

## **Factors Affecting Caregiving for Dependent Older Adults in Thai Families: A Grounded Dimensional Analysis Study**

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### **Abstract**

This qualitative study aimed to identify conditions influencing how Thai families care for dependent older adults. As a part of a research study of family caregiving for dependent older persons in Thai families, in-depth interviews with 30 family members who identified themselves as caregivers were used for data collection. The dimensional analysis was used for data analysis. The finding revealed four main conditions for choosing types of care and approaches for care: (a) sources of motivation, (b) caregivers' characteristics, (c) family size, (d) degree of dependency.

**Keywords: Family caregiving; older adult / grounded theory / dimensional analysis**

### **Introduction**

Caregiving by families is widely acknowledged to serve as primary support for older persons. Thailand provides a good example of providing family care to their elderly relatives where it is a common practice that people in old age are taken care of by younger people, generally their relatives and family members. Normally adult children have participated in providing support and comfort to aging parents, as well as providing assistance during illness, primarily in the form of physical care and psychological support.

The need for long term care is required in the presence of any declining health and increasing frailty associated with aging. Functional limitation in daily activities for older persons is common and leads to dependency in their living. Data from the Third National Health Examination Survey 2003-2004 indicated that 5 percent of older persons need support for their daily activities and 15 percent of them need domestic help. In 2011, 18.25 % of older adults in Thailand were homebound and 5.11% are bedbound (Situation of Aging in Thailand, 2011).

It is anticipated that due to decreasing family size there will be less adult children or family members available to provide care and support for the future generations of older persons and less chance

among siblings to share caregiving responsibilities in the family. Increasing numbers of women who work away from their houses means that there is a decreasing in the number of full time homemakers to assume full time responsibility for the care of frail older persons . Moreover, the smaller number of household members due to offspring living separately implies that the ways in which the Thai family responds to family caregiving might change. For instance, it is ironic that as families become smaller and traditional caregivers less available, the need for caregivers and the chances of becoming a caregiver are actually increasing.

### **Objective**

To identify major conditions influencing how Thai families care for dependent older persons.

### **Literature Review**

According to literature review, there is no single reason which makes a family member become a caregiver or being involved in caregiving for an older person relative. Individual and family conditions show the significant relation to family caregiving. However, for this instance, family conditions were much consider for this section.

According to Matthews (1988), when a sibling group was mobilized to meet parental needs, family structure, family history and extra familial ties affected the inclusion of specific styles of family caregiving system and the likelihood that a sibling would use a particular style. The two family structure properties- size and gender compositions affected the likelihood that which style would be included, as well as which siblings were likely to adopt it. The important of the size of the sibling group is a way how care was organized in those groups. It was indicated in the study that gender affected the likelihood that a particular style would be adopted by one or the other. Routine involvement was common for daughters but atypical for sons.

Similarly to the work of Matthews (1988), Keith (1995) found that gender and family size are family composition in which contributes to the development of its care giving system. It appears that, larger families with two or more daughters may readily develop a partnership than other families. In addition to family composition, family values held by families also appear to distinguish the three types of family systems. Four predominant values; 1) justice, 2) affiliation, 3) equity, and 4) emotional protection, were identified through the explanation of care giving arrangement among offspring. It is clearly that family size, gender to be significant determinant of the type of care giving systems and styles of participation in care giving families.

Familial values were found to underline caregiver behavior. As a result of these values respondent were unable to point out one single predominant motive for caregiving, result in a blurring of innumerable reasons such as sense of duty, love, lack of choice, humanitarian concern and social reason.

In some instance, attachment among family member influences the caregiving. The attachments

across the life course to a spouse, other kin, and even other non family members might also provoke similar protective behavior in the form of caregiving. Cicirelli (1983a, 1991,1993) has suggested attachment as a motivator for caregiving, particularly caregiving to an aging parent. Using the attachment framework, he has posited that just as a young child is motivated to engage in “protective behavior” to preserve or restore the existence of the attachment figure (usually the parent), so might an adult child be motivated to protect and do what is possible to extend the life of a parent who is disabled and needs care. An interesting psychological view of why they take on caregiving that assumes the person is deliberately choosing. The work shows that sometimes it just happens, it might be an extension of what family members just do for each other and they might be asked to do it.

