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The importance of family functioning in elderly care: associated factors*

A importância do funcionamento das famílias no cuidado ao idoso: fatores associados

La importancia del funcionamiento familiar en el cuidado a los ancianos: factores asociados

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This study aims to verify the family functionality of elderly community members and the associated sociodemographic and health factors. This is a cross-sectional, quantitative study carried out with 637 elderly people from a municipality in Triângulo Mineiro (MG). Sociodemographic questionnaire, Mini Mental State Examination, Scales for assessing functional capacity and family Apgar were applied. The associated factors were verified by means of difference tests for independent groups, Pearson's correlation and multiple linear regression (p <0.05). There was a predominance of elderly people who consider their families to have good functionality. They were consolidated as factors associated with family functionality, respectively: perception of health, age, falls and depression. The detection of factors that generate family dysfunction provides subsidies for health professionals to plan actions in order to prevent or reestablish the balance of intrafamily bonds and promote the well-being of the elderly and their family.
Descriptors: Aged; Family; Family relations.

Este estudo tem o objetivo de verificar a funcionalidade familiar de idosos comunitários e os fatores sociodemográficos e de saúde associados. Trata-se de um estudo transversal, quantitativo, realizado com 637 idosos de um município do Triângulo Mineiro (MG). Foram aplicados questionário sociodemográfico, Mini Exame do Estado Mental, Escalas para avaliação da capacidade funcional e Apgar familiar. Verificou-se os fatores associados por testes de diferença de média para grupos independentes, correlação de Pearson e regressão linear múltipla (p<0,05). Predominaram idosos que consideram suas famílias com boa funcionalidade. Consolidaram-se como fatores associados à funcionalidade familiar, respectivamente: percepção de saúde, idade, quedas e depressão. A detecção de fatores que geram disfunção familiar fornece subsídios aos profissionais de saúde para o planejamento de ações no intuito de prevenir ou restabelecer o equilíbrio dos vínculos intrafamiliares, de modo a promover o bem-estar do idoso e de sua família.
Descritores: Idoso; Família; Relações familiares.

Este estudio tiene como objetivo verificar la funcionalidad familiar de los miembros de la comunidad de edad avanzada y los factores sociodemográficos y de salud asociados. Este es un estudio transversal y cuantitativo realizado con 637 personas mayores de un municipio de Triângulo Mineiro (MG). Se aplicaron cuestionario sociodemográfico, mini examen del estado mental, escalas para evaluar la capacidad funcional y Apgar familiar. Los factores asociados se verificaron mediante pruebas de diferencia para grupos independientes, correlación de Pearson y regresión lineal múltiple (p <0.05). Hubo un predominio de personas mayores que consideran que sus familias tienen una buena funcionalidad. Se consolidaron como factores asociados con la funcionalidad familiar, respectivamente: percepción de salud, edad, caídas y depresión. La detección de factores que generan disfunción familiar proporciona subsidios para que los profesionales de la salud planifiquen acciones con el fin de prevenir o restablecer el equilibrio de los lazos intrafamiliares, con el fin de promover el bienestar de los ancianos y sus familias.
Descriptores: Anciano; Familia; Relaciones familiares.

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INTRODUCTION

The aging process predisposes the appearance of high rates of diseases and comorbidities which can interfere with functional capacity[1]. In this context, the need for care arises as well as the family as the primary source of informal health support[2].

The family is a significant social support for the elderly, a place for building lasting bonds, a source of affection, attention, support and care[3]. It is responsible for decisions related to the health of the elderly, supporting the coping with difficulties inherent to aging.[2,3].

The concept of family has undergone constant transformations, producing new types of organization, values and relationships, which can interfere in the well-being of the elderly[4]. Nowadays, people are more prone to a greater variety of family structures[5].

There have been changes in the role of each family member, such as the role of women as caregivers. With their insertion in the job market and even as a financial reference at home, other family members take care[5,6]. The practice of home care provides the family with proximity to the elderly and creates opportunities for adaptations in the family structure when necessary[6].

The investigation of family functionality focuses on the relationship between members, the way they solve problems, face difficulties and moments of crisis, as well as the distribution of functions among individuals[7].

In view of this concept, the family that performs these tasks is considered functional, capable of maintaining harmony, integrity and accountability for the actors, and a dysfunctional family is not able to resolve and deal with problems and conflicting situations[7].

Thus, the study of family functionality and associated factors is relevant. Knowing about family relationships, measuring the degree of satisfaction of the elderly in relation to their family and identifying factors which can interfere in intra-family relationships could contribute to the development of diagnostic methods, multidimensional assessment, reception practices and social support for the elderly and their family[8].

The objective of this study was to verify the family functionality of elderly community members and the sociodemographic and health factors associated with it.

