Saúde e Pesquisa
Health Promotion
DOI: 10.17765/2176-9206.2022v15n4.e11312

Living habits, purpose in life, and functionality of seniors of a community center

Hábitos de vida, propósito de vida e funcionalidade de idosos de um centro de convivência

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ABSTRACT
To verify the relationship between life habits, purpose in life, and functionality of elderly members of a community center. A cross-sectional study was conducted with 100 seniors. The research used a lifestyle habits questionnaire, Purpose in Life Scale, and Whodas 2.0. Data analysis was conducted using the Kolmogorov-Smirnov tests*,* U of Mann-Whitney, and Kruskal-Wallis ($p<0.05$). The elderly had a high score in purpose in life. Elderly non-drinkers presented better mobility functionality ($p=0.02$). Smokers had worse self-care functionality ($p=0.01$). Members of the community center who practiced educational and cultural activities showed better total functionality ($p=0.03$) and were better in the domains "participation in society" ($p=0.00$) and "Life Activities" ($p=0.01$). The elderly showed a high level of purpose in life. Those with better functionality were those who attended cultural and educational activities.

Keywords: Social participation. Aging. Motor activity. Personal satisfaction.

RESUMO
Verificar a relação entre hábitos de vida, propósito de vida e funcionalidade de idosos integrantes de um centro de convivência. Estudo transversal realizado com 100 idosos. Utilizou-se questionário de hábitos de vida, Escala de Propósito de Vida e o Whodas 2.0. A análise dos dados foi realizada por meio dos testes Kolmogorov-Smirnov*,* U de Mann-Whitney e Kruskal-Wallis ($p<0,05$. Os idosos apresentaram escore alto no propósito de vida. Idosos não etilistas apresentaram melhor funcionalidade na mobilidade ($p=0,02$). Aqueles fumantes tiveram pior funcionalidade no autocuidado ($p=0,01$). Notou-se que os integrantes do centro de convivência, praticantes de atividades educacionais e culturais mostraram melhor funcionalidade total ($p=0,03$) e nos domínios "Participação na sociedade" ($p=0,00$) e "Atividades da vida" ($p=0,01$). Os idosos apresentaram alto nível de propósito de vida. Aqueles com melhor funcionalidade eram os que frequentavam as atividades culturais e educacionais.

Palavras-chave: Participação social**.** Envelhecimento. Atividade motora. Satisfação pessoal.

Received in November 14, 2022
Accepted on December 14, 2022

INTRODUCTION

Population aging is a worldwide and established phenomenon with social, economic, and cultural impact, generating diverse health and social needs (social inclusion, for example) in different contexts[1]. According to the World Health Organization (WHO), in 2050, the world population will have about two billion individuals over the age of 60, and in Brazil, this population will be 30%[2].

Much of this population's longevity can be explained by the improvement in lifestyle habits during life; after all, aging is influenced, positively or negatively, by hereditary factors, lifestyle habits, physical exercise, sedentary lifestyle, and social and cultural issues[3,4]. An example of a place for social activities for the elderly is the community center (CC). The community center aims to offer a better quality of life and reintegration into society, as well as promote healthy aging, precisely by providing activities of this nature, such as dance, choirs, Pilates, games, various physical exercises, meetings, and socializing with friends[5].

Although a large part of the elderly population has some disease, it does not imply dependence or limitation that restricts daily activities and social participation[6]. Thus, even carrying a disease, the elderly can continue to play their social roles since the focus of health is related to the functionality of the individual[7]. Functionality is the ability to manage one's own life, that is, make their own decisions (autonomy) and live independently, without the help of another person (independence)[8].

Currently, there are some instruments to assess functionality and disability, among which the following stands out: World Health Organization Disability Assessment Schedule (Whodas 2.0)[9]. This instrument is based on the conceptual framework of the International Classification of Functioning, Disability, and Health (ICF). Its questions assess levels of health and disability according to the main domains of life. This tool is not restricted to a physical or mental health condition or specific population groups[10].

Psychological factors can moderate the impact of age on functionality, among them eudaimonic or psychological well-being (PWB)[11]. PWB addresses contexts of mental health, self-acceptance, autonomy, personal growth, and purpose in life (PIL)[12].

In particular, according to Ryff[13], PIL is a psychological variable. It can be evaluated and refers to the understanding that life has meaning, direction, and intentionality. This sense plays a guiding role in setting life goals and making decisions. Adults and older people with a strong sense of purpose have beliefs that give meaning to their life and have desires and goals worth living for[14].

