REVISTA ONLINE DE PESQUISA

CUIDADO É FUNDAMENTAL

Universidade Federal do Estado do Rio de Janeiro • Escola de Enfermagem Alfredo Pinto

RESEARCH DOI: 10.9789/2175-5361.rpcfo.v13.9336

PERCEPTION OF ELDERLY PEOPLE WHO LIVE ALONE ABOUT THEIR CONDITIONS OF LIFE AND HEALTH

Percepção de idosos que moram sozinhos acerca de suas condições de vida e saúde

Percepción de nosotros que muere sozinos acerca de sus condiciones de vida y salud

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How to quote this article:
Medeiros APM, Viana LRC, Silva CRR, *et al*. Perception of elderly people who live alone about their conditions of life and health. Rev Fun Care Online.2021. Jan./Dec.; 13:1242-1248. DOI: http://dx.doi.org/10.9789/2175-5361.rpcfo.v13.9336

ABSTRACT

Objective: To understand the perception of elderly people who live alone about their living conditions and health. **Method:** qualitative study, carried out with 21 elderly people living alone in João Pessoa, Paraíba, Brazil. The data were collected through interviews, using a semi-structured instrument containing sociodemographic data and questions on living and health conditions, being processed with Iramuteq software, using the Descending Hierarchical Classification method. **Results:** five classes or categories were formed: What causes the elderly to live alone; Falling risks for the elderly; Comorbidities of the elderly; Satisfaction and dissatisfaction of the elderly who live alone; and Attention to the health of the elderly. **Conclusion:** Knowing the needs, risks and vulnerability of the elderly who live alone helps to plan care, focusing on the prevention of emotional losses and falls from solitude, in the treatment and rehabilitation of chronic diseases and their consequences.

Descriptors: Aging, Aged, Health of the elderly, Health status, Geriatric nursing.

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RESUMO

Objetivo: Compreender a percepção de idosos que moram sozinhos acerca de suas condições de vida e saúde. **Método:** estudo qualitativo, realizado com 21 idosos que viviam sozinhos em João Pessoa, Paraíba, Brasil. Os dados foram coletados por meio de entrevistas, utilizando um instrumento semiestruturado contendo dados sociodemográficos e perguntas sobre condições de vida e de saúde, sendo processados no software Iramuteq, sendo utilizado o método da Classificação Hierárquica Descendente. **Resultados:** foram conformadas cinco classes ou categorias: O que leva o idoso morar sozinho; Riscos de queda para o idoso; Comorbidades dos idosos; Satisfação e insatisfação do idoso que mora só; e Atenção à saúde do idoso. **Conclusão:** Conhecer as necessidades, os riscos e a vulnerabilidade dos idosos que moram sozinhos auxilia no planejamento de cuidado, com foco na prevenção de quedas e desgastes emocionais provenientes da solidão, no tratamento e reabilitação das doenças crônicas e suas consequências.

Descritores: Envelhecimento, Idoso, Saúde do idoso, Nível de saúde, Enfermagem geriátrica.

RESUMEN

Objetivo: Comprender la percepción de los ancianos que viven solos acerca de sus condiciones de vida y salud. **Método:** estudio cualitativo, realizado con 21 ancianos que vivían solos en João Pessoa, Paraíba, Brasil. Los datos fueron recolectados por medio de entrevistas, utilizando un instrumento semiestructurado que contenía datos sociodemográficos y preguntas sobre condiciones de vida y de salud, siendo procesados con software Iramuteq, siendo utilizado el método de la Clasificación Jerárquica Descendente. **Resultados:** se conformaron cinco clases o categorías: Lo que lleva al anciano a vivir solo; Riesgos de caída para el anciano; Comorbilidad de los ancianos; Satisfacción e insatisfacción del anciano que vive solo; y Atención a la salud del anciano. **Concusión:** Conocer las necesidades, los riesgos y la vulnerabilidad de los ancianos que viven solos auxilia en la planificación de cuidado, con foco en la prevención de caídas y desgastes emocionales provenientes de la soledad, en el tratamiento y rehabilitación de las enfermedades crónicas y sus consecuencias.

