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Predictors of depressive symptoms in older adults living in care homes in Thailand☆,☆☆,☆☆☆

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ABSTRACT

BACKGROUND: Thai culture traditionally abhors elders living in care homes due to the belief that this represents a dereliction of filial piety by their children, thus care homes are stigmatized as the domain of poor older adults with no family. This may impact negatively on psychological wellbeing of residents, although little is known about the key factors influencing depressive symptoms. Therefore, this study explores factors associated with depressive symptoms, internalised stigma, self-esteem, social support and coping strategies among older adults residing in care homes in Thailand.

METHOD/DESIGN: A cross-sectional questionnaire study was conducted with 128 older residents recruited from two care homes in Northeast Thailand. Data were collected using the 15-Item Thai Geriatric Depression Scale, Internalised Stigma of Living in a Care Home Scale, Thai Version of Rosenberg Self-Esteem Scale, Thai Version of Multidimensional Scale of Perceived Social Support and the Coping Strategies Inventory Short-Form.

RESULTS: Depressive symptoms were significantly correlated with internalised stigma, self-esteem and social support ($r = 0.563$, -0.574 and -0.333) ($p < 0.001$), respectively. Perceived internalised stigma of living in a care home was the strongest predictor of care home residents reporting depressive symptoms (odds ratio = 9.165).

DISCUSSION: Older adults who perceived high internalised stigma of living in a care home were over nine times as likely to report experiencing depressive symptoms. Efforts to decrease or prevent perceived internalised stigma might help to reduce depressive symptoms. Interventions might include media collaboration, educational interventions in the care home setting and organising social activities for residents and their families.

INTRODUCTION

Depression is common among older adults residing in care homes worldwide, with an average prevalence rate of 14.4% (systematic review: Polyakova et al., 2014); in Thailand reported rates are significantly higher, up to 24% (Wongpakaran & Wongpakaran, 2012, 2013). Experience of depression in care home residents may be associated with the impact of physical and psychological illness (Ganatra, Zafar, Qidwai, & Rozi, 2008; Tsai, Chung, Wong, & Huang, 2005), social isolation (Drageset, Espehaug, & Kirkevold, 2012; Scocco, Rapattoni, & Fantoni, 2006), poor social support (Drageset, Kirkevold, & Espehaug, 2011), negative coping strategies and stigma specifically associated with living in care homes (Dobbs et al., 2008; Fisher, 1990).

Stigma is experienced when members of society hold a set of negative beliefs toward an individual who belongs to one or more groups that are commonly viewed unfavourably (Goffman, 1963). Living in a care home is a risk factor for perceived stigma (Dobbs et al., 2008, Fisher, 1990), particularly in conservative Asian cultures such as Thailand, where it is viewed as a mark of social shame on older parents not to be cared for by family members, and on the younger generation not to care for one's aged parents personally (Choowattanapakorn, Nay, & Fetherstonhaugh, 2004). Some families believe that a residential care home is a place only for older people who have no family

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(Choowattanapakorn et al., 2004). In addition, 93% of elderly parents expect their children to take care of them when they get older (Philips & Chan, 2002). Recent research conducted in a rural district in Northeast Thailand suggested that the value of familial responsibility for older adults reinforces the expectation of filial care from children (Rittirong, Prasartkul, & Rindfuss, 2014). These beliefs may influence negative perceptions of living in a care home among older residents and impact on their psychological wellbeing, lowering self-esteem, and increasing feelings of isolation, self-harm and depression. However, the evidence for this is scarce, and little is known about the key factors influencing the experience of depressive symptoms. The biopsychosocial model (Borrell-Carrió, Suchman, & Epstein, 2004; Engel, 1980, 1989; Sarafino & Smith, 2014) was used in a holistic approach to identify the factors associated with depressive symptoms among participants. These included: physical impairment or disability (biological influences); social support and perceive internalised stigma (social-cultural influences); self-esteem and coping strategies (psychological influences). An improved understanding of the relationship between these factors and depressive symptoms is required to inform the development of future intervention to prevent or decrease depressive symptoms in older care home residents.

This study aimed to investigate: [1] the demographic characteristics of older adults living in care homes in Thailand; [2] levels of depressive symptoms, internalised stigma, self-esteem, social support and coping strategies among older adults living in care homes; [3] the relationship between depressive symptoms, stigma associated with living in a care home, self-esteem, perceived social support and coping strategies of older adults residing in care homes; and [4] factors predicting depressive symptoms among older adults residing in care homes.

MATERIALS AND METHODS

A cross-sectional questionnaire study was conducted in two care homes in Northeast Thailand (Isan). Data were collected between 10 July 2015 and 15 November 2015.

PARTICIPANTS

Older adults were selected according to the following eligibility criteria: Thai adults aged 60 years and above; fluency in Thai language; absence of severe cognitive impairment or severe psychological disturbance (which may have prevented comprehension of the study information sheet and completion of the questionnaire). A total of 128 residents consented to take part in the study from two care homes, with a response rate of 98.46%.

