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The various perspectives of Iranian families of elder care in family: A Q-methodology Study

Shahnaz Pouladi[*],Monireh Anoosheh[**],Anoshirvan Kazemnejad [***],Armin Zareiyan[****]

[*]*BScN, MScN, Assistant Professor ,Department of Nursing and Midwifery Faculty of Medical Bushehr University, Iran Email:sh.pooladi@bpums.ac.ir*

[**]*Professor, Department of Statistic, Faculty of Medical Science, Tarbiat Modares University, Tehran, Iran*

[***]*Associate Professor, Department of Nursing, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran*

[****]*Nursing PhD Candidate, Department of Nursing, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran*

ABSTRACT-While there is an increasing number of family elderly caregivers; three are no plans to expand the capacity of family elderly care facilities for these families. This will almost inevitably lead to an increase in the burden placed on family careers. We investigated how family caregivers living and care to elder in family.

***Aim*: Objective of the study is expressing the subjectivities of Iranian families on elderly care**

***Method*: A Q-methodological study was conducted. Fifty four family elderly care giver asked to rank-order statements on issues potentially associated with elderly care. Q-factor analysis was applied to uncover patterns in the ranking of statements.**

Results: Seven distinct subjectivity profiles concerning family elderly care were found among Iranian families: (a) Care based on religious values (b) Elder centered care (c) Family centered care (d) Feelings based care (e) Compulsion based care (f) Inactive care (g) Holistic care.

***Conclusion*: The findings contribute to the development of supportive interventions for reinforcing family foundations for effective elder care.** *© 2014 Bull. Georg. Natl.Acad. Sci.*

Key words: *family, aged, care givers, Iran*

The growth of elderly population in various countries [1] has increased their caring needs in the family [2]. Iranian's population is becoming increasingly older. According to Sheykh & Taghi (2006), the changes such as decline in fertility, an increase in life expectancy and aging of the "babay boom" generation are the main demographic trends contribute to the aging of Iranians population [3]. The increasing aging population has increased the demand for care of aging adults. Ninty percent of the Iranian population will become family or informal caregivers [4]. A review of the literature related to caregiving of aging adults indicated the Iranian families are encountering several dificulties and challenges for elder care in their families [5-7]. Most of these studies carried out on elder care based on the perception of researcher. Such a position excludes caregivers from describing their perspectives about their experience and needs [8]. Hilton et al. (2009) were the first to investigate specifically what caregivers' perceptions are about successful aging. They use mixed method technique in their study including a theme analysis of caregiver responses to open-ended questions about their care giving experiences. Their result indicated those caregiver perspectives on successful aging and their needs for support need to be studied further and with more diverse populations [9].

Ramlo & Berit (2013) were other researchers to explore the views of American's families about their caregiving experiences via Q methodology. Factor analysis of the sorts, in their study resulted in three views: dutiful caregivers new to caregiving, nurturing and prepared caregivers, and loving and fun caregiving relationship [8]. We know the Iranian society in term of social, economic and cultural aspects is different to UA society. In Iran was expected that religion to be an important factor in families to demonstrate the view of family caregivers. It should be accepted that in Iran also no study has been conducted in the context of expressing the subjectivities of Iranian families on elder care in the family. As due to the different reasons including several hardships in controlling the unwanted

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variables on the phenomena that has to do with human behavior in quantitative approaches, hence it is necessary to use the combined qualitative and quantitative approaches to research in the field of social and behavioral problems [10]. In this regard the Q methodology in addition to enjoying the traits of qualitative approach has also the quantitative approach and as the discovering research and trying to find the novel thoughts and new and useful suppositions on the research subject [11]. As the traditional studies by quantitative or qualitative approaches lonely no enough and necessary sufficiency to respond to some stakeholders problems; the use of Q methodology by the stakeholders will be the appropriate way to expand their knowledge [12]. Therefore the aim of this study was to demonstrate the benefits of determining the various perspectives of aging adults via Q methodology. The authors will also demonstrate how these views can be used a need-assessment for programs and other support services to reduce burden of care on caregivers.

Method

General overview of Q methodology

Q methodology is a form of pattern analysis that combines qualitative and quantitative aspects. This method specifically invented in the 1930s by William Stephenson [13, 14]. This type of research is relatively new to the field of health care but has been widely used in other areas of policy research during the last 70 years [15, 16].

Q methodology provides a foundation for the systematic study of subjectivity, people's viewpoints, beliefs, attitudes, feeling, opinions, and the like[16, 17].

