DEPRESSION LITERACY AMONG FAMILY CAREGIVERS OF OLDER ADULTS: A QUALITATIVE APPROACH

BY

WARIYA CHANKHAM

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY (NURSING SCIENCE)
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ABSTRACT

Background: In Thailand, caregiving for the elderly with depression is becoming a serious social issue as life expectancy is increasing, resulting in the need for special care. This is why family caregivers' depression literacy is critical for the depressed older adult.

Objectives: To explore family caregivers' depression knowledge, factors contributing to depression, attitudes, and management strategies toward caring for the older adult with depression.

Method: A qualitative approach was used to explore family caregivers' depression literacy regarding geriatric depression. The participants were 17 family caregivers who had experience in caring for an older adult with depressive disorder at home. Semi-structured interviews were used to collect data, and thematic content analysis was used to analyze the data.

The results showed that depression literacy in family caregivers was insufficient. A qualitative content analysis of the data revealed five themes and ten categories. The themes defined how knowledge of depression arises from perceptions and observations of behavioral changes. There are 3 sub-themes: perceiving suffering of stress and emotional changes; observing speech and behavioral changes; and perceiving depression by informing healthcare providers. The themes had multiple factors leading to depression, such as

personal habits, loss of a significant person, feelings of disappointment, and socio-economic problems such as an unsuccessful business, and unemployment. There are themes of rethinking in positive ways by accepting being a caregiver and being happy and proud of providing care for a loved one. Themes of negative attitudes included being frustrated. Themes of having strategies to properly manage care included the calming down of feelings, providing comfort and encouragement, and seeking resources.

Conclusion: Depression literacy in family caregivers was significantly higher among older adults with depressive disorder. Family caregivers' attitudes were important and directly affected the older adult with depressive disorder. There is a need to develop a network of health volunteers to watch for abnormal symptoms and complications, and to organize a health volunteer mentor system to provide initial assistance and knowledge support.

Keywords: DEPRESSION LITERACY, FAMILY CAREGIVERS, OLDER ADULTS

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MISS WARIYA CHANKHAM

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CHAPTER 1
INTRODUCTION

1.1 Background and Significance

The social structure has been changed in Thailand. In 2014, the 'Foundation of the Thai Gerontology Research and Development Institute' (FTGRDI) reported that the Thai older adult population has increased due to the low birth rate and the development of medical technology and healthcare. In 2016, the Thai population aged 65 and over is approximately 7.50 million, consisting 11.00 % of the general population, compared to approximately 5.00 % in 1995. (Department of Provincial Administration, 2019). In 2021, there were 12.07 million people aged 60 years and over, representing 18.24% of the Thai population (National Statistical Office, 2022). It has been predicted that by 2040, the Thai older adult population will be 17 million (World Bank, 2016), which is more than a quarter of the population and the highest share of any developing country in the Asian and Pacific area (McQueen, 2012).

Depression can occur at any age, but is more common with age, especially the older adults (Wongpakaran, 2008). Geriatric depression is not a normal part of aging, but it is one of the most common mental and psychiatric disorders which need management (Centers for Disease Control and Prevention, 2017). It is estimated that 4.40% of the world's population suffers from depression. Global prevalence rates of depression vary by age, peaking in older adulthood, aged between 55 and 74 years, above 7.50% in female, and above 5.50% in male reported in 2015 (WHO, 2017). In Thailand, it is also the most prevalent mental health problem among older adult in women and the third most common health problem among older adult in men (Department of Mental Health, 2017; Bureau of registration of administration, 2018). The prevalence of depression in Thai older adults population increased from 4.2 million (7.20%) in 1990 to 7.2. million (11.50%) in 2010, (Wongpakaran, 2008) and to 18.50% in 2019 of older adults population (Charoensakulchai, et al., 2019).

The aging process is a dynamic biological reality that is largely beyond human control. The causes of depressive conditions in the older adult includes biological, psychological, and social factors. Researches have shown that physical decline and mental impairment are correlated to depression in older adults. Risk factors for depression among the geriatric population were identified as low socioeconomic status, loss of a spouse, living alone, cognitive impairment, other chronic health problems, bereavement, and limited activities of daily living (WHO, 2017). The social factors were social participation activities and family relationships (Yoelao, Thammapitak & Prasertsin, 2016).

Depression is an illness that affects the mental health of older people who may generate low self-esteem, and often feel worthless and burdensome. Individuals aged 60 years and older are prone to commit or attempt suicide when compared to any other age group (Conejero, Olié, Courtet, & Calati, 2018); WHO, 2018). There are more than 75,500 suicide cases among older adults in Thailand associated with depression with high suicidal risks in 2017 (Kongsuk, et al., 2017), i.e., depression can eventually lead high-risk individuals to commit suicide with such cases closed to 800,000 people annually worldwide (WHO, 2017). World Health Organization recommends that depression is a major global burden that needs long-term care (Gautam, Jain, Gautam, Vahia, & Grover, 2017). Early diagnosis and treatment of depression decrease medical costs and pressures on caregivers (Padayachey, Ramlall & Chipps, 2017; WHO, 2017). However, treatment obstacles include lack of resources, a shortage of knowledgeable healthcare practitioners, and social stigmatism. In Thailand, 76.00% to 85.00% of people in low and middle-income countries does not received care for depression (WHO, 2020). Although psychiatric hospitals provide services for this group of people, the older adult have difficulty accessing this kind of healthcare system by themselves, particularly in rural areas. Therefore, it is relied on family caregivers' awareness and care given to the older adult who have chronic illnesses or mental health problems (DMH, 2017).

In Thailand, the majority of the population does not recognize and have restricted knowledge of depressive disorder (Phantong, et al., 2019), which may cause high suicidal rates among older people. Depression in the older adult is rarely diagnosed or overlooked due to unclear symptoms. It often is difficult for elders with a depressive disorder to describe

how they feel. Family caregivers' recognition of depression is crucial to identify and detect the older adult who have depression. Research on the benefit of depression awareness of the family suggests that family members play an important role in the quality of life and well-being of the older adult (Schulz & Eden, 2016).

The National Academies of Sciences, Engineering, and Medicine (NASEM) in 2016, indicated that the older adults always depend on their families in providing them emotional support and assistance when they can no longer function independently. In older adults, the aggressive or negative attitudes of family caregivers and their well-intentioned backfire acts are correlated with greater depressive symptoms (González, et al., 2010). Older adult cooperation and prevention from experiencing symptoms of depression could help alleviate the problem (Kleebthong, Chareonsuk, & Kristiansen, 2017). Family caregivers were significant to older people's decisions about engaging in social activity.

Older adults are historically the key or decision makers in a family and highly respected by society. In general, families are the basic social unit that provides gratifying physical needs, food, shelter, mutual sexual relationship, and belongingness especially for its elder members (Lu, Yuan, Lin, Zhou, & Pan, 2017). A family function has a close relationship with a variety of influential factors that are related to physical health and mental health including depression and loneliness (Guan, Wen, Gong, Liang, & Wang, 2014). Positive family relationships could increase the chance of a positive health outcome and improve the quality of life of its members as this is strongly practiced in the context of Thai culture of whom children has a strong sense of gratitude towards the parents. Therefore, it is believed that members of family caregiver’s participation in all dimensions of health care will become effective with the older adults at risk of depression (Wongsaree, 2019). Family is an informal resource. It is important to prevent depressive symptoms of older people. Mental health literacy is the way to prevent severe mental illness (Kaewprom, Yuthavisut, Pratoom, & Boontum, 2014).

If the older adults suffer from depression and did not enter the treatment process, they may commit suicide. Therefore, depression prevention and helping older people with depression enter the treatment process is important. Access to treatment for depression

among the elderly is currently limited, as the depressive condition in the elderly is caused by a combination of factors. The symptoms of the older differ from those of other ages, with more physical symptoms than depression or melancholy (Ediriweera, Fernando & Pai,2012). Therefore, depression in the older is frequently difficult to screen, aged misdiagnosed and adequate therapy necessitates a doctor's diagnosis. As a result, depression in the elderly is frequently difficult to detect, leaving the aged misdiagnosed, and adequate therapy necessitates a doctor's diagnosis.

A review of the literature on older adults with depression found that Families play an important role in involving the older into the treatment process. However, recent studies have found that few families encourage or take depressed elderly people to the doctor. compared to taking a child or other member with depression to the doctor (White&Casey, 2017), if a relative, caregiver or close person with depression knowledge is able to observe symptoms, and they has depression literacy, or a good level of knowledge. It is important to prevent depression and suicide in the older. Therefore, it is necessary for family caregiver to be aware of depression literacy.

Depression literacy is a specific type of mental health literacy and defined as the ability to recognize depression and make informed decisions on the appropriate management. With profound knowledge in mental health, this enables family caregivers to recognize, detect factors and prevent depression. The component of depression literacy is knowledge, perceived factors of depression, attitudes toward caring for depression and manage depression for their relative. The knowledge of depression was recognition of the disorder includes knowledge of symptoms, intervention, first aid, causes and prevention. Perceived factors of depression are characterized as the ability to identify risk factors and protective of depression and make decisions a treatment and management for appropriate situation (Ho.et. al, 2018), seeking for professional treatment or intervention its correlated with positive attitudes towards using mental health care services (Jorm, 2000; Rickwood et al., 2005).

Depression literacy effect with depressive disorder during the person having depressive symptoms. The study in parental responses, attitudes, and understanding of

teenage depressive symptoms founded the moderated of depression literacy can improve of teenage depressive symptoms (Johnco& Rapee, 2018). From randomized controlled trial study, depression literacy can improve depression symptoms in workers (Imamura ,et al., 2016) and same with a control group depression literacy program among adolescent in Malaysia can improve depression symptoms (Ibrahim, Mohd Safien, Siau, & Shahar, 2020).

In some parts of rural areas in Thailand, people could not access mental health service, so mental health literacy became the responsibility of the family caregivers. Understanding the cause of depression and recognizing symptoms of depression is very important to be able to undertake the next step. As family caregivers live together with older adults, it is essential to understand that depression is not a normal sign of aging. Seniors need help to deal with the depression symptoms as anyone else to protect and prevent them from harm. However, family caregivers may lack knowledge about depression and skills to observe symptoms of geriatric depression.

Basing on the emphases of these researchers emphasized that there was insufficient evidence on the study regarding depression literacy in rural areas of developed, developing and less developed countries around the world (Deen & Bridges, 2011; Tonsing, 2018), The presence of current literature nowadays pointed out that members of the family with either poor knowledge or awareness with certain facts were not even considered to implement a resolution of the client's condition. Recognizing symptoms executed by family caregiver with depression literacy is based on how an individual manage the situation and being personally observed. The researcher desired to ensure every family's on-hand experience will be expressed verbatim, then the researcher will include qualitative in-depth interview and opinions that would allow deeper and comprehensive understanding about depression literacy.

Although some researchers have identified factors related to geriatric depression and tried to find out the programs and interventions to solve this problem (Forsman, et al., 2011; Reangsing, Rittiwong, & Schneider, 2020). Some studies in mental health literacy are found and geriatric depression has not been widely recognized by the general public. Although there are a few studies on depression literacy among professionals in Thailand that have

been conducted (Kraithaworn &Noinam, 2021), no study has been carried out about depression literacy among family caregivers nor using a qualitative approach to deeply understand this problem. This study was to explore depression literacy among family caregivers.

1.2 Research Questions

1. How does the family caregivers recognition of depression literacy?
2. What are the components/dimension of depression literacy of family caregivers caring for older persons with depression ?
3. What are the family caregivers management strategies for caring for geriatric depression ?

1.3 Research Objectives

1. To explore family caregivers' recognition of depression about geriatric depression
2. To explore the components/dimension of depression literacy of family caregivers' perceived of older persons with depression.
3. To explore family caregivers' management strategies for caring for geriatric depression.

1.4 Philosophy underpinning

The philosophy underpinning this study is existentialism that concerns with what is at hand and current of which the four (4) keys, meaning, freedom, choice, and responsibility are the core concepts and having a mind of its own perception on the rising circumstances around its environment, recognizing that resolutions should be based on the realities of its presence (McDonald, 2000).

Externalists claimed that an individual would not be able to know about his existence without the results of personal experiences. Through these particulars, the researcher believed from life experiences, perceptions, understanding based in an individual's beliefs.

The aforementioned ethical values were essential because the research questions were based on these claims. The researcher realized the complexities involved with every structure of families, roles, relationships, and functions of an older adult member with depression as well as with other members of the family circle. Each member of the family has their own different attitudes, interests, experiences, educational backgrounds, and economic status that would make it tough to determine depressive symptoms among older adult members of the family. However, the researcher discerned the different impacts of family decisions to manage, primary prevention of symptoms, providing first aid or bringing older adult family member to the hospital. Therefore, the researcher recognized that this phenomenon is crucial to incorporate qualitative techniques.

The researcher conducted a qualitative study to explore depression literacy among family caregivers following the knowledge, attitude, belief, understanding, and management of depressive symptoms should be on an individual perspective and survival experience. Therefore, family caregivers' perceptions and experiences of caregiving with older adult depression is important because these research questions were based on personal value system. The researchers have realized the complexities involved with family, role, relationship, and functions of an elder who has depression and family caregiving as well. In particular, the researcher realized that in order to understand the phenomenon, it is crucial to incorporate qualitative techniques (Guba & Lincoln, 1994).

The qualitative approach utilized in this study was based on exploratory qualitative research methodology (Hill et al., 2005). Exploratory qualitative believe that the investigator and the object of investigation was assumed to be interactively linked so that the findings are literally created as the investigation proceeds. Reality is viewed as being socially constructed by interpretivists. Knowledge is subjective and idiographic, and the truth is dependent according to the context. (Stebbins, 2011). Exploratory qualitative is more of exploring and understanding design. Human existence is a phenomenon of the true origin of all senses and significance (Stebbins, 2011). According to exploratory qualitative, the researcher's role is to explore knowledge, examine the structures of perception, in particular consciousness, imagination, relationships with other people, and the place of the human

subject within society. These were applied to explore knowledge in perspective's view of family caregivers on depression literacy and understanding the pattern of elder's depressive symptoms management by depression literacy for prevention from suicide.

1.5 Preconceived notion

In older adults, depression is often seen as a normal part of aging or as a reaction to the stressors and losses that most people associate with growing old. Depressive in older adults may be difficult to recognize because they may have symptoms different from younger people. In some older adults with depression, sadness could not be the primary symptom (APA, 2013). They might have certain, less obvious signs of distress, or they might not be able to speak about their emotions. As a consequence, physicians could be less inclined to accept that their patients have depression. This is a complex phenomenon that needs to understand and perceived experiencing depression from its harmful effects. The early diagnosis and treatment of depression decreases the increased medical costs of suicidal people and eliminates the substantial caregivers' burden. The reality, the knowledge, and understanding of elders with depressive disorder in general is not widely understood. Currently, there are few studies on this aspect.

The family members are the first responder and significant persons to help the elders from harm caused by depressive symptoms. They play a caregiving role for household task-assistance, activities of daily living, emotional and social support, care, and transitions to medical services. Family caregivers play an important role in the quality of life of the older adult with depressive disorder. According to White and Casey in 2017, little is known about the causes that affect which influence the probability of a family member supporting an older adult relative seeking mental health assistance. Existing literature has shown that family caregiver either have poor knowledge or awareness about some facts which are not adequate for efficient management of the existing problem depression management.

From the review of literature, the antecedent of depressive symptoms in elders are biological, psychological, and socio-economic factors including genes, neurotransmitters, stressful events and deficits in social support. The depressive symptoms in the older adult show the signs of lost interest in daily activities, struggles with feelings of helplessness or

hopelessness, difficulty concentrating, sadness or feelings of despair or in a depressed mood, physical changes, lack of motivation and energy, sleep disturbances, and self-worthlessness. The severe impact of depressive symptoms in the older adult is suicide. Recognition of depressive symptoms in family members related to respect, reciprocal relationship, and esteem of family. The review of the literature shows the associations between depressive symptoms and family functions, family relationships, roles, attachment communication, and social support in unhealthy family functioning and lower social support. In families with worse family function and lower social support, the older adult most likely to have developed depressive symptoms when compared to elders having a healthy family.

The researcher put elders in the central of a picture, the second circle was the family context surrounding the elders and the external circle was 'depression literacy' including knowledge of how the family seeks information, risk factors, causes of illness, health-seeking, recognition of depression symptoms' and decision making for a management-appropriate situation (attitudes that promote appropriate health-seeking behavior) to first aid' and primary prevention for elders. The depression literacy may vary considerably across the course of the illness Jorm, 2012; Nielsen-Bohlman, Panzer Kindig, 20014).

The cyclic interplay of perception of depression literacy, family caregiver, and management shown in the picture represents the recognition of depressive symptoms which could particularly play an important role in depression and health outcomes among the older adult population. The first phase involves developing the association of each component of depressive symptoms in elders and perceptions of depressive literacy among family members from the review of the literature and descriptive study in the qualitative method.

The qualitative approaches by exploratory research design, to explore experiences of family caregiver who had depression literacy and explain the pattern of depressive symptoms management in older adult for prevention from suicide.

1.6 Definition of Terms

1.6.1 Older adult with depression

Referred to an individual aged 60 years old or over and was diagnosed with major depressive disorder executing signs and symptoms of inability to feel any pleasure or anhedonia and malfunctioning that include loss of interest in daily activities, struggling with feelings of helplessness or hopelessness, difficulty concentrating, sadness or feelings of despair or depressed mood, physical changes, weight loss or loss of appetite, lack of motivation and energy, sleep disturbances, loss of self-worth, slowed movement or speech, memory problems, neglecting personal care and with positive depression score. (Huang, Hsieh, Wu, & Lu, 2017).

1.6.2 Depression literacy

Referred to family caregivers' knowledge and ability to care for depression in seeking information for screening, assessment, evaluating, and decision-making in behavior modification for both themselves and the elderly with depression symptoms, as well as understanding and analyzing the source of problems, being able to decide the appropriate management for each situation, used information to making decisions when they need medical services, and having appropriate strategies for managing depression symptoms.

1.6.3 Family caregivers

Referred to a family member aged 18 years and older included a husband, wife, son, daughter or grandchildren who upholds the role of a primary caregiver in caring an older adult with depression at home such as bathing, cooking, doing laundry, providing medication etc. for more than 6 months.

CHAPTER 2
REVIEW OF LITERATURE

2.1 Geriatric Depression

2.1.1 Prevalence of geriatric depression

The prevalence of geriatric depression is around 5 million worldwide, it increases with age group. According to the World Health Organization (WHO, 2020), the prevalence of depression among the world's aged population varies between 10% and 20% with 5% and 17% in primary care, depending on cultural circumstances. A meta-analysis study reported that 7.2 % of individuals aged over 75 suffered from major depression, ranged between 4 % and 10.3% for women and between 2.8 and 6.9 % for men (Aziz & Steffens, 2013).

In the United States, the percentage of geriatric depression increased from 13.4% in 2013 to 16 % in 2019 (America health ranking, 2019). In England, the prevalence of older adult depression was 8.7% in 2007 (McDougall, et al., 2007) and increased to 28% for women and 22% for men in 2015 (WHO,2017). The trend of depression prevalence are double and the ratio between women and men is 2:1 (women: men).

In 2016, the range of older people's depression in Asian countries was 12-34% with Indonesia 33.8%, Japan 30.3%, Malaysia 27.8%, Vietnam 17.2%, and Indian 12.7% (Vanoh, Shahar, Yahya, & Hamid, 2016), but in a systematic review and meta-analysis study in 2019 indicated that the prevalence of geriatric depression (60 years and above) in India was 34.4% **(**Pilania, et al., 2019). In 2020, a systematic review among older adult depression in South Asian countries reported 42% in prevalence (Assariparambil, et al., 2020). China with the world's largest older adult citizen showed the prevalence of geriatric depression in local area was 36.94% (He, et al., 2016). In 2020, a meta-analysis study in empty-nest older adult group showed that the prevalence of depression was 38.6% (Zhang, 2020). The overall prevalence of depressive symptoms was found to be 10.5%, of which 10.6% was in men and 9.8% was in women globally. In Bangladeshi, a highlight problem,

prevalence rate was 36.9%, compared with the prior in other countries is higher (Disu, Anne, Griffiths & Mamun, 2019).

In Thailand, the geriatric depression prevalence increased from 7.2% in 1990 to 11.5% in 2010 (Wongpakaran, 2008) and to 18.5% in 2019 (Charoensakulchai, et al., 2019). In tertiary care hospitals, the prevalence in this group increased to 23.7% (Wongpakaran, et al., 2019) and 18.5 % in rural areas (Mitsiriswat, 2018). Between 2011- 2013, one published report on living homes and homes for the aged, found the prevalence rate of depression was around 25-42% (Somporn, 2011; Suwattanakoop, 2013; Wongpakaran & Wongpakaran, 2012) and another study about older adult living at home at the Western Part of Thailand, found the highly prevalence that 41.1% suffered from depression (Karuncharernpanit et al., 2016).

2.1.2 Diagnosis of geriatric depression

Diagnosis for depressive disorders is challenging in the older adult. It is often based on 'DSM-V' (Diagnostic and Statistical Manual of Mental Disorders) (APA, 2013) and 'ICD-10' (International Classification of Diseases and Health Related Problems) diagnosis criteria (WHO, 2016). In DSM-V, the client must have five or more out of nine symptoms to present with at least one from the first two (one of which must be depressed mood and loss of interest in pleasurable activities) (APA, 2013). In ICD-10, the client must have two of typical symptoms that comprises of depressed mood, loss of interest and enjoyment in everyday activities, reduction in energy and plus at least two of the remaining seven common symptoms.

Both systems are based on the same basis for identifying depressive episodes: first to define the minimum number of typical symptoms and associated symptoms and second to define a minimum duration of symptoms for at least 2 weeks of symptoms to make a diagnosis and in DSM-V add a third indication that there must be a functional or social defect (APA, 2013), that ICD-10 has not defined.

According to DSM-V, clinical depression is generally characterized as a major depressive episode (MDE) whom the clients have the criteria for MDE if: a symptom from five of nine psychical and behavioral including,

1) sadness or depressed mood,

2) loss of interest or pleasure in all activities,

3) weight change more than 5% a month or change in appetite,

4) sleep disturbance,

5) agitation or retardation,

6) fatigue or loss of energy,

7) feelings of worthlessness or guilt,

8) diminished thinking ability or ~~a~~ decreased concentration,

9) thoughts of death.

In ICD-10, mostly are similar, but there are differences in reduced self-esteem and self- confidence (WHO, 2016).

According to “Thai Clinical Practice Guideline of Major Depressive Disorder for General Practitioner: CPG-MDD-GP in 2010”, The term "depression" in Thailand often refers to depressive disorders, which must rely on the standard criteria for diagnosis. Now, two criteria in diagnosis have been used, which includes ICD 10 that was developed by the World Health Organization and DSM developed by the American Psychiatric Association. The diagnostic criteria for both systems currently develop very close (DMH, 2010).

1) A sad mood that lasts almost all day and every day, it might be more or less in some days.

2) All activities previously that are interesting or enjoyable were decreased.

3) Loss of appetite until weight loss or some people may have increased appetite and weight gain.

4) Insomnia or sleeps a lot almost every day.

5) Psychomotor agitation or retardation that does something, speak and walk slowly but move faster, some people have irritability and restlessness.

6) Fatigue or lack of energy all day and every day.

7) Feeling worthlessness or too guilty.

8) Decreased concentration or thought,

9) Suicidal idea

And a client with at least five symptoms almost every day for at least two weeks.

In older adult depression, concurrent physical illness is the norm (Kennedy, 2015). Older people with depression are less likely than younger adults to manifest affective symptoms and are more likely to show somatic and motivation symptoms. Risk factors contributing to geriatric depression possibly involve complex associations between genetic defects, cognitive diathesis, age-specific neurobiological changes, and traumatic events. Insomnia is frequently underestimated risk factor for depression in geriatric (Fiske, Wetherell, & Gatz, 2009). All must directly cause significant distress or social impairment.

2.1.3 Symptoms of Geriatric Depression

Geriatric depression is an important public health concern worldwide (WHO, 2020). This is a serious mental health condition that causes older adult to experience depressive mood, feelings of guilt, loss of interest or concentrate, low self-worth, low energy, appetite and sleep disturbance, lack of confidence or enjoyment (WHO, 2017), it can affect every aspect of older adult's life and relationships. (American Psychiatric Association, 2013)

Depression in the older adults have difficult to diagnosed because it is often misunderstood as a normal part of aging of which some symptoms look like a physical illness (Stuart, 2013). Symptoms of depression in older adult may present probably different from another (Fiske, Wetherell, & Gatz, 2009) which includes feeling depressed or hopelessness, unhappy, worthlessness and guilt more than another, lack of interest in hobbies or other usually pleasurable activities, sleep disturbances, loss of appetite or weight loss, fatigue and powerless, psychomotor retardation, social withdrawal and isolation, loss of self-worth lack of self-esteem and self-trust, loss concentrations, physical pains and aches, thinking about suicide and death, self-harm or attempts (Fiske, Wetherell, & Gatz, 2009; Lotrakul, 2013; Runcan, 2013;APA, 2019). Pratt and Brody (2014) distinguished the symptoms of depression as a group of symptoms in 3 categories including mood, cognitive and physical.

The symptoms of depression can range from mild to extremely severe. Symptoms must occur most of day, nearly every day for more than two weeks. However, if a person has symptoms of depression along with other symptoms, this may lead to a depressive episode (APA, 2013; Tolentino & Schmidt, 2018).

Defining depression as an illness, on the other hand, entails the condition as pathological and candidates for the form of biological treatment thus minimizing important psychosocial components (As the emotional meaning) disabled. Depression is a state of breakdown of behavior (Henriques, & Panizo, 2018). According to the behavioral shutdown model (BSM), it usually occurs when a person is unable to meet psychological needs, the negative emotional system of the individual is jacked up, their positive emotional system is dampened, and they have a lot of difficulty beginning new activities. Although depression generally makes practical sense, it sometimes makes things worse, leading to a vicious shutdown loop (Henriques, & Panizo, 2018).

2.1.4 Factors contributing to geriatric depression

Factors contributing to geriatric depression include biological factors, socio-demographic factors, physical or disease condition and psychosocial factors (Li, Theng & Foo, 2015). The biological factors contributed to depression include genetic or ~~a~~ history or family depression, neurological, hormonal or hormone levels, immunological, and neuroendocrinological mechanisms appear to play a role in the development of geriatric depression, (Fiske, Wetherell, Gatz, 2009).

The socio-demographic factors significantly associated with geriatric depression were found to be female, single or unmarried (Fiske, Wetherell, Gatz, 2009). More recent studies found an association between gender and depression with increased prevalence in women (Girgus, Yang & Ferri, 2017; Olivera et al., 2011; Jee & Lee, 2013; Padayachey, Ramlall & Chipps, 2017; Ferrari, 2013). Also, material challenges, poor socio-economic status, low income or decreased economic and income standards, low education, and difficulties at work, lead to the progression of depression (Maideen, Sidik, Rampal, & Mukhtar, 2014). A Romania study identifying the factors contributing depression included

low incomes for meeting their needs, no sexual activity, and infrequently social activity with friends or neighbors (Rada, 2020).

