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Review

Self-care profiles of the elderly institutionalized in Elderly Care Centres

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ABSTRACT

The concept of self-care in the elderly has been frequently associated with autonomy, independence and personal accountability. Self-care practices are a result of individual lifestyles and paths adapted to the circumstances and expectations of the elderly. Based on the model by Backman and Hentinen (1999), the present study attempts to categorically describe the types of self-care of the elderly. This is an exploratory study, transversal, of a quantitative nature. The sample was comprised of 313 participants, randomly selected among Elderly Care Centres in the interior North of Portugal. The Portuguese version of Self-care of Home Dwelling Elderly was used for data collection. The results call for a replication of the study, using the theoretical derivation of the four self-care profiles (responsible, formally guided, independent and abandoned).

1. Introduction

The concept of self-care has been commonly associated with levels of autonomy, independence and personal accountability. The definition of self-care includes the performance of free-initiative activities aiming at the preservation of life, health and personal well-being (Orem, 2001), namely health promotion or recovery. Therefore, it is a complex and multidimensional phenomenon (Petronilho, 2012).

This notion of self-care emerges as a means of health promotion performed intentionally and rationally (Backman & Hentinen, 1999, 2001; Rasanen, Backman, & Kyngas, 2007; Zeleznik, 2007).

However, self-care should not be considered exclusively from a logical perspective of health promotion, but rather as part of a broader context, which takes into account the importance of self-care with regard to the activities of daily living (ADLs). Thus, self-care practices are the result of individual lifestyles and personal adaptation of the elderly's life history to their circumstances and personal expectations (Backman & Hentinen, 1999, 2001; Rasanen et al., 2007; Zeleznik, 2007).

The literature suggests that the factors influencing self-care actions can be divided into external and internal factors (Backman & Hentinen, 1999). The living conditions, the aid services provided to the elderly and the social support are all part of the external factors. The latter combines the emotional, instrumental or educational support contributing to the maintenance of autonomy and independence (Backman & Hentinen, 1999; Rasanen et al., 2007; Wichmam, Couto, Areosa, & Menéndez Montañes, 2013). Concerning the internal factors, the health condition can be seen as *a priori* determinant for self-care. There are also other internal factors to be considered, such as functional capacity and health, coping strategies and resilience (Backman & Hentinen, 1999, 2001; Zeleznik, 2007).

Backman and Hentinen (1999) outlined the construction of a theoretical model explaining the types of self-care found among the home-dwelling elderly. Self-care behaviours in the elderly are viewed as actions aimed at maintaining or restoring health, and the performance of their ADLs. The model presents different self-care types with their corresponding conditions in terms of action and associated meanings. Therefore, it is possible to identify four profiles: responsible, formally guided, independent and abandoned.

The responsible self-care implies activity and accountability in all the ADLs, including concern over the health processes. The elderly with this profile control the management of their own treatment regimen, understand the assumptions for the suggested therapies and want to make informed decisions about alternative therapies. Once they perceive any health problems, they take an active attitude, seeking appropriate help immediately and without hesitation. They want to be informed about the conditions and symptoms presented, as well as the different treatment options. Therefore, they actively collaborate with health care professionals, often establishing long-life relationships. These elderly people adopt healthy daily lifestyle habits, taking care of their physical condition, either as part of a healthy diet, or in their exercise routines. For these elderly people, the performance of daily

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activities is a positive accomplishment. The positive, future-oriented attitude and the positive experience of ageing are important prerequisites to the responsible self-care profile. These people value their professional activity and after retirement, they finally have the opportunity to engage in different projects involving tasks and activities they wish to experience. They devote time to themselves, realizing that the hard work has given way to the enjoyment of everyday living. Therefore, ageing means a new kind of living. Being responsible is to wish to continue living actively, enjoy social activities, have positive relationships with family and friends, trust and hope in the future, and also to expect the support of others if and when it is necessary.

The formally guided profile consists of regular compliance, but an uncritical attitude towards the therapeutic counselling, involving simple routines with no satisfaction involved in the performance of daily tasks. This profile is often associated with people who have experienced a life history based on the dependency of others. It concerns people who left the nuclear family early to start a professional activity, frequently reporting a life cycle characterized by hard work. They do not recognize their own personal needs and perceive ageing only as an inevitable decline of physical and cognitive skills. These people face the course of their life cycle with the cognitive bias of inevitability and accept their increasing decline. Ageing is associated with retirement and therefore they accept limitations in the ADLs. Despite their wish to remain in their own houses, they are conscious of the potential need for future institutionalization.

