# PATTERN OF CAREGIVING FOR ELDERLY BY THEIR FAMILIES IN RURAL COMMUNITIES OF SURATTHANI PROVINCE

**CHALOUY LAUBUNJONG**

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**2005**

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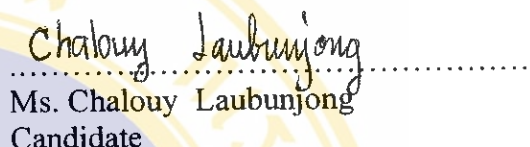

Ms. Chalouy Laubunjong
Candidate

Assoc. Prof. Nawarat Phlainoi,
Ed.D.
Major-Advisor

Asst. Prof. Siriwan Grisurapong,
Ph.D.
Co-Advisor

Asst. Prof. Wanna Kongsuriyanavin,
Ed.D.
Co-Advisor

Prof. M.R. Jisnuson Svasti, Ph.D.
Dean
Faculty of Graduate Studies

Asst. Prof. Teeradej Chai-aroon ,
Ph.D.
Chair
Doctor of Philosophy Programme in
Population Education
Faculty of Social Sciences and Humanities

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for the degree of Doctor of Education (Population Education)
on
6 October 2005

Chalouy Laubunjong
..................................................
Ms. Chalouy Laubunjong
Candidate

Nawarat Phlainoi
..................................................
Assoc. Prof. Nawarat Phlainoi,
Ed.D.
Chair

Praphaphan Un-Ob
..................................................
Assoc. Prof. Praphaphan Un-Ob,
Ed.D.
Member

Siriwan Grisurapong
..................................................
Assoc. Prof. Siriwan Grisurapong,
Ph.D.
Member

Y. Porapakkham
..................................................
Assoc. Prof. Dr.Yawarat Porapakkham
Md., M.Sc.

Member

Wanna Kongsuriyanavin
..................................................
Asst. Prof. Wanna Kongsuriyanavin.
Ed D.
Member

..................................................
Prof. M.R. Jisnuson Svasti, Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University

Jiraporn C.
..................................................
Assoc. Prof. Jiraporn Chuckpaiwong.
M.A.
Acting Dean
Faculty of Social Sciences and Humanities
Mahidol University

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Chalouy Laubunjong

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PATTERN OF CAREGIVING FOR ELDERLY BY THEIR FAMILIES IN RURAL COMMUNITIES OF SURATTHANI PROVINCE

CHALOUY LAUBUNJONG 4037344 SHPE/D

Ed. D. (POPULATION EDUCATION)

THESIS ADVISORS: NAWARAT PHLAINOI, Ed.D., SIRIWAN GRAISURAPONG, Ph.D., WANNA KONGSURIYANAVIN, Ed.D.

## ABSTRACT

This qualitative and quantitative research aimed to study the pattern of elderly caregiving by a family living in the rural community of Suratthani Province. The method of survey research was used for the quantitative style using a questionnaire form with the sample group of 397 families (161 male elderly and 236 female elderly) while in-depth interview of 8 well cared elderly and of 7 not well cared elderly was used for the qualitative research. Both of the elderly sample groups were obtained based on the feature of the caring that their families provided.

The findings revealed that there were 3 features of the pattern (1) a pattern that the elderly needed little help from others as they were able to perform their daily functions normally (2) a pattern that the elderly required more help from others as their abilities in daily functioning were less, and (3) a pattern that the elderly needed complete help from others due to their physical sickness.

The recommendation includes the fact that although qualitative caring for the elderly is necessary but it is insufficient. An improvement of quality and competency must be made, along with development that can lead to a method of community support. Not only state enterprises but also other sectors in the community should pay more attention to this issue which includes physical, mental and spiritual aspects. This can be achieved by conducting a vital development of the public and administration policy especially on the community based public policy. Such achievement can result in an improvement of elderly caregiving as well as empowerment that further leads to social capital allowing the community to learn how to care for the elderly and among family members.

KEY WORDS: CAREGIVING / ELDERLY / FAMILY

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รูปแบบการดูแลผู้สูงอายุโดยครอบครัวในชุมชนชนบทจังหวัดสุราษฎร์ธานี (PATTERN OF CAREGIVING FOR ELDERLY BY THEIR FAMILIES IN RURAL COMMUNITIES OF SURATTHANI PROVINCE)

ฉลวย เหลือบรรจง 4037344 SHPE/D

ศษ.ด. (ประชากรศึกษา)

คณะกรรมการควบคุมวิทยานิพนธ์: เนาวรัตน์ พลายน้อย, กศ.ด., ศิริวรรณ ไกรสุรพงศ์, พบ.ด., วรรณา คงสุริยะนาวิน, ศษ.ด.

**บทคัดย่อ**

การวิจัยครั้งนี้ ใช้วิธีการวิจัยเชิงปริมาณและการวิจัยเชิงคุณภาพเพื่อศึกษารูปแบบการดูแลผู้สูงอายุโดยครอบครัวในชุมชนชนบท จังหวัดสุราษฎร์ธานี โดยการวิจัยเชิงปริมาณใช้วิธีการสำรวจ (survey research) โดยใช้แบบสอบถามกับกลุ่มตัวอย่างจากจำนวน 397 ครัวเรือน (แบ่งเป็นผู้สูงอายุเพศชาย จำนวน 161 คน และผู้สูงอายุเพศหญิง จำนวน 236 คน) สำหรับวิธีการวิจัยเชิง คุณภาพใช้เทคนิคการสัมภาษณ์แนวลึก (in-depth interview) ผู้สูงอายุที่ได้รับการดูแลอย่างดี จำนวน 8 คน และผู้สูงอายุที่ไม่ได้รับการดูแลอย่างดี จำนวน 7 คน กลุ่มตัวอย่างผู้สูงอายุที่ใช้ในการศึกษาแนวลึกทั้งสองกลุ่มนี้ ได้จากการจำแนกลักษณะการได้รับการดูแลจากครอบครัวของผู้สูงอายุทั้งหมดที่เป็นกลุ่มตัวอย่างในการสำรวจของการศึกษาในครั้งนี้

ผลการศึกษาพบว่า รูปแบบการดูแลผู้สูงอายุแบ่งออกเป็น 3 ลักษณะ ได้แก่ 1) รูปแบบการดูแลในลักษณะที่ผู้สูงอายุต้องการความช่วยเหลือจากผู้อื่นเพียงเล็กน้อย เนื่องจากสามารถปฏิบัติกิจวัตรประจำวันได้ตามปกติ 2) รูปแบบการดูแลในลักษณะที่ผู้สูงอายุจำเป็นต้องได้รับการช่วยเหลือเนื่องจากมีความสามารถในการปฏิบัติกิจวัตรประจำวันลดลง และ 3) รูปแบบการดูแลในลักษณะที่ผู้สูงอายุจำเป็นต้องได้รับการดูแลเอาใจใส่อย่างใกล้ชิด เนื่องด้วยภาวะการเจ็บป่วยทางกายภาพ

ข้อเสนอแนะจากการศึกษา ได้แก่ การจัดการดูแลอย่างมีคุณภาพแก่ผู้สูงอายุโดยครอบครัวแม้จะมีความสำคัญ (necessary) แต่ก็ยังไม่เพียงพอ (sufficient) จึงต้องมีการพัฒนาคุณภาพและสมรรถนะ (competency) ผู้ดูแลผู้สูงอายุของครอบครัวเพิ่มขึ้น รวมทั้งการพัฒนาให้เกิดกลไกการสนับสนุนจากชุมชน ซึ่งไม่เพียงจากภาครัฐแต่ยังรวมถึงทุกฝ่ายในสังคมที่ควรมีหน้าที่ในการดูแลและเอาใจใส่ในเรื่องนี้อย่างเป็นองค์รวม ทั้งในทางกายภาพ ทางจิตใจ ทางจิตวิญญาณ (spiritual) โดยพัฒนานโยบายสาธารณะและบริหารนโยบายในเรื่องนี้อย่างจริงจังเป็นรูปธรรม โดยเฉพาะนโยบายสาธารณะขององค์กรปกครองส่วนท้องถิ่น (Community Based Public Policy) ในเรื่องนี้ที่จะเอื้อให้เกิดการยกระดับการดูแลผู้สูงอายุโดยครอบครัว รวมทั้งการเสริมพลัง (empowerment) ให้เกิดทุนทางสังคม (social capital) ให้ท้องถิ่นเรียนรู้ดูแลผู้สูงอายุ

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# CHAPTER 1
# INTRODUCTION

## 1.1 Rationale and justification

Presently, the number of the elderly population in Thailand is annually increased and subsequently the ratio of the dependent elderly is respectively increased. The forecast on the number of the elderly population conducted by the Office of the National statistic reveals that the number of the country population whose age is over 60 years is 5,969,030 in 2001; 8,118,000 in 2010; 10,494,000 in 2016 (The Office of National Statistic, 2001: 35). A reason of the rapid growing number is due to medical and public health advancement that it increases life expectancy. In 2000, the life expectancy was 65.25 years for male and was 69.75 years for female whereas in 2005 the number increased to 69.25 years for male and 71.50 years for female (The Office of Public Health Statistic, 2003: 38). People live a longer life hence the number of personal chronic disease is also increased.

A study on the elderly in Suratthani Province, a province in the upper south of Thailand, which consists of 18 districts along with one subdivision district and the population of 940,779 showed that the number of the elderly in the area was 68,595. The popular illness found among the elderly was the fatigue of muscle, bones and joints which was 31.8% followed by 18.4% of digestive system and headache, dizziness as well as high blood pressure respectively. It was further found that 61.3 % of the elderly possessed a chronic disease while 16.5% was unhealthy (The Office of the Provincial Public Health, 2003: 24). This was correlated with the previous study stated that the biology of the elderly would be degraded that subsequently effected their mental, emotional and social changes. This would lead to the unhealthy conditions in the elderly as they could become sick easily from accident, infection and chronic disease. The older they got the more increasing of diseases. One elderly

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person of over 65 years of age would have at least one irregular case or more and for those over 80, they would have at least 3 chronic diseases or more(Chavalee Yamvong, 1995: 19). It was also discovered that half of the number of the elderly had various chronic diseases or irregular cases within one person. The sickness found among the elderly was mainly muscle pain, bone and joint problems, dizziness, cataract, heart problem, diabetes, and high blood pressure (Pornrat Intarakoseth, 1993: 22).

The biological degradation of the elderly not only leads to personal sickness but also to the reduction of working abilities which further change personal roles in a family; from a family leader who used to bring the main income and play many important roles both within a family and a community to someone who has to depend on others especially family members. Their wages are smaller, sometimes insufficient. The provincial statistic demonstrated that 24.6% of the elderly earned less than Baht. 1,000/month. The statistic also showed that 82.3% of the elderly earned insufficient amount and in the item of career, 36.8% stated "jobless" (Sa-ing Chawarangkul, 1995: 39). Besides loosing their role in an economic issue, a lot of the elderly have lost their love ones i.e. their spouse (Surakul Jane-obrom, 1991: 19). Such elderly can cope and adjust themselves with the changes and continue living a happy life if they receive help and support from their family members as well as the social networks. On the other hand, the biological changes can additionally effect their skillful competency, that is, they forget things, lose memories partly or completely, show unstable acknowledgement and reduce abilities in functioning such as blurred sight, having problems with hearing, breathing, digesting, toileting or moving around. All these effect the elderly mentally as they feel that their self-value and their competency are reducing and at the same time the physical sickness can lead to various feeling of annoying and depressing. Most of all, the elderly can become mentally sick from being afraid that they are left alone unaided. The study on the elderly in Suratthani Province showed that there was 13.7% of mental sickness i.e. depressed, disappointed, annoyed as well as loosing self-value (Sa-ing Chawarangul, 1995: 38) All these feeling changes cause the reduction of self-caring among the elderly or, another word, their self-caring becomes limited. Consequently, the elderly need a caregiver who

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mostly is a member of the family such as their children or grandchildren, spouse or someone having a good relationship with them which can be a relative or a neighbour (Yupapin Sirapo-ngarm, 1996: 89).

The elderly who possess a good quality of life and live a happy life are mostly live with their own family, that is, they live among their children and grandchildren who not only look after them closely but also listen to them and respect them. The elderly receive both physical comfort and mental happiness as they are treated with daily care such as preparing and making sure of nutrient food, washing and tidying clothes and attires, cleaning and tidying a place they stay, etc. Moreover, they also receive different treats of personal healthcare, medical care and other cares that help them to perform various suitable functions i.e. participating in social activities, participating in family activities, attending religious performances or becoming a member of organizational groups within the rural community, being supported for self-value, and being aware of personal value in the society.

The country economic and social situations have currently changed and become more modernized. Mass communication through radio, television and printing matters has been widely spread and influenced. People, especially in city societies, possess opportunities to gain more experience, conceive more things, obtain better education and become more modernized and at the same time the approach of the western cultures lead them to change their perspectives, beliefs, value that somehow degrade their respect in the seniority. They seem not to accept the older people's ideas, they do not ask for older people's opinions or consult older people as they may think that the older people are behind the time and old fashioned. The respect to the older people is less (Sutthichai Jitapunkul & Srijitra Bunag ,1997: 49). Economic and education aspects are additionally parts of the changing as city people are more educated that they change their profession, from an agricultural society where they have to depend on the elderly experience to industrial society where they do not need the elderly experience. Some may even think that the older people are less educated than them and that education makes them smarter and more modernized. All these also make the younger generations pay less respect to the older. An increasing of the

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cost of living is another factor. A person has to spend a lot of time working, both in agricultural field and the movement of labour work into the industrial field which include women who used to have a role of looking after family members. Even some of the elderly have to move themselves into the industrial labour force. The elderly are left alone at home or they may be asked to look after the younger grandchildren during daytime. Once the family members return home in the evening or late evening they are too tired to talk or discus any topic with the elderly, resulting in a creation of a more depressed and lonely feeling within the elderly (Arom Wuttipruek, et al., 1989: 36-47). All these situations cause a reduction of care toward the elderly (Passorn Limanont, 1992: 6). Furthermore, people nowadays tend to be materialistic that they become more selfish and less attention is given to the older people (Banloo Siriphanich, 1996: 18).

The economic changes also alter the Thai culture of helping others. More importantly, an accomplishment of the family planning reduces the number of young population. A family prefers to have only 2 or fewer children therefore the number of a caregiver is also less but the number of a single family is increased. It was disclosed that 36.7% of the elderly live in a family of 1-3 members and the care giving provided to the elderly was moderate (Chavalee Yamvong, 1995: 37) Nevertheless, as the situation of sickness is growing, it is imperative that the elderly require more care and attention hence the family members are unable to sufficiently respond to their needs. So the care giving to the elderly has to rely on the community aids who can be the public health volunteers or public health officers. It is mandatory that these volunteers or officers be educated on caring for the elderly by family in the rural community in order to help the elderly learn about self-care as well as to develop and promote family care giving to elderly and respond to their needs. The community should participate more in elderly care giving. Meanwhile, state and private enterprises should participate in helping, supporting and arranging different welfares to make the elderly live happily in the society. The aforementioned situations interest the researcher to study this topic of the pattern of care giving to elderly by family in the rural community, Suratthani Province

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## 1.2 Research questions

1.2.1 What is the condition of caregiving for elderly by their families in rural communities of Suratthani Province?

1.2.2 What is the pattern of caregiving for elderly by their families in rural communities of Suratthani Province?

## 1.3 Objective of the study

1.3.1 To study the situation of caregiving for elderly by their families in rural communities of Suratthani Province.

1.3.2 To study the pattern of caregiving for elderly by their families in rural communities of Suratthani Province.

## 1.4 Scope of the study

This research was study on the pattern of caregiving for elderly by their families in rural communities of Suratthani Province.

## 1.5 Research definitions

1.5.1 The elderly means a person whose age is over 60 and can be either male or female living in the rural areas of Suratthani Province.

1.5.2 Family caregiver means a person who cares for the elderly in a family and is related to the elderly. He/she can be a son/daughter, a grandchild, a spouse or a relative.

1.5.3 Caregiving to elderly by a family means an action that the offspring, the grandchildren, a spouse or a relative who live in the same house with the elderly provide an assistance to the elderly in regard to the routine daily functions as well as socio-psychological and economic caring aspects

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1.5.3.1 Providing the assistance on routine daily functions includes assisting the elderly regarding meals, physical movements, getting dress, toilet using, bathing, shopping, cooking, house cleaning, managing expenses, walking from places to places

1.5.3.2 Socio-psychological aspect means a respond to the social needs in terms of showing respect, supporting the elderly to participate in activities and interacting with others

1) Actions of showing respect to the elderly include spending time talking, consulting with the elderly as well as following their guidance, asking for advice, inviting them to be parts of family problems and activities.

2) Actions of supporting the elderly to participate in various activities and interacting with others include supporting the elderly to meet or visit relatives, supporting the elderly to participate in activities i.e. social activities, religious performances, recreations.

1.5.3.3 Economic caring aspect means responding to the need for security in term of economy which includes providing fund for daily expenses, helping in the payment of the household expenses, providing items for facilitation, supporting the elderly to do some work.

## 1.6 Benefits of the study

1.6.1 To be able to use the data in setting up a work plan or determining an operation to improve and increase the competency of a caregiver in the family to the elderly that further results in the development of life quality among the elderly in the rural community of Suratthani Province.

1.6.2 To use the knowledge to improve and develop the pattern of caregiving for elderly by their families in rural communities of Suratthani Province. .

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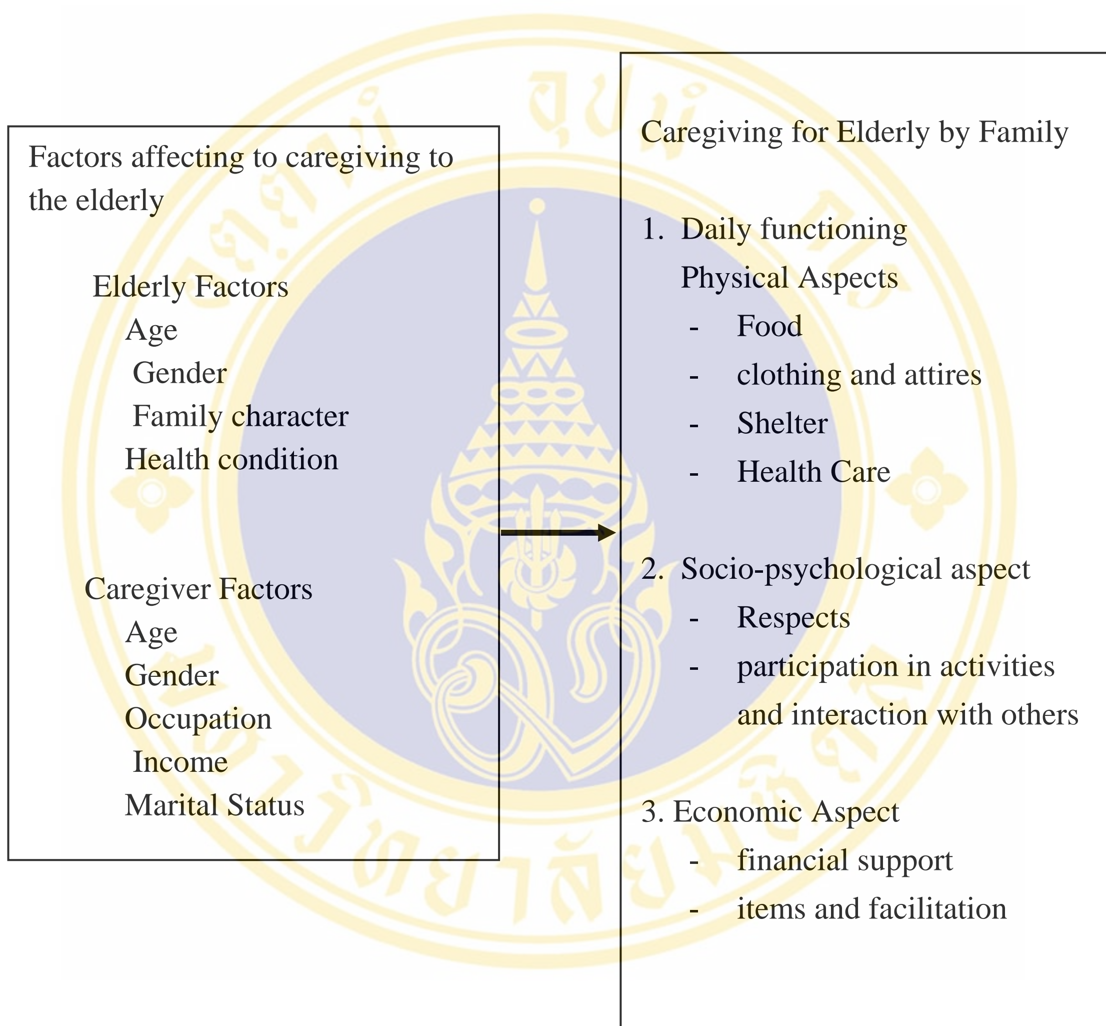
## 1.7 Conceptual framework

This is a study on the pattern of caregiving for elderly by their families in rural communities of Suratthani Province.

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# CHAPTER 2
# LITERATURE REVIEW

This research was to study on the pattern of caregiving for elderly by their families in rural communities of Suratthani Province. Therefore, the researcher has studied about concepts, theories, and related researches that involved to elderly, and caregiving for elderly to be used as the fundament and guideline for research implementation. They were as follows:

2.1 Concepts and theories about elderly
2.2 Division of elderly
2.3 Changing in the elderly
2.4 Theories of the elderly in the biological, psychological, sociological approaches
2.5 Concepts about elderly caregivers
2.6 Concept about caregiving for elderly
2.7 Demand of elderly caregiving
2.8 Health state assessment
2.9 Theories of health promotion for the elderly
2.10 Theories of social support
2.11 Related literatures

## 2.1 Concepts and theories about elderly

The researches about Thai elderly population, population characteristics, and Thai society from different formal source were reported by Napaporn Chayowan, John Nodel, and Siriwan Siriboon (1990: 2). They gave the definition of elderly that the population who is 60 years old or older than 60 years old since it is the retirement age for the governmental officers with the perception of this age going to be old age. Moreover, the age of 60 years old is the last year of fifth and it is a starting year of the

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sixth cycle. Therefore, there is general opinion that the elderly will start at the 60 years old.

