Importance of the Family in Diabetes Care – A Review Article

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Abstract

Diabetes is one among the leading non-communicable diseases which has to be addressed with different strategies involving the individual and family in addition to the health care services. A significant portion of diabetes management takes place in family or home settings. Family support plays a vital role in treatment adherence, illness adaptation, and blood sugar control. This article reviews about the importance of family in care of family members with chronic diseases such as diabetes.

Introduction

Diabetes is one among the leading non-communicable diseases which has to be addressed with different strategies involving the individual and family in addition to the health care services. Despite recent advances in treatment, health-care technology and increasingly sophisticated guidelines, sub-optimal diabetes control remains a problem in many countries with adverse consequences for the individual with diabetes.

A significant portion of diabetes management takes place in family or home settings. It is the family members who identify symptoms of hypoglycaemia and ensure prompt management. Family support plays a vital role in treatment adherence, illness adaptation, and blood sugar control. Each member take up assigned roles like giving insulin injection, buying medication, taking the patient to the doctor for follow-up etc. as part of routine practices. Family members often decide which food to buy or keep around the house, what food to make for meals, what activities fit into the family schedule. Family members often provide the emotional support that helps patients handle the stresses of illness. Hence family relationship may also be strained in chronic diseases like Diabetes, Hypertension etc.

Here few questions arise such as how does a family promote or hinder the well-being of its individual adult members suffering from diabetes? How does the family nurture health among the individual family member with diabetes? Let’s begin to understand the answers by knowing about the basic family structure, family roles and family models of care in managing chronic diseases.

The larger social structure impinges on individuals through the family. A family is an economic unit bound together by emotional ties. The U.S. Bureau of the Census defines a family as two or more individuals related by blood, marriage, or adoption who reside in the same household (Cherlin, 1981). The Institute of Family Centred Care defines the word “family” as two or more persons who are related biologically, legally or emotionally.

The Bowen family systems theory identifies the family as a closed group and calls it an emotional unit as all members are emotionally interconnected. In a family each individual affects the thoughts, actions, emotions of the family tremendously. Bowen expressed this that the family members live under the same ‘emotional skin’. This theory emphasis

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three terms namely family roles, family roles and homeostasis/equilibrium. A family role is the expected role taken up by the family member. In basic, the roles may be broadly classified as father, mother, sister and brother etc. However finer classification is something like ‘the responsible one’, ‘the emotional one’. These are roles of the members and they give the characteristics to the family system. Often the roles of the members are related to each other.\(^3\)

Family rules are the rules of operation of the family. Many times all these rules are not spoken or laid out, but are known well to the members. Some examples such as the liberties the children have; the relationship and respect the mother, father expects from their children. These are patterns and are unspoken regulations of a family system.

Homeostasis may be called as the tendency of a system to keep things as they are and not let any force change the course of the system. There is an internal force from the system on its members to keep things as they are, to prevent change. Each family system has patterns. The family runs along these patterns. These are unspoken and undefined patterns, they just exist amongst the members. These patterns are formed due to the above three terms, roles, rules and equilibrium. The family pattern runs according to these three defining conditions. As conceptualized, family life is composed of three domains: family structure and organization, family world view, and family emotion management.

According to the family theory, diabetic patient is a single element in the family and is interdependent with the other members who are also elements within the family structure. In order to maintain haemostasis the diabetic patient and the family take up different roles and abide or frame different rules. These rules are rarely, explicit or written down. The roles and rules give power; induce guilt; control or limit behaviours; among the family members thereby providing supportive or non-supportive behaviours for health maintenance.\(^4\)

Family members provide unique and effective support to patients self care management for the following reasons:

Family members

- Usually have frequent and ongoing contact with the patient.
- Often share cultural background and value systems with the patient.
- Often have a detailed and intimate knowledge of how patients are managing their disease and the context in which they are managing it.
- Usually have developed relationships and communication patterns before chronic illness is diagnosed.

Disease management is best in families described as well organized, in families with clear traditional sex roles, in families that have an optimistic belief that life is understandable and manageable, and in families in which both spouses are able to resolve differences of opinion regarding diabetes care.\(^5\)

In a recent study where the relatives of Patients with Diabetes were educated about six cardinal management targets of diabetes namely fasting and prandial blood glucose levels, HbA1c, blood pressure, high-density lipoprotein, low-density lipoprotein and triglycerides on first visit and follow-up. Interestingly, relatives of Patients with Diabetes had a better recall of these cardinal targets and their respective family members had a much better disease control (HbA1C) when compared to the 10 enrolled participants for the National Diabetes Educator Program.\(^6\)

Children in the family also play an important role in health maintenance of their parents. Diabetic parents expressed that children monitored their dietary intake and reminded them what they should not be eating. Some children helped with shopping and meal preparation. Families described children reminding parents to exercise and exercising with their parents. Children reminded parents about medications and assisted with tasks such as checking blood sugar. However both parents and children perceived that children played a role in tempting parents to stray from their diabetes diet, because children’s diets included food that parents desired but tried to avoid.\(^7\)

It is also important to understand the perceptions of diabetic patients about their family members involvement in helping patients with diabetes and what the patients with diabetes experience in the family structure. Instrumental support was the most common form of family support received from family members in areas such as diet, exercise, medication adherence, blood glucose monitoring, and managing doctors’ appointments.

Two types of non supportive behaviours:

1) Sabotaging behaviours from family members who were well informed about diabetes but did not help the participant perform diabetes self-care behaviours.
2) Miscarried helping behaviours, in which family members’ attempts to help with diabetes self-care produced conflict.\(^8\)

Family measures had the strongest associations with patient morale. Unresolved family conflict about diabetes was statistically significantly related to more depressive symptoms and lower Disease related Quality of Life (DQOL). High family coherence, a belief that the social world is meaningful and manageable, was significantly positively associated with general health and DQOL-Impact and negatively associated with depressive symptoms. Finally, structural togetherness in families was positively related to DQOL-Satisfaction. One statistically significant association was
found between the family variables and self-management behaviours. Coherence was positively associated with levels of physical activity.

Family functioning is related to family support for diet self-care and that such support is inversely related to perceived barriers to following the diet regimen. It is also vital to understand the family members’ perceptions towards diabetes care management. It was also observed that family members reported distress with particularly high rates in India, Algeria and Turkey. In a study conducted to know the distress of family members of Diabetes clients 61.3% were worried about the risk of hypoglycaemic events and a notable burden of diabetes on the family was perceived by over one-third of respondents. Indian family members reported the second highest rate of worrying about hypoglycaemia (79.0%), just behind Algerian family members. 39% of family members liked to be more involved in the diabetes care, but 37% reported not knowing how to best help the person with diabetes they live with. India, however, had the largest proportion of family members (59.5%) willing to be more involved in diabetes care and the second highest percentage (57.5%) willing to be involved in helping people with diabetes deal their feelings about diabetes.

**Implications for Nursing Practice:**

- Guide family members through goal setting process.
- Teach communication techniques to family members that are likely to be perceived as supportive by the patient.
- Encourage family members to practice and refine support techniques and communication techniques over time, with feedback from the patients and professionals.
- Focus on Autonomy support for adult patients. Such type of support emphasizes the patient’s needs, feelings and goals as the primary determinant of self management success. Focusing on Autonomy support can help family members avoid the stress of taking too much responsibility for illness management.

**Conclusion**

Despite changes in the Indian family system it becomes imperative that nurses understand the importance of family support in chronic disease management. Nurses should invest time in self preparation in areas like communication and goal setting process in diabetes care management. Further Research in Indian family support mechanisms will help dealing with the disease which requires abundant support from the family.

**References**

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