METHOD

It was an observational, analytical, cross-sectional, household survey type study, part of a larger study, entitled: "Dependence for activities of daily living, fragility and use of health services among elderly people in the Triângulo Mineiro", developed by the Public Health Research Group of the Federal University of Triângulo Mineiro. The population was composed of elderly men and women aged 60 or over with no cognitive decline, living in the urban area of a municipality in Minas Gerais, according to the Mini Mental State Examination - MMSE[9].

The urban area population was recruited to compose a multi-stage cluster sampling. To calculate the sample size, a prevalence of functional disability in Instrumental Activities of Daily Living of 28.8% was used, with an accuracy of 1.5% and a confidence interval of 95.0%, for a finite population of 199,172 (total number of urban elderly in the Triângulo Mineiro). However, for this research, the outcome was the variable family functionality. Admitting the estimated elderly population (36,703) in the municipality, a sample of 711 was arrived at.

The interviews took place in the period from January to April 2014, at the elderly's home, by trained researchers (undergraduate and graduate students in the health field), and were reviewed by field supervisors (teacher and graduate students). The first household to be held the interview was selected at random and the subsequent interviews took place in the households, in a standardized sense, until the sector was saturated - the number of households/ elderly was four elderly per census sector. Thus, considering the losses, 637 elderly people were interviewed.

As for the study variables, the sociodemographic and health aspects considered were: sex (male and female), age (full years), individual monthly income (without income; <1; 1; 1- | 3; 3- | 5; > 5), self-reported morbidities (Arthrosis, Osteoporosis, Kidney Problems, Depression), hospitalization in the last twelve months (yes and no), falls in the last year (yes and no), according to an instrument prepared by the authors who are part of the CollectiveHealth Research Group of UFTM[10], perception of health and functional capacity.

The perception of health was measured through the following question in the questionnaire of the HWBA - Health, Well-Being and Aging - Study: “In general, you would say that your health is: (Great, good, regular, bad and terrible)[11].

Functional capacity was assessed by performing basic activities of daily living (BADLs) and instrumental activities of daily living (IADLs). The BADLs were evaluated by using the Katz Scale, developed by Katz (1963) and adapted to the Brazilian reality[12]. This scale consists of six items measuring the person's performance in self-care activities. The score ranges from 0 to 6 points, in which the lower the score the greater the independence. The individual who was able to perform all six functions without supervision was considered independent.

The IADLs were measured by using the Lawton and Brody Scale, developed by Lawton and Brody (1969), adapted in Brazil[13]. This scale consists of seven items, with scores ranging from 7 to 21 points. The higher the score, the greater the individual's independence. Dependency is considered when the final score is 7 to 20 points and independence when the elderly person has 21 points[13].

For the evaluation of family functionality, the Family Apgar instrument, developed by Smilkstein (1978), translated and cross-culturally adapted in Brazil in 2001, adapted in Brazil14 was used. Evaluates the respondent's satisfaction with five questions: **A**daptation (Adaptação), **P**artnership (Companheirismo), **G**rowth (Desenvolvimento), **A**ffection (Afetividade) e **R**esolve (Capacidade resolutiva). Em cada questão são atribuídos os seguintes valores: 0= nunca, 1= raramente, 2=algumas vezes, 3= quase sempre e 4= sempre. A pontuação total varia de 0 a 20 com maiores escores indicando boa funcionalidade. A pontuação final possibilita a classificação dos níveis de funcionamento: elevada disfunção familiar – 0 a 8; moderada disfunção familiar – 9 a 12 ou boa funcionalidade familiar – 13 a 20 pontos[14].

The collected data were entered into an electronic spreadsheet, with double entry and, subsequently, its consistency was verified. For data analysis, the software “Statiscal Package for Social Sciences” (SPSS) version 19.0 was used

Univariate analysis was performed by using descriptive statistics on the distribution of absolute and relative frequencies and calculation of central tendency and dispersion measures.

To compare the results of family functionality (score) according to the dichotomous categorical independent variables, analysis of mean difference between two independent groups was used by t-Student test, respecting the principle of homoscedasticity and normality (normality being assessed by Kolmogorov - Smirnov p≥ 0.05; homogeneity of variance by Levene p≥ 0.05). In the violation of the assumptions, Mann Whitney's non-parametric test was used, with a significance of 5% for all tests.

For quantitative variables, Pearson's correlation measures and the correlation coefficient for Spearman posts were used for the variable perception of health and income. The magnitude of these correlations was classified as: weak (0 <| r | <0.3), moderate (0.3 ≤ | r | <0.5) and strong (0.5 ≤ | r | ≤ 1.0) . A significance level of p <0.05 was considered.