In the various studies about the elderly, had different definition of elderly by starting with the report of David Hacked Picher was dons in the eighteen century in New England. The 60 years old age was defined as elderly. While the American history hold it as different period of life cycle. Therefore, in the past some American lets the elderly start at 50 years old, some lets it start at 80 years old or some lets it between 50-80 years old (Wold, 1993: 36).

The study on the factors affecting to perception of elderly process, and life quality with the approach of life quality by Sawittree Limchai-Arunrueng (1993: 174), found that The elderly perceives the process of elderly of himself/herself when he/she perceives the state of health with the physical changing in term of degradation in the anatomy and physiological aspects. The part with dominant change was the muscle and bone systems that cause the slow movement and body weakness with the more fatigue appearance. Moreover, the elderly would have the wrinkle skin, being partial blind. This physical health state will occur during the age of 50-60 year up so the elderly perceives to the process of elderly according to the physical health state and the criteria of elderly setting.

The information from the qualitative research was done by Sasipat Yodpetch, et al., (1993: 28), the elderly expressed their point of view that the age was set as "old age". Most of them defined that the one who had 60 years old up but in other places, they had other factors for considerations such as the health state, body strength because someone was only 50-55 years old but they were not healthy, sick, and with white hair, bent backbone and could not work. They were called "old". Someone fells himself/herself get old, he/she would start to decrease the activities in the economic aspect. The researcher compiled his opinion after he had made conversation with the group of elderly persons that it could be concluded that the elderly group did not pay much attention to the figure but they would consider from other factors such as physical state, white hair, being partial blind, being hard of hearing, bent backbone,

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wrinkle skin, teeth losing, pain at backbone, pain at waist, pain at joints, unable to walk for far distance, unable to work hard, easily exhausted, and weakness. When they were asked about age, they would answer by estimation or forecasting. Therefore, the elderly who were in the conversation group, they would be grouped in the elderly with age between 70-80 years because they had a rather deteriorated health due to their passed hard work.

On the other hands, to identify being elderly by holding age as criteria that was 60 years old up, in Thai society it was widely used by the elderly themselves, other involved persons about the acceptance of being elderly.

## 2.2 Division of elderly

The elderly were divided into group as follows:

Alfred Kahn(cited by Sritubtim Ratanakosolpanich,1982:96), explained that the elderly did not have a solely group and did not have similar characteristics but they had different characteristics in accordance with calendar year with three groups as follows:

1. The "young" elderly group had age lower than 74 years old
2. The "middle aged" elderly group had age between 75-84 years old
3. The "old" group had the age higher than 85 years old.

Matteson, et al., (1980: 31) divided the elderly according to the American National Institute of Aging into 2 groups as follows:

1. Young old group had age between 60-74 years old. They were not very old and they were still able to work if they were have the good mental and physical health.

2. Old-old group had age with 70 year up. This age was accepted to be a real old age.

Hall, (1979: 6) studied on the elderly and divided the elderly into 4 types as follows:

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1. Chronological aging meant the elderly according to the calendar year. This meant the elderly in accordance with calendar by counting from the year was born to present state so one could be told that how old he/she was.

2. Biological aging, there were different changes both state and function process that was appear while one' age was increasing

3. Psychological aging, there were changing in the functions of perception, conceptual, memory, intelligence, and personality that were presented in different age of aging process.

4. Sociological aging, would include the changing of role, function, status of individual in the social system such as family.

Birren and Renner (1997) explained the process of aging that was a regular change in the human life with the maturation in changing circumstance according to aging. It can be divided into 3 patterns as follows:

1. Biological aging was the physical change due to the decrement of efficiency function of different organs in the body. It resulted from the aging process in accordance to the life span of individual.

2. Psychological aging meant the high ability of adaptation according to the changing environment in term of learning, problem solving, attitude, and personality with more developing.

3. Sociological aging meant the role and function in the family and work place, including the social expectation for that person with the congruence to his/her age, including the expression of that person according to social demand.

Auoy Ketsing (1983: 34) divided the elderly in Thailand into 4 types as follows:

1. Old by age, was old due to being born long time ago.
2. Old by body, was old according to physical state.
3. Old by heart, was old according his/her thinking.
4. Old by society, was old because of environment and experiences such as work position.

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For Thailand, the elderly club of Thailand, defined the characteristics of elderly that were the one who had higher than 60 years old (Office of Permanent Undersecretary of Public Health Ministry, 1988: 39).

From different criteria of different group, the researcher will used the criteria of 60 year up was an elderly.

## 2.3 Changing in the elderly

The state of changing in the elderly, there were a wide verities of researchers and academic people studied and explained to the state of problem occurring in the elderly. The conclusions were in the similar direction that the state of problem occurring in the elderly was resulted from the changes of body, mind, emotion, and society, including the influences of environment in the society that gave pressure to body and mind of human being. Moreover, pathological state was an important element that affected to degradation of body. The elderly was an age of degradation because the different changes were mentioned above. Pramote Wang Sa-Ard (1987: 25) mentioned tat problem state of elderly was caused by three major changes that were the changes of body, mind, and emotion. In addition to the social and cultural facets would be classified in following details:

### 2.3.1 Physical change

When the person entered to the old age, the physical change that can be obviously seen from outer part of body was wrinkle skin because the tissue under the skin had lesser oil. Therefore, the skin would change to be brown color. They generally slow moving, being tried, body imbalance, and the hair become grey color.

The changes of bone, the bone will be thinner and easily broken since the calcium was decreased, so the joints were often degenerated, and inflamed.

Sensible aspect of sensory organs such as eye, ear, nose, tongue, and skin, would decrease the receiving sense.

Heart system and blood vessel system would obviously degrade. The ability of increasing the rate of beat and force of heat beating were decreased.

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The blood vessel wall had calcium adhered increasing so it caused the blood vessel wall would loose it flexibility, and blood vessel would constrict and get hard. It was a cause of hypertension, and heart disease such as heart muscle lack of blood supply.

**2.3.2 Psychological change**

State of mental change was the change that related to the physical change and social change because the degradation of various organ affected to state of mental of the elderly.

From the previous studies on the concept of hope and need of elderly, it could be conclude that the elderly needed from society about the family support, and need for income assurance, self-development, and self-independence. In the social aspect, the elderly needed the acceptance and respect. The concept of Maslow about the basic need of human being, explained the nature of human about the basic need and high level need. This need would develop from the basic needs that were the need of physical need, need of security, need of participation, need of prestige. Then the person would develop the need in the fifth stage that was the high level need was using of one's competency, intelligence, and justice in order to be good effect to himself/herself, others and society. Therefore, the person would have good life quality, it depended on the response to his/her needs all body and mind according to the concept of Maslow.

**2.3.3. Social and Cultural change**

Factors in the socials and cultural aspects involved to the cause of body and mind problems of the elderly. The change of Thai society had tendency to follow the western styles increasingly, subsequent result affected to elderly. These changes were as follows:

1. The change of social status, at present society had the impeding feature for the elderly in different facets such as role on labor and role in family. The elderly had ever been the earner and the leader of the family, but they must become a dependent person who was converted into receiver instead of giver so they lost their prior authorities and social role (Brearley, 1977: 46).

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The role change to be dependents in the family caused the elderly to have feeling of loss of self-confidence because of the new function of baby caregiving instead of role of leader or advisor. Tinker, (1988: 31 ) stated that if people felt that they lost their important role, and they were dependent on others. These factors would make them feel shame and they thought they were the problem or chronic burden of society.

2. To be neglected, the results of social change from the prior society, leaded to the modernization age, the consequences of expanding or growth of urbanization. The new system of production had changed the agricultural society to industrialization so it changed the way of life. The elderly who was dependent or unable to work or invaluable in the economic aspect often be left behind (Peerasit Kamnuansilp, et al., 1980: 39). This made the elderly who was left behind felt lonely.

3. The declining of respect, in the ancient time, the elderly was respected by the younger based on the state of person who had experience and advisor but currently, these values were changed according to the westernization that held the individual independence, and they thought that the elderly was the out of date person or was behind the time. The elderly should live with their group and the young should live with the young (Supatra Supab, 1978: 26) This concept caused the gap of generation.

The changes in body, mind and society of elderly were the events that the elderly must unavoidable face in their lives during elderly stage so it caused the conflict inside their mind. Finally, they felt lonely (Cruze, 1986: 48).

## 2.4 Theories of the elderly in the biological, psychological, sociological Approaches

The study were done according to the theories, it was obviously seen that the phenomenon of aging had very wide meaning, the process of aging and factors affecting to aging, therefore aging could not explained by any sole theories but it needed the comprised of different theories for explanation. It might conclude into 3 main group as follows:

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1. Biological theory
2. Psychological theory
3. Sociological theory

**2.4.1. Biological theory**

It is a theory involved the physical change when person become old age. Woramont Treeprom (1991: 37) complied and divided into 3 main groups as follows:

**Group 1: Genome based theories**

1.1 Evolution Theory stated that aging is an adaptation of life evolution in order to create the better thing for survival in the changing environment. Aging of people is an addition to the life during the period of growth and reproduction of life. The life span will shorter when There is a vigorous changes of culture, living, and environment.

1.2 Watch Spring Theory / Programming Theory / The Biological Clock stated that aging is set with the code of gene under the process of aging that composes of growth, development, degradation until death finally. It is a cycle that happens during a certain period and it is already set so that the cells in the body or some system in the body will degrade when arrive to the set time.

1.3 Somatic Mutation Theory stated that aging is occurred due the mutation and it cause the accumulation of abnormal cells and mutant cells that lead to the synthesis of abnormal protein more than normal state so that the new cells will express their new attributes and it cause the normal system to be varied by decreasing the function of cells and efficiency of organs, finally, it became a cause of aging, sickness due to degradation, and cancer.

1.4 Error Theory stated that aging happen due to the accumulation of error or defect about the composition at molecule level of cells in the body. The living cells and tissues changes and regenerate all the time, including building the essential element for living such as enzyme, hormone, and neurotransmitters. In each stage of biological chemical process, it has a chance to err if the error occurs. This error will accumulate until it reaches to certain level, cells or tissues will be gradually degraded and died or even though, the cells are still alive but their function will be paused so it makes the control of body balance will be varied, particularly, the brain cells.

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1.5 Genetic Theory stated that the aging is a characteristics that happens according to gene that changed the structure of some organ in the body when people gets older and had similar feature in various generation such as attribute of bald head, and early grey hair. These attributes will be only found in someone, even though they are the same age with others.

**Group 2: Organ theories**

2.1 Wear and Tear Theory stated that the structures and function of body will change in the degradation way with unequally in individual, even though they are the same age.)

2.2 The Neuroendocrine Theory stated that the essential element for living and homeostasis of body are nerve and hormone. The aging is resulted decrement of functions of nervous system and endocrine glands.

2.3 The Immunological Theory stated that aging is occurs from the defect of immune system with the belief that when persons get older, they will produce the lesser immunity in the same time body will produce more autoimmunity. This causes the body weakness so it can not fight with the infection.

**Group 3: Physiological theories**

3.1 Stress Adaptation theory stated that reaction of body to stress in daily life, it irritates to the function of cell and makes the cells died so that the person who frequently face with the stress, they will enter to the aging process earlier.

3.2 The Cross – Linkage Theory of Aging stated that aging happens composition of collagen and fibrous Protein tightly link together, and it makes the fiber shrinks.

3.3 Waste – Product Accumulation Theory stated that aging expresses to the waste accumulation in the cells for a long time so it cause the change of shape and function of cells until the capability of cell decreases and cell death. It may be arranged in a part of aging process, particularly, somatic cell that is not divided any more so it can not change itself such as heart muscle cell, brain nervous cell, spinal cord nervous cell and kidney cell.

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3.4 The free Radical theory stated that the aging is occurred due to the free radical occurs in the utilization of oxygen and catabolism process of protein, carbohydrate, and others. It will be sensitive to the chemical reaction. It causes the gene abnormality and it is a substance that makes the collagen and elastic, which is important protein of holding tissue to degrade and lose its flexibility.

It is obviously seen that the biological theories are the theories to explain the cause of physical change with degradation when we get older. It is heath state and capability of human. Everybody can not avoid and it is mechanism and function of inner systems, including the somatic cells will degrade and lacks of efficiency and finally die.

**2.4.2. Psychological theory**

It is a group of theories that explain to the cause that makes the elderly change their personalities. Boriboon Pornpiboon (1983: 29) investigated and mentioned to the two important concepts of psychological aspect as follows:

Personality Theory stated that the elderly will be happy or sad it depends on his/her background and mental, development of that person. If the elderly grows with warmness, and security, and loves with caring other persons, he/she will love others and happily works together with others. If he/she grows without security and warmness, he/she will not cooperate and will not help the others. Then he/she thinks that no one is realize his/her value and he/she will live at the old age without happiness.

Peck's Development Theory believed that the elderly has three stage of development as follows:

1. Ability of distinguish the difference of self and prior role of life, he/she is proud to himself/herself and feels about his/her value that depends on his/her role and function in his/her job. In the opposite way, after retirement some person feels that he/she is invaluable. Nevertheless, the one who feels proud on the work value that is not from the work position, after retirement, that feeling still stays with him/her such as the elderly loves for growing tree, he/she will be happy after retirement because he/she has a change to do the fond of activities instead of prior occupation.

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2. Physical ability is changes according to the nature. The elderly understands about the physical state with healthiness, he/she will accept the decrement of physical ability and tries to properly adapt himself/herself. If the elderly only thinks about the regression of body, it will make him/her unhappy and unsatisfied.

3. The acceptance of the physical change according to nature, one who accepts about the aging process of body, one will accept the death. In addition to one will participate the activities about death without scare. Contrasting, one who holds with living as long as possible, one will be unsatisfied with the existing state and will be scare of death.

Erikson's theory explained that the development in the sociological aspect of the elderly is a period that elderly feels life is valuable, secure or hopeless. For the person who feels life is valuable and secure, that person will satisfy and will feels happy, including accepting some event such as death. In the complementary way, the elderly who can not accept , he/she will feel that he/she had/s a few choice to select so he/she does not extend his/her further life, he/she will depress, and will feel hopeless, and being invaluable so he/she will be hard to face old age stage.

The conclusion according to the psychological theory, believed that the elderly will be happy or sad, it depends on his/her background and development of one's mind. The acceptance of change, the elderly can properly adapt oneself, one will be satisfied, feel his/her life is valuable and happy. The elderly practices the satisfied activity and participates with caring others; it will stimulate him/her feel to do in order to respond his/her satisfaction.

### 2.4.3. Sociological theory

It is a group of theories that tries to analyze the cause of making the elderly to be changed their social status of adult who have job. In addition to these theories try to help the elderly to live in society with happiness There are various theories as follows:

1. Activity Theory tries to explain that the person has behavior to respond the aging and it is accepted as principle to view the elderly.

Decker, (1980: 42) who was the activity theorist explained that the elderly is able to control his/her behavior and create the new situation for replacing the lost

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thing or person such as loosing his/ her beloved person, living alone, having no children to care and so forth. Therefore the elderly searches for other activities to do replace the lost things in order that the others will accept him/her so he/she will be a valuable person in the society. Barrow and Smith, (1979: 64) believed that activities were necessary, particularly; it makes the elderly have good health both body and mind. Moreover, the elderly participates in the activities so he/she will play role and express his/her competency, finally, he/she feels that he/she is a valuable person and accepts by the society.

Activity is divided into 3 types as follows:

1.1 Informal Activity, such as meeting with friends, relatives and family member, and helping the family member to do job.

1.2 Formal Activity, such as participate to the different associations as social volunteer, join with the religious group, and political group, these are outside family activities.

1.3 Leisure Activity and Hobby, such as hobbies, recreations, entertainments, gardening, and home decorating, are important for everybody.

Decker, (1980: 49) stated to support that social activity was a core of life and it is essential for all ages. Activity is an importance for the elderly, therefore, the elderly who can maintain the social activity, he/she will be satisfactory for his/her life.

2. Disengagement Theory mentions to the decrement of participation in activities and social roles when the elderly enters the old age since he/she tries to escape the pressure and stress by withdrawing himself/herself from the society. This is a result of feeling of ability declining of the elderly. Decker, (1980: 44) expressed his opinion that this theory contradicts to the Activity Theory because Disengagement Theorist stated that it is a normal and unavoidable event for the elderly to decrease his/her activity, and he/she does not believe the most importance is to sustain the activity because it naturally decrease due to the adaptation of the changes according to aging process (Decker, 1980: 51).

3. Continuity Theory is proposed with the belief that the elderly will be happy and will participate to activities or not, it depends on his/her personality and pattern of life of individual. Such as the elderly who is fond to join the social activity, her/she will do as before entering to old age. For the one who does like to participate

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because he/she prefers solitude and has never play role in the society before so he/she will withdraw himself/herself from society when he/she get older.

4. Role Theory stated that when person enters to the old age, he/she must adapt himself/herself to different events such as leave out the prior role for instance omit social role and relationship in the adult age to accept social role and relationship in the old age, including pass over the sense of belonging about his/her spouse because of spouse's death.

## 2.5 Concepts about elderly caregivers

Caring for a patient was combined with nursing the elderly in the times of Florence Nightingale, with Nightingale defining caring as helping a life or helping to care for the physical and surrounding environments. Caring therefore also meant maintaining cleanliness, exposure to fresh air, providing nutritious food, enabling good sleep, and exercising, with the goal being good health (Leininger, 1988: 42). defined caring as taking care of dependant individuals through helping them with their individual needs, such as dressing, walking, nursing (e.g., medication), counseling, and even with shopping. The caregiver may live either in the same house or in a different place.

Leininger (1988: 54) defined caring as giving support or help to an individual or group according to needs, in order to develop and maintain quality of life and human worth, while Watson (1988: 42) stated that caring also takes into consideration the value and the pride of a person, which displays the relationship between the caregiver and the receiver. The care given would cover physical, emotional, social, and environmental needs.

There are different theories of elderly caregiving, depending on the opinions of each individual. Davis (1995: 39) stated that the elderly still are functioning members of society who can participate in various activities; care would usually be received from family members. If family is unable to help, then friends and neighbors would be next in line, followed by government agencies.

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Differences and similarities exist within the various theories depending on individual opinion, but in summary caring for the elderly means giving help or supporting the elders' needs, physically, emotionally, socially, and environmentally. From a study of past research documents, many academics have talked of elderly caregiving in many angles depending on the objective of the research – details are as follows:

A-Porn Sooksawad (1991: 38), gave the rules that the children should practice for elderly caregiving as follows:

1. Preparing food, should be suitable for situation of the elderly. If he/she loses his/her apatite, they should consult the medical doctor for improving.

2. Let the elderly work in accordance with his/her satisfaction, such as clean the house, gardening, repairing the things. These will make the elderly feels that he/she is a valuable person. Nevertheless he/she does not like to get any order from anyone to do work.

3. The elderly should be receive money to pay for minor things or for merit.

4. Let him/her to get proper entertainment, enjoyment, and fun. If the elderly enjoys reading, they should provide books, radio, television and other program of entertainments.

5. Take them to join the social programs such as viewing the shows, participating in the interesting discussion and visiting the interesting places.

6. The elderly who pays worship to religion. Their children should take him/her to the church or temple to join and to converse for religious teaching.

7. Let him/her a opportunity meet his/her friend so the elderly will not feel lonely or lacking of friend.

8. Children and grand children should perform themselves in order to make the elderly feel that he/she is a valuable person., and be paid respect from the family members.

9. Providing the hobby such as the elderly loves to domesticate the pet, they should provide the pet for him/her.

10. Maintain the safety in the house.

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11. The shelter of the elderly or room should be convenient and safe such as the floor is not slippery, and having enough light. In addition to, it should be at the ground level.

12. The elderly should properly have hair cut, nail cut, and beard shaven.

13. The elderly should properly be checked up for him/her health every six months and take care when he/she get sick.

Cicirelli, (1981: 26) stated that the necessary care for the elderly, should be gotten and be under the responsibility of their children as follows:

1. Help the elderly to do house work such as buying food, cleaning the house, and clothing.

2. Provide the appropriate shelter.

3. Repair the house ware such as repairing house, and painting the house for instance.

4. Give money or household care or personal care.

5. Caregiving for the elderly body such as hair cutting, nail cutting, bathing, and dressing.

6. Caregiving for the elderly health such as primary first aid, and minor health care.

7. Facilitating for the transportation such as take and drop them when they go outside.

8. Social activity and creation such as providing the house entertainment and take them to visit programs.

9. Supporting the mental, such as hearing the problem, and giving the morale with love and understanding.

10. Providing the appropriate work for the elderly.

11. Religious supporting such a taking them to church, and temple.

12. Let them receive the governmental information about the service sectors.

13. Providing the printing materials for reading.

14. Supporting the elderly to learn and train for the new career.

15. Supporting the elderly to have hobby.

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Brody, (1981 cited by Robinson, 1986: 44) proposed the need of the elderly that is necessary for family to care the elderly as follows:

1. House caring such as house work and personal care.
2. Helping when live together.
3. Assisting the budget such as giving money and assist for health care.
4. Need of health care expense exception.
5. Tax deduction.
6. Need for caring when they are sick and sad

Phillips and Rempusheski (1986: 27) proposed caregiving for the elderly into 4 types as follows:

1. Caregiving for living such as house cleaning, food caring, eating, drinking and smoking, and practice for religious activity.

2. Caregiving for development of life quality such as promote the elderly to be interested in self-care and practice activity , and the environment is included.

3. Caregiving on living together in the family such as pay attention to activity in the family, and perceive the elderly state.

4. Caregiving the relationship includes inside and outside family.

Bower (1987: 39) divided elderly care into 5 facets as follows:

1. Anticipating Caregiving is a care given by the children and grand children in the family. It is caregiving for parents for return their favor service performance as children. The children and grand children perceive according their social value that what the elderly should be received back and their intentions of caregiving. Caregiving may be in term of being a friend, closely staying, and opening mind conversation between the elderly and children.

2. Preventing Caregiving is a care for prevention the sickness, accident or complicated state and abnormality symptom such as asking about the abnormality, preparing the proper food for elderly, arrange the environment to safe for them, including arrange the house to be secured, orderly, and appropriate to the elderly.

