Social support networks and self-care in older women with diabetes: a social work and gender perspective

Redes de apoyo y autocuidado en adultas mayores con diabetes: trabajo social y la perspectiva de género

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ABSTRACT

Population aging and the high prevalence of type 2 diabetes mellitus in older adults present health and social challenges that require coordinated responses. In Panama, approximately 14% of the population over 15 years of age suffers from diabetes, with 35,000 new cases annually, older adults being the group with the highest incidence. Although literature demonstrates the influence of social support on glycemic control, the biomedical perspective predominates, omitting socio-familial characteristics and gender perspectives. A narrative review with thematic content analysis was conducted, analyzing studies on diabetes in older adults, support networks, and self-care in Latin American contexts. It was found that between 60% and 80% of older adults with diabetes have deficits in their support networks, especially in the affective and social interaction dimensions. Distinguishing between nominal availability and effective functionality of support networks demonstrates that the presence of family members does not guarantee support for managing the disease. It is evident that gender is a significant determinant, as women often assume the role of caregivers, which frequently results in neglecting their own health and having more fragile support networks. Diabetes in older

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adults presents a challenge for social work intervention, requiring a socio-familial assessment focused on the functionality of support networks. Self-care necessitates interventions that strengthen relationships and activate community and institutional resources, making it essential to incorporate socio-familial assessment protocols into geriatric hospital care.

Keywords: social worker, gender focus, support networks, social policy, aging.

RESUMEN

El envejecimiento poblacional y la alta prevalencia de la diabetes mellitus tipo 2 en adultos mayores enfrenta situaciones sanitarias y sociales que necesitan respuestas conjuntas. En Panamá, cerca del 14% de la población mayor de 15 años padece diabetes, con 35 mil nuevos casos anuales, siendo los adultos mayores el grupo de mayor incidencia. Aunque la literatura evidencia la influencia del apoyo social en el control glucémico, predomina la visión biomédica que omite características sociofamiliares y perspectivas de género. Se realizó una revisión narrativa con análisis temático de contenido, analizando estudios sobre diabetes en adultos mayores, redes de apoyo y autocuidado en contextos latinoamericanos. Se detectó que entre el 60% y el 80% de los adultos mayores con diabetes presenta déficits en sus redes de apoyo, especialmente en las dimensiones afectiva y de interacción social. Distinguir entre disponibilidad nominal y funcionalidad efectiva de redes demuestra que la presencia de familiares no garantiza el apoyo para el manejo de la enfermedad. Se evidencia que el género es un determinante importante, ya que las mujeres asumen el papel de cuidadoras que muchas veces resulta en el descuido de su propia salud y en redes de apoyo más frágiles. La diabetes en el adulto mayor es un problema de intervención del Trabajo Social que supone la valoración sociofamiliar centrada en la funcionalidad de las redes. El autocuidado necesita intervenciones que mejoren los vínculos y activen los recursos comunitarios e institucionales siendo necesario incorporar protocolos de valoración sociofamiliar en atención geriátrica hospitalaria.

Palabras clave: trabajador social, enfoque de género, redes de apoyo, política social, vejez.

Introduction

Population aging has emerged as one of the most critical demographic phenomena in recent years due to its far-reaching economic, social, and healthcare implications. It directly impacts the sustainability of pension systems and the organization of health services while altering intra-familial dynamics.

According to the Pan American Health Organization (PAHO, 2024), it was estimated that by 2025, the global population of older adults would exceed 1.2 billion, presenting unprecedented challenges for social protection and healthcare systems. PAHO defines healthy aging as "the process of developing and maintaining the functional ability that enables well-being in older age" (para. 6)—a concept that acquires distinct nuances when associated with chronic conditions affecting older adults' physical health, functional autonomy, and social integration.

Type 2 diabetes mellitus has emerged as one of the most prevalent chronic degenerative diseases among older adults. It is pathophysiologically linked to risk factors such as insulin resistance and pancreatic dysfunction, which impair blood glucose regulation and can trigger long-term complications that severely compromise patients' quality of life (De León Soto et al., 2024). Within this age cohort, individuals with diabetes face a heightened risk of functional decline and disability due to disease-specific microvascular and macrovascular complications, as well as potentially modifiable risk factors such as poor glycemic control, sarcopenia, frailty, low physical activity, and social isolation (PAHO, 2024).

In Panama, the magnitude of this public health challenge is reflected in recent data from the Social Security Fund (Caja de Seguro Social [CSS], 2025), which indicate that approximately 14% of the population over 15 years of age lives with type 2 diabetes mellitus. With an average of 35,000 new cases diagnosed annually, the incidence is highest among individuals aged 65 and older. Furthermore, according to the Economic Commission for Latin America and the Caribbean (ECLAC, 2024), the country is undergoing a "rapid aging process alongside accelerated urbanization" (p. 32)—a demographic trend identified as a critical area for achieving the Sustainable Development Goals (SDGs).