Even given the above, knowledge about how life habits may be related to the PIL and functionality of the elderly, especially those who attend a community center, is still superficial. Therefore, the present study aimed to verify the relationship between lifestyle habits, purpose in life, and functionality of elderly members of a community center.

METHODS

It is a quantitative, analytical, observational, and cross-sectional study approved by the Research Ethics Committee (REC) under Opinion number 5,439,145.

POPULATION

The non-probabilistic and convenience sample consisted of 100 seniors aged 60 to 89 years attending a CC, with 81 (81%) female and 19 (19%) male. The inclusion criteria were: age equal to or greater than 60 years and participation in groups of seniors in the CC. The exclusion criteria were: being a wheelchair user and having a score lower than the cut-off grade in the Mini-Mental State Examination (MMSE).

The MMSE is a screening instrument that assesses immediate memory, temporal and spatial orientation, calculation, commands, recall, and language. All participants presented sufficient cut-off scores according to their level of education. Cut-off scores: 17 points for illiterates, 22 for people with 1 to 4 years of study, 24 for those who studied from 5 to 8 years, 28 for 9 to 11 years of study, and 29 for those with more than 11 years of study[15].

INSTRUMENT

The study used a questionnaire prepared by the researchers to characterize the sociodemographic profile and lifestyle habits of the elderly. This questionnaire contained questions regarding age, sex, marital status, monthly income, education level, retirement, and issues related to lifestyle habits, such as smoking and alcohol consumption.

The PIL was evaluated by a ten-item version of the Ryff and Keyes scale16, translated and validated for use in Brazil by Ribeiro et al.[17]. Survey participants were asked to rate their degree of agreement with each statement, on a five-point Likert scale: I do not agree at all (1), I somewhat agree (2), I moderately agree (3), I strongly agree (4), and I strongly agree (5). The scores of items 2, 3, 5, 6 and 10 were inverted for analysis. The final score is the result of the average of the answers to the ten questions (sum/10), which can vary from 1 to 5. Higher scores reflect higher levels of PIL.

The World Health Organization Disability Assessment Schedule - Whodas 2.0 is a practical and generic tool for assessing health and disability in the

population and was used to collect data related to functionality. The version used in this study had twelve questions divided into six domains of life: cognition, mobility, self-care, interpersonal relationships, life activities (household responsibilities, leisure, work, and school) and participation (community activities and in society)[10]. Each domain contains two questions. The 12-item version administered by an interviewer explains 81% of the variance of the 36-item version, and respondents are asked about difficulties that have occurred in the last 30 days, scoring the difficulties through the following answers: none (1), mild (2), moderate (3), severe (4), extreme or unable to do (5)[18].

PROCEDURE

Before the start of data collection, the interviewers underwent a training process for the application of the scales. During their activities, the CC members were invited to participate in the research as volunteers when they were informed about the project, objectives, and justification. Those who agreed to participate in the study signed the Informed Consent Form.

After a prior appointment, during the information collection, individual care took place in rooms available in the CC, which offered comfort and privacy to the participants. Each collection lasted, on average, 15 minutes. Researchers collected the data in May and June 2022 after approval by the REC.

DATA ANALYSIS

The software JASP0.16.1 performed the data analysis using descriptive and inferential statistics. It used frequency and percentage as descriptive measures for categorical variables. For the numerical variables, the Kolmogorov-Smirnov test initially verified the normality of the data. As the data did not present normal distribution, the survey adopted the median (Md) and the interquartile range (Q1-Q3) as central tendency and dispersion measures. The comparison of the PIL score and functionality of the elderly according to sociodemographic and health variables was performed using the Mann-Whitney U test (two groups) and Kruskal-Wallis test (more than two groups).

RESULTS

Table 1 shows the prevalence of women aged between 60 and 69 years retired, with a monthly income of up to two minimum wages, with incomplete primary education, non-drinkers, and non-smokers among the 100 elderly participating in the research. 41% of the participants were married, 29% were widowed, 19% were divorced, and 11% were single.

Table 1. Profile of the elderly member of the community center

VARIABLES	*f*	%
Sex		
Female	81	81.0
Male	19	19.0
Age range		
60 to 69 years	52	52.0
70 to 79 years	34	34.0
80 years or older	14	14.0
Marital status		
Married	41	41.0
Single	11	11.0
Widow	29	29.0
Divorced	19	19.0
Retirement		
Yes	73	73.0
No	27	27.0
Monthly income		
Up to 2 MW	56	56.0
2.1 to 2.5 MW	22	22.0
3 MW or more	15	15.0
Has no income	7	7.0
Schooling		
Illiterate	5	5.0
Incomplete Primary School	51	51.0
Complete Primary School	19	19.0
Complete High School	14	14.0
Higher Education	11	11.0
Alcohol consumption		
Yes	31	31.0
No	69	69.0
Cigarette consumption		
Yes	3	3.0
No	78	78.0
Ex-smoker	19	19.0

MW: minimum wage(s)

Table 2 presents the comparison of PIL and functionality scores according to alcohol consumption. The participants had an average PIL of 4.1, indicating a high level of PIL.