3. Supervisory caregiving is a care in the facet of adjust the shelter to safe and secure, including giving money, buying personal care, and caregiving during sickness.

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4. Instrumental Caregiving is a care of doing, and aiding for maintain elderly physical function and health state such as the aid in daily activity performance, in the aspect of physical and living facets in community.

5. Protecting Caregiving is a care in the aspect of mind by paying respect to the elderly so he/she will feel that he/she is a valuable person.

Caffrey (1991: 48), studied the caregiving for the elderly in Thai society by studying in the Northern region. He concluded that caregiving for elderly can be divided into 3 periods as follows:

The primary period is the stage that the elderly is able to do daily activity very well so that caregiving will emphasize on socio-psychological aspect. The elderly decrease their roles in the economic activity, and then he/she will be consultant and participate as decision maker in the family activities so he/she will accepted as the peaceful umbrella of family.

The secondary period is the stage that the elderly get older, therefore caregiving will involve the food preparation, cleaning clothing, cleaning environment, rest place, sleeping place or helping in the daily life activities.

The thirdly period is the stage that therefore caregiving will involve taking to hospital, buying medicine from drug store, drug preparation, and personal health care such as taking a bath, clean the elderly body, and take care about rest, including the special caregiving for elderly in case of specific disease such as special food preparation, care giving for wound, giving the morale, and take to see the monk for merit water pouring.

## 2.6 Concept about caregiving for elderly

Yupapin Sirapo-ngam (1996: 86) gave the meaning of “caregiver” are the relatives or persons who gave their aids for the elderly. There were different words for consideration as follows:

- Relatives may be son, daughter, grand children, father, mother, brother, sister, cousin, uncle, aunt, friends, or important person in his/her life.

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- The elderly must be a person that his or her health state is change due to disease, disability, or degradation of his/her degradation of body, mind or emotion, which affects to the elderly has the restriction in daily life activity performance or causes the need of special medical care with the continuous response.
- Voluntary caregiver is the person provides the care and help without any expense or rewards. He/she give the aid at home or community but not in the hospital or any health care places.

Moreover, home caregiver can be separated according to the responsible level of caregiving as 2 levels as follows:

- Primary caregiver meant the person who is the principle caregiver that gives the direct and continuous care for the elderly.
- Secondary caregiver is a person who gives care for elderly by substituting for the primary caregiver when it is necessary for occasionally but he/she can not do continuously.

**General characteristics of caregiver**

From the research in foreign countries, It found that most of caregivers were female, middle age, single marital status or having children, housewife, or work outside house. To consider, who will be appropriate to caregiver in the house, it must be considered on different factors such as age, sex, marital status, occupation, or permanent work, education level and healthy of caregiver (Wimonrat Puwarawutpanich, 1994: 35; Yupapin Sirapo-ngam, 1996: 86).

- Age One who is older, one will have life experience more than others, and have information for make decision, face with problems, and skill, that one should give care better than the younger. However, the older also has the physical degradation so one will have lesser time to give care.
- Sex Female is nurtured to be the caregiver for the family so as to play this role as caregiver, she will adapt more easily. For male is nurtured to be the earner of family to look for income to support family so that he is more difficult to adapt himself than female.

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- Education Level The more educated person will be able to use the reasoning and mean to solve the problem better, including well searching the knowledge and sources of benefits.
- Marital Status The single marital status will have the lesser burden of herself than the marriage one. Moreover, the spouse who has good relationship will be a caregiver with lesser stress than one who has bad relationship with the spouse.
- Occupation or Permanent work One is business man often travel, one will be not proper to be caregiver so one who works nearby the elderly will be a better caregiver.
- Health of caregiver One who has poor health, anxiety, and pessimist, will be difficult to face to stress that the healthy one (Wimonrat Puwarawutpanich, 1995: 30).

## 2.7 Demand of elderly caregiving

**Caregiving needs of the elderly**

The responsibility of becoming a caregiver to the elderly comes from 3 main reasons, as follows (Yupapin Sirapo-ngam, 1996: 88):

1. Physical or functional impairment – This limitation can result in disease or impairment of various organs, which would affect activities of daily living or instrument activities of daily living. In addition, specific care for each disease – such as injecting insulin – becomes the responsibility of the caregiver in charge of the elderly person. Help with these physical limitations can usually be predicted or planned in advance.

2. Cognitive impairment – This is a deviation from normal behavior or situations, such as an elderly person having memory loss. Care for these problems usually cannot be predicted, so the family would be enveloped in a state of uncertainty due to the unpredictability of whether help is needed.

3. Emotional changes – Changes in the emotions or wants of elderly people usually happen all the time, depending on the elderly person's characteristics

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The various problems that occur with the elderly can also dictate the scope of a caregiver's responsibility as follows:

Direct care in daily personal activities due to physical impairments; emotional support; avoiding situations or words that may make the elderly people feel unwanted or unworthy; responsibility in general communications, such as organizing travel, household chores, financial duties, and various negotiations and communications. Nevertheless, many caregivers have positive feelings from caring for the elderly, as they feel good about taking care of other people. They also have positive feelings about caring for the elderly in the future and that their relationship deepens with time, as well as feeling rather capable and valuable as they are needed by another individual (Yupapin Sirapongam, 1996: 90).

## 2.8 Health state assessment

**Healthy state**

Orem (1985: 28) defined a healthy condition as a healthy state without any problems. A healthy person is someone who has full health and is able to suitably fulfill his responsibilities – a person with good strength and no symptoms of disease or pain, able to live his life in an environment according to his wishes. A healthy condition therefore consists of physical and emotional health, where the physical assessment of the elderly could be categorized into 4 main parts:

1. Physical assessment: Much of the assessment emphasizes the pathological level and the symptomatic level, such as any symptoms that are displayed

2. Functional ability assessment: This is an assessment of the necessary skills in taking care of physical and daily living needs without depending on others. The assessment is based on the ability to participate and do various activities. The developer has many tools to use in the assessment, including Barthel ADL Index; Katz Activity of Daily Living Scale; Euro QOL Questionnaire; and Lawton and Brody (1996: 34), with the functional assessment divided into the 2 following levels:

2.1 Physical ADL, such as eating, washing one's face, bathing, going to the bathroom, dressing, and household chores

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2.2 Instrumental ADL, such as going to market, using transportation, calculating monetary expenses, creating an expense account, and cooking

3. Psychological assessment: A psychological assessment is done to evaluate the psychology and mental processes of a person. The tools include:

3.1 Geriatric Depressions Scale (GDS) by Yesavage, Brink and Rose (1983: 44) and the Thai geriatric depression scale by Nipon Thepawan, et al., (1994: 46)

3.2 Tools to evaluate wit and mental quickness, such as the Chula psychological test and the Thai Mini Mental State Exam, which are not very widely used.

4. Social function assessment: An assessment of the person's economic standing, beliefs that affect daily living, social relationships, family type, and family relations.

Assessments of health consist of many tools that are used to evaluate the various angles of physical, psychological, and social states.

## 2.9 Theories of health promotion for the elderly

Pender (1987: 57-69) proposed a health promotion model, which emphasized the importance of mental processes and inner behavioral control. Involved factors were organized into knowledge and reception factors, supporting factors, and variables which affected the trend of individuals to participate in health-promotion behaviors.

For assessing health promotion behaviors, Pender (1982 cited by Walker, Sechrist & Pender 1987: 76) stated that health-protecting behaviors shows the ability of an individual in protecting or decreasing chances of illness, while health promoting behaviors show the ability of an individual to maintain or elevate his health level for personal well-being. These can be assessed or considered from the health-protecting lifestyles plan. Therefore, Pender (1987, 1996) developed a tool to help in the assessment of health promoting behaviors, where he defined lifestyle plans as supportive behaviors that prevent disease and promote health, resulting in good lifestyles. Health protection behavior helps to maintain and decrease the chance of

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disease or illness, whereas health promotion behavior helps to maintain or increase the level of happiness, success, and fulfillment of a person's desires if an individual is aware of his own potential in health promotion. Christine (1991: 42) defined a lifestyle plan that promotes health as a behavioral group that includes health protection and promotion behavior together.

Walker, Sechist, and Pender (1987: 74) defined a lifestyle that promotes health as multi-dimensional behavior and perception of an individual, to maintain or promote value and full health in life. They also divided the lifestyle plan into 6 health promoting parts:

**1. Self actualization**

Self actualization is the topmost tier on a person's hierarchy of needs. This need is triggered when all the needs on the levels below it have been fulfilled satisfactorily. Self actualization is a desire for everything suitable for a person who has achieved that level of success. A person would put his energy into challenging his abilities and reaching his full potential, with the desire to improve himself. If the person is able to reach set goals, that person has achieved true success (Maslow, 1954: 42). Self actualization shows the very last goal of individual development and growth in the physical, psychological, mental, and conscience factors (Atkinson & Murry, 1992: 48). The older an individual is, the better he can fulfill his needs at this level. Individuals can achieve self actualization through various behaviors: being optimistic, having pride in oneself, being enthusiastic and taking care of every part of one's life, being creative, establishing life goals, and trying to meet those goals (Walker, Sechist & Pender, 1987: 39).

**2. Health responsibility**

Usually, every person has his own health responsibility, as everyone tries to maintain or get good health through appropriate behavior (Bedworth & Bedworth, 1982: 37). When a person becomes elderly, physical, emotional, psychological, and social changes occur. Changes in every system in the body are normally in the form of deterioration rather than growth (Patrick, Wood, Rokosky & Pruno, 1991:46), which

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affects the elder's health and creates health problems. Therefore, elderly people need to pay extra attention to health problems that result from various changes in the body, with careful attention to health. They should also receive nursing care both in times of normalcy and in times of illness from social agencies such as clinics, hospitals, and health insurance companies. This can be considered a part of the individual's health responsibility (Edlin & Golanty, 1985: 35). They also need to search for health information from various health care centers in order to follow the suggestions to have better health (Bedworth & Bedworth, 1982: 31).

Edlin & Golanty (1985: 45) stated that health protection behavior is the responsibility of the individual, in order to avoid disease, have good health, and live a long life. These activities include sleeping for 7-8 hours each night; eating breakfast; not snacking; controlling weight; avoiding alcohol; not smoking; exercising regularly; and being aware of the individual's state of health. The individual can adapt the various health information received from health care centers to his own lifestyle, as well.

**3. Exercise**

Exercising is an important health promotion activity. Numerous researches found that exercise is beneficial to the heart and blood vessels; increases longevity; and creates overall better health. Regular and sufficient exercise helps decrease illness, cardiovascular disease, diabetes, and osteoporosis (Friedman, 1992: 44), as well as makes the body strong. Exercise also has emotional benefits, resulting in good mood, improving an individual's self-image and even helps decrease stress. It also improves a person's nutritional habits and helps control weight, which decreases heart rate and the level of cholesterol in the blood (Ardell, 1970: 38; Forbes, 1992: 49). Exercising is necessary for the elderly. Exercise should be engaged in regularly and according to the daily lifestyle plan in order to help the elderly achieve better health. Exercise for the elderly should be light aerobic exercise such as fast walking, bicycling, and playing sports that don't require exerting a lot of energy or strength such as table tennis, swimming, and badminton (Jarutwan Thienprapas, 1993: 31). Walking is the best and safest form of exercise for the elderly. In the beginning, the elderly should partake in light or easy exercise first; strenuous exercising may be very

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dangerous. The intensity of the exercise should slowly be increased, as they adapt and become familiar to the routine. May (1990: 39) stated that exercise for the elderly must be safe and done according to their ability so that they receive no harm, with the exercises designed to help increase muscle strength and flexibility. This is to increase the durability of the muscles and various organs to work better. Exercise should start slowly, with a warm-up and cool-down session, with slight increases in pace during the workout. It should be done regularly, taking at least 20-30 minutes a day. The elderly person's heart beat should be at 70-85% of the highest heart rate (the highest heart rate equals 220 minus age in years) (Chusak Wechapat, 1995: 41).

Some precautions to exercise include are that person should not exercise until he feels dizzy, faint, becomes out of breath, or achieves a heart rate higher than 120 – 130 times/minute. In addition, the elderly should not exercise when they are ill, right after they recuperate from an illness, or after they have eaten. They should also avoid exercising in hot, arid weather. Duangduen Pantuyothee (1996: 42) studied the relationship among the importance of health, receiving information about the benefits of exercise, and exercising behavior of elderly people in the provincial areas of Chiang Mai. An assessment was done on exercising behavior from the amount of energy used in doing various activities during the week. It was found that the elderly had low levels of exercise, and no relationship was found for the importance of health, receiving information about the benefits of exercise, and exercising behavior. This reflects that the elderly exercise less. Therefore, extra attention should be given to encouraging elderly people to regularly and appropriately exercise.

Besides exercise, elderly people should engage in relaxing activities such as teaching gardening/cooking, reading, listening to the radio, watching television, and resting in areas such as parks and beaches. These activities help decrease stress and thus results in good emotional health.

**4. Nutrition**

Nutrition is another aspect of healthcare for an individual. Everyone eats to stay alive, and the food consumed also affects a person's state of health, especially for the elderly. The reason is that elderly people experience changes in their digestive systems, which creates nutritional problems. That is, it becomes more difficult for

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them to chew and swallow food because of dental problems and decreased capability of the saliva gland. Hunger also decreases because there are decreases in taste and smell reception. It was also found that gastrointestinal activity decreases, such as decreased absorption of food and contraction of the intestines, which results in difficult, slow digestion (Wilaiwan Thongchareon, 1993: 45). An unsuitable nutritional lifestyle may manifest itself through bloated feelings, discomfort, and digestive problems for the elderly. Chlosri Daengpiam and Charinrat Putthapuan (1993: 39) studied the elderly in Tambol Umong in Lampoon province, where it was found that the elderly had digestive problems with the most common being decreased ability to eat, bloated feelings, and difficulty in chewing.

The elderly need to have appropriate nutritional lifestyles and receive nutritious food with meat, milk, eggs, vegetables, fruit, and minerals present, and decreasing intakes of flour, sugar, and fat because of the elders' decreased activities and need of energy. This is because the organs decrease activity and the metabolism of the elderly also decreases 2% every 10 years (Venus Tantibul, 1993: 37). People aged 60-69 years should have a 10% decrease in energy, while people aged 70 years or older should decrease by 20% (Walai Intrampan, 1987: 28). Nevertheless, the elderly should not consume less than 1,200 calories each day, since it would prevent sufficient intake of nutrients (Uruwan Walaipatchara, Kraisith Tantisirint, and Kalya Kijboonchoo, 1991: 24). The food of the elderly should be soft, easily chewed, with colors, smells, and tastes that help encourage consumption. The quantity of food at each meal should be decreased but the meals should be more frequent, about 4-5 meals each day with a late-morning meal and a late-afternoon meal. Lunch should be the main meal of the day to lessen any problems with stomach discomfort after meals. In general, the elderly should intake the following nutrients:

4.1 Protein should make up 12-15% of the energy each day. The protein should be rich with amino acids, such as in meat, fish, eggs, and milk (Niya Soari, 1992: 28).

4.2 Carbohydrates should make up 50-60% of energy each day. It should be in the form of flour, taro, and potatoes. The elderly should avoid foods high in sugar such as dessert and canned fruit, as the elderly get obese easily.

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4.3 Fat should be no more than 30% of the total energy each day. The energy should be fat from plants that have linoleic acid, which helps in flushing cholesterol and triglyceride from the body. The elderly should avoid animal organs, brains, and duck and chicken skins, as these have high cholesterol (Niya Soari, 1992: 34; Pender, 1996: 46).

4.4 Minerals and vitamins. Usually adults need 800 milligrams of calcium a day, while the elderly need 1,000-1,500 milligrams a day because of the deterioration of the bones from decreased movement and exercise (Chulaporn Rungpisuthpong, 1988: 24). However, a nutritional research found that Thai people consume only 301 milligrams of calcium each day (Thai RDA, 1989). The elderly should also consume 10 milligrams of iron each day and should eat a lot of fruits and vegetables, which are a large source of vitamins. The consumption of vitamins, especially vitamin E and C, help decrease free radicals and the rate of physical deterioration (Maddox, 1995: 49).

4.5 Water. Elderly people have a decreased thirst, as the water content in their bodies decrease (Bell, 1997: 51). Changes in the urinary system results in frequent urination and decreased control of the bladder, which results in less frequent drinking and makes the elderly dehydrated and tired (Wilaiwan Thongchareon, 1993: 36). Therefore, the elderly who do not have any limitations to water intake should consume at least 30cc per 1 kilogram, or 6-8 glasses a day (Bell, 1997:45).

In summary, the elderly should consume nutritious food appropriate to the person and their economic status, with supplements for areas they lack and a decrease in foods they consume too much of.

**5. Interpersonal support**

From psychological social research, it was found that the elderly have social needs as much as any individual, but because of various physical, emotional, psychological, and social changes that decrease their ability to work and function well, elderly people feel they have less value and become depressed, separate from society, and take less care of themselves. This creates changes in their way of life and results in health problems. In addition, changes to society and the family structure have created distant relationships between the elderly and other members of the family,

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creating feelings of loneliness for the elderly. Some of them may feel that they are all alone in the world. Ryan & Patterson (1987 cited by Supanee Nantachai, 1991: 37) stated that these feelings of loneliness come from a lack of meaningful relationships with others.

It makes that person feels self-invaluable. No one loves and cares about him/her. So he/she wish to leave from society. Kerksak Boonyanupong and Somsak Chantha, (1990: 35), found that the family that has a good relationship among children, grand children, and the elderly is an important factor to make the elderly has a good health because family and relationships among members in the family are the sources of social support that pays very important role to person. It is a natural support system that transfers the value, belief, and behavior about health, and pattern of living (Lindberg, Hunter,& Kruszewski,1990: 42).

Moreover, the elderly who has a good relationship with the neighbor and people in the society, particularly, friend with the similar age, it will be very beneficial for the elderly. He/she has a conversation with close friend, he/she can release his/her secret to each other so this make them happy. It affects to make him/her have a good mental health. Therefore, to maintain the good relationship between the elderly and people around him/her help the elderly with changes of body, mind, emotion and society is able to live with happiness. The people around him/her will make him/her to realize the value of having good health so the elderly will try to improve the health habit and improper pattern of life in order to have a better health and living longer (Beckman & Breslow, 1983 cited by Walker, Volkan ,Sechriht, & Pender, 1988: 56).

**6. Stress management**

Stress can be happened in the daily life of the elderly. The occurred stress will affect to the health state of the elderly, therefore the elderly needs to search the mean to control or manage the stress in order to maintain the good mental health. Pender, (1966: 62) proposed the way to control and manage the stress, and it covered three groups of the belief and concepts of stress as follows:

6.1 Decreasing the frequency of stimulant that stimulates the person to have the stress such as change of environmental situation, avoiding of the vigorous change in the life, set the time, and manage the time.

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6.2 Increasing the resistance to stress such as exercise, added valued for oneself, promoting self-efficiency, increasing self-confident, develop the replaced goal to reach the achievement, and coping resources.

6.3 Building the resistant situation for physical stimulant such as use the relaxation technique for body, and decrease the stress.

## 2.10 Concepts of social support

Concepts about the social support has been broadly known in 1970 (Norbeck 1981: 85). It was interesting in the different branches of social science, particularly, the behavioral science in the health issue. The social support played an important role for promotion of living, and it causes person to properly adapt himself/herself for the passed event in his/her life since living in the society of human has an attribute of social network that need to depend on each other. The social members trust and help each other, and share their experiences. This makes people to feel more secure and acceptance from people in the society, and makes people to happily live and more meaningful (Jariyawat Kompayup, 1988: 96).

Living together of people in the society, lead to the aid of each other, and communicate among people in the society, such as during sickness they will help each other, and search the way to cure from sickness. Even though, they give suggestion, and morale. These activities will occur every ways. The relationships among social members are the relationship system in social approach by starting from a small group in the society, and then it expands to be network in the society. Therefore living together as groups in the society, it begins at the family, community, and become big society that has the network characteristics to help in every facets in order to survive and live with happiness. This attribute is counted as social support Pimpawan Preedasawat, 1990: 160). Therefore, social support is an action or a process of human being that naturally occurring of living together of every people in every societies.

**Social support theory**

The concepts about social support theory have 3 concepts as follows:

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1. The concept about social support with main or direct effect to health (Main or Direct affect Models).

2. The concept about social support that is a buffer or absorbency to prevent the health problem (Stress- Buffering Models).

3. The concept about social support that emphasizes the relevance of demand to receive the support and provide environment for support (Person- Environment Fit Model).

**Level of social support**

Level of Social Support of the elderly can be divided into 3 levels as follows:

1. Micro Level: It is considering on the relationship of person level that has closed relationship such as husband and wife or relationship among members in the family that they are closed emotions to express their loves, and concern. This is an affective support with the belief that Quality of relationship is more important than quantity.

2. Maze Level: It is considering on the relationship in the level of social networking group that the relationship regular occur among group of people such as friend group of the elderly. This type of social support will be in form of giving, friendship, giving advice, aid for materials, and respects.

3. Macro Level: It is considering on the participation in society in the broad level that is the relationship among institutes in the societies such as general participation to different groups with willing and voluntary mind and informal living in the society such as participating to elderly club for instance.

It is obviously seen that in a society, everyone in the society has a chance to be a source of social support but in the real situation. That person will have only people in the same system or network of that society. The sources of social support can be divided into 7 sources That are his/her spouse, relatives, friend, neighbor, boss, s coworkers. Moreover, the sources of social support can be divided into two main groups as follows:

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Primary groups are small groups that members interact by informal face to face communication with close bonding in form of personal relationship such as the relationship within the family, among relatives, and group of friends. Primary group is a source of emotional support and accept people as a part of group with the friendship with sharing sadness and happiness together, and exchanging the interesting things among them.

Secondary groups are the big group or small group by they join together in order to do some work according to objective. The relationship is a formal approach according to the role in the work of that person without the personalization such as relationship within the friend in the same career, the same association, or clubs (Caplan, 1984: 4).

**Social support is divided into two types as follows:**

1. Social - Emotional Aid is a response for demand in the emotion in the aspects of love, intimation, trust, care, respect, perceive value, help to feel secure, and be a part of society.