To survey the 'understanding of families with elderly caregiving' concourse a series of semi-structured interviews with families with elderly caregiving experience were conducted, alongside a comprehensive review of the elderly caregiving by family's related literature. In this study, 331 statements were taken from semi-structured interviews and by comprehensive review. The statements were taken from participants' responses to the following questions: "Will you please tell me about your experiences on providing care to the elderly family member? Why do you take care of the elderly at the home? Why do you think that you are successful or unsuccessful in provision of care to the elderly at the home? The outcome of these two sets of studies created 3 information levels including: basic themes (the information that is extracted from text data); sub themes (set of similar themes); and overarching theme (encompassing all basic and sub themes). Four overarching themes extracted in this research include: reinforcing factors, limiting factors and the negative and positive consequences of elder care in the family. Of the original 331 statements, 72 were selected for sorting and these are listed in the Appendix A.

In Q methodology, such data is first collected in the form of ' Q sorts' (the vehicle for the expression of subjective viewpoint) and then factor analysed to yield patterns of community and divergence in expressed viewpoint [18].

Participants

In this method, 54 participants are presented with a sample of statements about some topic, called the P-set, are asked to rank-order the statements from their individual point of view, according to some preference, judgment or feeling about them, mostly using a quasi-normal distribution (Fig.1). The demographic information of the participants is shown in table1. After cutting out and carefully reading the 72 items, participants were asked to arrange them into three broad piles: 'agree', 'neutral' and 'disagree', and then to sort them into a profile ranging from -6 (most disagree) through 0 (neutral/irrelevant) to +5 (most agree). The number of items to be placed under each category was specified in advance (as shown in table1). Hence the two most agree with items were placed under +6, followed by the three next agreed with items in +4 and so on until a quasi normal distribution is produced which is consisted to be a fair representation of the participant's viewpoint.

By Q-sorting people give their subjective meaning to the set of statements, and so reveal their subjective viewpoint [19, 20].

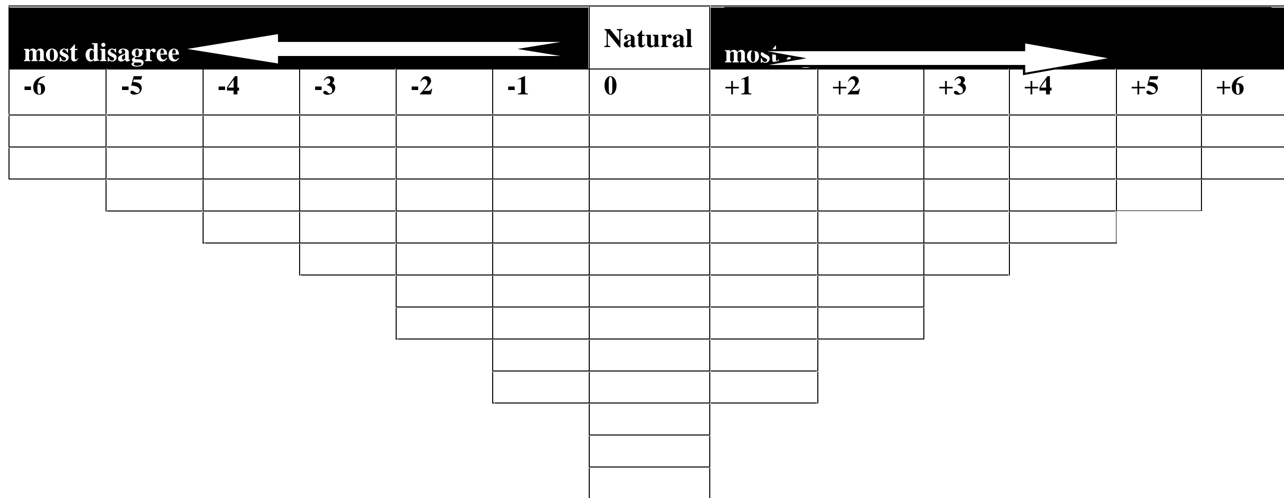

Fig.1: Sorting grid used in this study in spectrum -6 (most disagree) to +6 (most agree)

