Family Caregiving for Dependent Older Adults in Thai Families

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Abstract
Purpose: The aim of this study was to understand how Thai families care for dependent older adults.

Design and Methods: The methodology used for the study was grounded dimensional analysis. Participants were 30 adult family members from 15 families who were involved in caregiving. A total of 46 interviews were conducted. Data were collected and analyzed in three phases: (a) calling up dimensions, (b) assigning relative value to each of the dimension considers, and (c) inferring.

Findings: In Thai families, “natural caregiving” precedes care of dependent older persons (dependent caregiving). Dependent caregiving begins when dependency is first noticed and care needs are identified. Dependent caregiving is a dynamic process integrating three major processes: (a) mobilizing family members, (b) performing dependent care, and (c) maintaining continuity of care. The consequences of performing dependent care and unpredictable changes lead to care remobilizing.

Conclusions: Dependent care for older adults varies across and is influenced by many conditions. Health personnel need to assess and monitor these varying conditions in order to support Thai families caring for dependent older adults.

Clinical Relevance: The conceptual model developed from the findings of this study provide a starting place for increasing our understanding of how to help Thai families care effectively and continuously for their older family members.

Thailand is a country where families have historically provided care for their elderly and dependent relatives (Knodel & Chayovan, 2008, 2011; Sritharnrongsawat, Bundhamcharoen, Sasat, & Amnatsatsue, 2007). Nearly 90% of older and disabled elderly in Thailand receive daily care from their families (Knodel & Chayovan, 2008). However, changes in demographics, women’s workforce participation, and increasing geographic mobility threaten the family caregiving infrastructure. The drop in average number of children per family from 7 in 1974 to 1.5 in 2000 leaves many fewer available family caregivers (Ministry of Public Health, 2007). These changes will create even greater challenges to continue family caregiving in the future (Knodel & Chayovan, 2011; United Nation Population Fund, 2011).

Geographic dispersion has increased significantly, particularly for rural Thai families. Children living outside the province where their parents reside has increased over the past decade from 28% to 35%, with an even greater increase for rural families. This accounts, in part, for the decreasing percentage of older adults living with an adult child (from 77% in 1986 to 59% by 2007; Knodel & Chayovan, 2011). Despite these changes in family size and structure, the cultural expectation of
providing care to parents remains strong (Knodel & Chayovan, 2011). The juxtaposition of continuing expectations for family caregiving and changes in family size and structure raises questions about whether and how family caregiving will be sustained.

Research on Thai family caregiving has increased over the past 2 decades. Most of the studies are limited to a focus on caregivers who provide hands-on care, assuming they are the “primary” caregivers (Limpanichkul & Magilvy, 2004; Sethabouppha & Kane, 2005; Subgranon & Lund, 2000). Only a few studies have addressed the role of family members who were not providing hands-on care, even though distribution of care among family members is the usual and expected pattern of caregiving in Thai families (Dangdomyouth, 2008; Niyomthai, Tonmukayakul, Wonghongkul, Panpa, & Chanprast, 2010). Research has not yet addressed the dynamics of extended Thai family caregiving. This limits our understanding of the full range of family caregiving.

This study was designed to explore how the extended Thai family provides care for older family members, to understand the range of caregiving strategies engaged in by the family, and to observe how caregiving family members work together to provide care.

Methods

Because the purpose of the study was to explore an area that has received very little attention from prior research, an exploratory methodology was selected. Specifically, grounded dimensional analysis (Bowers & Schatzman, 2009; Kools, McCarthy, Durham, & Robrecht, 1996; Schatzman, 1991), a second-generation grounded theory, was selected to conduct the inquiry. The method was considered suitable because it is designed for discovering and elaborating social processes, particularly in substantive areas that have not been well researched. Based on symbolic interaction (Blumer, 1969), the methodology was designed specifically for developing conceptual models or theory from the perspectives of the actors involved.

Participants

Participants in this study included family caregivers from 15 families, most of whom (13 of 15) were from rural areas and all of whom were from the Ratchaburi province in central Thailand. The thirty adult caregiver participants were female (23 of 30), married (18 of 30), daughters or daughters-in-law (16 of 30), and sons (5 of 30). Others included nieces, nephews, grandchildren, wives, and husbands. Caregivers were equally divided between those who were employed (n = 16) and those who were unemployed (n = 14). Six of the unemployed caregivers had been employed prior to taking on caregiving responsibilities, leaving employment to provide care. The average number of caregivers per family was 4.6, ranging from 1 to 8. Six caregiver participants were living with the older adults. Many of the caregiver participants were engaged in more than one type of care, and some were engaged in several types. Those living nearby were more likely to provide hands-on care, while those living at some distance were more likely to be engaged in organizing care and providing support.