2. Instrumental Aid is an assistance regarding the information giving, suggestions, and materials as follows:

- Instrumental Support is an aid in the aspect of material support, services, including Financial Aid.
- Information Support is an aid in the aspect of information support, suggestions, facts, selecting the method for practice in order to help the person to be able to use for solving the problem in work and personal issue that they are facing.

## 2.11 Related literatures

Nisa Chooto (1982: 4) studied the topic “Thai Elderly”. The finding showed that the family has an important role in the life of the elderly. Most of the elderly, ninety percents lived with their spouse or their children’ family because most of them lived with their children, or their spouse, or relatives. This makes the elderly receive the aid in their daily life, and they played roles as consultants of the family.

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Prapimdao Sukhon (1983: 1-2) studied on the mental health of The elderly, and it was a case study of Paengpatanma Community, Yannawa District, Bangkok. The finding revealed that most of the elderly need the children and grand children to take care but their children and grand children did not have enough time for the elderly because they must go out to work. The status of the elderly, 71.87 percents were in the good level. The family still loved and respected them in the status of an important person in the family.

Division of Aid Welfare, Department of Aid People (1985: 2) surveyed the need of the elderly in Din Daeng Community. It found that Most of the elderly lived with their children. The children would manage the house expense and gave the money to the elderly. The elderly had duty to look after house and grand children. Most of them had no occupation. Few of them were merchants. Even though, their children were poor but they had taken care for their parents very well. The problem that was a conflict between the elderly and family was the health and economic problem.

Thong-U Kaew Sai Ha, et al., (1985) studied on The elderly in Thai Society. The finding showed that the elderly in Bangkok were anxious about income, health, worried about their children and grand children. The satisfaction of the elderly was to live with their family. The elderly wanted to aid their children and grand children do activities. When they stayed with family, the following problem was their opinions were not relevant to their children and grand children. Their self-proud were from their economic security and they received the respects from their children and grand children.

Edwards and Klemmack (1973) studied the life satisfaction of the people who had 45 years up. The finding revealed that the factors that correlated to life satisfaction were family income, education, time used for social activity, time used for religious activity, time used for conservation with friends.

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Harris and Cole (1980) stated that the elderly wanted the caregiving from the family. If the elderly lacked of caregiving or lacked of good relationship within the family, they would have low life satisfaction. Therefore the good relationship in the family meant the action of family members did to the elderly, and the action of elderly did to family members.

Pramote Wang Sa-Ard (1987: 97) studied on factors relating to the mental health of the elderly in the town municipal area of Kalasin Province. The finding revealed that the relationship in the family was a powerful factor to predict or the most important factor associated to the mental health of the elderly. The elderly who lived in the good relationship family, he/she would have a good mental health as well.

Suthera Nuichan (1987: 84-86) studied the role of family in caregiving for the elderly, particularly. In the case study of the family that receive the social service of Din Daeng Elderly and family of member of elderly club of Monk Hospital. It found that the relation in the family was in the positive direction. That was the children, and grand children still looked after the elderly in the physical, social, emotional, and mental aspects and they pay the respect to the elderly at moderate to high level.

Peerasit Kamnuansilp, et al., (1990: 153) found that the elderly who lived in the expanded family were more happy than the nuclear family because the expanded family would have person that gave the important social support more caregiving for the elderly both body and mind. The chance to promote the proper behavior of more caregiving for the elderly to have a good health so that the elderly who lived in thev expanded family had a better behavior of self-care thast the one who lived in the nuclear family.

Kerksak Boonyanupong, Suree Kanjanpong, andSomsak Chantha,( 1991: 461) studied on the relationship between the elderly and children and grand children by emphasizing on the relation that pointed to the status as family umbrella of the elderly in form of respect, obey, asking for advice in case of problem or activity of children and grand children. The study was done by let the elderly assess self-status in

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different issues. Therefore, the answers received were the answer get from the assessment of the relationship between children and grand children and the elderly in the various relationships. It appeared that the elderly felt that children and grand children still paid the respect, and obey to him/her. They had important roles as trainer, teacher, advisor, and decision making in different case occurred in the household. Furthermore, the activities were done by the family members, most of the elderly acted as advisor to give suggestions or opinion in various activities. This rate was still high in the household in the urban area, rural area.

Munthana Charoenkusol (1991: 47) studied the family roles about caregiving for elderly in and out side the municipality area: A case study for Pranakorn SriAythaya District revealed that the followings:

1. Attribute of family relationship between family members and the elderly both in and out side the municipality with good direction that are assistance, pay attention together, most of them harmony opinion, love each other with good emotion, have dinner other, have the interaction, have daily exchange opinion and experiences. Even though, they have some conflicts but most of their children still pay expect to the elderly and accept the elderly ‘s advice when they have different problems.
2. Role of the family in caregiving for elderly, the finding revealed that most of the member family both elderly in and out side the municipality area have role to take care physical, emotional, mental, and social aspects. The family members in municipality area will give care to the elderly on physical and mental aspect lesser than outside municipality area but outside municipality area will provide care for elderly in social aspect more than inside municipality area. In the economic aspects, they will give care to the elderly both inside and outside municipality area few.

Jarunan Somboonsit (1992) Studied the association between the demographic factors and daily life activities and life satisfaction of the elderly. The finding revealed that the life satisfaction correlated to the daily life activities in the positive direction (r=0.57). The activities that correlated to the life satisfaction of the elderly were the activity that did by themselves alone that they did alone and did not join with the other persons such as cleaning house. The activities that joined with other persons such as

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visiting their children, and doing activity with others, these made them had life satisfaction. Moreover, the living attribute such as living their spouses, children, and grand children, having good relations among them, and good income had the association to life satisfaction.

Tussanee Kerkkulthorn, (1993: 84) studied on : Social Support and Self-Adaptation of the elderly in the municipality area of Saraburi Province" The finding revealed that the elderly in the extended family had opportunity to get caregiving both physical and mental aspect from family members who may be their spouses, children, and relatives more than the one who lived with the nuclear family.

Sasipat Yodpecth, el al., (1993: 37) studied on "The Competency of Supporting Factors in Social Aspect toward Service Provide for Elderly" was undertaken by using Focus Group Discussion. The finding revealed that the one of the most important of social support was family support, family caregiving, and aid the elderly both physical and mental aspect, particularly, the elderly received caregiving from their spouses, and needed their spouse aid as "Supporter". The aid would in terms of caregiving food, cloth cleaning, hose cleaning, and taking them to hospital, including aid the family about earning such as feed herd, farming, gardening, and handicraft. Considering to their children, if female and living in the family, they would take part in care on house work, as mentioned above in accordance with the earning activities. If male would aid on the earning, buying clothes, taking to hospital, health station, or clinic in the town, and giving money to them for necessary expense, including sharing the good quality food to them. For the caregiving, and house work responsibility would be in charge of daughter in law or grand children who lived in the same family.

Sukunya Rampuengkij, (1994) researched about the relationships between personal factors, activity performance, and health state of the elderly in the nakornsawan Province. There were 318n elderly persons. The finding found that the activity performance interacted with society, and activity concern to mind, intelligence positively correlated to mental health state.

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Pornpoj Kingkaew, (1995: 9), studied on " Family Components that affected to the mental health of the elderly, Changpuek Subdistric, Muang District, Chiangmai Province". The finding revealed that the elderly who had good relations ships within the families with good relationship would have the better mental health state than the one that had poor relationship.

Puangpaka Chuensaengnetra (1995: 116) studied on "the association between the relationship within family, self-care behavior, and life satisfaction of the elderly". The finding revealed that the relationship within the family was an essential factors to the best predict for satisfaction of the elderly.

Sujitra Nillert (1996) studied the correlation between their children support and life quality of the elderly in the rural area of Supanburi Province. The finding showed that the receiving their children support positively correlated to their like quality rather high (0.627), and the receiving their children support was able to predict the life quality of the elderly 45.1 percents.

Patraporn Pairao (1997: 110-111), studied about "The Correlation between the selecting factors and self-care of the elderly in Nakhon Pathom Province". The finding illustrated that the elderly who lived with the extended family had more opportunity in acidental prevention than the elderly with the nuclear family.

Chonlada Pukdeeprapin (1998: 104) studied on "The Association between Personal Factors, family factors and the response received from Family according to the basic needs of the elderly in the city area of Bangkok Metropolis. The finding showed that the elderly who had the children more than 7 persons, and the elderly with 4-6 persons, most of them received the most response for the basic needs from their families. The elderly who had children 1-3 persons would received the moderate response for the basic needs from their families, and the one who had no child would received the low levels.

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Malinee Wongsithi, et al., (1997: 16-22), studied on the project of "Participation Project of Community of services giving and different activities about the elderly: primary data, of Community and the elderly of Mae Sa District, Mae Rim District, Chiangmai Province ." The finding revealed that the health, economic, and lack of caregiver, or children and grand children problem, the community leaders expressed their opinions that the elderly needed the main aid that are the sickness and medical care. The community leader expressed that the community provided some aided to the community elderly. In case of no aid given for the elderly, it resulted from the community members received no aids because they must earning or lack of the budgets.

The development of Pubic Health Plan during the during the Eighth National Social and Economic Plan (B.E. 2540-2544) mentioned that health promotion for the elderly had the following objectives: (Administrative Committee for Plan of health development, 1996: 18).

1. To make the elderly have the good health, and be able to take care themselves.

2. To promote the family members and community members to participate in caregiving and health promotion of the elderly.

3. To promote the elderly to have an opportunity to express their competencies to promote their health and family and community health with the main activity of health promotion for elderly group with 9 issues as follows:

3.1 Develop the service quality with health promotion, surveillance, and prevention for the elderly.

3.2 Disseminate the knowledge for the elderly to have the right health behavior, and be able to have a self-care.

3.3 Develop the personnel in every level about the health promotion.

3.4 Develop and promote to utilize the technology to take care for the elderly population in order to promote health.

3.5 Promote the education, and research to search for the appropriate pattern for implementation about the elderly, including promoting, preventing, surveillance, and evaluation.

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3.6 Cooperate with the related work sectors, included the governmental sector and private sector about the caregiving for the elderly.

3.7 Support the family and community to participate in caregiving and accepted that the elderly was a part of society.

3.8 Support about to be grouped of the elderly in the communities of the whole country by cooperating as network for facilitating the elderly to exchange their experiences and knowledge on the development of the life quality.

3.9 Develop the information technological system and management with facilitating for health promotion according to the target group on health promotion, control, and prevention that disease. The Ministry of Public Health had defined the goal that made the elderly having the required good health with 10 percents increased.

**Factor affecting toward caregiving the elderly**

**The elderly aspect**

- **Age**

The elderly in the group with age more than 70 years old will face with the problem of daily living activities by themselves were the highest proportion. It may be the age was related to the sickness. The more they get old the high change to sick (Sutthichai Jitapunkul & Srijitra Bunag ,1997 :49). This affected to the ability level of doing daily living activities, having problems of self-aid. The problems are found when they get older were walk or movement such as walking around the house, and getting on the car. Moreover, the change of disability or sickness laid on the bed is increasing (Sirawan Siraboon, 1996: 25), therefore the needs for caregiving has been increased when they get older. The characteristics od caregiving will be different according to the period of age.

- **Sex**

The results of the study illustrated that the female elderly will have longer life span than male but the but the healthy life expectancy will be shorter than the male, and the change to sick is higher than the male. It can be said the female elderly will

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face with problem in daily living more than the male. Therefore, the female needs more caregiving than male (Malinee Wongsithi, 1998: 41-42). The Thai society defined the male to be family leaders to have the authority to make decisions and received the respect from the family and society, while the female has the duty to look after people in the family. The finding revealed that most of the elderly who received from the spouse, and children was male. Therefore, it should be different of caregiving between female and male elderly.

**Family characteristics**

Thai society perceived that the family is an institute to act in the elderly caregiving, particularly, children, grand children in the family is an economic support and give the motivation for the elderly, including the aid providing for the elderly up to their self-aid ability. The study of Peerasit Kannuansilp, et al., (1990: 39). Revealed that the old age who lived with the extended family will be more happily than the nuclear family. But in the study of Patraporn Patrao (1997: 41) found that the elderly lived with the extended family will have more opportunity to participate in the social activities and preventive behavior than the nuclear family. The elderly lived with the extended family will have more happily, and more opportunity to participate in the social activities. It might due to the elderly lived with the extended family will have more family members to take care for both physical and mental aspects more than nuclear family. For the single elderly who has no spouse or children or grand children, they will have lower life quality than the elderly who live with the family and their spouses.

For the number of children or family members for the elderly caregiving, will be appear of the phenomenon called "Bystander effect" that stated that the more people, the lesser aid will be decreased (Yupapin Sira Po-Ngam, 1996: 36 )

Attribute of Living of the elderly and caregiver, in case of living in the same household, the elderly should receive more caregiving than from the one who does not live in same household because elderly living in the same household with caregiver should receive more caregiving than one who does not live in same household. Therefore, the researcher must study to the attribute of shelter, and living toward the caregiving for the elderly

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**Health state**

The elderly has ability to do the daily living activity will have better health and be more life satisfaction. The elderly who is healthy and has ability to do daily life activity, the finding revealed that the elderly who lives with the big family comprised of numerous members, this makes the elderly receive the caregiving from family so they should make the elderly healthy (Wapawan Cha-Um, 1994: 39). From the study of Sujitra Nillert (1996: 32), the finding revealed that the good health associated to caregiving for the elderly. The elderly who is healthy, it is probably that the elderly get caregiving from the family very well. On the other hand, the elderly who has poor health will do the fewer daily living activities. They should receive more caregiving but they receive few caregiving or they receive no caregiving.

**Marital status**

The marital status of the elderly is a factor that affects to the satisfaction of marriage life of the elderly since they have the spouses to be a good companion, true friend, and do not feel lonely. Moreover, their spouses will be caregiver, assistant, consultant, by make calm, and give the motivation in order to make them feel more secure, and happily (Supchaya Chunsanit, 1996: 14).

For the elderly who is marital status, the health of spouse is very interesting because the spouse will be an assistant. If their spouse have a poor health, they become a burden for the elderly (Malinee Wongsithi & Siriwan Siriboon, 1998: 34).

The marital status associates to life quality in the material and mental aspects. The elderly with marital status, 57.2 percents of them have the life quality at higher level than the elderly with singular marital status such as single, widow, divorce, (Umaporn Udomsapayakul, 1993: 67). The spouse will be assistant to motivate their spouse to take care himself/herself so this makes the elderly has the mental health that affects to make them to be able to take care themselves (Wipawan Cha-Um, 1993: 53).

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**Factor of caregiver for the elderly**

**- Age**

The age of elderly caregiver is a factor that involves the caregiving for the elderly because the age of caregiver will tell abut the readiness and strength. Therefore the age of caregiver has relationship with the behavior of caregiving. The eldest child often function as caregiver for the elderly in the house (Upapin Sirapothi-Ngam, 1996: 36).

The caregiver who is the adult age will face with time limited, is the highest proportion since it might be the adult age is the age with various social activities. The adults who have the burden to take care the elderly so they can not do in the thing that they wish to do or decreasingly do. The caregiver who is in the middle age will face with the money problems, tiredness, mental problem, feel not free because this age must work and has different status so it causes the stress, and tried. The caregiver who is in the old age often has problems both physical and mental aspects because they also need to receive the caregiving from the others.

- **Sex**

Sex of caregiver is a factor that relates to the capability of the elderly caregiver. Therefore, the different sex may have belief, attitude, and value. That is the female caregiver often is nurtured to take care house, and help to look after the members in the house such as small child or the elderly for instance while the male often nurtured to be earner to search income to support family (Wamolrat Puwarawutpanich, 1996: 23). Therefore, taking the role as female caregiver is able to develop, perceive and perceive the lesser burden of caregiving than male. From variety of the previous studies, the finding revealed the relationship between sex and caregiving burden, Therefore it should be difference of caregiving between male and female (Montgomery,1989: 212).

**- Education**

The education level of caregiver is an importance toward the development of knowledge, skill, and positive attitude about health care (Orem, 1985: 231-232). These are the fundaments of personal caregiving by using knowledge in caregiving for the needed person. In addition, it is used for considering, thinking, making decision

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and using as guideline to perform for caregiving for person who needs for care. The person who has the low education level often face with the problem of understanding or perceiving the cause of disease, plan of treatment, and mean of performance for caregiving. The one who has high education level will be able to correctly assess the situation to be pertinent to the fact, has the skill in searching knowledge, and understanding the plan of treatment, including, know to use the sources of benefit better than the one who has low education (Muhlenkamp & Sayles,1986: 336). The study of Bulger, et al.,(1993: 48) indicated that the education negatively correlates to the burden of caregiving. Therefore, the education level should correlate to the burden of caregiving foe elderly.

**- Occupation**

Occupation of caregiver is a variable that affects to toward the caregiving for the elderly. The study of Siriwan Siriboon, (1998: 18) revealed that the work or occupation affects to the time for caregiving performance for the elderly. The caregiver who is the important person for nurturing the household members will face with money problem, health problem, the emotional stress, and mental problem. In addition, they feel the limitation of time with rather high proportion when compares with the one who has no work, while the one who has no work feels he/she lacks of independence to go any place with the rather high proportion. It may be the one who has no work will be often defined as caregiver for the elderly alone so this makes them lack of independence.

**- Income**

Income of caregiver is a factor affects to caregiving for elderly so the different income of caregiver affects to cause the different caregiving for the elderly. The high income caregiver repotted that it was his/her duty to give the care for the elderly since most of the caregiver lived in the town perceived that caregiving was a duty with the proportion higher than the rural area. Moreover, the caregiver with high income has more economic and money readiness than the other group. The caregiver who is the earner of the family and has the secure economic status will accept the caregiving for the elderly is his/her duty. The caregiver has low income will face the money problem, feel tried, and stress in the emotional aspect with the rather high

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level. Since the expense of caregiving for the elderly, is a rather heavy burden for the one who has low income (Sutthichai Jitapunkul, 1999: 48). Besides, the low income might make the caregiver has no opportunity to hire the other person to decrease the burden of house work, and caregiving for the elderly so this makes the caregiver to take the burden with different aspect, therefore they feel tried, and have stress in the mental aspect. This might affect the quality of caregiving, therefore the caregiver with the high income should give care for the elderly better than the lower one.

- **Marital status**

The marital status of caregiver is a factor that affect to caregiving for the elderly. The study of Viriya Sumpathanukul (1999: 23) revealed that the marital status of caregiver. If there is a opportunity to select the caregiver, most of people will select the person with the single to be a caregiver since it has a lesser conflict in the role than the one who get marry. When considering, the marriage status, it found that the male who married will have different problems with the proportion closely to the female. The exception, the mental aspect and emotional stress, it revealed that the female caregiver faces with the mind strain and stress for the elderly caregiving more than male since the female caregiver is in the middle age and female in this age will have different statuses and roles such as mother, wife, housewife, working woman, and caregiver. The diverse statuses and role cause the conflict and make woman in the middle age to take responsible do she must face with the problem of stress and mind in the rather high level (Angelique Chan,1997: 42). This will affect the caregiving for the elderly that they need more care from the increment of sickness, and get older.

Therefore, this research will study the pattern of caregiving for the elderly by the family in the rural community of Suratthani Province, and study the situation of caregiving for elderly, besides their families for instance by village health volunteers, public health station in the community, community hospitals, elderly club, and non-governmental organization (NGO) in rural community of Suratthani Province in order to develop the pattern of caregiving for the elderly by the family in the rural community of Suratthani Province.

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# CHAPTER 3
# RESEARCH METHODOLOGY

This research was performed in a mix-methodology by using the quantitative method through survey research and the qualitative method by applying the technique of an in-depth interview. The research methodology in details is as followed.

## 3.1 Quantitative research

### 3.1.1 Research design

In this part of this research uses a survey research.

### 3.1.2 Population and Sample

Population in this study are elders whom have age over 60 both male and female and live in the rural area in Suratthani Province

Sample Size Determination Suratthani Province has elder citizens reside in rural area equal to 63,480 people Calculate with Taro Yamane's formula (1973: 725) with known population from the formula

$$n = N/1+N(e^2)$$

Where:

n = Number of sample group

N = Total Population

e = Error at 0.05

When compute in the formula, the result of the sample size is 397 people

Multi-stage sampling method was used to get the sample for this study as the following stages:

Stage 1. Classified 18 amphurs and 1 sub-amphur in Suratthani Province with geographical data into 5 groups and select 1 amphur from each group which are

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Amphur Baan Nasarn was randomly selected from group 1

Amphur Karnchanaditr was randomly selected from group 2

Amphur Poon Pin was randomly selected from group 3

Amphur Baan Than Khun was randomly selected from group 4

Amphur Tha Chang was randomly selected from group 5

Stage 2. Randomly selected 1 Tambol from each Amphur to get 5 Tambols

Stage 3. Randomly selected 2 Moo Baan from each Tambol to get 10 Moo Baan

Stage 4. In each randomly selected Moo Baan, researcher explores all of the elder name list in the Moo Baan and randomly selected based on the list of house numbers.

**3.1.3 Research instruments**

Instruments use in collecting the data consisted of 2 parts which are:

Part 1 consisted of personal data of elder such as age, gender, family type, and health status and demographic, economic, and social of elder caregiver in the family consisted of age, gender, career, income, and marital status.

Part 2 is the questionnaire for investigating the caregiving behavior of the family toward elder consisted of the caregiving for elder in daily life, caregiving in social psychology and economy which have details as follows:

1) Caregiving in Activities of Daily Living – ADL for elders by adjust from the ability to perform activities of daily living appraisal tool which are further classified into 2 difference parts which are:

From Suthichai's Modified Barthel Acvities of Daily Living Index of elders (Sithichai Jitapankul) which adjusted from Barthel Index (Marhoney and Barthel) which include the measurement of daily caregiving of elders consisted of 10 activities which are:

(1) Caregiving in daily meals

(2) Caregiving in face washing, hair brushing, teeth brushing, and shaving

(3) Caregiving in stand up from bed and walking to chair

(4) Caregiving in usage of toilet

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(5) Caregiving in moving around room and house

(6) Cargiving in clothing

(7) Caregiving in step up and down stair

(8) Caregiving in bathing

(9) Caregiving in evacuate waste matter

(10) Caregiving in urination

Having criteria in giving marks as follows:

Mark 1 means Fully caregiving was given

Mark 2 means Some caregiving was given

Mark 3 means No need for caregiving

2) Instrumental Activities of Daily Living – AIDL of elder which consisted of shopping activities, cooking activities, budget management, journey to other places, and housekeeping.