This scenario becomes particularly significant when analyzed through a gender lens, given the phenomenon of the feminization of aging. Women constitute the majority of the older population and have historically borne the primary responsibility for family caregiving. This dual condition—being an older woman with a chronic illness while simultaneously serving as a caregiver for others—engenders a burden that directly impairs their self-care capacity and the quality of their social support networks. Consequently, a Social Work approach is essential to make these gendered inequalities visible and systematically address them.

De León Soto et al. (2024) emphasize that the discipline of Social Work offers a distinctive framework by conceptualizing illness as a biopsychosocial phenomenon that restructures family dynamics, social support networks, and the older adult's capacity for autonomy. From this perspective, diabetes management in this population must extend beyond direct medical care to encompass emotional and social support, facilitate access to community and health resources, and strengthen self-care capacities. According to these authors, social work professionals can amplify the positive outcomes of self-care through interventions that provide a structured support network, assist service users in coping with their condition, enhance their access to medical and community services, and deliver necessary psychoeducation and support.

The significance of social support as a health determinant in the diabetic population is well-documented, demonstrating that family and social support correlate strongly with quality of life. Bowen et al. (2015) identified significant associations among social support, self-efficacy, and quality of life in older adults with diabetes. Similarly, Chan et al. (2020) highlighted the mediating role of social support in self-care outcomes. Baig et al. (2015) examined the efficacy of family-based interventions in improving diabetes management, while Naranjo Hernández and Concepción Pacheco (2016) corroborated that because diabetes is a "chronic condition involving drastic shifts in lifestyle, occupation, social relationships, and family dynamics, restoring patient self-sufficiency is paramount" (p. 219).

Despite the extensive global literature on this subject, a review of local antecedents revealed no national studies examining this reality from a Social Work perspective, as domestic research has predominantly adhered to a biomedical paradigm. This deficit in local scientific literature underscores the urgent need to shift away from purely biomedical frameworks and generate knowledge grounded in a rights-based and self-determination approach—the ethical pillars of Social Work. This imperative demands a paradigm shift: older adults must no longer be viewed as passive recipients of care or mere medical subjects to be assisted, but rather as rights-bearing citizens capable of making autonomous decisions regard-

ing their lives and health. Under this core principle, the State and society must guarantee their protection while respecting their agency, even within contexts of vulnerability.

Although initiatives such as PAHO's DIABFRAIL-LATAM Program aim to improve the functional status and quality of life of older adults with diabetes through multi-component interventions (PAHO, 2024), such programs rarely incorporate socio-familial assessment as a standardized, central diagnostic tool or position network strengthening as a primary axis of professional practice. Intervention within this domain does not seek to control the patient or override their agency; rather, it aims to ensure that older adults with diabetes fully exercise their citizenship. This is achieved by empowering both the individual and their family to collaboratively make informed decisions regarding disease management, ensuring that provided support enhances their capacity to remain the self-determined protagonists of their own lives with dignity and quality of life.

Within acute care settings, an older adult's admission to a geriatric ward constitutes a health crisis that disrupts both family and social dynamics. To address this problem, this study seeks to answer the following research question: What are the theoretical foundations and conceptual components that, from a Social Work perspective, should inform a socio-familial intervention aimed at strengthening self-care and social support among hospitalized older adults with diabetes mellitus in a geriatric ward?

To theoretically delineate the conceptual pillars of a Social Work socio-familial intervention promoting self-care among older adults with diabetes mellitus, four operational objectives are established:

1. To analyze diabetes in older adults as a complex problem for Social Work intervention.

2. To characterize the socio-familial approach and its conceptual foundations in the assessment of this population.

3. To examine the role of social support networks as key determinants of self-care practices.

4. To substantiate the relationship between functional autonomy and self-care capabilities within the discipline of Social Work.

To answer the research question, this study is grounded in an integrative conceptual framework. Within Social Work practice, it adopts the systems model to understand diabetes as a system-level crisis that alters communication patterns, roles, and boundaries within the family unit (Flaskas, 2007). It further incorporates social network theory, which Rúa (2008) describes as a privileged methodological approach for Social Work, enabling practitioners to analyze the structural topology of an older adult's interpersonal ties and identify available support systems. Finally, it integrates the capabilities approach and the strengths perspective (Saleebey, 2006), reorienting professional assessment beyond deficits and risk factors toward the resources, competencies, and inherent potential of older adults and their families to cope with chronic illness. Together, these theoretical frameworks provide the foundation for a socio-familial intervention that fosters autonomous self-care within Social Work practice.

Ultimately, this study addresses the need to systematize Social Work knowledge within geriatric healthcare. Given the high prevalence of diabetes among older adults, therapeutic strategies cannot rely solely on biomedical management (De León Soto et al., 2024). Robust theoretical frameworks are essential to guide professional practice and highlight the distinct value this discipline brings to interdisciplinary healthcare teams. The theoretical foundations established herein serve as an important antecedent for future research focused on designing and evaluating standardized socio-familial intervention protocols in hospital settings.