Table 1: Characteristics of participants in each factor

Factor	Sex		Age				Family relative to elder		Education				Family income				Number of respondents loading on factor
	Female	Male	20-30	31-40	41-50	51-60	children	Others	Diploma	Associate	Bachelor	Master and over	Fair	Moderate	Good	Very good	
Factor 1	12	10	4	7	9	2	17	5	8	4	8	2	7	9	2	4	22
Factor 2	8	3	1	3	6	1	8	3	1	1	5	4	1	5	2	3	11
Factor 3	4	-	1	1	2	-	1	3	1	2	1	-	1	2	1	-	4
Factor 4	3	2	1	3	1	-	2	3	3	-	2	-	2	1	1	1	5
Factor 5	1	2	-	3	-	-	2	1	1	-	2	-	2	1	-	-	3
Factor 6	1	2	1	1	1	-	2	1	1	-	1	1	-	2	1	-	3
Factor 7	4	2	3	-	3	-	4	1	3	1	1	1	2	2	2	-	6

Results

Statistical overview

In Q methodology, factor analysis is used to correlate/group similar sorts/sorters. In this way, the subjective becomes operant via factor structure. Each factor that emerges represents a view about the topic [14, 17].The

individual Q-sorts were analysed using PQMthod 2.32 (statistical method: factor analysis with a varimax rotation) [21]4. The objective of the analysis was to reveal a limited number of corresponding ways the statements were sorted by the respondents. For the factors identified in this manner, composite sorts were determined [22]. A first interpretation of the characterizing statements of each factor (those with a rank value +6, +5, -5 or -6 in the composite sort). Next, differences and similarities between factors were highlighted using the distinguishing statements (those with a statistically significantly different rank value on those factors as compared to the other factors) and the consensus statements (those that do not distinguish between any of the identified factors). Analysis of 54 individual Q-sorts revealed seven factors.

Factor interpretation

Interpretation is based on the factor arrays. Factor interpretation is a hermeneutic process, which involves making a reading, not just of individual item ranking, but of the mode of understanding which informs the sort pattern as a whole. It is important to affirm that there is inevitably a subjective element involved in factor interpretation (which is fitting, since the aim is to reconstruct the subjective viewpoint that originally informed the Q sort). Nevertheless, interpretations are based upon the factor array (which is why, in the following interpretations, the item numbers of key aspects of the interpretations are provided) [18]. We provide below detailed interpretations of seven factors. In the detailed interpretations, the numbers in brackets represent factor item ranking. For example (15: +6) indicates that item 15 is ranked in the +6 (most agree) position in the factor 1 array and that this ranking is relevant to the unit of interpretation which preceded it. The factors have been given titles for mnemonic reasons.

Factor 1' Care based on religious values'

Factor 1 with Eigen value 8.94, describes the 32 % variance of the whole study (Appendix B). This subjectivity that allocates the maximum percentage of study variance to it as compared with all other mentalities is considered as the dominant subjectivity in this study. The people describing this subjectivity believe that the elder care in family should be in the way of divine obedience (15: +6) and under the shadow of abiding by innocent Imams (17: +5) in a way that Godly consent of family members (2: +5) as well as prays of elder for family member (12: +3) are achieved by these acts. The individuals describing this subjectivity also emphasize on this matter that the own elder care in the family do not expect the supports of social organizations such as Imam Khomeini Committee and or social organizations (40: -6) but, they have accepted the hardships of elder care with patience and forbearance (31: +2) and never accept this elder care out of family center such as elder care house (14: -6). Summarily, based on this viewpoint the elder care in the family should be for God and to attract divine consent and as this theme was continuously obvious in the sayings of the people expressing this subjectivity, the title of care based on religious values was chosen for this subjectivity.

Factor 2 'Elder centered care'

Factor 2 with Eigen Value 5.89, describes 21 percent of the variance related to the whole study (Appendix B). The second dominant subjectivity in the study is of the view; the elder care should be in the direction of somatic and psychic health protection (63: +6; 64: +6) along with the necessary respects (8: +6); and the necessary condition to perform such a care will not necessarily be the family exploiting of elder person's respect (5: -3) and or his blessing prays for family members (12: -2). Based on this view, the elder should live in the family (13: +5) and along with all family members and should not keep the elder in an outside family atmosphere such as aged centers (14: -6). The people creating and revealing this subjectivity suggest that having the scientific information (46: +3) and the experience to care the elder (52: +1), thinking over the results of personal behavior with elder (4: +1) in addition to anticipating the factors related to creating danger for elder (16: +1) enjoy high significance in elder care in the family. This view as well expresses the thinking that the work distribution among family members (29: +3) is very important to orderly and punctually performing the elder works (25: +1) with a goal of prioritizing his works (10: +2).