Physical or disease conditions include chronic/physical illnesses such as cardiovascular disease, sleep disturbance (Fiske, Wetherell, Gatz, 2009; Chen, 2012; Leblanc, Desjardins & Desgagné, 2015; Soonthonchaiya, 2017). Depression is highly prevalent in people with cardiovascular disease. (Huffman et al., 2013; Zhang, Chen & Ma, 2018). Insomnia is a risk factor often dismissed for older adult (Fiske, Wetherell, Gatz, 2009). In 2015, Leblanc, Desjardins and Desgagné found increased depression symptoms are associated with poor quality of sleep (Leblanc, Desjardins & Desgagné, 2015). Geriatric depression is associated with poor sleep efficiency including waking up at the middle of the night and having difficulty to sleep again, then waking up too early in the morning (Soonthonchaiya, 2018). Recent research by Chen Study (2012) in Taiwan and study by Hu, Zhu, Kaminga, et al (2020) in China, also identified an association between chronic insomnia and depression in the older adult. They concluded that insomnia is a major problem in MDD, and approximately 40% to 80% of those patients complained insomnia or poor sleep quality (Chen, 2012).

The psychological risks related to geriatric depression are complicated. Environmental triggers and other factors like social risks and stressful life event are especially important in the older adult (Fiske, Wetherell, Gatz, 2009; Chen, 2012; Leblanc, Desjardins & Desgagné, 2015), Grief and loss due to the death of a loved one, having experienced physical or emotional violence, living with someone with serious illness, lack of social support and socioeconomic factors or loneliness and no care-taking responsibilities (Fiske, Wetherell, Gatz, 2009; Age UK, 2016). In Korea, a study of geriatric depression in a geriatric hospital showed that the factors associated with depression includes decreased ability to perform daily activities, decreased self-esteem, decreased life satisfaction, pain, fatigue and lack of social support (Jee & Lee, 2013). In older people who have low self-esteem were easily experience progression of depression (Maideen, Sidik, Rampal, & Mukhtar, 2014).

In 2012, Leggett and colleague published a study among older people in Vietnam in their study found that depression was due to war, lack of social support, number of diseases and less social activities and lack of emotional support, which is similar to the study of He and team found that the main risk factors of depression were living situations, frequency of children's visits, physical activity, number of chronic illnesses, and educational levels (He, et al., 2016). Similarity, the previous study in United state found that depression was the highest among older adult at the lowest income level and also higher among those with less than a high school education and some college (Patel, et al., 2018).). According to the community-based study in China, Cong, Dou, Chen & Cai (2015) found that the highest risk factors of geriatric depression were lack of social engagement, low family support, chronic illnesses and sleep disturbance.

A study at the tertiary hospital in central area in Thailand found that alcohol drinking and stressful life events were the contributing factors to geriatric depression. The cognitive function, self-esteem, resilience, social support, functional capacity, and religious values were statistically significant with older adult depression (Putthametta & Soonthornchaiya, 2016). Kansri, Malai and Soonthornchaiya (2019) found the factors contributing geriatric depression were female, poor family relationship and insufficient source of income (Kansri, Malai, & Soonthornchaiya, 2019).

In Thailand, previous research about factors contributing to geriatric depression in Ban Bangkhae Nursing Homes, Bangkok, found insomnia, loneliness, lack of social activity, physical activity and inadequate vitamin D were prominent factors to depressive symptoms (Somporn, Neeser & Iamsupasit, 2012). In Karuncharernpanits' et al. (2016) study, in the Western Part of Thailand, found that it is negatively associated with depression and income, perceived health status, and ADL index, and positively associated with the number of chronic diseases.

2.1.5 Management of geriatric depression

Depression, in the more severe instance, is a strongly treatable condition. Pharmacotherapy with anti-depressant, electroconvulsive therapy (ECT) and psychosocial

intervention were standardization for management of geriatric depression in secondary and tertiary setting (Avasthi & Grover, 2018). The electroconvulsive therapy is an alternative treatment of choice based on the evidence, which is commonly applied to older adults than in any other age group (Kelly & Zisselman, 2000). Treatment effectiveness in over 80% of the patients in the majority of trials is remarkable, but adverse effects, such as cardiac failure, memory loss and delirium, indicate caution when using ECT in older adults (Garekar & Grover 2017). A variety of late-life psychiatric therapies for depression meet evidence-based requirements. Most of these therapies include a behavioral intervention aspect that specifically tackles the issue of action limitation; others concentrate on task significance; some concentrate on cognitions that can intensify and sustain depressed disorder. Such treatments include behavioral therapy, cognitive behavioral therapy, cognitive library therapy, problem-solving therapy, brief psychodynamic therapy, and life-examination therapy.

Aaron Beck (MD), a psychiatrist from Philadelphia developed Cognitive Breathing Technique (CBT) then Cognitive Behavioral Therapy (CBT) for patients with depression (Thompson, Eagle & Dunn, 2017). In 2020, Bilbrey and colleague published a report on Cognitive Behavioral Therapy (CBT) for older adult depression and discussed on the evidences such as structured therapy techniques issues and recommendations~~,~~ found the efficacy of CBT for this group, and suggested Cognitive and behavioral strategies may be frequently juxtaposed within a CBT framework **(**Bilbrey et al., 2020).

Aakhus and team reported protocols on the management of geriatric depression and founded efficient approaches to strengthen collaborative treatment for this group in primary care in municipalities and healthcare professionals. The intervention protocol includes social contract, care provider should be socially in close contact with geriatric depression and recommend actions for those who have limited access to it. When needed, regular social contact should be provided with trained volunteers and the family should be involved in the plan to improve social contact, collaborative care for this group, counselling to offer some help for the geriatric depression and family when they need help-seeking all about knowledge and aid symptoms management (Aakhus et al., 2014).

Soonthornchaiya's study in 2013 found that family support was important in caring. Family support in this study referred to creating positive relationships between family members and receive family members' care such as caretaker, assist daily activities, able to provide emotional and social support to improve depression symptoms (Soonthornchaiya, 2013). In addition, Park & Unützer (2011) also pointed out the importance of engaging and supporting family caregivers of older adult with training.

Music therapy or music intervention were effective in older adult depression because listening to music is beneficial for the older adult to communicate thoughts non-verbally without being intimidated. Chan, et al. (2009) evaluated the effect of music on older adult depression in the community. A randomized controlled study was conducted by using the music and its results showed significantly ($p < 0.001$) decreased depression scores and physiological responses such as blood pressure, heart rate, respiratory rate in older adult depression (Chan, et al., 2009). Another study by Sung et al. (2017) indicated that the older adult with depression symptoms had shown a significantly decreased depression levels after listening to "embedded binaural beats of alpha frequencies at 10 Hz music"(Sung et al., 2017).

Molassiotis et al. (2020) indicated that the effectiveness of acupressure on depressive symptoms among older people in the community can improve quality of life similar with Tseng, Chen, Lee & Lin (2020) acupuncture treatments delivered and reduction in the severity of depression (Armour, 2019). Mindfulness and meditation intervention were effective on depression (Prakhinkit, Suppapitiporn, Tanaka & Suksom, 2014; Lopez-Maya, Olmstead, & Irwin, 2019; Misal & Upendra, 2020; Shanok, Reive, Mize, & Jones, 2020; Lindayani, Hendra, Juniarni, & Nurdina, 2020; Bringmann, Bringmann, Jeitler, Brunnhuber, Michalsen, & Sedlmeier, 2021).

In 2001 Manes et al. published a report on "Repetitive transcranial magnetic stimulation (rTMS)", a new technique was used to induce electrical currents in the brain. However, it was found out that its not effective when compared to ECT (Manes et al., 2001), and in 2020 Dai and research team has been conducting research on "repetitive transcranial magnetic stimulation" treatment among older adult depression in a hospital in China with a

randomized double-blinded study, it was found out that Hamilton depression scale was decreased after 2 weeks of treatment (Dai et al., 2020) similar with Sayar et al. study in 2013; Sabesan, et al. in 2015; Desbeaumes, Miron, & Lespérance, in 2019.

Some researchers suggested the efficacy of aerobic exercise. Miller and the research team (2020) conducted a systematic review with randomized controlled trials to compare the effects of aerobic, resistance, and mind-body exercise on depression and reported its equivalent effects on depressive symptoms of older adult (Miller, et al., 2020). The aerobic exercises intervention among older adult depression in ~~8~~ eight weeks significantly improved the self-esteem and overall quality of life scores (Rao, Noronha & Adiga, 2020).

The substantial body of evidence supports the used of different methods of psychotherapy and somatic therapies in older adults' depression. Randomized clinical trials of depressed older adults have shown comparable efficacy for selective serotonin reuptake inhibitors, tricyclic antidepressants, and monoamine oxidase inhibitors of small to broad effect sizes of respect to pharmacological therapies. Older adults 'prognosis is similar to middle-aged adults'. Efficacy of the procedure was found with medical comorbidities in older adults with cognitive disability, it has been found that only those with impaired executive functioning respond poorer than younger adults.

Conclusion

Geriatric depression is associated with higher risk of suicide. The symptoms have been shown to be associated with significant negative consequences ranging from poor quality of life, lack of support or difficulties with activities of daily living, physical comorbidities, and cognitive impairments. Geriatric depression management has been managed through pharmacotherapy with anti-depressant and non-pharmacotherapy such as ECT and psychosocial interventions. Several alternative treatments have been recognized to depressive symptoms improved include acupressure, acupuncture, relaxation technique or intervention, exercise, and magnetic stimulation. Social contract and family support has been efficient approaches for improving knowledge and symptoms management.

2.2 Depression literacy

2.2.1 Definition and content of mental health literacy

1) Definition of depression literacy

The meaning of the word “depression literacy” was first described by Parslow & Jorm, (2002) which means “awareness and understanding of depression”, later Loureiro, et.al., (2013) defined depression literacy as “knowledge and beliefs about depression which aid their recognition, management or prevention” (Loureiro, et.al., 2013). And Nigam, Pole, & Vankar (2013) in their study indicated depression literacy as knowledge of depression as a medical condition and of epidemiology, etiology, symptomatology, treatment, and depression prognosis (Nigam, Pole, & Vankar, 2013).

In general, depression literacy according to Jorm et al., contains the mental health literacy (MHL) following six components. 1) the ability to recognize depression; 2) knowing how to seek information related to depression; 3) knowledge of risk factors and its causes; 4) knowledge of self-care activities; 5) knowledge of professional help available; 6) attitudes which facilitate recognition of depression and appropriate help-seeking. There is an assumption that individuals who have a higher level of MHL will be able to recognize mental disorders earlier and be more willing to seek professional help. (Jorm et al., 1997)

2) Mental health literacy

Health literacy is “the ability to gain access to, understand, and use information in ways which promote and maintain good health” (Nutbeam, Wise, Bauman, Harris & Leeder,1993). Mental health literacy has been defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Loureiro, Jorm, Mendes, Santos, Ferreira & Pedreiro, 2013). Mental health literacy is broadly defined as the mental illness awareness and attitudes that can impact how these disorders are understood, treated, and prevented in various societies (Jorm, 2012). In 1997 Jorm et al. introduced the word mental health literacy (MHL). It refers to mental disorders awareness and beliefs which help in their identification, management, and prevention. (Jorm et al.,

1997) MHL contains the following six components according to Jorm et al. There is an assumption that individuals who have a higher level of MHL will be able to recognize mental disorders earlier and be more willing to seek professional help. (Jorm et al., 1997)

(1) The ability to recognize specific disorders

Recognition of depressive symptom in older adult individuals were very important to be able to provide safety away from harm and suicidal tendencies. If the family member can detect these warning signs and recognize the symptoms, appropriate response can be done to help them. As family members enter their senior years, it is important to understand that depression is not a normal sign of aging, and as such, seniors need just as much help dealing with the symptoms of depression as anyone else to protect and prevent them from harm.

In China, the study of traditional values and beliefs in aging showed significant changes in family structure and social system context of fast modernization and economic development. This study examined the effects of burden views toward Chinese older adults on their depressive symptoms as a burden to family and society. Findings of this study can inform the development improving family relationship quality and fostering a positive attitude toward aging in the wider society (Bai, Lai & Guo, 2016).

Depression in the older adult can be hard to identify as they can experience different symptoms than younger people. Sadness isn't their primary symptom for certain older adult people with depression. They may have other, less noticeable depressive signs, or may not be able to speak about their feelings. Doctors may also be less likely to accept that their patient has depression. The recent research by the American Journal of Geriatric Psychiatry found that 27 percent of older adults examined by aging care providers met the requirements for a major depression diagnosis, and 31 percent had depressive symptoms that did not qualify as a psychiatric condition but had a substantial effect on their lives.

The Michigan State University extension study on the ways to improve is to learn about and understand the signs and symptoms of depression in older adults and older

adult people. Older people who are depressed often tend to feel drained, have trouble sleeping or appear grumpy and irritable. Problems of misunderstanding or focus induced by depression may often sound like Alzheimer's disease or other brain disorders. Older people may also have more medical problems, such as heart disease, stroke, or cancer, which may cause signs of depression. Or they may be taking drugs that lead to depression with side effects.

Recognizing depression in the older adult had begun with the knowledge of signs and symptoms which include hopelessness or sadness, pain and aches that cannot be explained, loss of interest in socializing or hobbies, loss of weight or loss of appetite, feelings of despair or helplessness, lack of motivation, change of pattern of sleep and energy, loss of self-worth, slowed movement or speech, increased use of alcohol or other drugs, freeze thoughts of suicide, memory problems, neglect of personal care.

The study of recognition of mental disorders the findings from a cross-sectional study among medical students in Singapore was the most poorly recognized condition. Given that primary care providers are often the first professional help-seeking source for people with mental health problems, medical students should be equipped with the skills and ability to recognize signs and symptoms of various mental illnesses (Picco, et.al., 2017). If the family member can recognition of mental disorders that mean the patient was early detection and safe.

The study of multiracial population in Southeast Asia about recognition of mental disorders. Finding the most well recognized conditions were dementia (66.3 %), and depression (55.2 %). In planning intervention plans that address mental health literacy, socio-demographic factors that affect mental health literacy should be taken into consideration. (Chong, et.al., 2016).

Klineberg E., el.at research in 2011 on the identification of signs and helping young adults search for depression. 61.4% of respondents have acknowledged the presence of extreme depressive symptoms. Young men were less likely to identify a mental health issue than women, particularly those from poor backgrounds. Men were also less likely than

women to consider seeing a doctor. 64.7 % of respondents who acknowledged a mental health issue recommended seeing a doctor, only 16.4 % assumed that a person who was seriously depressed would actually see a doctor.

(2) **Knowing how to seek mental health information**

According to Department of Mental Health, “the primary care provider can treat basic mental problems, particularly through medication, but that may not be enough. Historically, it has been difficult for a primary care provider alone to offer effective, high-quality behavioral health care”. Research has found that a combination of therapy and medication, particularly for depression and anxiety disorders, are the most effective treatment strategy. However, many patients often refuse to accept referral of mental health due to stigma, but more often due to the difficulty of finding the right, or any, mental health provider in their area.

(3) Knowledge of risk factors and causes

What factors put people at the greatest risk for specific mental health disorders. Factors of risk may include unemployment, low wages, lack of education, prejudice and crime.

(4) **Knowledge of self-treatments**

What people can do to help themselves heal without having to work with clinicians, by using books and television self-help. Though many self-treatments are quite ineffective and even harmful because of a lack of knowledge.

(5) Knowledge of professional help available

Where professional assistance may be provided and/or what professional assistance is available.

(6) Attitudes that promote recognition and appropriate help-seeking.

Attitudes are analyzed in two sub-components: mental illness attitudes, or individuals with mental disabilities, and attitudes to receive medical assistance or care. Attitudes can differ greatly depending on each and sometimes with intervention it can be difficult to quantify or aim. Nevertheless, on both sub-components, a large deal of research literature does exist, but not directly relevant to literacy on mental health. Recent research considers as more negative the differing views of mental health practitioners towards prognosis, long-term results and the probability of discrimination than those of the public. Mental health practitioners may have varying attitudes towards therapies, although this variation is generally due to professional orientation.

Mental health literacy is generally defined as the mental illness awareness and beliefs that can affect how such disorders are understood, treated and prevented in different communities (Jorm, 2012). Most research on mental health literacy has currently been conducted in countries with higher incomes. (Burns&Rapee,2006; Cotton et.al., 2006; Farrer, et.al.,2008; Gong & Furnham, 2014; Lui, Wong &Furnham, 2016).

Previous research shows that help-seeking has a strong connection with mental health literacy (O'Connor & Casey, 2015). Conversely, early help-seeking for symptoms of mental ill-health promotes opportunities for early intervention and is known to result in improved long-term outcomes. (Swami, 2012) 'mental health literacy' are refers to the knowledge and beliefs that the general public has about mental health disorders and their prevention. Indeed, there is growing evidence that poor mental health literacy negatively impacts upon help-seeking behaviors for psychiatric symptoms and influences decisions about treatment and compliance. Converging evidence indicates that literacy on mental health is typically low in many community samples in many countries, mostly because it is unable to correctly recognize cases of mental ill health (Furnham & Swami 2018). This is significant because insufficient research on mental health leads to low levels of mental health assistance (Swami, Vintila, Tudorel and Bucur, 2020).

The finding of mental health literacy in Singapore shows many people without knowledge of the problem were unable to recognize different types of mental disorders such as depression. Negative attitudes toward mental illness that hinders individuals from seeking professional treatment, and help-seeking, are the common themes that emerged from the findings (Tonsing, 2018). With profound knowledge in mental health, this enables family members to recognize, manage and prevent emotional disorders such as depression in Thailand, The study of mental health literacy among the people in Lampang province was found that mental health literacy was at a moderate level of knowledge and acknowledged the information regarding mental health (Inchaithep, Punsawat & Nuntana, 2016). There is little empirical evidence of the ability of the family to assist older adults with mental illness. A recent research, however, investigating help-seeking on behalf of someone displaying symptoms of early-onset dementia that provide clues. (Phillipson, Magee, Jones, Reis, & Skaldzien, 2015). In Thailand, the department of mental health indicates that the high suicidal attitude in older adults continued over the years and the cause of suicide is depression. Depression literacy are the process of management by knowledge and understanding of depressive symptoms, recognition or appropriate help seeking in primary prevention.

However the knowledge, beliefs and attitude of mental health is culture-specific and contextual and has an impact on the socio-political environment, such as problems of access to care, inadequate human rights protection and insufficient financial and human resource resources as well as privacy and privacy concerns. (Altweck, et al., 2015) Thus, there is a large gap in understanding how best for many countries to target and improve mental health services and uptake. This is a significant gap that exists in knowing how best for many countries to approach and develop mental health services and take on.

The study of depression literacy and health-seeking attitudes in Cambodia, Philippines, Fiji, the Western Pacific region, showed that depression knowledge was comparatively lower in these regions, and the higher knowledge was significantly associated with more positive attitudes toward mental illness and professional help seeking (Ho.et. al, 2018). A systematic review in Malaysia, Western Pacific region showed a recognizing depression in adolescents was poor, about knowledge, help-seeking and stigmatizing

attitudes (Singh, Zaki & Farid, 2019). Lack of depression literacy is associated with low help-seeking behaviors for mental health care in adolescents (Jeong, McCreary, & Hughes,2018).

The important suggestion from these studies provided a baseline to gain a better understanding of depression literacy and emphasizing the need to increase public knowledge on depression and health-seeking behaviors in this part of the world (Ho, et. al, 2018; Singh, Zaki & Farid, 2019). Ghadirian and Sayarifard's study on overall general population, the results showed depression literacy was low (Ghadirian & Sayarifard, 2019), especially in men and older participants but significantly higher in people with previous treatment experience (Tomczyk, 2018).

To date, there has been relatively limited number of research to examine depression literacy in the Western Pacific region. The prevalence of depression and the need to enhance mental health care in this region, it is important to gain a better understanding of depression literacy and health-seeking behaviors in this part of the world.

3) **Health literacy**

Over the past two decades, the term "health literacy" has gained more and more attention. Definitions have widened as interest in the subject of health literacy has increased. Despite claims that health literacy is merely a "repackaging of a number of other important concepts central to the ideological commitments, and the theory and practice of health promotion", the concept has stirred up a lot of discussion and gained widespread acceptance in the realm of public policy. Its mean achieving a degree of health literacy entails acquiring the knowledge, interpersonal abilities, and self-assurance to take action to enhance one's own and the community's health by altering one's own lifestyle and living circumstances.

Health literacy is vital to empowerment because it increases people's access to and ability to use health information (Glossary of Health Promotion, 1998). Health literacy is the cognitive and social skills that determine a person's motivation and ability to access,

understand and use information in a variety of ways to promote and maintain one's health (WHO, 1998). Health literacy is knowledge, understanding, and social skills that determine individual motivation and ability to access, understand and use information for good health. (Nutbeam, 2000). Health literacy means the ability and skills to access knowledge and understanding to analyze, assess, practice and self-manage as well as to be able to guide personal, family and community health issues for good health.

According to the U.S. Department of Health and Human Services (HHS), health literacy is the ability of a person to access, analyze, and comprehend essential health information and services required to make wise health decisions (HHS, 2010). And Paasche-Orlow and Wolf (2006) has given the definition of HL is a group of individual skills and abilities involved in health decision-making, often related to an understanding of health conditions in a variety of contexts.

In Thailand, HL mean the knowledge and ability of a person's health to screen, assess and make decisions about appropriate behavior modifications for health products and services (Ministry of Public Health, 2017). HL refers to the cognitive processes and social skills that give rise to a person's motivation and ability to access, understand and use information to make appropriate decisions. Leading to wellness, reducing health risk behaviors, increasing individual health empowerment, and reducing health costs (Pengchan, 2017).

Many health literacy scholars have defined the components of health literacy differently. In Thailand, the Division of Health Education, Department of Health Service Support, Ministry of Public Health has classified the components of health literacy into 6 components based on the concept of Don Nutbeam as follows:

1. Access to health information and health services refer to the ability and skill in selecting health resources, knowing how to locate and use search equipment, finding accurate information, and being able to verify information from multiple sources is referred to as access to health information and health services.

2. Knowledge and comprehension refer to having knowledge and remembering the essence of health, the ability to explain the understanding of health subject matter in order to implement it as well as having the ability to rationally analyze and compare the content of health practice guidelines.

3. Communication skills refer to the ability to communicate in order to obtain health information and to communicate health knowledge to others by speaking, reading, and writing, as well as being able to persuade others to accept health information.

4. Health condition management refers to the ability to set goals and plan actions and implement them, including reviewing and modifying behavioral practices to achieve correct health behaviors.

5. Information and Media Literacy refers to the ability to verify accuracy. The reliability of the health information presented by the media and the ability to compare media opt-in approaches to avoid risks to oneself and others, as well as the ability to assess media messages to guide communities and society.

6. Making the Right Discrimination Decision refers to the ability to make choices and to deny/avoid or choose a healthy course of action, including rationalizing or analyzing the good and the bad for rejection. The ability to make choices that have less impact on oneself and others or to properly disprove misconceptions.

There are many levels of health literacy. Each level affects different health behaviors and health outcomes, which can be classified into four levels as follows:

Level 1: Basic/Functional Health Literacy refers to the ability and basic skills to understand health information used in daily life through listening, speaking, reading, and writing, such as reading a consent form. Understanding the information provided by health team personnel, both written and verbal, and acting on doctor and nurse advice.

Level 2 Communicative/Interactive health literacy is the ability to apply knowledge and information. Communication and social skills were apply together in taking care of own health and person in care, for example, asking people who know how to pass on their own health knowledge to others to understand.

Level 3 Critical Health Literacy is the ability to consciously think and analyze a person's selection of health data to apply health data, health care, and health management to

suit their own context, as well as incorporate this level of health literacy into social participation in pushing for community restructuring to suit the community context. The result in good health at the individual and family level.

Level 4 Media literacy refers to the ability of a person to consider, analyze, and value content and intent in conveying health information through technology and methods divided into 2 types. is information literacy, which means a person's ability to perceive information, facts, knowledge and events that have been collected and selected through information technology and media literacy, communication channels literacy, which refers to a person's ability to understand assess and analyze the credibility of various types of media including the information presented by the media, as well as know the depth and depth of the media, which are the hidden objectives of the media.

In summary, HL is the continuous action of a person using cognitive skills and social skills (2 - way communication, interaction) to reach understanding and assess health information and services that have been transmitted or learned from the environment. which is the self-motivation to make decisions about the way of care and manage health to prevent and maintain good health all times. Therefore, HL is the skill and ability of a person in accessing, understanding information and decision-making health services to use it in behavior modification. can take care of and manage the health of oneself and family (self-management) to be good continuously.

Therefore, the development of family caregivers in health literacy means the level of ability to access, understand, and communicate health information, as well as assess and select health information appropriate to their context, family, and the community. In order to promote the maintenance and protection of health conditions in different contexts across different life stages, it is important because people with low health literacy have difficulty understanding and remembering health information, including acting according to the advice of the health team, resulting in limited health options, causing behaviors that risk health conditions easily, being unable to manage health on their own.

2.2.2 Family caregiver’s knowledge of depression

Geriatric depression is known as a complex condition, a qualitative study among family caregivers in Chile by González et al. (2010) found that “Perceiving the disease” is mainly refers to how the care delivers the innate feelings of the relative in need of support but perceiving many obstacles and barriers to providing care. Similar, the study by Tamdee et al., (2019) found that family caregiver did not receive any training skills before taking care the older adult but mainly done by experience, relationship and gratitude. Same with Chinese caregivers' knowledge about the information of depression, only 43.6% and low recognition rate both the caregiver and client to the describe depression symptoms (Li, Wenjing & Reavley, Nicola, 2020). A cross-sectional study in family caregivers of mentally ill patients such as bipolar depression found out that the knowledge of mental illness were poor in family caregivers (Gabra et al., 2020).

The study by Niv et al. (2018) found psychoeducational intervention and motivational interviewing through telephone can increase the knowledge of depression among family members (Niv et al., 2018). Baird, et al. (2019) reported that the families can increase depression literacy among older Korean Americans. Additionally, depression literacy was significantly related to age and education (Bernstein, 2020). Therefore, the knowledge about mental health and depression increases health literacy and depression literacy. It is important for family caregiver to recognize older adult’ depressive symptoms as early as possible and to hold positive attitudes toward the use of mental health care services, as these factors can significantly impact help-seeking behaviors.

2.2.3 Family caregiver’s recognition of factors to depression

Depression in the older adult can be hard to identify as they can experience different symptoms than younger people. Sadness isn't their primary symptom for certain older adult people with depression. They may have other, less noticeable depressive signs, or may not be able to speak about their feelings (Ansary, 2020). Recognition of depressive symptom in older adult individuals were very important to be able to provide safety to prevent harm and suicidal tendencies. Thus, the family members can identify or detect these warning signs and recognize the symptoms, appropriate response can be done to help them. As family

members enter their senior years, it is important to understand that depression is not a normal sign of aging, and as such, seniors need just as much help dealing with the symptoms of depression as anyone else to protect and prevent them from harm (Ansary, 2020).

