UNDERSTANDING, KNOWLEDGE, AND FAMILY SUPPORT IN CARING FOR OLDER ADULTS WITH MAJOR DEPRESSION

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ABSTRACT: Public health care system is globalized and well-organized in Thailand. Providing care for older adults with major depression needs the attention of healthcare providers in the community long-term care. The purpose of this qualitative research was to describe the essence of caring for older adults with major depression as perceived by the health care providers. Nine registered nurses and a psychologist who experienced caring for older adults with major depression for one to five years, were asked to interview for 60-90 minutes, using in-depth interviewed and semi-structure questions. Data were analyzed by thematic analysis. Three themes were emerged: 1) Understanding about the nature of illness as well as patients, and their families; 2) Applied knowledge to integrated care by a team and its network; and 3) All supports of family members are meaningful to care. The findings of explicit contents lead to develop the intervention to care for these specific individuals with major depression.

Keywords: Caring, Older adults, Depression, Family support

INTRODUCTION

The quality of long-term care for older adults has a profound effect on their quality of life. In Thailand, long term care is widely available [1]. However, little is known about how the quality of care for older adults with major depression in the long-term care setting is achieved. In general, providing care for these patients has been based on management using antidepressant medication and psychosocial treatment, which has proven to be effective in decreasing depressive symptoms. However, the rate of recurrent depressive episodes remains high [2].

This is an important issue for the public health system in Thailand as the prevalence of major depression in later life varies from 12% to 35% [2-5]. While some studies support antidepressant therapy, resistance to medication has also been reported [6-8]. This complicates care strategies and increases the need for collaboration between facilities and providers. In any case, older adults experiencing depression are a vulnerable group and will continue to need long-term care in appropriate facilities and in the home.

Providing care for older adults with major depression in the long-term care setting needs the attention of healthcare providers. Patients might report somatic symptoms as physical illness [9]. This can result in undetected psychological conditions, inadequate treatment after diagnosis and, further, increased incidents of non-adherence to treatment. Provider barriers referred to physicians, psychologists, and mental health nurses who perceived depression as normal response to loss with long-term condition [6] and lack specific training for depression care [10]. Lack of collaboration among healthcare providers in community hospitals, district health centers, and mental health specialty facilities in the referral systems can lead to inappropriate and complicated care because the referral system focus in one-way communication. As such, caring for those older adults with depression does not respond to the patients' need.

The caring concept is defined variously in the literature. Studies have described two aspects of caring. First, Caring transfers internal feelings into actions to improve individual health and well-being. In this sense, feelings of love and friendship are major components of the role of health care providers. The other aspect of caring includes communication, concern, commitment and competence [11]. Caring has also been described as attributes of relationship, attitudes, action, acceptance, and variability [12]. Relationship was a state of being related or reciprocally interested. Attitudes referred to feelings or things lead to action. Acceptance delivered ideas or actions leading to normal life. Variability is making

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difference or changeable in feelings and action related to individual health. Second, caring is working with moral decision. Professional healthcare providers interact with patients and family members to provide treatment and related information, including other stakeholders. Caring with error or malpractice might happen anytime. Using moral decision as a guide of caring action would provide more benefit to patients/clients. Considering morality in clinical practice would save and prevent harm or any danger to patients, family, and others [13]. Therefore, the purpose of this study was to explore the essential characteristics of caring for depressed older adults as perceived by the healthcare providers.

MATERIALS AND METHODS

A qualitative research design was used in this study.

Participants and setting

This study was conducted with ten participants who worked at the central hospital, community hospital, and the district health centers in a rural area. The central hospital had a psychiatrist, a psychologist, and advanced practiced psychiatric nurse, whereas the community hospital and the district health centers provide a physician and registered nurses who treat mentally ill patients. However, these settings provide mental health services as the out-patient clinic. A purposive sampling was consisted of two registered nurses and a psychologist worked at the central hospital; two registered nurses who worked at the community hospital, and five registered nurses who worked at the district health center. These health care providers provided care for depressed older adults for 1-5 years; five had 3-5 years of experience. Eight had graduated at the master level in psychiatric mental health nursing. The rural setting is a combination between agricultural and tourist business and the local population worked primarily as gardeners, merchants, and government officers.