Literature Review

Population aging is a multifaceted demographic, epidemiological, and social phenomenon charac-

terized by a growing proportion of individuals aged 60 and older, an increased prevalence of chronic conditions, and structural shifts in family size and intergenerational roles (Ochoa-Vázquez et al., 2018). The World Health Organization (WHO, 2025) projects that this demographic cohort will reach 1.4 billion by 2030, carrying significant public health implications. Consequently, strategic efforts are currently underway to "ensure that older adults remain independent and actively participate in family and community life" (para. 5). This conceptual shift is particularly relevant to the discipline of Social Work, as it reorients the analytical focus away from pathology and toward preserved functional capabilities within a contextual framework.

Fajardo Ramos et al. (2021) contend that active and healthy aging presents a contemporary opportunity—despite its inherent structural challenges—requiring multi-level interventions that address the biological, social, economic, and cultural determinants influencing older adults' quality of life. Type 2 diabetes mellitus, as a highly prevalent chronic degenerative condition in this age group, exemplifies the necessity of adopting a 360 holistic perspective on geriatric health. Bellary et al. (2021) highlight that older adults with diabetes face a heightened risk of functional decline and disability, noting that "the presence of frailty, cognitive impairment, and functional deficits in older adults with type 2 diabetes underscores the critical role of caregiver relationships and social support" (p. 535). Furthermore, given the marked heterogeneity of this population—a phenomenon that remains insufficiently defined—the authors emphasize the need for systematic assessments to implement targeted social support interventions alongside clinical medical care, leveraging existing personal and community resources to optimize health outcomes and mitigate social isolation.

The importance of social support as a structural health determinant is empirically demonstrated by Ortiz Solache et al. (2025) in a cross-sectional study of 372 older Mexican adults. The authors revealed that 80.6% of participants exhibited minimal social support indices, with affective support and social interaction constituting the most severely compromised domains. They concluded that familial companionship and emotional support are essential adjuncts to routine medical management. This finding aligns with evidence reported by Mendoza-Núñez et al. (2016), who observed that unaddressed social needs—such as social isolation (OR=1.36, IC 95%: 1.06-1.74))—were significantly associated with increased emergency department utilization among older adults with diabetes, highlighting the direct impact of psychosocial determinants on disease management and healthcare utilization.

Similarly, Arredondo Sánchez et al. (2024) evaluated the relationship between health literacy, social support, and glycemic control in a sample of 417 older adults. Their results indicated that 62.82% of participants lacked adequate social support, demonstrating a statistically significant association ($p < 0.0001$) between lower levels of social support and higher rates of glycemic dysregulation. The authors argued that among the adaptive coping strategies deployed by individuals living with diabetes, seeking help and social support from healthcare professionals, peer networks, and primary family units is paramount.

In another empirical study comprising 386 older adults, Valdez Rumbo et al. (2025) observed that 53.4% of participants demonstrated low therapeutic adherence. Conversely, individuals receiving higher levels of emotional and affective support achieved superior glycemic control (mean blood glucose of 109 mg/dL). Their findings established that affective and emotional support function as key determinants of medication adherence and therapeutic success, suggesting the urgent need to strengthen community-based support programs that actively involve primary caregivers and family networks.

Further empirical grounding for the Social Work perspective in geriatric healthcare is provided by the seminal study conducted by Merodio Pérez et al. (2015) among 113 older adults. In mapping the structural configuration of participants' support networks, the authors found that 68.1% were married or cohabiting, 100% had children, 93.8% main-

tained contact with extended family, 92.9% relied on peer/friendship networks, and only 9% participated in community groups. Crucially, despite these dense relational structures, 64.7% of male participants and 60.8% of female participants presented with uncontrolled glycemic levels. This key finding demonstrates that the mere structural presence of a social network does not automatically guarantee its functional efficacy in supporting chronic disease self-management.

These findings lead to the conclusion that socio-familial assessment is a distinctive methodological procedure of Social Work, serving as a key diagnostic mechanism to evaluate the older adult's environmental conditions and interpersonal relationships. The Gijón Socio-Familial Evaluation Scale—which gathers specific social parameters including housing, economic status, household composition, social relations, and social support networks (Alarcón Alarcón & González Montalvo, 1998)—was originally developed in 1993 to detect social risk among older populations and has since been widely implemented across healthcare settings. At the theoretical level, Rúa (2008) posits that social network analysis is a fundamental framework for Social Work, noting that "the primary application of the social network analysis approach in social work has been within the domain of social support" (p. 15). This framework allows practitioners to map the structural layout of an individual's interpersonal ties, identify the types of support circulating within the network (emotional, material, instrumental, informational), and detect potential resource deficits or structural imbalances. As a methodological approach, social network analysis is particularly pertinent to interventions with older adults living with diabetes, whose support requirements continuously evolve across all stages of the disease trajectory.

From these premises derives the conceptualization of self-care operationalized in this study—a concept traditionally developed within nursing theory, particularly following Orem's self-care deficit model (Moreno Izquierdo, 2018). However, De León Soto et al. (2024) argue that Social Work professionals involved in diabetes management can amplify the positive outcomes of self-care through structured interventions. These include facilitating well-defined support networks, assisting service users in the daily management of their condition, improving their access to medical and community resources, and providing targeted education and support that strengthen their self-care capacities.