The study of factors contributing to the recognition of anxiety and depression were adequate in general practice. (Sinnema, et al., 2018) The report shows patients' age, chronic medical condition, somatization, severity of anxiety and depression, and functional status were not associated with the recognition of anxiety and depression.

In the past, one study about recognition of older adult depression only by nurses and public health personnel (Brown et al., 2003). The study in medical students in Singapore about recognition of mental disorders such as depression. They found most of medical students cannot recognize this condition. The medical students were suggested to be equipped with the skills and ability to recognize signs and symptoms of various mental illnesses and find out the factor that contributes to depression (Picco, et.al., 2017).

The study of mental health literacy among family caregivers in Malaysia shows many of the family caregivers need help to educate their family members about mental illness, while this study emphasized on the family members who should be targeted to improve mental health literacy it also become significant to the public to reduce cost and burden the person with mental illness and their family (Mohd Suhaimi, et.at., 2012).

Recognizing depression in the older adult had begun with the knowledge of signs and symptoms which include hopelessness or sadness, pain and aches that cannot be explained, loss of interest in activity daily life, loss of weight or loss of appetite, feelings of despair or helplessness, lack of motivation, change of pattern of sleep and energy, loss of self-worth psychomotor retardation or speech, increased use of alcohol or other drugs, thoughts of suicide, memory impairment, neglect of personal hygiene (Robinson, Smith & Segal, 2020).

In reality, the elder stay with the family and the first responder is a member of family. The nurse and other health care providers are second responders when the family recognize it and take them to hospital. Symptom-recognition cannot be measured by any medical

instrument because recognition of symptoms were perceived by caregiver experiences and requires a deep understanding. Doctors may also be less likely to accept that their patient has depression. The recent research found that 27 % of older adults examined by aging care providers met the requirements for a major depression diagnosis, and 31% had depressive symptoms that did not qualify as a psychiatric condition but had a substantial effect on their lives (Richardson, et al., 2012).

Recognizing depressive symptoms is key essential for family members to provide effective care at home to the older adult person with depressive illness and get it diagnosed or safe from suicide.

2.2.4 Family caregiver's attitude towards geriatric depression

González, and colleague (2010), found out that caregivers perceived the geriatric depression as a deep limitation on their way of living, involving loneliness, sadness and melt downs. The feelings of the depressed in geriatric extend to the family caregiver, who also faces the risk of suffering from depression. Thus, the family caregiver adapts, reorganizes to assume the attitudes they should take toward geriatric depression. They understood the onset of the condition, its characteristics, treatment options, and willingness to help in these circumstances with a complex task such as listening, observing, and giving support when needed. They play an important role in providing support and care during the recovery process (González, at al., 2010).

In Vermeulen et al., 2015, founded the caring for older adult with severe mental illnesses such as depression may involve a simultaneous feeling of burden and a positive attitude towards mental care experience, around 69 % of family caregivers have become more understanding of others with problems and 54% have discovered inner strength. They were found ~~a~~ significantly correlated with more time on care and more positive experiences. These positive attitude towards caregiving experiences such as growing in competence or finding own strength. However, the experience of caregiving has both negative (burden) and positive (resilience) aspects, around 35 % of family caregivers is to the "breaking point", they feel they cannot carry on with things the way they are (Vermeulen et al., 2015).

McCann, Bamberg & McCann, 2015 founded family caregiver's positive attitude towards geriatric depression, such as the satisfaction of the family caregiver can be seen from the observation that the older adult relative is satisfied and happy, a sense of mission and fulfillment by more interaction with their older adult.

In Asian culture, the strong sense of gratitude towards parents when the older adult in family or parent has a health problem, family caregiving is a way to express gratitude by taking care of them and caregiving perceptions as a positive experience. The perceived family caregiver attitude towards the care of older adult depression with optimism would lead to positive outcomes (Bunthumporn, 2014). Similar to the publications by the National Opinion Research Center (2014), it was found out that family caregivers' experiences with positive attitude resulted to around 83% returned the favor to someone who was once cared for them, the satisfaction of knowing that their loved one is getting excellent care, personal growth and increased meaning and purpose in one's life. Mostly feel the positive relationships between the caregiver and the recipient.

Today, caregiving for the older adult relies not just on medical care, but also and stimulates active older adult aging. In Thailand, family and community caring for the older adult needs to be operational and provided. Therefore, staying with their family in the community in a familiar environment and gets support from their relatives yields positive outcomes between the older adult and the family caregivers with positive attitude towards caregiving for the older adult depression (Tamdee, et al., 2019).

2.2.5 caregiver's management strategies of depression

A limited number of previous studies described ways in which family caregivers managed depression in their daily lives. Bursack (2020) indicated that the management strategies of depression by all these caregivers, they are making connections with other caregivers to support each other with engagement and learning from shared experiences, self-education about the management of depression. Find out information from health care agencies or health providers, understand the outcomes of care given, help seeking behaviors,

observations and recording of the present situation including behavior change, emotional and symptoms of physical illness (Bursack, 2020).

A research found that family caregivers spending more caregiving times gained more positive experiences and understanding of the problem (Vermeulen, et al., 2015). In terms of management strategies of depression, the family caregivers were 87% knowledgeable on how to provide long-term care "on the job" or by teaching themselves how to do it.

The management strategies of depression in family caregiver needed ~~a~~ guidelines and support from health professionals and other stakeholders to provider mainly through psycho-educative programs or other forms of support, which permit the perception that caregivers of geriatric depression are not alone in their experience such as "perceiving the disease" by family caregivers observation and highlight inexplicable changes of mood or behavior by experiences and of sharing daily life with a depressive person, recognizes and identifies the disease in different ways (González, et al., 2010).

Rohren from Mayo Clinic, indicated the family caregiver can help the older adult depression by learning the symptoms of depression, encourage treatment, identify warning signs of worsening depression by observation, learn how depression affects and what to do when it gets worse. Call for help from care coordinators who gathers information from healthcare providers. (National Alliance on Mental Illness. 2015)

Muscat, D. M., Gessler, D., Ayre, J., Norgaard, O., Heuck, I. R., Haar, S., & Maindal, H. T. (2022). Seeking a deeper understanding of "distributed health literacy": A systematic review. Health Expectations, 25(3), 856–868. https://doi.org/10.1111/hex.13450

CHAPTER 3
RESEARCH METHOD

Introduction

This chapter is composed of the aspects of research design, and is followed by the research setting, the participants, the recruitment processes, research tools, ethical considerations, data collection, data analysis protocols, and trustworthiness in this qualitative research study.

3.1 Research Design and Rationale

An exploratory research design with a qualitative data collection approach was used in this study. The exploratory qualitative research methodology allowed for the discovery, through words and text, of meaning and connections in inductively collected, rich, detailed, qualitative data by means of development and application of a rigorous, systematic, and consensus-based coding system (Hill et al., 2005; Denzin & Lincoln, 2017). This design sought to understand the phenomenon of a reality or situation, and the existence of multiple realities, and it primarily involves human perspectives (Kivunja & Kuyini, 2017). This was related to an emotion, such as loneliness or depression, a relationship, or being part of an organization. In this study, in-depth semi-structured interviews were conducted for qualitative data collection (Horrigan-Kelly, Millar, & Dowling, 2016; Stebbins, 2011; Fawcett, & Garity, 2009).

3.2 Research Setting

The respondents in this study came from hospitals in provinces situated in semi-rural communities in central Thailand. The total population of these provinces was roughly 645,532 and 14,074, with 23.1% accounting for older adults (Department of Provincial Administration, 2019). Approximately 99% of the population were Buddhists, as Buddhism is the major religion being practiced in Thailand. The said religion has known to influence the values and practices of a family member regarding gratitude. It is believed as

a culture tradition that when a parent becomes ill, a certain family member would uphold the role of a caregiver, which is passed from one generation to another.

The data collection occurred in the community of the selected hospitals. This setting was selected for recruiting the sample because these hospitals provided routine geriatric depression care more so than others. Family caregivers of older adults who were diagnosed with depression and referred to the sub-district health promotion hospitals were recruited as study subjects. The researcher visited the participants' location to conduct the interviews as per the wishes of the participants.

3.3 Participants

3.3.1 Participants

In this study, participants were family caregivers who cared for their older relatives who were diagnosed with depressive disorder. The researcher approached hospitals and local communities, which transferred participants to the study.

The inclusion criteria were as follows:

1) Primary family caregivers aged 18 years and older.

2) Care recipients aged 60 years or older with a depressive disorder diagnosis.

3) Be a relative such as a husband, wife, son, or daughter.

4) Ability to understand and communicate in Thai language.

5) Take care of older adults with MDD such as bathing, cooking, doing laundry, providing medication, etc. for more than 6 months

6) Agree to participate in the study project.

The following were the exclusion criteria: The care recipient was currently in an acute or severe stage of disease, such as

1) Having a history of severe physical conditions such as heart attacks, strokes, active cancer, etc.

2) Having a history of psychiatric illness or receiving psychiatric treatment

The terminating criteria were as follows:

1) Withdrawn from the research project, or moved out, or passed away.

2) When no new information was elicited by sampling more units.

3.3.2 Sample Size

According to Creswell & Poth (2017), an appropriate sample size for a qualitative study is one that adequately answers the research question. In essence, the "richness" of the collected data is much more important than the number of participants. In practice, the number of required subjects usually becomes obvious as the study progresses, as new categories, themes, or explanations stop emerging from the data (data saturation) (Morse, 2000). Clearly, this requires a flexible research design and an iterative, cyclical approach to sampling, data collection, analysis, and interpretation. The literature recommended a typical qualitative study with roughly 10–25 participants (Marshall, 1996; Vasileiou, Barnett, Thorpe & Young, 2018; Creswell & Creswell, 2018).

3.4 The Recruitment Processes

In this study, the researchers used purposive sampling to recruit participants, in that participants were recruited according to pre-selected criteria relevant to a particular research question. This was designed to provide information-rich cases for in-depth study because participants were those who either had the required status or experience of depressive symptoms and management or were known to possess special knowledge to provide the information researchers seeking.

3.5 Research Tools

3.5.1 Researcher’s Background and Competency

In a qualitative approach, the researcher was the primary research instrument. In this study, the researcher has had the background and competency to run this project. The researcher took the course "Qualitative Research in Nursing" a subject for the Doctoral Degree at the Faculty of Nursing, Thammasat University, and had a nursing practicum experience focused on qualitative research for more than one hundred hours. For previous qualitative research experiences, the researcher worked on the research project "Togetherness in Co-Creating Healthy Communities". This project was subsidized by the Thai Health Promotion Foundation. The researcher's position was during data collection, data evaluation, data analyzing, and writing a report in qualitative research for three years, (300 hours) with more than six titles of publications in TCI.

3.5.2 Demographic Data Sheet

The demographic sheet included sex, age, educational level, history of illness, living arrangement, relationship between caregiver and the older adult, economic status, and race/ethnicity of both family members and the older adult.

3.5.3 Interview Guide

Having an established interview protocol is a necessary step in reducing bias in the data collection process (Creswell, 2007). Each interview was designed as semi-structured questions to increase the depth of questioning and to build rapport between the researcher and participants. The average length of any interview was 60 to 90 minutes. Each interview was submitted in a semi-structured format with general and specific questions. The questions were set to ensure they covered the research questions and research objectives. Five experts accessed the interview guide, including a psychiatrist who was a specialist in depressive disorders, (1), a psychiatric nurse who was a specialist in depressive disorders (1), a lecturer nurse specialized in psychiatric nursing (2), and a lecturer nurse specialized in qualitative research.

5.3.4 Semi-structured Questions: (for example)

- When I say, “depression,” what is the meaning you associate with it? or how would you describe this word in your own view?
- Could you briefly explain the depressive symptoms you have noticed in your _____ at home?
- What factors do you think cause your _____’s depression?
- What do you think about caring for older people with depression?
- I would like to hear about your attitude toward caring for your_____ with depression.
- I would like to hear about what strategies or methods you use to care for the depression of your_____?

5.3.5 Tape Recorders

A tape recorder was beneficial. It helped the interviewer gave their full attention to the participants during the interview, and avoided the need to continuously write down notes. It also allowed data to be left before analyses and applied more rigorously and in a more leisurely manner.

3.6 Ethical Considerations

The researcher submitted the research proposal for the consideration of the Research Ethics and Research Methodology Subcommittee of the Faculty of Nursing (COA No. 077/2564) to the Human Research Ethics Committee of Thammasat University (Science), (HREC-TUSc). The study has been approved by the Ethics Review Sub-Committee for Research Involving Human Research Subjects of Thammasat University: Faculty of Health Science and Science and Technology (NO. code: 064/2564) between the date of approval of August 2, 2021 and the expiration date of August 1, 2022.

Permission to use the General Practice record in this study was given by the Director of Samchuk Hospital, the head of the Outpatient Department, and participants.

The first step of collecting data was to gave the information sheets to all participants, which were printed in plain language. The contents of the sheets used easy-to-understand language; they included information about the project, and informed consent, which the participants had to sign for agreeing to participate in the interview sessions. The researcher asked the participants to engage in the study willingly and provided them with enough time and study material to make an informed decision. To ensure that the participants understood the study, the researcher communicated with them in two ways, including written and verbal forms.

In the second step, the participants were told about the background and objective of the research, as well as the procedures, including the Ref. code: CP1 potential risks and advantages.

The advantages of taking part in this study included knowledge, understanding of depression literacy, and self-awareness to lessen depression in older adults. In terms of risk assessment of study participation, the researcher frequently assessed people's physical and mental health readiness. Participants who agreed to participate in the study were required to sign a consent form. The researcher gave the participant complete freedom to withdraw from the research project. All study techniques were authorized by professors with experience in the field of mental health and a nurse practitioner from the Department of Outpatients, Samchuk Hospital. Participants received compensation for lost time of 150 baht after every conversation was completed.

To ensure confidentiality, the researcher changed participants' names to pseudonyms during the process of data analysis and report. All documents related to the study, such as interview transcripts and data collection, were kept in a locked cabinet at the researcher's department at Nakhon Pathom Rajabhat University, and electronic data was stored in password-protected external data storage. All types of data were securely kept for a minimum period of five years. The published information, presented results, and key findings and insights were communicated in a manner that could be understood by the participants. The information could not be linked to the participants.

3.7 Data collection

After the ethical approval, data were collected between August 20, 2021- June 20, 2022.

The first step, the researcher sent an official letter to the director of the selected Samchuk hospitals to seek permission to undertake the research.

Second, after obtaining permission from the director of Samchuk hospital, the researcher contacted the nurse to seek cooperation for data collection. The researcher's coordinator was informed about the study and the process of data collection.

Third, the researcher established a good rapport before each interview started. The researcher explained the goal of the study as well as the methods, including potential risks or hazards and rewards.

Fourth, the participants were given explanations of all the facts stated in the documents. If participants agreed to participate in the study, they were required to sign a consent form. At this stage, the researchers spent an average of 60–80 minutes. The minimum time was 60 minutes, and the longest time was 80 minutes. To interview via LINE video call about 2 weeks later with friend adding by phone numbers and demonstrate the use of LINE video in rarely used cases was conducted.

Fifth, in light of the current COVID-19 pandemic, the researcher utilized social media platforms such as LINE video call to conduct interviews of the participants based on the essential information in accordance with the person's rights and appropriate timing within acceptable limits.

Sixth, the participants were informed about their rights to withdraw from the interviews at any time if they felt uncomfortable or when needed, and the researcher also asked for permission to tape record them during the interviews.

Seventh, a semi-structured in-depth interview was administered by the researcher to collect data from family caregivers of older people with depression. The participants participated in research until the data was saturated.

Lastly, the researcher performed a preliminary analysis of the data to provide the necessary information for the interview. Following this, the researcher asked for permission to contact the participants after 2 weeks for 1-2 additional interviews, which took approximately 35–45 minutes at the time convenient for the family caregiver. The researcher interviewed 3 participants for the 3rd time, which took approximately 30–45 minutes each to check some issues.

The information gathered from participants and medical records was safely and pseudonymously retained, and only overall results were provided.

3.8 Data Analysis

The study began with descriptive qualitative data and was followed by thematic content analysis, which was used for content analysis by categorizing verbal or behavioral data to classify, summarize, and tabulate the data, such as following the suggestions developed for the study and the framework that was developed to organize cases with interpretive understanding and content analysis (Murphy & Dingwall, 2003).

Content analysis was used to interpret meaning from text data content and hence for threats to trustworthiness, comprising discursive, thematic analysis, structured and instrumental analysis, data content analysis and interpretation of the results. In this study, qualitative data analysis and data gathering occurred concurrently (Sutton & Austin, 2015).

In this study, the transcripts of the interview were analyzed using thematic analysis via the following 6 steps (Braun & Clarke, 2006):

First, familiarization of data: the researcher repeatedly read the interview transcript for an overview of the documents and notes so that understanding of the data was achieved.

Second, generating initial codes: this process was divided into two steps. The researcher discovered words and sentences with similar meanings that had been identified into small units, which were groups of words, sentences, or paragraphs containing aspects related to the purpose of study (data condensation) and coded after labeling. For example, "sad," "blue mood," and "tied" had similar meanings to the word "depressed." The coding used to analyze the interviews afterward had given effect. Therefore, after the interviews, the researcher analyzed and compared the interviews and answers according to the aspects or specific themes covered in the interview guidelines.

Third, the researcher searched for the emerging themes and their meanings within the text and identified and labeled them appropriately. The researcher took the information from the interviews and coded it for the advisor to check accuracy and made triangulation. Following that, the researcher translated themes and codes into English and sent them to the Language Institute of Nakhon Pathom Rajabhat University for editing.

Fourth, reviewing themes: themes were executed with more statements and quotes analyzed repeatedly. For researcher triangulation, themes and subthemes were vetted by the advisor and the rest was examined referential adequacy by returning to raw data.

Fifth, defining themes: codes with similar meanings were classified into sub-themes, which were further grouped into themes that reflected their main content. During the process of analysis, the codes and themes were discussed among the research team until the first agreement was reached.

Sixth, after further discussion, prominent themes comprising frequently reported overlapping data were selected from the researcher's analyses, renamed, and included in the final analysis.

Lastly, the themes from the texts were connected and clustered into superordinate themes with related sub-themes. The process was repeatedly reviewed with subsequent transcripts. Texts were examined more closely for detailed meaning and interpretation. A similar analysis was also performed by three other authors, and the results from both analyses were discussed and merged into a final organization of the findings. According to Smith et al. (2009), the tables of detailed summary of group themes, interpretative, and reflexive written accounts were summarized.

The interview was paraphrased in strict verbatim form, with researchers observing all the words. Feedback from participants after the interview showed that they spoke openly. A number of comments were made about not fully revealing their situation in other contexts and describing positive effects, although some topics were somewhat difficult to discuss due to their distinct emotional characteristics.

3.9 Trustworthiness in this Qualitative Research

The trustworthiness of this study, frameworks for ensuring rigor in this form of work, was in existence for many years. The researcher agreed that data trustworthiness, whether collected from direct observations or interviews, were evidenced by the following four criteria by Lincoln & Guba (1985). In particular, Guba's constructs were the focus of this study. The researcher attempted to meet the four criteria, including credibility, transferability, dependability, and confirmability.

Credibility

In this study, the researcher used a proxy for prolonged engagement, persistent observation, and data triangulation by different data collection methods and operationalized through the process of member checking to test the findings and interpretations with the participants through data feedback. With truthful confidence and credibility, the researcher conducted standard operating procedures as indicated in the qualitative approach of this study. Additionally, sufficient justification was provided for variations and decisions to demonstrate a true picture of the phenomenon based on the observation being presented. Evidence of the repeated questioning of the data was presented and revised several times (Polit & Beck, 2014).

Transferability

The researcher ensured transferability by providing readers with evidence that resulted from the study's inability to relate to other circumstances, conditions, times, and

populations. It was essential to remember that the researcher could not guarantee the results of the study.

Dependability

In this case, the researcher gathered evidence to support the claims that similar findings could obtained if the study was repeated. The process was audited by the researcher. The information from the interviews and the coded were sent to the advisor to check for accuracy and make recommendations. However, if the study was repeatedly applied in the same context with the same participants, it became a "new" study, given the ever-changing social world and perceptual shifts (including news events that may change our thinking overnight).

Confirmability

Finally, the researchers took steps to demonstrate that the findings were driven by the data and not biased. Biases in qualitative research were an ever-present issue, but objective interpretations were more probable if self-reflection of the researcher acknowledged them freely and incorporated them into the design by, for instance, deliberately pursuing potentially conflicting evidence expected by alternatives. Confirmability is neutrality, or the degree to which findings are consistent and could be repeated (Polit & Beck, 2014). This was analogous to objectivity in quantitative research. The methods included the maintenance of an audit trail of analysis and methodological memos of the log. The researcher kept detailed notes of all progress, such as decisions and analyses. In addition, depending on this study, the researcher conducted member-checking with participants.

Specific techniques were used to increase the importance of qualitative initiatives across the entire research process. Some strategies needed to be tackled in the design stage of the study, while others needed to be applied during data collection and interpretation of data thereafter. A small portion of these strategies were discussed in detail, such as

reflexivity and triangulation, because they were critical to the quality of the research, while other, simpler strategies were briefly described. One of the four qualitative trustworthiness criteria outlined the strategy.

CHAPTER 4

RESULTS AND DISCUSSION

The purpose of this study is to present the results of the study of depression literacy in FC who take care of older adults with depressive disorders by method and qualitative discussion.

4.1 RESULTS

In total, 17 family caregivers participated in the interview to reach data saturation. The results of the study begin with an overview of qualitative participant demographics and contexts. Next, themes, sub-categories, and categories are presented.

4.1.1 Participants

Pseudonym **CP1** was the first participant, and all participants were given numbers consecutively until the last participant was identified as **CP17.**

Table 4.1 The demographic information of the participants.

Pseudonym	Age (Years)	Gender M=male F= female	Marital status	Educational attainment	Occupation	Economic status	Relation to older adult	Length of care/year
CP1	45	M	married	Secondary sch.	agriculture	insufficiency	son	3
CP2	41	F	married	Primary sch.	laborer	sufficiency	daughter	8
CP3	66	F	married	Primary sch.	laborer	insufficiency	daughter	2
CP4	65	M	married	Primary sch.	laborer	insufficiency	son	2
CP5	66	F	married	Bachelor's degree	laborer	sufficiency	daughter	4
CP6	44	F	single	Secondary sch.	agriculture	sufficiency	daughter	2
CP7	33	F	single	Bachelor's degree	laborer	insufficiency	daughter	1
CP8	73	F	married	Primary sch.	laborer	sufficiency	husband	1

Pseudonym	Age (Years)	Gender M=male F= female	Marital status	Educational attainment	Occupation	Economic status	Relation to older adult	Length of care/year
CP9	67	F	married	Primary sch.	government officer	sufficiency	daughter	2
CP10	68	M	single	Primary sch.	laborer	sufficiency	son	5
CP11	17	F	married	Secondary sch.	student	insufficiency	daughter	5
CP12	42	F	married	Secondary sch.	laborer	sufficiency	daughter	8
CP13	47	F	married	Bachelor's degree	government officer	sufficiency	daughter-in-law	2
CP14	45	M	single	Secondary sch.	agriculture	insufficiency	daughter	2
CP15	62	F	married	Bachelor's degree	laborer	insufficiency	sister	5
CP16	61	M	married	Primary sch.	laborer	insufficiency	brother	0.7
CP17	67	F	married	Primary sch.	agriculture	insufficiency	husband	3

Most of the participants were female, aged between 17 – 73 years with a mean age of 53.47 years. 13 were married and 4 were single. 9 participants had a primary school level of education. All of them were Buddhist. The length of caregiving of those with elderly depression was between 0.7 – 8 years. The majority were involved in labor and agriculture, monthly income was between 0 - 40,000-baht with an average of 11,550 baht, and most had insufficient disposable incomes.

The family characteristics included both extended family and a single family in which children married and separated from the family to build another house in the same area. The elderly lived together to care for each other or in some families the children were the elderly caregivers.

Of the elderly people suffering from depression, most were females, aged between 60 - 78 years old with a mean age of 67.73 years old, 15 were married and 2 were widowed, all of them were Buddhists. 14 participants had a primary school level of education. In terms

of economic status, 15 elderly people were unemployed and had no income. All of them had 1-3 underlying diseases, such as high blood pressure, atherosclerosis, and diabetes.

The majority of family caregivers were sons, daughters, spouses, siblings, grandchildren, and daughters-in-law, and were living together. The minimum caregiving role was 7 months, and the maximum was 8 years. Family caregivers were responsible for activities of daily living, diet, and medication administration, taking regular medical appointments and managing symptoms of depression when they occurred.

Most of the older adults with MDD have quiet, anxious, irritable, aggressive, self-centered behavior. The terms of speech were characterized by little talking, or shouting, having little sleep during the day, eating less, and sometimes some needed to take more medicine when symptoms occurred. Some older adults could also partially care for themselves.

4.2 Themes

Rich information about changes in the family caregivers' experiences of accessing, understanding, evaluating, and implementing health information across multiple health contexts was gleaned from the interviews. The themes are listed in Table 4.2 and explained in more detail below. The following list of themes in the functional, interactive, and critical domains of health literacy is linked to changes in each of those areas. Where relevant, citations to the research that support the variations across levels are also presented.

Table 4.2 Overview of themes and corresponding changes in levels of depression literacy.

