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Family-Centred Approach in Elderly Care

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ABSTRACT

Individual, family and community health care cannot be separated. Family, as a social support network, increases its importance with the aging of its older members. Further, with aging the family problems become more complex. Thus, family care in the elderly has differential nuances that partly overlap: 1. Family life cycle (genogram is the instrument for the study and approach of the family); 2. Characterization of family care for the elderly (the family structure and dynamics, the nature of relations with relatives, and the forms of intergenerational solidarity, are fundamental elements for the analysis of the quality of life in old age); 3. Clinical interview with elderly patients (a greater heterogeneity of patients, a sensory loss, decreased memory, slower processing of information, etc.); 4. Ethical problems (older adults are at risk of being marginalized and deprived of their rights); 5.-Care focused on psychological support (chronic diseases of the elderly substantially affect their psychological state and that of their families); 6. Care focused on caregivers (family members accompany elderly patients to their medical appointments); 7. Relationship-focused care (the risk of stigmatizing dependence is in the lives of many older patients); 8. Family-centered approach (there is a mutually beneficial association between general practitioners, patients and families in the planning, delivery and evaluation of medical care); 9. Interventions for elderly and family in the home (the process of working in the home enhances the clinician's ability to understand and address the complexity of the dynamic reality of both elderly and their families).

INTRODUCTION

General Practitioners / family doctors (GPs) as specialists working in the community need to remember that the family's experience is a crucial part of the individual's social environment [1]. The family provides the individual with the most intense and influential relationships they will likely experience [2]. In addition, many problems that doctors initially identify as belonging to the individual may be more appropriately seen as problems of the family system [3]. On the other hand, the sick or disabled individual can often survive outside the institutions only thanks to the support and care provided by their families. The family has great potential as a vehicle for treatment. Families play an integral role in providing care for people with health problems. As the number of people facing chronic diseases continues to increase worldwide, there is a need to increase recognition of the contributions of care made by family members. Almost half of people 15 years of age or older have treated other people with diseases and / or disabilities [4]. On the other hand, the aging of the population, the

increase in life expectancy, the pluripatology and the burden of disease, as well as the situation of dependence and the level of frailty of the elderly patients have caused a growth in health demand [5,6]. Demographic studies document rapid increases in the size of the elderly population. It is estimated that, in 2050, there will be two billion older people in the world, and 21% of the world's population will be age ≥ 60 years, up from 9% in 1990 [7,8].

Contrary to the widespread belief that older people are institutionalized, 95 percent of people over 65 live in the home, and many of them are cared for, to some extent, by a relative [9]. Recently it has been recognized that the family caregiver is at risk of greater physical and mental morbidity due to this often stressful task. If the situation is too stressful, it can result in elder abuse. GPs are in a good position to identify the caregiver's stress, recognize the danger signs of elder abuse, provide support, education and advice and intervene when necessary [9]. It has been reported that the main physical problems of the elderly are hypertension, decreased daily activities, impaired vision and digestive and urinary disorders. The psychological problems mentioned by their families are agitation, depression, anxiety and low body image. And the main socio-economic problems are loneliness and limited income [10-14]. Research on the care given to the elderly (people over 80 years old) is a new focus of attention in the population aging research. In this scenario, this article is a personal view, whose aims, based on a mini narrative review and the author's experience, are to reflect, conceptualize and synthesize the fundamental aspects of family care for the elderly and their practical implications.

DISCUSSION

What is traditionally called individual, family and community care is elements of the same reality and cannot be separated [15]. The family is the one that provides the emotional contributions and, above all, the necessary materials for the development and well-being of its members. Family plays a decisive role in formal and informal education; it is in her space where ethical and humanistic values are absorbed and where ties of solidarity are deepened. The family, as a social support network, increases its importance with the aging of its older members, conditioned at this stage of life by the reduction of their social activity, which increases for the elderly the value of family space. With aging the family problems become more complex because, among other factors, there is overlap of several generations with different needs, demands and different regulatory systems. Hence the need to address the problem of old age from the family space [16].

Fortunately, a family-focused, holistic approach to health and health care has garnered more attention and credibility over the last decade, with numerous studies demonstrating the benefits of patient-centered, family-focused, and integrated care. A holistic approach to health takes into account the physical, mental, emotional and spiritual aspects of health. Holistic health often includes thinking about nutrition, physical activity and chronic disease management. The role of the family in the lives of older adults, as well as the way in which this term is defined among the populations of older adults, continues to gain refinement. The values and resources of older adults and how their family's influence them are central elements of how older adults age and how care is provided to cover both the individual and family systems. This makes it essential to recognize the ways in which family function influences aging. This includes the recognition of various family structures, such as gender differences, ethnicity, etc., that may give rise to different nuances in family care, such as differences regarding caregiver overload, social isolation, stigma or mechanisms through of which pain alters relationships and family roles , and the needs of older adults for whom they are providing care [17].