Within this framework, self-care extends beyond mere compliance with medical prescriptions; it is intrinsically linked to functional autonomy. Functional autonomy is defined as the capacity to make informed decisions regarding one's own care, maintain agency over daily life within preserved functional limits, and negotiate necessary environmental support without falling into passive dependency—a concept that fully aligns with the World Health Organization's framework for healthy aging based on functional ability (WHO, 2025). Ultimately, this capacity for self-care is nurtured through the family system, which functions both as a primary support structure and as a critical locus of professional intervention.

Methodology

This study is designed as a narrative literature review, conceptualized as an analytical synthesis of available knowledge within a disciplinary domain. This approach is particularly suitable when the objective is to examine a phenomenon from a broad, integrative, and conceptual perspective—such as constructing the theoretical foundation for a Social Work socio-familial intervention (Universidad de Navarra, 2024). This theoretical review and conceptual analysis articulate empirical findings from the literature with theoretical developments native to the discipline of Social Work to build a conceptual framework aimed at guiding professional practice. The core research question framing this review is broad and comprehensive, justifying the selection of a narrative review over more restrictive designs (Codina, 2023).

The units of analysis comprised scientific publications, institutional reports, and technical documents addressing the intersection of diabetes

in older adults, social support networks, and self-care within the Latin American context. Sources were identified across multiple electronic databases using key search terms in Spanish and English (adulto mayor / older adult, diabetes mellitus tipo 2 / type 2 diabetes mellitus, apoyo social / social support, redes de apoyo / support networks, trabajo social / social work, intervención sociofamiliar / socio-familial intervention, autocuidado / self-care, and autonomía funcional / functional autonomy). Inclusion criteria encompassed studies conducted on populations aged 60 and older that explicitly addressed the social or familial dimensions of diabetes, published in Spanish, English, or Portuguese. Studies focusing exclusively on biomedical or pharmacological aspects without accounting for psychosocial variables were excluded. Given the narrative nature of the review, a rigid systematic protocol with strict reproducibility criteria was not established; instead, a strategic search aimed at achieving conceptual saturation and thematic representativeness was employed.

The selected literature was analyzed using thematic content analysis (Díaz Herrera, 2018), a method that allows for the identification, organization, and synthesis of recurrent patterns across the text corpus. Analytical categories emerged inductively through iterative reading of the sources and were grouped around each operational objective to characterize diabetes as a problem for Social Work intervention, the sociodemographic profile of the population, social risk factors, network typology and functionality, and the relationship between autonomy and self-care. This analytical process synthesized empirical findings with disciplinary interpretation by the author, grounded in the systems model (Palomar Villena & Suárez Soto, 1993), social network theory (Gil Ríos, 2015), and the strengths perspective (Juárez Rodríguez & Lázaro Fernández, 2014).

The methodological rigor of this narrative review is maintained through four core properties: exhaustiveness, transparency, argumentative coherence, and explicit acknowledgment of potential bias. It is exhaustive in its retrieval and consideration of available literature, encompassing diverse perspectives and empirical findings within the field (Benítez de Vendrell, 2008); transparent in explicitly detailing selection criteria and analytical procedures (Aizpurua Galdeano et al., 2023); coherent in aligning review findings, the adopted theoretical framework, and proposed conclusions (López Marcos & Ortiz Gutiérrez, 2025); and explicit in recognizing the inherent risk of selection bias associated with narrative reviews due to the absence of a systematic, reproducible search protocol. As a theoretical study focused on conceptual foundation, standard metrics of statistical validity or empirical replicability do not apply; rather, evaluation rests on conceptual soundness and disciplinary relevance.

Results

Characteristics of Socio-Familial Phenomena in Older Adults with Diabetes

The literature review across Latin America—encompassing empirical data from Mexico, Peru, Brazil, Ecuador, and Argentina—reveals that the most consistent finding is that between 60% and 80% of older adults with diabetes experience some degree of insufficiency in social support. The most severely compromised domains are affective support and positive social interaction. Clinically and socially, this deficit is decisive, as it correlates statistically with poorer glycemic control and reduced therapeutic adherence. Conversely, studies incorporating metabolic control parameters confirm that older adults with higher levels of emotional support achieve significantly better health outcomes.

From a Social Work intervention standpoint, the primary significance of these findings lies in the critical distinction between nominal network availability and effective network functionality. Nominal availability refers to the mere inventory of individuals present within the older adult's social environment (e.g., adult children, neighbors, friends, peers, healthcare personnel). For instance, an individual who cohabits with a spouse, has

four adult children residing nearby, and attends a healthcare center with a designated medical caregiver possesses a nominal network of six or more individuals—a network that would conventionally be classified as broad.

However, the structural presence of individuals within a social environment is insufficient; these interpersonal ties must actively deliver the specific support required by the individual. This conceptual distinction dismantles the prevalent assumption that an older adult who is not living alone or who has immediate family (nominal availability) automatically receives the support necessary to sustain a complex treatment regimen such as that required for diabetes management (effective functionality). Effective management of diabetes requires instrumental support from the family, such as monitoring meal times and insulin administration schedules. Furthermore, because anxiety and depression can trigger metabolic dysregulation, emotional support through psychological containment is paramount. When a support network exists only nominally, the older adult remains as vulnerable as an individual living in isolation, as the support received is inherently dysfunctional, intermittent, or non-existent.