Materials

All participants were asked by using an interview guide. A semi-structured interview guide was developed using open-ended questions to obtain participants' perspectives about the crucial elements of care giving. The major questions were: 1) What are the essential attributes of caring for patients? 2) What are the most important aspects of caring and why?

Data Collection

After obtaining approval of the ethics review committee for research involving human research subjects at Chulalongkorn University, the researcher asked the director of the community hospital and the health centers to arrange a meeting with potential participants. The researcher explained the study to participants and made appointments to interviews. Each participant signed the consent form before the interview began. This was an in-depth interview and lasted approximately 45-90 minutes. All interviews were audio taped and the interviewer made field notes during the interview. Dependability, consistency, was achieved by asking each participant the same questions and noting the point at which repetitive answers were received.

Data Analysis

Thematic analysis was used to analyze data [14]. After transcription, the researcher read transcripts several times to become familiar with the data. Provisional codes were created. As the interviews were coded, additional codes were created to allow themes to emerge. When all transcripts were coded, the codes were and separated types into related patterns. Secondly, codes were combined to create groups of themes in order to find the related themes. At this point, the themes were refined and recoding was done as required. In the final step, the essential meanings were formulated and each theme was named. The themes were reviewed by several participants and agreement was obtained.

According to Lincoln and Guba [15], Credibility of this study was obtained by characteristics of the participants who experienced caring for depressed older persons and were able to describe caring experiences using their own words, phrases or terms. Two research assistances who experienced working with depressed elderly were peer debriefing. Also, member checking was used to apply the credibility. Transferability was achieved by the readers understood and perceived the findings from the thickness of descriptions. Dependability was addressed in the process of data collection and analysis of themes and subthemes. Confirmability was that the researcher and the research assistances checked and rechecked transcription, field notes, data analysis procedure and findings.

RESULTS

Three major themes of characteristics of caring for older adults with major depression emerged: 1) Understanding about the nature of illness as well as patients' and families' needs**,** 2) Applied knowledge to integrated care by a team and its network; and 3) All supports of family members are meaningful to care.

Theme I: Understanding about the nature of illness as well as patients' and family's needs

Regarding this theme, the healthcare providers reported that understanding about the nature of illness in terms of the physical and mental changes due to aging process, pathophysiology, sign and symptoms, treatments and care management are significant aspects to the caring relationship. Moreover, the healthcare providers identified attributes of patients by using severity of depressive symptoms and patients' abilities to take care of themselves. To understand the nature of illness, the healthcare providers assessed care needs of patients and their families. Understanding the patients and family would allow the healthcare providers to assess, plan, and provide care as needed; and also increased the likelihood that patients and their families might agree with a plan of treatment. One participant said:

> "*Regarding caring for this group, I need to understand the patients and their illness in terms of pathophysiology, and the response to illness of each patient, theory of aging, and mental health and psychiatric nursing theory because this knowledge would help to tell them to cooperate with treatment." (ID5)*

Another participant said:

> *"…The depressed aged-population – not only physical and mental functioning were degenerated by nature of aging process leading to poor ability to care for self , but their feelings and thinking were unpredictably changed. Moreover, if they got chronic illness, their depressive symptoms seems worse and worst..." (ID2)*

In addition, understanding the care needs of patients and family members were addressed. Participants considered responses to care needs of patients and family members in both physical and mental health. One participant said:

> *"In general, because nobody takes care of patient's minds, she needs to build up her self-esteem. If she feels her self-esteem increase, her depression would decrease as well as her suicide ideas. She needs someone to take care of her, for example, come to talk to her, pay attention to her, and then she feels good. Actually, she needs other people to accept her as she is; she needs someone to listen to her". (ID 1)*

Another participant explained:

> *"Relationship between the depressed elderly and family members is influenced by responding to care needs. The depressed elderly needs the expression of love and cohesive relationships of family members. Getting together among family members on a special holiday is the thing that the depressed elderly desire and wait to see it. However, family members and the depressed elderly need to talk about how well they care about each other. Their children have more work and responsibility, so they take turns in coming to see the depressed elderly. This will help the patient (mother) feel that everyone in the family loves her. If we care for the depressed elderly into her heart, she perceives our sincere concern; then she will have better compliance to treatment." (ID8)*

This theme provided one of the major characteristics of caring for older adults with major depression. Those healthcare providers shared experiences about making understanding the knowledge of depressive illness. Knowledge content referred to major depression diagnosis, causes of disease, consequences of physical and psychosocial functioning, and caring need responses. In addition, understanding about how to perform a care needs assessment of the elderly depressed patients and their families is required. In order to care for a specific patient, providers need to assess – and directly respond to – the aged-specific and disease-specific care needs of each patient.

Theme II: Applied knowledge to integrated care by a team and its network

Participants reported that the healthcare providers not only had specific knowledge, but they were able to apply and integrate their knowledge of caring. The integration of care referred to the pooling of the knowledge of providers from a variety of disciplines, including primary care physicians, psychiatrists, psychologists, pharmacists, registered and advanced practice psychiatric nurses. This approach included working with patients' family members, the healthcare volunteers, and community resources. One participant stated that:

> *"We integrated knowledge about nurse-client relationship, individual and family counseling, nursing theory and psychology, and Buddhist beliefs to assess and care for the patients. We also build up the connection between family*

caregivers and healthcare volunteers to spread joy and help each other to observe the patient with symptom changes." (ID3)

Another participant said:

"We need to use our knowledge of depression; how to screen symptoms, nursing therapeutics, psychological interventions, and psychotherapy etc. Moreover, we used all of competencies to manage the care. We also provide the care for family." (ID5)

Working as a team and network is useful in caring for older adults with major depression. Currently, healthcare providers work with the family members, volunteers, and the community resources such as a sub-district organization and local temple. The volunteer helps family members take care of the patients by providing supervision around taking medications, and encouraging interpersonal and social relations. The healthcare volunteer has influenced on caring for patients. One participant explained:

"…We need the healthcare volunteer to be in our network. They help us to screen the depressed elderly; they make a record which shows the number of patients and their families with a house map; they initially talk to the patients and families and act like a bridge between the patients and the healthcare providers. We need to train them about primary knowledge and skills of caring approach to the depressed elderly." (ID1)

Another participant stated:

"…Working as a team is very important, for example, we trained the healthcare volunteers to talk in the way of primary counseling to the patient and family; then they can give an advice about continuously taking medication and supportive talking to the patient, so that the patient's depressive symptoms decrease. The activity of the healthcare volunteer is strong powerful in caring the depressed elderly. The patient believes and listens to them rather than the relatives. I think because the patient feels that the healthcare volunteer has the knowledge and is reliable. Another reason is that the patient feels consideration and faithfulness from the healthcare volunteer's work." (ID2)

Theme III: All support by of family members is meaningful to care

This theme reflected that family support was an important matter of caring. This theme reveals components of the family supportive care for their depressed older person. Family support means the patients perceive a positive connection among family members and receive care from family members to improve symptoms. When family member talked together with support and encouragement, this made the patient cooperate with taking medication, performing daily activities, and feeling good. As such, depressive symptoms were decreased. One participant said:

"One important thing in caring for the depressed older person is the family connection because they need attention of their children, they love to talk to their children and grandchildren. The depressed older person wants to see a warm relationship among family members, no quarreling, no shouting. When family members talk to each other, the older person feels cheered up to do things i.e. taking pills, taking a bath – that's what makes her happy." (ID10)

"Indeed, when family members participate in care giving, it decreases depressive symptoms. The role of family members can influence a change in the patient's symptoms. If family members realize this and urge patients to take their pills, their depressive symptoms will decrease within six months; some cases only take 2-3 months." (ID8)

