

# Caring behavior of caregivers of elderly at Baan Bangkae social welfare development center

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## Abstract

**Background:** To study the self-care behaviors of elderly caregivers at Baan-Bangkae Welfare Development Center for older persons, Bangkok. **Methodology:** Descriptive research was conducted among thirty two elderly caregivers by purposive sampling technique. Data were collected using the questionnaires that constructed by the researcher during May- June 2016. Data were analyzed using basic statistic and stepwise multiple regression.

**Findings:** The caregivers' knowledge of self-care, belief in self-efficacy, caregivers role acceptance, social support and caregivers' self caring behaviors of elderly persons score were as being in a moderate level. The respondents in perimeter which were different in sex age would be statistically difference at 0.05 in self-care behavior. Supportive factors for self-care behavior, sex, age, marital status, educational level, occupation and family's monthly income, caregivers' knowledge of self-care, caregivers role acceptance and social support predicted the caregivers' self-care behaviors at 35% with statistically significant at 0.05.

**Conclusion:** These study results emphasized the rising public health of elderly. The goal was to reduce burden and depression and increase self-care by providing participants with information and tools to assist in their role as caregivers. Further research is needed to clearly understand the needs and determine effective interventions for our rapidly aging population and diminishing number of caregivers. Nurses are in a pivotal position to implement and evaluate evidence-based interventions for elderly or other dementias.

**Key words:** caregivers' self-care behavior, predictors of caregivers' self-care behavior, elderly caregivers

## I. INTRODUCTION

According to United Nations, Thailand entered into the period of "the ageing society" in 2005 [1]. The number of elderly persons in Thailand is expected to rise significantly over the next 25 years. An important issue for Thailand is the very high pace of growth of its ageing population. In order to prepare our society for this increase in elderly population, the Ministry of Public Health and the Ministry of Social Development and Human Security had submitted a proposal on "Development of a Community Based Integrated Health Care and Social Welfare Services Model for the Elderly" Caregivers in Thailand are increasing rapidly they are especially required to care for elderly people and elderly people with dementias. A lack of training and support puts them at risk of depression, anxiety, and failure to take care of their own healthcare needs [2]. Caregivers in Thailand are predominantly women. They provide 75-80% of long-term care and face many challenges that create both physical and psychological stress. This is due to that fact that they are increasing expected to provide more demanding and complex care including medication management [3]. Self care behaviors are defined as activities of self care which consist of individual self care, family care or community self help group. D. Orem's paper presents his theoretical constructs (TCs) of self-care and reviews the literature concerning knowledge of medication self-care requisites, social learning and self-care, deliberate action as self-care behavior, and design of nursing systems for monitoring self-care.

Care giving often seriously reduces the quality of life of caregivers, creating severe physical, psychological, emotional, social, and financial problems [4]. Care giving may also

increase early mortality among caregivers [5]. The caregiver burden is associated with the poor outcomes of elderly with and without dementia patients [6-7]. Only a few researchers have studied the burden of dementia on caregivers in Thailand [8-10]. They found that there is a risk of physical and psychological disorders among caregivers of those with older or other dementias, indicated by depression, anxiety, and reported burden in caused by lack of time for self-care, inadequate supportive services, burden of providing care and lack of respite services to relieve caregivers of their duties [11-12]. The primary aims of this study were to study the level of self-care behavior, knowledge of self-care, belief in self-efficacy, caregivers role acceptance, social support and caregivers' self caring behaviors of elderly caregivers and determine these parameters as predictors of caregivers self-care behaviors. It then aims to compare the caregivers' self-care behavior as classified by sex, age, marital status, educational level, occupation and family's monthly income.

Caregivers are the key to successful elderly or dementia care. This is especially the case where, caregivers- are adult family members or of government public welfare caregivers who provide uncompensated care are essential in caring for older adults with disabilities or dementia. The research of caregivers and behavior problems of care receivers sought to identify those caregivers who are most susceptible to fluctuations around causative factors: increased task; increased problematic behaviors; and increased family discord [13]. Age and gender of the caregiver along with behavior problems of care receivers were found to be predictive of care giver depression [14]. The relationship between a caregiver's stress and functional ability as they related to self-care behaviors

responding to physical and psychological symptoms was studied by Lu and Wykle [15]. They found that caregivers who reported poorer self-health also reported higher levels of caregiving stress.