Studies of the social demographic predictors of giving care have yielded a theory of the “hierarchical substitution principle” for the choice of primary caregiver . A spouse is the first to be enlisted in family caregiving if available. Next in line is an adult daughter, followed by an adult son (Coward, Horne, & Dwyer, 1992). Proximity understandably plays a role in who becomes a caregiver; adult children living closer to a parent are more likely to become caregivers. Evidence for birth order effects, however, has not been found (Horowitz, 1985).

Historically, unmarried children (especially daughters) were more likely to be enlisted than married children (Ikels, 1983). However, there is now some evidence that formerly married children (in contrast to never married children) may be somewhat less likely to become caregivers than married children. This is perhaps due to additional responsibilities they may carry alone for rearing children and self-support (Cicirelli, 1983b; Marks, 1996). When children are not available, siblings and other relatives (e.g., nieces, nephews, cousins), close friends, and neighbors may be enlisted. Formal services are turned to usually only as a last resort (Horowitz, 1985).

Viewing family caregiving in a context of Buddhism, the connection between Buddhist philosophy and family caregiving was identified in a work of Sethabouppha . According to Sethabouppha, caregiving is Suffering, Buddhist belief, Acceptance, Management, and also Compassion. As reflected in the Buddhist practices of compassion, management and acceptance, Buddhist beliefs regarding Karma, Boon and Babb concepts and Dharma were essential to caregiving (Ratanatikanon, et al., 1997; Rujirapipat, et al., 1992, Rungreungkulkij & Chesla, 2001).

## **Research Methodology**

### **Setting and Recruitment**

The data for our study were generated through in-depth interviews with 30 family caregivers from 2011-2012. The data were obtained as a part of larger study to examine the over all experiences of family caregiving for dependent older persons in Thai Families. The availability of a sample from the study provided an opportunity for theoretical sampling for the purpose of understanding the conditions in relation to type of care and caregiving approaches. The participants were recruited through public health personnel who work in Ratchaburi province located in the central part of Thailand.

### Sample

The majority of the participants were female (27 of 30), and got married (18 of 30). Half of them (15 of 30) were daughters. Nearly half of them (14 of 30) were being at home and having no job. More than half (18 of 30) of them lived with older persons, while 6 of them lived in the commutable distance (less than 10 kms), far from older persons. The participants provided care to 15 older members who were identified by the caregivers as unable to take care of themselves. The older adults were primarily female (10 of 15), ranging from having no children to 8 adult children. Most of them were bed bound or totally dependent (8 of 15 older persons) and had at least one offspring living with them (14 of 15).

### Analysis

Grounded dimensional analysis approach was used to guide both the data collection and analysis of textual data for this study. Subjects for this study were family members who experience taking care of older person who need care. The participants in this study were 30 adults who represent family members involved in caregiving of 15 families. One to five persons in each family were interviewed. A total of 46 interviews were conducted. As theoretical sampling conducted at the middle and final phase of the study, various characteristics of families were included.

Dimensional analysis was applied for data analysis within three phases of 1) calling up dimensions, 2) assigning relative value to each of the dimension considered and 3) inferring. The early phase which consists primarily of open coding, the middle phase uses axial coding for integration of categories and dimensions, and the final phase uses selective coding to form a theory or conceptual model. In a grounded dimensional study, open, axial, and selective coding can be integrated throughout the entire analytic process. In this study, credibility was ensured by consistent use of the grounded dimensional analysis. Additionally, several techniques were used such as member checking and peer debriefing.

To protect the rights of human research subjects, the proposal, research procedures, and subject consent form was approved by the ethic committee of the Faculty of Public Health, at Mahidol University, Thailand. Subjects, called participants, were given a complete explanation and brief written information about the purpose of the study, the method, and benefits of participating in the study.