Despite not showing statistical significance,, those that showed statistical significance in the bivariate analysis and those identified as variables of influence in the literature were integrated into the model for the analysis of the simultaneous influence of the variables. Sociodemographic, health and functional capacity were considered for the analysis of multiple linear regression. The significance level for alpha (α) was 0.05 and the contribution (β) to the response variable (increase or decrease).

The research was approved by the UFTM Research Ethics Committee, under protocol No. 493,211. All research participants signed the Free and Informed Consent Term, following the precepts established by Resolution 466/12, dated from 12/12/2012 and issued by the Ministry of Health[15].

RESULTS

Among the 637 respondents, there was a predominance of females (66.6%), average age of 72.21 years, with a maximum of 97 years old (± 8.1), with an individual income of a minimum wage (45.1%) .

Among the elderly, 39.9% rated their health as regular, 39.1% self-reported arthrosis, 22.6% osteoporosis, 10.8% kidney problems and 20.4% depression. It is noteworthy that 17.9% was hospitalized in the last 12 months and 26.8% reported falls in the last year.

Concerning functional capacity, it was found that 76.9% of the elderly are independent for BADLs and 62.0% are dependent for IADLs.

It was found that 87.8% of families have good functionality, 6.4% poor and 5.8% moderate.

The bivariate analysis between the independent variables (sex, arthrosis, osteoporosis, kidney problems, depression, hospitalization and falls) and family functionality, showed difference in: depression (p <0.001) and falls (p <0.001), as shown in Table 1. These results indicate that those with depression and falls have worse family functioning.

Table 1. Comparison of family functionality in the elderly according to sociodemographic, clinical and falls variables. Uberaba-MG. 2014.

Variables	*n*	Family Functionality		*p*
		Average	Standard deviation	
Sex				
Male	213	17,65	4,45	0,470
Female	424	17,37	4,67	
Arthrosis				
Yes	249	17,10	4,90	0,120
No	388	17,70	4,39	
Osteoporosis				
Yes	144	17,26	4,77	0,535
No	493	17,53	4,54	
Kidney Problems				
Yes	69	16,48	5,80	0,129
No	568	17,59	4,42	
Depression				
Yes	130	16,03	5,74	**0,001**
No	507	17,83	4,18	
Hospitalization				
Yes	114	17,26	4,80	0,603
No	523	17,51	4,55	
Falls				
Yes	171	16,43	5,40	**0,001**
No	466	17,85	4,21	

Regarding the analysis of the variables age, income, health perception and functional capacity and family functionality, a positive correlation was found for age (p = 0.004), but there was a weak correlation (r = 0.115) and for health perception (p > 0.001), however there was a weak correlation (rs = 0.181, table 2). In this sense, the older the age and the better the perception of health, the better the family functionality.

Tabela 2. Correlation between sociodemographic and health variables and the elderly's family functionality. Uberaba – MG. 2014.

Variables	**Correlation**	***P***
Age	0,115	**0,004**
Income*	0,030	0,455
Health perception	0,181	**<0,001**
BADLs	-0,010	0,792
IADLs	0,048	0,222

aAccording to the Brazilian Inter-Union Department of Statistics and Socioeconomic Studies (DIEESE), the minimum wage in 2014 corresponded to R $ 724.

Table 3 presents the multiple linear regression model with the outcome of the variable family functionality and as predictors: sex, age, health perception, depression, falls, BADLs and IADLs.

In the analysis of multiple linear regression, the perception of health (β = 0.168) was the variable that was most strongly associated with family functionality, followed by the variables age (β = 0.125), falls (β = -0.114) and depression (β = -0.104). Good family functionality is associated with older age (p = 0.002) and better health perception (p <0.001). On the other hand, the presence of depression (p = 0.010) and the self-report of falls (p = 0.005) indicated poor family functionality as shown in Table 3.

Table 3. Multiple linear regression model for Family Functionality. Uberaba-MG. 2014.

Variables	*B*	***p***
Sex	0,039	0,323
Age	0,125	**0,002**
Perception of health	0,168	**< 0,001**
Depression	-0,104	**0,010**
Falls	-0,114	**0,005**
BADLs	-0,016	0,711
IADLs	-0,013	0,779

bBADLs= basic activities of daily living; IALDs= instrumental activities of daily living.

DISCUSSION

The good functionality of the families corroborates a study carried out in Dourados, state of Mato Grosso do Sul with 374 elderly people assisted by the FHS (Family Health Strategy), where 76.2% of the families are functional[16]. In Mexico, among 139 elderly people, 81% had good family functioning[17]. According to those elderly, families face difficulties and adverse situations with harmony and responsibility[2].