In this study the level of self-care behavior (SC), knowledge of self-care (KN), belief in self-efficacy (SEF), caregivers role acceptance (CRA), social support (SS) and caregivers' self caring behaviors of elderly caregivers was explored.

## II. METHODS

**Study design and participants** The subject: This study was a-cross-sectional research consisting of data collection from thirty two elderly caregivers at Baan-Bangkae Welfare Development Center for older persons, Bangkok. The respondents were selected using the purposive sampling technique. Data was collected between May and June 2016. The research instrument was the self-administered questionnaire which conducted of 6 parts. These were; 1) Personal information: age, education level, maternal status, economic status, current gender. 2) Knowledge on self-care form: this was developed by the researcher and it consisted of 10 items that elicited a true or false response. Positive questions scored 1 for true option and negative questions scored 2 for false. 3) Perceived self-efficacy form: it consisted of 10 items using 5- point Linkert scale from 0 (not at all) to 4 (highly confident). 4) Caregivers role acceptance of elderly: it is consisted of 10 items using 5- point Linkert scale from 0 (lowly accepted) to 4 (highly accepted). 5) Perceived social support: 10 items were conducted from the social support concept using 5- point Linkert scale to measure levels with social supports received from significant persons. The scale was from 0 (lowly supported) to 4 (highly supported). 6) Self-care behaviors for elderly persons from: it was used a self-care behaviors of elderly caregivers by researcher. The questionnaires had negative and positive items. The negative items scored from 0 (never) to 4 (always). This questionnaire was reviewed by 3 experts for content validity. 30 caregivers who had the same characteristics with target population were included in pilot study to reliability test of this questionnaire. All parts has internal consistency reliability Cronbach alpha coefficient equal to 0.870 or more.

### Statistical Analysis

Data analysis was performed using the Statistical Package for the Social Science (SPSS) Version 17.0 for Windows. Descriptive statistics were frequency, percentage, mean and standard deviation. The correlation between independent and dependent variables was analyzed using Pearson's product moment correlation coefficient. Stepwise multiple regression analysis was applied in finding the factors correlating and predicting the self-care behaviors. The significance level was set to <0.05.

## III. RESULTS

All of the 32 caregivers who were working at Baan-Bangkae Welfare Development Center for older persons approached in the study, 100% returned complete questionnaires. The mean (SD) age of caregivers was 49.5 (10.0) years. 22 (68.7%) were women. 37.5% were married.

81.2% of the caregivers had an educational levels of high school or diploma level education, while 18.8% had educational levels of bachelor degree and above. 65.6% were part time employee and 46.9% had an income of 10,000-14,999 Baht/month. 25 caregivers (78.1%) reported that they did not have health problems.

The older persons that were cared for by the respondents were likely to have moderate to severe illness, as indicated by the need for assistance in basic activities of living and suffering from dementia more than 5 years (Table I).

Regarding the caregivers, 65.6% had a moderate level of knowledge, participants had a moderate level of belief in self-efficacy, caregiver role acceptance, social support and self-care behavior of caregivers (71.9%, 75%, 65.6% and 75%) respectively, (Table II).

Through the calculation of Pearson's product moment correlation coefficient it was shown that knowledge of caregivers' self-care (KN), social support (SS), belief in self-efficacy (SEF), and caregiver role acceptance (CRA), were correlated with self-care (SC) behaviors: 0.574, 0.497 ( $p < 0.01$ ), 0.143 and 0.167 ( $p < 0.05$ ) respectively, (Table III).

## IV. DISCUSSION

### Caregiver Demographic Variables

The following characteristics of caregivers are discussed in this section: (a) age, (b) female gender, (c) spouse status, (d) education, and (e) financial status. These variables were believed to be associated with self-care behavior for caregivers.