### Research Findings

With respect to the performance of dependent care, conditions related to what to perform and how to perform emerged. Once, family members made themselves available for fulfilling care needs of the older person, a numbers of factors affected what type of care those family members would engage in, which approaches they would use, and how likely it was that they would use those approaches when providing care. According to the findings, sources of motivation, personal characteristics and family characteristics and degree of dependent were among those factors.

### **Sources of Motivation**

#### **Sense of Family Obligation and Responsibility**

Sense of family obligation and responsibility played an important role in encouraging family members to make themselves available to perform care and also in motivating caregivers to continue their care provision. Relationship to the older adult, particularly parent-child relationship affected caregivers to provide the care as their obligation, as well as an inherent responsibility. One daughter said “ They are my father and my mother. So I had to take care of them. It seems like this (Family 10- daughter-1st interview)” There was a case when family obligations of the family of procreation limit caregivers for doing the best. We do it together. We help each other to take care of him. Anyhow, if you ask me “Are you doing your best?” I would say “No. Everyone has their own obligations. For example, I have children. My elder also has kids. (Family 12-daughter1-1st interview)

In relation to approaches for performing dependent care, family members who were motivated to provide care because of ‘sense of family obligation and responsibility’ were more likely to apply any approach for dependent care. However, the family members who apply focusing on ‘caregiver’s self’ commonly mention about the care as obligation and responsibility compare with other who apply another approaches.

#### **Sense of Repayment**

Sense of repayment also played an important role in motivating family members to perform and keep the care continued. This was offered as motivation by caregivers who had received support and care earlier in their lives, particularly good parenting from the older person when they were young. Caregiving for them was simply repayment. Grandchildren, such as nieces, mostly motivate themselves by applying this sense. Having the sense of repayment, family members commonly perceive the level of care as ‘doing the best’ for the care-receiver meanwhile applying focusing on ‘care needs’ as an approach for care. The quotation is an example from a niece who had a strong sense of repayment and described her care as the best she could do for the old person.

I believe, I should do the best for her. As if she was my own mom. We should think about the time when she was raising us, when she was bathing us. ...Now she can’t feed herself. We must take care of her. She was in so much pain. How long she would be-with us...(Family14-daughter-2nd interview)

#### **Sense of Attachment and Love**

Sense of Attachment and love was also a source of motivation for dependent caregiving, particularly, continual care. Feeling strong attachment to the family kept caregivers going on although it was considered difficult. Family members who had good relationships with others in their immediate families, for example husbands and wives who are in good terms, found it easier to continue the care. Attachment and love among caregivers as well as between caregivers and the older persons also made the continuation of caregiving easier.

It was about love and attachment. It seem like she was my mom. The love and attachment are (conditions). This helps a lot.... We are together as long as we have attachment. ... The attachment (between her and me) make me were able to provide care to her.”(Family 11-niece-1st interview)

### **Sense of Willingness**

Willingness was another source of motivation and often went along with other sources of motivation. Family members who have willingness to care for parents or relatives were more likely to make themselves available for the care, especially for being-with and hands-on care. Willingness was almost opposite to ‘inevitability’ of caregiving role.

After I got married, I moved in to live with my husband. After dad got sick, I came back to live with mom and dad again because I would like to take care of him....(Family9-daughter1-1st interview)

For some family caregivers, there were multiple sources of motivation to continue caregiving, including a sense of obligation or responsibility, compassion, love and attachment to the older person as well as to other caregivers and repayment for what the person had received from the older person earlier in their life. The family members who had multiple sources of motivation, particularly the ‘sense of family obligation and responsibility’ and the ‘sense of attachment and love’ between caregivers and older persons are more likely to apply focusing on ‘care needs’ as an approach for performing dependent care.