Concisely, based on this view, the family members make endeavors by managing the family in the direction of providing more possible ground for elder care in the family. As the whole family efforts are accomplished in the direction of elder and safeguarding his health as a duty and without any expectation, the title of ‘elderly centered care’ has been given to this subjectivity.

Factor 3 'Family centered care'

Factor 3 with Eigen Value 3.33, describes 11 percent of the whole study variance (Appendix B). The creators of this subjectivity believed that personal somatic (64: +5) and psychic (70: +5) health protection as well as the health consideration (22: +5) and sufficient rest for family members (68: +3) and accompaniment opportunity for family members together (3: +3) is of the most important instances that should be considered when caring an elder in the family. Based on this viewpoint the financial independence of elder (38: +6) is very important indicator to provide the elder care conditions in the family. In addition, the creators of this subjectivity are of the view that the elder care requirement in the family needs a specific place for elder in the family (60: +3) as well as the financial power of the family (50: +2). In such a viewpoint it is very important for family members that the elder respect them (5: +4), have critic acceptability (57: +3) and in such a condition in spite the consent attracting for their performance in elder care is not important for them (2: -1), expects that elder prays for them (+4) too; and show consent feelings (12: +5) for this act. Summarily, based on this view, the family expects the elder against this elder care that bounds the elder person to perform a series of duties as well as the priority of their view in care, the first is him or herself or the family members and then looks to the elder person. As in such subjectivity the family continuously speaks of its expectation of the elder as well as being important of its health and the health of family members, the title of family centered care is allocated to this subjectivity.

Factor 4 'Feelings based care'

Factor 4 with Eigen Value 2.62, describes 9 percent of the whole study variance (Appendix B).. The people created this subjectivity believed that the kindness of family members to each other (34: +6) as well as with elder (35: +6), listening the heart pains of the elder (6: +5), respect them (8: +5) are of the important instances of elder care in the family. Considering that this viewpoint emphasizes the importance of above instances in elder care in the family but gives no importance to family members health (22: -2), the safeguarding of somatic health of elder (65: 0), feelings protection of being useful in the elder (59: -4), preventing the disability progress in elder (33: -1). In addition, under the shadow of such thinking, the presence of empowerment grounds in the family to care the elder in family such as financial power of the family (50: -5), the empowerment of family members in solving the problems of whole family members (51: -4) and maintaining the personal health during elder care (64: -3) is not essentially important. Concisely, it should be expressed that the family viewpoint is a superficial view towards the elder care in this subjectivity and as no importance has been given to a desired elder care in the family, the title of feeling based care has been allocated to this subjectivity.

Factor 5 'Compulsion based care'

Factor 5 with Eigen value 2.6 describes the 8% variance of whole study (Appendix B). The creators of this subjectivity believed that keeping of elder in elder keeping house (14: +2) enjoys the higher importance degree as compared with living in family center (13: +1). Based on such a viewpoint the requirement of elder care in family needs a specific place for elder in family (60: +4), so that the elder care could be dealt with by utilizing the guidance of experienced persons (53: +3). In addition, the describers of this subjectivity believed that the elder care should be subdivided into all family members (29: +6). In such a viewpoint where the elder care in the family enjoys the lowest degree of importance in the family, the family is not hopeful for elder care in the family (30: -5), cannot accept the care hardships of elders (31: -3) and does not consider it important to think on the results of his/her behavior with elder (4: -2); and would not further make effort to prevent the progress of elder disability in the family (33: -6). Summarily, this can be expressed that in this subjectivity the family has no tendency for elder care in the family in different manners and by different ways he is trying to reduce his/her responsibilities in accepting the elder

care in the family and as his/her behaviors in the family indicates his being compelled in elder care, the title of compulsion based care was allocated to this subjectivity.

Factor 6 'Inactive care'

Factor 6 with Eigen Value 2.24, describes the 8 percent of whole study variance (Appendix B). Based on this thinking despite the family considers it important matter to develop new ways of elder care and orderly performing his/her works (48: +4) but not hopeful to elder care in the family (30: -2) and based on it enjoying the elder care experience (52: -1), being informed of aged services providing centers (49: -1), does not consider it important to preventing the disability progress in the elder (33: -1). Based on such a thinking because basically there is no hope for elder care in the family hence, does not consider it important to having a trust in family members for elder care (30: -4; 42: -4) and does not feel any need for duties distribution for elder care among family members (29: -2) and the accompaniment of family members together (34: -4), sufficient rest for them (68: -3) as well as does not consider it useful to maintaining the elder interest in family members in this way. Summarily, this should be expressed regarding this approach that the family has no enough motivation for elder care in the family and does not indicate any considerable effort in the direction of his/her elder care and based on this reason the "inactive care" title has been assigned to this subjectivity.