**Age:** In this study a mean age of 49.5 years (ranging from 26 to 59) was found. Results indicated that age was not related to self-care behavior. Very few studies exist in the literature about the effects of caregiving on caregiver self-care behavior. Unfortunately, findings of the only two known studies appear to be inconsistent. One study by Sisk (2000) [18] found that the increase in caregiver age was associated with a decrease in exercise, while another study [19] indicated that increased age was associated with better practice of health behaviors including exercise. One possible reason for this inconsistency in findings may be that advanced age combined with another latent factor such as poor general health are barriers to caregiver exercise. Poor health was projected to contribute to increased burden [20]. Both studies [18-19], however, did not examine caregiver health status. Therefore, it is unknown whether general health was a factor that contributed to differences in the findings of both studies. In this study, good and excellent health was reported by 78.1% of participants; the increase in age was not associated with decreased general health or increased burden. The findings indicate that poor health is not an issue for respondents. This included caregivers with advanced age whose health was not significantly different from their younger counterparts. Similar with our result, another large sample, longitudinal study observed that older caregivers generally had better physical health compared to non-caregivers [21]. Better physical health was a prerequisite for older people taking on the role of caregiving in the first place. This supports our finding that age is not associated with general health.

**Female gender:** Caregiving is traditionally viewed as a role of women. Females accounted for over two-thirds

(68.7%) of study's sample. These consisted of wife caregivers (37.5%) and adult daughters (55%), with the remainder being mothers. Female gender in this study was associated with greater caregiving satisfaction and better performance in nutrition. These findings are not unexpected since female caregivers compared to male caregivers were more likely to commit to a caregiver role and view caregiving as part of their familial duties [22]. By contrast, male caregivers often experienced conflicts in their gender role due to their traditional beliefs of masculinity [23]. They were therefore, understandably, less likely to have feelings of meaning or satisfaction from caregiving than women. Similarly, planning and preparing foods were the traditional familial role of women. Given the cumulative experience in food preparation, it is conceivable that women were more knowledgeable in food selection and consumption for the sake of continued family health and well-being than the male caregivers. Previous studies indicated that female caregivers experienced greater burden and poorer emotional well-being than male caregivers [24]. Our findings agreed with this.

**Marital status:** 38% of participants were spouses; two-thirds were wives. Spouse status in this study was not significantly associated with co-residence and less caregiving mastery. No significant relationships were found between spouse status and self-care. This was consistent with previous studies [25]. Spouse status was also not associated with burden in this study. This further indicates that poor health may play an important role in other studies that observed a greater burden in spouse caregivers [24]. In other words, being a spouse as well as having poor health together may explain the escalated burden in spouse caregivers.

**Education:** 81.2% of the caregivers had educational levels of high school or diploma. Education is a well-known indicator of health and life expectancy in the general population. The general belief is that knowledge, skills and better life circumstances transferred through education contributed to better health [26]. This study, however, indicates that education was not significantly associated with self-care behavior.

**Financial status:** Similar to educational attainment, socioeconomic status was well-known to be associated with better life circumstances and access to medical care [27]. Older people with higher household income were found generally having better health and life expectancy than others whose socioeconomic status was low. Studies revealed that the disparity of socioeconomic status in health was also evident among caregivers. This was because health care accessibility mediated the adverse effects of caregiving on caregiver health [27]. Our study confirms these findings (not present in table). About two-thirds of our study subjects reported no financial strain, three-quarters had good or excellent health; financial status was positively associated with better caregiver health.

The predictors of Caregiver Self-Care behavior that were found were: (a) knowledge of caregivers' self-care, (b) perceived self-efficacy in self-care, (c) social support, and (d) self-care behaviors for caring elderly persons, when controlling for caregiver demographic variables.