(1) Social Psychology aspect is the response for requirement in social psychology of elder for example paying respect to elder and support elder to engage in social activities and interaction to others.

- Paying respect to elder means time spent in talking and advising from elder include asking for recommendation from elder solving family difficulties and engaging in family activities.

- Support and helping elder to engage in social activities and interaction with others for example supporting elder in talking with and visiting relatives include support elder in engage in social activities both social, religion, and leisure time.

(2) Economic aspect is the caregiving in supporting need for economic stability include money pocket for everyday life, supporting for house maintenance, supporting in giving materials and facilities and support elder to work.

### 3.1.4 Quality of research instrument

Researcher bring questionnaire to investigate the content validity by giving questionnaire to 7 professionals in elders to approve the content, after the professions examined the contents researcher had adjusted the questions according to the recommendation of those professionals.

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#### 3.1.5 Reliability measure

Reliability was measure by using questionnaire part 2 about caregiving to elder to test in the pilot study which have similar characteristics with the population intended to study and measure reliability of the research instrument with Cronbach's Alpha Coefficient of Reliability. The result was 0.7885.

#### 3.1.6 Data collection method

Researcher are undertake the data collection method with 4 assistant researchers whose are nurse instructors.

#### 3.1.7 Data analysis

SPSS (Statistical Package for Social Science) was used in analyzing the data by using descriptive Statistics included percentage, means, and standard deviation.

### 3.2 Qualitative research

After the quantitative data was collected through the questionnaire form completed by 397 families, the next step was applied qualitative research where an in-depth interview with the 8 elderly who were well looked after by their families along with 7 elderly who were not properly looked after by their families. The questions being asked in the questionnaire form for the quantitative research were used as an interview guide for the in-depth interview as well as the following steps.

3.2.1 Requesting the coordination from the provincial public doctor in Suratthani Province to interview the elderly and the caregivers at their homes.

3.2.2 Prior to the interview date, the researcher provided all necessary details to her four assistances who were the nursing lecturers to simultaneously understand both the technique of the in-depth interview and the interview question guide.

3.2.3 The samples obtained from the survey research were divided into 2 groups (a) the elderly who were well looked after, in 8 families (2) the elderly who

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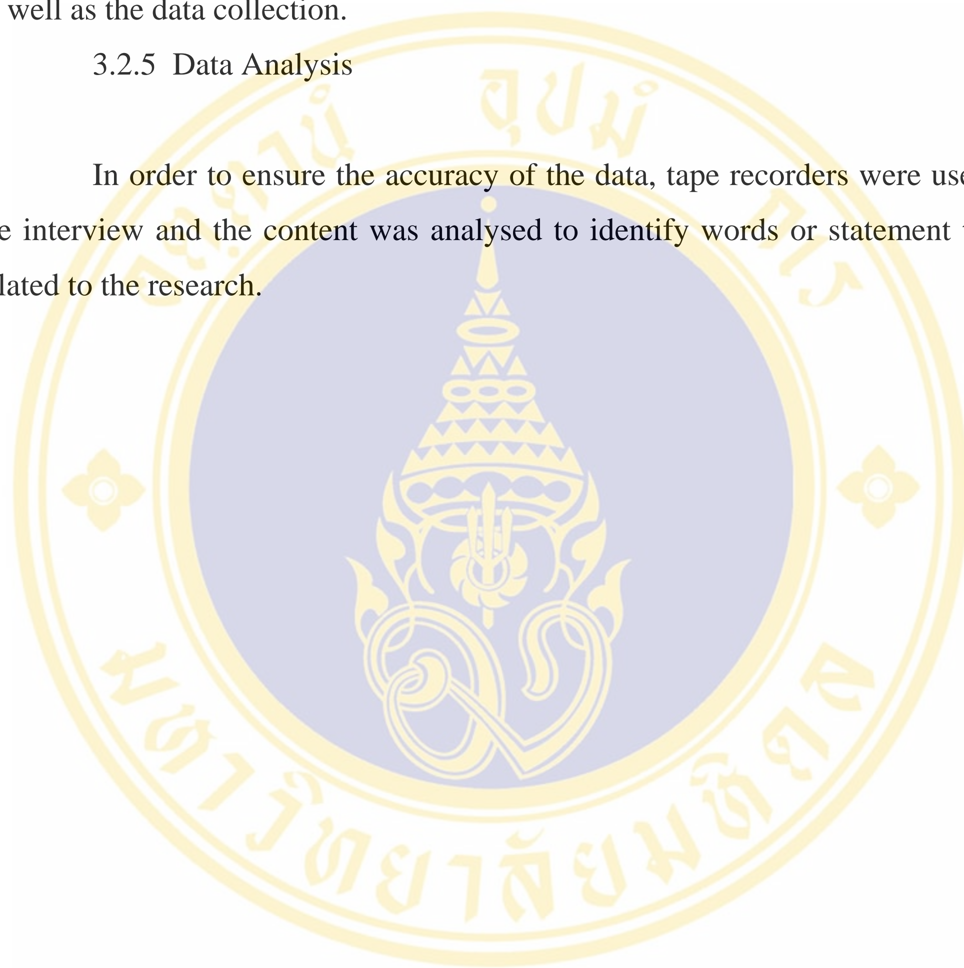
were not well looked after, in 7 families. The scores were respectively marked based on the family caregiving.

3.2.4 An appointment was made with the elderly and the caregivers at their homes during March-April 2004 along with date and time for the in-depth interview as well as the data collection.

3.2.5 Data Analysis

In order to ensure the accuracy of the data, tape recorders were used during the interview and the content was analysed to identify words or statement that were related to the research.



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# CHAPTER 4
# RESULTS

The results of this study on the pattern of caregiving for elderly by their families in rural communities of Suratthani Province, has categorized the analyzed information into 2 parts, as follows:

4.1. Quantitative research results

4.2. Qualitative research results

## 4.1 Quantitative research results

### 4.1.1 General characteristics and health state of the elderly

4.1.1.1 General characteristics

There were 397 elderly were used as the sample group. Most of them were female with 236 person (59.5 percents), and male with 161 persons (40.5 percents). The majority of them were the age group between 60-74 years old, which were the young elderly of the elderly up to 75.3 percents; subsequently, they were the age group between 75-84 years old (19.6 percents), and they were old elderly with older than 85 years old with only 5.1 percents. Most of them had the married status with 236 persons (59.5 percents); subsequently, divorce with 35.4 percents, and separated status was the least with 5.1 percents.

The elderly were entirely Buddhist religion. Most of them graduated the primary school education level with 61.9 percents, subsequently, they were illiterate with 22.2 percents, and religious study or literate with 12.6 percents respectively. The work characteristics of the elderly work in the garden that was rubber tree plantation and rubber collecting with 30.4 percents, and subsequence was house work aid with 21.5 percents. Moreover, it was found that that the elderly who had no occupation but they were still house work that grass cutting, and grand children look after with 17.1 and 10.8 percents respectively. Most of the elderly were still working

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because most of them were in the age group between 60-74 years. Therefore, they were still healthy so they could do the jobs.

The shelter attribute of the elderly, most of them lived in their own houses with 88.0 percents, and the subsequences were lived with their children with 10.1 percents, and 5 cases (1.3 percents) of the elderly had no houses. So the community helped by building the houses for them. The number of member of the family, most of them had 4-6 members with 51.3 percents, subsequently they had 1-3 members (36.7 percents) and they had more than 6 members with 12.0 percents were the least. It was obviously seen that most of them that was above a half lived in the middle size family. There was only one of third lived in the small family or sub-family that was the household composed of husband and or wife with one child and grandchild with marriage or other relatives living together (the details show in the table 1).

**Table 1** Number and percent of the elderly classified according to population and social characteristics

| Population and social characteristics | Number (n = 397) | Percents |
|---|---|---|
| Sex | | |
| Female | 236 | 59.5 |
| Male | 161 | 40.5 |
| Age (years) | | |
| 60-74 years | 299 | 75.3 |
| 75-84 years | 78 | 19.6 |
| 85 years up | 20 | 5.1 |
| Marital status | | |
| Couple | 236 | 59.5 |
| Divorce | 141 | 35.4 |
| Separation | 20 | 5.1 |
| Religion | | |
| Buddhist | 397 | 100 |

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**Table 1** Number and percent of the elderly classified according to population and social characteristics (Cont.)

| Population and social characteristics | Number (n = 397) | Percentage |
|---|---|---|
| Education level | | |
| Illiteracy | 88 | 22.2 |
| Primary school level | 246 | 61.9 |
| Secondary school level | 8 | 2.0 |
| High school level | 5 | 1.3 |
| Diploma/ vocational level | 50 | 12.6 |
| Others (Religion , Literacy) | | |
| Host | | |
| Owner | 349 | 88.0 |
| Children house | 40 | 10.1 |
| Grand children house | 3 | 0.6 |
| Others (Community social welfare house) | 5 | 1.3 |
| Family members (Persons) | | |
| 1-3 | 146 | 36.7 |
| 4-6 | 204 | 51.3 |
| > 6 | 47 | 12.0 |
| Present work attributes | | |
| House work aid | 85 | 21.5 |
| House care | 73 | 18.4 |
| Grass cutting | 68 | 17.1 |
| Grand children care | 43 | 10.8 |
| House gardening | 8 | 1.9 |
| Others (Rubber plantation/ rubber collecting) | 120 | 30.4 |

4.1.1.2 Health state of the elderly

The findings of this study found that 70.9 percent of the elderly had chronic disease. The most chronic disease was found were muscle fatigue, bone and joint pain with 32.0 percents. Subsequence was alimentary tract sickness with 17.1 percents. During the past year, it was found that the elderly were never sick were 37.0 percents, and once in while and never sick were equivalent with 31.5 percents.

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Regarding the perception of health state, most of the elderly perceived that they had their health state were as moderate level with 26.0 percents, and subsequence was rather strong with 22.2 percents as show in table 2.

**Table 2** Number and percent of the elderly classified according to chronic disease attribute and health state perception

| Chronic disease attribute and health state perception | Number (n = 397) | percentage |
|---|---|---|
| **Chronic disease** | | |
| Have | 281 | 70.9 |
| No have | 116 | 29.1 |
| **Chronic disease** (n = 281) | | |
| Muscle fatigue, bone and joint pain | 127 | 32.0 |
| Alimentary tract sickness | 68 | 17.1 |
| Headache/ dizziness | 43 | 10.8 |
| High Blood pressure | 39 | 9.8 |
| Allergy/Asthma | 39 | 9.8 |
| Constipation / Hemorrhoid | 25 | 6.3 |
| Diabetes | 21 | 5.3 |
| Heart disease | 18 | 4.5 |
| Lung disease/Tuberculosis infection | 7 | 1.8 |
| Others (dermatitis/blood disease,/cancer/cataract eye) | 10 | 2.5 |
| **Sickness during the past year** | | |
| Often sick | 125 | 31.5 |
| One in a while | 125 | 31.5 |
| Never sick | 147 | 37.0 |
| **Health state perception** | | |
| Strong | 68 | 17.1 |
| Rather strong | 88 | 22.2 |
| Moderate | 103 | 26.0 |
| Rather weak | 78 | 19.6 |
| Weak | 60 | 15.1 |

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### 4.1.2 Caregiver and the caregiving for the elderly

4.1.2.1 Caregiver

In this study, the finding revealed that caregiver for the elderly. Most of them were their children with 79.7 percents, and subsequences were their spouse with 15.8 percents and grand children with 4.4 percents. Regarding on the shelter attribute, it was found that most of the elderly lived in the same house with 79.7 percents. Only 18.4 percents of them lived in the different house in the same boundary. When it was considering with the ownership, it was found that 88.0 percents lived in their houses, and only 10.0 percents lived with their children. Regarding together with the number of family member, the finding illustrated that 51.3 percents of the elderly lived the family number with 4-6 members, and 12.0 percents of family 6 numbers up. The details present in table 3.

**Table 3** Number and percent of the elderly classified according to relation with elderly and residence attribute

| Variables | Number (n = 397) | Percentage |
|---|---|---|
| **Relation with the elderly** | | |
| Children | 316 | 79.7 |
| Spouse | 63 | 15.8 |
| Grand children | 18 | 4.4 |
| **Shelter attribute** | | |
| The same house | 316 | 79.7 |
| Different house but in the same boundary | 73 | 18.4 |
| Different house and far away | 8 | 1.9 |

4.1.2.2 Caregiving for the elderly

Receiving care in the physical aspect, the data of caregiving questionnaires were answered by the elderly to select. They were able to select more than one choices and it was analyzed by using frequency, and percents. The detail of results were as follows:

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1) Physical aspect

(1) Caregiving about Food

Regarding with this study, the elderly received 3 meals with 62.7 percents, and subsequence was 2 meals with 33.5 percents. Every meals, the food feature was given composed of 5 nutrition elements that are rice (carbohydrate), meat (protein and fat), vegetable, and fruit (starch, fiber, mineral and vitamin) with 13.3 percents. The elderly received meat, vegetable, and fruit for some meal and some day with 74.1 percents. The food was soft and easily to chew with 30.4 percents. The elderly preferred the foods that were given with 24.1 percents. The foods without strong taste flavor were 38.0 percents, and it was the food that the same as the other members in the family received with 40.5 percents. The finding revealed that the elderly with 12.0 percents received the strong taste flavors that were spicy, sour, salted, and sweet tastes. Regarding to the food caregiving for the elderly, they were received by caregiver to buy, and cook according to the desire of the elderly with 41.8 percents. It was the highest percents. The caregiver provided the preferred taste for the elderly with 19.0 percents, and they gave the preferred food for them with 15.8 percents. Moreover, the elderly cooked by themselves with 14.6 percents by the caring of caregiver buying the raw materials and washing the dishes with 44.9 percents. Drinking and utilizing water, the elderly would be supplied the caregiver with 58.9 percents. Providing the equipments and cleaning the equipment with 25.9 and 14.6 percents. There were 26.6 percents of the elderly could help themselves for arrangement the drinking and utilizing water by himself. Considering for the adequate amount of water and food received, it was found that 95.6 percents were sufficiently received the foods and water, and only 4.4 percents were inadequate. The details show in table 4.

(2) Clothing

From table 4, the clothing for the elderly, most of them were obtained from their children with 74.7 percents, and the subsequence 57.6 percents of them bought it for himself. Regarding to the aid in clothing care for the elderly, it was found that the caregiver aided them for cleaning clothing with 60.8 percents, and buying with 53.8 percents. In addition, the caregiver would help them when they got sick or they would prepare the cloths for them when they went to the

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social party with only 10.1 percents. Considering on the caregiving for providing the appropriate and sufficient clothing with the season and special occasion, only the elderly with 32.9 percents received the sufficient cloths. Details show in table 4.

(3) Shelter

Caregiving for shelter, the elderly received the most care about the bedding in terms of washing and sun drying with 55.0 percents. Subsequences were sweeping with 41.8 percents, and laying the bed/ hanging on mosquito net/ hanging off mosquito net with 33.5 respectively. The elderly received the care about preparing the pillow and mosquito net with 22.8 percents, and arranging the sleeping place with 15.2 percents. Moreover, it was found that only 19.0 percents of the elderly received care about arranging the sleeping place to have adequate light and air flow. Regarding to shelter, 74.1 percents of the elderly received care from the caregiver, and subsequently, sweeping and collecting the trash around the house area with 51.9 percents and only 43.1 percents received the care about arranging the house to have adequate light both inside, outside house, walking way, and toilet respectively. Details show in table 4.

(4) Care When the Elderly Get Sick

When the elderly got sick, most of them asked for aid from others with 63.3 percents, and only 34.2 percents would go by themselves to the health station or the hospital nearby house. Regarding to go to the health station or the hospital by himself, 64.8 percents went to the health station or the hospital by himself, and subsequence was buying from drug store, drug fund of village or health station with 27.8 percents. The elderly who asked for aid from others, most of them were their children so they brought them to health station with 76.0 percents, drug bought with 20.0 percents, and 2.5 percents of the elderly would not go receive the treatment but they would like to take care themselves. If they did not recover, they would go to hospital or health service.

Caregiving for the elderly when they got slight sickness, it was found that 57.0 percents of the elderly were taken by the caregiver to clinic or health station as their needs or the place, which they have often gone, and 32.3 percents were brought to clinic or health service and aid for the expense and transportation. The finding found

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that 13.9 percents of caregiver would buy drug and prepare drug for the elderly, 8.8 percents brought the drug but let them take by himself, 1.9 percents gave money to the elderly to buy.

Regarding with the caregiving when the elderly got sick and rest at home, the elderly would receive the care from caregiver was arrangement drug for them with 68.2 percents, preparing the favorite and proper valuable food for disease with 65.9 percents, and aid to care about the adequate food with only 34.1 percents. During sick and rest at home, there was the caregiver and not them live alone and request the answer the question with 54.3 percents. Moreover, the similar 1.6 percents of no caregiver during sick, and the equal amount of self-care and not require any caregiver were found in this study.

In case of sick, the elderly who sick or ever received the treatment at the hospital during the past year, 56.3 percents of them were received the caregiver to sit as aid to closely aid, including providing the food, cleaning the body, dressing and caregiving with 95.5 percents.  They brought the food, drink, and supplements with 55.1 percents, and aid for health care with 38.2 percents. Only 1.1 percents of the elderly had no caregiver. Details show in table 4.

**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect

| Caregiving in physical aspect | Number (n = 397) | percentage |
|---|---|---|
| **Caregiving about Food** | | |
| **Food that the elderly received** | | |
| Every meals have meat, vegetable, fruit | 53 | 13.3 |
| Some meals have meat, vegetable, fruit | 294 | 74.1 |
| Soft food and easily chew food | 120 | 30.4 |
| Favorite food  for the elderly | 95 | 24.1 |
| Not strong taste food | 150 | 38.0 |
| The similar food as others in the family | 160 | 40.5 |
| Strong taste food (spicy, sour, salted, and sweet) | 47 | 12.0 |
| Supplementary food that  proper to disease | 14 | 3.6 |
| Others (Sweets, Soft drinks) | 11 | 3.0 |

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**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect (Cont.)

| Caregiving in physical aspect | Number (n = 397) | percentage |
|---|---|---|
| **Food caregiving for the elderly** | | |
| Take the preferred food for the elderly | 30 | 19.0 |
| Ask and buy preferred foods for the elderly | 25 | 15.8 |
| Buy, and cook foods for the elderly | 66 | 41.8 |
| Buy, and aid then to cook for the elderly | 21 | 13.3 |
| Buy, and let them cook foods by themselves | 23 | 14.6 |
| Provide the food for the elderly | 51 | 32.3 |
| Aid in washing the dishes | 71 | 44.9 |
| Have meal together | 54 | 34.2 |
| Provide the special food for the elderly | 7 | 4.4 |
| Arrange drinking and utilizing water | 93 | 58.9 |
| Providing the equipments for storing drinking and utilizing water | 41 | 25.9 |
| Cleaning the equipment for drinking and utilizing water | 23 | 14.6 |
| **Number of meals received** | | |
| 1 meal | 2 | 1.3 |
| 2 meals | 53 | 33.5 |
| 3 meals | 99 | 62.7 |
| 4 meals | 4 | 2.5 |
| **2. Clothing** | | |
| **Sources** | | |
| Children | 118 | 74.7 |
| Grand children | 26 | 16.5 |
| Spouse | 23 | 14.6 |
| Relatives | 13 | 8.2 |
| Buy by himself | 91 | 57.6 |
| Neighbor | 3 | 1.9 |
| Others (Relatives, children, grand children gave as present in the New Yare occasion) | 23 | 14.6 |

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**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect (Cont.)

| Caregiving in physical aspect | Number (n = 397) | percentage |
|---|---|---|
| **Cloths caregiving for the elderly** | | |
| Bring them to buy or let the dress maker do According their wants | 23 | 14.6 |
| Buy cloths according to their wants | 85 | 53.8 |
| Clean and neatly keep | 96 | 60.8 |
| Repair the cloths to be in good condition | 9 | 5.7 |
| Provide the appropriate and sufficient cloths with the season and special occasion | 52 | 32.9 |
| **Cloths caregiving for the elderly (Continued)** | | |
| Clean cloths when they get sick | 16 | 10.1 |
| Self-managed | 12 | 7.6 |
| **Shelter caregiving for the elderly** | | |
| **Sleeping place** | | |
| Provide bed, pillow, and mosquito net. | 36 | 22.8 |
| Arrange the sleeping place relevant to the elderly Wants | 24 | 15.2 |
| Arrange the sleeping place with light and air Flow | 30 | 19.0 |
| Lay the bed/ hang mosquito net /bedding | 53 | 33.5 |
| Sweeping, and ribbing | 66 | 41.8 |
| Clean bed/let dry with the sunlight | 87 | 55.0 |
| Repair the bedding | 18 | 11.4 |
| Self-managed | 4 | 2.5 |
| **Shelter** | | |
| Sweeping inside the house | 117 | 74.1 |
| Arranging the house to have adequate light both inside, outside house, walking way, and toilet | 68 | 43.0 |
| Keep the house equipment inside the house | 42 | 26.6 |

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**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect (Cont.)

| Caregiving in physical aspect | Number (n = 397) | percentage |
|---|---|---|
| Repair the house in a good condition | 22 | 13.9 |
| Sweeping and collecting the trash around the house area | 82 | 51.9 |
| Self-managed | 18 | 10.8 |
| **Caregiving for the elderly when they sick** | | |
| **Self-performance of the elderly when they sick** | | |
| Self-care (drink the warm water and take rest) | 4 | 2.5 |
| Receive the treatment or buy drug by themselves | 54 | 34.2 |
| Request for help | 100 | 63.3 |
| **Receive the treatment by themselves** | | |
| Buy from drug store, and drug fund of village | 15 | 27.8 |
| Receive the treatment | 35 | 64.8 |
| Medical Clinic | 4 | 7.4 |
| **The elderly who asked for aid from others** | | |
| Children /grand children | 20 | 20.0 |
| Children /grand children brought them to health Station | 50 | 50.0 |
| Spouse | 4 | 4.0 |
| **Caregiving for the elderly when they got slight Sickness** | | |
| The elderly taken to clinic or health station as their Wants or the place, which often gone | 90 | 57.0 |
| Take the elderly to see doctor and aid for the Expense and transportation | 51 | 32.3 |
| Take the elderly to see doctor and they pay for the Expense and transportation by themselves | 34 | 21.5 |
| Buy drug and prepare drug | 22 | 13.9 |
| Buy drug and let elderly take drug by themselves | 14 | 8.8 |