Thus, this family care in the elderly has differential nuances (Table 1). At least, the following aspects can be cited, which may partly overlap, but which for pedagogical and practical reasons, it is preferable to identify:

Table 1: Differential Characteristics of Family-Centred Approach in Elderly Care.

1	Family life cycle
2	Characterization of family care for the elderly
3	Clinical interview with elderly patients
4	Ethical problems
5	Care focused on psychological support
6	Presence of caregivers / family members in consultation
7	Relationship-focused care
8	Family-centered approach
9	Interventions that serve the elderly and family in the home

Family life cycle

Family life cycle concepts are a practical and effective way to help GPs implement a biopsychosocial approach. The moments of transition in family life produce tensions that demand changes in the family organization to adapt to the changing needs of its members [18]. Many studies reveal the importance that the family has in the process of health and illness, because in it there are a series of vital events and / or normative crises (marriage, birth of a child, etc.) and non-normative ones (divorce, imprisonment, etc.). Changes in family structures, associated with an increase in the size and levels of dependence of the elderly population, have strongly affected family life, both emotionally and financially. Changes in mortality and fertility patterns have led to significant changes in family architecture, which can influence the way families care for their older members. On the one hand, the decline in fertility has reduced the size of families, reducing opportunities for intergenerational relationships; on the other hand, longevity has increased the number of multigenerational families.

Family structures among the elderly are generally divided into one of four different categories [7]:

1. Those that live alone
2. Those that live with their partner, children or other relatives
3. Those that live with children or other relatives, but without their partner
4. Those that live only with their partner

The majority of the elderly live with family members (90%), but without their spouse (70%), and the majority of elderly patients have a regular relationship with family members. And the family composition of elderly patients is multigenerational [19].

In a community study conducted in our context on the population over 70 years of age, it was found that 8% of people living alone had some cognitive deficit and 13% were not fully autonomous to carry out activities of daily living. This proportion increases in the people who reside accompanied and reaches 20% and 87% respectively, in those admitted to nursing homes [20].

Another phenomenon of great importance is the changes in family structure and the incorporation of women into work. For many years the family has assumed a leading caregiver role, often excessive and exclusive. The figure of the “hidden patient” in the family caregiver is very well documented because of the risk that the work overload confers and the psychological and health fragility that develops throughout the process. In addition, the incorporation of women into the labor market has reduced their availability. Many of the people who care for the elderly and disabled within their own family combine this activity with their work outside the home, forcing the elderly to spend many hours of the day alone. This elderly population living alone is subject to the so-called "risk of dying without any help." Therefore, this segment of the population should be considered as a risk group, and therefore subject to surveillance by social and health services.

Our society also shows the tendency to reduce the number of children, which also restricts the number of potential informal caregivers in the future. Therefore, the current care model, in which the family assumes the care that these patients require, is not sustainable over time [20]. The longevity of the population has increased the multigenerationality of family life. Although multigenerational families are now a majority, there is no guarantee that these families are prepared to assume the role of caregivers for the elderly. The main reasons that lead families to offer care to older relatives include financial, personal and social factors. Situations of fragility and dependence create the need to adapt and reorganize families, which leads to changes in family roles, which are redefined over time, depending on the way in which each member interacts with the others. At the same time, readjustments in family structure depend on how changes occur in the needs of older relatives and the resources available to address these changes. In addition, within the group of the elderly, the oldest constitute a group of special risk of frailty in old age [7,19].

Family support, therefore, varies according to the context of greater or lesser social vulnerability. Vulnerability is a multidimensional construction that refers to a dynamic context in which someone is at risk of developing health problems, as a result of inadequate economic, social, psychological, family, cognitive or physical resources [21].

It has been reported that low-class families, in relation to upper-middle-class families, have little regard for the nutrition of the elderly, regular visits to the doctor, foot care and personal hygiene [10,11].

There are several instruments to study the family, but due to its functionality and applicability the genogram is the instrument that stands out in its use as an instrument for the study and approach of the family. The genogram is the ideal document to record the family life cycle: in it can be found family information, with data concerning both the phases of the cycle and the structure, vital events and relationships.