This study found that caregivers who had higher knowledge of caregivers' self-care or who had higher

perceived self-efficacy in self-care or who had higher social support would have better self-care behaviors for caring elderly persons. For self-care knowledge in this sample group, there was mostly on a moderate level of knowledge. There was a significant correlation between the education level of participants and their self-care behavior for caring elderly persons. This result was similar to various recent studies [28-29]. This contrasts with the study of Lawton et al. (1989) [30] that did not find a significant correlation. Furthermore, the findings pointed that KN, SEF, CRA, SS and age were correlated with self-care (SC) behaviors of pregnant Thai adolescents. This can be illustrated that order for individuals to successfully practice behaviors, they need to have perceived self-efficacy to define their own ability to conduct and perform the behaviors until they complete their goal [31]. Perceived self-efficacy is a qualification of individuals who have the potential to take care of themselves, individuals who have knowledge, thinking ability, and skills to employ cognitive and intellectual processes to memorize and utilize knowledge in actual practices [32].

The majority of caregivers reported low denial but high positive reframing and acceptance. This indicated that intensively using emotional coping results in emotional dysfunction, leading to more distress and burden. This was not an issue for this group of caregivers who had a relatively high educational attainment [33]. In addition to this social supports and advice received from health care providers can reduce psychosocial problems of elderly caregivers. Furthermore, self-esteem makes individuals accept and believe in themselves. This makes them not only feel valuable but also influences positive self-care behaviors. In addition, in order for individuals to perform behaviors successfully, they ought to have perceived self-efficacy. As an outcome, CRA, KN, SEF and SS for elderly persons could predict the variation of self-care behaviors of caregivers. From the study finding that CRA, KN, SEF and SS were related to self-care behavior ( $r=0.759, 0.777, 0.790$  and  $0.803$ ;  $p<0.01$ ) respectively. These findings were in line with Antonucci [34]. He demonstrated perceived social support has stronger predicting power for the effects of social support on adaptation than the measure of received social support. Despite this some studies [35-36] have argued that perceived social support is conceptually distinct from received social support.

**Lessons learned:** It would likely be more effective and more personal to those attending and would offer each member more opportunities for active participation and questions. For future practice and research will manage in a large group setting. It is focusing on community partnership to address caregiving among elderly people. At the completion of 3-month program, caregivers will invite to join an ongoing support group scheduled. The next project goal is to create a model caring community and society for the elderly. To develop integrated community base health care and social welfare services resulting in sharing of resources, benefits and provision of holistic health and welfare services contributing to increase the quality of life for the elderly and sustainable healthy life style.

TABLE I. THE CHARACTERISTICS OF 32 CAREGIVERS PERSONAL FACTORS WITH SELF CARE BEHAVIOR

| PARAMETER                   | n (%)                                      |
|-----------------------------|--|
| Age (year)                  | $\bar{X}$ (SD) = 49.5 (10.0) range (26-59) |
| 25-34                       | 9 (28.1)                                   |
| 35-44                       | 5 (15.6)                                   |
| 45-54                       | 15 (46.9)                                  |
| ≥ 55                        | 3 (9.4)                                    |
| Gender                      |  |
| Male                        | 10 (31.3)                                  |
| Female                      | 22 (68.7)                                  |
| Marital status              |  |
| Single                      | 6 (18.8)                                   |
| Married                     | 12 (37.5)                                  |
| Widow                       | 3 (9.4)                                    |
| Others                      | 11(34.3)                                   |
| Education                   |  |
| High school/Diploma         | 26 (81.2)                                  |
| Bachelor degree             | 3 (9.4)                                    |
| Higher than Bachelor degree | 3 (9.4)                                    |
| Occupation                  |  |
| Permanent employee          | 6 (18.8)                                   |
| Part time employee          | 21 (65.6)                                  |
| Government officer          | 5 (15.6)                                   |
| Monthly income (Baht)       | $\bar{X}$ (SD) = 15,271.56 (7,257.42)      |
| <10,000                     | 6 (18.7)                                   |
| 10,000-14,999               | 15 (46.9)                                  |
| 15,000-19,999               | 4 (12.5)                                   |
| ≥ 20,000                    | 7 (21.9)                                   |
| Health status               |  |
| Healthy                     | 25 (78.1)                                  |
| High risk                   | 6 (18.8)                                   |
| Ill                         | 1 (3.1)                                    |
| Illness                     |  |
| Hypertension                | 1 (3.1)                                    |

