

# Attitudes of Caregivers of Older Thai Adults with Major Depression: A Qualitative Study

Wariya Chankham, Rangsiman Soonthornchaiya,\* Pranom Othaganont, Jing Jy Wang

**Abstract:** Family caregivers are essential people. They are the primary source of support and care for the person they are caring for, and such care is reflected in and affected by their attitudes. This qualitative descriptive study explored 17 primary family caregivers' attitudes toward caring for older adults with a major depressive disorder living at home in Thailand. Purposive sampling was undertaken, and data were collected in semi-structured interviews and analyzed using content analysis. As a result, two themes emerged. The first theme, "Rethinking in positive ways about caregiving," included accepting being a caregiver and feeling happy and proud to provide care for a loved one. The second theme, "Began with negative attitudes towards caregiving," included uncertainty about life, feelings of suffering, and frustration with caregiving duties. The caregivers met with challenges, and their attitudes directly affected the care they provided to older adults with major depressive disorders. Therefore, nurses and other healthcare professionals need to understand caregiving better, positively and acceptably, to improve caregivers' ability to manage depressive symptoms. Caregiving will be enhanced by educating and training families and health professionals on effective care techniques and mentoring families in the early stages of caring for older adults with depressive disorders and throughout the care.

*Pacific Rim Int J Nurs Res 2023; 27(3) 485-499*

**Keywords:** Attitudes, Caregiving, Depression, Family caregivers, Major depressive disorder, Older adults, Qualitative description

Received 14 February 2023; Revised 21 May 2023;

Accepted 22 May 2023

## Introduction

Major depressive disorder (MDD) in older people is rarely diagnosed and may be overlooked due to vague symptoms. It is often tricky for such people to describe how they feel.<sup>1</sup> Caregivers' recognition of depression is crucial to identifying and detecting depression in their older family members. Family caregivers often lack the necessary knowledge and skills to provide adequate care for them, which could

Wariya Chankham, RN, PhD, (Candidate) Faculty of Nursing, Thammasat University, Thailand. E-mail: wariya110@nurse.tu.ac.th

**Correspondence to:** Rangsiman Soonthornchaiya,\* RN, PhD (Nursing), Associate Professor, Faculty of Nursing, Thammasat University, Thailand. E-mail: rangsiman@nurse.tu.ac.th

Pranom Othaganont, Ed.D, Professor, Faculty of Nursing, Thammasat University, Thailand. E-mail: otpranom@gmail.com

Jing Jy Wang, RN, PhD, Professor, Department of Nursing, College of Medicine, National Cheng Kung University, Tainan, Taiwan. E-mail: ns127@ncku.edu.tw

be attributed to their negative attitudes toward caring for this population. Negative attitudes towards caring for older adults with MDD, such as stigma and fear, may contribute to a lack of interest in learning about

depression and its treatment, resulting in a lack of knowledge and skills in providing care. These attitudes can lead to reduced quality of care for older adults with MDD and increased burden on their caregivers. Research on the benefits of depression awareness in the family suggests that family members influence older individuals' quality of life and well-being.<sup>2</sup> Studies have found that depression literacy and mental health literacy are positively associated with attitudes toward seeking help for depression and providing support to those who suffer from it. Individuals with higher levels of mental health literacy are more likely to recognize depression and seek treatment and may also experience an increase in their overall mental well-being.<sup>3</sup> Those more knowledgeable about depression are likelier to have positive attitudes regarding depression care.<sup>4</sup> Prior research has shown that positive attitudes are associated with high levels of knowledge regarding depression.<sup>5</sup> Depression literacy is vital in promoting positive attitudes towards caring for depression. The same can be said for improving education and raising awareness about depression.<sup>6</sup>

There has been limited research on family caregiver attitudes toward the care of older people with MDD, hence this study. It is expected that findings from this study will serve as a foundation for nurses to develop a plan to support family caregivers in caring for older people at home so that effective continuation of such care occurs.

## **Review of Literature**

Geriatric depression is not a normal part of aging, but it is one of the most common mental health disorders requiring management.<sup>7</sup> It is estimated that 5% of the world's population suffers from depression. Global prevalence rates of depression vary by age, peaking in older adulthood in 5.7% of those aged 60 and over.<sup>8</sup> In Thailand, depression is the most prevalent mental health problem among older females and the third most common health problem among

older males. The prevalence of depression in older Thais increased from 4.2 million (7.20%) in 1990 to 7.2 million (11.50%) in 2010 and 18.50% in 2019.<sup>9</sup>

MDD is an illness that affects the mental health of older people, who may experience low self-esteem and often feel worthless and burdensome. Individuals aged 60 years and older are more prone to commit or attempt suicide than any other age group.<sup>10</sup> The World Health Organization states that depression is a significant global burden that needs long-term care.<sup>11</sup> Early diagnosis and treatment of MDD decrease medical costs and pressures on caregivers.<sup>8</sup> However, treatment obstacles include a lack of resources, a shortage of knowledgeable healthcare practitioners, and social stigmatism. In Thailand, 76 to 85% of people in low and middle-income countries do not receive care for MDD.<sup>12</sup> Although psychiatric hospitals provide services for this group, older adults have difficulty accessing this kind of healthcare system alone, particularly in rural areas.<sup>12</sup> Therefore, there is a reliance on family caregivers to be aware of and care for older adults with chronic illnesses or mental health problems.

