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Role of autonomy in self-assessment of health by the elderly

ABSTRACT

OBJECTIVE: To understand the meanings attributed to self-assessment of health by the elderly.

METHODS: Qualitative study performed with 17 elderly individuals (≥ 70 years of age) of both sexes, living in the city of Bambuí, Southeastern Brazil, in 2008. An anthropological approach based on the model of signs, meanings and actions, which associates individual actions, cultural codes and the macro-social context, was used. Semi-structured interviews were conducted, focusing on self-assessment of health, description of health as "good" and "poor" and the criteria used by the elderly to rate their own health.

ANALYSIS OF RESULTS: The idea organizing reports associates self-assessment of health by the elderly with the "participating in life" and "being anchored in life" logics. The first logic has autonomy as its basic line of thinking, including the following categories: remaining active within advanced instrumental and functional abilities, being in charge of one's life (as opposed to being dependent on others), being able to solve problems and acting at will. The second logic unites the following categories: being able to interact, being engaged in meaningful relationships and being able to rely on family members, friends and neighbors.

CONCLUSIONS: Health is understood by the elderly as having autonomy in the exercise of functional abilities required by society, such as the ability to meet family obligations and the ability to perform social roles. By defining their health as good or fair, the elderly individual is not characterized as someone free from diseases, but rather able to act over the environment.

DESCRIPTORS: Health of the Elderly. Self Assessment (Health). Personal Autonomy. Health Knowledge, Attitudes, Practice.

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INTRODUCTION

Since the 1950s, epidemiological research has focused on determinants and consequences of self-assessment of health in the elderly, recognizing it as an indicator of quality of life, morbidity and physical decline, in addition to considering it as a strong predictor of mortality.[14]

However, due to the subjective nature of self-assessment of health, epidemiological studies do not clarify which elements are involved in this assessment, which criteria are used in its construction and which health dimensions the elderly consider when assessing their own health. Another point is the disagreement between results of self-assessments of health and objective data on health, reported by epidemiological studies on aging in the last decades. Some authors argue that, in advanced ages, self-assessment of health results more from active interpretative processes.[14,15]

By assessing their own health, an elderly individual often mistakes and overlaps aging, health and disease. This assessment will vary according to the meaning attributed and the logic of the socio-historical moment, which incorporates a variety of physical, cultural and affective components. In this process, medical and non-medical factors are mistaken for one another, based on their bio-psychological process, social conditions and interaction with their group. Alves[1] suggests that, by attributing a quality to their health and disease, elderly individuals are referring to a reality founded on meaningful processes inter-subjectively shared. Based on the statement by Ayres[2] that our different experiences are what define us as individuals, it is assumed that the social (re)construction of the elderly as individuals involves this rationality.

In terms of health practices, the identification and critical appraisal of this issue can be seen under two aspects. One is pragmatic and concerns the existence of certain coherence between the selection of criteria for self-assessment of health by the elderly and the organization of health-related actions. The other concerns the relational nature of attribution of meanings to health and disease, creating shared criteria for assessment.[1]

This evidence presupposes an analysis whose logic is in the grasp of meanings underlying shared strategies. This means having culture as a reference point, which shapes and gives meaning to reality. According to Geertz,[11] culture is in itself "a universe of symbols and meanings which enable individuals of a group to interpret an experience and guide their actions".

The objective of the present study was to understand the meanings attributed to self-assessment of health in the elderly.

METHODOLOGICAL PROCEDURES

This study is part of the *Projeto Bambuí*, developed in the city of Bambuí, Southeastern Brazil, which has about 23,000 inhabitants.[8]

A total of 17 elderly individuals participated in the study (≥ 70 years of age), of both sexes (nine women and nine men), and with varied socioeconomic levels. Criteria for inclusion of participants were as follows: to agree to participate in the study and to be able to give clear information. The number of participants was defined by the saturation criterion.[20]

Data were collected in the homes of elderly individuals following semi-structured interviews (with a mean duration of 40 minutes). The main subjective health aspects that comprised the interview guide were: self-assessment of health, description of heath as "good" and "poor" and the criteria used by elderly individuals to assess their own health.