Descriptores: Envejecimiento, Anciano, Salud del anciano, Estado de salud, Enfermería geriátrica.

INTRODUCTION

The population of people aged 60 or more is constantly growing.[1] Related to this aging population, there is an increase in the proportion of single-person arrangements, that is, elderly people who live alone. Between the period 2005 to 2015, this rate went from 57.3% to 63.7%.[2] In general, this can occur due to the choice for a lifestyle with greater privacy and independence.[3-4] In this sense, speeches with justifications for "not imposing" and "disturbing the family" are used as a strategy by the elderly to have autonomy.[5]

Furthermore, marital separations and increased life expectancy have also contributed to the formation of single-person arrangements among elderly people, especially for women, since, often in the face of widowhood, they prefer to live only to remarry. Men, in turn, prefer to rebuild a family through new unions or even live with their children.[5] It is reiterated that the decision of a single-person arrangement is not only for the elderly and their family, but as a result of a series of historical, socio-cultural, demographic and economic factors, which can intervene in a negative or positive way in your life.[4-5]

In this sense, the growth of single-person arrangements among the elderly brings greater vulnerability and consequently the need for care, [5] it being essential that the Primary Health Care nurse identifies this group, prioritizing it in home visits, which should count on the help of instruments such as family risk assessment, for example. The genogram and ecomap are also effective for the planning and execution of health care, as they enable the visualization of formal and informal resources available to the elderly and their family.[3] Furthermore, nursing in individual assessment can encourage the adoption of strategies to overcome difficulties living alone, emphasizing, above all, the strengthening of the social support network.[6]

The elderly population is worthy of protection and a different view on the part of governmental public policies, and it is necessary, for this, to know their reality.[7] Given the above, the investigation of the group of elderly people who live alone is relevant, it is essential to understand their perception in relation to their living and health conditions, in order to subsidize and direct specific actions in the nursing care plan, as well as interventions by a multidisciplinary team to this clientele.

Thus, the present study aims to understand the perception of elderly people who live alone about their living and health conditions.

METHODS

This is a qualitative research, carried out between the months of March and April 2017, with 21 elderly people registered in a Family Health Unit (USF) in the city of João Pessoa, Paraíba, Brazil. The defined inclusion criteria were: being 60 years old or older, living alone at home and being registered at the chosen FHU. Elderly people with cognitive impairments were assessed, assessed by means of the Mini Mental State Examination.[8]

Data collection was assessed through interviews, which were carried out at the elderly's home. Initially there was a survey of the names and telephone contacts of the elderly users of the USF, in order to provide guidance on the research objectives, request participation in the study and schedule the meeting for the interview, respecting the individual availability of each elderly person.

A semi-structured instrument was used, composed of sociodemographic data and questions about the living and health conditions of the elderly. The speeches were recorded and then transcribed in full, being organized in a corpus in the OpenOffice.org software and processed with the aid of the Iramuteq software (Interface for R pour les Analyzes Multidimensionnelles de Textes et de Questionnaires). The Descending Hierarchical Classification (CHD) method was used, by which classes of text segments are obtained that

are organized in a dendogram illustrating the relationships between them, with the description of each one, above all, by its lexical vocabulary and its variables.9

The research respected all ethical and legal aspects recommended by Resolution nº 466/12 of the National Health Council. The project was approved by the Ethics Committee of the Health Sciences Center of the Federal University of Paraíba under CAEE nº 64574917.7.0000.5188 and opinion nº 1,984,567. To maintain anonymity, the statements were identified in the text with the letter "I", followed by the ordinal number corresponding to the order of the interview (I1, I2 ... I21).