In addition to the 30 caregivers interviewed for the study, 39 other family members were providing care. With only one exception (a monk), all adult offspring were involved in some aspect of caregiving. Some were hands-on caregivers, while others were performing other types of care. Several of the caregivers were geographically separated from the older adults, involved in caregiving from a distance.

The 15 older adults, all had significant physical dependence, with 8 of 15 completely bed bound. Four were described as having cognitive impairment. Ten of the older adults were women and 5 were men, ranging in age from 65 to 102 years. All were co-residing with a caregiving family member at the time of the study.

Data Collection and Analysis

Data collection and analysis were conducted concurrently, as is the process in a grounded theory study. The study was conducted from July 2010 through July 2011. Data were collected through in-person and telephone interviews, depending on caregivers’ locations. Interviews were audio recorded and transcribed prior to analysis. Since the study was designed to understand how family members defined and implemented caregiving, no definition of caregiving or caregiver was used to select participants. This was important because there was considerable inconsistency in definitions of caregiving. For example, some family members who identified themselves as primary caregivers were not seen by other family members as primary caregivers. In a few families, more than one caregiver participant saw themselves as the primary caregivers.

Phase I: Calling up dimensions. The researcher interviewed any family members who identified themselves as caregivers and were willing to participate. During the initial phase of the study, participants were asked to “tell me about your family” or “tell me about your mother’s (or) father’s care.” This unstructured approach allowed the researcher to discover caregivers’ perspectives on caregiving. Open coding (a line-by-line analysis;
Bowers & Schatzman, 2009; Kools et al., 1996; Schatzman, 1991) was conducted following each interview. Theoretical sampling was achieved through both evolution of subsequent interview questions and identification of theoretically relevant participants who could provide insights on specific issues (Strauss, 1987).

Phase II: Assigning relative value to each of the dimensions considered. In Phase II, theoretical sampling was used to target and compare different types of families in relation to the emerging categories. For example, families with different numbers of adult children (one to more than three), all adult children working outside the home, not living in a traditional three-generation home, and geographically dispersed offspring were all sought and sampled. This led the researcher to 20 new participants during phase II. This phase also explored strategies for initiating and sustaining caregiving, and how different general approaches to caregiving influenced the care and the caregiver. Conceptual diagramming was used to assist the researcher in identifying how family caregiving processes evolved.

Phase III: Inferring. The purpose of Phase III was to fill in the gaps identified in the evolving tentative model of family caregiving. Theoretical sampling was used to seek out specific occurrences such as “care before the onset of dependency” and “the event or change leading to dependent care.” As a result, four additional participants were recruited in phase III.

Several strategies were used to enhance trustworthiness. Member checks were conducted by taking preliminary results back to the family caregivers to verify that the emerging caregiving model represented their experiences. Memoing was used throughout the study to record the researcher’s decisions. Peer debriefing was conducted with members of research teams at two universities, one in the United States and one in Thailand. The teams included several experienced grounded theory researchers.

The study was approved by the ethic committee of the Faculty of Public Health at Mahidol University, Thailand (Institutional Review Board No. MUPH2010-145). A signed consent form for each participant was obtained prior to conducting each interview. In order to protect the confidentiality of participants, each transcript was assigned a code and all identifying information was deleted.

Findings

Natural Caregiving

Participants in this study described caregiving that began long before older adults become functionally dependent or need care (Figure 1). This “natural caregiving,” common to all families in the study, was described as a way to honor the older adults, and to demonstrate affection and obligation. As described by the participants, natural caregiving is unrelated to the older adults’ need for care. Speaking of what she had done for her father prior to the father needing any care, one daughter said:

I would put his appointment on the board, when he would visit the doctor and which doctor ... I did it because it was my duty ... It wasn’t like I had to help him .... (Family 15, daughter, first interview)

Common to all participants was a strong sense of obligation. Some caregivers attributed this to their strong Buddhist philosophy, while others were less explicit about the source of their caregiving obligation:

When I was young mom took care of me for everything .... Now we are grown up, we are able to take care of ourselves. Now, mom cannot take care of herself. We do turning for repaying for her. This repayment to her. (Family 6, son, third interview)