Themes	Domains of literacy	Sub themes	categories
Theme 1: Start to recognize depression through observation of symptoms and seek medical assistance	Changes in functional HL and	1)Perceiving suffering of stress and emotional changes	- Perceiving suffering of stress in elderly, - emotional changes included aggressiveness, anger,

Themes	Domains of literacy	Sub themes	categories
	The ability to recognize major depressive disorders (DL)		easily experience angry and mood swings
		2) Observing talking and behavioral changes	- Knowledge of leading signs and symptoms from observing. - Learning depression through experience
		3) Perceived depression observed by healthcare providers	- Knowledge of MDD - understanding of depression.
Theme 2: Increased understanding of multiple factors leading to depression		1) Recognition of personal habit and psychosocial effects of older adults.	- Loss of a close person or an important person - The patient's habitual basis - The habit of drinking alcohol - Disappointment from work and family members' expectations
		2) perceived Social-economic problems such as unsuccess	Economic problems
Theme 3: Perceive negative views		1) uncertainty for life	- lack of knowledge about depression and care.
		2) Negative attitudes and frustration	- Feeling a negative (burdened, tired, stressed) - Disappointment in elderly behaviors, - no exact time.
Theme 4 : Try to perceive in a positive ways	Changes in critical literacy	1) Acceptance of being the caregiver	Eccepted the symptoms and behavior.
		2) Adaptation	- Change behavior - Adapt for a new situation for maintaing everything in a family.
		3) Be happy and proud of providing care of a love one	- Rewarding goodness and sense of gratitude
	Apply		- Both are happy

Themes	Domains of literacy	Sub themes	categories
			- Not a burden. - Proud of self
Theme 5: Having strategies to properly manage care	Changes in behavior and practices when dealing with elderly with illness	1) Making changes by using different techniques.	- Staying still or using silent techniques - Diverting attention and plan activities for the patient - Praying and taking to make merit,
	Changes in critical literacy		Medication should be taken under supervision.
	Changes in behavior and practices when dealing with elderly with MDD	2) Provide comfort and encouragement	Pay attention, pamper your heart, and let your grandchildren do their thing.
			"Handle with indulgence and close supervision"
	Changes in critical literacy	3) Seek resources by seeking help from those who have experience	Seeking help from those who have experience

4.2.1 Start to recognize depression through observation of symptoms and seek medical assistance

4.2.1.1 Perceiving suffering of stress and emotional changes

4.2.1.2 Observing talking and behavioral changes

4.2.1.3 Perceived depression from observed by healthcare providers

4.2.1 Starting to recognize depression through observation of symptoms and seeking medical assistance

This theme was shown by caregivers' perception and observation of any changes in symptoms, such as mood swings which ranged from normal to tantrums, and behavior that developed into depression. Depressive symptoms were not stable, and changed over time. The family caregiver would find that the behavior of the elderly changed, then would seek answers to those health problems. Family caregivers searched for answers from various sources, starting with asking experienced people, family members, and neighbors, to reading books and searching the Internet, until the desired answer was reached to a certain level. At this point, it was believed to be a disorder that was already associated with depression. When the caregivers brought the older adult to be treated, they received knowledge of the disease from doctors and nurses. This was considered crucial for encouraging changes in the health literacy and depression literacy capacities of accessing, understanding, and applying health information of health services, to family caregivers which created a learning process of accumulating knowledge, resulting in the correct knowledge, understanding, and ability to select health resources to find reliable information that connects to increase DL in the ability to recognize major depressive disorders (DL).

4.2.1.1 Perceiving suffering of stress and emotional changes

According to the perception of the family caregiver, this disease makes the older adult display aggressiveness, anger, and easily experience angry mood swings. They cannot be offended by other family members. Most of the older adults with depression had a quiet personality, seldom talked, but were easily irritated, self-willed and angered, aggressive and rude. It was perceived that the disease was caused by behavior that saw the older adult love themselves more than normal by forging behavior from a spoiled childhood, as well as was from the lack of love received during their childhood, a stressful personality, and the need for family members or loved ones to show behavior as they pleased.

The family caregiver found that the depressive symptoms were not stable, and changed over time. That made FC understanding, applying the data for handling the symptoms of each situation.

"Mom seems to be suffering from depression, so we immediately took mom to the doctor. We talked to a psychiatrist and asked him about the disease." CP7

"The symptom was that my mother saw a picture over there. After taking the picture, my mother couldn't sleep. She was thinking a lot and saw the person who had passed away come to her. At first, we didn't know about the symptoms, but we realized something was wrong." CP9

4.2.1.2 Observing talking and behavioral changes

The caregivers used the skill of observing the change in behavior, including what affects the dissatisfaction. The preliminary symptoms before the onset of symptoms included noticing the appearance of speech impairment. Ironically, yelling at the triggering of symptoms was something that could not be avoided, and most of the symptoms were anger. The mood changed quickly, they were easily angered, could not be offended, and this knowledge accumulated from the experience of caregivers. The family caregivers became knowledgeable about the disease by receiving information from:

The observations of the family caregivers by themselves found that the knowledge of depression was derived from observing the behavioral changes of the patients in the experiences of living together and caring for the older adult. According to the perception of family caregivers, older adults with depression are prone to tantrums, irritability, selfishness, overpowering, and an unwillingness to do anything to achieve success or achieve the desired results with frugality. They are thrifty to the point of being skittish, with clear goals for spending money, and are selfish. Caregivers could also analyze the underlying behaviors that contributed to depression, such as: the behavior of expressing themselves with other people was better than with family members. Habits were easily irritatable, easily angered, and overpowering. Such as:

"If I offend him... If we do this work ...He didn't like it... He's being fierce..."

"..... Yes... having depression in my heart. I see that he is normal, but he was stressed. I don't know what was stressful. "

“Since he was born, he has been bored. That is, he has said bad things since birth, in the sense that it's a habit, not a disease. It is his habit that he has been like this for a long time if he speaks to others very well…..”

"...He wouldn't give up on taking a gun like this... Whoever is offended will go shoot him to death..... He can't be bothered... He can't lose any benefit..... from being a very stingy person about money. " “...It's motor oil. He had to go for a ride in the district at the big gas station because the price was cheaper....I don't want anyone....he wouldn't listen.. because he must be economical……”

"...do not understand! What more could he want? because the child is not unruly! Didn't say anything. He is also very fond of himself…” (CP1)

“….observe from the environment, like she is easily stressed out?

“…….He will be irritated. We noticed…”.

“.....Yes, and she will be bored. My mother said, ‘ I don't want to live’, ‘ I'm easily tired, ‘I want to sleep’. I know ‘ There was a problem back’ then. After all, his son was in prison. So, she felt that it was like she was really depressed back then. We looked, and we knew she had symptoms again……”.

... “Tired, I don't want to stay. I want to take the pills to death.” When my mother was stressed, she would say these words. If mom is stressed, she will be drowsy, she is silent as she thinks, but she is not getting anything…”. (CP2)

"My mother is depressed. I didn't know it at first, but she has been like this since I have been in Bangkok. I just noticed and found out the reason when I was in Suphan, about 3 years, 2-3 years since taking the pills.

" Mom's expression on her face if she's stressed out, she'll go out. She'll be sad and withered like this. Her calm face will look like a person who's sick. If she's stressed, her symptoms will go away, and she'll be easy to see. Yeah, what's wrong, what's stressful? Mom said, "What are you stressed about?" and he'll say something stupid. No, it's better.”

“I mean, I'm always with my mother. I know how my mother is now. My mother's face will show it. I will know automatically. If she is like this, her face would look like a tense face. My mother is dizzy. When she feels stressed, she gets dizzy. I asked if she was taking sleeping pills, and my mother said she was just asleep. If my mother was not feeling better, I would ask if she should go to the hospital.”CP6

"Mom seems to be suffering from depression," so I immediately took her to the doctor. “We talked to a psychiatrist and asked him about the disease.” CP7

“When my father is stressed, it shows on his face.”

“....Symptoms are that his mother saw this picture over there, and then couldn't sleep and thought about it and ended up seeing that person in the picture come to her. Let the acquaintances listen, he suggested that "it's like his mother." (CP 8)

1) Knowledge of leading signs and symptoms from observing.

The family caregiver could recognize and was able to detect the leading signs because of their experience as caregivers and knowledge of leading signs and symptoms. As a result they were well-versed in observing symptoms. The preliminary symptoms before the onset of symptoms were observation of speech characteristics; poor speech; sarcastic comparisons; and shouting. The factors that triggered the symptoms were frustrating, uncomfortable, or unsatisfactory. Most of the symptoms were emotional: anger, mood swings, angered easily, upset, wanting something done immediately, such as wanting to go somewhere or wanting to do something. The thought of killing oneself or killing others was also evident. Sometimes, they had symptoms of speechlessness and experienced a self-willed mood. Patients wanted people to be interested all the time. The details of sub-categories are as follows.

“...His symptoms weren't even that bad to have to see a doctor. That is, he seems to be an angry person. Anyone who can't say anything off-putting is fussing.”

“...He is a person who likes to talk. So we walk away. We don't want to argue…”

“……If you don't get what you want or someone says something or if someone is offended, he will not be satisfied. It’s like he can't be offended. What he does, he has to do it. Wherever he goes, he has to take him….. He is easily angry….. Like a selfish person... When he looks at someone, his eyes will widen ... he will be loud, he will shout, we will not speak, and we will be silent.”

“…….His condition was not like going to the doctor…. Well, he's like an angry person...it's a stimulus. That is, nothing affects him……. He had no symptoms, he ate well, slept, took the medicine and he was fine…. He said that once he ate it, he was relieved.” (CP1)

“...that one was clearly in a bad mood at that time..” (CP2)

“...We used to live with my mother all the time. My mother is the type who is easily irritable, angered, and will be like a person who doesn't want to…, and then be scolded, something like that..”

"…….At that time, when we stayed with you, you were easily irritable, and it seemed like you didn't like it and yelled something like this”.

“……..You can't say the least bit of the wrong thing… The thing that you are fussing about is like the mood of someone spoiled. Like a child who, like I can't. ...if you offend me or you can't hear me! I will scream as if people are interested..."

“... I don't want to live, I don't want to eat, I want to die!.. Our feeling is ah! No, talk to her..... And that's until my brother comes out. But now ask? Are you better than before? You're better than before. Now his brother has been out (of prison) for many years. It's like you're still alive, are you still self-absorbed?”…….Perhaps you have a bit of frustration. It's like the emotion that we don't understand if it's the age that's getting older or not. You will be like a child. Like a child's feelings. Well, if you don't like it, you will be angry ….”

“……You would be like…why! what! Something like this……..” (CP2)

2) Learning depression through experience

The family caregiver can capture the early warning signs by learning depression through experience when they stay together. Learning depression symptoms is based on

experiences that are shared with older adults with depression, learning what is true of their symptoms, behavior, and changes.

“We stay together every day. Our experience teaches us that when mom has a slight change, we know. For example, when mom is upset, we take her to stay in an air-conditioned room for her to be comfortable so that she won't be more irritable.” CP5

4.2.1.3 Perceived depression from observations by healthcare providers

FC's caregivers perceived depression from observations by healthcare providers. The knowledge of the disease was the acceptance of information from the doctor and medical diagnosis that gave the caregivers knowledge and awareness about depression. Then FC's caregivers could develop knowledge and the capacity of caring. The knowledge of the disease came from observing the behavior and personality of elderly people suffering from depression until it became a set of accumulated knowledge in the caregivers. It made FC acquire a new way to care for each situation.

FC's caregivers found that the behaviors of the depressed elderly which led to the depressive symptoms had self-love, exhibited self-centered, aggressive, and paranoid behavior, and irritability, as the basis of depression. From the viewpoint of caregivers, it was believed that childhood parenting, such as being spoiled in childhood or not being loved in childhood, caused depression and was a fundamental factor in the development of depression.

“Because the doctor at the hospital said, "My father was depressed, and he had this disease." Stress-related neurotic disorder:”

"The first time, he went to the doctor himself; he told the doctor." Following that, we made an appointment to see a doctor at the clinic and instructed them to inform the clinic doctor. He's a psycho... mental”

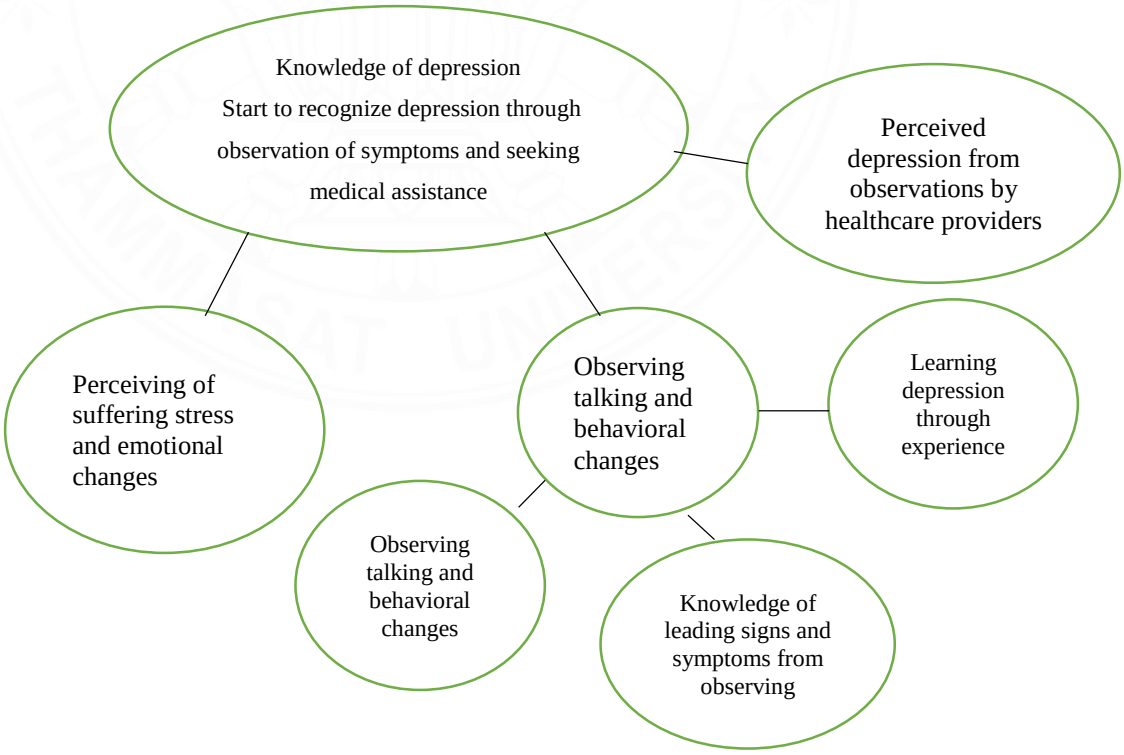
“...illness and depression are the same thing? The doctor said he had a psychiatric disorder. He was a psychiatric patient. "

"The doctor diagnosed him with depression, but I can see that he is fine. I think he's fine…. sometimes he gets angry! ...Let's say you talk to me or your mother to offend him. He seems to be fierce." (CP1)

"At that time, I took my mother to the doctor. And it's like, it was a bit of a problem back then. So, let's talk about something like this. When I took her to see a psychiatric nurse, we talked about something and tried to check it out. And she has, like, a depressive point. She must have said, "I don't want to stay; I don't want anything like this." CP2

"My mom was stressed, so I took her to a consultation where there were a number of psychiatrists like this. I tried calling to consult and tell the symptoms that my mom is having is that she is stressed, sleeps more, is dizzy and rarely talks. Then the nurse would tell me to consult a psychiatrist. So I took mom to Sam Chuk Hospital. I went to see the doctor, and he gave me the medication first." CP6

"The doctor examined her, and he said she was depressed". CP 17



4.2.2 Increased understanding of multiple factors leading to depression

The study found that FC's changes and developments in understanding and awareness were reported, which led to its application. This was particularly evident in relation to the complex causes or triggers of depression and are thought to arise from a combination of factors, including feelings of loss, inferiority, regret, and/or worthlessness, and experiencing traumatic events. Often, there may be a combination of factors that contribute to the development of a depressive disorder. Sometimes, the causes may not be completely clear. The study found that depression is a disease caused by stress or a stress-related disease. Many stories come into contact at the same time, causing sensory disturbances and expressions of irritability and aggression with family members. This in turn was connected to improvements in the management of risk factors and sickness engagement.

The cause or triggers of the symptoms of depression from the study found that perspectives of family caregivers of depressed older adults on the perception of depression had four sub-aspects of the causes of symptoms that affect caregivers' perceptions of depression, and these findings are also connected to increases in functional health literacy, where FC' capacity to act on factual information about trigger hazards is improving.

4.2.2.1 Recognition of personal habit and psychosocial effect of older adults

1) Loss of a close person or an important person

Changes and developments in understanding and awareness were reported, which led to how information was applied. This was related to changes in engagement with and management of depression symptoms and risk factors. The loss of a close or important person in one's own life. From what caregivers perceive, losing a husband or wife from a chronic illness or disease, prolonged illness or the sudden loss of a family member makes it unacceptable. The occurrence of symptoms of depression comes from a loss that affects the mind until it is unable to adjust one's own thoughts to normal life. If, at any time, a close

incident or a reflection of the person who had experienced loss occurs, symptoms of the disease can arise, such as:

“At that time, his brother was imprisoned in Singburi. Mom was depressed until we noticed.” CP2

“ We think it started when my mother's parents passed away, then 2-3 years later, my father passed away, and since then.. Mom must have been thinking of things like this for a long time because they have been together for many years.”CP7

"……..It's very difficult……….",

“It's sad to wake up. I immediately thought of my son. I feel like I don't know why I stay."

(Remark -patients must take the role of caregivers and support each other.)

The loss of an important person in life such as a child causes depression. It was found that only two older adult people were living together from the interview. Losing someone important in life causes depression. The father, who was unable to adjust, remained silent, refused to speak out, but those close to him could observe from his gestures, facial expression and eyes. CP 3

2) The older adult's habitual basis

The report found the FC perceived health information and analyzed the background habit data of the elderly, and were able to link the background habits to depressive symptoms. The older adult's habitual basis had an important effect on the perception of the caregiver, especially the habits that were brought up by indulgence. Being the last child in a family, being cared for and being indulged could have an effect on the symptoms of depression. The fact that the family provides everything they need, when they are offended or left unwilling, leads to a clear manifestation of symptoms. In addition, the original basis of patients who were economical, thrifty, and stingy was also a pattern of depressed patients, reflecting that sticking to or cultivating ideas about spending money had an effect on the accumulation of stress in oneself and caused symptoms of the disease. Such as:

"…Well, it's been his habit for a long time. If he talks to other people, he's very good." CP1

You know, like you're the type, if you go back to when you were a kid, you're like, your mother doesn't love you, she's like, you're already stressed. ....." (CP2)

"This may be due to the habit of raising them from a very young age. His personality traits……..CP5

"…You have to follow me I say this, you have to do this if you interrupt me or you can't hear me. I'll be whistling something ……"CP6

"…it can't be a single misunderstanding. So we have the feeling that the mother's anger is like a spoiled person, like a child who can't be ……" CP7

3) Drinking alcohol regularly or drinking heavily during a time of disappointment

The report also found the habit of drinking alcohol regularly, drinking heavily during a time of disappointment, drug issues in the living environment, or a family member becoming addicted to drugs and going to prison, can result in the family being affected by such behavior. These factors are what makes caregivers more understanding of the risk factors of causes of depression for patients with depression, as the patients try to find a replacement to manage keeping their thoughts out of things that do not go as planned. This is linked to FC's increased interactive literacy to communication or dealing with the elderly.

" Heavy drunk all day……" CP5

"*When he was stressed, he did not know what to do, so he got drunk." CP16*

4) Disappointment from work and family members' expectations

Disappointment from work and from family members' expectations. Disappointment from family leadership roles results in depression. According to the caregivers, it was possible to process when disappointments or mistakes in lifestyle made the patient suffer from disappointment. Happiness in life was reduced if thoughts of abandonment or revision were not managed. Patients become overwhelmed with their past and disappointing events

that signs and symptoms of depression continue. These findings showed the FC's improved understanding of the root of the risk factors for depression.

Such as:

You know, like you're the type, if you go back to when you were a kid, you're like, your mother doesn't love you, she's like, you're already stressed. ....."

My mother likes to say "that Grandma doesn't love her." All the treasures she has are given to her aunt. " She spoke up. I came out of the house and Grandma never gave me anything. She used to complain to me... (CP2)

"Husband has a new wife" CP 10

"He was stressed. When COVID hit, the traditional massage business was closed, he had depression and suicidal thoughts." CP15

"The husband is unfaithful; the sister was very sad and has money problems, so thinking too much is depressing and she has to take medicine."CP16

"……At that time, there was a problem that his son, his elder brother was in prison. So he felt that like he was so depressed back then…" CP 17

4.2.2.2 Socio-economic problems such as unsuccessful business and unemployment

1) Socio-economic problems

Economic problems from the COVID-19 pandemic affected work, in addition to natural disasters such as flooding, which resulted in damage to rice fields, and the inability to harvest crops. There was also not enough income from doing business because there were no consumers to use the service in the business, resulting in reduced income, incurred losses, and being unable to continue the business or trade. There was no money to invest to continue working, there was termination of employment, debt, and debt repayments. Being in debt made children and family members suffer. This is what caregivers perceive as a cause of depression.

Most caregivers recognize that the economic situation of both the older adult and family members affects depression in the older adult. This report showed the FC' was more understanding of the risk factors. If the family had a stable foundation, strong enough to help one another take care of each other in the family, the older adult would not have to worry or think a lot about expenses. For example, in a family with money problems:

"Cause from my sister first. When my sister came, she came to my grandson. Grandchildren come to see about money, rarely, rarely use like this. It's many things. Collecting them, they start to get stressed." CP6

"Make a living, not enough to eat…." CP8

"Sometimes I worry about my children. There is no money for the children." CP 12

"He was stressed. When COVID hit, the traditional massage business was closed, he had depression and suicidal thoughts." CP15

"The husband was unfaithful; the sister was very sad and has money problems, so thinking too much is depressing and she has to take medicine."CP16

When adjusting, there were activities that generated income, making the older adult feel better for the family, having an income the older adult had stability, and family members were economically stable.

"*Now you have planted butterfly peas. Klaeng planted them by himself. Plant your own trees, whatever you are doing, you look a lot better…* CP 12

4.2.3 Perceive negative views

This theme most occurred in the early stages of caregiver duties and in the early stages of depression. Most of them occurred after the family has had a hard time or life crises such as the loss of a person, the loss of a job, or economic problems. Participants believed they lacked a basic understanding of the disease and medications, therefore felt uncertain with life.

4.2.3.1 Uncertainty for life

Most participants noted at first that they did not have knowledge about depression, symptoms, drugs, and how to care for someone with depression. Some people did not even know that it is a mental illness. These made them feel stressed.

At first, I didn't know what to do. Why did my mom have to do that? She was so sad, ate less, and said she wanted to die. At that time, I didn't know what to do. My mom, and my work is so hard. CP2

4.2.3.1 Negative attitude and Frustration

The family caregivers said, *"feeling stressed, anxious, and confusion in the caregivers"* during the first 3 months of illness and symptoms until the point of entering the treatment process. Most negative attitudes were *"feeling burdened, tired, stressed*". The participant noted that they no time to do anything because they did not know what disappointment in elderly behaviors was. The details of the attitudes that occurred are as follows:

> *"……if there is no us, who will look at him? Suppose if we leave someone, who will take care of him, at least now my father can take my mother to the doctor. But when one day that his father can't drive. Must we be the same? .....but ask if it is a burden? It is not a burden……..CP2*
>
> *"…….During his new illness I thought it was a burden……". CP8*
>
> *"…….I let my aunt who lives next door come to take care of my mom….and …. let my son come to be here…….let my aunt who lives in a foreign country fly get back to stay together……. **It's a very hard time!** Everyone comes to take care of each other for 2-3 months. There were many people who come to take care of each other in my family……. CP13*

The '***frustration'*** found in this study occurred with family caregivers who had a less close relationship, such as a daughter-in-law and spouse who experienced boredom. This role is a burden and looks at the older adult negatively. Such as:

"…….I do not understand, He must have something like this. Their child is not unruly……..He is very loving of himself…….CP1.1- daughter-in-law

"…… Since he was born his brothers were bored with each other like this. Well, he's been speaking badly since he was born…... CP1.1- daughter-in-law

"……..He has no one, his elder brother is old, like a burden to him. burden on us…… It was like a burden…. But it must be a burden because he has no one. The children were in each other's place. …" CP5

Therefore, the researcher concluded that negative attitudes and frustration towards the elderly with depression by the participants' perceptions in the early stages were perceived feelings of burdened, tired, and stressed, due to the participants and family already experiencing difficult circumstances.

4.2.4 Rethinking in positive ways

This theme was very important because it refers to abilities of personal control boundaries and potential of individuals' greater understanding, as well as self-efficacy, individual motivation and ability to access, understand and use information for good health. The study found that family caregivers who had a positive attitude toward older adults with depression after a period of care became more able to cope with the patient and their symptoms. The FC' reported that this time for understanding and accepting the role, changed attitudes and behavior for caring for the elderly increased more than six-fold. Part of this was the acceptance of what happened as an illness. When taking care of the patient, the symptoms improved. They not only felt better but were also proud of themselves for being able to cope with the symptoms and manage them successfully. The older adult was starting to change for the better. This result showed the FC' developed knowledge and individual capacity at that time.

Most caregivers viewed people with depression as poor, in need of care, and if the caregiver's mindset sees positive caregiving, the caregiver will be happy to perform daily care activities.

4.2.4.1 Acceptance of being a caregiver

Families who accepted the situation of being caregivers, learned from the experience of living together with the older adult, followed the advice of doctors and psychiatric nurses, told stories, read, and studied about the disease, could better understand the older adult's depressive illness. This then lead to accepting their symptoms and behavior.

Acceptance of roles in the caregiving of older adults by a family caregiver depended on factors emanating from commitment to familial relationships. This result showed that the FC' changed insights and acceptance of roles.

"……if there is no us, who will care for him? Suppose if we leave, who will take care of him, at least now my father can take my mother to the doctor. But one day when my father can't drive. We must be the same? .....ask me! Taking care of him is a burden? It is not a burden……CP2

"Even if we are tired, we must accept it. It has already happened."CP5

"……We have to make up our minds and accept to take care of anyone. We must do it first. When we are comfortable, we can do it……." CP 10

"……When she was depressed the first time, I was stressed. After being together for a long time, I can accept it now." CP8

"……It turns out that everything has their own karma. Everyone has their karma and must use their own karma. I made him fun, like funny." "When I'm fine, he's fine too." CP8

1) Adaptation

This result showed improved individual capacity for caregiving of the elderly by increasing functional and interactive literacy and the ability to recognize depression literacy. The family caregiver learned from patient behavior to try to adapt to what occurs in the older adult, such as admitting that it is an illness, "I know the reason why I have to take care of them when my heart accepts that I can take care of the patient", and adaptation by taking care of daily activities, trying to modify their behavior to be

accepted and compatible with an environment where the patient is in the home and needs close appropriate care until they are able to live happily without stress. Such as,

".....I went to ask myself and it was a burden. I take it as mine. It has to be my burden, like having children. It has to be my father's burden. What should a father do for his son? What kinds of things do we have to do for our loved ones? .. " Take good care, understand well. You have to make your own mind up first and get comfortable first. " When your mind accepts it, you have to know the reason why you have to take care of them to take care of the sick....." CP8

"……..A person who understands, someone close to him must take good care of themselves first, to be able to relax. When we take care of someone, we have to take care of ourselves first, we need to find out the reason why, we need to be comfortable, we need to be comfortable first……."

"Do it yourself. New episodes are stressful….. New episodes are good….. But now it's like this. It is an old karma and we have to take care of her. We have to understand that today the healer will be the first person to be comfortable and uncomfortable. Taking care of someone who keeps someone well. If you look at it and don't curse, then why is it that you don't know anything if the person is stressed to a large extent? "You have to smile to make it funny"……." CP 10

2) Be happy and proud of providing care of loved ones

The study found that caring for an elderly person suffering from depression in a parent's family was to repay the kindness or gratitude of the benefactor with the feeling of gratitude that had been ingrained growing up. For couples, caring was a reward for the goodness that the patient had in the past. They had been in misery together, so they felt that it made their loved ones happy and gave them a positive view of the world, so they did not feel burdened. It was analyzed that there was an increase in interactive literacy.