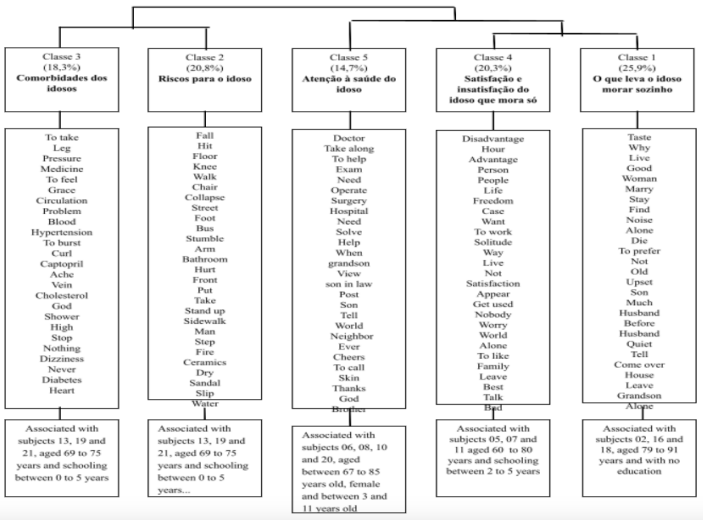
RESULTS AND DISCUSSION

Of the 21 elderly participants, 15 (71.4%) were female, with the predominant age group between 70 and 79 years old, represented by eight subjects (38.0%). As for education, 13 (61.9%) had incomplete primary education. With regard to income, 19 elderly people (90.5%) claimed to receive a minimum wage, corresponding to R $ 954.00. Regarding marital status, 14 (66.7%) were widowed.

Regarding health conditions, it was observed that 10 (47.6%) elderly people did not practice physical activities, 15 (71.4%) reported having some type of leisure, three (14.3%) consumed alcohol and cigarettes, 11 (52.4%) considered their health as good and eight (38.1%) as regular.

The corpus formed from 21 interviews, constituted 270 Text Segments (ST) that generated the textual set. The analysis of textual data was based on the distribution of vocabularies, following the steps from a CHD of words, performed in different stages. The results obtained from this analysis considered the texts by dividing them into Text Segments, thus 73.0% of the texts were considered in the CHD, with 197 words used. From the hierarchical analysis, five different classes or categories of ST emerged from each other (**Figure 1**).

Figure 1 - Dendogram of the classes regarding the perception of the living and health conditions of elderly people who live alone. João Pessoa, PB, Brazil, 2017



With regard to the classes referring to the perception of the condition of life and health of the elderly who live alone, in Class 1 - Which leads the elderly to live alone (25.9% of the ST in the corpus) - based on the association of the main mentioned words, it was possible to identify that some prefer to live alone because many years after the death of their wife or husband, they do not like to disturb anyone, even noise, so they say that it is more peaceful to stay home alone. In addition, their children marry, form another family and end up leaving them alone. Participants in the construction of this class, participants I2, I16 and I18, aged between 79 and 91 years and with no education.

This result corroborates with a study carried out in the municipality of Timóteo, Minas Gerais, which observed that the elderly women who lived alone for long years showed satisfaction for being in this condition and reported not feeling lonely. Living alone reproduces the normal cycle of life, and while leaving the children from home can mean disappointment or disgust for some, for others, it can have the sense of "duty accomplished". [16] This aspect can be evidenced by the following statements:

> *[...] when she died I was alone, I think I even prefer to be alone because there is nobody to disturb me, sometimes the person is married, has a good wife and when she dies it is difficult to find another one [...].* (I2)

> *[...] I always lived in my house and I never lived in anyone's house that's why I think it's good to live alone because I don't abuse anyone and nobody bores me, so I'm very comfortable [...].* (I16)

> *[...] I lived with my children, after my husband died my children were getting married one by one [...].* (I8)

The one-person arrangement can represent an achievement of the aging process, since this group experiences the passage of years with greater privacy and independence to carry out their activities.[3] Furthermore, living alone is not synonymous with neglect or abandonment by the children , nor weakening family ties or feelings of loneliness, and in many cases, do not represent psychological suffering for the elderly.[14]

In **Class 2 - Risk of falls for the elderly** (20.8% of the ST in the corpus) - the participants reported some risks to which they are vulnerable in their daily lives. They said they should be aware when they walk down the street, due to the uneven sidewalks, because they run the risk of stepping on the wrong foot, stumbling and falling to the ground, besides being careful when getting on and off when taking the bus. As well as indoors, where there is a risk of falls. Contributing to the formation of this class, participants I3, I14 and I17 aged between 61 and 82 years and schooling between one and 10 years.