Data analysis was supported by the semiological postulate of non-equivalence between sign and reality. To reveal this question, the model of analysis of signs, meanings and actions was used,[6] based on the theory of meaning that aims to associate individual actions, cultural codes, the macro-social context and historical determination.[7] The analysis starts from the pragmatic level to clarify the semantic level, promoting a dialogue between specific types of behavior towards health and the general biomedical model, seeking underlying cultural logics.[21]

This study was approved by the Research Ethics Committee of the *Centro de Pesquisas René Rachou, Fundação Oswaldo Cruz*.

ANALYSIS OF RESULTS

The majority of participants defined their health as good or fair, although most of them had chronic health conditions that varied in degree and severity. Even though health, as reported by these participants, was sometimes close to the biomedical model, the logics of "participating in life" and "being anchored in life", present in the interviews, were the first analytical categories constructed from these interviews. A total of 12 elderly individuals associated the meaning of health and disease with "participating in life", especially as the capacity to perform an advanced instrumental activity, i.e. the capacity to work or perform leisure time activities. One interviewee, suffering from pulmonary emphysema, reported that his incapacity to work was the key factor to rate his health as very poor.

"... my health's been bad my whole life, but it used to be better. (...) I used to work and live" (EH6)

Another participant went beyond the health/work dichotomy, associating health with the possibility of participating in life in a broader sense:

"Someone's health is bad when they're in bed, when they can't do something, work, eat and so on. (...) But we manage to live with the other things..." (EM3)

Health assessment was associated with the logic of "being independent/dependent", understood as the capacity to survive and control context-structuring conditions. One interviewee, who reported multiple episodes of diseases, stated that they did not interfere with her health, as she still felt she was in control of her own life:

"No, it doesn't interfere with my life that much. As I was saying, I still manage to survive on my own." (EM3)

"Solving problems" was another theme present in participants' speech. By assessing his health as good, one participant stated that this was associated with the fact of having control over objects and one's mind and body, thus being a source of a feeling of fulfillment, competence and being in tune with one's time.

"I'm 77 years old, so I think my health is good. I still work, I wake up early, at about 6, 6:30, then I make breakfast and go to work. I've been retired for 17 years and I got a garage there in the back of the garden, I'm a mechanic. What I think is good is when I make a mistake (...) then, I find another way to do it, I take it all apart and do it again. I think it's good when I make a mistake, look for a way to correct my flaws and pull it off." (EH2)

In addition, health assessment was associated with the capacity to identify and evaluate problems and have control over one's own life.

"Well, I can't complain about my health at my age, because I'm already 79 years old, I can still walk and my mind is good. If I think about it, I even have to thank God (...). But, lately, some things that I don't like have come up, but unfortunately we got to accept them because of our age (...) But, you know, I've grown so much used to my life being like this. I've had surgeries done and I've fought against these diseases." (EM3)

One interviewee, whose husband had been in bed for several years and whose grown children depended on her, balanced the negative health assessment with feelings of competence towards problem-solving, revealing an association between this assessment and her capacity to perform a socially expected role. The biomedical argument, which was her basis to define her own health as poor, was reinterpreted in light of these feelings:

"To say that I'm well is not true, because I'm not. I've had a surgery done in my gall bladder, I got Chagas' disease, I've also had three surgeries done in my intestines this year. The last time, they took part of my intestines out (...). It's quite a struggle, because he is there in bed, my daughter works and I have to manage everything, I have to work and take care of our home (...). I also got two sons, their wives left them and now they live with me, so I have to be responsible for them and help them every way I can, because one is sick, he's not retired (...) I have to be responsible for my money (...) I got a daughter who doesn't have a husband anymore, she's the mother of that boy who's passed by here. She drinks a lot, she's always sick and she's going through a difficult situation. (...) Health is something I don't have either." (EM5)

Another logic in the association with self-rated health contrasts with the previous logic in terms of the capacity to perform the social role expected by the immediate surroundings, "to perceive the other's mistrust of one's capacity to perform expected roles". One elderly woman reported a negative perception someone had of her and reacted by stating again her integrity and capacity to manage her own life.