The genogram is an instrument or tool of the biopsychosocial model that gives information about the patient, their family and context, and that implies a prognostic value and useful information for the consultation. The biomedical family history means collecting problems of genetic transmission, but from the biopsychosocial point of view it can go much further: the elaboration of the genogram produces a therapeutic link with the family, implying a qualitative change in the relationship [22].

The genogram is an excellent tool to describe elderly patients and their family environment, allowing to define a profile of the elderly or immobilized patient. If the patient is poorly cared for, he will need special consideration; The degree of immobilization and type of family relationships can make care difficult, leading to a worse prognosis [23].

The genogram is a tool that allows the GP to represent, the family structure as a group, with a history, limits, hierarchy, internal and external alliances with the social environment; it values changes in family organization over time, in relation to events that occur in their existence, that mobilize resources or resistances; it shows the intrafamily cohesion and the quality of communication, the perception of roles, myths, beliefs, etc.; It helps to understand family processes, thanks to the abundant information it provides about the family group. It also allows the GP to obtain information on the type of household, stages of development, vital events, see their family context, friends and / or neighbours, social institutions, school, work, transgenerational experiences of health and illness; it allows determining repetitive patterns on the forms to relating, how to facing critical situations, etc. [24,25], and contributes to the proper planning of care for the elderly [10,19].

Other important elements that can be observed in the family life cycle in late life are:

-Death of a spouse

-Pathological grief

-Prolonged reactions of grief

-Depression

-Dementia

-Organic diseases

-The impact of death on the family

-The effects of chronic diseases on relationships

-The fear of disease and death

-Retirement and old age

-One caretaker spouse of the other

-Loneliness

-Widowhood

-Important psycho-physical deterioration of a family member

-Terminal patient

In the other hand, the expression of symptoms also depends on the life cycle. For example, when an acute coronary syndrome occurs, the different stages of the family life cycle may show differences in the patient presentation of symptoms. The recognition of this type of phenomenon (the fact that patients express themselves with a particular clinic type, which shows different nuances in certain aspects, for example in the classic thoracic pain syndrome, according to their life cycle, that can be evidenced through the elaboration of the genogram; That is to say, according to their age and family structure), can be useful for GPs for diagnosis, as it can provide additional information on the assessment of risk factors, clinical history and exploration in elderly patients [26].

Characterization of family care for the elderly

The problem of aging demands to know the role of the elderly, the nature of relations with relatives and the forms of intergenerational solidarity as a fundamental element for the analysis of the quality of life in old age. The satisfaction of the elderly regarding their health is related to the care provided by their relatives.

It has been reported that 70% of the elderly present family neglect at the expense primarily of lack of affection (30%); in this group, the age over 70 years, the female sex (60%) and the widowed marital status (50%) predominate. The largest number of neglected senescent comes from dysfunctional families and 50% of them refer to physical abuse [16].

Addressing the problem of aging as a process, demands knowing the role of the elderly: within the family structure and dynamics, the nature of relations with relatives, and the forms

of intergenerational solidarity, as fundamental elements for the analysis of the quality of life in old age. The greatest expressions of physical and psychological well-being in old age are always associated with a strong interaction with the family.

The advantages of the family in their role as caregiver for the elderly is indicated by generally having as their objective greater emotional security and greater intimacy, while avoiding the psychopathological problems of institutionalization: depersonalization, abandonment, negligence, mental confusion, exaggerated medicalization and lack of affection

Family has a leading role in guaranteeing the elderly the necessary food resources for adequate nutrition and hygiene, which will influence the development of a large number of diseases and disabilities, including dementia. On the other hand, old age is mostly feminine, because the majority of the elderly are women in advanced societies. The results show that the elderly who live as a couple and also have a large number of children, become very beneficial elements for their health and enjoyment of their well-being, where family life turns out to be an element that protects health.

Studies show that old age is a vulnerable stage of life, related to the increase in maladjustment in the family nucleus, where feelings of loneliness and sadness are manifested. Modern life leads the family to have a large workload plus parenting, which sometimes makes it difficult for these families to solve problems and conflicts of the elderly. The incidence of abuse is much higher than statistics can indicate, because a large number of patients go unnoticed. Abuse of the elderly is the product of a cultural deformation that makes the old valued as useless. Psychological and physical aggression occurs mainly in people who are recharged from work with the elderly [16].

Clinical interview with elderly patients

Physicians use a wide range of family interviewing approaches with individual patients and with family members who accompany patients to office visits [27].