Falls in the elderly can occur due to physiological

limitations of balance, strength, vision or reaction time, as well as due to illness. Thus, the main risk factors for the occurrence of falls pointed out by the elderly are: stumbling / slipping, sidewalks and irregular streets, impairment of the skeletal-muscle system and steps.[17-19]

[...] I slipped on a paper in the city center then I skidded and hit my knee on the curb of the sidewalk ... the other day I was getting off the bus and my sandal stuck on the door, when I went down I was still on the second step so I fell sitting on the step and my foot got stuck in the bus door [...]. (I3)

[...] at home I got dizzy and fell over the fan, I spent 2 hours without being able to get up and there was no way anyone could help me then I got up alone and sat in the chair until I recovered well [...]. (I14)

[...] when I was leaving the house, my puppy passed in front of me and so as not to step on it, I became unbalanced and fell to the ground, I scraped all over, lost the skin on my knees and my arms were hurt because I supported myself not to hit my face in floor [...]. (I17)

In a survey conducted in Portugal, 25% of the elderly who live alone reported having suffered a fall in the last 6 months, 87% confessed to being afraid of falling and 66% stopped doing any activity due to fear.[15] It is reiterated that there is a tendency for the elderly with problems of auditory, visual acuity and drowsiness to suffer falls more frequently.[15,20] In this context, it becomes worrying when the elderly who lives alone suffers a fall, since in most cases, they do not have the assistance from others to get up or seek a health service when necessary.[6]

The educational actions provided by the nurse and the health team form the basis for health promotion, which can assist in the prevention of falls, provided that, together with the elderly, they are attentive to the intrinsic and extrinsic factors that predispose them, expanding the capacity of the same for the care with this event.[17-18] In addition, the home visit of the nurse can contribute to the identification of risks.

In **Class 3 - Comorbidities of the elderly** (18.3% of the ST in the corpus) - it was shown that the majority of the elderly have some chronic diseases and / or other health problems. The most common are hypertension, diabetes, heart disease and also have risk factors such as increased cholesterol that lead to poor blood circulation in the veins resulting in leg pain and dizziness. From this, the need arises to take several remedies, the best known for high blood pressure, captopril, metformin for diabetes, simvastatin for cholesterol and others. In this class are the participants I13, I19 and I21, aged between 69 and 75 years and schooling between zero and five years.

The elderly population often has a higher prevalence of chronic diseases and disabilities, causing a great demand for health care, [21] highlighting the increase in the consumption of medications, as expressed in the following reports:

[...] I have several spinal problems, arthrosis, arthritis, hypertension, prediabetic and kidney problems. I take puran before breakfast, then losartan after it and hydrochlorothiazide for pressure, another for leg circulation, simvastatin for cholesterol and a sleeping pill [...]. (I13)

[...] I only have high blood pressure, but it is controlled and I have a back problem ... I only take captopril and omega 3 [...]. (I19)

[...] I have very high diabetes, high blood pressure, circulation problem, some days my legs burn a lot and a kidney problem ... I take insulin, pressure medicine, one for circulation and one for cholesterol [...]. (I21)

In a recent study, results showed that the presence of chronic diseases in elderly people who live alone was directly related to low well-being, a higher level of nursing care and frailty.[22] Develop appropriate strategies to prevent or delay the onset of chronic diseases, as well how to improve functional capacity, prevent depression and facilitate access to health services can contribute to improving the perception of the elderly about their health status, and thus promote quality of life.[12]

In Class 4 - Satisfaction and dissatisfaction of the elderly who live alone (20.3% of the ST in the corpus) - the participants showed their opinions, exposing the advantages and disadvantages of living alone. Many do not like to give satisfaction of their life to anyone, prefer to have freedom and do not like to worry the family. Others think loneliness is bad. The participants I5, I7 and I11 contributed to the constitution of this class, aged between 60 and 80 years and education between two and five years. It can be seen through the reports of the elderly that loneliness stands out as the main disadvantage of living alone:

[...] I am calm for my age, I had too many appointments, my life was very busy because everything was on top of me because I was the owner of the house ... the disadvantage might be if you happen to need someone and have no one at home [...]. (I5)

[...] the advantage of living alone is freedom, we don't worry about doing things for people, I eat what I want, when I want, I do what I want without worrying about anyone ... the disadvantage is if in case of getting sick and not having help, having no one to call, that's the only bad part[...]. (I7)

[...] the advantage is that I'm used to it, I don't get used to anyone anymore ... the disadvantage is the loneliness that is bad [...]. (I11)

Several studies have evaluated loneliness in this specific population.[11-13] In a survey conducted with elderly people who live alone in Spain, almost two thirds of them experience a greater sense of loneliness in relation to those who live with someone.1[0] In fact, those who live alone have a greater likelihood of social isolation.[12]

The behaviors in search of staying active through leisure activities and participation in activities in the community comprise a strategy that avoids idleness, collaborates to maintain social relationships, and possible sources of exchange of support.[6] These activities should be encouraged, since they promote the strengthening of the social network.

In **Class 5 - Health care for the elderly** (14.7% of the ST in the corpus) - the elderly revealed that it is easier to monitor their health in the primary care network, as they always call the health center, because they live near the unit, and if necessary at the hospital for exams and / or surgery. Most of these elderly people take care of their health by actively participating in the programs offered by the Family Health Unit. When they cannot move to receive medical care, they count on the help of their family members or even a good neighbor. This class was produced by participants I6, I8, I10 and I20, aged between 67 and 85 years old, female and schooled between three and 11 years old.

The strategy of seeking informal support, that is, that provided by neighbors, friends and family, is widely used in the elderly who live alone, both for maintaining friendships and companionship, and for helping in cases of need, because despite some having an independent lifestyle, many need the help of others in some specific activities.[6]

[...] once my diabetes was at 36, lucky that my neighbor who is a health worker was here and gave me enough food for the glucose to rise, I always have help from someone, it usually comes from a neighbor, I can't count on any family member. (I6)

[...] in here, anything I turn to my neighbors, if they need, they take me to the hospital, to the market, or to solve anything, they take me [...]. (I8)

[...] I'm just hypertensive but the doctor at the health center said I had diabetes so I started on a regimen when it was in May last year I did three types of blood tests and it didn't flag for diabetes, my glucose was on 90 [...]. (I10)

[...] yes, my son my granddaughters and grandson when i need to go to the doctor or take me to the exams, everyone helps me thanks to god [...]. (I20)

Aware of the search for health promotion and disease prevention, it is necessary to have a careful monitoring by family members, the community and also the health team, to ensure them a better life and health condition, and can count on with the services of the Family Health Strategy, as well as institutions of greater complexity.[16]

With regard to nursing, it is of great importance to carry out multidimensional assessment in the elderly, and it is necessary to organize a care plan aiming at a better service to this clientele.[23] In addition to being the nurse's competence to learn and intervene in the search for promotion health and prevention of complications, through strategies that promote opportunities for elderly people to be able to adopt healthy lifestyles, according to their peculiarities, expectations and health conditions.[24]

CONCLUSIONS

The data obtained revealed that the elderly started to live alone after the death of their spouse and the removal of their children by marriage. They showed satisfaction in living alone related to the freedom to live life the way they want; dissatisfaction was linked to loneliness.

It was also found that most receive health care, actively participate in the programs offered by the USF, and when they cannot move to receive care, they count on the help of third parties. Regarding health problems, the participants reported having some chronic disease, in addition to having already suffered falls.

In this perspective, knowing the needs, risks and vulnerability of the elderly who live alone helps in planning care. Respecting the decision of the elderly to live alone is essential, however, the family, together with the health team must create strategies to promote the well-being of the elderly.

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25.

Received on: 20/09/2019
Required Reviews: 24/09/2019
Approved on: 05/02/2020
Published on: 31/08/2021

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The authors claim to have no conflict of interest.