In contrast, family members who were motivated only by the sense of family obligation and responsibility were more likely to apply an approach of focusing on ‘caregiver’s self’. Additionally, this source of motivation did not show any relation to an approach of focusing on ‘family unit’. There was a case where family members had no willingness to care but had to accept their tasks as their responsibility. Consequently, the good care might not be achieved under this condition. Under the combination of sense of willingness and other senses of motivation, good care was more likely to be met.

### **Personal Characteristics of Caregivers**

There were a number of personal characteristics that were identified as inclusion criteria for engaging in what type of care and also how to perform them. These personal characteristics were more likely relate to time availability and ability to perform any types of care. Personal characteristics such as living conditions (being at home, living nearby, living far away), working conditions (jobless, having flexible job and having permanent job), marital conditions (single, married without children, married with dependent child(ren), financial conditions, expertise conditions and health conditions were among those significant factors affecting performing care.

### **Living Conditions**

In relation to type of care, family members who live with older persons generally accepted being-with older person and providing hands-on care as their responsibility. The family members who

lived nearby or live far away are more likely to do other types of care such as managing care, monitoring care and supporting care. There was a case when a family member living nearby involved in being-with and hands-on care. However, this was not a common situation.

According to how to perform the dependent care, it was difficult to use living condition to identify what approaches individual family members would use for dependent care. The family members who live with older persons may or may not apply the same approach for care. The family members who live with or nearby may or may not apply the same or different type of care.

### **Working Conditions**

Working conditions mostly related to time availability. The family members who were jobless were more likely to be engaged in being-with and hands-on care. Family members who had permanent job or inflexible work were able to be engaged in any type of care but the duration of care and approach of care that they use for getting the care done would be varied. Family members with inflexible work were more likely to apply focusing on ‘caregiver’s self’ and focusing on ‘family unit’ whereas the approach of focusing on ‘care needs’ was more likely to be applied by family members with flexible working hour or jobless.

### **Marital Conditions**

Marital conditions was a personal characteristic that affected what types of care that family members would be engaged in and how to perform them. Different conditions of marital status such as being single, married without children, married with either dependent or grown up children affected dependent caregiving. The marital conditions affected the family members in term of time availability or flexible or inflexible lifestyle in relation to the type of care they would be able to perform. Generally, unmarried children were likely to be able to be engaged in any type of care whereas, married children were more likely to be engaged in the care that did not take much time to get done such as visiting, providing financial support. However, there was a case where a married child who had no children of her own was able to do a large amount of care. Therefore, marital condition was not a single factor that influenced individual to perform which type of care.

### **Financial Conditions**

Financial conditions of family and individual family members provided possibility of which types of care that family members would be engaged in and how to perform them. If families of older persons have sufficient family income, they might hire caregivers when the family members were not available for particular types of care such as being-with and hands-on care. The financial conditions of the individual provided opportunity for the family members to identify, to what extent, they would be responsible for the care. The financial availability provided a chance of a family member to get involve in supporting care, particularly in financial support, either directly to older persons, to being-with

caregivers or to hands-on caregivers. The possibility of hiring caregivers was not present in the families where financial support within families was limited.

### **Expert Conditions**

The expertise conditions may have come in the form of what specific ability family members had whereas others family members were not able to do. Being able to drive, being close to older persons, being able to communicate with health personnel were examples of expertise. This expertise sometimes related to work conditions of individual family members. For example, having a daughter as a nurse was perceived as a reason why an older person would like to be-with her. This also made the daughter involved in managing care for her mother.

### **Health Conditions**

In some cases, health of family members was considered to be a condition to whom caregivers would not ask for help. However, in some cases, a congenital disease such as hypertension of a family member was not considered as a criterion to exclude the person from dependent care. For example a son who was generally being-with older person and provide hands-on care on the daily basis mentioned about his health problem. Therefore, having congenital diseases might not be a direct condition of excluding someone from elderly care.