3) Rewarding goodness and sense of gratitude

Some caregivers view treating patients as something they must do. If you can not do it yourself, you can have someone close take care of them, including their daily routines. Daily follow-up of the symptoms by phone, is something that must also be done to compensate the grace of the parents.

Asked? If she was happy, feeling indifferent because we had been with him for a long time and we could take care of him and love him. It's like bonding. When we think back in the past, when we were young, she raised us, and our mother had a hard time. Now it's like my mother has returned to being a child for us to take care.CP7

" Yes, I'm trying to be like, 'Everything is what it's most with my mother. Yes, everything. Mother returns home. I do everything for my mother. For example, food is like I bought it in the refrigerator. I don't want you to warm up anything yourself. I don't want my mother to do anything that is too difficult. So I facilitated everything for my mother." CP12

"Yes, we'll regret it later." CP13

"...I want to have time for you like before. I want to take my mom on a trip like before. But now, her relatives are all dead. ……..CP13

4) The caregiver is happy; the sick person is happy.

Some caregivers view that if they have a caring mentality, and their acts are heartfelt, it will not be viewed as a displeasure. The patient would be happy as well.

"……the old people must be caring with heart……

" Take good care, understand well. You have to make your own mind up first and get comfortable first. " When your mind accepts it, you have to know the reason why you have to take care of them to take care of the sick....." CP8

" Mother is getting better; we are glad that my mother is doing better." CP 10

His face shone with happiness. His tone of voice showed his pride.

5) Not a burden.

Most of the caregivers had at least a primary education background and were middle-aged, so most caregivers saw it as a cultural factor in which family members must take care of each other. The caregiving role does not burden or create problems in the life of the caregiver or patient. For the most part, patient care was about medication because the context of the majority of patients was self-help, so it was not a burden to take care of the older adult with depression.

"…… We are not tired, that is, we are just… because we are not good people. We're just people looking for medicine. Finding morning pills, finding evening pills to take. Because we are rice cookers, he does what he eats, he does his own thing. And that's what we do. What we do is that we go to him again. He will not eat. We don't force. ……..CP7

".....Even if she is worse than this, I can take care of her and not feel burdened....." CP13

6) So proud of themselves

Family caregivers were proud that they were able to better care for the sick and elderly, and by the nature of Thai society, when they are in the same community, they all know each other, and when they see family members who are sick and are getting better, they will appreciate those who take care of them, which reinforces to the caregiver that what they have been doing is good and admirable. This result was linked to the FC's integrating into their own.

It's a good thing. It's not only at home. I walked out on my feet. Going outside or going anywhere, going too far, but people will say, "Oh! He takes good care of him. He is good. His son is good. I said no. It's not close. Sometimes he goes out of the sub-district. He sees everyone. He sees. He says, "Ouch!" His husband is good, treats him well, takes good care of him, like this, he said. I'm happy and so proud too. CP8

“.....Wherever I go, everyone compliments me on taking care of my wife. I am proud…” “.Husband takes good care of him…..When I heard that, I was happy….” ...It's a pleasure to take care of loved one…." CP 10

“.....I feel proud that our mother is getting better.” CP 13

Theme 5: Appropriated decision making and having strategies to properly manage care

1) Making changes by using different techniques.
2) Provide comfort and encouragement
3) Seek resources

4.2.5 Appropriated decision making and having strategies to properly manage care

The FC’ described how their interactions with their elderly changed when they showed signs of depression and how they could create strategies or activities to handle the elderly when they had abnormal behaviors. The FC identified increased confidence due to improved understanding of their conditions. According to the experience of caregivers, knowledge of depression management strategies came from living with the depressive patient every day and proving reliable information from other sources. Learning and observing how to manage strategies could calm the depressive patient, resulting in normal living conditions with family members. These results show changes in the critical and interactive levels of health literacy, which increased FC's motivation and self-confidence to act on information and produce or improve environmental health outcomes. Knowledge of risk factors and causes, and caring activities of depression literacy also increased.

4.2.5.1 Making changes by using different techniques.

FC’s perceived changes in how they could create strategies or activities to handle the elderly when they had abnormal behaviors. Knowledge of depression management strategies gained through experience caring for older adults, which include the accumulation

of knowledge of the management of handling symptoms and of calming down, handling of indulgence and close supervision, and of medication supervision, will aid in the prevention of depressive symptoms. However, the administration of medication when observing the leading symptoms of disease or abnormal symptoms in the elderly was not when the drug was administered orally, the older adult with depression showed similar signs of calmness, and symptoms of the disease did not recur or show any signs of being severe. On the other hand, indulgence management helped to not affect the mind, so did not alter the behavior of the older adult with depression in any way. These findings are also linked to changes in depression literacy, which are risk factors, causes, and caring activities of depression.

1) Strategies for staying still or using silence

The caregiver noticed that if a depressed patient developed symptoms, the caregiver should use a silent, passive, non-responsive approach to the patient's words. Failure to show resistance or dissatisfaction could result in depression patients' being able to calm their mood and return to normal. However, this must be addressed by giving medication together to prevent symptoms of depression. This report showed FC' altering their behavior and practices, which may be related to the interactive literacy level.

"We didn't speak, and he went silent." CP1

When the mother has symptoms, it is indifferent. We'll be silent, look at each other, and then we'll be silent, we won't talk, we know…"We were to be quiet. She had to be quiet too, and sit and watch television. We are silent. My mother was not angry any more". CP2

When my mother was angry, we were silent throughout the house, not responding. CP4 same as CP5,CP8, CP12 used silent techniques due to the older adults.

2) Strategies to divert attention and find activities to do.

FC's also perceived changes in how they could create activities to divert attention for creating feelings of calming down. When the older adult showed signs of depressive symptoms, the family learned to use strategies to divert attention by watching television, listening to the radio, and finding activities to do continuously. As detailed, caregivers knew that if they found activities that the patient liked, the patient would be at ease and the symptoms of the disease would be calm. Some caregivers, when confronted with the emotional emergence of patients with depression, turned on the television for the patient to listen to. Therefore, they focus on the things that are used in everyday life. Some listened to a radio program about dharma; some chanted; and some added more activities to the household. Butterfly pea trees were planted to collect pea flowers every day for continuous activities. Some people let the patients grow vegetables in the kitchen garden so they could have time to water the soil and focus on the growth of the vegetables. As such, they found activities to do to reduce free time by keeping them occupied. This showed FC' change their behavior and practices, which may be related to the interactive literacy level. This was a crucial component of FC's learning for change, which they were able to apply to their daily lives.

"She would like to make sweets. She also makes bua loi. If that's her happiness, then I'm going to buy Bua Loi ingredients.

"She would be the type that likes making sweets. Maybe do some of the cooking? After finishing she couldn't eat it all." *CP2*

"My mother has planted butterfly peas and is starting to plant them herself. She is planting a tree by herself. Whatever, my mom looks a lot better. CP6

".. If she wants to do something, she does it. I will buy it and prepare it for her.

" We used ***to hang out*** with her. My mom went out, as in the past I brought her to travel... Take me there... take me here... we are very close. *CP7*

Yes, I think the older generation may not know about this disease, but now, as we watch TV, search the Internet, watch YouTube, open a lot, then turn around. My mother prays before going to bed. It's better….

I will print a picture for my mother to learn to paint while she kills time without stress. My mom carved and painted like a child….CP13

3) Praying, taking to make merit, praying, meditating

The participants reported increased confidence in choosing the meditating activity after they analyzed and applied the activity based on their understanding of the elderly, as well as some caregivers' focus on calming the mind by reading the Dharma book. Some people took them to make merit and offer food to monks on festival days, or took them to pay homage to monks, as the patient desired. Some people prayed or meditated before bed to keep their minds calm and not suffer.

"Made merit, went to prayer, went to do something calm, went to pray with 'Luang Pho' and try to pull your mind to be with yourself and help yourself." CP3

4) Medication should be taken under supervision.

The study found the FC' were improving in critical literacy by decision-making when the elderly had depressive symptoms and needed more caring. Initially, the caregiver prescribed medication according to the doctor's prescription and supervised oral medications when observing the patient's leading symptoms of disease or abnormality. The FC' had critical literacy to evaluate the symptoms and how they would manage that situation. When the drug was administered orally, the patient had calm symptoms like normal people, able to do their daily routines. When taking the drug, some people may experience drowsiness, sleep soundly, not talk badly to anyone, and show no symptoms. Most caregivers believed that medication does not cause relapses or does not show severe symptoms, so they do not consider seeking help from healthcare professionals or health care facilities. Although many FC' were on long-time drug uses (such as medications for

insomnia), they were able to acquire new learning in relation to their use of medications as well as improved understanding regarding side effects. The details were as follows:

When showing abnormal symptoms, mom needs to find medicine to take when taking the drug continuously. There will be no symptoms of normal speech behavior, or she remains silent and does not speak badly to anyone.".....

Take the medicine and feel like you are addicted. Eat and sleep. Feel comfortable. If you don't take the medicine, you will be irritable. If you take the medicine, then go to sleep. "

If he doesn't take the pills, then it's okay to run out of pills, but he seems to be stuck. After eating, he goes to bed and turns on the radio to sleep. He takes medicine and sleeps well. (CP1)

Nothing more than me like someone to let it go. Seriously (laughs). Like in the morning, I have prepared medicine for you. In the evening, the medicine was given. (CP2)

"He had been taking pills all along; if he didn't take them continuously, he would have anxiety." (CP4)

4.2.5.2 Provide comfort and encouragement

Participants showed an improved capacity for reflection on environmental issues that may affect health. They choose to change their practices and behaviors, which some caregivers focus on providing encouragement, good words, or listening to their opinions to express their feelings of distress. These findings can also be related to changes in critical literacy.

Most of them were married couples to help each other share their suffering and happiness together, making them feel comfortable.

"*We have to take care of each other through hardships together." CP5*

When she is good, we take care of our suffering together. CP8

"My father was always good to us even though we were just daughter-in-laws who took care of our suffering together." CP13

"Brothers and sisters must take care of each other when they are sick. There are only two of them." CP15

1) Pay attention, pamper your heart, and involve grandchildren

Another FC' perceived changes in behavior and practices included some caregivers using family members, such as the patient's grandchildren, to talk about things with them, take them to temples, make merits, and do their favorite activities outside of the home to show interest and concern, or let the patient cook their favorite food. These findings showed increased interactive literacy of health and attitudes, which facilitates recognition of depression literacy.

I felt good and then I gave up on my work in Bangkok so I could come and take care of it before we had no time. So hurry up and apply now. CP13

"My son, talks about the school activities with his grand mother" CP16 same as CP14 take them to temples, make merits.

"We used our grandson to take my mother to the temple."CP14

I take care of my grand mother such as giving medicine, and taking her to the temple." CP11

2) Handled with indulgence and close supervision

Most caregivers do not want their patients to suffer trauma or disruption. The family caregiver therefore indulges and responds to the needs of the patient, including not frightening or traumatizing them in front of older adults, and including having to take care of each other because they are family members. Silence is also used so that they do not clash with each other, which improves the situation.

Family caregivers changed their lifestyle to stay with the elderly with MDD. They should be aware that caring for an older adult with depression requires close monitoring with care to be able to recognize changes quickly. Close supervision could help reduce the dangers of symptoms and self-harm in older adults. These findings showed the FC's increased understanding and recognition in functional literacy and the ability to recognize depression.

The details are as follows.

"……Maybe he yells! We'll be quiet, more and more angry with you. What's going on with you? ……. Immediately become emotional, that is, the whole house is silent. They're not saying anything at all. Our silence is that he was not focused on us and focused on the television instead…"

"……. We are indifferent. The feeling is that we are silent. If the more you quarrel with you What's more about you? You will..Why is this still happening? Is your father suddenly people at home will know. If you feel like this. That is, the whole house will be silent. That is, we will not say anything……"

"....that is, it will be indifferent. When you get up, he will be silent. Look at each other and they'll be silent. We won't talk. Oh, I know…"

"……..Turn on the music, he will like to watch music. What do you like to watch? Singing contest, what? He likes to watch it…." CP2

"……If you speak the native language! Like someone who offends him, does not indulge him if he wants to eat something….Tell each other and make them eat....."

"....Let me talk without interrupting to please all the time…. Take me on a trip...last year, I took him to Wat Rai Khing hospital (that place is far from here) to check his eyes and make a new lens…… "

"……This one cannot speak because it is not in front of him, in front of him cannot speak……."

"……He must be taken care of because he is an only child Not a burden because he can help himself. We are cooking rice. Cook like this. If he eats, he eats. If he doesn't eat, he orders his mother to do this." CP14

4.2.5.3 Seeking resources

1) Seeking help from those who have experience

Before starting the treatment process. The FC's perceived improvement understanding comes from knowledge from seeking help from close people, acquaintances, or neighbors who have experienced or cared for a family member who was initially depressed when the disorder first appeared. The family members who had never experienced depression or were unsure of what the disorder was, asked close contacts, or people who had experienced symptoms in the past for advice before taking their family member to the doctor for treatment, as they wanted to follow the advice given on treatments and results from those who had experience in the matter, before officially entering them into the treatment system to get diagnosed with depression.

When the elderly was in the treatment process, the FC' reported when a professional provided information and resources, they improved their real understanding and recognition of depression. That information was a database for understanding of depressive symptoms, recognizing when they were abnormal, applying the behavior, created activities and practices for appropriate situations. Caregivers discovered that they could decide which situations they needed to seek help with or which situations they could manage on their own that stemmed from learning and experience. These findings showed increased functional interaction and critical literacy to be evaluated in making decisions for help-seeking when needed.

Such as:

We saw. We have been with my mother for a long time. This symptom is enough to take medicine. Or symptoms like this can't be taken and need to be taken to the hospital, this is what we know. CP2

"I have a sister-in-law. Her friend has a mother who is depressed, she said. Her friend's mother didn't speak to anyone. She stays in the room but doesn't go out anywhere. That one is serious." CP 8

The results of the analysis of caregivers' data sets: It was found that the factors affecting family caregivers' perceptions of depression in the elderly could be analyzed on 5 issues. (according to Table 2.1)

Main issues	**sub- issues**				
1. Symptoms lead to the change	Being annoyed at little things	Irritability	Insomnia	Depressed	Eat less
1.1 Speech	Do not speak, remain silent	Yelling, Shouting.	Scolding,	Talking badly	Talking to other people well
1.2 Expressive behavior	Insomnia "I want to sleep, I don't want to do anything". Difficulty sleeping	Restless	Change of eyes	Uncontrollable emotions, Unable to offend, dissatisfaction, irritability, mad mood	Silent Lethargy
1.3 Thoughts	Back and forth	Distracted	Suicidal ideas	Self-blame	
2. Relationship of caregivers, spouses	Love and bond with parents	Gratitude	Being together, caring for each other,		

Main issues	sub- issues				
			brothers, and sisters		
3. Depression resources	Close relatives, friends, telling stories	Doctors, nurses	Internet		

1. Symptoms that lead to change

Caregivers can recognize changes in depressive symptoms by observing the behavior closely over the long term. Symptoms include irritability, moodiness, and irritability over minor things. Sleep patterns, insomnia, eating less, and depression, can be divided into three types of behaviors: speaking, expressive behavior, and thinking.

1.1. Speech

Family caregivers noticed that when a depressed patient had symptoms, changes began in verbal behavior, starting from "not speaking, being silent", to not speaking how they used to in daily life. For example, questions were asked, no response, end of conversation. Furthermore, if a patient spoke to their caregiver and did not get a response immediately, tension arose. The patient exhibited rants, fussing, speaking loudly, expressing displeasure, which could escalate into "swearing and cursing", insulting things in front of him, or insulting the person in the situation or environment resulting in "speechlessness". Change the ability to call names. Change the pronoun in place of oneself. If an incident occurred where the caregiver was with another person in a traumatic environment, the patient would express his words by saying “speak well with other people”, which expresses a change in mood through speech, with the caregiver clearly recognizing the change in speech.

1.2. Expressive behavior

Caregivers know that when there are symptoms of depression, patients showed apparent sleeping behavior signs. Some “didn’t sleep”, rummaging through things for no reason, some “can’t sleep” all night, while others “want to sleep and do nothing”. Sleep patterns had changed without medicine being administered. The caregiver then immediately inquired about the medication intake as they believed that it was probably caused by not taking medication. In addition, caregivers also reflect that some patients are immobile, experience hand tremors or symptoms of sitting still and unable to get up to stand. If there was a question regarding symptoms that occured, some patients would show it visually. “Eyes change or expression of eyes” where the eyes would close or open depending on displeasure or pleasure. If there are visual symptoms, caregivers must be careful as it reflects the occurrence of “I can't control my emotions.” Patients showed signs of anger, some threw objects, others showed intense anger, and dissatisfaction. If interrupted or had speech blocking actions, the patient showed a marked restlessness and the caregiver's final disregard for the behavior as "drowsy", would disregard the environment, experience inaudible calls, would not respond to presence, and interact with other people.

1.3. Thoughts

The caregivers observed the thought behaviors of the depressed patients from the speech and behaviors they expressed, and this was reflected when symptoms changed. Patients with depression were having unusual thoughts. Some people had a cycle of thoughts which involved questions and answers, repeating the same stories and talking about the past. Some people, based on their mindset, would overthink and think beyond current events to express their thoughts, be “distracted,” and overthink to the point where no solution to their thoughts was reached. Some people thought of suicide during their travels, they saw an environment that could lead to their own death. People with depression had brief thoughts of suicide. Some people, when experiencing a traumatic event, such as the sudden loss of a family member or spouse would have suicidal thoughts. Finally, if the depressed patient continued to have thoughts and images of the traumatic event in their minds, this would

result in feelings of guilt and "self-blame" for the incident. Some patients blamed themselves for teaching their children badly, causing loss in life, and having unsuccessful family members.

2. Relationship of caregivers

Relationships of caregivers is a factor affecting the perception of caregivers who believe it is important that depressive patients are cared for. When analyzing the basis of relationships or interactions between people, it is important to address the question; "How to plan for future care together?

The quality of family relationships in the form of support and supervision determines the favorable influence and consequently acceptance among children of the responsibility that they take care of the parents with gratitude (Thomas et al., 2017). Similar to other family relationships, sibling relationships can have both positive and negative aspects that can influence components of the stress process and a trigger factor for symptoms of depression in older adults depending on factors such as relationships, resources and crisis situations in the family. (Degeneffe & Burcham, 2008) Siblings play important roles in supporting exchanges and caregiving, especially if their sibling experiences physical disabilities and other close ties, such as when a spouse or adult child are not available (Namkung, Greenberg, & Mailick, 2017). Although sibling caregivers report lower well-being than non-caregivers, sibling caregivers experience lower well-being to a lesser extent than spousal caregivers (Namkung et al., 2017). Most people believe that their siblings would be ready to help older adults in difficult situations. Therefore, an interdisciplinary approach is required to recognize and address the psychological, emotional, and social needs of these caregivers, as well as provide culturally appropriate support from friends and family that can help them cope with the physical and mental stress associated with caregiving and better accept new roles (Taleghani, et al., 2021).

In the early stage of illness, caregivers were initially confused, worried, and uncertain of their responsibilities in the caregiving of depressed older adults in the family.

Their lives were turned upside down due to the changes associated with being caregivers. (Paiva, Valadares, &Silva, 2012). Yet all the problems and needs of family caregivers showed different ways to address the changes that occurred. When starting to care for the older adult and how to cope with these changes in behavior and mood, two outcomes were found to be either generally accepted or were resistant to care (Shaw, et.al., 2013).

A synthesis of the findings found in the article in the first moments in dependent family care shows that the primary need for early caregivers is the need for supportive assistance, time, information, knowledge, and advice for caregiving needs, detailed care information about the disease, family members' prognosis, guidance manuals and care-training to develop the skills needed to perform caregiving tasks (Giosa, et.al., 2014).

After taking on the role of caregiver and starting to realize the consequences, caregivers tried to adopt some strategies that made the job more manageable for them. They tried to prepare themselves to be competent to cope with and perform their role as caregivers by seeking knowledge from medical personnel, inquiring about care information, researching information, recognising symptoms, and self-learning. These strategies were used by caregivers to adapt to the changes affecting their families. (Moral-Fernández, Frías-Osuna, Moreno-Cámara, et al.,2018).

2.1. Love and commitment of spouses

From the caregiver's context, it was found that if the caregiver's relationship with a spouse created awareness of the nature of a marriage that has been in sorrow for a long time, it would be necessary to take care of each other with a basic understanding of the parenting habits and behaviors of the caregivers. Each family member has a positive relationship that reinforces and encourages one another to improve mental health.

2.2. Gratitude

From the context of caregivers, it was found that most of them are children who take care of their parents. In particular, daughters take care of their parents by thinking that it must be in return for the kindness of being raised by their parents (Tamdee,2019). The care is not considered a burden. Some people have families that need to divide time to care for their own family as well as their parents. Some people do not have families to take care of and will live in the same house and take care of each other closely. Understanding each other makes caring and relationships move in a positive direction. Strengthening relationships is easy. They still want and are willing to care for the older adults in their family because of the bonds between them as well as the value of gratitude, which is rooted in Thai society (Srithamrongsawat & Bundhamcharoen, 2010), and has been adhered to and observed within the community.

2.3. Live together with care

From the context of the caregiver, it is found that it is a son-in-law or a daughter-in-law who lives in the same house and acts on behalf of the child of the patient in caring for the cause of an only child, a deceased child, or when the child works in other provinces. They are still concerned but are taking care of their parents from a distance. If in the event the family is separated, the patient must not be left alone, as the patient may behave in a manner that causes embarrassment. As a result, the daughter-in-law or son-in-law is willing to take care and think of the patient as their own parent.

3. Depression Resources

From the knowledge assessment of caregivers, it was found that most caregivers have access to different depression resources. Factors affecting the perceptions of caregivers from diverse sources of information have three sub-categories:

4.1. Relatives, close friends, tell stories

According to the caregivers, most of the perceptions of depression came when patients had symptoms and these symptoms were discussed, resulting in information about depression through comparison of symptoms with real people. In addition, caregivers tried to compare the symptoms with the relatives' genetic history, resulting in relatives identifying information regarding a family history of the same or similar symptoms and signs, which can then be confirmed when the doctor diagnoses depression.

4.2. Medical personnel

From the patients visits to the doctor with congenital disease, health personnel were told to acknowledge the symptoms through consultation, so they passed the depression screening assessment, entered the treatment system and received a diagnosis from a doctor. In addition, if a depressed patient entered the clinical treatment system, they would be referred to a doctor who is a specialist in treating depression, and to another doctor until they feel that they have improved from the treatment.

4.3. Internet

The Internet is a source of information or news published via media and is used for the comparison of symptoms of the patient by family members. Information was sought in order for caregivers to be more informed of the care to be given. It assisted caregivers to have basic knowledge of caring and talking to patients correctly, treating symptoms, and administering oral medications.

4.2 DISCUSSION

The purpose of this study was 1) to explore family caregivers' recognition of geriatric depression 2) to explore the components/dimensions of depression literacy in family caregivers of older adults with depression. 3) to explore family caregivers'

management strategies for caring for geriatric depression. The results following five themes were in line with an approach that examines larger social circumstances in addition to health literacy's functional (Nutbeam, 2008) and depression literacy components (Singh, et al., 2019) as 1) starting to recognize depression through observation of symptoms and seeking medical assistance, 2) multiple factors leading to depression, 3) rethinking in positive ways, 4) negative attitudes, and 5) having strategies to properly manage care.

The result showed the development of depression literacy in FC. The participants started to recognize depression through observation of symptoms and sought medical assistance. There was an increased understanding of multiple factors or triggers leading to depression and improved understanding of depression. When the elderly had depressive illness, they adapted their attitude, behavior, and practices to try to perceive the elderly with depressive symptoms in a positive way. They evaluated the data and made appropriate decisions and had strategies to manage care properly. These findings explain the components of depression literacy, which include: 1) recognizing depression and seeking medical assistance; 2) understanding of multiple factors that contribute to depression; 3) changing attitude toward care; 4) analyzing situations for adaptation behavior and practices; and 5) evaluating and making care decisions.

The results revealed crucial details about the conditions that encourage the growth of literacy abilities and show that caregivers with different degrees of depression literacy can participate in care management. Findings support the development of depression literacy skills across the functional, interactive, and critical literacy domains as well as engagement with depression knowledge that extends beyond personal symptom management to the social determinants of health as follows:

4.2.1 Starting to recognize depression through observation of symptoms and seeking medical assistance

The FC’s started to recognize depression through observation of symptoms and seek medical assistance following three categories, perceiving suffering of stress and emotional

changes, observing speaking and behavioral changes, perceived depression observed by healthcare providers.

4.2.1.1 Perceiving suffering of stress and emotional changes

The family caregivers play a vital role in the quality of life for the older adults with depressive disorders, and they did not receive any training beforehand for taking care of the older adults, but mainly by experience, relationship, and gratitude (Tamdee et al., 2019). This study showed that there was knowledge of depression among 16 of 17 family caregivers, which was derived from experiences of staying with the elderly by perception and observations of changes in symptoms among the elderly. Symptoms included being silent, not speaking, "eating less", "eating", "looking sad", "not sleeping" or "talking, not answering". Once family members noticed abnormal symptoms had arisen, they began to have doubts. The finding showed this learning process was used through trial and error for problem solving and trying a new method. This process is repeated until success or a solution is reached. (Thorndike, 1947). Then they sought answers or knowledge of the symptoms that occurred.

This finding can be explained by the fact that the ability to recognize depression starts with knowledge and beliefs about depression, which started to recognize depression through perception and observation of symptoms. This study regarding the state of their depression literacy increased.

4.2.1.2 Observing speaking and behavioral changes

The knowledge base was obtained from the above people and nurses, including from the experience of those who have used it for themselves and by adjusting the appropriate method. Using that method works like this: "Don't leave the patient idle; make good use of their free time." But the activities that are appropriate for each elderly person are different. Caregivers learn from experience what kinds of activities the elderly they care for like or are suitable for them. In some cases, they like to make merit at the temple. Some people do

not like the activities that have merit, like planting trees or drawing pictures, "until the process of learning and accumulating knowledge is complete." Observing symptoms and caring for the elderly with depression, such as recognizing and being able to distinguish between "the symptoms seen were normal or unusual for the elderly and can be recognized with the onset of depression as opposed to beginning to show symptoms of depression. Each one showed different symptoms. "

In perception, the human senses play an important role in the activities that allow for the construction of conclusions. As a result, if the senses are so crucial in the observation and perception process, it is worthwhile to pay them greater attention (Szewczyk, 2002). Perception is one of the fundamental cognitive activities that involves processes that are responsible for receiving stimuli from the outside environment via various types of receptors. There are two phases in this process that can be distinguished: the first is connected to the passive reception of stimuli (without any interpretation) and the second is related to the attribution of meaning to stimuli (using the knowledge and context in which the stimulus appeared) (Lskawa, 2013).