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**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect (Cont.)

| Caregiving in physical aspect | Number (n = 397) | percentage |
|---|---|---|
| Give the money or let them doctor by Themselves | 3 | 1.9 |
| Suggest health service and support to get treatment | 9 | 5.7 |
| **Caregiving for the elderly when they got slight sickness (continued)** | | |
| Give suggest about for self-care | 8 | 5.1 |
| Relative, Neighbor, children who were not caregiver brought to get treatment | 12 | 7.6 |
| Be able to help themselves and need no help | 3 | 1.8 |
| No caregiver | 3 | 1.8 |
| Caregiver wants to take them to see the doctor but they do not want. | 3 | 1.8 |
| **Caregiving for the elderly when got sick and rest at home (n=129)** | | |
| Caregiver was arrangement drug for them | 88 | 68.2 |
| Preparing the favorite and proper valuable food for disease | 85 | 65.9 |
| Caregiving about the adequate food | 44 | 34.1 |
| Arrange the sleeping place to be clean and air flow | 21 | 16.3 |
| Arrange the elderly to sufficiently rest and sleep | 30 | 23.3 |
| Do not them stay alone and request the answer the question | 70 | 54.3 |
| Provide soft drinks and supplements | 36 | 27.9 |
| Visit and bring food for them | 2 | 1.6 |
| Self-care and not require any caregiver | 2 | 1.6 |
| No caregiver during sick | 2 | 1.6 |
| **Sick and must be stay at hospital** | | |
| Never stay at hospital | 69 | 43.7 |
| Ever stay at hospital | 89 | 56.3 |

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**Table 4** Number and percent of the elderly classified according to caregiving in physical aspect (Cont.)

| Caregiving in physical aspect | Number (n = 397) | percents |
|---|---|---|
| **Caregiving for the elderly when got sick and stay at hospital** | | |
| Aid for treatment expense | 34 | 38.2 |
| Take the food, soft drinks, and supplements | 49 | 55.1 |
| Look after and closely aid (arrange food, drug, and clean body) | 85 | 95.5 |
| Caregiver no time to look after (Children and Spouse) look after | 1 | 1.1 |
| No caregiver | 1 | 1.1 |

2) Caregiving in the socio-psychological aspect

This study was done the caregiving in the socio-psychological aspect regarding the respect from the family members, caregiving for the elderly to have activities and interact with other people, and support them to use spare time to be benefit for leisure. The answers provided for the elderly to select, they could select more than one answer. Data were analyzed in terms of frequency and percents with the following details:

Regarding the respect from the family members, the elderly still received in this aspect by the family members. Talk to the elderly with closely feeling was the highest percent with 79.7 percents. Subsequences were perform according to the suggestion and teaching with 57.6 percents, ask for the advice and exchange the experiences each with 51.3 percents, perform the courteous manner with 47.5 percents. This study revealed that the elderly had children, grand children or family members were disobey, dispute, rude speaking with 8.4 percents, and do not tell the problem because they did not want to make the elderly unhappy feeling with 1.2 percents. The details present in table 5.

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Caregiving for the elderly to have activities and interact with other people, it was found that most of the elderly were support to visit relatives with 81.0 percents, and did not receive the aid with 19.0 percents. Regarding to the elderly who did not receive the aids, most of them needed to visit them because relatives, children/grand children came to visit them or they may had children/grand children lived nearby his house, therefore they did not receive aids in this aspect with 40.0 percents, 23.3 percents of the elderly who did not receive aids was able to visit, and therefore they did not receive aids because children, grand children pay no attention with 6.7 percents.

Regarding the elderly who received the aids, it was found that caregiver would support by providing transportation with 77.1 percents, and subsequences were giving money with 37.5 percents and prepare gifts with 29.7 percents respectively. The details show in table 5.

In the aspect of support the elderly to participate the activities, the findings revealed that the activity, which was highest support, was religious activity with 79.1 percents. Subsequences were social activity with 68.4 percents. Aids provided for activity participation, it was found that provide transportation with 68.4 percents, provide the gifts with 56.3percents, and give the money with 35.4 percents. Nevertheless there was the elderly who received aid but they did not want to participate because they had poor health. The details show in table 5.

For the part of support those to use spare time to be benefit for leisure, it was found that the elderly received care in this facet very few. They were support to have conversation to friends with 37.3 percents, and 36.7 percents provided materials such as radio, television, and books for them to read for amusing purpose. The details show in table 5.

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**Table 5** Number and percent of the elderly classified according to caregiving in socio-psychological aspect

| Caregiving in socio-psychological aspect | Number (n = 397) | Percentage |
|---|---|---|
| **1. Receive respects from the family members** | | |
| Perform the courteous manner | 75 | 47.5 |
| Talk to the elderly with closely feeling | 126 | 79.7 |
| Ask for the advice and exchange the experiences each other | 81 | 51.3 |
| Perform according to the suggestion and teaching | 91 | 57.6 |
| Let them perceive the family problems | 45 | 28.5 |
| Let the elderly to make decision for family problems | | |
| Visit and ask for blessing | 22 | 13.9 |
| Disobey, dispute, rude speaking | 7 | 4.2 |
| Do not tell the problem because do want to make the | 14 | 8.4 |
| elderly unhappy feeling | 2 | 1.2 |
| **2. Caregiving for the elderly to have activities and interact with other people** | | |
| To visit relatives | | |
| Do not receive the aid (n = 30) | 30 | 19.0 |
| Go by himself, Have money, healthy | 7 | 23.3 |
| Poor, poor caregiver, no time | 4 | 13.3 |
| Poor Health | 5 | 16.7 |
| Children/grand children pay no attention | 2 | 6.7 |
| Relatives, children/grand children come to visit | 12 | 40.0 |
| **Receive the aid when go to visit relatives** (n = 128) | 128 | 81.0 |
| Provide the transportation | 99 | 77.3 |
| Provide the gifts | 38 | 29.7 |
| Give money | 48 | 37.5 |
| Prepare dress and aid for dressing | 11 | 8.6 |
| Go together | 2 | 1.6 |

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**Table 5** Number and percent of the elderly classified according to caregiving in socio-psychological aspect (Cont.)

| Caregiving in socio-psychological aspect | Number (n = 397) | percentage |
|---|---|---|
| **Support the elderly to participate the activities** | | |
| Religious activity | 125 | 79.1 |
| Social activity | 108 | 68.4 |
| Group activity (the elderly) | 17 | 10.8 |
| **Aid to support the elderly to participate the activities** | 108 | 68.4 |
| Provide transportation | 89 | 56.3 |
| Provide gifts | 59 | 35.4 |
| Give money to aid for expense | 11 | 7.0 |
| Tell the information | 27 | 17.1 |
| Support the will power | 10 | 6.0 |
| Prepare the cloths | 7 | 4.2 |
| Children support but their have poor health | | |
| **3. Support those to use spare time to be benefit for leisure** | | |
| Support to have hobbies | 27 | 17.1 |
| Provide materials (radio, television, and books) | 58 | 36.7 |
| support to have conversation to friends | 59 | 37.3 |
| Persuade to exercise or play games | 8 | 5.1 |
| Bring them to visit fair or tour | 35 | 22.8 |
| Go to temple to practice the Dharma | 10 | 6.0 |

3) **Caregiving in the economic aspect**

This study was done the caregiving in the economic aspect; it was found that 74.7 percents of the elderly paying their expense by themselves, and 62.0 percents of them paid for the house expense such as pipe water, electricity, food, and household care. Moreover, 10.8 percents of them still paid for house or things repair.

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Regarding the income of the elderly, 94.9 percents of them had income, and only 5.1 percents of them had no income. The source of income was gardening with 62.0 percents. Subsequences were their children with 56.7 percents, business with 9.3 percents, hiring for rubber collecting with 8.7 percents, and the governmental welfare aided 200 Bahts per month with 12.5 percents. Even though, they received aid from their children and governmental welfare, but their income did not cover their expenses. Therefore, most of them would ask for aid from their children with 50.0 percents. Subsequence was relatives with 15.5 percents. Considering their income per month, most of them had income lesser than 4,000 Bahts per month with 47.5 percents. Subsequences were income per month more 8,000 Bahts with 28.5 percents, and 24.0 percents of them had income between 4,000-8,000 Bahts. Moreover, considering on the insufficient income, it was found that 36.7 percents of them had insufficient income since it might be that the elderly must take the responsibilities for both their own expenses and household expense. The details show in table 6.

**Table 6** Number and percent of the elderly classified according to caregiving in economic aspect

| **Caregiving in economic aspect** | **Number (n = 397)** | **percentage** |
|---|---|---|
| **1. Daily living expense** | | |
| Personal expense | 118 | 74.7 |
| Household expense (pipe water, electricity, food, and others) | 98 | 62.0 |
| House and thing repair | 17 | 10.8 |
| **2. Income** | | |
| Have | 150 | 94.9 |
| No have | 8 | 5.1 |
| **3. Source of income of the elderly** (n=150) | | |
| Gardening | 93 | 62.0 |
| Farming | 3 | 2.0 |
| Their own superannuated money/ spouse | 2 | 1.3 |
| Gardening | 93 | 62.0 |

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**Table 6** Number and percent of the elderly classified according to caregiving in economic aspect (Cont.)

| Caregiving in economic aspect | Number (n = 397) | Percentage |
|---|---|---|
| Farming | 3 | 2.0 |
| Their own superannuated money/ spouse | 2 | 1.3 |
| Their children | 85 | 56.7 |
| Business | 14 | 9.3 |
| Hire (rubber collecting) | 13 | 8.7 |
| Saving/ interests | 5 | 3.3 |
| Grand Children, relatives | 11 | 7.3 |
| Massage | 2 | 1.3 |
| **4. Sufficiency of income** (n=150) | | |
| Sufficiency | 100 | 66.7 |
| Insufficiency | 50 | 33.3 |
| **5. Sources of income of the elderly who had no income** (n = 8) | | |
| Their children | 7 | 87.5 |
| Governmental welfare (200 Bahts per month) | 1 | 12.5 |
| **6. Sufficiency of income of the elderly who had no income** (n = 8) | | |
| Insufficiency | 8 | 100 |
| **7. Sufficiency of income per month** | | |
| < 4,000 Bahts | 75 | 47.5 |
| 4,000-8,000 Bahts | 38 | 24.0 |
| > 8,000 Bahts | 45 | 28.5 |
| **8. Sources of aid when insufficient income** | | |
| Their children | 29 | 50.0 |
| Relatives | 9 | 15.5 |
| Neighbors | 5 | 8.6 |
| Bank Loan (Agriculture and Cooperation Bank) | 7 | 12.1 |
| Search work | 6 | 10.3 |
| Not spend and let children to spend and earn | 2 | 3.4 |

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**Summary of the quantitative research based on the survey**

The conclusion based on the quantitative data collection from the interview method with the sampling group of 397 families revealed the following result.

On the topic of personal factor, it was found that the health of most elderly whose age was between 60 and 74 was still strong and they were able to perform their routine daily functions. In case of unhealthy elderly, most of them were sick with muscle problems. The elderly were mostly married, Buddhist, and had received primary school certificate. Their previous occupations were mainly agriculture i.e. rubber farming, and palm farming. Therefore, in economic term these elderly had their own income from the farming but did not have to spend on the family. On the contrary, they expect their children to look after them when they were ill in term of caring and medical expenses as well as financial help, regular visits and mental support.

Another personal factor included the fact that caregiving were mostly a daughter, not a son. This was because daughters were better at caretaking than sons. This fact was in accordance with the social belief that women possess the character of a caretaker (Klien, 1989). Moreover, it was also found that the majority of the daughters was married, between 30-44 years of age which was considered mature enough to make an appropriate decision, if required, for the elderly.

Most of the caregiving lived in the same house that enabled them to closely look after the elderly. The caregiving worked and earn enough money. They did not feel that the elderly were their burden although there were some who mentioned that looking after the elderly was a boring situation.

## 4.2 Qualitative research results

After the quantitative data collection through interviewing the sampling group of 397 families, the survey research taken from the step of the quantitative research was then divided into 2 groups by an in-depth interview.

4.2.1 A group of the elderly in 8 families who were well looked after by their families.

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**4.2.2 A group of the elderly in 7 families who were not well looked after by their families.**

The in-depth interview was conducted using the prepared interview guidelines as an interview frame. The tape recorders were used to assure that the data of the 15 families was properly recorded. The result of the in-depth interview with the first group – the elderly who were well looked after by their families.

**Family number 1**

Information: Family number 1 is a Thai Buddhist stem family whose numbers are a frail elderly mother aged 75 (care receiver), her seven year ago. Currently, the mother and the daughter (caregiver) lives in a house owned by the caregiver and husband. The mother has five adult children which includes four daughters and one son. However, one daughter died when she was young. Caregiver is the eldest child in the family. Her youngest sister married and lives elsewhere with her own family. The elderly caregiver has five adult children, and three of them who are not married still reside in the same house which is owned by the informant and her husband. The unmarried children of the caregiver are 3 daughters and 3 sons, all of whom live in the house. The husband of the informant is a retired officer. The living expenses of the household comes form the pension of the informant's husband, their savings, and their children's contribution for them every month.

Family caregiver: is a 46 year old, the eldest child, married homemaker who lives with her own family and her mother. She is primary level (grade 4) educated. The informant has taken the role of primary caregivers for her mother for the past five years.

Care receiver (the mother): is a 75year old woman. She also has cataracts in both eyes, but still has memory intact and is without any problems of communication or intellectual functions. However, she needs help to some degree with activities of daily living (ADL) such as assistance in bathing, transferring, and toileting. The car receiver cannot perform IADL independently; the caregiver is the main person who provides the assistance with the tasks such as meal preparation, housekeeping medications.

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Caregiving practice and supportive system: the key informant is a primary caregiver to the elderly mother. She helps in caregiving activities for ADL which the care receiver could not perform herself. The caregiver's children (the grandchildren of the care receiver) usually assist in caregiving. There is no support from the care receiver's other children (a son and a daughter) in caregiving tasks. However, the youngest daughter visited or gives money to the mother from time to time.

**Family number 2**

Information: Family number 2 is a Thai Buddhist stem family whose members are 78year old mother (care receiver) and the daughter's family The father died nearly five year ago. Currently, the mother and the daughter (caregiver) lives in the parent's home. The mother has seven adult children which includes three sons and four daughters. However, one son and one daughter died several years ago. The remained (five) children are all married. Four of them live elsewhere with their own families. The daughter is the third child in the family. Her family (her husband and three daughters) also live in this house. One of her daughter (the middle) is married but still lives in the same household. The living expenses of the household comes from the informant's husband and her daughter.

Family caregiver: is a 57year old, third child, married, housemaker who live with her mother. She is secondary level (grade 10) educated. The informant has taken the role of primary caregivers for her mother for about year.

Care receiver (the mother): is a 78year old woman. She now is conscious and has no problem with communication or intellectual functions. However, she needs help to some degree with her activities of daily living (ADL) such as bathing, transferring, and toileting. For the instrumental activities of daily living (IADL), the care receiver cannot perform IADL independently, the caregiver is the main person who pervades the assistance with the tasks such as meal preparation, housekeeping, medication.

Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She helps in caregiving activities for ADL which the car receiver cou not perform herself. The caregiver's (the grand-daughters of the care receiver) usually assist in caregiving for the frail elderly mother. There is no support from other children (brothers and sister)

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**Family number 3**

Information: Family 3 is a Thai Buddhist stem family whose numbers are a frail 69year old mother (care receiver), a widowed daughter (caregiver), and her own family. The father died about 15 year ago. They all live in a house owned by the caregiver. The daughter's husband died 10year ago. She reared her three children (two daughters and a son) by herself and has not remarried. One of the caregiver's daughters is now married and resides in this house. The parents has eight adult children which includes four sons and four daughter. They used to live in Nakorn srithummarath province which is about 80 kilometers from Amphur Kranchanadit Suratthani Province. Almost all of the children are married except the youngest daughter who is not married but lives by herself in a house not far away from this family. Other married children live elsewhere with their own families. The living expenses of the household come from the caregiver's saving, caregiver's children contribution, and financial support from the caregiver's brothers and sisters.

Family caregiver: is a 52yesr old, fifth child, widow who is grade 4 (primary level) educated. She has taken the role of primary caregivers of her mother for about a year since the mother started to have problem of dementia. Se used to run her own business by selling fresh seafood at a market but stopped the business about ten month ago after she had a hysterectomy. Now, she considers herself to be a primary caregiver to her mother.

Caregiving practice and supportive system: is a primary caregiver to her mother. She does most of the assistance for the activities of daily livings such as feeding, bathing, bedding and toileting (evacuating, cleaning, changing clothes) for the mother. She also gets assistance in caregiving from both of her daughters such as preparation of the slenderized feeding diet and taking care while the key informant goes outside. Other sister and brothers regularly contribute financially for caregiving supplies, medications, and all health services.

**Family number 4**

Information: Family 4 is a Thai Buddhist joint family whose numbers are a 72 year old mother (care receiver), a youngest daughter (caregiver), and a second son and

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his own family. The father died about 30 years ago. They all live in a house owned by the second son. The mother and the informant used to live together in other rented house but moved to live in this house nearly 20years ago. The parents has seven adult children which includes three sons and four daughters. The mother raised all children up by herself since her husband died and she did not remarry. All children are married and five of them live elsewhere with their own families. The living expenses of the household come from the second son's incomes which he runs his own business of auto and machinery repair shops at home.

Family caregiver : is a 39yesr old, divorced woman who is grade 4 (primary level) educated. She has taken the role of primary caregivers of her mother for the past three years. She used to be married then divorced, but has no children. However, she said that she has been staying with her mother all the time even the time that she was married. Now she considers herself as a primary caregiver to her mother and gets the monthly income from her second oldest brother who asked her to help him look after his children and chores.

Care receiver (the mother): is a frail 72year old woman who has health problems of arthritis and diabetes mellitus (DM). Three years ago she was diagnosed with osteoporosis and having the difficulty in walking or standing from time to time. She still can perform al the ADL by herself, but needs assistance in IADL such as preparation, transportation, houseworks.

Caregiving practice and supportive system: The key informant is a primary caregiver to her mother. She dose most of the assistance for the activities of daily livings such as feeding, bathing, bedding and toileting (evacuating, cleaning, changing clothes) for the mother. She also gets assistance in caregiving from her sister-in-law sometime. Other sister and brothers do contribute financially for caregiving supplies or health services from time to time but not as a routine help. The second son mainly provides financial support for the mother's care needs including health services and medications. The informant pays for the mother's care supplies such as blue Chux pads, contons, supplement feeding formula from her own money.

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**Family number 5**

Information: Family number 5 is a Thai Buddhist nuclear family whose numbers are a frail 63year old mother (care receiver), the mother (a 57year old working woman), and daughter . She is considered to be head of the family since her husband has been sick. The living expenses of the household come from the mother's alary and the father's pension.

Family caregiver: is the unmarried daughter who lives at with her parents. She is 30yesr old, high school educated. and could not find a job so her mother asked her to look after the father and gives her a monthly allowance to her 3,000baht every month. She has taken the role of primary caregivers of her father for the past four years.

Care receiver (the mother): is a frail 63year old man who has been retired from his work five years ago due to his illness (a stroke). He now is conscious, hemiplegic on the left side, aphasia, and still has problems with chewing and swallowing. He is totally dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The mother used to be a primary caregiver during the first three mother of her husband's illness. After that she hired a maid to help in taking care of him for a year. However, now the daughter takes the role as his primary caregiver especially during the time that the mother goes to work (6 AM until 4 AM.). The key informant takes all the responsibilities in caregiving activities for ADL such as feeding, toileting, and position changing during the daytime.

**Family number 6**

Information: Family 6 is a Thai Buddhist stem family whose numbers are a frail 79year old frail father (care receiver), a son (caregiver), and his youngest daughter. The mother died about five years ago. They all live in a small rented room in a shared, rented house. The family moved from Songkla province to live in Suratthani more than twenty five years ago when the key informant got a job as a bus driver in the city. The parents have seven adult children which includes three sons and four daughters. Two of the elder daughters died a couple of years ago. The other adult children are all married and live elsewhere with their own families. The living

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expenses of the household come from the caregiver's income and financial support from the caregiver's grown children sometimes.

Family caregiver: is a 47yesr old, fourth child (the first son), divorced man who is grade 10 (secondary level) educated. He has taken the role of primary caregivers of his father for the past seven years. He used to be married, then divorced, and has three adult children, two sons and a daughter. Now his youngest daughter, who is sixteen years old, also lives within this family home. His grown sons live elsewhere. He considers himself to be the primary caregiver to his father with the assistance from his daughter.

Care receiver (the father): is a 79year old man who is conscious and still can maintain the activities of daily living by himself. However, because of his age and deterioration of his physical abilities such as his eyesight, mobility, and movement the care receiver needs assistance based on the functional assessment of IADL such as preparing meals, housework, and getting about the community. The elderly father can no longer maintain the house chores or prepare foods for himself.

Care giving practice and supportive system: defined himself as a primary caregiver to his elderly father. He help in caregiving activities for IADL which the care receiver could not performed himself such as meal preparation, housekeeping, and transportation. The caregiver's youngest daughter also assists in caregiving activities and looks after the care receiver part of the time while the informant is working.

Other sisters and brothers do contribute financially for caregiving supplies from time to time but not as a routine. Nearly all of the expenses for caregiving of the father are paid by the primary caregiver.

**Family number 7**

Information: Family 7 is a Thai Buddhist nuclear family whose members are a frail 60year old woman (care receiver), her husband and their children. The husband, 63 year old, is a retired officer who is considered to be the head of the family. This couple has three adult children which includes two sons and a daughter. None of them are married. The daughter. The middle child is a son who works in a private company in Bangkok. The youngest son works in the public railway Department and lives in a another province. The daughter and the middle son reside with their parents. They live

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in a two-bedroom apartment owned by parents. The living expenses of the household come from the father's pension, the sons financial support from their salaries, and the daughter's earning sometimes.