Table 2 Comparison of the scores of purpose in life and functionality of the elderly as a function of alcohol consumption

VARIABLES	Alcohol consumption		*P*
	Yes (n = 31)	No (n = 69)	
	Avg (Q1-Q3)	Avg (Q1-Q3)	
Purpose in life	4,00 (3,80-4,30)	4,10 (3,90-4,50)	0,10
Domains of Functions			
Cognition	2.00 (2.00-4.00)	2.00 (2.00-4.00)	0.82
Mobility	3.00 (2.00-4.00)	2.00 (2.00-3.00)	**0.02***
Self-care	2.00 (2.00-2.00)	2.00 (2.00-2.00)	0.22
Interpersonal relationships	2.00 (2.00-3.00)	2.00 (2.00-3.00)	0.26
Life activities	2.00 (2.00-3.00)	2.00 (2.00-3.00)	0.87
Participation in society	3.00 (3.00-4.00)	3.00 (3.00-4.00)	0.73
Total score	16.0 (13.0-19.5)	14.0 (13.0-17.0)	0.26

Significance level – $p < 0.05$ – Mann-Whitney U Test

There was a significant difference in the mobility score between the elderly drinkers and non-drinkers (p = 0.02), demonstrating that the participants who reported not consuming alcoholic beverages (Avg = 2.00) presented better mobility (lower score) than the drinkers (Avg= 3.00). Table 3 shows the comparison of PIL and functionality scores as a function of cigarette consumption.

Table 3. Comparison of purpose in life and functionality scores of the elderly as a function of cigarette consumption

VARIABLES	Cigarette consumption			*P*
	Yes (n = 3)	No (n = 78)	Ex-smoker (n = 19)	
	Avg (Q1-Q3)	Avg (Q1-Q3)	Avg (Q1-Q3)	
PIL	3.80 (2.65-3.95)	4.10 (4.10-4.40)	4.30 (3.95-4.45)	00.46
Domains of Functions				
Cognition	2.00 (2.00-4.00)	2.00 (2.00-4.00)	2.00 (2.00-4.00)	0.98
Mobility	2.00 (2.00-2.50)	2.00 (2.00-3.00)	3.00 (3.00-4.00)	0.34
Self-care	3.00 (2.00-3.00)[a]	2.00 (2.00-2.00)	2.00 (2.00-2.00)	**0.01***
Interpersonal relationships	2.00 (2.00-2.50)	2.00 (2.00-3.00)	2.00 (2.00-3.00)	0.85
Life activities	2.00 (2.00-2.00)	2.00 (2.00-3.00)	2.00 (2.00-4.00)	0.99
Participation in society	2.00 (2.00-2.00)	3.00 (2.00-4.00)	3.00 (2.00-4.00)	0.98
Total score	12.0 (12.0-16.0)	14.0 (13.0-18.8)	15.0 (14.5-21.0)	0.33

Significance level (p < 0.05) - Kruskal-Wallis U Test between: a) Yes with no is ex-smoker.

There was a level of significance in the self-care score of the senior person as a function of cigarette consumption (p = 0.01), demonstrating that smoking seniors (Avg = 3.00) presented worse self-care (higher score) when compared with non-smoking seniors (Avg = 2.00) and ex-smokers (Avg = 2.00). Table 4 compares the PIL and functionality scores of the elderly, depending on the type of activity performed in the CC.

Table 4. Comparison of PIL and functionality scores of the elderly, depending on the type of activity performed in the CC

VARIABLES	Type of activity		*P*
	Physical (n = 78)	Educational/cultural (n = 22)	
	Avg (Q1-Q3)	Avg (Q1-Q3)	
Purpose in life	4.10 (3.80-4.40)	4.10 (3.90-4.30)	0.60
Domains of Functions			
Cognition	3.00 (2.00-4.00)	2.00 (2.00-3.00)	0.11
Mobility	2.00 (2.00-4.00)	2.00 (2.00-2.75)	0.24
Self-care	2.00 (2.00-2.00)	2.00 (2.00-2.00)	0.50
Interpersonal relationships	2.00 (2.00-3.00)	2.00 (2.00-2.75)	0.78
Life activities	2.00 (2.00-3.75)	2.00 (2.00-2.00)	**0.01***
Participation in society	3.00 (2.00-4.00)	2.00 (2.00-3.00)	**0.00***
Total score	15.0 (13.0-19.0)	14.0 (12.0-15.8)	**0.03***

Significance level: p < 0.05 - Mann-Whitney U Test.
Life activities: household responsibilities, leisure, work, and school.
Participation: participating in community activities and society.