Depression literacy is a component of mental health literacy that involves the capacity to identify signs and symptoms of depression and make informed decisions about appropriate treatment options.<sup>13</sup> Depression literacy involves identifying depression and making well-informed treatment decisions. With a deep understanding of mental health, family caregivers can recognize and detect risk factors for illness, prevent depression, and make informed decisions about care and management in appropriate situations.<sup>14</sup> The attitudes toward caring for depression is one component of depression literacy, described as the ability to recognize depression and make intelligent decisions on appropriate management. Research has shown that depression literacy positively correlates with positive attitudes towards using mental health care services and can improve mental health outcomes.<sup>15</sup>

Most of Thailand's society does not recognize MDD and has restricted knowledge of this,<sup>4</sup> which

may cause high suicidal rates among older people. As mentioned above, depression in older adults is rarely diagnosed or overlooked due to vague symptoms; it is often difficult for them to describe how they feel.<sup>16</sup> Family caregivers' recognition is crucial to identify and detect depression in their older relatives.<sup>17</sup> Research on the effects of health education programs in the family suggests that family members play an essential role in the older adult's quality of life and well-being.<sup>6</sup>

A family caregiver is closely related to various influential physical and mental health factors, including depression and loneliness.<sup>18</sup> Positive family relationships can increase the chance of a positive health outcome and improve the quality of life of its members, as this is practiced in Thai culture, where children have a strong sense of gratitude towards their parents. Therefore, family caregivers' participation in all dimensions of health care is effective in helping older people at risk of depression.<sup>19</sup> Furthermore, family is an informational resource, and it is essential to prevent depressive symptoms in older people. Depression literacy is the way to prevent major depressive illness.<sup>20</sup> A study of depression literacy and health-seeking attitudes in Cambodia, the Philippines, Fiji, and the Western Pacific region demonstrated a relatively lower level of understanding about depression in these areas. There was a notable correlation between increased knowledge and more favorable attitudes toward mental illness and seeking professional help.<sup>14</sup> According to a recent study in the Fako division, Cameroon, nurses and others who provide primary health care displayed negative attitudes toward depression.<sup>21</sup>

In a national sample in Korea, middle-aged and older people with more unfavorable attitudes toward aging had higher depressive symptoms.<sup>22</sup> Not many families encourage or take an older adult with MDD to seek medical help, compared to seeking help for children or other family members with depression.<sup>21</sup> This may be due to the misconception that depression or embarrassment surrounding the condition is a regular aspect of aging. In addition, negative attitudes towards

individuals with depression or suicide attempts can further contribute to this problem.<sup>23</sup>

In the past, recognizing MDD in older adults was challenging because they might have exhibited symptoms that differed from those seen in younger people. This complexity makes it necessary to gain a thorough understanding of the condition and the experiences of MDD in older adults. Unfortunately, the knowledge and comprehension of MDD in older adults, as a whole, are not widely spread. There have been only a limited number of studies conducted on this topic, and no research has specifically focused on the attitudes among family caregivers or utilized a qualitative descriptive approach to gain a deep understanding of this issue.

For this study, a qualitative method was crucial in describing and understanding the feelings and attitudes among family caregivers. By employing this approach, researchers were able to capture the subjective experiences and gain a more nuanced understanding of the caregivers' perspectives. In addition, it allowed for an in-depth exploration of their thoughts, emotions, and attitudes, shedding light on the complexities they face when dealing with MDD in older adults. It is essential to better understand mental health among family members, caregivers, or close people to prevent depression and suicide among older adults. Therefore, studying caregivers' attitudes in families with MDD is essential to understand the caregivers' attitudes and planning for future assistance.

## Study Aim

This study aimed to explore family caregivers' attitudes toward caring for older Thai relatives with a major depressive disorder.

## Method

**Study Design:** The descriptive design utilized in this study was based on qualitative research

methodology.<sup>24</sup> This design was chosen to provide straightforward descriptions of experiences, perceptions, attitudes, and beliefs and to understand participants' inner experiences. And this method has the potential to describe a comprehensive summarization of what, how, and why family caregivers do when they have different attitudes toward care. This qualitative approach is underpinned by a naturalistic, interactive, constructivist approach to understanding a particular phenomenon better.<sup>25</sup> In our reporting of this study, we strictly adhered to the Consolidated Criteria for Reporting Qualitative studies (COREQ) checklist.<sup>26</sup>

**Sample:** Participants were selected via purposive sampling, targeting primary family caregivers responsible for coordinating and providing most or all the necessary care and bringing the older adults with MDD to the community hospital. The caregivers were confirmed by the health database from geriatric psychiatry and mental health clinics. We obtained information about family members involved in older adults' care and asked permission to contact their family members about the study. In addition, participants had to meet the following inclusion criteria to be eligible for the study: (1) serving as the primary caregiver for an older relative with MDD for at least six months (had a blood relationship or was spouse); (2) the older adult was  $\geq 60$  years and had a diagnosis of MDD according to DSM-IV; (3) able to communicate in Thai, and (4) willing to participate in the study. Participants were excluded if the care recipient was in the active phase of severe or acute disease, such as a heart attack, cardiovascular disease, cancer, or COPD. This would add complexity to caregiving.

**Data Collection and Settings:** This occurred in the community of the sub-district health promotion hospitals in Suphanburi province and the participants' homes between August 2021 and June 2022. These settings were selected for recruiting potential participants because these hospitals provided routine geriatric depression care more so than others. Family caregivers and their relatives were referred to the sub-district health promotion hospitals and were recruited by the

research team. The primary investigator (PI) was a female doctoral candidate who was trained in qualitative research and had experiences in this. First, The PI visited the participants' homes to conduct interviews as the participants wished. Purposive sampling was used to select participants based on inclusion criteria. Participants were firstly interviewed through a semi-structured interview guide validated by five experts and examined before usage on a small test group in pilot interviews. Open-ended semi-structured question examples were: 1) What do you think about caring for older adults with depression? and 2) What is your attitude towards caring for your (father/mother/wife) with depression? Face-to-face interviews were conducted for approximately 60–80 minutes with digital recorders. Data saturation was reached after interviewing 17 participants, and no new information was revealed after reading and rereading the transcripts. In light of the COVID-19 pandemic, second interviews were conducted via social media platforms such as LINE video calls and took 30 to 45 minutes.