Family caregiver: is 37year old, unmarried, eldest child of the family.

The informant has taken the role of primary caregivers of her mother for the past two years. Now, she defines herself as a housemaker who stays and look after both of her parents (mainly the mother). She sometimes works as a baby sitter for her neighbors to earn some money for herself.

Care receiver (the mother): is a 60year old woman the right side hemiplegia from a stroke two years ago. She now is conscious and alert, but still has a problem with communication. However, she needs help to some degree with her activities of daily living (ADL) such as assistance in bathing and toileting. For the instrumental activities of daily living (IADL), the care receiver cannot perform IADL independently. The caregiver is the main person who provides the assistance with the tasks such as meal preparation, housekeeping, medications.

Caregiving practice and supportive system: The informant is a primary caregiver to the fail elderly mother. She helps in caregiving activities for ADL which the care receiver could not performed herself. , her two brothers also helped her in the caregiver activities such as bathing, toileting, feeding. Now they help in providing financial support and all health services for the mother's needs.

**Family number 8**

Information: Family 8 is a Thai Buddhist stem family whose numbers are a frail 63year old mother (care receiver), a third daughter (caregiver), her son, and nephew (a son of the fourth daughter). The father has been dead for two years. The parents has six adult children which included five daughters and a son. Two elder sisters are married and live elsewhere with their own families. This family lives in a small rented room on a second floor of a shared house. The living expenses of the household come from the caregiver's earning, financial support from elder sisters sometimes, and support from a brother-in-law (husband of the fourth daughter).

Family caregiver: is 34 years old divorced woman, the third daughter, and has the education level of primary school (grade 4). The informant has been worked as a

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temporary employee for several kids of jobs. Now she makes her living from washing and ironing cloth for people in the neighborhood. She married twelve years ago and has a son who is now 10years old. However, she is now divorced and takes care of her son by herself. The informant has taken the role of primary caregivers of her father for a about year because her mother became very frail and lost ability to take care for herself.

Care receiver (the mother): is a frail 63years old woman who is completely dependent due to a stroke year ago. She now is conscious, hemiplegic on the left side, aphasia, and still has problems of incontinence. She needs total assistance in all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system:_The key informant is a primary caregiver to the fail elderly mother. She takes all the responsibilities in caregiving activities for ADL such as feeding, bathing, toiling, changing bedding due to incontinence, and position changing. The elder sisters visit the mother from time to time and provide financial support occasionally (which the informant said is still not adequate for caregiving expenses) but do not provide help in caregiving activities.

It could be concluded that the analysis of the above mentioned 8 families disclosed the factors why the elderly were well looked after.

The first factor involved age, gender of the caregiving and the situation of living together in one family between the elderly and the caregiving. The result showed that the female caregiving, age 30 – 44, and living in the same house with the elderly were able to closely care for the elderly better than those who lived in the separate house.

1. The other factor involved the age and the health condition of the elderly. Most elderly were in the age of 60-74 which were the young elderly who were still in good health and able to perform their daily functions. There were some whose health was not good but the main symptom was muscle problems.

2. The final factor was an economic issue. It was found that the financial status of the elderly 's family was at a good level. They mostly possessed a solid profession with enough income. At the same time, the elderly themselves earn their own living from farming although they did not need to share the expenses with the families.

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**The result of the in-depth interview with the second group – the elderly who were not well looked after by their families**

**Family number 1**

Information: Family1 is a Thai Buddhist nuclear family whose members are a frail 68years (care receiver), a adult daughter (caregiver) and her husband. The mother (care receiver) has three children with her ex-husband which includes two daughter and one son. She married once again but has no child with new husband. Now they are separated. The daughter (the key informant) is the eldest child in this family. The middle child is a son who was adopted by an other family since she was young. Now she is married and a lives elsewhere. The youngest son is also married and lives with his own family.

Family caregiver: is married, eldest child. She is 48years old with compulsory level (grade 6) education. The informant has taken the role of primary caregiver of her mother for the past two years since the mother has been diagnosed with Parkinson's disease. The mother has moves to live with her for about six years. Before being sick, she could do all daily activities by herself. The informant used to work in a private company but she quit her job nearly two years ago. Now, she defines herself as a homemaker who stays at look after her mother and takes responsibility of all household chores.

Care receiver (the mother): She now is conscious but still has problem in controlling body movement. Based on the functional assessment of ADL, she needs some assistance in toiling, bowel continence, and transferring. For the instrumental activities of daily living (IADL), the care receiver cannot perform IADL independently. The informant is the main person who provides the assistance with the tasks such as; meal preparation, housekeeping, medications.

Caregiving practice and supportive system: The key informant is a primary caregiver to the fail elderly mother. She helps in caregiving activities for ADL which the care receiver could not performed herself such as helping in transferring from place to place (if the distance is far), shampooing, fleet enema or bowel evacuation every three days. The informant's husband sometime helps in transportation of the mother to

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get health care services at the clinics or the hospital. The younger sister does contribute financially sometime but not very often. The younger brother has not routinely contribute financially or physically to the care needs of the mother.

**Family number 2**

Information: Family 2 is a Buddhist nuclear family whose members are a frail 63years old frail mother (care receiver), a son (the key informant), and the younger daughter. The father died nearly fifteen years ago. The parents had four children which includes two sons and two daughter. However, the eldest daughter died when she was young. The key informant is the eldest son in the family. The middle child is a son who was adopted by a related family when he was young. Now, the middle son is married and a lives elsewhere. The youngest daughter is not married and still lives in with the family.

Family caregiver: is 38yaers old, single, eldest son who has completed grade 10 education. The informant has taken the role of caregiver of his mother for the past four years since she had a stroke. .

Care receiver (the mother): is a 63year old woman Assessed by the Adl by herself. However, she still need some assistance in activities of daily living (IADL) such as; meal preparation, housekeeping, medications.

Caregiving practice and supportive system: He defined himself as a primary caregiver to the elderly mother. He helps in caregiving activities for IADL which the care receiver could not perform herself such as meal preparation, housekeeping and transportation. Since he said that now the care receiver is in a much better condition than the time that she was first had the stroke. At the time he and his younger sister provided all the caregivings to their mother including the ADL assistance. The younger brother does not provide any financial or caergiving activity support to the mother.

**Family number 3**

Information: Family 3 is a Thai Buddhist joint family whose numbers are a frail 78year old mother (care receiver), a second daughter (caregiver), and the youngest daughter and her family. The father passed away a year ago. They all live together in a

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small rented shared house. The parents have four adult children which includes three daughter and one son. The eldest daughter and son are married and live elsewhere with their own families. The caregiver and her youngest sister live together in this house. The living expenses of the household come from both of these to daughter in the household. The informant earns her living by selling juice and drinks a market near by her house.

Family caregiver: is the 50 years old, unmarried, second daughter of the family. She did not finish her primary school because of her parent's poverty. She has taken the role of primary caregivers for her elderly mother of the past 5 years and also took care of her father before he died. He passed away about a year ago in this house.

Care receiver (the mother): is a 78 year old woman who could maintain all the activities of daily living by herself. However, for the IADL such as preparing meals, housework, getting about the community are the tasks that the mother has difficulties in doing herself. Thus, it is difficult for the mother to live alone because she no longer could maintain the household chores or prepare food for herself. The mother is very thin but has no major health problem.

Caregiving practice and supportive system: He defined himself as a primary caregiver to the elderly mother. She helps in caregiving activities for IADL which the care receiver could not perform herself such as meal preparation, housekeeping, and transportation. The younger sister assists her sometime in taking the mother to see the doctor or buying medicines for her.

**Family number 4**

Information: Family 4 is a Thai Muslim, joint family with a 71 years old frail mother (care receiver), her 73 years old husband, a second child daughter and her family, the youngest son, and the youngest daughter (the caregiver) and her family. The father is still healthy. The parents lives in their own home.

This couple has seven adult children which includes three son and four daughters. Six of them are married and four of the married children live elsewhere with their own families. The living expenses of the household come from the parents saving and incomes of the daughter who share the house.

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Family caregiver: is a 36 years old, married, the youngest child of the family. She is primary school (grade 4) education. She took the role of primary caregivers of her mother about two year ago. The key informant married seven years ago and has only one daughter who is 5yaers old. She and her elder sister (the second daughter) run their own business by opening a small food parlor near their home.

Care receiver (the mother): is a 74year old woman who has health problems of arthritis and diabetes mellitus (DM). Three years ago she was diagnosed with osteoporosis and having the difficulty in walking or standing from time to time. She still can perform all the ADL by herself, but needs assistance in IADL such as preparation, transportation, houseworks.

Caregiving practice and supportive system: He defined himself as a primary caregiver to her mother because she is the youngest daughter who lives in with parents. Her elder sister also takes turn in taking care of the mother. Other married children live with their own families but not far away from their parent house. So, they sometime come to visit and help the key informant to look after parents and provide financial support.

**Family number 5**

Information: Family 5 is a Thai Buddhist stem family whose members are a demented mother aged 69 (care receiver), a daughter (caregiver), a sister-in-law and her children. The father died several years ago. The parents had three adult children which includes two daughters and a son. However, the informant is the only remaining child in her family because her daughter brother and an elder sister died a couple of years ago. They live in the house owned by her late brother. The living expenses of the household come from the caregiver's saving, nieces and nephew's financial support, and their earnings from receiving a packaging job to work at home sometimes.

Family caregiver: is the 44 years old, single, youngest daughter who has the level of education of primary school level. The informant used to work as a housemaid for several years. Then, she quit her job and has taken the role of primary caregivers for her mother for three years because her mother became very frail and lost ability to take care of herself. The informant is now a homemake who mainly looks after her mother.

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Care receiver (the mother): is a 69 years old woman who is completely dependent due to the severe degree of her impairment in cognitive functions (loss of all verbal and psychomotor abilities). She needs total assistance in all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The key informant is a primary caregiver to the frail elderly mother. She takes all the responsibilities in caregiving activities for ADL such as feeding, bathing, toileting, position changing, The sister-in-law and nieces help in caregiving activities sometime.

**Family number 6**

Information: Family number 6 is a Thai Buddhist nuclear family whose numbers are a frail 63year old mother (care receiver), the mother (a 57year old working woman), and daughter . She is considered to be head of the family since her husband has been sick. The living expenses of the household come from the mother's alary and the father's pension.

Family caregiver: is the unmarried daughter who lives at with her parents. She is 30yesr old, high school educated. and could not find a job so her mother asked her to look after the father and gives her a monthly allowance to her 3,000baht every month. She has taken the role of primary caregivers of her father for the past four years.

Care receiver (the mother): is a frail 63year old man who has been retired from his work five years ago due to his illness (a stroke). He now is conscious, hemiplegic on the left side, aphasia, and still has problems with chewing and swallowing. He is totally dependent for all care needs based on the functional assessment of ADL and IADL.

Caregiving practice and supportive system: The mother used to be a primary caregiver during the first three mother of her husband's illness. After that she hired a maid to help in taking care of him for a year. However, now the daughter takes the role as his primary caregiver especially during the time that the mother goes to work (6 AM until 4 AM.). The key informant takes all the responsibilities in caregiving activities for ADL such as feeding, toileting, and position changing during the daytime.

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**Family number 7**

Information: Family 7 is a Thai-Chinese, Buddhist joint family whose members are a 72 years old father (care receiver), a daughter (caregiver), her younger sister and three nephews (sons of the elder brother). The mother is a 67year old woman who is still healthy and lives in a home. She stays in this house from time to time. They bought this house nearly twenty years and let children who were not married live in this house. The other two daughters, who are not married, are the eldest and the youngest daughter. Two sons died several years ago. Three nephews (sons of the third child) currently live in this house. One daughter (daughter 7) and one son (son 6) are married and immigrated to the United States nearly twenty years ago. The living expenses of the household come from the informant's saving, the youngest daughter's salary, and assets of their parent.

Family caregiver: is the 43 years old, the eldest, unmarried woman who is grade 4 educated. She has taken the role of primary caregivers for her father for about a year since he has been sick.. Now she considers herself as a homemaker who looks after the house, takes care of her father and the nephews.

Care receiver (the mother): is a frail 67years old man who is semiconscious due to viral meningitis about a year ago. He was admitted to family decided to take care of him at home.

Caregiving practice and supportive system: The key informant defined herself as a primary caregiver to her father. At the same time, she also gets assistance in caregiving from her youngest sister and a live-in house maid. The youngest sister works fulltime during the daytime so she helps in caregiving during the night. Other sisters and brothers do contribute financially for caregiving supplies or health services as they are mindful of the fact they are not able to physically care of their father.

This was summarized from analysing 7 families and factors could be identified why the elderly were not well looked after.

1. An economic issue was the first factor. The elderly did not have any self-income while the caregiving families were poor. The caregiving were a farmer or an employee with unstable wages. Their income was not enough to share with the elderly.

2. The elderly' s age and health condition was another factor. It was found among these families that the elderly had regular sickness of more than one disease

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that required an ongoing treatment or sickness such as cataract, diabetes, high blood pressure, etc. that reduce their abilities in performing the daily functions. Other factor included the situation where the elderly and the caregiving were not staying in the same house. The caregiving had to care for their own family especially their offsprings and at the same time they had their own residence that could be within or outside the area. Having to pay more attention to their young children led to the declining attention toward the elderly. Their visits to the elderly were mostly restricted to the special occasions such as Thai New Year "Songkran" day, New Year Day, etc.

It was additionally found in 2 families of this latter group that the caregiving were also the young elderly whose abilities in performing the daily functions were also reduced. These caregiving looked after each other while their children were away for work.

**Summary**

**Finding Number 1:** Pattern of Elderly Caregiver by family, which was demonstrated in 3 patterns:

Pattern 1: This was the pattern that the elderly were able to normally perform their daily activities and they required only little help in their routine. The caregiver provided an assistance on socio psychological aspect through consultation and participation in family activities.

Pattern 2: In this pattern, the abilities of the elderly in functioning their routine became less and they needed assistance to perform their daily activities.

Pattern 3: The elderly that were ill needed close attention and caring.

**Finding Number 2:** Level of caring requirement

The level of the caring requirement depended on the level of sickness or the ability in routine functioning of the elderly. The caregivers of the elderly were respectively (a) their children (b) their spouse (c) their relatives. The reasons of being the caregivers were varied i.e. caring, being unemployed, non-available of others in the family. In the state of food preparation and cooking, it was focused on the physical

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condition of the elderly as well as their self-abilities. Normally, the caregiver and the elderly stayed together in one place. Most of the caregiver did not feel that the elderly were a burden although they might be few who may feel that. Nevertheless, most elderly preferred their children especially a daughter to be their caregiver. Most of the elderly also preferred the present caregiver as they not only felt that they have received good caring but also obtained close relationship and understanding. Furthermore, the elderly expected that they should obtain caring and loving as well as medical care and financial assistance from their children. They further expected that their children would visit and give them support.

**Finding Number 3:** In the Thai society, the elderly normally receive caring that responds to their needs which cover in term of physical, mental, emotion and social. The caregiving is categorized in 3 aspects.

1. Physical aspect
   1.1 the caring on food and water
   1.2 the caring on clothing and attire
   1.3 the caring on shelter
   1.4 the caring on medication
2. Socio psychological aspect
   2.1 being accepted and respected by family members
   2.2 participating in activities and interactions with others
3. Economic aspect

   Obtaining financial support or allowance

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# CHAPTER 5
# DISCUSSION

The result of the study on the pattern of caregiving for elderly by their families in rural communities of Suratthani Province is discussed according to the research objectives as follows:

## 5.1 General characteristic and health condition of the elderly

### 5.1.1 The elderly

The elderly used as the sample group of this research consisted of more female than male since 59.5 percent was female and 40.5 percent was male. This was congruent to the data of the elderly population of Suratthani Province that the number of female is more than male (Office of National Statistics, 2004: 29). Most of them were the age group between 60-74 years old, which were the 75.3% young elderly, followed by the age group between 75-84 years old with 19.6 percents, and old elderly who were older than 85 years old that was the old age group of only 5.1 percents. Most of them or 236 persons (59.5%) were married; 35.4 percents were divorced; and 5.1 percents were separated.

The elderly were entirely of the Buddhist religion. Most of them or 61.9 percents graduated from the primary school education, subsequently, 22.2 percents were illiterate, and religious study or literate with 12.6 percents respectively. The work characteristics of the elderly work were farming i.e. rubber tree plantation and rubber collecting with 30.4 percents, while 21.5 percents were housewives.

### 5.1.2 Health condition of the elderly

The perception of their health often depended on the capabilities to do their daily activities and living. The elderly could be sick from diseases which were no different_from other age groups. But the health problems of the elderly resulted from their body degradation (Suthichai Jitipankul, 1992: 36). The study of Niranath

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Vitayachokitikhuoon (1991: 24) revealed that more than half of the elderly had chronic diseases and most of them had more than one disease at the same time.

The findings showed that more than half or 70.9 percent of the elderly had chronic disease and they had at least more than one disease at any set time. The most prominent chronic diseases were muscle fatigue, bone and joint pain with 32.0 percents and 17.1 percent was alimentary tract sickness while 10.8 percent was headache/ dizziness, high blood pressure and 9.8 percent was allergy and asthma (as shown in table 2). These results are relevant to the previous study of the Ministry of Public Health in 2003, which revealed that most of the elderly had the health problems of back pain. Also, the study of Pornrachata Intharakoset (1993: 28) on the elderly inside and outside the municipal and rural area found that their chronic diseases were joint pain and fatigue followed by alimentary tract sickness.

## 5.2 Caregiving for the elderly

The research findings revealed that the elderly were moderately cared for as the statistic showed that the percentage of being moderately looked after was 36.8 which was the same percentage for being well looked after, while 27.8% was for not being well looked after. This was because most of the elderly were the young elderly between 60 and 74 years of age and still able to perform their self-daily functions that they needed little physical help. The assistance that the elderly needed from their children was mainly of difficult work. On the contrary, while staying at home the elderly could help the family do the housework or look after the young grandchildren. This is subsequently correlated with the previous study stating that the elderly reduced their roles from earning money for their family to helping within the household or, in another word, this is the character of helping each other in a family(Caffrey,1991: 39). Moreover, 79.7% of the caregivers was the elderly' s children who were working and unable to spend more time with the elderly. Meanwhile the caregivers who lived separately, especially those who lived far away could spend lesser time with the elderly. This is in accordance with the previous research of Napaporn Chatoyant (1992: 32) who disclosed that the children who lived nearby or within the same community would visit the elderly every day or 79.4% but for those who lived far

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away would visit the elderly only once a year or 90.2%. Their caring demonstrated in the non-physical form such as money or items.

In this study, the finding revealed that the elderly still received care and most of the caregivers or 79.9% were their children. This was harmonious to the expectation of Thai society that the elderly would receive support from their children because the social view perceives that caregiving for the elderly is a responsibility of sons and daughters (Malinee Wongsithi, 2000: 34). Consequently, the caregiver would live with the elderly in the same house which is mostly the house where the elderly live. Even though the family system may change but it was still found that 79.7 percents of the elderly lived in the same house with at least one child. Therefore, it can be said that the elderly lived with at least one child which was the dominant characteristic of this research. The elderly receive the caregiving not only from their children but also other persons such as spouse, and grandchildren.

### 5.2.1 Caregiving for the elderly in three aspects

#### 5.2.1.1 Physical aspect

1) Food

This study revealed that the elderly received 3 meals. The elderly received meat, vegetable, and fruit for some meal and some day. The preference of the given foods was 24.1 percents and 38.0 percents was for the foods without strong flavor taste. They received the same food as the other members of the family received with 40.5 percents and the amount was sufficient. The finding indicated that the elderly received inadequate food nutrition since it did not cover the 5 essential groups of nutrition and at the same time the food had strong flavor taste. The food received by the elderly that was the same as other members may be difficult to digest. Moreover the food for the elderly should covered 5 essential groups of nutrition. The taste of food should not be spicy, but should be soft, and easily to digest. If the elderly receive the good quality food with the valuable nutrients and appropriate for their health, it will decrease the aging process and prevent the sickness. So the elderly should receive the sufficient nutrients that contain both minerals and vitamins (U-Ruwan Walaipachara, et al., 1991: 37). This study indicated

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that the elderly may receive only sufficient amount. In addition, the elderly received the preferred food only 24.1 percents, therefore, they received the required food only about a quarter of the whole. Moreover, the strong tasting food such as too spicy, sourness, and sweetness is not good for the elderly. This may make the elderly eat less than normal. The fact that elderly received the same food as other family members, it might cause the alimentary tract disease such as peptic ulcer or gastritis, and stomach full of gas. This study revealed that many elderly were sick with alimentary tract disease. This result is pertinent to the previous studies.

The elderly received various types of caregiving. One elderly received different patterns of caregiving such as taking the food for the elderly, buying preferred foods and cooking for them or helping to cook for them, preparing and having meal together. From the study about the caregiving on food, it indicated that less than half of the elderly received food caregiving. Therefore, the elderly must help themselves in this issue. However, it was also found that one third of the elderly had meal together with other members in the family. The study of Sujitra Nillert (1996: 42) demonstrated that to having meal together with the family members correlated to life satisfaction, and this can a part of a prediction of the elderly life quality. Even though the social state may change but the elderly still receive the caregiving from the family members in various patterns.

2) Clothes

Most of the elderly obtained clothing from their children and the aid in clothing care for the elderly. It was found that most of the caregivers aided them for clothing care. It was obviously seen that their children was the first dependent sources of the elderly for cloths. It was also found that most of the caregivers who were their children would aid them for cleaning clothing, and providing clothes the elderly requirements. Few caregivers would clean the clothes for the elderly when they were sick or preparing clothes for them when they attended a social party. Therefore, their children still provided care for the elderly though they had to work for their earning, and some were able to even provide self-care. It was illustrated that the elderly were not a burden for their families or caregivers because the elderly were able to look after themselves on the clothing matter.