Members who practiced educational and cultural activities presented better (lower score) total functionality (Avg = 14.0) and in the domains "participation in society" (Avg = 2.00) and "life activity" (Avg = 2.00) compared to members practicing physical activities.

DISCUSSION

This article aimed to verify the relationship between lifestyle habits, purpose in life, and functionality of the elderly in a community center. It is the first study of the application of the purpose in life scale in the elderly, associated with the World Health Organization Disability Assessment Schedule - Whodas 2.0 in Brazil.

Based on the data analyzed, the participation of females was considerably higher than that of males (prevalence of 81%). Another study conducted in CC[19] also reveals these data, which calls attention to the feminization of old age, that is, the higher number of senior women when compared to men, and the greater socialization and integration of these, according to Barreto et al[20].

In Table 2, the PIL score was 4.1, denoting a strong purpose on the part of the research participants. Such result is consistent with the study by Ribeiro et al.[14] when they mention that the purpose is greater when the elderly is involved in significant activities, such as leisure, educational and cultural activities, promoted by the CC.

The PIL was not influenced by the income and low educational level of the participants. These findings were also found in a cross-sectional study of elderly from the countryside of the State of Amazonas. In this study, most of the members had low income and were illiterate, and the results of the PIL scale were above average[21].

When analyzing the "mobility" domain, with questions regarding the difficulty of standing and walking for long periods, the study found a slight difference in absolute values among the participants. Decreased mobility leads to complications in performing basic activities of daily living[22], as well as restriction of social participation, and drinking alcohol can further impair this mobility[23].

A lower PIL was observed in the elderly drinkers (Table 2). In the study by Kim et al.[24], there was no association between PIL and alcohol and cigarette consumption, but it observed that higher PIL scores were related to better health behaviors, physical activity practices, and reduced mortality[25].

Concerning cigarette consumption, a positive highlight was the prevalence of non-smoking and ex-smokers, as smokers obtained significant differences in "self-care" activities. Self-care is related to the basic personal activities of daily life, such

as bathing, dressing, walking, eating, and going to the toilet[26]. Smoking contributes to health complications. Those who consume it may have cognitive, circulatory, ventilatory, and sensory problems, generating a worsening in the quality of life since, many times, the elderly population is affected by comorbidities[27].

Table 3 shows that smokers had a lower PIL score. Wingo et al.[28] demonstrated that nonsmokers had higher PIL scores and fewer health, mental, and cognitive problems, and less memory decline. One hypothesis for these results may be related to issues of lack of self-care with health (smoking habit), which is possibly associated with low PIL.

According to Table 4, the results showed that, in the domains "life activities" and "participation in society," the elderly participants in the educational/cultural activities group had a better functional score (Avg = 14.0). The CC from Foz do Iguaçu offers several free activities to the elderly of the community, which are divided into two groups. Physical activities include collective gymnastics and Pilates, as well as educational/cultural activities, which include literacy, dance, crafts, choir, and conversation circle.

Hypothetically, this group was more functional because it was composed of younger elderly, as in the study by Antúnes et al.[29], revealing that advancing age is associated with more significant physiological, aerobic, and musculoskeletal changes, generating a decline in functional capacity.

The present study presents a first for relating the psychological variable PIL with the variable "functionality," with evaluation by Whodas 2.0, applied to the elderly in the community. The research achieved its objectives, and, from a perspective, there is a need for a sample with a larger number of research participants in different contexts.

This study has some limitations: the scarcity of research with the Whodas 2.0 instrument, especially among elderly who are members of a community center, to compare the results; the fact that this is a cross-sectional study prevents the evaluation of direct relationships of chance between the variables studied; and, finally, a sample with a reduced number of elderly due to some restrictions imposed by measures to combat the Covid-19 pandemic. Similar studies are suggested in other groups of elderly for the purpose of comparing the results, especially in longitudinal studies.

CONCLUSION

Given the results presented, the study concluded that the community center members showed a high level of PIL and a low percentage of cigarette and alcohol consumption. Older people with better functionality were those who attended cultural and educational activities.

As practical implications, it is worth highlighting the importance of spaces that promote physical and mental health and social participation aimed at the elderly population. Initiatives such as CCs are crucial to improve functionality and increase PIL among this population.

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