The data in this study reveal a good family function index as opposed to moderate and poor family functionality, which corroborates another study with elderly people undergoing outpatient treatment in Mexico, having found that 9% of families had moderate functionality and 10% poor functionality[17]. The study carried out with 27 elderly participants in a Support Group for the Elderly in Jequié, BA identified that 11.11% had moderate functionality and 3.7% poor[18], a result that differs from the research here in focus

Health professionals should promote socialization actions and strengthen family ties of the elderly[3], o that in this way they could achieve good family functionality[17].

As for the self-assessment of health perception, the elderly who reported better health conditions showed good family functionality. A study on the factors associated with the family functionality of elderly people living in Goiânia, GO, found a result different from that of the present study[19].

Studies[20,2120] point to a heterogeneity of factors associated with negative perceptions of health, such as the presence of disease, loss of independence, level of satisfaction with life, among others. Those perceptions have broadened the concept of health for the elderly. Thus,

the perception of health influences the peoples' quality of life which in turn may influence family functionality, that is, the worse the quality of life, the worse the family functionality.[21].

The findings of this research show a positive and significant correlation between age and the Family Apgar score of the elderly participants. This result differs from that observed in other studies such as the one in Sete Lagoas, with 2052 elderly community members[8] as well as the one in Viseu, Portugal, with 294 elderly participants[22.] Neither of them have shown correlation between age and family functionality. Despite these results, it was found that poor family functionality perception came from older members of the elderly group[8,22].

It is believed that good family functionality results found in the present research can be attributed to the good health conditions of the participants, since most of them are independent in ABVDs, have not been hospitalized and have not suffered falls in the last year. A study on the factors that determine family support and quality of life of elderly people in India shows that the health conditions of this population play an important role in family relationships[23].

The "Falls" variable revealed an association with family functionality, that is, the more the elderly person falls, the more dysfunctional the family is, which is consistent with the investigation of factors associated with the family functionality of long-living elderly in Goiás[19]. Another investigation carried out with 149 elderly people with family dysfunction found that the fall variable is a predictor of high family dysfunction[24]. The variety of consequences and the severity of falls can result in long-term care[25,26], which can impact family functionality[27]. Thus, it is important to implement rehabilitation programs after falls, as well as preventive actions to maintain functional capacity.[25,26].

In this study, the association between depression and family functionality was also detected, as in other studies. An investigation carried out in Mato Grosso do Sul with 374 individuals aged 60 years or older found that the presence of family dysfunction was significantly greater in the elderly with depression ($p < 0.001$)[16]. Research with Mexican elderly people who attended an outpatient clinic found that depression and family functioning are related ($p = 0.01$)[17].

Elderly people lack support from family members to deal with depression[28]. This lack of support and assistance can negatively interfere with their health, causing more comorbidities or accentuating existing ones[16,27].

Family functionality may be compromised in families where the elderly person has a chronic non-communicable disease (NCDs)[8,16,19,27]. In Portugal, 98.1% of respondents with NCDs rated their family functionality as poor[22]. In Chile, elderly people with type II diabetes showed dysfunctional families and social support deficits[29].

These are identified as situations that generate stress in the family due to the lack of adaptability, the difficulty of facing a situation where illness and dependence are present[2,27].

It is important to highlight that the lack of national and international studies to be contrasted to our research was presented as a limitation.

Despite the failure to obtain the total sample recommended initially, it is possible to generalize the findings of the present study to analogous populations, since the event was investigated among 637 community-based elderly.

The cross-sectional design of the study also presented itself as a limitation factor, since the methodological instruments for collection family functionality data are intended to cover situations of specific periods of time. This single cut in time results in a shorter precision to determine cause and effect relationships.

However, due to the absence of studies on the subject, the analyzes undertaken in this research present relevant reflections for the understanding of family functionality among the elderly population.

CONCLUSION

Good family functionality was associated with a better perception of health, older age, the absence of falls and depression.

By detecting factors that generate poor family functionality one can require health professionals to plan actions aimed at preventing or restoring the balance of intra-family bonds, which in turn promotes the well-being of the elderly and their families.

The results presented here support the conduction of new research and suggest the use of instruments such as Apgar as a viable reference for characterizing the performance of this variable in the elderly population. In this sense, this study opens doors for future research on the elderly population and family functionality.

Furthermore, these results can be an additional resource in the design of programs and policies for the elderly who cannot rely on family functionality to manage their life circumstances.

The development of future research should be oriented towards analyzes between family functionality and functional capacities which includes the caregiver in the research design.

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CONTRIBUTIONS
Tatiana Silveira Marzola has contributed to the project conception, analysis, data interpretation and writing. **Nayara Paula Fernandes Martins Molina** has participated in the project conception, analysis, data interpretations and revision. **Luiza Maria de Assunção** has collaborated with writing and reviewing. **Darlene Mara dos Santos Tavares** e **Leiner Resende Rodrigues** has collaborated with the project conception and revision.

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