Factor 7 'Holistic care'

Factor 7 with Eigen value 3.17 describes 11 percent of whole study variance (Appendix B). In this perspective, the family endeavors to maintain mental and psychic health of elders (63: +5; 65: +5) and in this direction, it tries to plan their works for maintaining mental and psychic health (70: +5) and physical health (64: +4) and it should supervise on elders' cleanliness in family (39: +4). In such a perspective, the family endeavors to find a solution about new ways of care in order to have a favorable care in family (48: +2). Therefore, it is important to be aware of dangerous factors for elder (16: +3) and the ways of meeting their needs (9: +2) and family tries to use guidance of experienced people (53: +3) for make difficulties of elder care easy (31: +2). In this view, attaining the goal of elder care in family is not accompanying with limiting family activities for elder care (67: -1) and the family doesn't consider its own sufficient rest for elder care as a very important issue (68: -2), in a way that it disagrees with elder care in the nursing homes (14: -6). In summary, it can be stated that family having the purpose of a good care looks to different aspects of care such as family health, elder health and using several methods for attaining a complete care, and based on this reason the "holistic care" title has been assigned to this subjectivity.

Discussion

This study provides some information about perspectives of Iranian families about elder cares in the family. The results obtained from Q Factor analysis showed that Iranian families have completely different views about elder care in the family. Generally, it is obvious that there are positive and negative attitudes about elder cares in Iranian families. Positive attitudes of the family about elder care in the family will be obtained such as care based on religious values, elder-based care and holistic care and negative attitudes of the family about elder care are views such as family-based care, feelings-based care, compulsory care and inactive or passive care. Discussion about these issues is as follows.

Factor 1, (care based on religious values) as the dominant view of this study indicates dominance of this view in Iranian family for elder care. In this view, family obliged to religious values canonically bound to elder care and in this situation, the family has no expectation for helping of others. The distinction between this perspective and other perspectives of this study is importance of religious thoughts and the role of religious behaviors in elder care in the family. As developers of this perspective are mostly people who are middle-aged and are children of elder, it is not surprising that they are trying to improve elder care in the family according to religious thoughts in this period of life and strong emotions between elder and them. Ando (2010) in his study about investigation of Japanese families for effect of religious care on member of family said that religious care has a positive influence on reducing mental

and psychic problems of the member of family who is suffering from cancer [23]. Bounding over religious thoughts plays an important role in reinforcing the foundation of families especially in ethical and spiritual training. Religious thoughts of Iranians rooted in Islamic thoughts include two parts of belief and practical. Belief part is faith in God, prophets, Innocent Imams and afterlife and practical part is bounding over religious, spiritual and praying acts and behaviors [24]. Factor 1 shown in this study as religious care is based on religious values and it shows some of Iranian families developing this perspective believe in faith and belief issues about elder care and they insist on practical obligation through their religious duties against elder and elder care.

Factor 2 (elder-based care) in this study indicates another part of Iranian families focused on attention to elder and elder care in the family just because of elder him/herself. According to this perspective, the family cares elder without any expectation and just for elder him/herself. Developers of this perspective similar to first group are those members of family who are middle-aged and are children of elder; therefore, it is not surprising that dominance of emotions between parent and child paves a way for sincere elder cares based on religious values. Ramlo etal (2013) in his study about perspectives of U.S families for elder care in family indicated that task-oriented care is one of the prevailing perspectives of new caregivers who are responsible for elder care in the family. In fact, task-oriented care in aforementioned study indicated a mental disturbance of young families elder care in the family who are hoping for giving a task-oriented elder care in future through gaining experiences [8]. This is while in our study, perspective of task-oriented and elder-based care does not indicate a mental disturbance but developers of this perspective acknowledge their duty against elder through a moral elevation and maturity of mental and behavioral skills and they achieve the capability of elder-based care in the family.