Doctor-older patient relationship and communication has special nuances and characteristics because there is a greater heterogeneity of patients, a sensory loss, decreased memory, slower processing of information, decreased power and influence over their own lives, and withdrawal from work and separation from his friends and family [28]:

1. Older patients are more likely to accept the doctor's authority. The elderly (> 75 years) have the least participatory visits with their doctors
2. Non-verbal communication (It becomes a greater way of expressing the mood and it plays a greater role compared to verbal expression)
3. Listening (The interview with the elder is a means for him to reconstruct his life)
4. Verbal communication (The doctor-elderly patient interview should be carried out appropriately to the neurocognitive, sensory and affective conditions of the patient)
5. Pathology in the elderly influences doctor-patient communication (multimorbidity, polypharmacy, and the fact that in the elderly the disease is seen as a structural situation, an intrinsic element of the person, and not a temporary event)
6. Empathy (The older patients need an empathic communication as n essential part of their treatment)
8. The disease with poor prognosis (Telling the truth is always a particularly delicate situation)
9. The doctor-older patient interview should pay special attention to psychosocial factors (the outcomes of health care for older patients depends on the psychosocial needs).

The sick generally want the family to participate in the main health decisions. Family interviews are admitted to be valuable when a member is terminal or has been hospitalized for a serious illness; Patients are also thought to want a family interview in cases of depression, marital relationship problems and stress-related symptoms [29-31].

Another important point when talking with relatives is honesty (especially in the terminal patient). One of the main reasons for this honesty is to preserve the trust between family and doctor, when in addition the same doctor can attend to other relatives [32].

Ethical problems

The doctor-patient relationship is the cornerstone of medical practice and ethics. In order to achieve respect for older adults, prudent medicine is necessary, based on a practice in which ethical and clinical reflection can contribute to medical interventions. The latter is possible if the rights of the elderly are enforced, in particular for decision making. Older adults

are at risk of being marginalized and deprived of their rights. This situation of rejection may lead to being considered as non-competent persons. A classic example is "institutionalization", a decision taken by family members, without consulting the affected. This discrimination occurs not only in the social -with great impact on the physical and mental of these people- but also in the field of health [33].

The elderly must have the same rights to care, well-being and respect as other human beings. The GP has the responsibility to help prevent physical and psychological abuse of elderly patients. The competent elder must decide on health issues, according to his wishes and after his informed and voluntary consent, although prudence seems to ask for a framework for decision-making and responsibilities shared between doctor and elder. When the elder is incompetent, the decision is transferred to a close relative who acts as his representative. If there is a conflict between the competent older adult and the doctor or between the doctor and the family representative, the doctor must always act to the best benefit of the patient [34].

Care focused on psychological support

Chronic diseases of the elderly substantially affect the psychological state of the elderly and their families. Thus, for example, heart failure substantially affects the psychological status of patients and caregivers or family members. However, the evaluation of psychological reactions to severe or advanced chronic diseases in the elderly is still limited to the evaluation of anxiety, depressive symptoms and quality of life.

A set of strategies to provide psychological care are required to supporting these patients: with severe or advanced chronic diseases (not only cancer), or terminal illness with a fatal prognosis and poor quality of life, or with a large number of comorbidities which require frequent contact with health services and recurring and prolonged hospitalizations), etc. Psychological adaptation of the patient to his illness is crucial not only for the quality of life, but also for the result of treatment. This situation is accompanied by dramatic and fundamental changes in the general lifestyle, including socioeconomic status, the hierarchy of the patient's life priorities and all members of his family [35].

Care focused on caregivers / family members

Traditional access to health care often ignores the importance of integrating family members by perpetuating what can be called the "dyad myth" in medical practice. However, it is possible to improve the positive impact of doctors on the health of an individual by including other family members in the care plan. In this way, it goes from a dyadic relationship in medical interaction, to the triad that includes the patient-family-doctor components [36].

The definitions of caregivers vary, but in general they are an unpaid family member, a close friend or a neighbor who provides assistance with daily activities, including practical care, coordination of care and financial management. We use the term family to include the patient, caregiver (s) and other family members. By caring for patients with progressively impaired conditions and increasing care needs, over time, caregivers perform more complex care tasks, similar to those performed by health professionals or social service providers. Therefore, caregivers play an important role in caring for people with diseases or disabilities throughout the course of the disease [37].

A second adult-usually husband or wife accompanying the patient consultation is always significant and deserves the attention of the doctor [38,39]. It is common for family members to accompany patients, especially in elderly patients, to their medical appointments, and these triadic visits differ from visits with only the doctor and the patient [40].