**Data Analysis:** The interview data were transcribed verbatim. The first participant was given the pseudonym FC1. All participants were then consecutively numbered until the last participant was identified as FC17. Thematic analysis was used in this study because it identified patterns or themes within the qualitative data. This analytic process allowed the researchers to use the themes to describe the significant issues and make more meaning of the study focus.<sup>27</sup> The thematic analysis helped to interpret qualitative data from what participants described within this. The analysis consisted of six steps. First, the PI repeatedly read interview transcripts to obtain familiarity with the overall data and made notes or the impression of data that came up. Second, the PI started to write the initial data codes after understanding the data meaning in the transcript. This process would be systematic and meaningful data after that. As the third step, the researchers conducted a systematic analysis by organizing the codes, exploring their inter-relationship, and clustering the relevant data to identify potential themes. Next, the potential

themes were reviewed by checking the relation to the coded extracts and generating initial codes, then defining and naming the themes, creating clear and concise descriptions that accurately represented the data. Lastly, analyses were discussed and merged into the final findings.

**Trustworthiness/Rigor:** This study used trustworthiness to ensure rigor. The researcher attempted to meet four criteria: credibility, transferability, dependability, and confirmability.<sup>28</sup> Credibility was established through source triangulation by the convergence of multiple sources of evidence such as history taking and patient chart report. In addition, the PI conducted member-checking with participants to check data accuracy. Transferability was achieved through the thick description by providing readers with evidence from the study. To ensure confirmability, the PI took steps to demonstrate that the data had no bias to drive the findings. The research team was informed of the meaning-in-context, transcription, field notes, ongoing data processing and findings. Additionally, the PI kept detailed notes of all progress, such as decisions and analyses. Finally, saturation was achieved by gathering data until no new information could be found.

**Ethical Considerations:** This study was approved by the Ethics Review Sub-Committee for Research

Involving Human Research Subjects of Thammasat University: Faculty of Health Science and Science and Technology No3. (project code 064/2564). The PI provided the potential participants with an explanation of their rights, including confidentiality, anonymity, and the option to withdraw from the study at their discretion. Prior written assent from participants and consent from their legal guardians or parents were obtained, and jointly signed a consent form in the case of a 17-year-old caregiver. Participants' permission to record interviews was also acquired, and psychological support was available throughout and after the interviews, although it ultimately proved unnecessary. The PI maintained a non-hierarchical relationship with all participants.

## Findings

This study explored 17 caregivers' attitudes toward caring for an older relative with MDD. Participants came from a wide range of backgrounds; ten were female, seven were men (ages ranged from 17–73 years, with a mean age of 53.47 years) and had a primary school level of education. All participants were Buddhist. The time spent caregiving ranged from seven months to eight years. Full details of the participants are found in **Table 1**.

**Table 1.** Demographic characteristics of participants

| characteristics                           | N  | %     |
|---|----|-------|
| Gender                                    |    |       |
| Male                                      | 7  | 41.18 |
| Female                                    | 10 | 58.82 |
| Age (min-max = 17–73, mean = 53.47 years) |    |       |
| > 20                                      | 1  | 5.88  |
| 21–30                                     | 0  | 0.00  |
| 31–40                                     | 1  | 5.88  |
| 41–50                                     | 6  | 35.30 |
| 51–60                                     | 0  | 0.00  |
| < 61                                      | 9  | 52.94 |
| Education                                 |    |       |
| Primary school                            | 8  | 47.06 |
| Secondary school                          | 5  | 29.41 |
| Bachelor's degree                         | 4  | 23.53 |

**Table 1.** Demographic characteristics of participants (Cont.)

| characteristics                    | N  | %     |
|------------------------------------|----|-------|
| Relation to older adult            |    |       |
| Daughter–Son                       | 7  | 41.18 |
| Grandchild                         | 1  | 5.88  |
| Brother–sister                     | 2  | 11.76 |
| Husband–wife                       | 6  | 35.30 |
| Daughter–in–law                    | 1  | 5.88  |
| Occupation                         |    |       |
| Agriculture                        | 4  | 23.53 |
| Laborer                            | 7  | 41.18 |
| Government officer                 | 2  | 11.76 |
| Non                                | 4  | 23.53 |
| Family income                      |    |       |
| 0–10,000 (0.00–292.24 USD)         | 4  | 23.53 |
| 10,001–20,000 (292.25–584.49USD)   | 11 | 64.71 |
| 20,001–30,000 (584.50–876.73 USD)  | 1  | 5.88  |
| 30,001–40,000 (876.74–1168.98 USD) | 1  | 5.88  |

Regarding occupations, ten participants were laborers, and three worked in agriculture. The monthly income of participants ranged from 0 to 40,000 Thai baht (USD 0–1,168.98) with an average of 11,550 Thai baht (USD 337.54), which was insufficient for their needs. In addition, participants had one to three underlying diseases, such as high blood pressure, atherosclerosis, and diabetes.

The caregivers in the study were seven sons and daughters, six spouses, two siblings, one grandchild, and one daughter–in–law. They lived with the older adults in the same house. Caregivers were responsible for activities of daily living, diet, medication administration, and managing the symptoms of depression when they occurred.

The family characteristics of the participants varied, with some coming from extended families and others from single–family households where children had married and established separate homes in the same area.

The older adults were primarily female (aged 60–78 years, with a mean age of 67.73 years and had a primary school level of education, lived with their caregivers, or were cared for by their children. Most were married (15) or widowed (2), and all were Buddhist. In addition, 15 of the older adults were unemployed and had no income, and all had one to three underlying health conditions, such as high blood pressure, atherosclerosis, and diabetes.