Factor 3 (family-based care) in this study shows one of the negative attitudes of the family in elder care in the family. Demographic characteristics of developers of this perspective indicate lower than average economic revenue for people of this group. Economic ability of the family is an important index for suitable care of elder in the family. When economic difficulties of the family limits the family in elder care, if the family is not able to be compatible with difficulties of life, then it will be expected that it guides care aspect to its survival and other members of the family and it will place care of elder at the lower priorities. With this respect, it can be expressed that changes of social demands and needs of Iranian families during recent 30 years and changes of their lifestyles caused to increase financial and economic needs. In this situation, the family has to strive more for balancing itself in a way that women are trying to earn revenue beside the men in social areas and this will put more pressure on the families elder care [25]. Mohammadi et al. (2008) in their study about self-efficiency and care pressure of caregiver about elder in the family indicates that those families who do not work will more understand the pressure of elder care in the family [26]). In addition, Mohammadi et al. (2006) in another study about facilitating and preventing factors of elder care from Iranian family's view said that financial ability of caregiver and caretaker in the family plays an important role in facilitating elder care such as having personal house, having salaries and life pensions, financial independence and financial ability of caregiver [7].

Factor 4 (feeling-based care) indicates another part of unfavorable views of elder care in the family. In this perspective, family having a superficial look based on feelings believes in respecting elder and in observing ethical matters for communicating with elder. Yet, in contrast to factor 1 (care based on religious values) and factor 7 (holistic care), this perspective is not based on insight and not focused on reinforcing issues of family for elder care and it hasn't endeavored about this. On the other hand, developers of this perspective are those persons who are non-relative with elder as children. Therefore, contrary to those in first and second perspective who have strong parent and child relation, it is expected that lower level of this part of emotions in this perspective caused to make elder care less important in their view. The stronger the relation between parent and child in the family is the more obligations the children will have in elder care [27] and in these situations, they feel difficulties and adversities of elder care less than before and they complain less in elder care [28].

Factor 5 (compulsion based care) and factor 6 (inactive or passive care) in this study indicates another part of negative perspectives of families about elder cares in family. Developers of this perspective are most men who have low-level economic revenue and they are children of elder in the family. While developers of these perspectives are not hopeful about elder care in this family, then they do not want to elder care in family. Based on these two

perspectives, family has no choice because of economic problems and low revenue and it has to elder care in the family. Alexander (2010) in his study about the role of gender in matching with temper and cognitive problems of couples in the family said that women have more conformity with temper and cognitive problems of their husbands in care them and men have less conformity with temper and cognitive problems of their wives [29].

It is obvious that in this study, one of the important factors in making negative attitudes in the family for elder care is caregiver. According to factor 5 and 6, it should be mentioned that men in Iranian families are responsible for family, economy of family, responsibility of elder care is difficult for them, and they want to find a way for reducing the problems of elder care in the family.

Factor7, (holistic care) as one of the positive attitudes of the family has a favorable comprehensiveness in elder care. Based on this perspective, the family with investigating necessary conditions for elder care in the family and reinforcing them provides a favorable elder care in the family. In this perspective, the family with a view full of insight and awareness without any useless feelings and expectations endeavors for its own health, members of family and elder. While developers of this perspective have high revenue, but individual growth and awareness of them caused to be compatible with difficulties and they do not refuse any effort for family health.

Caregivers of elder in the family who have holistic care perspective is one of the most essential work forces in care systems in order to manage elder programs in the family [30]. Since the members of family have better cognition about talents, capabilities, environment and diet of elder in the family, so they can receive a holistic perspective from elder. Holistic care of elder in the family reduces the needs of elder to care systems and it caused to preserve physical abilities and to increase satisfaction in elder [31].

In this study, two positive and negative perspectives of Iranian families about elder care guides us to this subject that different understanding of Iranian families from elder care in the family causes to create different perspectives about elder care. At this point, it is expected that each one of the unique perspectives of Iranian families for elder care generate a spectrum from their ability to inability about elder care and prerequisite of knowing their ability in this field is to have a unique view to Iranian families based on their different perspectives about elder care in the family.

Limitations of study

With respect to religious culture which is dominating in Iranian society and value of elder care in the family as an ethical act, it is probable that families participating in the study would not be comfortable in expressing their ideas about importance of those care behaviors contrary to Islamic values. Therefore, in order to tackle and reduce such limitations, a private space has been ready for participators for ranking their measures out of reach of other people and they are sure that they are anonymous in all parts of study.

Conclusion

Inefficiency of health system of family in Iran for using family strengths in order to reduce limitations of elder care paves a way for creating negative perspectives in Iranian families about elder care.

Using study results in research field is a direction for continuing studies of nurses in international area about investigating the correlation of caregiver perspective in the family with capability of family in elder care. In addition, nurses of society aware of existing perspectives about elder care tried to discover factors making positive and negative perspective in the family in order to reinforce positive factors and to tackle negative factors.