Sociodemographic Profile for Social Work Assessment

Synthesizing the reviewed literature yields a representative sociodemographic and familial profile of older adults living with diabetes in Latin America, characterized by the following parameters:

- Sex Distribution and Gender Dynamics: Women predominate within this demographic cohort, accounting for 55% to 60% of cases across the majority of studies—a trend that aligns with the global phenomenon of the feminization of aging. Crucially, from a gender perspective, the most critical empirical finding is the persistent role of these women as primary caregivers. Older women with diabetes frequently manage their own chronic condition while simultaneously maintaining caregiving responsibilities for spouses, grandchildren, or other family members. This dual caregiving burden, compounded by a lack of tailored support networks, places them in a position of heightened vulnerability and increases the risk of self-care neglect. Consequently, gender operates as a primary social determinant of health within this population.

- Age Distribution: Although diabetes can manifest at various stages of the life course, its prevalence increases significantly after age 60, with a major concentration in the 65–75 age cohort.

- Educational Attainment: Secondary education (either completed or incomplete) represents the predominant level of educational attainment, accounting for 35% to 40% of participants. Low formal educational attainment correlates with higher risks of glycemic dysregulation, functioning as a structural social determinant of health that directly impairs health literacy and the ability to navigate complex healthcare systems. Educational interventions delivered by Social Work practitioners must therefore adopt a dialogic approach tailored to individual comprehension capabilities, avoiding technical jargon and unidirectional communication models.

- Marital Status: Being married or in a stable cohabiting union represents the predominant status, encompassing approximately 60% to 65% of cases. Conversely, 35% to 40% of individuals are single, widowed, or separated, facing their condition without the daily instrumental support of a partner. This reality underscores the professional imperative to strengthen alternative social ties—such as adult children, neighbors, or community-based networks.

- Socioeconomic and Employment Status: The majority of individuals in this cohort are retirees or pensioners, experiencing a sharp reduction in income at a life stage

characterized by escalating healthcare-related expenditures. This socioeconomic precariousness severely restricts access to non-covered medications, specialized dietary requirements, and supportive resources, necessitating social work interventions focused on securing financial aid, non-contributory pensions, or social assistance programs.

- Healthcare Coverage and Access Barriers: Findings indicate that while a significant proportion of the population maintains public health insurance or social security coverage, they routinely encounter structural barriers to service utilization. These include bureaucratic administrative delays in securing medical appointments, obtaining prescriptions, or authorizing specialized treatment procedures, illustrating a persistent gap between nominal healthcare coverage and actual service accessibility. Social Work professionals play a key role in mitigating these administrative and institutional barriers by facilitating access, guiding families through bureaucratic procedures, and providing clinical case management to ensure continuity of care.

Social Risk Factors and Social Work Intervention

Delineating the sociodemographic profile allows for the identification of specific social risk factors that directly condition the onset, progression, and self-care management of type 2 diabetes in older adults. Analyzing these determinants highlights their strategic relevance for Social Work practice:

- Low Socioeconomic Status (SES): Low SES conditions both the probability of developing diabetes and the capacity for effective disease self-management post-diagnosis. Economic precariousness severely restricts access to nutritionally adequate diets, essential medications non-covered by public health schemes, and built environments conducive to physical activity. This vulnerability mandates targeted professional resource navigation, including the identification of food assistance programs, financial subsidies for pharmaceutical acquisitions, and referral to supportive networks to mitigate socioeconomic impacts.

- Social Isolation and Unpartnered Status: Living alone, bereavement, and structural social isolation constitute significant social risks supported by longitudinal evidence demonstrating their direct association with an increased incidence of diabetes and suboptimal glycemic control (León-Hernández et al., 2023). The absence of close social ties deprives individuals of essential emotional coping mechanisms. Facing this risk factor, social work practice focuses on network activation—identifying latent interpersonal ties, connecting patients with companionship programs, leveraging volunteer networks and mutual aid groups, and fostering community participation to buffer the adverse effects of isolation.

- Institutional and Communicative Barriers: Systemic delays in securing specialist appointments, prescription refills, and procedural authorizations represent institutional barriers that disproportionately impact socioeconomically disadvantaged populations. These structural hurdles are frequently compounded by cultural and communicative gaps that hinder effective therapeutic alliances. Social Work acts as an institutional mediator by guiding families through complex administrative workflows, assisting patients in navigating healthcare infrastructure, and fostering horizontal communication between healthcare providers and patients.

- Sedentary Behavior and Environmental Determinants: Physical inactivity, while a modifiable behavioral risk factor, cannot be addressed in isolation from macro-level structural constraints. The lack of safe public infrastructure, accessible recreational spaces, and social accompaniment constrains

physical activity, particularly within marginalized urban environments. Professional intervention must target the identification and promotion of community-based physical assets or advocate for their establishment when non-existent.