The elderly with an independent self-care profile tend to manage their health-disease processes by questioning the therapeutic recommendations of health professionals. They find original ways to take care of themselves and when they perceive any problems associated with their health or well-being, they do not seek the help of health professionals. These people try to find answers to their problems by themselves, based on their life cycle experiences and personal beliefs. This type of profile is grounded on “the school of life” philosophy. It is based on a strict view of managing their personal lives, often characterized by stories of personal determination in relation to their lives, professional activity and social relationships. People in this profile usually deny the ageing process and tend to hide disease signs and symptoms. They often compare themselves to other elderly people, by emphasising that they are healthier and do not need medication. They expect to remain in their own houses because it gives them a sense of safety and they tend to prefer being alone, while undermining the importance of their social network.

Lastly, the abandoned self-care profile is characterized by personal representations of helplessness and lack of accountability. These elderly people do not care for themselves and are unable to manage the ADLs. This sense of helplessness and incapacity is multidimensional, often revealed by the desire to give up on life. This self-care profile is commonly characterized by reports of life stories embedded in bitterness and sadness. They tend to be introverts and their past and current lives are characterized by poverty, lack of respect or understanding from significant others or third parties. The feeling of bitterness often seems to be based on the perception of negative experiences throughout life, including reports of hard work, unsatisfactory marital relations or episodes of violence, or experiences and recall of traumatic events. They have a negative attitude towards the ageing process, with personal representations of the life cycle involving pain (physical and/or psychological) and incapacity, resulting in feelings of helplessness, loneliness and abandonment. This profile is characterized by a desire to give up and entails a feeling of loss of control of their personal life, due to their perception of personal physical and mental decline and to a low or non-existent social support. Concerning the future, the fear of pain is constantly present, as well as the decline of functional capacities, the continued loss of personal control over their lives and the fear of death itself.

Rasanen et al. (2007) developed a self-report instrument to evaluate self-care in the elderly, living either in care institution or in clinical contexts. The instrument presents five independent scales, in which the behaviours in self-care, self-care guidance, functional capacity in the basic activities of daily living (BADLs) and in the instrumental activities of daily living (IADLs), satisfaction with life and self-esteem. Based on this model, Backman and Hentinen (1999), designed a scale with 42 items to assess self-care profiles.

The present study sought to describe categorically the self-care profiles of a random sample of institutionalized elderly, using the Backman and Hentinen (1999) and analysing the theoretical derivation of the identified profiles.

2. Methods

This is an exploratory, cross-sectional study, of a quantitative nature. The research is non-experimental or *Ex Post Facto*. Preliminary analyses to establish the correct number of clusters or profiles were performed using the Latent Profile Analysis approach (LPA). A multivariate data analysis was then performed, through a clusters' analysis by means of the combinatory procedure (Hair, Black, Babin, & Anderson, 2010).

This study was approved by the ethical committee of Abel Salazar Institute of Biomedical Sciences, under the registration number 166/2016.

The data was collected and processed only by the main researcher, in a single moment with each respondent in a reserved room. All ethical principles, anonymity and confidentiality were assured. The participants were asked to sign an informed consent form after being provided with all the information concerning the researcher, the nature of the research and its objectives. Given the age and educational limitations of the participants, the questionnaires were administered orally by the person in charge of this study.

2.1. Participants

Participants were recruited from the 56 Elderly Care Centres (ECC) located in the interior north of Portugal (in the Vila Real district and in each municipality), registered as Private Institutions of Social Solidarity. Only the institutions that gave written permission to participate in the study and that were willing to integrate the sample were included. Data collection took place between August 2014 and July 2015. Prior to this process, the people responsible for each institution were informed of the protocol to be used. A total of 25 ECC accepted to participate in the study. Participants were recruited from these 25 ECC, through a simple random procedure. Each elderly person was assigned a number on a card, placed in a bag and 30% of the total number of residents of each ECC were selected (Field, 2009; Fortin, 2003). If the selected elderly person refused to participate, another card was selected. Participants without the cognitive capacity to give consent were also included after their families' consent. In these cases, only the physical assessment was performed.

2.2. Instruments

The Self-care of Home Dwelling Elderly (SCHDE, Backman & Hentinen, 1999, 2001; Rasanen et al., 2007) was applied. This instrument is a part of a larger protocol that includes a total of five evaluation instruments (Self-care orientation; Self-esteem; Life satisfaction; Functional capacity (Personal activities of daily living and Instrumental activities of daily living) and Types of self-care. All these instruments were already translated and adapted to the Portuguese population, with several psychometric studies already performed.

The SCHDE was not fully applied, since the main goal of the researcher was to categorically describe the four main types of self-care of the studied sample. So, the SCHDE Types of Self-Care Scale (TSCS; Rasanen et al., 2007), included 42 items of the self-report, with a five-point Likert scale (from 1 = Total Disagree to 5 = Total Agree). The