These family members who accompany the elderly in the consultation assume important roles in improving the understanding of the patient and doctor [38]. In addition, elderly and comorbid patients need the help of family members to complete their treatments, go to medical appointments, etc. It is considered that the presence of the companion in the consultation can improve participatory decision making, and influence patient satisfaction with medical assistance [41-44].

Relationship-focused care

The current focus on person-centered care runs the risk of overly emphasizing independence and stigmatizing dependence and interdependence, which are in the lives of many older patients. When caregivers are involved, relationship-centered attention should be the goal: on interactions between the patient, family, caregivers and health

and social assistance staff. Supporting these interactions is important to provide effective medical care [45].

FAMILY-CENTERED APPROACH

Care giving can be associated with negative outcomes. Caregivers 'physical and mental health, financial status, and social life are often negatively impacted, regardless of the care recipients' illness. As a result, the quality and sustainability of care provision at home may be threatened. The need to support caregivers to minimize negative outcomes and optimize the care they provide has received considerable attention in recent political initiatives to allow people to continue to lead healthy and independent lives in their own homes. Family-centered care has been proposed to address the needs not only of the patient, but also of their family members [46].

The basic element that defines family-centered care is the mutually beneficial association between GPs, patients and families in the planning, delivery and evaluation of medical care. Alternatively, family-centered care is an organized system of medical care, education and social services offered to families. Family-centered care can achieve perfect continuity to address the needs of patients, family and community through interdisciplinary collaboration. In the broadest scope, the notion of family-centered care encompasses the client's vision of care as the patient and his family, rather than just the patient. Family-centered approach for provision of medical care (developed especially for pediatric care) values a partnership with family members to address the medical and psychosocial health of patients [47].

Family-centered care offers an opportunity to support families and strengthen a working partnership between the patient, family and health professionals during end-of-life care. Thus, family-centered approach takes into account the strengths and needs of all family members [48,49].

But, to date, there has been no synthesis of key components of original family-centered care models across all illness and populations [37]. In any case, by helping older adults and their families, the most useful conceptual skill of the GP is to embrace the belief that "disease is a family matter." This belief of the disease calls for a systemic or interactional approach specifically in the communication patterns of the relationship. By discovering maladaptive and distressing family interactions, the GP can intervene and offer ideas for more useful interaction patterns [50,51].

Interventions that serve the elderly and family in the home

The benefit of working directly in homes of the elderly and their families is well established. When GPs include in the diagnosis the rich texture and personal environment of each home, it allows them to know the family individual ecology, which is much more difficult to obtain in the traditional examining room (although it can be very approximated by the tool of the genogram, and the triangulation of the vision between the different actors). The process of working in the home enhances the clinician's ability to understand and address the complexity of the dynamic reality that constitutes the everyday world of both elderly and their families. Bringing services you the home also address the problems of resistance and access to service that surface regularly with vulnerable populations. It can be difficult for many elderly people and their families to use medical services in a traditional way. This way they can break appointments, or not make them, and not receive the appropriate level of medical care. In-home, family-focused intervention is a necessary component of a comprehensive system of elderly care [47].

Home care is a broad and global concept that contemplates the social and health aspects necessary to maintain the autonomy of people who remain at home. Home care in elderly patients is a continuous, comprehensive and multidisciplinary process, in which, in addition to health functions and tasks, social aspects must always be taken into account. Target population of home care, includes: "High risk" elderly (very old (> 80 years old), living alone, lacking family, with serious or disabling diseases, with recent hospital discharges, with vital medications, chronic patients with multimorbidity, disabled and physical or psychic dependents, terminal elderly, home hospitalization, and patients with certain demographic or geographical or socio-economic characteristics [20].

CONCLUSION

Individual, family and community health care cannot be separated. Family care in the elderly is not an option, but a necessity, since the elderly generally need help from the next actors in their context: family, caregivers, friends, neighbours. Longevity, fragility and multigenerationality are key issues in understanding the dynamics of families that live in different

contexts of social vulnerability, especially in contexts of greater poverty. There are a certain number of elderly people with family neglect, mainly due to affection problems and limitations in financial resources. As the age of the elderly increases, family attention may decrease due to the increase in the problem of aging and its care difficulties. Family dysfunctionality causes greater family neglect for the elderly. Physical abuse is a not uncommon problem in neglected elders. The well-being or satisfaction of the elderly is related to the family care received. The genogram is a useful tool to delineate the family structure of elderly patients. It is recommended to provide from general and community medicine family care about the aging process and the problems and needs of the elderly.

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