**Table 2.** Theme, sub–themes, and quotations

| Theme                                | Sub–themes                                | Codes/Quotation   |
|--------------------------------------|---|---|
| Theme 1: Rethinking in Positive Ways | 1) <u>Acceptance</u> of being a caregiver | <u>Acceptance</u> of being a caregiver:<br><i>When she was depressed the first time, I was stressed. After being together for a long time, I can <u>accept</u> it now.</i><br><u>Adaptation:</u><br><i>A person who understands, or someone close to him, must take good care of themselves first to be able to relax. So, when we care for someone, we must take care of ourselves first. So, we need to find out the reason (for change and adapt the suitable situation) why we need to be comfortable, and we need to be comfortable first.</i> |



**Table 2.** Theme, sub-themes, and quotations (Cont.)

| Theme   | Sub-themes  | Codes/Quotation   |
|---|---|---|
| Theme 2: Begin with Negative Attitudes Towards Caregiving | 2) Be happy and proud of providing care for a loved one | Rewarding goodness and sense of gratitude:<br><i>I try to do my best for my mom. When I go home, I do everything for my mom, like the food I buy and put in the fridge. I don't want my mother to suffer, so I make everything possible for my mother.</i><br>The caregiver is happy; the sick person is happy:<br><i>Mom is better. We are glad that Mom is getting better.</i><br>Not a burden:<br><i>She is my love one, and she is not a burden.</i><br>So proud of themselves:<br><i>I feel proud that our mother is getting better.</i> |
|   | 1) Uncertainty about life                               | Uncertainty:<br><i>I didn't know what to do. My mom and my work are so hard.</i>  |
|   | 2) Feelings of suffering and frustrated                 | Frustration:<br><i>During his new illness, I felt burdened, tired, stressed.</i>  |
|   |   |   |

In this study, the data analysis revealed two main themes and four subthemes (see **Table 2**). The findings elucidated the attitudes exhibited by the participants and offered insights into their strategies for managing the situation while fulfilling their caregiving responsibilities.

### **Theme 1: Rethinking in Positive Ways**

Participants who had a positive attitude toward older adults with depression became more able to cope with them and their symptoms after a period of care. Part of it was the acceptance of what happened as an illness. When providing care, the symptoms improved. They felt better and were proud of themselves for coping with the signs and symptoms and managing them successfully. The older adult was starting to change for the better.

Most participants viewed people with depression as poor and in need of care. If they saw positive caregiving, the participants' mindset made them happy to perform daily care activities.

#### **Sub-theme 1: Acceptance of being a caregiver**

Families who accepted being caregivers learned from the experience of living with the older adult. They also learned from the advice of doctors

and psychiatric nurses, telling stories, reading, and studying until they gained knowledge and understanding of the older adult's depressive illness. They then accepted their symptoms and behavior. Acceptance of caregiving roles was influenced by elements arising from familial commitment.

*If there is no one of us, who will take care of him? Suppose we leave. Who will take care of him? At least now my father can take my mother to the doctor. But one day, when my father could not drive. Must we be the same? ... ask me! Is taking care of him a burden? It is not a burden. (FC2)*

Participants also learned to adapt to the new situation of caring for an older adult with MDD. They learned from the relative's behavior and tried to adapt to what was happening, such as recognizing that it was an illness and taking care of daily activities in a way compatible with the relative's needs and the home environment. They also tried to modify their behavior to be accepted and to create a stress-free environment for them, for example:

*When we accepted that our mother was sick, our hearts could accept her behavior. We began to adjust our minds and find a way to deal with her behavior. How do we live happily for both mom and us? (FC6)*

**Sub-theme 2: Be happy and proud of providing care for loved ones**

For some participants, caring for an older adult with depression was a way to repay the kindness or gratitude they felt toward their loved ones. Others viewed caregiving as a reward for the better their loved one had shown in the past. They had been through difficult times together and felt that caregiving gave their loved one a positive outlook on life and did not feel burdensome, as follows:

Some participants view treating relatives as something they must do, which brings about rewarding goodness and a sense of gratitude. Participants with positive thoughts often expressed mature personalities, kept calm, being polite, easy to laugh and smile, were compromising, and believed in gratitude. This philosophy was grounded in the belief that if you cannot do it yourself, you can have someone close care for them, including their daily routines. Daily follow-up of the symptoms by phone must also be done to compensate the parents by grace.

*If she was happy, feeling indifferent because we had been with her for a long time, we could take care of her and love her. It's like bonding. When we think back to the past, when we were young, she raised us, and our mother had a hard time. Now it's like my mother has returned to being a child for us to take care of. (FC7)*

Participants explained that they took care of their relatives with love. When the participants saw their loved ones were happy, they felt happy too. Some participants believed that they would not be viewed with displeasure if they had a caring mentality, and their acts were heartfelt. As such, the relative would be happy as well.

*.....the old people must be caring with heart, take good care, and understand well. You have to make your mind up first and get comfortable first. "When your mind accepts it, you have to know why you have to take care of them to take care of the sick. (FC8)*

Many participants consider caregiving a cultural duty and do not consider it a burden. For some, the care required was mainly administering medications and did not involve extensive physical care.

*Even if she is worse than this, I can take care of her and not feel burdened. (FC12)*

Participants reported feeling proud of their ability to manage the symptoms successfully and observed positive changes in the older adults they cared for.

*It's a wonderful thing. It's not limited to just our home. When I go outside or anywhere, even to distant places on foot, people exclaim, 'Oh! He takes excellent care of him. He's a good person. His son is also good.' Sometimes I go beyond the sub-district, encountering and interacting with numerous individuals. They say, I hear, 'Ouch!' Her husband is good, treating her well and providing exceptional care. I'm happy and so proud too. (FC8)*

*Wherever I go, everyone compliments me on taking care of my wife. I am proud when someone says to me, husband takes good care of her. When I hear that, I am happy. It's a pleasure to take care of a loved one." (FC 9)*

**Theme 2: Began with Negative Attitudes Towards Caregiving**

Negative attitudes towards caregiving often occurred in the early stages of caregiving and when the relative is in the early stages of depression. In addition, these negative attitudes may be triggered by



life crises such as losing a loved one, loss of a job, or financial problems. As a result, 16 of 17 participants explained the feeling of uncertainty in life, feeling stressed, anxious, and confused during the first few months of caregiving, and also expressed feeling overwhelmed or tired.