- Multimorbidity and Caregiver Burden: The co-occurrence of two or more chronic conditions is highly prevalent in this population, significantly complicating clinical management in resource-constrained environments. Where access to specialized multidisciplinary care is limited, the burden of disease management falls almost exclusively on the informal family unit. In these scenarios, Social Work interventions center on mitigating informal caregiver burden, coordinating sociosanitary resources, and ensuring that complex clinical trajectories do not exacerbate social exclusion.

Structure and Functionality of Social Support Networks

The typology and functional efficacy of social support networks provide a clear rationale for Social Work intervention. A support network may exist structurally without effectively addressing the ongoing demands of a chronic condition that fundamentally alters both patient and family lifestyles.

Identified Network Typologies

Familial Support: The primary family unit constitutes the principal, and frequently sole, source of support for older adults with diabetes in Latin America. Merodio Pérez et al. (2015) reported that within their study sample, 100% of participants had adult children, 93.8% maintained contact with extended family, and 68.1% had a spouse. However, the structural presence of a family unit does not automatically ensure functional support for chronic disease management.

Alarcón Urbina and Briones Quiroz (2025) identified that while 64% of participants were married, the remaining 36%—comprising single, widowed, separated, or divorced individuals—managed their chronic condition without daily spousal support. This aligns with findings by Rodríguez Tomalá (2022), who reported that 35% of older adult participants in an Ecuadorian sample were single. It is precisely this segment of the population lacking spousal support—conventionally considered the most proximate source of care—that necessitates increased professional focus on identifying alternative support mechanisms. Furthermore, the statistically significant association between marital status and therapeutic adherence identified by Alarcón Urbina and Briones Quiroz underscores that married individuals receive more consistent support and are less frequently perceived as a burden. Conversely, when care reliance shifts exclusively to adult children or collateral relatives, unidirectional care dynamics often generate heightened relational conflict.

Although systematically aggregated data regarding living arrangements remain limited, the reviewed literature indicates a growing proportion of older adults living alone, particularly within urban centers. While solitary living does not inherently equate to affective isolation, it introduces substantial operational challenges for daily disease management, particularly during acute metabolic crises or health decompensations where immediate instrumental assistance is unavailable.

Findings confirm that primary caregiving responsibilities—including medical accompaniment, pharmacological administration, specialized dietary preparation, and transportation to clinical consultations—are disproportionately assumed by women (spouses or adult daughters). Alarcón Urbina and Briones Quiroz (2025) observed a statistically significant association between sex and healthy lifestyle practices ($p < 0.05$), demonstrating that older women exhibit higher engagement in self-care behaviors, whereas older men remain substantially more dependent on female caregiving. This structural pattern, characteristic of societies with traditional gender roles, highlights a paradox: women, who function as the pri-

mary supportive pillar for others, simultaneously demonstrate higher rates of unaddressed personal support deficits. Consequently, older female caregivers constitute a high-priority demographic for Social Work practice.

Qualitative evidence demonstrates that the structural presence of family members does not guarantee harmonious relational dynamics or optimal supportive environments. On the contrary, unresolved familial conflict, systemic dysfunction, caregiver overload, and interpersonal resentment can transform a potential support system into an additional stressor for the patient. This highlights the imperative for socio-familial assessments in Social Work to look beyond merely enumerating relational ties, systematically evaluating the nature, quality, and functional efficacy of interpersonal relationships.

Community Support: Engagement in community organizations and formal networks represents a underutilized resource within this population. Merodio Pérez et al. (2015) reported that only 9% of older adults participated in organized community groups, despite 92.9% declaring having active peer relationships. This discrepancy highlights a fundamental distinction between informal sociability (e.g., casual friendships) and organized community participation. For Social Work practice, this gap positions the practitioner as an essential facilitator connecting older adults with structured community spaces capable of mitigating social isolation and providing supplementary social support.

Although informal in nature, neighborhood and friendship networks fulfill important supportive functions. Friends and neighbors often serve as a localized system of mutual vigilance and episodic aid. However, these informal ties remain structurally fragile compared to familial bonds, exhibiting higher vulnerability to dissolution due to geographic relocation, morbidity, or mortality. Consequently, social work interventions must focus on reinforcing linkages between older adults and permanent, sustainable community organizations.

Similarly, religious and faith-based groups function as significant supportive spaces for specific demographics, particularly older women. Within these settings, participation extends beyond spiritual practice to encompass stable social networks that offer regular group activities and, in certain instances, material assistance. While systematically aggregated data on this domain remain sparse in the broader literature, empirical evidence from Ross (2015)—in a study of 468 individuals with cardiovascular disease or diabetes (54.3% female, 58.5% Hispanic)—demonstrated that regular attendance at religious services positively influenced diabetes self-management, with social support, psychological mood, and self-regulation operating as significant mediating variables.

Institutional Support: Healthcare coverage among older adults living with diabetes is widespread across Latin America, though far from universal. In Argentina, the Programa de Asistencia Médica Integral (PAMI) guarantees 100% coverage for diabetes medications to its more than five million beneficiaries; however, access remains contingent upon meeting specific socioeconomic eligibility criteria, including income caps and formal verification of vulnerability status (Perfil, 2025). In Brazil, Magalhães Lima et al. (2024) observed that while 80.6% of participants lacked private health insurance, this did not denote an absence of coverage, as the Sistema Único de Saúde (SUS) provides universal healthcare access. Nevertheless, administrative bottlenecks and bureaucratic hurdles frequently impede continuity of care. Navigating these institutional barriers constitutes a classical domain of Social Work practice, encompassing rights orientation, clinical case management, and administrative system navigation.