PROCEDURE

Ethical approval for the study was obtained prior to data collection from a University Institutional Review Board in The UK (Ref: OVSa16042015 SoHS) and a Hospital Institutional Review Board in Thailand (Ref: 053/2015). Permission to approach residents was obtained from the head of each care home. Screening for eligible residents was undertaken by care home staff. A range of strategies were adopted to maximise recruitment. These included: an advertisement during meal times, an incentive raffle ticket for a prize draw, and follow up contact from the researcher with eligible residents. All eligible residents who expressed their interest in participating in the study were approached face-to-face by a nurse researcher, who explained the study purpose and procedures. Eligible residents who agreed to take part in the study were asked to provide their written, informed consent. They were informed that participant anonymity would be preserved and that they could withdraw from the study at any time without giving a reason. Data were obtained through single face-to-face structured questionnaire interview conducted by the nurse researcher, taking approximately 1 h per interviewee.

RESEARCH MEASUREMENTS

The questionnaire consisted of six parts. Section 1 included personal demographic characteristics: age, gender, marital status, religion, highest qualification, length of time the participant had lived in a care home, frequency of visitors, general health problems and reason for living in the care home. Sections 2–6 included the following questionnaire measures: the 15-Item Thai Geriatric Depression Scale (Wongpakaran & Wongpakaran, 2012), Thai Version of Internalised Stigma of Living in a Care Home Scale (Tosangwarn, Clissett, & Blake, 2017), Thai Version of Rosenberg Self-Esteem Scale (Wongpakaran & Wongpakaran, 2010), Thai Version of Multidimensional Scale of Perceived Social Support (Wongpakaran, Wongpakaran, & Ruktrakul, 2011) and the Thai Version of Coping Strategies Inventory Short Form (Tosangwarn, Clissett, & Blake, 2016). The questionnaires were pilot tested with 15 older adults of a similar age range, to determine the feasibility of data collection using these measures and to verify the approximate length of time to complete.

THE 15-ITEM THAI GERIATRIC DEPRESSION SCALE (15-TGDS)

Depressive symptoms were measured using the 15-TGDS (Wongpakaran & Wongpakaran, 2012). The Geriatric Depression Scale (GDS) was first created by Yesavage et al. (1983). The Short-Form GDS (15 items) is easier to use for older adults residing in a care home who have physical illness and mild-to-moderate cognitive impairment (i.e. due to short attention spans or feeling easily fatigued) (Yesavage & Sheikh, 1986). Of the 15 items, questions 1, 5, 7, 11, 13 indicate depression when answered negatively; the remainder indicate depression when answered positively. It takes about 5 to 7 mins to complete. Scores of 0–4 are considered normal; 5–8 indicate mild depression; 9–11 indicate moderate depression; and 12–15 indicate severe depression. The validity and reliability of the 15-TGDS has been demonstrated (Yesavage & Sheikh, 1986). The Thai version shows good internal consistency (n = 130; Cronbach's alpha = 0.85) (Wongpakaran & Wongpakaran, 2012).

THAI VERSION OF INTERNALISED STIGMA OF LIVING IN A CARE HOME SCALE (THAI VERSION OF IS-LCH SCALE)

Perceiving internalised stigma of living in a care home was assessed using the Thai Version of IS-LCH Scale, adapted from the Thai Version of Internalised Stigma of Mental Illness Scale (ISMI) (Wong-Anuchit et al., 2016). The ISMI was created by Boyd Ritsher, Otilingam, and Grajales (2003) and has been widely used in 55 versions in many different countries (Boyd, Adler, Otilingam, & Peters, 2014). The Thai Version of IS-LCH consists of 26 items, answerable on a four-point Likert scale (1 = strongly disagree, 4 = strongly agree). It takes approximately 15 min to complete. Higher scores indicate increased internalised stigma of living in a care home; the mean scores of 1.00 to 2.00 are considered minimal-to-no internalised stigma; 2.01 to 2.50 indicate mild internalised stigma; 2.51 to 3.00 indicate moderate internalised stigma and 3.01 to 4.00 indicate high internalised stigma (Lysaker, Roe, & Yanos, 2007). Thai version of IS-LCH Scale has good internal consistency with a reported Cronbach's alpha of 0.87, and a reported Intraclass Correlation Coefficient of 0.90 for the entire scale (Tosangwarn et al., 2017).

THAI VERSION OF ROSENBERG SELF-ESTEEM SCALE (THAI VERSION OF RSES)

Self-esteem was measured using the Thai-RSES (Wongpakaran & Wongpakaran, 2010). The RSES (1965) is a globally utilised self-esteem measure. It has been used in diverse populations and has been subject to more psychometric analysis and empirical validation than any other self-esteem measure (Robins, Hendin, & Trzesniewski, 2001).

The Thai-RSES is a 10-item questionnaire with a four-point Likert scale ranging from “strongly agree” to “strongly disagree”. It takes