DISCUSSION

The findings revealed the essence of caring for the older adults with major depression from the healthcare providers' experiences. All themes reflected the participants' view of understanding the nature of illness and applied the knowledge to integrated care in order respond to patients and families' needs. Moreover, family members are an important part of care. Each theme was discussed. First, the healthcare providers needed to understand about the nature of illness, patients' and families' needs. Understanding about depression as illness led to the way how to provide specific care for the older persons. In Asian culture, depression was viewed as emotional distress expressing by somatization [16, 17] for example, depression were feelings of disappointment, loneliness, pressure in

the mind due to their living situations and family relationships [9]. Not only understanding the perspective of depression viewed by older persons, the healthcare providers achieved the knowledge of major depression as written in the psychiatric textbook and other related literature. The knowledge of major depression, a type of mood disorders, was required for the healthcare providers who took care of older adults with depression. This knowledge of depressive illness included prevalence, cause of major depression, pathophysiology, diagnosed criteria, sign and symptoms, treatment and care management. Moreover, the knowledge of nursing theory, biopsychosocial theory, and psychological theory was basic knowledge in caring for older adults with major depression. This showed that caring for this population needed specific knowledge to improve patients and their families' life, so that they lived longer in the community. Without this knowledge, caring for this vulnerable population would not be successful. This may affect the quality of care and patient's satisfaction. In a previous study, the healthcare providers reported that they lacked of self-confidence in caring and assessing the patients because their specific knowledge was limited. The findings provided a similar theme of professional carers' knowledge and response to depression [18]. One theme of that study showed abilities of profession career included knowledge and awareness of depression, and skills in working with depressed older people. It meant that the healthcare providers also obtained skills in detecting and assessing major depression, and working with depressed older people [18].

Understanding patients' and families' needs was one of the essential characteristics of caring for depressed older adults. For Thai culture, older adults obtained respect from their children and grandchildren, including people of young generation. Likewise, older adults with major depression needed respect from their children and grandchildren. To perform respect, patients needed attention of caring from their children; when the children asked patients about daily activities living with kindly tone and positive attitude, the patients would feel happy and induce them to cooperate in treatment. Another way to express the respect to the depressed older adults was those children brought preferable things to them such as food and fruit, flowers and clothes etc. This meant the healthcare providers understood the patients' need, so that they developed the plan to care for them as what the patients needed. Another family needs were assessed by the healthcare providers. Family needs included accurate information of treatment or service [19], emotional support, helped thinking to solve problems and counseling process from the healthcare providers. When the healthcare providers understood family needs, they could help family members provide specific care for depressed older adults. In addition, family needs were promoted and obtained appropriate solution.

Second, the theme of applied knowledge to integrated care by a team and its network was deliberately described. The healthcare providers agreed that integrated care using applied knowledge was the essence of caring for older adults with major depression. In general, integrated care was defined as the healthcare providers brought about the knowledge and skills of each professional area and put together in delivery care, management, and service related to diagnosis, treatment, care, rehabilitation, and health promotion [19]. In this study, the term of integrated care referred to working as a team with a multidiscipline approaches and pooling knowledge of each discipline to provide specific care for older adults with major depression. Studies were shown the effectiveness of integrated care in depression management [20]. This approach was happened among working together by professional mental health providers such as psychiatrists, psychologist, social workers and psychiatric nurses. These mental healthcare specialists integrated their knowledge and skills to diagnose depressive disorders among older adults in primary care settings, provide depression treatment, scheduling home visit, ensured transportation and emergency consult service. For depression management, the healthcare providers integrated a variety of care, for example, patient education and self-management, care management to patient contact, mental health specialty treatment, care management counseling (problem-solving therapy, interpersonal therapy, and supportive psychotherapy) and psychological supervision. The outcome showed that depressive symptoms and remission rates were decreased [21]. However, a study revealed a little effect of integrated care for depression of veterans [22]; the results showed no significant difference of depressive symptoms and patient satisfaction between groups; only a higher referral rate at three months was significant. In that study, there were several limitations, for example, participants were veterans, older men, who had medically complex; so they could not participate in the whole program. Another thing was that there was not true control group because of the contaminating between groups.