Beyond primary healthcare services, additional institutional support mechanisms exist, including non-contributory pension schemes, social cash transfers, day centers, community food programs, and specialized geriatric physical activity initiatives. However, the reviewed literature reveals a notable lack of systematic data regarding healthcare utilization and access rates to these non-clinical resources among older adults with

diabetes—representing a critical knowledge gap to be addressed in future empirical research.

Network Functionality

This analysis reveals that different types of social support circulate within the interpersonal networks of older adults with diabetes, varying significantly in both intensity and therapeutic effectiveness. For instance, emotional support—manifested through active listening, psychological containment, companionship, and affective validation—functions as a vital component in the management of chronic disease. Older adults who receive higher levels of emotional and affective support achieve significantly superior glycemic control outcomes (maintaining a mean blood glucose level of 109 mg/dl) This finding demonstrates that the affective dimension of social support is not a secondary psychosocial variable, but rather a direct determinant of physiological health outcomes (Valdez Rumbo et al., 2025). However, Ortiz Solache et al. (2025) identified that emotional support and positive social interaction were precisely the domains exhibiting the most severe deficits within the studied population, with 80.6% of participants demonstrating only minimal social support.

Instrumental Support: comprises tangible assistance with day-to-day disease management—such as pharmacological administration, therapeutic meal preparation, medical accompaniment, administrative procedures, and the procurement of food and medications—instrumental support is predominantly delivered by cohabiting or geographically proximate family members. Its intensity scales directly with the patient's degree of functional dependency. Although instrumental support is structurally present in the majority of cases, its consistency and quality vary widely.

Informational Support: Pertaining to health literacy and disease self-management, informational support originates from healthcare professionals, informed family members, peer support networks, and public health media. Arredondo Sánchez et al. (2024) emphasize health literacy as a critical mediating variable between social support and glycemic regulation. The efficacy of informational support hinges on the patient's access to reliable sources and the adaptation of medical information into accessible, culturally tailored language.

Social Companionship: Defined as the regular presence of peers for shared daily activities, conversation, and mutual engagement, social companionship serves a key preventive function against social isolation and depressive symptoms. By counteracting the loneliness that frequently leads to the abandonment of healthy behaviors, companionship indirectly facilitates disease self-care. The low participation rate in organized group activities (9%) underscores social companionship as the support domain with the most pronounced deficit.

The Dynamics of Care

In advanced age marked by chronic illness, support systems frequently become unidirectional, as older adults receive substantially more care than they are capable of reciprocating. This structural asymmetry carries profound psychological and social implications for both care recipients and caregivers. For many older adults, the physical or cognitive inability to reciprocate care engenders feelings of guilt, a heightened perception of being a burden to the family unit, and a diminished sense of social utility and personal worth. Conversely, for informal caregivers, this persistent lack of reciprocity often leads to chronic caregiver burden, emotional exhaustion, and interpersonal resentment—particularly when caregiving responsibilities are prolonged over time without respite care or institutional support mechanisms. Alarcón Urbina and Briones Quiroz (2025) substantiate these dynamics, demonstrating that therapeutic adherence was significantly associated with marital status: individuals with a spouse received more consistent, stable support and were less frequently perceived as a family burden. In contrast, when care reliance shifted primarily to adult children or collateral family members, the resulting unidirectionality of care generated significantly higher levels of relational strain and conflict.

A core finding for Social Work practice is the critical distinction between nominal network availability and effective network functionality. Merodio Pérez et al. (2015) demonstrated that despite high structural network density among participants—68.1% married, 100% with children, 93.8% with extended family, and 92.9% with friends—64.7% of men and 60.8% of women exhibited uncontrolled glycemic levels. This empirical reality proves that the mere physical or relational presence of individuals does not automatically translate into effective, health-promoting support.

A social network may be structurally intact yet functionally deficient regarding the complex demands imposed by diabetes. The underlying mechanisms of network dysfunction are multifaceted: Family members frequently lack technical health literacy regarding specialized nutrition, medication administration, or the identification of clinical warning signs. Chronic caregiver exhaustion leads to inconsistent or low-quality care provision. Supportive actions are occasionally perceived by the patient as intrusive, controlling, or source of psychological stress. Geographically distant relatives, despite high intentions, cannot provide necessary daily instrumental support. Competing social and economic obligations—such as employment or childcare responsibilities among adult children—limit caregiver availability.

Differentiating between available and functional networks constitutes a central diagnostic function of Social Work socio-familial assessment, which moves beyond enumerating interpersonal connections to systematically evaluate the quality, competence, and availability of each relational tie.