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For each participant in the study, natural caregiving had established a caregiving infrastructure prior to the need for assistance. Participant descriptions suggested that, as older family members developed functional dependencies and required more help than was being provided “naturally,” a threshold was reached. This was the point at which the family began to realize that natural caregiving was insufficient, that the older adult had become dependent. Referring to this threshold, one daughter said:
The point at which I think he started being unable to take care of himself was when he was having difficulty walking. He did things slowly. Without walking stick, he could not walk... (Family 15, daughter, first interview)

The degree of dependency at the threshold was not consistent across families. In families where a high level of natural caregiving was being performed, dependency might not be noticed until it was quite advanced. For example, if a family was providing meals, transportation, housework, and shopping, dependency was not visible until it reached a high level or there was an interruption in natural caregiving. This sudden unmasking of dependency occurred in one family, for example, when a primary natural caregiver (daughter) was required to travel for work. When the older adult was living alone or caregiving was intermittent, decline was obvious at a much lower level.

Mobilizing Family Members

Caregiving on the other side of the threshold differed from natural caregiving in that it was more deliberate, predictable, planned, and often more consistent from day to day. It was consequently more time consuming and less flexible than natural caregiving and often required a mobilizing of family members to maintain the continuity required. The first step in mobilizing was to determine availability of family members, particularly for hands-on care, and deciding what each person’s role would be. Some caregivers volunteered to provide care. “I am his child. I am home. It should be my direct responsibility... There is no need for someone to tell me [to be with mom]” (Family 2, son, first interview).

When no family member stepped forward, someone in the family was “made available.” This was most often done when determining a hands-on caregiver. In some families, one family member took responsibility for making decisions about and assigning caregiving roles. This was done by identifying, considering, and placing a value on each family member’s competing responsibilities. Frequently, this involved telling a family member with a “not very valuable job” to quit his or her job and become the hands-on, live-in caregiver. In most instances, the request was honored.

Previously, Lex (my younger sister) worked at a factory. She had a full time job... In my opinion, working at the factory was not important because of the low salary... I asked Lex to come and stay with mom. I requested that she quit her job because I needed her to take care of mom... (Family 9, daughter 1, first interview)

Performing Dependent Care

While some care continued unchanged after crossing the threshold, dependent caregiving was generally characterized by substantially increased care, including strategies for maintaining the consistency and continuity of care. Only one of the caregiver participants interviewed for the study described any deliberate, explicit planning or collaboration among family members. They just did what they believed needed to be done and assumed that other family members would do the same. Conversations about care and caregiving roles seemed to occur mostly when a caregiver needed a temporary replacement or when something nonroutine, like a trip to a specialist, was needed.

In addition to the hands-on care, family members engaged in four types of caregiving: being with, organizing care, monitoring care, and supporting care. Hands-on care consisted of tasks such as serving and feeding, assistance with toileting, assistance with bathing, cleaning after toileting, taking them outside, giving medications, and assistance with rehabilitation activities. “Being with” care included being home, keeping company, sitting alongside, and sleeping at home. “Organizing care” included managing treatment, hiring caregivers, finding replacements and supplemental caregivers, making decisions, making plans, and solving problems. “Monitoring care” consisted of monitoring activities of daily life, checking tubes and bed sores or wounds, and reporting information. “Supporting care” involved financial and emotional support. In most families, there was little or no discussion of who would take on these roles. Caregivers simply started to identify needs and do what they believed should be done. Caregivers participating in the study represented each type of caregiving, sometimes with more than one caregiver identifying themselves as the primary caregiver. Self-identified primary caregivers were found in each caregiving category, most often those engaged in hands-on and organizing care.

Approach to Caregiving

Interviews with caregivers engaged in each type of caregiving revealed three distinct approaches, with clear implications for both the caregivers and the older adults. Nearly half of them employed the first approach (11 of 30). The numbers of caregivers who employed the second approach (5 of 30) was closed to the numbers of caregivers who employed the last approach (6 of 30). Eight of 30 could not identify what approach they used.