In addition, family members and health volunteers

incorporate in assisting patient's self-care behaviors, medication management, and monitoring depressive symptoms. The healthcare providers carried out the knowledge of depressive illness and its treatment whereas family members and health volunteers facilitated caring situation, opportunity in accessing to care, and maintained continuous care. In this study, most of the healthcare providers reflected on family caregiving in the same way; that was family members were the key persons who improved the patients' health. However, consequences of family caregiving showed positive and negative aspects. For positive aspect, the healthcare providers reported an increase of family caregivers' self-esteem, self-confidence in caring, and satisfaction. Contradictory, the healthcare providers described how family members faced suffering of patients' symptoms, treatment, and living situation; their poor physical and mental health increased including low quality of life; family burden also found in common [22, 23].

A team work and its network played an important role in caring for the depressed older adults. In community-based care, the healthcare providers worked as a team and established their networks, which included the family members, the health volunteers, and other individuals related to care such as a community leader, a monk leader, and a teacher. Healthcare networkers encouraged and improved quality of care for the depressed older adults. For example, the health volunteers not only helped healthcare providers in caring process such as screening, accompanying patient care visit, and participating in health education activities, but they also promoted emotional support and performed efficient monitoring during the continuum of care. In addition, the community leader facilitated the place and budget to support health activities.

Third, all supports of family members are meaningful to care. This theme reflected that family members performed as partnership of depression care. The national survey of the United State indicated that older adults who expressed depressive symptoms required additional hours of assistance and led high cost [23]. Family members or caregivers needed to effectively spend more time to take care and encouraged older adults with major depression. In this study, the health care providers experienced working with family members and notified that family members who supported the patients in different ways would improve functioning and activities in daily life. The advantages of family support may influence both patients and family members. Family support influenced older adults' health service use, treatment adherence, medication management, depressive symptoms, and health behavior changes [24]. The depressed older adults with positive family support are less likely to be institutionalized [25]. Family support was similar to social support, which included emotional, material, and informational support. Regarding emotional support, family members encouraged or approval when the patients felt sad, discomfort or suffered. This type of support helped the patient feel warm, not lonely. Family members used material support in helping with tasks and financial condition. Informational support was applied when family members offered information to increase patients' knowledge, solve the problems and give advice. Thus, family support was a great significance and meaningful for patients and families along with the process of care.

RECOMMENDATIONS

The researcher described three aspects of recommendation to apply for caring of older adults with major depression. It is note that learning from experiences of the healthcare providers allowed us to be aware of providing care. First, caring for the older adults with major depression needed the understanding nature of illness, patients' and families' needs. This is a specific pattern of care by both mental health specialist and non-mental health specialists. The healthcare providers should assess the nature of illness and the needs in order to obtain data about how older adults with major depression needs. Because caring for this specific group of patients included holistic care in physical, psychosocial, and spiritual dimension, as such caring would help over of oldest with major depression. Furthermore, understanding nature of illness, patients and their family needs were the key entry point to care. As mentioned earlier, depression care for older adults was a specific approach. The healthcare providers needed to gain specific knowledge by attending the education program plus clinical practice experiences. Otherwise, the healthcare providers lack of self-confidence and competency in caring those of people.

Second, knowledge based-care and caregivers' network were provided in the community. To improve the quality of care, the healthcare providers would provide an education training program for caregivers' network, focusing on the health volunteer or family members. Those health volunteer could be significant persons who facilitated time, budget, and opportunity to promote specific depression care for older adults. Finally, the program of care focusing on family support was

required. The findings showed that family support was meaningful of caring; it urged patients to connect with family members, adhere to treatment and perceive positive views. As a result, bonding of family relationship had occurred. Findings of this study could be a foundation of knowledge to make better understanding of the essential characteristics of caring for older adults with major depression. Therefore, instrument development of specific need assessment and the family support program should be conducted in the future.

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