**Sub-theme 1: Uncertainty for life**

Most participants reported feeling uncertain about how to care for someone with depression and had little knowledge about the illness, its symptoms, and treatment options. This lack of knowledge can cause stress and confusion, for example

*At first, I didn't know what to do. Why did my mom have to do that? She was sad, ate less, and said she wanted to die. At that time, I didn't know what to do. My mom and my work are so hard. (FC2)*

*I was terrified at the time; my mother was depressed and lonely after my father died; I didn't know what to do; I didn't know how to live. (FC13)*

**Sub-theme 2: Feelings of suffering and frustration**

Negative attitudes and frustration toward the older adult with depression, the participants' perceptions in the early stages were perceived as burdened, tired, and stressed due to the participants and families already experiencing challenging circumstances. The participants said they felt suffering and were frustrated, stressed, anxious, and confused during the first three months of caregiving until their relative entered the treatment process. For example, one participant noted that they had no time to do anything because they did not know what disappointment in older adults' behaviors was. Expressed attitudes included:

*It's a tough time! Everyone comes to take care of each other for 2–3 months. Many people came to care for each other in my family; we're exhausted and stressed, and there's no time for rest. (FC13)*

The frustration found in this study occurred with participants with less close relationships, such as that of a daughter-in-law and spouse who experienced boredom. This role was a burden to her, and she looked at the older adult negatively. Such as:

*He has no one. His elder brother is old, like a burden to him, the burden on us. However, it must be a burden because he has no one. (FC14)*

## Discussion

The findings revealed two major themes of family caregivers' attitudes towards the care for older adults with MDD: 1) Rethinking in positive ways, and 2) Began with negative attitudes. This study showed negative attitudes in the early stages of caregiver duties and depression. Negative attitudes towards caring for older adults with MDD can include stress and lack of knowledge about the condition and its treatment. These attitudes can result in reduced quality of care for relatives and increased burden on their caregivers. Most family caregivers reacted negatively after the family had a hard time caring for older adults or life crises such as the loss of a person, the loss of a job, or economic problems. The consequence of caregiving led to stress, anxiety, and confusion among family caregivers. The suffering of caregiving occurred during the first 3–6 months of illness and symptoms until entering the treatment process. Therefore, they would feel burdened at the beginning of their caretaking role or the first time they did this. Negative attitudes about those who have mental illnesses and inadequate knowledge of such conditions as MDD are widespread.<sup>29</sup> Mostly negative attitudes are feeling burdened, tired, and stressed. Otherwise, the family caregivers who had negative attitudes were arrogant, easily agitated, unhappy with them, and feeling bored. The frustration found in this study occurred with family caregivers who had a less close relationship, such as a daughter-in-law and spouse

who experienced boredom. This role became a burden, and the older adult was viewed negatively.

A positive attitude occurs after entering the treatment process. The family caregivers learned from psychiatric nurses, physicians, and other reliable sources and gained experience and rethinking in positive ways. There was acceptance and adaptation after 6–12 months. They learned the symptoms of the illness to adapt and accept, forgive, and become accustomed to the feeling of it not being a burden. These were underlying factors to shift from negative to positive attitudes toward caring for older adults with MDD. It is essential to increase awareness and education about MDD and its treatment, reduce stigma and fear, and support caregivers.<sup>20</sup> Additionally, attitudes refer to a person's feelings, thoughts, and beliefs toward something.<sup>30</sup> Therefore, when the caregivers brought the older adults into the treatment process and received information about depression, they had conversations to express emotions, provided encouragement and support, and had individualized access to other caregivers, such as nurses. This process resulted in caregivers adopting accurate thoughts and beliefs, leading to an improved attitude towards their relatives with depression.

We found that caregivers who developed a positive attitude towards caring for an older person with depression were better able to cope with them and their symptoms. Positive attitudes occurred partly due to the acceptance of the illness and the improvement in symptoms resulting from caregiving. A similar study discovered that increasing depression literacy could increase acceptance, attitudes, and positive stigma regarding depression.<sup>6</sup> Similarly, accepting roles in the caregiving of older individuals by family caregivers was influenced by elements derived from familial commitment.<sup>2,31</sup> Awareness is the first step toward acceptance or rejection. Illness and care responsibilities are the roles that will arise.<sup>2,31</sup> In our study, caregivers noticed and recognized that older individuals had abnormal symptoms. Afterward, the caregivers became interested, searching for information and learning

about behavioral changes or increased symptoms. This behavior was intended to give them more knowledge and understanding. At this stage, the person can be educated about the symptoms and depression, depending on personality, values, society, or past experiences. It affects the caregiver and influences the search for knowledge.<sup>31</sup>

In this study, the participants used trial and error as a moderation process using experimental approaches and methods of care and solving problems to find a more suitable way to care for older adults. They had the responsibility of deciding whether to accept that method or not. At that stage, the individual sought specific advice about providing adequate care from peers, physicians, and nurses, and the outcome was critical in the decision to accept or reject. The acceptance process is the stage where the caregiver accepts the illness, the role of care, and how to live after trying it and implementing it continuously. These moderators sought further information to support decision-making and enhance the quality of care provided.<sup>31</sup>

Our participants learned from the experience of living with older people, the advice of doctors and psychiatric nurses, telling stories, reading, and studying until they gained knowledge and understanding of the depressive illness and finally accepted the symptoms and behavior. They were adapting to a new situation to maintain the function of living in a family.

Caregivers with a positive mindset towards caregiving were happy to perform daily care activities and viewed their older relatives with MDD as needing care and support. These findings are significant and refer to the abilities of personal control boundaries and the potential of individuals' greater understanding, self-efficacy, motivation, and ability to access, understand and use the information for good health. In addition, positive mental health attitudes and beliefs positively affect seeking help and treating diseases and mental disorders, especially depression, in older adults.<sup>32</sup>

Caregivers felt they could cope with symptoms and manage them successfully and felt a sense of pride. Their attitudes towards those in their care changed positively, seeing them as beloved. Most of the time, these positive attitudes occur in the caregiver of the child or spouse with a pre-existing positive family relationship.<sup>32,33</sup> Most family caregivers, such as children, wives, and husbands, knew that care was not a burden even if the illness became more severe, and they chose whether to care for or not to care for the sick older adult. Each caregiver in our study insisted on caring for their relative with depression because they saw responsibility as a duty and were happy to fulfill this role.