The first approach was “focusing on the older adult’s care needs.” This approach involved identifying care needs and accepting responsibility for providing the care.
regardless of difficulty, inconvenience, or time required. This approach was summed up by two caregivers as “Just do it” or “Just get on with it.” The second approach, “focusing on myself (caregiver),” involved caregivers explicitly considering their own needs as well as those of the older adult. Caregivers who used this approach often spoke of “doing as much as I can,” but, unlike the previous approach, openly accepting that some things would not be done:

This is what I could do. I could not do anymore…. There was no one to help me since there is no one else here. I was alone…. So, I did as much as I could. (Family 4, son, second interview)

Lastly, some caregivers “focused on the family unit,” as demonstrated by caregivers who saw caregiving as a collective (family) responsibility. Unlike the previous two approaches, their accounts of caregiving explicitly considered what other family members were doing. Despite the absence of open discussions with other family members, decisions about what and how much they would do were clearly informed by what they observed or knew that others were doing. This extended to observations about other family obligations and just filling in when they knew another caregiver had competing responsibilities.

Everyone was able to help. Suppose one is busy, another one would step in and do it. For example, she has her kids to take care of on Sunday. When I am at home on the weekend, I will do it. (Family 3, niece 2, first interview)

**Consequences of Performing Dependent Care**

The consequences of performing dependent care were largely related to the caregiving approach. For example, “focusing on care needs” had a significant impact on caregivers’ daily lives and consequently on the stress caregivers experienced. In contrast, “focusing on myself (caregiver)” had a negative impact on the quality and amount of care provided, but less impact on the daily life (and stress) of the caregivers.

“Focusing on the family unit” generally led to a high level of care and a relatively low level of stress for individual caregivers, while family harmony was maintained. However, when some family members focused on the family unit while others focused more on themselves, harmony was not achieved, sometimes leading to resentment and disappointment:

It [feeling unsatisfied with another] happens sometimes when needs and help do not go in the same direction. This happens when I ask my sister, “why doesn’t she ever take care of mom? Why do Om and I always have to be with mom? She always say she has meetings…. (Family 7, daughter 3, first interview)

**Maintaining Continuity of Care**

Maintaining care over extended periods of time required significant, ongoing effort. Long-term caregiving often led to a shift in how caregivers valued what other caregivers were doing, with initially critical caregivers often becoming more accepting over time. When caregiving demands were high, family members often encouraged and supported more involved caregivers, who they had previously been critical of, noting the stress experienced over their caregiving work, encouraging them to keep going. Caregivers who were engaged in day-to-day caregiving also described adjustments that enabled them to keep going. Some changes affected only the caregiver.

It’s about attachment and deciding to change how I live my life. I used to drink a lot. I used to go out for fun with my friends. I knew it was not important. So I quit all of that…. (Family 6, son, third interview)

**Remobilizing**

Unpredictable changes in caregivers’ lives, such as passing away, getting older and less able, or becoming ill, could affect availability, making it necessary to remobilize. Extended family members not previously involved in care were often recruited at this time. Also, family members less involved or intermittently involved in care often volunteered or were asked by another caregiver to increase their participation. Some were asked to take over hands-on care, others were asked to provide additional support for primary caregivers. More distant family members who had not previously been providing care were often drawn in as well at this time. The process was similar to initial mobilizing.

I just moved back to be with her…. One of my relatives asked me to be with mom. My sister who used to be with mom passed away. She had an accident. I moved back here after that…. (Family 4, son, first interview)

Remobilizing was also sometimes influenced by the consequences of prior care. For example, when a family member’s caregiving was perceived by others as poor quality (generally involving a “focusing on self” approach), they might be replaced by another family member. Finding a replacement, once again, involved a determination of family member availability.
Remobilizing was repeated whenever necessary to maintain caregiving.

Discussion

The findings from this study provide insight into the transition from natural to dependent Thai family caregiving (crossing the threshold) and reveal the different approaches taken by family members as they engage in caregiving roles. Participants' descriptions of caregiving reflect the Thai cultural values of obligation to parents, through both natural and dependent caregiving (Sethabouppha & Kane, 2005). However, the findings also reflect the cultural and demographic shift that Thailand is currently experiencing. Specifically, although tradition dictates that women (daughters and daughters-in-law) provide care to older adults in the family, this study reveals the emergence of a much broader base of involvement by family members, including an active and sometimes central role of men as caregivers. This finding is consistent with a study that revealed an increase in the role of men as informal caregivers in developed countries (Ovseiko, 2007). The current study also demonstrates how caregivers, some living at great distances and some with employment, maintain caregiving of older family members over time.