This finding can be explained by the participant learning how to seek information about depression by living experiences with elderly people suffering from depression, as well as through observation, symptoms, trial and error, and seeking information from health professionals. The participants could assess the symptoms, evaluate the signs, and engage in decision-making in behavior modification for both of them and the elderly, as well as understand and be able to decide the appropriate activities for each situation because they were growing in depression literacy and health literacy.

4.2.1.3 Perceived depression observed by healthcare providers

The majority of them asked close friends or neighbors who had family members that had experienced symptoms similar to those seen in the older adults in their families (Kraithaworn &Noinam 2021). A small number of them asked the question to strangers. 2-3 people used the Internet to search for answers as well as ask knowledgeable people. For

example, a psychiatrist read a book, called, and asked for a number that they knew. When there was some level of knowledge that the elderly were likely to suffer from depression, they took them to see a doctor. When the doctor diagnosed the patient with depression, they received knowledge from other doctors, psychiatrists and nurses. Only one patient had symptoms and went to the doctor himself, and then told his family to take him to the doctor next time.

The knowledge of family caregivers about depressive disorder in the elderly mainly consisted of knowledge about the cause and abnormal symptoms, as well as knowledge of care and coping with abnormal symptoms, and seeking ways to care for the patient. Characteristics of knowledge emergence: 1) Knowledge is gained through inquiries from close and trustworthy people. The findings in this study consisted of acquaintances who had experience caring for patients with similar symptoms or the same service hotlines for mental health and nurses who provided information and advice when going to the hospital. Findings showed depression and suicidal literacy were significantly related to suicidal behavior and seeking mental health (Kraithaworn &Noinam 2021).

Most of the symptoms that were found included emotional symptoms. It manifests itself in a negative way, such as "emotions, irritability, dissatisfaction, behavior, lethargy, quiet, slow thinking, not responding to the surrounding environment," and "self-negative thoughts," which manifest in behaviors like being offended, not speaking, looking sad, and isolating. They were asked to remember and use the methods they previously learned with the patient or had received advice from a nurse to deal with depression or symptoms that occurred.

Many of the older adult family caregivers in this study had misunderstandings about the significance of the symptoms or symptoms of the disease, depressed, as expressed by most of the words "he is stressed, "stress disorder," indicating that most caregivers still have confusion between stress disorder and major depressive disorder. They said "stress" differed from perceived stress symptoms, but they were unable to explain those differences or identify how they differed in detail. The findings from this study found that most caregivers

of the elderly still lacked a true understanding of depression in the elderly. Most elderly caregivers search for knowledge or for information on social media, which produces a body of knowledge that lacks approval, accuracy, and cannot be trusted at all (Tamdee, 2019). While offering information can help people learn more about mental diseases, it does not guarantee that the mentally ill will be integrated into society (Mehrotra, Nautiyal & Raguram 2018).

The findings revealed that knowledge of depression in older adults in family caregivers is still insufficient at first, because the general public still has a misunderstanding about depressive disorders in older adults and because there were ambiguous symptoms, which may have contributed to the perception that it was a physical disease (White & Casey, 2017). This meant the elderly could not receive proper care and treatment. Although there was a great deal of awareness about depression being promoted, it was not enough to provide adequate care for depressive disorders (Kraithaworn &Noinam 2021). These are problems that families often face together with poor service. The main theme of research question one is formed from information related to the theme.

4.2.2 Increase understanding of multiple factors leading to depression

The results showed the cause of the **factors** or triggers of the symptoms of depression **perceived by family caregivers in caring for a depressed older adult were** 2 sub-themes of the causes of symptoms that affect caregivers' perceptions of depression literacy, which can be summarized as follows:

Factors affecting depression and exacerbation in the elderly according to the perceptions of family caregivers from caregivers' contextual data. The majority of family caregivers who were able to recognize the symptoms of illness or the transition of the elderly quickly, had a high school education level or above where they were able to seek knowledge from resources such as reading websites related to mental health, books, or from social media via YouTube and observe the symptoms of depression. Most caregivers believed that the elderly were driven to show symptoms of depression by life crises that were affected by

multiple causes at the same time or during the same period, such as the loss of important people in life (Kraaij, Arensman & Spinhoven, 2002; Ruan, Shen &Chen, 2022). For example, a child or a spouse, disappointment from children and important people in life, disappointment from work, economic problems, and business failure to name a few (Fiske, Wetherell, Gatz, 2009). This is caused by the personal habits of the elderly themselves, whether they are stingy or inflexible. Even drinking alcohol can affect the illness and the recurrence of symptoms. These factors increase the risk of developing or triggering depression in the elderly (Maideen, Sidik, Rampal, & Mukhtar, 2014)

4.2.2.1 Personal factors

1) Loss of a close person or an important person

The loss of a close or important person in one's own life. From what caregivers perceive, losing a husband or wife from a chronic illness or disease, prolonged illness or the sudden loss of a family member makes it unacceptable. The symptoms were brought on by a stressful life event as well as grief and loss due to the death of a loved one (Age UK, 2016). The occurrence of symptoms of depression comes from a loss that affects the mind until one is unable to adjust their own thoughts to normal life. If, at any time, a close incident or a reflection of the person who had experienced loss occurs, this can trigger symptoms of the disease. which resulted in a lack of social engagement by the elderly (Cong, Dou, Chen & Cai, 20215).

2) The patient’s habitual basis

The older adult's habitual basis had an important effect on the perception of the caregiver, especially the habits that were brought up by indulgence. Being the last child in a family, being cared for and being indulged could have an effect on the symptoms of depression. The fact that the family provides everything they need when they are offended or left unwilling leads to a clear manifestation of symptoms. In addition, the original basis of patients who were economical, thrifty, and stingy was also a pattern of depressed patients, reflecting that pushing or cultivating ideas about

spending money had an effect on the accumulation of stress in oneself and caused symptoms of the disease.

3) The habit of drinking alcohol

Most caregivers who take care of older male adults recognize that heavy alcohol consumption increased the risk of depression (Kim et al., 2021). Older adults were drinking to calm their nerves, forget their worries or manage their depression. Families and health-care providers, for example, frequently overlook their worries regarding older people's drinking. The effects of seniors' drinking habits are sometimes misdiagnosed as other age-related health issues such as dementia or depression, but increased alcohol usage warrants special attention.

How well a family caregiver can take care of an older adult person suffering from MDD depends on some basic factors of the family caregiver such as age, gender, health conditions, beliefs, traditions, family relationships, family system, and the health care system. The lifestyle, environment, benefits, and important life experiences in caring for older adult people with symptoms of depression also plays a role. In this study, age, length of care of caregivers, knowledge, and perceptions of the severity of the disease were found to be factors. It enabled caregivers to effectively care for older adults with MDD, which entirely depended on the caregiver's accumulated knowledge and experience in managing problems when symptoms arose (Orem, 2001)

Psychological theory states that depression is caused by severe psychological trauma or stress resulting from the loss of relationships with important people in life. Studies have also shown that the parenting of mothers who are too strict or too neglectful is stressful for their children, which is a causal variable that can predict the incidence of depression in children.

Cognitive theory is based on the belief that a person's thoughts, especially older adults, affects their mood. These are concepts that deviate from normal negative attitudes, such as feeling that they are burdened, and unemployed, which results in depression. Older adult people tend to have negative thoughts about themselves, constantly

worrying about future health and illness concerns. Therefore, when faced with problems or pressure, they are more prone to depression which can develop into severe depression later. The third category is related to the management of depressive symptoms. The older adults with MDD had many different behavioral problems due to stress and the environment. Most of these problems can be managed by providing education to family caregivers. The current findings showed that family caregivers referred to hospitals when problems occurred because they had limited knowledge about depression and its management as they had received limited education in this area. This practice increased caregiver burden and stress as they expected healthcare providers to give them more information.

The relationships category found that family relationships were tested in terms of mental tension, financial problems, and lack of support. Limited information support by healthcare providers can also negatively affect caregiver relationships. In most cases, family caregivers need to take care of the sick at the same time. Most family caregivers also must seriously limit their social lives due to the heavy burden of being caregivers. Some caregivers may lose their jobs due to the intensity of being a caregiver. As a result, utilizing the practice of routine self-directed daily activities, promoting healthy behavioral changes, and encouraging older adults to play a role can all help in reducing the burden. Additionally, creating self-worth appropriately as well as giving older adults an opportunity to participate and to continually carry out more activities within the community can also be beneficial.

4) Disappointment from work and family members' expectations

The older adults with depression were disappointed with work and expectations from family members (Maideen, Sidik, Rampal, & Mukhtar, 2014). Depression symptoms are caused by dissatisfaction with the function of the family leader. According to the caregiver, it is possible to process when the patient is disappointed due to setbacks or lifestyle faults. If thoughts of abandonment or revision were not addressed, happiness in life would be reduced. When the signs and symptoms of depression persist,

patients feel overwhelmed by both past and unpleasant experiences. The result showed that it was correlated to a lack of emotional support (He, et al., 2016).

4.2.2.2 Socio-economic problems such as being unsuccessful

Economic problems from the COVID-19 pandemic affected work, in addition to natural disasters such as flooding, which resulted in damage to rice fields, and the inability to harvest crops. There was also not enough income from doing business because there were no consumers to use the service in the business, resulting in reduced income, incurred losses, and being unable to continue the business or trade (Rada, 2020). There was no money to invest to continue working, there was termination of employment, debt, and debt repayments (Maideen, Sidik, Rampal, & Mukhtar, 2014). Being in debt made children and family members suffer. It is what caregivers perceive as a cause of depression. (Mehta et al., 2016).

In addition, the participants were recognizing that the economic situation of both the older adult and family members affects depression in the older adult. If the family has a stable foundation, and is strong enough to help one another take care of each other in the family (Malai, et al., 2019), the older adult will not have to worry or think a lot about expenses, which would not be the case in a family experiencing financial hardship (Sasithorn & Lueboonthavatchai, 2015).

The family caregiver's attitudes towards the care of the older adult with depression

With most participants, there was a relationship between depressive older adults, namely sons and daughters, living together in some families, but also living in separate houses in the same area, taking the role of caring for the older adult who was suffering from depression. The least time spent caring was 0.7 year, and the maximum was 8 years, with caregivers taking care of daily living, food, and medication administration, medical appointments and managing symptoms when depressive symptoms relapsed.

Most family caregivers had a good, close relationship with the older adult. They love each other and care passionately for the older adult with the bond of love and respect as a basis. The results showed that participant attitudes were 2 characteristics of caregivers' attitudes in caring for the older adult with depression:

1) Positive attitude which was found in families who had a source of support or adequate economic status and **2) a negative attitude** where the opposite situation was found.

The attitudes that emerged were opinions and feelings of the older adult family caregivers towards the older adult suffering from depression. When analyzing the family context on economic issues, it correlated with the economic status, (Patel, et al., 2018), families with stable economic bases and loving families were more able to cope with their caregivers than families with poor income and lack of other sources of social support (Jee & Lee, 2013).

The results of the study found that the length of time in caring for the older adult with depression affected the attitude and duty of caring for the older adult.

4.2.3 Perceive negative views

Most of the participants noted at first that they had no knowledge of depression, symptoms, medications, or care. Some did not even know they were psychotic. These things made them feel stressed, insecure and confused. Participants felt a lack of a basic understanding of the disease and medicine (Etemadifar, Bahrami, Farsani, & Shahriari, 2015). They also did not get much help from the medical staff at the beginning, and with the life problems that they were facing, it only added to the negative feelings, confusion, and despair.

4.2.3.1 Uncertainty for life

In this study, we found that the participants' experiences of caring contained a significant amount of participant uncertainty. In situations characterized by

unpredictability and insufficient information, uncertainty emerges. Hebert and colleagues reported similar results (Hebert, Schulz, Copeland, & Arnold, 2009: Etemadifar, Bahrami, Farsani, & Shahriari, 2015). In this study, the majority of participants expressed uncertainty about both practical and medical matters. These typical forms of ambiguity signify a need for information, which is typically offered by the healthcare team, including the diagnosis and prognosis as well as how to carry out caregiving tasks.

4.2.3.2 Negative attitudes and Frustration

Negative attitudes of family caregivers must be present at the early stages. Due to this stage, the participants had poor knowledge about mental illness, as MDD and negative attitudes toward people with mental illness are widespread (Abi Doumit, et al.,2019). This study showed that the "negative *attitudes"* occur in the early stages of caregiver duties and in the early stages of depression. Most of them occur after the family has had a hard time or life crisis, such as the loss of a person, the loss of a job, or economic problems that the family caregivers described as *"feeling stressed, anxious, and confused"* during the first 3 to 6 months of illness and symptoms until entering the treatment process. Negative attitudes are characterized by "feeling burdened, tired, and stressed" (Svensson & Hansson, 2016).

The *frustration* found in this study occurred with family caregivers who had a less close relationship, such as a daughter-in-law and spouse who experienced boredom. This role is a burden and looks at the elderly negatively. The result referred to the feeling of participants' disappointment in elderly behaviors and there was no exact time.

4.3.4 Try to perceive in a positive way

Positive attitudes occur after entering the treatment process. Caregivers learned both from psychiatric nurses, physicians, and reliable sources, and gained experience. There was "acceptance" and "adaptation" after 6-12 months. Family caregivers learned the symptoms of the illness so they could adapt and accept, forgive and become accustomed to the feeling of it not being "a burden." This study showed that the

component could increase the capacity of depression literacy. When the participants have knowledge and experience, they change and apply strategies or activities for suitable care. After a successful situation, the elderly's symptoms improve. It gives them confidence and empowerment in their own right.

Family caregivers feel that they can cope with symptoms and can manage the symptoms successfully, so they *feel* ***a sense of pride (self-esteem)***, and their attitudes towards the older adult begin to change positively, seeing the older adult as a beloved person. The group of caregivers will have positive feelings for the older adult with a positive attitude. Most of the time, this feeling occurs in the caregiver of the child or spouse who has a pre-existing positive family relationship.

Positive mental health attitudes and beliefs have a positive effect on seeking help and in the treatment of diseases and mental disorders, especially depression in the older adult (Jorm et al., 1997; Jorm, 2000; Reavley & Jorm, 2011).

From the view of caregivers in families who are in a husband-wife relationship, most of them think of the hardships they have spent together and think of their love for each other. It is an act for the people you love, despite feeling tired at times. Although families can face difficulties that affect their care (Namkung, Greenberg, & Mailick, 2017), such as economic problems, they still insist on taking care of the older adult without feeling burdened.

From the perspective of family caregivers of those who have a family relationship with children or grandchildren, their duty to repay the merit and act with feelings of love and gratitude to the elders who took care of them in their youth was a reward. This group must act with love and understanding as the saying “Old people have to be cared for with heart” and “do not feel difficult”. Both groups felt "happiness" and "pride" that they did a good job in taking care of their loved ones.

From the perspective of family caregivers, such as daughter-in-laws, they felt that the older adults were “arrogant,” “easily irritable,” “unhappy with them,” and “bored.”

The study showed the families experiencing family-related changes, such as the loss of a child, cause older adults to suffer from depression, creating the role of the caregiver in the family during a time of loss. They understand each other's feelings and support each other in resolving problems when symptoms or emotional crises arise. Activities that help improve symptoms include prayer, meditation, and listening to monks' prayers, and going to make merit on Buddhist holy days which both caregivers and sick older adults will follow.

From a study in caregivers and dementia patients in Thailand, it was found that most caregivers still insisted on taking care of the elderly. This is due to the following reasons.

1. Repaying merit. Caring for the sick in the Thai context is influenced by Buddhism. This led most caregivers to respond that caring for a sick adult relative was a substitute for the grace that was received and a great willingness to provide further care.

2. Having performed duties as a husband / wife for children. That is what most respond. However, if the duties are performed with a willingness, this will result in quality care.

3. Rewarding merit. This issue is often found in husband-and-wife caregivers, some of whom are bored from the patient's workload and behavior but because the patient was once very good to them, they cannot be abandoned. This is also found in cases where the patient is a relative who has given mercy to a caregiver before. The caregivers are happy to provide care in return for that good deed.

4. Promote better relationships between older adults and caregivers. Although some studies found that the relationship between caregivers and patients got worse, there were some caregivers who admitted that caring for the patient made the relationship between themselves and the patient better. This is because of the time spent closer together and the patients showing more love for themselves.

4.3.4.1 Acceptance of being the caregiver

Family caregivers learned from the experience of living together with older adults, the advice of doctors and psychiatric nurses, telling stories, reading, and studying

until they gained knowledge and understanding of the older adult's depressive illness and finally accepted their symptoms and behavior.

Acceptance of roles in the caregiving of older adults by a family caregiver depends on factors emanating from commitment to familial relationships.

Awareness is the first step towards acceptance or rejection. Illness and care responsibilities are the roles that will arise. The caregivers are aware that the older adults are sick or acting unusual for the first time. It is only the process of acknowledging this that change can occur as they begin to recognize that the behaviour is a depressive illness (Feliciano, Feliciano, Palompon& Gonzales, 2022).

After that, the caregiver became interested and started searching for information and learning about behavioral changes or increased symptoms. This behavior is intentional and cognitive rather than just cognitive. At this stage, it allows the person to be educated about the symptoms and depression, all dependent on personality, values, society or past experiences. It affects the caregiver and influences the search for knowledge (Feliciano, Feliciano, Palompon& Gonzales, 2022).

Trial and error is a moderation process using experimental approaches, methods of care, and methods of solving problems to find a more suitable way to care for the older adult, and to have the responsibility in deciding whether to accept that method or not. At this stage, the individual seeks specific advice about how to provide effective care from peers, physicians, nurses, the outcome of which will be critical in the decision to reject or accept further.

The acceptance process is the stage where the caregiver accepts the illness and the role of care and how to live after having tried it and implemented it continuously. These moderators will seek further information to support decision making and better care.

4.3.4.2 Adaptation

Family caregivers learned from the experience of living together with the older adult, and they changed their behavior and ‘adapted’ to a new situation to maintain the harmony of living in a family. Making it suitable and able to survive in that environment is the type of adaptation caused by natural selection of living organisms whose variations cause genetic

differences. ***The adaptation of living beings is the result of natural selection*** (Bradley,2022). All living things adapt to the environment in which they live. This is to survive and continue to reproduce because there are many types of life in the world. The adaptation of each species is therefore different which can be summarized as follows:

Problem awareness, perception and understanding of depression and the problems facing the older adult are important elements to consider and assess how important or severe the problem is related to the caregiver. Throughout the situation, how much conscious awareness of the problem is involved? Taking into account various related situations, caregivers can independently learn how to solve problems or situations that occur or get help from other people effectively. When the older adult experiences these behavioral changes, caregivers will be able to react accordingly. It will help caregivers learn, accept and adjust their manner in a suitable way, as well as find ways to appropriately deal with the older adult in their care.

The process of adjusting and changing feelings of discomfort, anxiety and frustration arise from feelings, thoughts, and behaviors in certain situations. Adaptation is correcting and improving grievances by seeking ways to meet one's own needs, both inside and outside the body to be able to adapt well to the surrounding environment, including meeting physical, mental and social needs.

Adapting to and assisting individuals who have difficulty adjusting to events or changes in life by adaptation is a process. It is the result of a person who has thoughts and feelings from intellectual awareness and creativity in integrating between the person and the environment. Roy uses concepts from systems theory to explain the approach. Making adjustments to that person, a person is like a holistic adaptive system and an open system. It consists of an input, a coping process, an output, and a feedback process, each of which operates in relation to one another. When stimuli caused by environmental changes, both internal and external, in the adaptation system, it encourages the individual to adapt in response to that stimulus through a coping process.

There are two types of adaptation outcomes, adaptive and inefficient, where the output from the system is fed back to the input for further adaptation. However, the adaptive ability of each person varies depending on the severity of the stimuli and the level of adaptability of a person. Important factors that cause a person to adjust into two types are:

1. Internal factors. Mental needs which are inherent in a person is love, warmth, safety, and success in life causing people to have to adjust to reach their desired goals.

2. External factors. The needs of society and the environment which are cultural customary values of religion, rules of society causing individuals to adapt to meet various needs and living without psychological pressure.

Adaptation has two main objectives: 1) to adapt to overcome the environment or problem to balance the lack of one; 2) to adapt to the environment or problem. When it cannot be overcome, it adjusts itself according to the environment and the problem to maintain that balance.

4.2.4.3. Be happy and proud of providing care of a loved one

Family caregivers in the family who can adapt to the symptoms, and roles that they play can then provide care in the sense that they are willing to serve their loved ones. In return, they feel gratitude, respect and happy to make the older adult feel better (Teedee, 2019). In Thailand, the fraternal society in the same village community is known for seeing the behavior of caregivers who take good care of their family members. The older adult's symptoms improved, and they were appreciated. This compliment reinforces that what caregivers do are worthy of commendation. This makes caregivers feel proud of themselves (self-esteem) that they can take care of their loved ones very well.

The family caregiver's attitude 'Caring does not increase the burden'. Adaptive caregivers felt that caring for the older adult with depression is a duty that depends on their actions. It is in return of the gratitude to loved ones, not feeling tired, not burdened. It is a duty of showing gratitude. Family caregivers believed that having time for the older adult can help the older adult feel better.

Most family caregivers, such as children, wives, and husbands, will know that care is not a burden even if the illness becomes more and more severe, and they choose whether to care for or not to care for the sick older adult. With depression, every caregiver

still insists on taking care of the older adult who is suffering from depression because they see it as a duty to be responsible and are happy to fulfil this role.

The study found that most of the positive caregivers had mature personalities, were calm, polite, easy to laugh, easy to smile, compromising, and believed in gratitude.

Family caregivers are trying to adapt to the depressive problem that occurs in the older adult by adjusting their behavior and accepting a home environment in which patients need close supervision to be able to live happily. Based on the role and environment given or changed, it is a way for caregivers to keep their mental well-being through remediation and find solutions to eliminate or alleviate suffering, frustration, and stress (Ross & Mackenzie, 199)

4.2.5 Having strategies to properly manage care

4.2.5.1 Create feelings of calming down

The family caregivers having strategies to properly manage care, according to the experience of caregivers, knowledge of depression management strategies comes from living with the depressive patient every day, learning, and observing how the management could calm the depressive patient, have normal conditions, and live with family members normally. One of the effective strategies is "**creating feelings of calming down"** such as **"**staying still or using silent techniques". The caregiver should use a silent, passive, non-responsive approach to the patient's words and **divert attention and find other activities to do**. The family learned to use strategies to divert attention by watching television, listening to the radio, and finding activities to do continuously which reduced free time. Some caregivers focused on calming the mind by reading the Dharma book. Some people took them to make merit and offer food to monks on festival days. The family learned from experience and adapted until they found effective strategies that were suitable for their older adult. Each elderly person has different personalities and different preferences, resulting in individual responses to emotions and behaviors based on individual character and nature that caregivers must observe and learn.

The one effective strategy the FC must use is prescribed medication. The caregiver administered medication according to the doctor's prescription and supervised the administering of oral medications when observing the patient's leading symptoms of disease or abnormality. According to research, the benefits of antidepressants may be greater the more severe the depression is (FAD, 2019). When the drug was administered orally, the patient had calm symptoms like a healthy person, and was able to do their daily routines. When taking the drug, some people may experience drowsiness, or sleep soundly, not talk badly to anyone, and show no symptoms. Most caregivers believe that medication does not cause a relapse nor does it not show severe symptoms, so they do not consider seeking help from healthcare professionals or health care facilities.

The family caregivers focused on providing encouragement or emotional support, good words, or listening to their opinions to express their feelings of distress which contributed to a positive environment. The family caregivers believed that the positive environment made seniors feel safe, reduced anxiety, and reduced depression.

However, most of them were married couples who shared their suffering and happiness together, making them feel comfortable.

In families who had children, the members used strategies like paying attention, pampering them, and letting their grandchildren do things such as talking about things with them, taking them to temples, making merits, and doing their favorite activities outside of the home to show interest and concern, or letting the patient cook their favorite food. Making food that the child likes to show interest and take care of the sick as well was also beneficial.

4.2.5.2 Provide comfort and encouragement

In this study, the caregivers may use strategies handled with indulgence and close supervision. Most caregivers do not want their patients to suffer trauma or disruption. The family caregiver indulges and responds to the needs of the patient or uses silence so that they do not clash. Silence techniques improve the situation, and caring for an older adult with depression requires close monitoring with care to be able to recognize changes quickly. Close supervision could help reduce the dangers of symptoms and self-harm in older adults,

according to a study by the American Psychiatric Association (APD) and the National Institute on Mental Health (NIH).

4.2.5.3 Seek resources

In this study, when older adults were symptomatic of depression, most FC sought help from those who had experience. They used the method of asking close people or acquaintances for advice, who had experienced symptoms prior, before taking the older adult to see a doctor or treating them according to the advice given to them. After this, they would then enter the treatment system. Consistent with past studies, half of the caregivers had moderately formal mental health-seeking behaviors, and another sought informal assistance or counseling from family members or friends (Kraithaworn & Noinam 2021).

From the analysis of factors affecting the caregiver's perception of depression, 3 key similarities and differences of this work can be considered as follows:

4.1 Development of activities/services for caregivers of people with depression

4.2 Concrete knowledge management of future caregivers.

4.3 Development of a ‘Depression literacy Assessment’ for Caregivers with MDD Patients

4.3 Development of activities/services for caregivers of people with depression

4.3.1 Home visits and remote counseling.

It is a home visit service to assess management outcomes, whether caregivers are able to provide care and what support needs to be provided. Mental Health Medicine Hotline Service, and home visit service screening assessments of mental health and depression literacy.

4.3.2 Mental health and depression promotion activities.

A network of peer caregivers. A daycare center can help caregivers provide effective care. Develop a network of health volunteers to watch out for abnormal symptoms

and complications. Organize a health volunteer mentor system to provide help in cases of needing support, knowledge, and initial assistance.

4.3.3 Health care support.

Activities for exchanging information on symptoms and taking care of depression. It would help to exchange knowledge and help caregivers take care of themselves. Developing pre-depression media applications to help people better recognize and understand the symptoms of depression in the older adult. Create educational materials to enable caregivers to manage their own depressive symptoms in the older adult.

Create a model mental health communicator in educating people to seek health for themselves.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 CONCLUSIONS

Family caregivers' attitudes are important and directly affect the older adult with depression. If the family caregiver has a positive attitude, love, and attachment as the foundation, this will encourage family caregivers to accept, adapt and seek appropriate care methods for coexisting with older adult people with depression. Family caregivers need time to adjust to care for the older adult with depression. Most of the caregiver adjustments occurred after 1 - 3 months of caring for a depressed older adult person. In the early stages, family caregivers had difficulty adjusting and caring for the older adult.

After 6 months, most of them began to accept, adapt, and have their specific care guidelines in place. All this stemmed from hands-on experience of living with older adults with depression and learning to seek external and internal assistance to help support the care of the older adult, either through employee knowledge or other sources of support.