"So, he [doctor] *called my attention. He said, 'But you needed to have a little consideration for your daughter and tell her this, talk to her about your health and your medication!' I have the impression he thinks I'm going senile. But I'm not! (laughs)."* (EM8)

By facing present and past, one participant assessed her health based on a feeling of physical and affective "strangeness" towards herself, combined with another of physical and affective discontinuance:

"I'm already feeling that I'm growing weak, you know? I'm 78 years old, so, this makes a difference in my memory, I get tired to go to work and I don't feel like going out. I used to get excited about going out, you know?" (EM8)

Some interviewees associated their health with a feeling of physical and affective strangeness, particularly after an episode of disease. One elderly lady expressed her insecurity after suffering from ischemia:

"I've had ischemia. After that, I grew afraid, you know? I'm not healthy, I don't feel safe to walk alone anymore. So, I go out holding someone's arm. I don't go out on my own, even with a cane." (EM6)

The association between being healthy and being capable of interacting with others, becoming involved in meaningful relationships and being able to rely on relatives, friends or neighbors was categorized under the logic of "being anchored in life", as illustrated by the following report:

"Look, the first thing is... I have plenty of support from my children. Three of them live in Belo Horizonte and one lives here. And he [partner] *also supports me a lot. I think we're healthy when we're at least a little happy and a little strong. When we talk to people. When we joke, you know? My neighbor is there and, then, she jumps over to my side. We even put a small ladder there."* (EM1)

In addition, incorporated into the idea of "being anchored in life" as the other side of the situation, there appears the opposition of the family eventualities to the detriment of their needs as individuals. One interviewee, who had to leave the city to have prostate exams performed, revealed his dilemma between the need to stay and care for his disabled son and the freedom to care for his own health:

"I'm almost 84 years old now. But my problem is... it's not health, it's this. (...) Even I didn't want to go, you know? But I have to find a way to go. (...) But how can I leave this boy? His medication is controlled. We have to watch him." (EH5)

Another logic belonging to the "being anchored in life" category and meaning its antithesis in the association with health was "poor health associated with annoyance and opposition caused by others", here defined as something that goes beyond the elderly individual's capacity of resolution. The association between health and "annoyance caused by others" is illustrated in the report of an interviewee who revealed his fear of falling seriously ill due to oppositions:

"Anything they do to me, as soon as I start feeling it, my body shakes and feels weak, you know? I'm afraid of having a stroke, you see? I'm almost 84 years old." (EH5)

The same participant clarifies this association, while referring to a son who opposes him:

"But this is what's making us sick. It's the annoyance and opposition. Annoyance and opposition are the same thing." (EH5)

DISCUSSION

The logics between the meanings of health and disease created by the elderly do not refer to analogies or equalities, but rather to affinities and similarities of ideas. Ideas grouped around the "participating in life" and "being anchored in life" analytical categories stand out as those most frequently used by the elderly to assess their own health. These ideas focus on the question that, with aging, women and men assess their own health according to psychosocial attributes and ways of life.

It becomes clear that the ideas the elderly have about health come from the integration of communicative processes, pointing to the relational nature of health. Such ideas are found to be guided by culturally constructed codes and submitted to standards of judgment defined by the social context. The relational nature of health has also been described by other authors.[9,13,16] The shared view of health expressed by the elderly individuals interviewed is, in principle, positive and it takes the form of descriptions of individuals who are capable of controlling context-structuring conditions and also confident in their relationships with meaningful others. However, reports reveal that this positive self-assessment of health hides the elderly individual's effort to remain active, preserve their inter-subjective identity and their role in the group (as in the case of the participant who defines her health as good and insists in managing her own life, but, at the same time, perceives other people's feeling of strangeness towards her capacities). The idea most frequently present in the interviews associates the understanding of health with the act of remaining active, based on one's physical and mobility capacities, and acting according to one's will. This logic is present in elderly communities of urban and rural areas of other countries as well.[13] For the purpose of analysis, it was dealt with based on the term "participating in life", used by Borglin et al[3] to mean that active participation in daily life brings the elderly the feeling of being necessary and in tune with their time.

The ideas gathered around this theme are related to the elderly individuals' capacity to perform advanced instrumental functional activities, being in control of their own lives (thus being opposed to being dependent), being capable of solving problems and having the feeling of being able to act according to one's will. These logics resemble the definition of autonomy used by the gerontological literature, consisting in the ability to make judgments and act. Among them, functional capacity is found to be one of the most significant units to understand health. The term "functional capacity" is defined by Caldas[4] as the individuals' capacity to perform activities required of them by their immediate environments and to adapt to routine problems. According to Caldas,[4] these activities are divided into three axes: basic daily life activities (self-care tasks); instrumental daily life activities, meaning indications of an independent life in the community (performing household chores, going shopping, managing one's own medication, handling money); and advanced daily life activities (work, leisure-time activities, social contacts, physical exercises). Pitaud[17] associates the performance of these activities with independence. In the present study, instrumental activities and advanced activities were those most valued by the elderly when rating their own health.