While “mobilizing family members” described in this study is similar to “mobilizing a parent care system by adult siblings” (Matthews & Rosner, 1988) and to “life restructuring” (Wells, Cagle, Bradley, & Barnes, 2008), this study demonstrates how Thai family members have responded to the newly emerging gender roles and responsibilities by engaging in a process of identifying and valuing competing responsibilities and determining availability. Although findings confirm that family caregiving involves a dynamic and nonlinear trajectory, as others have suggested (Donorrio & Kellett, 2006; Gage-Rancour & Purden, 2003; Kita, 2002; Kuo & Shyu, 2010; Montgomery & Kosloski, 2009; Seltzer & Li, 2000), considering availability, mobilizing, and remobilizing caregivers adds an important dimension to what we have learned from these prior studies.

Past researches have documented that Thais continue to act in accordance with Buddhist philosophy requiring repayment and obligation to older family members (Limpanichkul & Magilvy, 2004; Sethabouppha & Kane, 2005, Subgranon & Lund, 2000), suggesting that Thais are motivated by obligations to their families, and predictably give priority to the family goals over their own personal goals (Suttiammuaykul, 2002). This finding is consistent with research reported from other Asian countries (Tang, 2011; Yen et al., 2010) where caring for parents is a strong cultural value. However, the current study demonstrates the operation of somewhat different values held by at least some family members as reflected most clearly in the three different approaches to caregiving. Significantly, the distinction between those focused on family and those focused on self did not occur along predictable gender lines. Whether these different approaches have always been present or this reflects a shift in cultural values is not known.

Although different types of caregiving have been described previously, in ways that are similar to what was found in this study, the discovery of three separate approaches to caregiving adds an important dimension to our understanding of how caregiving is implemented and in our ability to anticipate the consequences for both caregivers and care recipients. The finding that, in some families, more than one family member considered themselves to be the primary caregiver has important implications for healthcare providers working with families caring for older people. The combination of limited negotiations among Thai family members related to caregiving and the apparent differences in perceptions of caregiving roles could lead to communication, and ultimately care quality problems.

Consistent with traditional Thai family caregiving, most older family members were living with a family member, either as the continuation of prior residential arrangements or as a response to increasing dependency. The importance of Thai family care of elders, occurring whether or not there is dependency (natural caregiving), has implications for the timeliness of identifying the increasing dependency of older family members. High levels of natural caregiving can mask the loss of function and delay accessing medical care that might slow or prevent decline.

Study Limitations

A major limitation of the study was the inability to include all family members. Unavailability or unwillingness of family members to participate in interviews might have influenced the study findings, as their voices and perspectives are not represented. It would also have been informative to conduct a longitudinal study, allowing the researcher to observe how caregiving roles actually changed over time, rather than relying on participant recall. This may be a reflection of changing cultural values. Participant observation (time with the family members as they provide care) would also have provided valuable insights into the dynamics of family caregiving. Finally, a more explicit exploration of how care types are differentially affected by care approaches, family size, or...
remobilization would provide important insights into the evolution of Thai family caregiving. These questions will be addressed in future studies. As most family members participating in the study are living in rural areas, the findings should be interpreted carefully, with the caveat that they may be less relevant for families living in urban settings.

Conclusions

Understanding the complexity of family caregiving, the contributions of multiple family members, the evolution of caregiving over time, and the impact of societal changes in Thailand shifts our focus from a single primary caregiver to a more inclusive and more accurate view of how care is provided in Thai families. These insights are important because they will aid healthcare personnel to engage in more informed assessments and interventions, decreasing the likelihood of negative consequences for the older adult receiving care, the individual family members providing care, and the family as a unit.

The general lack of explicit negotiations among family members over caregiving roles is also important for practitioners to understand in order to support families providing care. It is also important for practitioners working with families to understand that because Thai families engage in considerable caregiving, even in the absence of significant dependency or a need for care, they are often unaware of the older adult’s increasing dependency. Practitioners can use these findings as a basis for developing more culturally sensitive interventions and services for Thai caregivers.

Health personnel must be aware that family caregiving undergoes a transition, shifting both how and when family members mobilize to meet the needs of the dependent older adult. For example, identifying the approach caregivers use to perform care allows nurses to predict the consequences for older adults, individual caregivers, and the entire family. Regular monitoring of the progression of family caregiving will also enable families to recognize stress among caregivers and intervene early, leading to more effective support of caregiving families.

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Clinical Resources

- Foundation of Thai Gerontology Research and Development: www.thaigri.org
- Bureau of Empowerment for Older Persons: www.oppo.opp.go.th
- Family Caregivers Alliance: www.careziver.org

References

Family Caregiving for Older Adults