The knowledge that the family caregivers of older adults sought was mostly obtained by inquiring from those who had taken care of people who had been depressed, which is still a source of knowledge that is not of sufficient quality. When the family's caregivers took the older adult into the treatment process, the knowledge of taking care of depressed patients was given by nurses and psychiatric doctors. However, there were only a few of the older adult family's caregivers who had access to this treatment and who were educated by professionals. Knowledge of how to seek mental health information currently contains quite limited information. Family's caregivers sought knowledge and information about depression, including inquiries from neighbors, relatives, and people with experience in care or from those who had experienced mental health disorders or depression.

In addition, major sources included news reports, television dramas and social media such as YouTube. According to the study, media is the primary source of information for family's caregivers and general citizens. However, there are a wide range of sources and information about mental health such as books, libraries, the Internet, and educational curriculums. While it is known that some mental health sites are popular, the overall impact of such resources on mental health literacy has not been well-studied. Therefore, greater control of the quality of such resources is an important and necessary issue to ensure that people are provided with the correct information.

Many of the older adult family caregivers in this study had misunderstandings about the significance of the symptoms, or symptoms of the disease, such as depressed, as expressed by most of the words “he is stressed, 'stress disorder,” indicating that most caregivers were still confused between stress disorder and major depressive disorder. They said "stress" differed from perceived stress symptoms but they were unable to explain those differences or identify how they differ in detail. If a family caregiver who cares for an older adult with depression has inadequate knowledge of depression or an inadequate knowledge of care level, it can cause problems in communication with health care workers. This may lead to diagnosis and treatment delays, as family members think ‘they are older adults’, ‘silence is normal’, and ‘he’s normal’.

Depression is perceived by caregivers as still an unfamiliar new disease. Most of them gave information stating "*I don't know exactly what it is*? *What I know was from reading on the phone, listening to online media and listening to the experiences of those around me who used to suffer from this*.” There were some caregivers who did not admit that the older adult had depression, even though the older adult was being treated and had been diagnosed with depression by a doctor. For example, “Nobody has depression, but they have it. Taking medicine for the sake of taking medicine. I don't know, it's okay." CP17

The study found that most older adult family caregivers lack understanding of depression in the older adult most commonly in the early stages. The source of

knowledge that most older adult caregivers used was to search for knowledge, or to search for it on social media, however unreliable its validity and inability to be trusted may be. When they had begun the treatment process, they at least had been educated by professionals.

The cause of comorbid depression among older adults as perceived by family caregivers is due to unexpected life-changing events, such as the loss of important family members, especially the “death of a child”. The next order is “death of a spouse” and “facing the disappointment of breaking up and being unfaithful” from people they love and care about, such as their children in prison, and the loss of a job or being unable to work as they once did. Family caregivers are aware of these reasons. As a result, the older adult in their care suffers from depression. Some believe that it is fate caused by their own bad actions, therefore must take the role of caregiving.

5.2 RECOMMENDATIONS

5.2.1 Implications for future practice and professionalism on the family caregivers’ knowledge about geriatric depression.

1. The readiness of the family caregiver's literacy level of depression should be assessed to be able to provide capacity building health services according to the abilities of family caregivers.

2. Nurses and professional health teams should organize depression and suicide awareness activities for family caregivers to enhance knowledge and awareness about depression and suicide literacy, leading to further access to mental health services for older adults with depression.

3. Provide information and promote knowledge of depression problems. This encourages caregivers to understand the nature of MDD, their causes, risk factors, and causes of mental illnesses. Common mental health symptoms such as depression, MDD and other symptoms linked to depressive symptoms and psychotic symptoms, to be able to take care of patients with depression into the treatment process in a timely manner.

4. Knowledge of mental health and depression are an important skill for promoting depression literacy in all ages especially for family caregivers who are of the age and able to take care of their family members. Organizations or agencies should oversee the quality of these caregivers and mental health groups. This concept of depression literacy may be used to promote mental health of older adults in care. When caregivers have knowledge of depression or mental health, and have a positive attitude towards treatment, this will lead the older adult to receive appropriate therapy.

The results of this study are helpful to understand the depression literacy of family caregivers in caring for their depressed older adult family members, which can be useful as a reference for future interventions, provided the initial groundwork and guidelines for primary care management are met.

The study will help health professionals understand whether caregivers can recognize depressive symptoms, detect factors, and provide care and management for depressed older adults who need care.

Psychiatric nurses role:

Psychiatric nurses play an important role in providing treatment-related knowledge and information, counseling patients and family caregivers by acting as nurses and liaisons on the mental health team to communicate with patients' families. They prepare family caregivers to be able to care for the older adult with MDD at home and socialize, as well as counsel family caregivers when there is a problem or when there is aggravation of psychotic symptoms beyond the caregiver's ability. Lastly, they promote understanding between family members, and involve family members in older adult care as support is essential to patient recovery and reducing recurrence.

5.2.2 Implications for future management.

The health systems should provide health services to strengthen the capacity to cope in the early stages of caring for the family caregivers who take the role of caring for older adults with depression in families. It is a period when they face too many crises, including, emotional crises in which adaptation creates feelings of anxiety, especially when they are overwhelmed with knowledge on how to deal with the new situation, obtain social support, and how to try to adjust and perform well.

5.2.3 Implications for future practice and policy

1. The health care system should have a depression care competency assessment form and assess for depression literacy in a family caregiver. This would provide knowledge-based empowerment to caregivers and give them the ability to care for older adults with depression.

2. The health care system should provide health services to enhance the capacity of caring for the family caregivers' older adults with depression during the early stages of their role in caring. In this period, family caregivers are faced with too many crises, including emotional crises causing feelings of anxiety and adaptation. If they are provided with support on how to handle the symptoms of depression or receive social support, this will help them to adjust and adopt appropriate care for the older adult.

3. The Ministry of Public Health should empower health care providers to have the potential to coach or give care advice to family caregivers who care for older adults with depression. This will ensure that caregivers can initially assess their symptoms, what signs and symptoms of depression to watch for, which can show different symptoms depending on the individual.

5.3 Strengths and limitations

The strength of this study was the qualitative findings confirmed by the knowledge of family caregivers. The qualitative findings provided an in-depth understanding of family caregivers and created a sense of attachment, causing the

perception of no stressful situations, no overthinking, feeling free from problems, and producing peaceful feelings.

The limitation of this study was that it was performed with Thai participants. Therefore, the majority of the findings were obtained in Thai, which may differ from others. Hence the results cannot reflect the care experiences of family caregivers from other countries. In addition, the research was conducted during the COVID- 19 pandemic which resulted in data collection limitations, and delayed access to the participants because the movement of Thais between provinces was restricted at that time.

REFERENCES

Aakhus, E., Granlund, I., Odgaard-Jensen, J., Oxman, A. D., & Flottorp, S. A. (2014). A tailored interventions to implement recommendations for older adult patients with depression in primary care: a study protocol for a pragmatic cluster randomised controlled trial. *Trials, 15*, 16. https://doi.org/10.1186/1745-6215-15-16

Abi Doumit, C., Haddad, C., Sacre, H., Salameh, P., Akel, M., Obeid, S., Akiki, M., Mattar, E., Hilal, N., Hallit, S., & Soufia, M. (2019). Knowledge, attitude and behaviors towards patients with mental illness: Results from a national Lebanese study. *PloS one*, *14*(9), e0222172. https://doi.org/10.1371/journal.pone.0222172

Ansary, M. (2020). Recognising depression in older adult patients in general practice. *Middle East Journal of Family Medicine*, *18*(10), 112-114. https://doi: 10.5742/MEWFM.2020.93882

America's Health Rankings. (2019). *Senior Report*. Retrieved from https://www.americashealthrankings.org/

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5) (5th ed.). Arlington, VA: Author

Armour, M., Smith, C. A, Wang, L. Q., Naidoo, D., Yang, G. Y., MacPherson, H., Lee, M. S., & Hay, P. (2019). Acupuncture for Depression: A Systematic Review and Meta-Analysis. *Journal of clinical medicine, 8*(8), 1140. https://doi.org/10.3390/jcm8081140

Assariparambil, A., Noronha, J. A., Kamath, A., Adhikari, P., Nayak, B. S., Shankar, R., & George, A. (2020). Depression among older adults: A systematic review of south Asian countries. Psychogeriatrics. https://doiorg.ezproxy.tulibs.net/10.1111/psyg.12644

Avasthi, A., & Grover, S. (2018). Clinical Practice Guidelines for Management of Depression in Older adult. *Indian journal of psychiatry*, *60*(Suppl 3), S341–S362. https://doi.org/10.4103/0019-5545.224474

Aziz, R., & Steffens, D. C. (2013). What are the causes of late-life depression?. The

Psychiatric clinics of North America, 36(4), 497–516. https://doi.org/10.1016/j.psc.2013.08.001

Baird, B., Oh, K. M., Douglas, C., & Weinstein, A. A. (2019). Health Literacy, Depression Literacy, and Depression among Older Korean Americans. *Journal of health communication, 24*(5), 525–535. https://doi.org/10.1080/10810730.2019.1632395

Bernstein, K., Han, S., Park, C. G., Lee, Y.-M., & Hong, O. (2020). Evaluation of Health Literacy and Depression Literacy Among Korean Americans. Health Education & Behavior : The Official Publication of the Society for Public Health Education, 1090198120907887. Retrieved from https://doi.org/10.1177/1090198120907887

Bilbrey, A. C., Laidlaw, K., Cassidy-Eagle, E., Thompson, L. W., & Gallagher-Thompson, D. (2020). Cognitive Behavioral Therapy for Late-Life Depression: Evidence, Issues, and Recommendations. Cognitive and Behavioral Practice. https://doi-org.ezproxy.tulibs.net/10.1016/j.cbpra.2020.02.003

Bradley, B. Natural selection according to Darwin: cause or effect?. *HPLS* 44, 13 (2022). https://doi.org/10.1007/s40656-022-00485-z

Bringmann, H. C., Bringmann, N., Jeitler, M., Brunnhuber, S., Michalsen, A., & Sedlmeier, P. (2021). Meditation Based Lifestyle Modification (MBLM) in outpatients with mild to moderate depression: A mixed-methods feasibility study. *Complementary therapies in medicine, 56*, 102598. doi: 10.1016/j.ctim.2020.102598

Bunthumporn, N. (2014). Family Caregiving and Depression in OlderAdults. *Science & Technology Asia*, *19*(4), 7-15. Retrieved from https://ph02.tci-thaijo.org/index.php/SciTechAsia/article/view/41121

Bursack, C., (2020). Finding Caregiver Support Online. Retrieved from https://www.agingcare.com/topics/60/caregiver-support

Bureau of registration of administration. (2018). Official statistics registrations system: Demographic and household statistics. Retrieved from http://stat.dopa.go.th/stat/statnew/upstat_age_disp.php

Braun, V., & Clarke ,V., (2006). Using thematic analysis in psychology. *Qualitative Research Psychology*, 3(2). 77-101,

doi: 10.1191/1478088706qp063oa

Brown, E. L., McAvay, G., Raue, P. J., Moses, S., & Bruce, M. L. (2003). Recognition of Depression Among Older adult Recipients of Home Care Services. *Psychiatric Services, 54*(2), 208-213. doi:10.1176/appi.ps.54.2.208

Centers for Disease Control and Prevention. (2017). "Depression is Not a Normal Part of Growing Older," Division of Population Health, retrievedfrom: https://www.cdc.gov/aging/mentalhealth/depression.htm.

Chan, M. F., Chan, E. A., Mok, E., & Kwan Tse, F. Y. (2009). Effect of music on depression levels and physiological responses in community-based older adults. International *Journal of Mental Health Nursing*, *18*(4), 285–294. https://doi-org.ezproxy.tulibs.net/10.1111/j.1447-0349.2009.00614.x

Cong, L., Dou, P., Chen, D., & Cai, L. (2015). Depression and Associated Factors in the Older adult Cadres in Fuzhou, China: A Community-based Study. International Journal of Gerontology, 9(1), 29–33. doi:org.ezproxy.tulibs.net/10.1016/j.ijge.2015.02.001

Charoensakulchai, S, Usawachoke, S, Kongbangpor, W, et al. (2019). Prevalence and associated factors influencing depression in older adults living in rural Thailand: A cross-sectional study. *Geriatr. Gerontol*, *19*,1248– 1253. https://doi.org/10.1111/ggi.13804

Chen, Ying-Sheue. (2012). Association between chronic insomnia and depression in older adult adults. *Journal of the Chinese Medical Association : JCMA, 75.* 195-6. doi: 10.1016/j.jcma.2012.04.001.

Conejero, I., Olié, E., Courtet, P., & Calati, R. (2018). Suicide in older adults: current perspectives. *Clinical interventions in aging*, 13, p.691–699. https://doi.org/10.2147/CIA.S130670

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.

Creswell, J. W. & Poth, C. N. (2017). Qualitative Inquiry and Research Design : Choosing Among Five Approaches**.** (4rd ed.). London: Sage.

Creswell, J. W. & Creswell, J. D. (2018). Research design qualitative, quantitative, and mixed methods approaches (5rd ed.). London: Sage.

Dai, L., & Wang, L. (2015). Review of Family Functioning. Open Journal of Social Sciences. 03. 134-141. 10.4236/jss.2015.312014.

Dai, L., Wang, P., Zhang, P., Guo, Q., Du, H., Li, F., He, X., & Luan, R. (2020). The therapeutic effect of repetitive transcranial magnetic stimulation in older adult depression patients. *Medicine, 99*(32), e21493. https://doi-org.ezproxy.tulibs.net/10.1097/MD.0000000000021493

Degeneffe, C. E., & Burcham, C. M. (2008). Adult sibling caregiving for persons with traumatic brain injury: Predictors of affec- tive and instrumental support. *Journal of Rehabilitation*, **74**, 10–20.

Department of Provincial Administration. (2019). *statitic Statistics of the older adult in Thailand in 77 provinces*. Retrieved from http://www.dop.go.th/download/knowledge/th1550973505-153_0.pdf (in Thai)

Denzin, N. K., & Lincoln, Y. S. (2017). The SAGE handbook of qualitative research (5 th ed.). Los Angeles: Sage. Department of Mental Health (TH). (2018).

Desbeaumes Jodoin, V., Miron, J. P., & Lespérance, P. (2019). Safety and Efficacy of Accelerated Repetitive Transcranial Magnetic Stimulation Protocol in Older adult Depressed Unipolar and Bipolar Patients. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, *27*(5), 548–558. https://doi.org/10.1016/j.jagp.2018.10.019

Department of Mental health, Ministry of Public Health, (2010). *Thailand. Clinical practice guideline of major depressive disorder for general practitioner: CPG-MDD-GP*. Ubonratchathani: Siritham.

Department of Mental Health. (2017). Department of Mental Health Policy: Strategic plan in 2017 – 2018. Retrieved from https://www.dmh.go.th/intranet/p2554/%E0%B9%81%E0%B8%9C%E0%B9%88%E0%B8%99%E0%B8%9E%E0%B8%B1%E0%B8%9A%E0%B8%A2%E0%B8%B8%E0%B8%97%E0%B8%98%E0%B8%AF%E0%B8%89%E0%B8%9A%E0%B8%B1%E0%B8%9A%E0%B8%AA%E0%B8%A1%E0%B8%9A%E0%B8%B9%E0%B8%A3%E0%B8%93%E0%B9%8C.pdf

Disu, T. R., Anne, N. J., Griffiths, M. D., & Mamun, M. A. (2019). Risk factors of

geriatric depression among older adult Bangladeshi people: A pilot interview study. *Asian Journal of Psychiatry, 44,* 163–169. https://doi-org.ezproxy.tulibs.net/10.1016/j.ajp.2019.07.050

Ediriweera HW, Fernando SM, Pai NB. (2012). Mental health literacy survey among Sri Lankan carers of patients with schizophrenia and depression. *Asian J Psychiatr.;5*:246-50.

Etemadifar, S., Bahrami, M., Farsani, A. K., & Shahriari, M. (2015). Family caregivers' experiences of caring for patients with heart failure: A descriptive, exploratory qualitative study. *The Journal of Nursing Research,* 23(2), 153Y161. doi:10.1097/jnr.0000000000000076

Fawcett, J., & Garity, J. (2009). *Evaluating Research for Evidence-based Nursing Practice*: F.A. Davis.

Feliciano, A., Feliciano, E., Palompon, D., & Gonzales, F. (2022). Acceptance Theory of Family Caregiving. *Belitung Nursing Journal.* https://doi.org/10.33546/bnj.2004)

Ferrari, A. J., Charlson, F. J., Norman, R. E., Patten, S. B., Freedman, G., Murray, C. J., Whiteford, H. A. (2013). Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. *PLOS Medicine,* 10(11), e1001547. http://dx.doi.org/10.1371/journal.pmed.1001547

Fiske, A Wetherell, J. & Gatz, M. (2009). Depression in Older Adults. *Annual review of clinical psychology. 5,* 363-89.

Forsman, E.D. & Anthony, Robert & Dugger, Katie & Glenn, Elizabeth & Franklin, Alan & White, Gary & Schwartz, Carly & Burnham, Kenneth & Anderson,

David & Nichols, James & Hines, James & Lint, Joseph & Davis, Raymond & Ackers, Steven & Andrews, Lawrence & Biswell, Brian & Carlson, Peter & Diller, Lowell & Gremel, Scott & Sovern, Stan. (2011). Population Demography of Northern Spotted Owls.

Foundation of Thai Gerontology Research and Development Institute (TGRDI). (2014). Report older situation. Bangkok: Foundation of Thai gerontology research and development institute press.

Gabra, R.H., Ebrahim, O.S., Osman, D.M.M. & Ghada S. T. (2020) Knowledge, attitude

and health-seeking behavior among family caregivers of mentally ill patients at Assiut University Hospitals: a cross-sectional study. *Middle East Curr Psychiatry*, 27(10), https://doi.org/10.1186/s43045-020-0015-6

Garekar H, Grover S. (2017). Electroconvulsive therapy in the older adult: Anesthetic considerations and Psychotropic interactions. *Journal of Geriatric Mental Health, 4*(2), p.83-98. doi: 10.4103/jgmh.jgmh_2_17

Gautam, S., Jain, A., Gautam, M., Vahia, V., & Grover, S. (2017). Clinical Practice Guidelines for the management of Depression. *Indian Journal of Psychiatry, 59*(5), p. 34-50. https://www.indianjpsychiatry.org/text.asp?2017/59/5/34/196973

González, Luz Angélica Muñoz, Romero, Yocelyn Margaret Price, López, Marcia Reyes, Ramírez, Macarena, & Stefanelli, Maguida Costa. (2010). The experience of family caregivers of older people with depression. *Revista da Escola de Enfermagem da USP, 44*(1), 32-39. https://doi.org/10.1590/S0080-62342010000100005

Ghadirian, L., & Sayarifard, A. (2019). Depression Literacy in Urban and Suburban Residents of Tehran, the Capital of Iran; Recognition, Help Seeking and Stigmatizing Attitude and the Predicting Factors. *International Journal of Preventive Medicine*, 1-6. https://doi-org.ezproxy.tulibs.net/10.4103/ijpvm.IJPVM_166_18

Giosa J, Stolee P, Dupuis S, Mock S, Santi S. (2014). Experiences during care transitions of older adults. *Canadian Journal on Aging*, *33*(2):137–53.

Girgus, J. S., Yang, K., & Ferri, C. V. (2017). The Gender Difference in Depression: Are Older adult Women at Greater Risk for Depression Than Older adult Men?. *Geriatrics (Basel, Switzerland), 2*(4), 35. https://doi.org/10.3390/geriatrics2040035

Guan, C., Wen, X., Gong, Y., Liang, Y., & Wang, Z. (2014). Family Environment and Depression: A Population-Based Analysis of Gender Differences in Rural China. *Journal of Family Issues, 35*(4), 481-500. doi:10.1177/0192513X12474624

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Major paradigms and perspectives*. Thousand Oaks: Sage Publications.

Haque, A., Guo, M., Miner, A. S., & Fei-Fei, L. (2018). Measuring Depression Symptom Severity from Spoken Language and 3D Facial Expressions. In.

He, G., Xie, J. F., Zhou, J. D., Zhong, Z. Q., Qin, C. X., & Ding, S. Q. (2016). Depression in left-behind older adult in rural China: Prevalence and associated factors. *Geriatrics & gerontology international*, *16*(5), 638–643. https://doi.org/10.1111/ggi.12518

Henriques, G. & Panizo, M. (2018). The behavioral shutdown model: A consilient biopsychosocial view of depression. *Sociological Theory, Methods, and Perspectives.* p.159-187.

Hill, C. E., Knox, S., Thompson, B. J., Williams, E. N., Hess, S. A., & Ladany, N. (2005). Consensual qualitative research: An update. Journal of Counseling Psychology, 52(2), 196–205. https://doi.org/10.1037/0022-0167.52.2.196

Ho, G. W. K., Bressington, D., Leung, S. F., Lam, K. K. C., Leung, A. Y. M., Molassiotis, A., & Ligot, J. (2018). Depression literacy and health-seeking attitudes in the Western Pacific region: a mixed-methods study. *Social Psychiatry and Psychiatric Epidemiology*, 10, 1039. https://doi.org/10.1007/s00127-018-1538-6

Horrigan-Kelly, M., Millar, M., & Dowling, M. (2016). Understanding the Key Tenets of Heidegger's Philosophy for Interpretive Phenomenological Research. *International Journal of Qualitative Methods*. doi: 10.1177/1609406916680634

Hu, Z., Zhu, X., Kaminga, A. C., Zhu, T., Nie, Y., & Xu, H. (2020). Association between poor sleep quality and depression symptoms among the older adult in nursing homes in Hunan province, China: a cross-sectional study. *BMJ open*, *10*(7), e036401. https://doi.org/10.1136/bmjopen-2019-036401

Huang, S.-L., Hsieh, C.-L., Wu, R.-M., & Lu, W.-S. (2017). Test-retest reliability and minimal detectable change of the Beck Depression Inventory and the Taiwan Geriatric Depression Scale in patients with Parkinson's disease. *PLoS ONE, 12*(9), 1-9. doi:10.1371/journal.pone.0184823

Huffman, J. C., Celano, C. M., Beach, S. R., Motiwala, S. R., & Januzzi, J. L. (2013). Depression and cardiac disease: epidemiology, mechanisms, and diagnosis. *Cardiovascular psychiatry and neurology*, *2013*, 695925. https://doi.org/10.1155/2013/695925

Ibrahim, N., Mohd Safien, A., Siau, C. S., & Shahar, S. (2020). The Effectiveness of a Depression Literacy Program on Stigma and Mental Help-Seeking Among Adolescents in Malaysia: A Control Group Study With 3-Month Follow-Up. Inquiry (00469580), 1–10. https://doi.org/10.1177/0046958020902332

Imamura, K., Kawakami, N., Tsuno, K., Tsuchiya, M., Shimada, K., & Namba, K. (2016). Effects of web-based stress and depression literacy intervention on improving symptoms and knowledge of depression among workers: A randomized controlled trial. *Journal of affective disorders*, *203*, 30–37. https://doi.org/10.1016/j.jad.2016.05.045Institute of Medicine (US) Committee on Health Literacy, Nielsen-Bohlman, L., Panzer, A. M., & Kindig, D. A. (Eds.). (2004). *Health Literacy: A Prescription to End Confusion*. National Academies Press (US)

Jee, Y. J., & Lee, Y. B. (2013). Factors Influencing Depression among Older adult Patients in Geriatric Hospitals. *Journal of physical therapy science*, *25*(11), 1445–1449. https://doi.org/10.1589/jpts.25.1445

Jeong, Y. M., McCreary, L. L., & Hughes, T. L. (2018). Qualitative Study of Depression Literacy Among Korean American Parents of Adolescents. *Journal of psychosocial nursing and mental health services*, *56*(1), 48–56. https://doi.org/10.3928/02793695-20170929-03

Johnco, C., & Rapee, R. M. (2018). Depression literacy and stigma influence how parents perceive and respond to adolescent depressive symptoms. Journal of Affective Disorders, 236, 599–607. https://doi.org/10.1016/j.jad.2018.08.062

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. American Psychologist, 67(3), 231-243.

Jorm, A. F., & Kitchener, B. A. (2011). Noting a landmark achievement: Mental health first aid training reaches 1% of Australian adults. Australian and New Zealand Journal of Psychiatry, 45(10), 808-813. doi: 10.3109/00048674.2011.594785

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. The British Journal of Psychiatry, 177(5), 396-401.

Jorm, A. F., Korten, A., Jacomb, P., Christensen, H., Rodgers, B., & Pollitt, P. (1997).

"Mental health literacy": A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Medical Journal of Australia, 166 (4), 182-186. Retrieved from https://www.mja.com.au/journal/1997/166/4/mental-health-literacy-survey-publics-ability-recognise-mental-disorders-and

Kaewprom C., Yuthavisut S., Pratoom L., & Boontum A., (2014). Mental health literacy among village health workers A case study of two sub-districts in Kloong, Chantaburi. *Journal of health science, 8*(1),10 -16. (in Thai)

Kansri ,J., Malai , C. and Soonthornchaiya, R., (2019). Geriatric depression and its related factors among Thai older adult in Chainat province. *Proceedings of the 2018 ANPOR Annual Conference, 45-54.*

Karuncharernpanit, S., Limrat, W., Makaroon, W., Khumnate, W., Chayvijit, W., Sukomol, V., Shooshuenmanakid, S., Tubson, S., & Santiwarangkul, A. (2016). Factors Related to Depression among Older People Living in Homes for the Aged of the Western Part of Thailand. *Asian Journal for Public Opinion Research*, *4*(1), 38-50.https://doi.org/10.15206/ajpor.2016.4.1.38

Kelly, K. G., & Zisselman, M. (2000). Update on electroconvulsive therapy (ECT) in older adults. *Journal of the American Geriatrics Society*, *48*(5), 560–566. https://doi.org/10.1111/j.1532-5415.2000.tb05005.x

Kennedy, G. J. (2015). The Problem of Depression in Late Life. in Geriatric depression: A clinical guide. Guilford Press.

Kim, H., Yoo, J., Han, K., Fava, M., Mischoulon, D., Park, M. J., & Jeon, H. J. (2021). Associations Between Smoking, Alcohol Consumption, Physical Activity and Depression in Middle-Aged Premenopausal and Postmenopausal Women. *Frontiers in psychiatry*, *12*, 761761. https://doi.org/10.3389/fpsyt.2021.761761

Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education, 6*(5), 26-41. doi: 10.5430/ijhe.v6n5p26

Kleebthong, Chareonsuk, & Kristiansen, (2017). Older Thai Peoples' Perceptions and

Experiences of Major Depression. *Global Journal of Health Science*, *9*(9), p.26-35. doi:10.5539/gjhs.v9n9p26

Knodel, J., Teerawichitchainan, B., Prachuabmoh, V., & Pothisiri, W. (2015). The situation of Thailand's older population: An update based on the 2014 survey of older persons in Thailand. Ann Arbor, MI: University of Michigan population studies center. Retrieved from http://www.psc.isr.umich.edu/pubs/pdf/rr15-847.pdf.