With respect to high factor loads in the first perspective based on religious values, it is suggested that discovering influential principles on creating this perspective in religious families for factor reinforcing and using religious approaches in elder care should be done with grounded theory approach for compiling elder care model in the family based on religious values.

Meanwhile, negative perspectives of elder care in the family as threatening factors for attaining goals of Iran health Organization about elder care in the family has persuaded everyone to think about family focal point as central core of elder care in danger. Therefore, developing supportive directions for reinforcing family foundations in order to elder care should be included in macro policy making of family health system in global area.

Appendix A: Concourse statements

1. Appreciating the troubles of elders
2. God's consent of family members for elder care
3. Companionship of family members together
4. Thinking on the results of self behavior with elder
5. Respecting the family members by the elder
6. listening to the hardships of elder
7. Consulting with the elder before doing works
8. Respecting the elder
9. Awareness of the methods to remove the needs of elder
10. prioritizing the works related to elder
11. participation in religious programs
12. Good prays of elder for family members
13. Elder living in family gathering
14. The elder keeping in aged house
15. God obedience in elder care
16. The awareness of family members of danger creating factors for aged
17. Following the innocent Imams (religious leaders) in elder care
18. Sacrificing the personal interests for family members
19. Contentment in the life
20. Performing the obligatory acts (prayers, fast…) by family members
21. Performing the obligatory acts (prayers, fast…) by elder
22. Considering the health of family members
23. Truthfulness of elder with family members
24. Predicting the obstacles for elder care
25. Punctuality in performing the elderly related works
26. Awareness of self empowerment rate for elder care
27. Orderly performing the elder related works
28. Planning to perform the elder related works
29. Work division among family members to care elder
30. Hope maintaining in elder care
31. Accepting the care related hardships of elder
32. Planning to perform home related duties
33. preventing the disability progress in the elder Kindness towards elder
34. Family members kindness for each other
35. Kindness towards elder
36. Family awareness of economical and social situation to care an elder
37. Cooperation of personnel related to treatment and health centers with family in elder care
38. Financial freedom of elder

39. Supervision over the cleanliness of aged
40. the support of social organizations (welfare office, the Imam Khomeini Committee) to the family in aged care
41. kin cooperation/support with family in aged care
42. advising the family members to care of elder with godly intention
43. supervision over elder health
44. advise to family members to resist against the hardships of elder care
45. feeling shame on elder cleaning and washing
46. possessing scientific information for aged care
47. good behavior of elderly
48. Efforts to find new ways and methods for elder care
49. Having awareness of the centers providing elderly services
50. The financial ability of the family to care an aged person
51. The empowerment of family members in solving the problems of all families in elder care
52. Enjoying the experience to care elders
53. The utilization of peoples' guidance experiences in elder care
54. elder compromise with the hardships of agedness period
55. action freedom for aged individual
56. Maintaining the elder interest to family members
57. critic acceptability of elder
58. the support of elder relatives
59.Maintaining the feeling of usefulness in elder
60. Having the specific spot to keep elder in the family
61. Trusting to the family members in elder care
62. having no activity when caring elder
63. protecting the mental and psychic health of elder
64. protecting the self somatic health during elder care
65. keeping the somatic health of elder
66. satisfaction from personal performance in elder care
67. Not limiting the activities of family members due to elder care
68. Sufficient rest for family members
69.Elder's consent of family members
70. Protecting the self mental and psychic health during elder care
71. Compromise of family members with elder troubles
72. family members satisfaction from kin's cooperation in elder care