In Thai culture, an individual who provides exemplary care to their family members is appreciated. Our participants were proud that they could provide better care for older adults in Thai society. When family caregivers take good care of their sick family members who get better, they are appreciated; this reinforces to the caregivers that what they have been doing is good and admirable.<sup>34,35</sup> Staying with their family in the community in a familiar environment and getting support from their relatives yields positive outcomes between the older adult and the family caregivers and a positive attitude towards caregiving for the older adult with depression.<sup>36</sup> In Thailand and many other parts of Asia, cultural and social conventions have established that older individuals are supported by family members, particularly adult children, through co-residence, as a manifestation of generalized reciprocity. This practice is influenced by Buddhism, Thailand's national religion, which believes that caregiving is a means of repaying the care given by parents to their children during their upbringing. The notion of obligation or filial duty is deemed indispensable to Thai families.<sup>20</sup>

In a fraternal society situated within the same village community, the conduct of caregivers who provide excellent care for their family members is highly valued. This acknowledgment enhances the well-being

of older adults, validates the praiseworthy nature of the caregivers' behavior, and bolsters their self-esteem by instilling a sense of pride in their capacity to tend to their loved ones.<sup>36</sup>

Our study found that most caregivers insisted on providing care because this repaid merit and caring for their older adults. Caring for an older relative with depression was a substitute for the grace received and a willingness to provide further care.<sup>37</sup> This finding is similar to a previous study on the positive aspect of caregiving promoting better relationships between older people and caregivers.<sup>38</sup> Although some studies have found that the relationship between caregivers and relatives worsened, some caregivers admitted that their caring improved the relationship between them due to the time spent closer together and the relative showing more love for themselves.<sup>38,39</sup>

Caregivers try to adapt to the depressive problem in older people by adjusting their behaviors and accepting a home environment where relatives need close supervision to live happily. Based on the role and environment given or changed, it is a way for caregivers to keep their mental well-being through remediation and find solutions to eliminate or alleviate suffering, frustration, and stress. Family caregivers who adapt to their symptoms and roles can provide care because they are willing to serve their loved ones. In return, they feel gratitude and respect and are happy to make the older adult feel better.<sup>20</sup>

From the view of caregivers in families in a husband-wife relationship, most of them think of the hardships they have spent together and their love for each other. Despite feeling tired sometimes, it is an act for the people you love. Although families can face difficulties that affect their care, such as economic problems, they still insist on caring for older adults without feeling burdened. Consistent with previous research, this study showed that the caregivers understood their obligation to repay the favor and act with love and gratitude to the older adults who cared for them in their youth as a reward. FCs felt happiness and pride that they did a good job taking care of their loved ones.

## **Limitations**

Data collection was restricted due to the COVID-19 pandemic, which made it challenging to access participants in a timely manner due to the implementation of public health protocols and restrictions.

## **Conclusion and Implications for Nursing Practice**

This study found that family caregivers play a significant role in the care and well-being of older people with MDD. For example, suppose the caregivers have a positive attitude towards the older person, rooted in love and attachment. In that case, positive attitudes can facilitate acceptance, adaptation, and the pursuit of appropriate care methods for living with MDD.

Caregivers may need time to adjust to the demands of caring for a depressed older person, with most adjustments occurring within the first one to three months. In the early stages, caregivers may struggle with caring, but with time and experience, most caregivers learn to accept the situation and develop specific care guidelines. This process involves gaining practical experience and seeking external and internal support to assist in the care, whether through professional knowledge or other sources of support. Based on our findings, our findings support that nurses and healthcare professionals must prioritize their knowledge and skills in managing depression. Additionally, they should take on a mentoring role for caregivers in the initial stages of caring for older relatives. To help families adapt and acquire the necessary skills and attitudes for caregiving for older adults with depression, nurses have a significant role in providing education and guidance on treatment and offering emotional support and counseling to the families, particularly when there are difficulties or worsening symptoms. Nurses need to be prepared for

this role, and resources need to be available for them to have education and training regarding care for people with major depression in the community.

## **Acknowledgments**

The 1<sup>st</sup> International Conference in Palliative Care and Family Health Nursing, June 26–27, 2023, Faculty of Nursing, Thammasat University, supported this publication. The researcher would like to thank the nurse coordinator who assisted with participant access and all family caregivers and older adults for their knowledge and valuable experiences.

## **References**

1. Ansary M. Recognizing depression in elderly patients in general practice. *World Fam Med J.* 2020;18(10):112–4. doi: 10.5742/MEWFM.2020.93882.
2. Schulz R, Beach SR, Czaja SJ, Martire LM, Monin JK. Family caregiving for older adults. *Annu Rev Psychol.* 2020;71: 635–59. doi:10.1146/annurev-psych-010419-050754.
3. Sampaio F, Gonçalves P, Sequeira C. Mental health literacy: it is now time to put knowledge into practice. *Int J Environ Res Public Health.* 2022 Jun;19(12):7030. doi: 10.3390/ijerph19127030.
4. Pruksarungruang J, Rhein D. Depression literacy: an analysis of the stigmatization of depression in Thailand. *SAGE Open.* 2022;12(4):21582440221. doi: 10.1177/21582440221140376.
5. Egwuonwu CC, Kanma-Okafor OJ, Ogunyemi AO, Yusuf HO, Adeyemi JD. Depression-related knowledge, attitude, and help-seeking behavior among residents of Surulere Local Government Area, Lagos State, Nigeria. *J Clin Sci.* 2019;16(2):49–56. doi: 10.4103/jcls.jcls\_90\_18.
6. Mingkwanjai C, Prasertsong C, Kasipul T. The effects of community nurse practitioner's health educational program on the knowledge, attitude and practice of family caregivers of patients with depression. *J Royal Thai Army Nurses [Internet].* 2015 Dec [cited 2023 Mar 22];16(3):60–7. Available from: <https://he01.tci-thaijo.org/index.php/JRTAN/article/view/47665>

7. Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control and Prevention. Depression is not a normal part of growing older [Internet]. 2022 Sept 14. Available from: <https://www.cdc.gov/aging/depression/index.html>
8. World Health Organization. Depressive disorder (depression) [Internet]. 2023 Mar 31 [cited 2023 April 26]. Available from: <https://www.who.int/news-room/fact-sheets/detail/depression>
9. Charoensakulchai S, Usawachoke S, Kongbangpor W, Thanavirun P, Mitsiriswat A, Pinijnai O. Prevalence and associated factors influencing depression in older adults living in rural Thailand: a cross-sectional study. *Geriatr Gerontol Int*. 2019;19(12):1248–53. doi: 10.1111/ggi.13804.
10. Conejero I, Olié E, Courtet P, Calati R. Suicide in older adults: current perspectives. *Clin Interv Aging*. 2018;13:691–9. doi: 10.2147/CIA.S130670.
11. World Health Organization. Depression [Internet]. 2020 [cited 2023 Jan 30]. Available from: [https://www.who.int/health-topics/depression#tab=tab\\_1](https://www.who.int/health-topics/depression#tab=tab_1)
12. Department of Mental Health. Department of Mental Health policy: action plan in 2018–2022 [Internet]. 2018 [cited 2023 Jan 30]. Available from: <https://dmh.go.th/intranet/p2554/download/view.asp?id=237>
13. Singh S, Zaki RA, Farid NDN. A systematic review of depression literacy: knowledge, help-seeking and stigmatizing attitudes among adolescents. *J Adolesc*. 2019;74:154–72. doi: 10.1016/j.adolescence.2019.06.004.
14. Ho GWK, Bressington D, Leung SF, Lam KKC, Leung AYM, Molassiotis A, et al. Depression literacy and health-seeking attitudes in the Western Pacific region: a mixed-methods study. *Soc Psychiatry Psychiatr Epidemiol*. 2018;53(10):1039–49. doi: 10.1007/s00127-018-1538-6.
15. Tehrani H, Vali M, Nejatian M, Moshki M, Charoghchian Khorasani E, Jafari A. The status of depression literacy and its relationship with quality of life among Iranian public population: a cross-sectional study. *BMC Psychiatry*. 2022;22(1):607. doi: 10.1186/s12888-022-04251-0.
16. Triolo F, Harber-Aschan L, Belvederi Murri M, Calderón-Larrañaga A, Vetrano DL, Sjöberg L, et al. The complex interplay between depression and multimorbidity in late life: risks and pathways. *Mech Ageing Dev*. 2020;192. doi: 10.1016/j.mad.2020.111383.
17. Schulz R, Eden J. Family caregiving roles and impacts. In: Schulz R, Eden J, editors. *Families caring for an aging America*. National Academies Press eBooks; 2016. pp. 73–122.
18. Aung TNN, Aung MN, Moolphate S, Koyanagi Y, Supakankunti S, Yuasa M. Caregiver burden and associated factors for the respite care needs among the family caregivers of community-dwelling senior citizens in Chiang Mai, Northern Thailand. *Int J Environ Res Public Health*. 2021;18(11):5873. doi: 10.3390/ijerph18115873.
19. Wongsaree C. Nursing care for the older adult with depression: family-centered care. *RTA Med J*. 2019;72(1):69–77. (in Thai)
20. Kraithaworn P, Noinam S. Depression and suicide literacy and mental health seeking behavior among family caregivers of older people in community. *J Royal Thai Army Nurses* [Internet]. 2021 Sep 5 [cited 2023 Jan 15];22(2):260–9. Available from: <https://he01.tci-thaijo.org/index.php/JRTAN/article/view/247059>
21. Mulango ID, Atashili J, Gaynes BN, Njim T. Knowledge, attitudes and practices regarding depression among primary health care providers in Fako division, Cameroon. *BMC Psychiatry*. 2018;18(1):66. doi: 10.1186/s12888-018-1653-7.
22. Choi EY, Um S, Shin H, Kim YS. Attitudes toward aging, active coping, and depressive symptoms among middle-aged and older Korean adults: how do they differ by age group? *J Affect Disord*. 2022;296:380–7. doi: 10.1016/j.jad.2021.09.086.
23. Tonsing KN. A review of mental health literacy in Singapore. *Soc Work Health Care*. 2018;57(1):27–47. doi: 10.1080/00981389.2017.1383335.
24. Turale S. A brief introduction to qualitative description: a research design worth using. *Pacific Rim Int J Nurs Res* [Internet]. 2020 Jul 9 [cited 2023 Apr 29];24(3):289–91. Available from: <https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/243180>
25. Lincoln, SY, Guba, EG. *Naturalistic inquiry*. Newbury Park, CA: Sage Publications; 1985. pp. 289–327.
26. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349–57. doi: 10.1093/intqhc/mzm042.

27. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77–101. doi: 10.1191/1478088706qp0630a.
28. Holloway I, Galvin K. *Qualitative research in nursing and healthcare.* 4th ed. Chichester: John Wiley and Sons; 2017.
29. Doumit AC, Haddad C, Sacre H, Salameh P, Akel M, Obeid S, et al. Knowledge, attitude and behaviors towards patients with mental illness: results from a national Lebanese study. *PLoS One.* 2019;14(9):e0222172. doi: 10.1371/journal.pone.0222172.
30. Verplanken B, Orbell S. Attitudes, habits, and behavior change. *Annu Rev Psychol.* 2022;73:327–52. doi: 10.1146/annurev-psych-020821-011744.
31. Feliciano A, Feliciano E, Palompon D, Gonzales F. Acceptance theory of family caregiving. *Belitung Nurs J [Internet].* 2022 Apr 26 [cited 2023 Jan 29];8(2):86–92. Available from: <https://www.belitungraya.org/BRP/index.php/bnj/article/view/2004>
32. Bekhet AK, Garnier-Villarreal M. Effects of positive thinking on dementia caregivers' burden and care-recipients' behavioral problems. *West J Nurs Res.* 2020;42(5):365–72. doi: 10.1177/0193945919861970.
33. Thomas, PA, Liu, H, Umberson, D. Family relationships and well-being. *Innov Aging.* 2017;1(3):igx025. <https://doi.org/10.1093/geroni/igx025>
34. Tamdee D, Tamdee P, Greiner C, Boonchiang W, Okamoto N, Isowa T. Conditions of caring for the elderly and family caregiver stress in Chiang Mai, Thailand. *J Health Res.* 2019;33(2):138–50.
35. Junpanit A, Lawang W, Toonsir C. Factors influencing the positive aspects of caregiving among stroke family caregivers. *J Nurs Educ.* 2018;11(2):61–73 (in Thai).
36. Lawang W, Sunsern R. Positive aspect of caregiving: crucial concepts enhancing family caregivers' strength. *J Nurs Educ.* 2016;9(3):1–9 (in Thai).
37. Tangjitboonsanga N, Charnsil C. Attitude toward depression in Thai population. *J Psychiatr Assoc Thailand [Internet].* 2020 Mar 30 [cited 2023 Jan 31];65(1):75–88. Available from: <https://he01.tci-thaijo.org/index.php/JPAT/article/view/240795>
38. Gray RS, Hahn L, Thapsuwan S, Thongcharoenchupong N. Strength and stress: positive and negative impacts on caregivers for older adults in Thailand. *Australas J Ageing.* 2016;35(2):E7–12. doi: 10.1111/ajag.12266.
39. Zhong Y, Wang J, Nicholas S. Social support and depressive symptoms among family caregivers of older people with disabilities in four provinces of urban China: the mediating role of caregiver burden. *BMC Geriatr.* 2020;20(1):3. doi: 10.1186/s12877-019-1403-9.



## ทัศนคติต่อการเป็นผู้ดูแลผู้สูงอายุที่มีโรคซึมเศร้า: การศึกษาเชิงคุณภาพ

วริยา จันทร์ขำ รังสิมันต์ สุนทรไชยา\* ประนอม โอทกานนท์ Jing Jy Wang

**บทคัดย่อ:** ผู้ดูแลในครอบครัวเป็นบุคคลสำคัญที่ให้การดูแลผู้สูงอายุโดยเฉพาะผู้ที่เป็นโรคซึมเศร้า ทัศนคติต่อการดูแลของผู้ดูแลในครอบครัวเกี่ยวข้องกับสุขภาวะของผู้สูงอายุที่มีโรคซึมเศร้า การศึกษาพรรณนาเชิงคุณภาพนี้มีวัตถุประสงค์เพื่อสำรวจทัศนคติของผู้ดูแลหลักในครอบครัวต่อการดูแลผู้สูงอายุที่มีโรคซึมเศร้า ผู้เข้าร่วมการศึกษาคือผู้ดูแลในครอบครัวซึ่งเป็นผู้ดูแลผู้สูงอายุที่มีโรคซึมเศร้าจำนวน 17 ครอบครัวที่อาศัยอยู่ที่บ้าน คัดเลือกแบบเจาะจง รวบรวมข้อมูลโดยใช้การสัมภาษณ์แบบกึ่งโครงสร้างและวิเคราะห์ข้อมูลโดยใช้การวิเคราะห์เชิงเนื้อหา ผลการศึกษาพบประเด็นสำคัญสองประการ 1) “คิดใหม่ในแง่บวกสู่การดูแลผู้ป่วย” รวมถึงการยอมรับการเป็นผู้ดูแล และรู้สึกมีความสุขและภูมิใจที่ได้ดูแลคนที่รัก 2) “เริ่มต้นด้วยทัศนคติเชิงลบต่อการดูแล” รวมถึงความไม่แน่นอนเกี่ยวกับชีวิตและความรู้สึกของความทุกข์และความคับข้องใจกับหน้าที่การดูแล โดยสรุป ทัศนคติของผู้ดูแลในครอบครัวมีความจำเป็นและส่งผลโดยตรงต่อการดูแลผู้สูงอายุที่เป็นโรคซึมเศร้า ดังนั้น พยาบาลและบุคลากรทางการแพทย์ควรเข้าใจการดูแลด้วยวิธีการเชิงบวกและการยอมรับให้ดีขึ้นในผู้ดูแลในครอบครัว เพื่อส่งเสริมทักษะและความสามารถในการจัดการกับอาการซึมเศร้า โดยการให้ความรู้และการฝึกอบรมทักษะการดูแลที่มีประสิทธิภาพและให้คำปรึกษาแก่ครอบครัวในระยะแรกของการดูแลผู้สูงอายุที่มีโรคซึมเศร้า

*Pacific Rim Int J Nurs Res 2023; 27(3) 485-499*

**คำสำคัญ:** ทัศนคติ การดูแล ภาวะซึมเศร้า ผู้ดูแลในครอบครัว โรคซึมเศร้า ผู้สูงอายุ การวิจัยพรรณนาเชิงคุณภาพ

วริยา จันทร์ขำ นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์ มหาวิทยาลัยธรรมศาสตร์  
E-mail: wariya110@nurse.tu.ac.th

ติดต่อที่: รังสิมันต์ สุนทรไชยา\* รองศาสตราจารย์ คณะพยาบาลศาสตร์  
มหาวิทยาลัยธรรมศาสตร์ E-mail: rangsiman@nurse.tu.ac.th

ประนอม โอทกานนท์ ศาสตราจารย์คณะพยาบาลศาสตร์ มหาวิทยาลัยธรรมศาสตร์  
E-mail: otpranom@gmail.com

Jing Jy Wang, RN, PhD, Professor, Department of Nursing, College of  
Medicine, National Cheng Kung University, Tainan, Taiwan.

E-mail: ns127@ncku.edu.tw