Across the Latin American literature, the magnitude of unaddressed social support deficits in this population is substantial: Ortiz Solache et al. (2025) report that 80.6% of participants receive minimal social support; Arredondo Sánchez et al. (2024) observe insufficient support in 62.82% of cases; Valdez Rumbo et al. (2025) link 53.4% of low therapeutic adherence directly to support deficits; and Merodio Pérez et al. (2015) identify glycemic dysregulation in over 60% of patients despite the presence of immediate family ties. Synthesizing these cross-national data indicates that between one-half and three-quarters of older adults with diabetes experience major qualitative or functional support deficiencies.

These data allow for the identification of consistent determinants associated with social support deficits. First, while women constitute the majority of older adults with diabetes, traditional gender norms dictate that they prioritize caregiving for spouses, frequently neglecting their own health needs and support systems—raising critical questions for gender-responsive public care policies. Second, economic scarcity severely restricts access to private caregiving resources (e.g., formal home care aides or private residential facilities) while isolating individuals within under-resourced community environments. Third, among older men, the absence of a spouse strongly correlates with lower social support and worse glycemic outcomes; among older women, this loss is often buffered by extended peer and friendship networks, highlighting gender-differentiated support patterns. Fourth, in rural areas, geographic isolation, spatial dispersion, and lower service density severely hinder institutional support and continuity of care. Finally, advanced age increases the statistical likelihood of bereavement and peer morbidity, resulting in a structural paradox wherein individuals with the highest care requirements possess the weakest or most fragmented support networks.

Ultimately, a robust consensus in the literature links social support insufficiency with suboptimal glycemic control (Arredondo Sánchez et al., 2024; Hawkley et al., 2024), reduced medication adherence (Valdez Rumbo et al., 2025), elevated risk of microvascular and macrovascular complications, compromised quality of life, increased overall mortality (León-Hernández et al., 2023), premature institutionalization, and heightened healthcare system burden through preventable emergency department visits and hospitalizations. These profound psychosocial and clinical ramifications fully justify the systematic integration of social support network assessments into standard geriatric diabetes care protocols.

Conclusions

This study confirms that diabetes mellitus in old age extends well beyond a biomedical condition, constituting a complex social and gender-specific phenomenon that warrants rigorous scholarly investigation. Ultimately, the dual burden borne by older women erodes caregiver health and challenges the long-term sustainability of informal care networks in aging societies—raising a critical question for public policy: Who provides care for the women who have historically functioned as society's primary caregivers? The disproportionate caregiving strain placed on older female adults, alongside the systemic fragility of their personal support systems, underscores the imperative for Social Work to embed a gender perspective as a cross-cutting axis within socio-familial assessment and intervention frameworks.

Type 2 diabetes mellitus in older adults represents a core domain of Social Work practice, as evidence indicates that the condition fundamentally alters family dynamics, degrades social support systems, and compromises individual functional autonomy. The widespread deficit in social support—affecting between 60% and 80% of this population in Latin America—operates as a direct determinant of glycemic regulation, therapeutic adherence, and health-related quality of life. Consequently, addressing diabetes from a social perspective mandate intervening directly in the daily, lived social realities of patients.

Regarding the socio-familial approach, professional assessment cannot be reduced to merely verifying the nominal presence of family members or cohabitants. The distinction between nominal network availability and effective network functionality emerges as the central conceptual foundation for Social Work practice. Empirical data consistently reveal that an individual may possess a spouse, adult children, extended relatives, and friends, yet still exhibit marked glycemic dysregulation if those ties fail to deliver effective support. The qualitative nature of relational ties, caregiver competence, care burden, and interpersonal dynamics—whether supportive or contentious—must be systematically integrated into every socio-familial diagnostic assessment.

Social support networks serve as essential scaffolding for chronic disease self-management. Emotional support demonstrates a direct correlation with superior physiological health outcomes, whereas instrumental, informational, and social companionship support provide the requisite baseline conditions for older adults to sustain complex treatment regimens. However, the synthesized evidence indicates that these supportive dimensions remain deficient or dysfunctional across the majority of this population. Thus, strengthening social networks constitutes an essential therapeutic intervention with measurable clinical impacts, rather than merely a secondary, compassionate adjunct to medical care.

From the perspective of Social Work, the relationship between functional autonomy and self-care capabilities is rooted in the principle of self-determination. Self-care is conceptualized as the capacity to make informed decisions, maintain control over daily life, and negotiate necessary assistance without succumbing to passive dependency. Professional practice must focus on cultivating the socio-environmental conditions that make true autonomy possible—strengthening the family as a supportive system, activating community assets, streamlining access to healthcare institutions, and, above all, honoring the agency and preferences of the older adult as a rights-bearing individual.

The theoretical framework developed in this study provides the conceptual foundation for designing hospital-based socio-familial interventions tailored for older adults with diabetes. The gathered evidence justifies the systematic integration of socio-familial assessments into standardized geriatric care protocols and highlights the Social Work practitioner as an indispensable member of interdisciplinary healthcare teams. Future avenues of research must focus on designing and empirically evaluating intervention

models grounded in these theoretical premises, as well as addressing under-researched areas, such as the operational mechanisms of informal community networks and equitable access to non-clinical institutional resources.

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