Factor number and name	Number of respondents loading on factor (% variance) and [Eigen value] accounted for	Significantly loaded concourse statements with factor array	Z-score
(1) Care based on religious values	22 (32%) [8.94]	- God obedience in elder care (+6)	2.55
		- God's consent of family members for elder care (+5)	1.94
		-Following the innocent Imams (religious leaders) in elder care (+5)	1.88
		-Good prays of elder for family members (+3)	1.17
		-Accepting the care related hardships of elder (+2)	0.38
		-The support of social organizations (welfare office, the Imam Khomeini Committee) to the family in aged care (-6)	-1.36
		-The elder keeping in aged house (-6)	-2.34
(2) Elder centered care	11 (21%) [5.89]	-keeping the somatic health of elder (+6)	1.88
		-protecting the mental and psychic health of elder (+6)	1.86
		-Respecting the elder (+6)	1.81
		-Elder living in family gathering (+5)	1.76
		-Work division among family members to care elder (+3)	1.09
		-Possessing scientific information for aged care (+3)	1.07
		- prioritizing the works related to elder (+2)	.91
		- Orderly performing the elder related works (+1)	.61
		- Enjoying the experience to care elders (+1)	.34
		- Thinking on the results of self behavior with elder (+1)	.27
		- Predicting the obstacles for elder care (+1)	.21
		- Good prays of elder for family members (-2)	-.73
		- Respecting the family members by the elder (-3)	-1.00
		- The elder keeping in aged house (-6)	-2.24
(3) Family centered care	4 (11%) [3.33]	-Financial freedom of elder (+6)	1.61
		-Considering the health of family members (+5)	1.48
		-protecting the self somatic health during elder care (+5)	1.47
		- Elder's consent of family members (+5)	1.45
		-protecting the self mental and psychic health during elder care (+5)	1.32
		-Respecting the family members by the elder (+4)	1.30
		- Good prays of elder for family members (+4)	1.12
		- Having the specific spot to keep elder in the family (+3)	1.07
		-Sufficient rest for family members (+3)	1.00
		-Companionship of family members together	0.99
		-Critic acceptability of elder (+3)	0.77
		-The financial ability of the family to care an aged person (+2)	.72
		-Satisfaction from personal performance in elder care (-1)	-1.44

(4) Feelings based care	5 (9%) [2.62]	-Kindness towards elder (+6) -Family members kindness for each other (+6) -listening to the hardships of elder (+5) -Respecting the elder (+5) - keeping the somatic health of elder (0) - preventing the disability progress in the elder (-1) - protecting the self somatic health during elder care (-2) -protecting the self somatic health during elder care (-3) - Maintaining the feeling of usefulness in elder (-4) - The empowerment of family members in solving the problems of all families in elder care (-4) - The financial ability of the family to care an aged person (-5)	2.29 2.05 1.98 1.95 0.00 -.41 -1.01 -1.01 -1.42 -1.41 -1.53
(5) Compulsion based care	3 (8%) [2.6]	-Work division among family members to care elder (+6) - Having the specific spot to keep elder in the family (+4) - The utilization of peoples' guidance experiences in elder care (+3) - The elder keeping in aged house (+2) -Elder living in family gathering (+1) - Thinking on the results of self behavior with elder (-2) - Accepting the care related hardships of elder (-3) - Hope maintaining in elder care (-5) - preventing the disability progress in the elder Kindness towards elder (-6)	2.44 1.27 1.16 .70 .14 -.37 -.87 -1.49 -1.84
(6) Inactive care	3 (8%) [2.24]	-Orderly performing the elder related works (+4) - Having awareness of the centers providing elderly services (-1) - preventing the disability progress in the elder (-1) - Enjoying the experience to care elders (-1)	1.43 -.24 -.26

		- Work division among family members to care elder (-2) -Hope maintaining in elder care (-2) - Sufficient rest for family members (-3) -Companionship of family members together (-4) Trusting to the family members in elder care (-4)	-.32 -.54 -.77 -1.12 -1.20 -1.25
(7) Holistic care	6 (11%) [3.17]	-Protecting the self mental and psychic health during elder care (+5) - protecting the mental and psychic health of elder (+5) - keeping the somatic health of elder (+4) -Supervision over the cleanliness of aged (+4) - The awareness of family members of danger creating factors for aged (+3) -Efforts to find new ways and methods for elder care (+2) - The utilization of peoples' guidance experiences in elder care (+3) - Accepting the care related hardships of elder (+2) - Awareness of the methods to remove the needs of elder (+2) -Not limiting the activities of family members due to elder care (-1) - Sufficient rest for family members (-2) - The elder keeping in aged house (-6)	1.61 1.61 1.35 1.46 1.19 84 1.15 .84 .77 -.47 -.71 -2.68

Appendix B: Factor structure of Q-sorts

სხვადასხვა პერსპექტივები ირანული ოჯახი უფროსი მოვლისო ს -მეთოდოლოგიის შესწავლა

მიუხედავად იმისა, რომ გახშირებული ოჯახის ხანდაზმული მზრუნველთა; სამ არსებობს გეგმები მოცულობის გაზრდას, ოჯახის ხანდაზმული მოვლის საშუალებები ამ ოჯახებისთვის. ეს იქნება თითქმის აუცილებლად გამოიწვევს ზრდა ტვირთი განთავსებული ოჯახის კარიერა. ჩვენ გამოძიებული როგორ ოჯახზე მზრუნველთა მცხოვრები და ზრუნვა უხუცესი ოჯახს.

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