TABLE II. THE MEAN, SD AND PERCENTAGE OF KNOWLEDGE, BELIEF IN SELF-EFFICACY, CAREGIVER ROLE ACCEPTANCE, SOCIAL SUPPORT AND SELF-CARE BEHAVIOR OF CAREGIVERS (N=32)

| PARAMETER   | n (%)     | Mean (SD)     |
|---|-----------|---------------|
| Levels of knowledge of caregivers' self-care (KN) |           |               |
| Low (0-6 scores)                                  | 6(18.8)   | 7.375 (1.238) |
| Moderate (7-8 scores)                             | 21(65.6)  |               |
| High (9-10 scores)                                | 5(15.6)   |               |
| Levels of belief in self-efficacy (SEF)           |           |               |
| Low (0-32 scores)                                 | 4 (12.5)  | 36.87 (4.36)  |
| Moderate (33-41 scores)                           | 23 (71.9) |               |
| High (42-50 scores)                               | 5 (15.6)  |               |
| Levels of caregiver role acceptance (CRA)         |           |               |
| Low (0-32 scores)                                 | 5 (15.6)  | 38.87 (2.19)  |
| Moderate (33-41 scores)                           | 24 (75.0) |               |
| High (42-50 scores)                               | 3 (9.4)   |               |
| Levels of social support (SS)                     |           |               |
| Low (0-32 scores)                                 | 5 (15.6)  | 41.4 (2.96)   |
| Moderate (33-41 scores)                           | 21(65.6)  |               |
| High (42-50 scores)                               | 6(18.8)   |               |
| Levels of self-care (SC) behaviors                |           |               |
| Low (0-23 scores)                                 | 5 (15.6)  | 27.53 (3.59)  |
| Moderate (24-31 scores)                           | 24 (75.0) |               |
| High (32-50 scores)                               | 3 (9.4)   |               |

TABLE III. PEARSON'S PRODUCT MOMENT CORRELATION COEFFICIENT (R) BETWEEN SELF-CARE KNOWLEDGE OF CAREGIVERS' SELF-CARE (KN), SELF-EFFICACY (SEF), CAREGIVER ROLE ACCEPTANCE (CRA), SOCIAL SUPPORT (SS) AND SELF-CARE BEHAVIORS (SC)

| Variable | KN      | SEF     | CRA     | SS      | SC      | Age    | Income | Education |
|----------|---------|---------|---------|---------|---------|--------|--------|-----------|
| KN       | 1       | -0.027  | 0.058   | 0.445** | 0.574** | 0.387* | 0.378* | 0.673**   |
| SEF      | -0.027  | 1       | 0.462** | -0.024  | 0.143*  | 0.145  | 0.260  | -0.158*   |
| CRA      | 0.058   | 0.462** | 1       | -0.024  | 0.167*  | 0.377* | 0.070  | -0.107*   |
| SS       | 0.445** | -0.024  | -0.024  | 1       | 0.497** | 0.132  | 0.398* | 0.393**   |
| SC       | 0.574** | 0.143*  | 0.167*  | 0.497** | 1       | -0.087 | 0.093  | 0.178**   |

\*p&lt; 0.05

\*\*p&lt;0.01

## V. CONCLUSIONS

Perceived caregiver role acceptance, social support from close relatives and medical personnel and knowledge of caregiver self-care were predicted to caregivers' self-care behaviors for elderly and dementia persons in this study. However, the findings recommended that community health-care should providers promote self-care behaviors among this group by improving their knowledge of self-care. This should have enough detail to enable elderly caregivers to their community network. For improving their self efficacy, training should be provided in the form of

group discussion among caregivers to exchange attitude and to develop positive feeling towards themselves. The whole caregiver group are at risk for chronic illnesses. Self-care is determinant to their health promotion and disease prevention. Yet, of this group in the population, there is no common self-

care profile. They have no routine wellness or physical check-ups, they seldom take exercise, have little time for socializing and healthy eating, and have a severe lack of sleep or rest. This study expands on the existing understanding of the adverse effects of caregiving on caregiver health in the caregiver literature.

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