, Chi-squared may not be a valid test.

DISCUSSION

In line with what was observed in other studies, female participation was predominant. The female dominance of the elderly population is a phenomenon widely observed in the world demographic dynamics, reaching more than half of the elderly population in Brazil[8].

There was also a low level of education among study participants. It is believed that this fact is related to educational restrictions experienced in past times, especially in traditional cultures, where women were dedicated exclusively to domestic activities. Regarding health care, poor education is associated with less information retained, making health education actions with the elderly ineffective, as well as self-care[9].

In relation to life habits, it was noticed that smoking was reported by most of the elderly (n=67; 66.6%). Such practice is considered harmful to the organism, since it is responsible for the decrease in life expectancy and quality of life. In women, regular tobacco use reduces on average 4.47 years of life. In men, the same reduction is 5.03 years. In 2011, smoking was responsible for 147,072 deaths, 157,126 acute myocardial infarctions, 75,663 strokes and 63,753 cancer diagnoses[10]. In view of this, it is deemed necessary to develop accessible health strategies that are appropriate to the intellectual capacity of these elderly people, aiming at reversing these health indicators and improving the life cycle of the geriatric population.

Regarding lifestyle, physical inactivity was reported by 85 (85.8%) of the participants, being justified mainly by the lack of disposition (n=37; 37.3%) and motor difficulties (n=25; 25.2%). Irrespective of the existence of pathologies associated with the aging process, the elderly are subject to structural and functional changes, such as decreased muscle and bone mass, reduced flexibility, limited exercise capacity and reduced vital capacity. These characteristics, inherent to longevity, contribute to reduce the percentage of physically active elderly people, triggering greater chances of them developing chronic pathologies[11].

The presence of chronic diseases was reported by most participants. This fact has been pointed out by studies that reiterate the increased vulnerability to such morbidities as age advances. Chronic diseases affect all individuals of any socioeconomic class. However, the elderly are the most susceptible toward their development[12]. In this sense, there is a real concern from the health authorities, since in Brazil 650,000 new elderly people are incorporated every year, most with chronic diseases and some with functional limitations resulting from these health problems[13].

It is believed that the presence of these pathologies has contributed to the unsatisfactory (regular) perception of the elderly in relation to their own health, mentioned by 66 (66.6%) of the participants. Self-rated health is an important predictor of survival among the elderly, as it is useful in assessing the morbidity and mortality of this population. The negative perception in relation to the health status itself leads to the development of dependence in relation to health services, increasing public spending and reducing the quality of life of the geriatric population[14].

Regarding the assessment of basic activities of daily living (BADL), 17 (17.1%) of the participants reported dependence in one or more activities. As for Instrumental Activities

of Daily Living (IADL), 40 (40.4%) self-reported impaired functional capacity with partial dependence, revealing the existence of disabilities/ functional impairments among the oldest participants.

The BADL, activities aimed at self-care, and the IADL, mobility skills or activities for maintaining the environment, are widely used to assess the functional capacity of the geriatric population[15]. The results showed an association between these variables, which indicates that elderly people who have difficulty performing basic activities tend not to be able to perform more complex tasks, which are essential for an independent life[16].

Regarding the APGAR evaluation of the family, the data obtained revealed an index of functional families (n=67; 67.6%) overlapping dysfunctional families (n=32; 32.3%), meaning that the majority of the elderly showed satisfaction with the care of their demands by the family in the evaluated dimensions. However, a considerable number of families were considered dysfunctional (n=32; 32%).

Aging favors the development of chronic-degenerative diseases, which increase frailty and physical and mental disabilities in the elderly. In addition, there is a functional decline, inherent to the aging process. These conditions change the quality of life of the elderly, making it difficult to perform tasks previously performed easily, making them dependent on third parties to carry out their daily activities[18]. In this context, family support is essential for maintaining the health and well-being of the elderly.

The care directed to the geriatric population often generates conflicts for the caregiver, since they are faced with the burden and stress triggered by the total or partial dependence of the elderly[21]. Despite this, in the present study, the elderly reported satisfaction with family relationships, such as adaptation and companionship.

A survey showed that the frailty of the elderly is a naturally occurring process, regardless of the installation of pathologies19. This corroborates the statistically significant association between age and IADL classification (p=0.023), based on which the relationship between the elderly is shown to be dependent in IADL; which are more elaborate activities and involve intellectual state and social interaction. The association between BADL and IADL (p=0.024) may also be related to this weakening condition, since the elderly who are unable to perform basic activities were equally unable to perform more complex tasks.

With the rapid aging of the population, functional disability has become an important indicator of the health of the elderly in Brazil, as it represents a compromised quality of life and an increase in the use of health services; in addition to being associated with higher mortality in the elderly20. With regard to Basic Activities of Daily Living (BADL), it is possible to verify that the elderly enjoy good autonomy and independence in the performance of their tasks, since the majority claim to perform them without help.

A positive association was also obtained between the variables self-perceived health and APGAR Familiar (p=0.0006), since a significant proportion of the elderly who claimed to have excellent\ good or regular self-perception of their health, presented good family functionality, emphasizing the importance of the family for maintaining the well-being of the geriatric population.

Maintaining a good social relationship is considered an important strategy to help cope with daily adversities and feelings of loneliness. Thus, the family becomes the main support network for the elderly, and good contact with

them is an important factor for the well-being and quality of life of the elderly[21].

This study has some limitations that must be overcome in further investigations. Among them, there is the fact that the research was developed only in one UAPS and with a relatively small sample. It is also recognized that this study does not constitute an exhaustive evaluation of family functionality and associated factors, since it used the cross-sectional research design, which does not permit the inference of causality.

In view of this, the need to carry out further research in this same thematic line is reinforced, including in other regions of Fortaleza, in order to obtain a broader panorama of the health realities of the elderly population and their family life. It is reiterated that the knowledge of family functionality, as well as the factors associated with it, is important for the development of more effective nursing care strategies and in order to be capable of meeting the growing demands of the elderly and their families.

In summary, the findings of this study bring considerable contributions to nursing, as a science and profession. Thus, when evaluating the factors associated with the family functionality of the elderly, this research generated information that may be useful to direct the focus of nursing actions on the elderly in the context of the Family Health Strategy. From this information, the nurses will be able to focus their assistance on the main factors that interfere in the elderly family's functionality, directing care to the real needs of this population.

In addition, the results of this research may, together with the knowledge already produced on the theme of family functionality in the elderly, support nursing education regarding the process of caring for the health of the elderly. This is because the nurse who will work in clinical practice needs to be equipped with a theoretical-scientific contribution that will base their assistance to the elderly and their families.

CONCLUSION

It is concluded that the functional capacity of the elderly participants still reflects a significant dependence on instrumental activities of daily living. Age was a variable that was related to these activities and should be considered by nurses when analyzing clinical aspects of the elderly's independence in performing household chores, such as washing clothes and handling medication.

It was not possible to observe a significant association between functional capacity and family functionality in the elderly, although the majority had functional families, which is a positive factor for the elderly's well-being. Self-perceived health seems to be related to APGAR Familiar. The nurse must pay attention to this, as self-perceived health can be related to noises and failures in family life and can interfere with the individual's health behavior.

BADL was associated with IADL. This finding should also be considered in clinical nursing care, as elderly people with difficulties to perform simple tasks may not be able to perform more sophisticated activities. The information brought by this study may guide the nurse's assessment and provide them with support to intervene in a more effective and assertive way in improving the family's functionality of the elderly.

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