For instance, the difficulty of having those diseases might create a direct effect on performing specific types of care. For example, caregivers with low back pain or breast cancer were not able to move older persons regardless whether they were able to be engaged in hands- on care or not. The caregivers with alcoholism may sometimes not able to do any kinds of hands-on care when they got drunk. Therefore having alcoholism in caregivers temporary limited their abilities to perform dependent care.

### **Family Composition: Family Size and Gender**

#### **Family Size**

Family size reflected a number of family members who would be part of the caregivers' group. Generally, not all children of older persons were engaged in caregiving even though most of them were. Unmarried single child definitely involved in any types of care when it was indicated as needs. Married single child were more likely to have a better change chance to select which types of care they would perform especially when their children (the older persons' grandchildren) were also engaged in caregiving. Multiple children of an older person created a larger group of caregivers comparing with those having single child.

Among family member's group, some of the family member had a better chance to choose what they would perform as they did not meet any inclusive criteria of being available (particularly for "being-with" and "hands-on care"), whereas some of them have to accept type of care they would perform. When there was only one caregiver in the family the approach of focusing on 'family unit' would almost



impossible to apply. The choosing among focusing on ‘care needs’ and ‘caregiver’s self’ depended on other factors rather than family size. Families with more than one caregiver were more likely to apply any approaches of care. However, this depended on other factors as well.

### **Gender**

This study found that gender was not a condition which used to identify which types of care a family member would performed Even though, the majority of participants in this study were females, males were more likely to be involved in providing care to their older relatives. In many families males provided ‘being-with’ and ‘hands-on care’ while, daughters joined in managing, monitoring and supporting care. In four of the fifteen families, sons were the providers of the hands-on care. Among the four sons all of them performed “being-with” care daily. Three of them did it throughout the day, while one of them did it occasionally. When family members fulfilled the criteria of being available such as being at home, he or she had to become involved in particular types of care Moreover, when there was no choice, it did not matter which gender would join in the care. The important was down to whom who was available for care when it need, no master you are son or daughter.

“Being a male” seemed to be a good excuse for not providing some tasks of care such as ‘assisting for bathing’ and ‘spoon feeding’. Moreover, it was a good excuse of not concerning about re-checking: done was done. However, gender did not limit which approach male caregivers would apply for performing dependent care

A number of family members who involved in caregiving for an older person affect what approach the family member use for performing dependent care. Single child who was not married is more likely not to apply replacing care as it is difficult to fine other to replace his care. There is no sibling that a caregiver will be able to find replacement.

### **Degree of Dependency**

There was a condition when individual family members change their approach for care from focusing on ‘caregiver’s self’ to focusing on ‘care needs’. When older persons developed functional limitation and really need assistant from their relative, family members are more likely to apply an approach of focusing on ‘care needs’ such as accepting what to do. Therefore, once the degree of dependency was increased up to one point, family members change their approach from focusing on ‘caregiver’s self’ to focusing on “care need”. However, under the approach of focusing on ‘care needs’, not all strategy will be applied when the limitation of function of older person was increase up to one point. For example, the family member will applied replacing care strategy when it need but not apply with neighbor if degree of dependent is high.

The degree of dependency limited what strategy to perform dependent care. For example, asking help was applied when caregivers were not able to get the caregiving work done by their own and the work need to be done on time or need to be replaced by other person. However, the caregiver would

not ask help from friend when ability to do things of older persons was getting more difficult. For example, if the older person was not able to walk, the caregiver might not ask help from outsider to replace the care, replacing being-with.

### **Conclusion and Recommendations**

Source of motivation was important for both ‘performing dependent care’ and ‘keeping continuity of care’, especially when cares were hard to perform or were performed over a long period of time. Source of motivation encouraged individuals to continue providing care as long as it was not need the new round of mobilizing.

Obligation and responsibility of caregiving as motivation were found in previous studies (Del-Pino, Frias, & Palomino, 2011, De Valk & Schans, 2008). For example De Valk and Schans (2008) found that care as an obligation and a responsibility played an important role in motivating caregivers to continue providing care even though they might not have willing to do. Obligation, in this sense, refers to a culturally defined attitude of duty and responsibility to care for a relative Obligation is one of motives for caregiving. Walker and colleagues (1990) found that vast majority of mothers saw their daughter’s motive for caregiving as discretionary.