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3) Shelter

From the study, it was found that the elderly received the caregiving from their children and the most caring that they received were sweeping and cleaning, while few would arrange the house to have enough light and air flow. This indicated that the caregiver lacked care for the elderly regarding the environmental arrangement with safety for them. This might cause the harm to the elderly. The study of Anan Tunmukyakul (1993: 35) showed that the major cause of the hurtful case of the elderly was falling on the floor. Therefore, good environmental management can decrease the accident of the elderly as well.

4) Health care

When the elderly were sick, most of them would receive the aid from their children by taking them to a health service. The elderly were normally taken to a clinic or a health center as their needs or the place, which they have often gone. The children managed the medical care and the transportation. Few elderly received the aid from others who were not caregivers, or relatives, or neighbor. This case only happened when the caregivers were busy, or the elderly would like to receive the caring from other children who possessed better financial status. It might imply that the elderly understand the need or limitation of the caregiver to use the most of their time for their professions. It was noticed that when the elderly were sick, they received a visit and care from their children/grandchildren who lived far away. On the other hand, when the caregiver was busy, their relatives who lived nearby would bring the elderly to have the medical care. This illustrates that Thai society in the rural area still aid each other.

5.2.1.2 Caregiving in the socio-psychological aspect

The previous studies revealed that the progression and modernization both in town or rural area caused the respect of the young generations to the elderly to decline. Accepting the elderly opinions or asking advice from them became less as the younger generations thought that the elderly were old fashioned and out of date (Werasit Sithitrai & Yothin Sawaengdee, 2000: 39).

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This study found that the people of the sample family still paid respect to the elderly by performing according to their suggestions and teachings, asking for advice, being of a courteous manner, and talking with feelings. About half of the elderly received caregiving and consideration together with socio-psychological aspect, it was found that the level of the caregiving for the elderly was moderate to high level. This illustrated that the elderly still received the respect from the family members. The people in the family, paid attention to the elderly by supporting them to practice in the activity or participate in the community activities, particularly, religious activities. These activities made for peace and satisfaction within the family. Even though in this study it was found that some elderly did not participate because they were unable to do so due to their health problems. It could be concluded that the elderly still received caregiving in the socio-psychological aspect. Although some group of the elderly received fewer care or had disagreed on the aspect, this was depending on the children consciousness and parents behaviors. It was correlated with the studies of Caffrey (1991: 68), and Sujitra Nillert (1996: 36) which revealed that the children who paid respect and aided their parents were based on their consciousness as well as parents practiced behavior.

5.2.1.3 Economic aspect

This study found that the majority of the elderly still took the responsibility for their house and expenses. It might be that most of the elderly still had their income from farming and received some money from their children. The children might look after the products and bring the income to the elderly to pay for household expenses. The elderly who had the problem of financial aid, they were supported mostly by their children when they needed this aid.

**5.2.2 Results of analysis the level of caregiving for the elderly**

Most of the elderly caregiving was at the moderate level with 65.2 percents. The number of the elderly was equal at low and high level. This was relevant to Thai social environment that when parents became older, their children had a duty to take care them. The children who lived in the same house with the elderly looked after them while others took them to live in their houses. Therefore, the situations of

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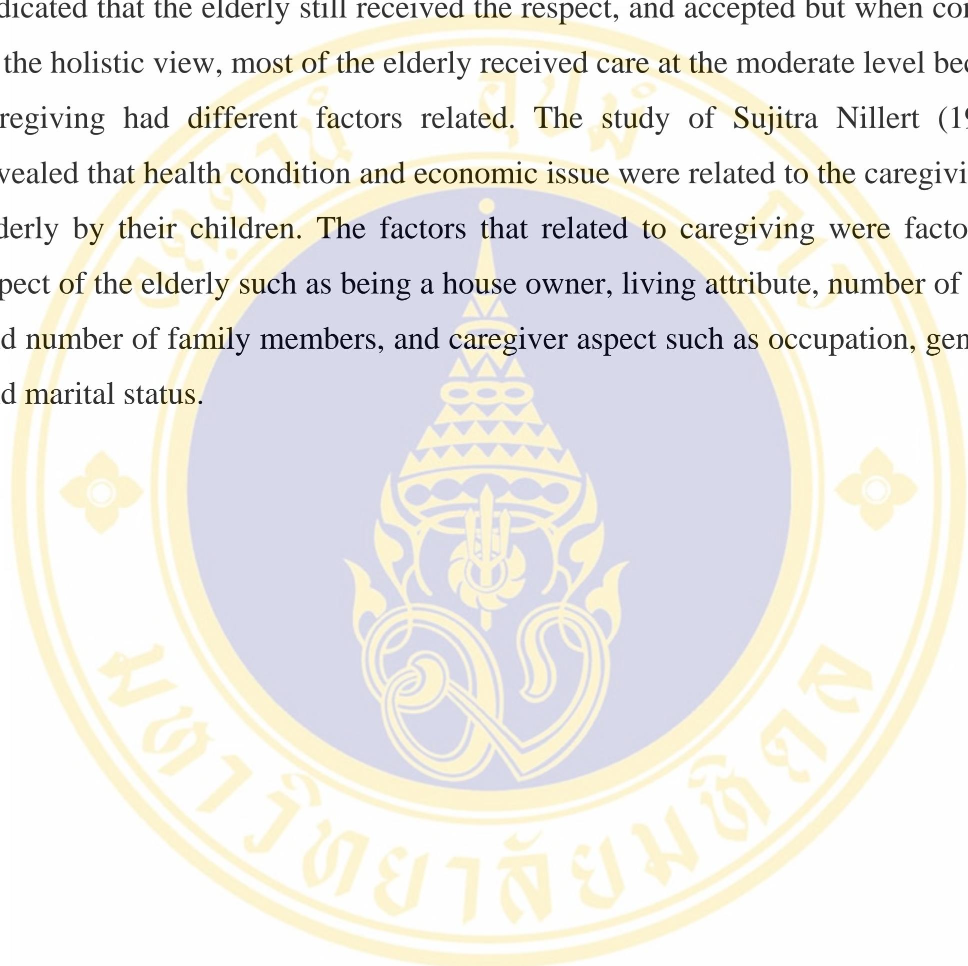
society, economic, value, and culture would be changed. This study indicated that the elderly in Thai rural areas still received care from their children or families even though there were some elderly who did not receive respect, and being disobeyed by the children claiming that they were out of date and old fashioned. This study also indicated that the elderly still received the respect, and accepted but when considering in the holistic view, most of the elderly received care at the moderate level because the caregiving had different factors related. The study of Sujitra Nillert (1996: 36) revealed that health condition and economic issue were related to the caregiving of the elderly by their children. The factors that related to caregiving were factors in the aspect of the elderly such as being a house owner, living attribute, number of children, and number of family members, and caregiver aspect such as occupation, gender, age, and marital status.



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# CHAPTER 6
# CONCLUSION AND RECOMMENDATION

This study is a descriptive and analysing research aiming to learn the pattern of caregiving for elderly by their families in rural community of Suratthani Province.

Mix-methodology was used through a survey research and the qualitative research applying a technique of an in-depth interview along with the following objectives.

1. study the situation of caregiving for elderly by their families in rural To communities of Suratthani Province.
2. To study the pattern of caregiving for elderly by their families in rural communities of Suratthani Province.

## 6.1 Conclusion

**6.1 The situation of caregiving for elderly by their families in rural communities of Suratthani Province.**

Focusing on physical, socio-psychological and economic issue on caring for the elderly, it was found that 36.8% of the elderly was moderately looked after. The caregivers included their children, spouse, and relatives.

Caring provided for the elderly was as followed.

It was discovered that 38.5% of the elderly was physically well looked after. They were cared for in terms of food, water, clothing and attire, shelter, along with medical caring. Food and water were prepared while clothes and attire were made, washed, cleaned and kept tidy by the caregivers.

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As for shelter or a living quarter, caregivers would clean and tidy the place for the elderly. Hence, it was noticed that the safety issue was of a less concern. However, should there be any sickness, medical caring was always provided which could be in a form of buying medicine from a drugstore or taking the elderly to the hospital or the healthcare center depending on the condition of the patient. If the elderly were admitted as an inpatient they would always be accompanied by someone in the family.

The caring in term of socio-psychological aspect revealed that 41.7% of the elderly was moderately looked after. They received praise and respect from members of the family. They also participated and interacted with members of the family.

On the other hand, 34.2% of the elderly received less care in the economic terms. The caregivers provided financial aid for the routine expenses and only when the elderly did not have enough to spend.

**6.2 The pattern of caregiving for elderly by their families in rural communities of Suratthani Province**

It can be concluded from this research that there are 3 patterns of the caregiving to the elderly

Pattern 1: The elderly are able to perform routine functions that they require less assistance. The caring for them is in the socio-psychological aspect through consultation and being part of the decision making in family activities.

Pattern 2: The elderly 's abilities to perform routine functions are less that they need help.

Pattern 3: The elderly are sick that they need care and attention.

## 6.2 Recommendation

As the findings revealed that the elderly were moderately looked after, therefore, a new caring method must be introduced in order the caregivers to possess more abilities to care for the elderly. At the same time the elderly should be encouraged to look after themselves.

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**Following is my recommendation.**

1. To encourage and develop the competency of caregivers. This is to assist the caregivers to properly look after the elderly at home. Counseling on elderly healthcare and general caring should be given to caregivers.

2. To encourage the competency of self-care of the elderly. This can be done by providing information and news together with advice on healthcare. At the same time, elderly caring service that can help them to properly adjust themselves should be arranged by organizing meetings, group discussion, promoting elderly healthcare groups, etc.

3. To encourage family and community to participate in elderly caring. Various activities should be arranged within a family in order to create good relationship as well as to implant social value among the young generations to respect and be aware of the senior citizens.

4. The concerned state departments and local private enterprises should support family members that provide caregiving to elderly in terms of finding work that suit the situation which will help the caregivers to earn their living and simultaneously look after the elderly.

It is also recommended that there should be special welfare for families providing cargiving to elderly such as tax reduction, free school tuition for the young of the caregiver family, etc.

Besides providing care to elderly, there should also be some development to encourage the community to reach out and support. Not only the support given by the state but everyone in the society as a whole should pay attention to this issue. The support should be in all aspects of physical, mental, and spiritual while the development should be effective especially on the public policy of the local administration office i.e. the office of the sub-district administration that should include a policy on the elderly, as following suggestion.

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1. Caring and promoting people healthcare focusing on elderly healthcare service should be added in an annual operational plan. The plan should stress on the development of caregiving to the elderly and elderly self-care such as arranging a training program for elderly caring, the competency development program for elderly self-care, knowledge providing program for students on elderly healthcare promotion, etc.

2. Determining a promotional policy by exchanging knowledge and experience relating to elderly caring and healthcare with other communities through the participation with elderly organization network. This will be an opportunity to exchange information, knowledge, experience and coordination with other communities for sustainable development on the elderly issue.

Moreover, healthcare officers and other related officers within the community as well as NGOs should identify a policy in supporting knowledge, experience, funds and facilities in the operation of different programs relating to the elderly. Thus, the community can smoothly perform functions which can lead to a better quality of life among the elderly in the community.

## 6.3 Research Constraints

I am aware of the weaknesses and incompleteness of this thesis. From these weaknesses, I learn how to conduct better research in the future. Apart from the time constraint, I also suffered from a chronic disease, which required that I took some time off during the period of thesis writing in order to rest and receive a strict scheme of treatment. In addition, I unfortunately had accidents. Worse of all, many of my computer files were damaged by a virus, which prevented me from deeper analysis. In the next occasion when I have an opportunity to conduct a study, I will bring this experience to bear to make it more complete.

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# APPENDIX

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# APPENDIX A
# SPECIALISTS

| | |
|---|---|
| 1. Assoc. Prof. Dr. Jintana Yunibhan | Faculty of Nursing<br>Chulalongkorn University |
| 2. Asst. Prof. Dr. Suchada Ratchukul | Faculty of Nursing<br>Chulalongkorn University |
| 3. Lect. Dr. Jiraporn Kheiwyoo | Faculty of Nursing<br>Khon Kaen University |
| 4. Assist. Prof. Dr. Panida Damapong | Faculty of Nursing<br>Chulalongkorn University |
| 5. Dr.Thusanee Nontason | Ministry of Public Health |

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## APPENDIX B

QUESTIONNAIRE

SUBJECT

**Pttern of caregiving for elderly by their families in rural communities of Suratthani Province**

**(Example of questionnaire)**

Test form number…………………………………………………………….

Date of data collection ……………………………………………………….

**Direction** Please answer the following items and mark ✓ into ( ) or fill in the blank with your true information.

**Part 1** consisted of personal data of elder such as age, gender, family type, and health status and demographic, economic, and social of elder caregiver in the family consisted of age, gender, career, income, and marital status.

1. Sex

( ) Male ( ) Female

2. Age ……….years

( ) 60 - 74 years

( ) 75 - 84 years

( ) 85 years up

3. Your marital status

( ) Couple

( ) Divorce

( ) Separation

4. Your highest education attaiment

( ) No schooling/ lliteracy

( ) Primary school level

( ) Secondary school level

( ) High school level

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( ) Diploma/ vocational level

( ) Others (Religion , Literacy) …………………………………….

5. Your present work attributes

( ) House work aid

( ) House care

( ) Grass cutting

( ) Grand children care

( ) House gardening

( ) Others (Rubber plantation/ rubber collecting)

6. Your's occupation

( ) No occupation

( ) Agriculturist

( ) A merchant

( ) An employee

( ) An officer of a semi-government sector

( ) An officer of government sector

( ) An employee or an officer in the same academic institute as you

7. Host

( ) Owner

( ) Children house

( ) Grand children house

( ) Others (Community social welfare house)

8. Your's family members (Persons)

( ) 1-3

( ) 4-6

( ) > 6

9. Chronic Disease

( ) Have

( ) No have

10. Chronic Disease

( ) muscle fatigue, bone and joint pain

( ) alimentary tract sickness

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( ) Headache/ dizziness

( ) High Blood pressure

( ) Allergy/Asthma

( ) Constipation / Hemorrhoid

( ) Diabetes

( ) Heart Disease

( ) Lung disease/tuberculosis infection

( ) Others (dermatitis/blood disease,/cancer/cataract eye)

11. Sickness during the past year

( ) Often sick

( ) One in a while

( ) Never sick

12. Your's Health State Perception

( ) Strong

( ) Rather strong

( ) Moderate

( ) Rather weak

( ) Weak

**Part** 2 is the questionnaire for investigating the caregiving behavior of the family toward elder consisted of the caregiving for elder in daily life, caregiving in social psychology and economy which have details as follows:

13. Relation with the Elderly

( ) Children

( ) Spouse

( ) Grand Children

( ) Others ……………………..

14. Shelter Attribute

( ) The same house

( ) Different house but in the same boundary

( ) Different house and far away

( ) Others ……………………..

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15. Caregiving about Food , Food that the elderly received

( ) Every meals have meat, vegetable, fruit

( ) Some meals have meat, vegetable, fruit

( ) Soft food and easily chew food

( ) Favorite food for the elderly

( ) Not strong taste food

( ) The similar food as others in the family

( ) Strong taste food (spicy, sour, salted, and sweet)

( ) Supplementary food that proper to disease(Others (Sweets, Soft drinks)

16. Food caregiving for the elderly

( ) Take the preferred food for the elderly

( ) Ask and buy preferred foods for the elderly

( ) Buy, and cook foods for the elderly

( ) Buy, and aid then to cook for the elderly

( ) Buy, and let them cook foods by themselves

( ) Provide the food for the elderly

( ) Aid in washing the dishes

( ) Have meal together

( ) Provide the special food for the elderly

17. Number of meals that the elderly received

( ) 1 meal

( ) 2 meals

( ) 3 meals

( ) 4 meals

18. Sources of clothing

( ) Children

( ) Grand children

( ) Spouse

( ) Relatives

( ) Buy by himself / herself

( ) Neighbor

( ) Others …………………

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19. Cloths caregiving for the elderly

( ) Bring them to buy or let the dress maker do

( ) according their wants

( ) Buy cloths according to their wants

( ) Clean and neatly keep

( ) Repair the cloths to be in good condition

( ) Provide the appropriate and sufficient cloths with the season /special occasion

20. Shelter caregiving for the elderly

Sleeping place

( ) Provide bed, pillow, and mosquito net.

( ) Arrange the sleeping place relevant to the elderly wants

( ) Arrange the sleeping place with light and air flow

( ) Lay the bed/ hang mosquito net /bedding

( ) Sweeping, and ribbing

( ) Clean bed/let dry with the sunlight

( ) Repair the bedding

( ) Self-managed

21. Caregiving for the elderly about Shelter

( ) Sweeping inside the house

( ) Arranging the house to have adequate light both inside, outside house, walking way, and toilet

( ) Keep the house equipment inside the house

( ) Repair the house in a good condition

( ) Sweeping and collecting the trash around the house area

( ) Self-managed

22. Caregiving for the elderly when they sick , Self-performance of the elderly

( ) Self-care (drink the warm water and take rest)

( ) Receive the treatment or buy drug by yourselves

( ) Request for help..................

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23. Receive the treatment or buy drug by themselves

( ) Buy from drug store, and drug fund of village

( ) Receive the treatment

( ) Medical Clinic

24. The elderly who asked for aid from others

( ) Children /grand children

( ) Children /grand children brought them to health station

( ) Spouse

25. Caregiving for the elderly when they got slight sickness

( ) The elderly taken to clinic or health station as their wants or the place, which often gone

( ) Take the elderly to see doctor and aid for the expense and transportation

( ) Take the elderly to see doctor and they pay for the expense and transportation by themselves

( ) Buy drug and prepare drug

( ) Buy drug and let the elderly take drug by themselves

( ) Give the money to buy drug or let them doctor by Themselves

( ) Suggest health service and support to get treatment

( ) Give suggest about for self-care

( ) Relative, Neighbor, children who were not caregiver brought to get treatment

( ) Be able to help themselves and need no help

( ) No caregiver

( ) Caregiver wants to take them to see the doctor but they do not want.

26. Caregiving for the elderly when got sick and rest at home

( ) Caregiver was arrangement drug for them

( ) Preparing the favorite and proper valuable food for disease

( ) Caregiving about the adequate food

( ) Arrange the sleeping place to be clean and air flow

( ) Arrange the elderly to sufficiently rest and sleep

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( ) Do not them stay alone and request the answer the question

( ) Provide soft drinks and supplements

( ) Visit and bring food for them

( ) Self-care and not require any caregiver

( ) No caregiver during sick

27. Sick and must be stay at hospital

( ) Never stay at hospital

( ) Ever stay at hospital

28. Caregiving for the elderly when got sick and stay at hospital

( ) Aid for treatment expense

( ) Take the food, soft drinks, and supplements

( ) Look after and closely aid (arrange food, drug, clean body)

( ) Caregiver no time to look after (Children and spouse) look after

( ) No caregiver

29. Caregiving in Socio-psychological Aspect

Receive respects from the family members

( ) Perform the courteous manner

( ) Talk to the elderly with closely feeling

( ) Ask for the advice and exchange the experiences each other

( ) Perform according to the suggestion and teaching

( ) Let them perceive the family problems

( ) Let the elderly to make decision for family problems

( ) Visit and ask for blessing

( ) Disobey, dispute, rude speaking

( ) Do not tell the problem because do want to make the elderly unhappy feeling

30. Caregiving for the elderly to have activities and interact with other people

( ) To visit relatives

( ) Do not receive the aid (n = 30)

( ) Go by himself, Have money, healthy

( ) Poor, poor caregiver, no time

( ) Poor Health

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( ) Children/grand children pay no attention

( ) Relatives, children/grand children come to visit

31. Receive the aid when go to visit relatives

( ) Provide the transportation

( ) Provide the gifts

( ) Give money

( ) Prepare dress and aid for dressing

( ) Go together

32. Support the elderly to participate the activities

( ) Religious activity

( ) Social activity

( ) Group activity (the elderly)

33. Aid to support the elderly to participate the activities

( ) Provide transportation

( ) Provide gifts

( ) Give money to aid for expense

( ) Tell the information

( ) Support the will power

( ) Prepare the cloths

( ) Children support but their have poor health

34. Support those to use spare time to be benefit for leisure

( ) Support to have hobbies

( ) Provide materials (radio, television, and books) support to have conversation to friends

( ) Persuade to exercise or play games

( ) Bring them to visit fair or tour

( ) Go to temple to practice the Dharma

35. Daily Living Expense

( ) Personal expense

( ) Household expense (electricity, food, and others)

( ) House and thing repair

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36. Income

( ) Have

( ) No have

37. Source of income of the elderly

( ) Gardening

( ) Farming

( ) Their own superannuated money/ spouse

( ) Their children

( ) Business

( ) Hire (rubber collecting)

( ) Saving/ interests

( ) Grand Children, relatives

( ) Massage

38. Sufficiency of income)

( ) Sufficiency

( ) Insufficiency

39. Sources of income of the elderly who had no income

( ) Their children

( ) Governmental welfare

40. Sources of aid when insufficient income

( ) Their children

( ) Relatives

( ) Neighbors

( ) Bank Loan (Agriculture and Cooperation Bank)

( ) Search work

( ) Not spend and let children to spend and earn

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# BIOGRAPHY

| | |
|---|---|
| **NAME** | Ms. Chalouy Laubunjong |
| **DATE OF BIRTH** | 19 April 1966 |
| **PLACE OF BIRTH** | Suratthani, Thailand |
| **INSTITUTIONS ATTENDED** | Phra Pok Klao Nursing College,1985-1989<br>Diploma in Nursing Science<br>(Equivalent to Bachelor of Science in Nursing)<br>Sukhothai Thammathirat University, 1993 - 1996 Bachelor degree of Education<br>(Educational Administration)<br>Chulalongkorn University, 1992 - 1995<br>Master degree of Nursing Science<br>(Nursing Education)<br>Mahidol University, 1997 - 2005<br>Doctor of Education<br>(Population Education) |
| **OFFICE ADDRESS** | Boromarajonani College of Nursing<br>Suratthani, Suratthani Province, Thailand<br>E-mail : chalouy19@gmail.com. |
| **POSITION** | Nursing Educator |
| **HOME ADDRESS** | 67 Mu 5, Tombon MaKamTae,<br>Amphoe Muang, Suratthani<br>Province, Thailand 84000 |

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