The ideas that emerged about the association between health and the capacity to perform advanced instrumental functional activities and being capable of solving problems are indissolubly connected to the

idea of "having control over one's life as opposed to being dependent". According to Caldas,[4] the term "dependence" is associated with fragility, defined by Hazzard et al[12] as an individual's vulnerability towards the challenges of the environment itself, reducing their capacity to adapt to it. In contrast, the emerging logic of "having control over one's own life", combined with self-rated health, implies the body's adequacy to the demands of the immediate environments. Findings from the present study are similar to those from other studies.[13,18] According to Hinck,[13] health is defined in terms of functional capacity, while, to Rosa et al,[18] the maintenance of this capacity may be associated with the elderly individual's capacity to remain independent and integrated to the community. In this way, "to have control over one's own life", as opposed to being dependent, "to solve problems" and "to be capable of performing the social role expected by their immediate environments are logics constructed by the elderly, based on a body and mind that meet their expectations and, as such, guide their understanding of their own health.

However, following the assessments of health based on the biomedical criterion, there are re-interpretations of these according to criteria shared by the group, related to the capacities and competences in the responses to the expectations of the immediate environments. Many times, in a situation of poor health, physical and mental capacities are submitted to culturally constructed judgments, constituting the parameter of assessment of health. Such capacities and competences are present as signs of strength in the fragility, simultaneously being a source of suffering and accomplishment for the elderly, as they establish their role in the immediate environments and confirm their inter-subjective identity.

The "participating in life" category and its subcategories are connected to another category, "being anchored in life". This term is defined by Borglin et al[3] as the design of strategies by the elderly that enable them to live with the changes that come with aging. The analytical category known as "being involved in meaningful relationships" is acknowledged as one of these strategies, as a sign of health and as one of the multiple social construction records for aged individuals. In a study on aging by Caldas & Bertero,[5] being involved in meaningful relationships is a recurring theme among the elderly of the city of Rio de Janeiro, Southeastern Brazil.

In the present study, the logics of "participating in life" and "being anchored in life" interconnect and overlap each other. Many times, ideas associated with the need to meet context-structuring conditions are found to be the other side of "being involved in meaningful relationships", becoming more important than the needs for self-care. Thus, the elderly face a dialectical situation between living the feeling of competence to solve problems and living the freedom to act in its broad sense, according to what is observed in the logics related to the capacity to perform their role and "poor health associated with annoyance caused by others".

Other logics are revealed to be associated with the capacities and competences to respond to the regulations of the context: "the elderly individual's feeling of strangeness towards their own physical or mental capacities" and "perception of discontinuity". These analytical categories express the fact that changes in the functional capacity of elderly individuals, in their autonomy and in their perception of physical and mental discontinuity act on their identity as a limiting factor. The elderly individual oscillates between feelings of trust in and mistrust of their capacities, in a discontinuous movement of reports of permanence of a state and decadence. The mistrust of the physical capacity accompanied by aging was reported by Erickson et al[10] and Silver.[19]

The logics of "strangeness" and "discontinuity" are frequently concomitant and can be described as "the elderly individual's mistrust of their performing expected roles". Such logic broadens the idea of "strangeness", going beyond the individual's notion and towards that of the individual in agreement with the external world. In this sense, it focuses on and means health as the elderly individual's capacity of relevance in the community. For aged individuals, fulfilling their role, even in the presence of changes resulting from aging, means to maintain the integrity of their inter-subjective identity.

The meanings of health created by the elderly can be elements that organize a collective social construction of the elderly individual. Connections between feelings of accomplishment and fulfillment and feelings of limitation would be elements that identify this construction, implying the need to maintain a delicate balance. From this perspective, elderly individuals' self-assessments of health, in addition to the types of behavior and strategies adopted, become meaningful and coherent.

In conclusion, an aging individual, by defining their health as good or fair, is not characterized as someone free from diseases, but rather as an inter-subjective being who claims the freedom to create knowledge about the meaning of his health. By observing this reality, researchers are led to consider this stage of life as one that involves not only vulnerability and dependence, but also the expression of capacities and competences. All this indicates that the elderly claim their strategic place in society, both as participants in their course of life and as creators of knowledge about their health.

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