Repayment also played an important role in motivation. The sense of repayment was closely related to Buddhist religious ideas. According to Buddhist teachings, caring for elderly and other family members was the expected norm. It would be viewed as ungrateful and disgraceful if family members did not take care of older person relatives. . Buddhist caregivers followed the law of karma, the bunkum system, and the ideas of merit and sin. Caregiving was viewed as a way to repay past deeds, to gain merit, and to return gratitude to their elderly relatives. (Subgranon, & Lund, 2000) Repaying parents for having bringing them into this world and caring for them for is generally viewed, by Thais, as a continual moral obligation. It was an obligation that begins when children were old enough to provide meaningful help, which was typically long before parents reach old age. They care and support their parents starting during childhood, and continue to do so throughout the time that their parents become frail and too old to care for or support themselves. This was viewed as the most important repayment. Buddhist family caregiving was described in Sethabouppha’s study. According to Sethabouppha (2002) caregiving from Thai Buddhist family caregivers was viewed as 1) suffering, 2) Buddhist belief, 3) compassion, 4) management, and 5) acceptance.

Finding of the attachment and love as source of motivation reflects the findings of Dozier. Dozier founded that attachment is strongly related to one’s motivation for providing care. Additionally, Mattews and Rosner, found that ties among family members, and extra-familial ties (ties between siblings), were important to the way that adult siblings were involved in the parent-care system.

With respect to personal characteristics of individual family members, there were a number of factors which was presented as inclusion criteria for engaging in specific types of care. These characteristics were more closely related to availability of family member to care for the older relative.

Personal characteristics significantly affected the 'availability' of family members, which affected the type of care that they performed. Lowenstein indicated that family support and kin relations are closely related to household composition and living arrangements. It was a meeting place for family members and provides opportunities for mutual help. Similar to the result of this study, family members who live with older persons generally accepted 'being-with' older adult and provided 'hands-on care' as their responsibility.

Family size and gender played an important role in the performance of dependent cares. Family size limited the approaches of care that family members used. For single family members, encouragement and getting help from other family members was not applicable, as there was no one other than that child who was available to engage in caregiving. Having multiple family members made it possible to use various approaches to dependent caregiving. The finding that family size affected the performance dependent care reflected the findings of other studies .

Additionally, families with good relationships were more likely to focus on the 'family unit', compared to families with less attachment between family members. The quality of inter-family relationships was a good predictor of which approach individuals and family as a whole use in their delivery of care needs.

According to the literature, gender was another importance factor for caregiving. This could be because caregiving was often seen as a defining characteristic of women . Sons were the caregivers often as a last resort, which tended to play this role only when daughters were not available. However, given the smaller families of today, sons were more likely to have to assume this responsibility (Aldous, 1999).

The present study found that gender was not a condition that affected family members' choice of which type of care to provide. Males, such as sons or husbands, provided 'being-with' or 'hands-on care' if they were the individuals who were available for care at the time of care needed. Sons made themselves available to 'be-with' the older person at home and provided personal 'hands- on care' on daily basis. When options were limited, gender was not a determinant for joining in on care provision.

When family members met the criteria of 'being available', such as 'being at home', he/she would involved in different cares. The results of this study showed that 'being at home', 'not having job' or 'being single', were more important than gender. In the past, male family members might exclude themselves from 'hands- on care' or 'being-with', because of thinking that caregiving was women's work. The findings of this study showed that regardless of the gender of the family members, if the one was identified as 'being available' for care at the time of care need, they accepted caregiving responsibilities, regardless of what task it may be.

In conclusion, the sources of motivation and other conditions were important factor affecting 'performing dependent care'. The sources of motivation were useful to predict what approach individual family members and family units would apply for performing the dependent care.

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