Kongsuk, T., Supanya, S., Kenbubpha, K.. Phimtra,S., Sukhawaha, S., & Leejongpermpoon, J. (2017). Services for depression and suicide in Thailand. *WHO South-East Asia Journal of Public Health,* 6, p.34-38. doi: 10.4103/2224-3151.206162.

Kraaij V., Arensman E., & Spinhoven P., (2002). Negative Life Events and Depression in Elderly Persons: A Meta-Analysis, *The Journals of Gerontology: Series B,* 57, (1),87–P94, https://doi.org/10.1093/geronb/57.1.P87

Kraithaworn P. and Noinam S (2021). Depression and Suicide Literacy and Mental Health Seeking Behavior among Family Caregivers of Older People in Community. *Journal of The Royal Thai Army Nurses* 22(2), 260-26

Leblanc, M. F., Desjardins, S., & Desgagné, A. (2015). Sleep problems in anxious and depressive older adults. *Psychology research and behavior management*, *8*, 161–169. https://doi.org/10.2147/PRBM.S80642

Leggett, A., Zarit, S. H., Nguyen, N. H., Hoang, C. N., & Nguyen, H. T. (2012). The influence of social factors and health on depressive symptoms and worry: A study of older Vietnamese adults. Aging & Mental Health, 16(6), 780-786. doi: 10.1080/13607863.2012.667780

Li, J., Theng, Y., & Foo, S. (2015). Depression and Psychosocial Risk Factors among Community-Dwelling Older Adults in Singapore. *Journal of Cross-Cultural Gerontology, 30*. 409-422. 10.1007/s10823-015-9272-y.

Li, Wenjing & Reavley, Nicola. (2020). Patients' and caregivers' knowledge and beliefs about mental illness in mainland China: A systematic review. *Asia-Pacific psychiatry : official journal of the Pacific Rim College of Psychiatrists.* doi: e12423. 10.1111/appy.12423.

Lincoln, S. Y., Guba, E. G. (1985). *Naturalistic inquiry*. (pp.289-327). Thousand Oaks, CA: Sage.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Chapter 6: Paradigmatic Controversies, Contradictions, and Emerging Confluences, Revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed., pp. 97-128). Thousand Oaks, CA: Sage.

Lindayani, L., Hendra, A., Juniarni, L., & Nurdina, G. (2020). Effectiveness Of Mindfulness Based Stress Reduction On Depression In Older adult: A Systematic Review. *Journal Of Nursing Practice, 4*(1), 8-12. https://doi.org/10.30994/jnp.v4i1.101

Lotrakul, M. (2013). Patient health questionnaire-9 Thai version. Retrieved March 10, 2016, from http://ramamental.com/phq9/

Lopez-Maya, E., Olmstead, R., & Irwin, M. R. (2019). Mindfulness meditation and improvement in depressive symptoms among Spanish- and English speaking adults: A randomized, controlled, comparative efficacy trial. PLoS ONE, 14(7), 1–13. https://doi-org.ezproxy.tulibs.net/10.1371/journal.pone.0219425

91. Loureiro, L.M., Jorm, A.F., Mendes, A.C. *et al.* (2013). Mental health literacy about depression: a survey of portuguese youth. *BMC Psychiatry 13***,** 129 https://doi.org/10.1186/1471-244X-13-129

92. Lu, C., Yuan, L., Lin, W., Zhou, Y., & Pan, S. (2017). Depression and resilience mediates the effect of family function on quality of life of the older adult. *Archives of Gerontology and Geriatrics, 71*, 34-42. doi:https://doi.org/10.1016/j.archger.2017.02.011

93. Manes F, Jorge R, Morcuende M, Yamada T, Paradiso S, & Robinson R.G. (2001). A controlled study of repetitive transcranial magnetic stimulation as a treatment of depression in the older adult. *Int Psychogeriatr, 13*(2), 225–231. doi: 10.1017/s1041610201007608

Malai, C. Chaiyoyingyong, R. Dangdomyouth,P Cheaplamp, S. (2019) Factors Related to Depression Among Older Adults, Songklanagarind Journal of Nursing,39 3 July - September 2019: 67-76

Maideen, S. F. K., Sidik, S. M., Rampal, L., & Mukhtar, F. (2014). Prevalence, associated factors and predictors of depression among adults in the community of Selangor, Malaysia. Public Library of Science One, 9(4), 1-14.

Marshall, M.N. (1996). Sampling for Qualitative Research. *Family Practice, 13*(6), 522-

525.doi: 10.1093/fampra/13.6.522

McCann, T. V., Bamberg, J., & McCann, F. (2015). Family carers' experience of caring for an older parent with severe and persistent mental illness. *International journal of mental health nursing*, *24*(3), 203–212. https://doi.org/10.1111/inm.12135

MacDonald, P.(2000). The Existentialist Reader-An Anthology of Key Texts (Edinburgh: Edinburg University Press)

McDougall, F. A., Kvaal, K., Matthews, F. E., Paykel, E., Jones, P. B., Dewey, M. E., Brayne, C., & Medical Research Council Cognitive Function and Ageing Study (2007). Prevalence of depression in older people in England and Wales: the MRC CFA Study. *Psychological medicine*, *37*(12), 1787–1795.

McQueen, M. (2012). Depression, suicide and the older adult. *Canadian Nursing Home, 23*(1), 24-27.

Mehrotra, K. Nautiyal, S. & Raguram A., (2018). Mental health literacy in family caregivers: A comparative analysis. Asian. *Journal of Psychiatry.* https://doi.org/10.1016/j.ajp.2018.01.021

Mehta, Charchit & Desale, Atul & Kakrani, Vandana & Bhawalkar, Jitendra. (2016). Economic Dependency and Depression in Elderly. *Journal of Krishna Institute of Medical Sciences University, 5.* 100-109

Miller K.J., Areerob P., Hennessy D., Daniela C., Bradley,G., Mesagno,C., & Grace. F. (2020). Aerobic, resistance, and mind-body exercise are equivalent to mitigate symptoms of depression in older adults: A systematic review and network meta-analysis of randomised controlled trials. *F1000Research*, *9*, 1325 (https://doi.org/10.12688/f1000research.27123.1)

Ministry of Public Health Thailand. (2012). The 11th National health development plan under the National economic and social development plan B.E. 2555-2559 (A.D. 2012-2016). Nonthaburi, Thailand: Bureau of policy and strategy office of the permanent secretary.

Misal, C., & Upendra, S. (2020). Effectiveness of Mindfulness Life Intervention on Depression among Older adult Persons in a Selected Old Age Home of Pune City. Indian Journal of Public Health Research & Development, 11(6), 299-301. doi: 10.37506/ijphrd.v11i6.9788

Mitsiriswat, A. (2018). The prevalence and associated factors influencing depression in

the geriatric population: A cross-sectional study in Ban Nayao, Chachoengsao Province, Thailand. Revue d'Epidemiologie et de Santé Publique, 66 (Supplement 5), S278. https://doi-org.ezproxy.tulibs.net/10.1016/j.respe.2018.05.106

Moral-Fernández, L., Frías-Osuna, A., Moreno-Cámara, S. et al. (2018). The start of caring for an older adult dependent family member: a qualitative metasynthesis. BMC Geriatr 18, 228. https:// doi.org/10.1186/s12877-018-0922-0

Molassiotis, A., Suen, L., Lai, C., Chan, B., Wat, K. H. Y., Tang, J., To, K., Leung, C., Lee, S., Lee, P., & Chien, W. T. (2020). The effectiveness of acupressure in the management of depressive symptoms and in improving quality of life in older people living in the community: a randomised sham-controlled trial. Aging & Mental Health, 24(6), 1001-1009. https://doi-org.ezproxy.tulibs.net/10.1080/13607863.2019.1584789

Morse, J. M. (2000). Determining Sample Size. *Qualitative Health Research*, *10*(1), 3-5. doi: 10.1177/104973200129118183

Murphy, E., & Dingwall, R. (2003). *Qualitative Methods and Health Policy Research*. New York: Routledge.

National Academies of Sciences, Engineering, and Medicine. (2016). *Families caring for an aging America.* Washington, DC: The National Academies Press. doi: 10.17226/23606.

National Alliance on Mental Illness. (2015). Depression. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Conditions/Depression/Overview.

National Collaborating Centre for Mental Health (UK). (2010). *Depression in Adults with a Chronic Physical Health Problem: Treatment and Management.* Leicester (UK): British Psychological Society;. (NICE Clinical Guidelines, No. 91.) Appendix 12, The classification of depression and depression rating scales/questionnaires. Available from: https://www.ncbi.nlm.nih.gov/books/NBK82926/

National Opinion Research Center. (2014). Long term care in America: Expectations and realities. Retrieved from http://www.longtermcarepoll.org/PDFs/LTC%202014/AP-NORC-Long-Term%20Care%20in%20America_FINAL%20WEB.pdf

Nigam, Tarun & Pole, Rachana & Vankar, G.K.. (2013). Depression literacy among High School Adolescents. *Archives of Indian Psychiatry*, *15*(2), 37-41.

Niv, N., Frousakis, N., Zucker, B. G., Glynn, S., & Dixon, L. (2018). A brief family intervention for depression in primary care. *Journal of Family Therapy, 40*(1), 100-119. https://doi-org.ezproxy.tulibs.net/10.1111/1467-6427.12147

Namkung, E. H., Greenberg, J. S., & Mailick, M. R. (2017). Well-being of sibling caregivers: Effects of kinship relationship and race. *The Gerontologist*, **57**, 626–636. doi:10.1093/geront/gnw008

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century, *Health Promotion International*, 15(3), 259–267, https://doi.org/10.1093/heapro/15.3.259

Nutbeam D, Wise M, Bauman A, Harris E, Leeder S: (1993). *Goals & targets for Australia's health in the year 2000 and beyond*, Canberra, Australian Government Publishing Service, 1-271.

Nutbeam, D., Levin-Zamir, D., & Rowlands, G. (2018). Health literacy and health promotion in context. *Global Health Promotion*, 25(4), 3–5. https://doi.org/10.1177/1757975918814436

Olivera J, Benabarre S, Lorente T, et al. (2011). Detecting psychogeriatric problems in primary care: factors related to psychiatric symptoms in older community patients. *Ment Health Fam Med*, *8*(1), 11–9.

Orem, D. E. (2001). *Nursing concepts of practice (*6 th ed.). St. Louis; MO: Mosby Year Book.

Padayachey U., Ramlall S.& Chipps J. (2017). Depression in older adults: prevalence and risk factors in a primary health care sample. *South African Family Practice*, *59*(2), 61-66. doi: 10.1080/20786190.2016.1272250

Paiva R, Valadares G, Silva J. (2012). The need to become family caregivers: grounded theory. *OBJN*, *11*(3):607-620.

Park, M., & Unützer, J. (2011). Geriatric depression in primary care. *The Psychiatric clinics of North America*, *34*(2), 469–487. https://doi.org/10.1016/j.psc.2011.02.009

Patel, V., Burns, J. K., Dhingra, M., Tarver, L., Kohrt, B. A., & Lund, C. (2018). Income

inequality and depression: a systematic review and meta-analysis of the association and a scoping review of mechanisms. *World psychiatry : official journal of the World Psychiatric Association (WPA), 17*(1), 76–89. https://doi.org/10.1002/wps.20492

Parslow, R. A., & Jorm, A. F. (2002). Improving Australians' depression literacy. *The Medical journal of Australia, 177*(S7), S117–S121. https://doi.org/10.5694/j.1326-5377.2002.tb04870.x

Phantong W., Khammathi A., Saengthong W., Nilphat O., &Khakhuen S. (2019). Prevalence and Factors Related to Depression among Older adult People in Community Hospitals. *The Southern College Network Journal of Nursing and Public Health,* 7(2), 114-126, Retrieve from https://www.tci-thaijo.org/index.php/scnet/index

Picco, L., Seow, E., Chua, B. Y., Mahendran, R., Verma, S., Chong, S. A., & Subramaniam, M. (2017). Recognition of mental disorders among medical students. *BMJ Open*, **7**(12), 1– 7 doi: 10.1136/bmjopen-2017-019038

Pilania M, Yadav V, Bairwa M, Behera P, Gupta SD, Khurana H., & Poongothai P. (2019). Prevalence of depression among the older adult (60 years and above) population in India, 1997–2016: a systematic review and meta-analysis. *BMC Public Health* 19, 832. https://doi.org/10.1186/s12889-019-7136-z

Polit, D. F., & Beck, C. T. (2014). *Essentials of nursing research: appraising evidence for nursing practice.* 8th ed. Philadelphia: Wolters Kluwer Health /Lippincott Williams & Wilkins. Pratt, L. A., & Brody, D. J. (2014). Depression in the U.S. household population, 2009-2012. *NCHS data brief*, (172), 1–8.

Prakhinkit, S., Suppapitiporn, S., Tanaka, H., & Suksom, D. (2014). Effects of Buddhism walking meditation on depression, functional fitness, and endothelium-dependent vasodilation in depressed older adult. *Journal of alternative and complementary medicine (New York, N.Y.), 20*(5), 411–416. https://doi.org/10.1089/acm.2013.0205

Putthametta, M., & Soonthornchaiya, R., (2016). Selected Factors Related to Depression of the Older Persons with Depressive Disorder in the Central Region. *The Journal of Psychiatric nursing and mental health* , 30(2),69-82

Rada, C. (2020). Factors Associated with Depression in Middle-Aged and Older adult People in Romania. *Psichologija / Psychology*, *61*, 33–50. https://doi-org.ezproxy.tulibs.net/10.15388/Psichol.2020.14

Rao, U. T., Noronha, J. A., & Adiga, K. (2020). Effect of aerobic exercises on depressive symptoms, anxiety, self-esteem, and quality of life among adults with depression. *Clinical Epidemiology and Global Health*, *8*(4), 1147–1151. https://doi-org.ezproxy.tulibs.net/10.1016/j.cegh.2020.04.006

Richardson, T. M., Friedman, B., Podgorski, C., Knox, K., Fisher, S., He, H., & Conwell,Y. (2012). Depression and its correlates among older adults accessing aging services. *The American journal of geriatric psychiatry:journal of the American Association for Geriatric Psychiatry, 20*(4), 346 - 354.https://doi.org/10.1097/JGP.0b013e3182107e50

Robinson L., Smith, M., & Segal, J. (2020). Depression in Older Adults: Signs, Symptoms, Treatment . *Help guide*. Retrived from https://www.helpguide.org/articles/depression/depression-in-older-adults.htm?pdf=13022

Ruan H, Shen K and Chen F (2022) Negative Life Events, Social Ties, and Depressive Symptoms for Older Adults in China. *Front. Public Health* 9:774434. doi: 10.3389/fpubh.2021.774434

Runcan, P. L. (2013). Depression in the Older adult. Cambridge Scholars Publishing.

Sabesan, P., Lankappa, S., Khalifa, N., Krishnan, V., Gandhi, R., & Palaniyappan, L. (2015). Transcranial magnetic stimulation for geriatric depression: Promises and pitfalls. *World journal of psychiatry*, *5*(2), 170–181. https://doi.org/10.5498/wjp.v5.i2.170

Sasithorn N, Lueboonthavatchai P. (2015). Depression and associated psychosocial factors of the elderly at the Elderly Associate of Public Health Center 48 Nakwatcharautid. *Chula Med Journal,* (6): 717-30. Thai.

Sayar,G.H., Ozten, G., E., Tan, O., & Tarhan, N. (2013). Transcranial magnetic stimulation for treating depression in older adult patients. *Neuropsychiatric disease and treatment*, *9*, 501–504. https://doi.org/10.2147/NDT.S44241

Schulz, R., Beach, S. R., Czaja, S. J., Martire, L. M., & Monin, J. K. (2020). Family

caregiving for older adults. *Annual Review of Psychology,* 71, 635-659. https://doi.org/10.1146/annurev-psych-010419-050754

Schulz, R., Eden, J., Committee on Family Caregiving for Older Adults, Board on Health Care Services, Health and Medicine Division, & National Academies of Sciences, 142. Engineering, and Medicine (Eds.). (2016). *Families Caring for an Aging America*. National Academies Press (US).

Shanok, N. A., Reive, C., Mize, K. D., & Jones, N. A. (2020). Mindfulness meditation intervention alters neurophysiological symptoms of anxiety and depression in preadolescents. *Journal of Psychophysiology*, *34*(3), 159–170. https://doi-org.ezproxy.tulibs.net/10.1027/0269-8803/a000244

Shaw J, Harrison J, Young J, Butow P, Sandroussi C, Martin D, Solomon M. (2013). Coping with newly diagnosed upper gastrointestinal cancer: a longitudinal qualitative study of family caregivers' role perception and supportive care needs. *Support Care Cancer, 21*(3):749–56.

Singh, K. (2007) "Quantitative Social Research Methods" SAGE Publications, p.64

Singh, S., Zaki, R. A., & Farid, N. D. N. (2019). A systematic review of depression literacy: Knowledge, help-seeking and stigmatising attitudes among adolescents. *Journal of Adolescence,* 74, 154-172. https://doi.org/10.1016/j.adolescence.2019.06.004

Sinnema, H., Terluin, B., Volker, D. et al. (2018). Factors contributing to the recognition of anxiety and depression in general practice, *BMC Fam Pract*, *19*, 99 https://doi.org/10.1186/s12875-018-0784-8

Smith, J,. Paul, F. & Larkin, M., (2009). Interpretative Phenomenological Analysis: Theory, Method and Research., *Qualitative Research in Psychology*, 6(4), 346-347, doi: 10.1080/14780880903340091

Somporn, D., Neeser, K. J., & Iamsupasit, S. (2012). Factors Influencing Depression among Older adult in Ban Bangkhae Nursing Homes, Bangkok, Thailand After Flooding. *Journal of Health Research, 26*(6), 313-316. Retrieved from https://he01.tci-thaijo.org/index.php/jhealthres/article/view/85488

Soonthornchaiya, R. (2013). *Understanding, Knowledge, and Family Support in Caring for Older Adults with Major Depression*. *Journal of Health Research, 27*(2), 97-103. Retrieved from https://he01.tci-thaijo.org/index.php/jhealthres/article/view/85783

Soonthornchaiya, R. (2018).Insomnia in Older Adults with Depression: Related Theories. The *Journal of* Psychiatric nursing and mental health, 31(3),1-16

Srithamrongsawat S, Bundhamcharoen K. (2010). Synthesis of long-term care system for the Elderly in Thailand. Bangkok: Foundation of Thai Gerontology Research and Development Institute.

Stebbins, R. A. (2011). Exploratory research in the social sciences. SAGE Publications, Inc. https:// http://dx.doi.org/10.4135/9781412984249

Stuart, G. W., (2013). Principles & Practice of Psychiatric Nursing. 10th ed. St. Louis, Missouri: ELSEVIER MOSBY

Sung, C.H., Li Lee, W., Ming Li, H., Ying Lin, C., Zu Wu, Y., Jy Wang, J., & Li Li, T. (2017). Familiar Music Listening with Binaural Beats for Older People with Depressive Symptoms in Retirement Homes. Neuropsychiatry *Journal*, 7(4), 347-353. https://doi.org/10.4172/Neuropsychiatry.1000221

Suwattanakoop, S. (2013). *A Comparison Study of Depression between the Older adult Living in Own Home and the Older adult in Home for the Aged, Mueng District, Chiang Mai* [Master of Science thesis]. Chulalongkorn University.

Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *The Canadian Journal of Hospital Pharmacy, 68*(3), 226-231. doi: 10.4212/cjhp.v68i3.1456

Svensson B, Hansson L. (2016). How mental health literacy and experience of mental illness relate to stigmatizing attitudes and social distance towards people with depression or psychosis: a cross-sectional study. *Nord J Psychiatry, 70*(4):309–313

Sykes, S., Wills, J., Rowlands, G. & Popple K. (2013). Understanding critical health literacy: a concept analysis. *BMC Public Health,* 13 (150). https://doi.org/10.1186/1471-2458-13-150

Taleghani, F., Ehsani, M., Farzi, S., Farzi, S., Adibi, P., Moladoost, A., Shahriari, M., &

Tabakhan, M. (2021). Challenges to Family Caregivers in Caring for Gastric Cancer Patients from Perspectives of Family Caregivers, Patients, and Healthcare Providers: A Qualitative Study. *Indian journal of palliative care*, *27*(4), 521–529. https://doi.org/10.25259/IJPC_98_21

Tamdee, D., Tamdee, P., Greiner, C., Boonchiang, W., Okamoto, N. and Isowa, T. (2019), "Conditions of caring for the older adult and family caregiver stress in Chiang Mai, Thailand", *Journal of Health Research*, *33*(2), 138-150. https://doi.org/10.1108/JHR-07-2018-0053

Thomas, P. A., Liu, H., & Umberson, D. (2017). Family relationships and well-being. *Innovation in Aging*, *1*(3), igx025. https://doi.org/10.1093/ geroni/igx025

Thompson, D.G., Cassidy-Eagle, E.L.,& Dunn, L.B. (2017). Cognitive Behavioral Therapy for Treatment of Late-Life Depression. *Today's Geriatric Medicine,* 10(1), P. 22 Retrieved from https://www.todaysgeriatricmedicine.com/archive/JF17p22.shtml

Tolentino, J. C., & Schmidt, S. L. (2018). DSM-5 Criteria and Depression Severity: Implications for Clinical Practice. *Frontiers in psychiatry*, *9*, 450. https://doi.org/10.3389/fpsyt.2018.00450

Tomczyk, S., Muehlan, H., Freitag, S., Stolzenburg, S., Schomerus, G., & Schmidt, S. (2018). Is knowledge "half the battle"? The role of depression literacy in help-seeking among a non-clinical sample of adults with currently untreated mental health problems. *Journal of affective disorders, 238*, 289–296. https://doi.org/10.1016/j.jad.2018.05.059

Tseng, Y.-T., Chen, I.-H., Lee, P.-H., & Lin, P.C. (2020). Effects of auricular acupressure on depression and anxiety in older adult residents of long-term care institutions: A randomized clinical trial. *Geriatric Nursing*. *42*(1), 205-212. https://doi-org.ezproxy.tulibs.net/10.1016/j.gerinurse.2020.08.003

Vanoh, D., Shahar, S., Yahya, H. M., & Hamid, T. A. (2016). Prevalence and Determinants of Depressive Disorders among Community-dwelling Older Adults: Findings from the Towards Useful Aging Study. *International Journal of*

Gerontology, 10(2), 81–85. https://doi-org.ezproxy.tulibs.net/10.1016/j.ijge.2016.02.001

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC medical research methodology, 18*(1), 148-148. doi:10.1186/s12874-018-0594-7

Vermeulen, B., Lauwers, H., Spruytte, N., Van Audenhove, C., Magro, C, Saunders, J. & Jones, K. (2015). Experiences of family caregivers for persons with severemental illness: an international exploration. *Leuven: LUCAS KU Leuven/EUFAMI.* revieved from *https://www.kuleuven.be/lucas/nl/Publicaties/publi_upload/copy_of_c4c-global-report-final.pdf*

White, M., & Casey, L. (2017). Helping older adults to help themselves: the role of mental health literacy in family members. Aging & mental health, 21(11), 1129–1137. https://doi.org/10.1080/13607863.2016.1206513

Wongpakaran, N. (2008). Geriatric Psychiatry in Thailand. *J Psychiatr Assoc Thailand,*

Wongpakaran, N., & Wongpakaran, T. (2012). Prevalence of major depressive disorders and suicide in long-term care facilities: A report from northern Thailand. *Psychogeriatrics, 12*(1), 11–17. https://doi.org/10.1111/j.1479-8301.2011.00383.x

Wongpakaran, N., Wongpakaran, T., Lerttrakarnnon, P., Jiraniramai, S., Sirirak, T., Assanangkornchai, S., Taemeeyapradit, U., Tantirangsee, N., Lertkachatarn, S., Arunpongpaisal, S., & Kuntawong, P. (2019). Prevalence, clinical and psychosocial variables of depression, anxiety and suicidality in geriatric tertiary care settings. Asian Journal of Psychiatry, 41, 38–44. https://doi-org.ezproxy.tulibs.net/10.1016/j.ajp.2018.10.007

World Bank. (2016). Aging in Thailand – Addressing unmet health needs of the older adult poor. Retrieved from https://www.worldbank.org/en/news/pressrelease/2016/04/08/aging-in-thailand---addressing-unmet-health-needs-of-the-older adult-poor

World Health Association. (2013). Ethical principles for medical research involving

human subjects. The journal of the American medical association, (310), 2191 2194. http://dx.doi:10.1001/jama.2013.281053.

World Health Organization. (2011). Global Health and Aging. Retrieved from https://www.who.int/ageing/publications/global_health.pdf

World Health Organization. (2013). The European health report 2012; Charting the way to well-being. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/197113/EHR20 12-Eng.pdf

World Health Organization (WHO). (2016). Definition of an older or older adult person. Retrieved from http://www.who.int/healthinfo/survey/ageingdefnolder/en.

World Health Organization (WHO). (2017). Depression and Other Common Mental Disorders Global Health Estimates. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf

World Health Organization (WHO). (2018). Elder abuse. https://www.who.int/news-room/fact-sheets/detail/elder-abuse

World Health Organization (WHO). (2017). Mental health of older adults. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults

World Health Organization (WHO). (2020). Depression. Retrieved from https://www.who.int/news-room/fact-sheets/detail/depression

Wongpakaran, N. (2008). Geriatric Psychiatry in Thailand. *Journal Psychiatric Association Thailand,*53, *p.39-46.*

Wongsaree, C. (2019). *Nursing care for the Oder adult with Depression: Family-centered Care*: Bangkok.https://doi.org/10.1080/13607863.2016.1206513

Yoelao, D., Thammapitak, P., & Prasertsin, U. (2016). Causes and Effects of Depression and Anxiety Disorders among the Older adult in Thailand. *International Journal of Behavioral Science,* 11(2), 51-62.

Zhang, H., Jiang, Y., Rao, W., Xiang, Y.T., Zhang, Q.E., Qin, M.Z., Ng, C. H., & Ungvari, G. S., (2020). Prevalence of Depression Among Empty-Nest Older adult in China: A Meta-Analysis of Observational Studies. Frontiers in Psychiatry, 11. https://doi-org.ezproxy.tulibs.net/10.3389/fpsyt.2020.00608

Zhang, Y., Chen, Y., & Ma, L. (2018). Depression and cardiovascular disease in older adult: Current understanding. *Journal of clinical neuroscience : official journal of the Neurosurgical Society of Australasia*, 47, 1–5. https://doi.org/10.1016/j.jocn.2017.09.022

APPENDICES

Memorandum

Depart The Human Research Ethics Committee of Thammasat University (Science) **Tel.** 02-986-9213 ext. 7358

No. ๐๖ 67.04.2/(ECSc)689 **Date** 9 August 2021

Subject: Notification of approval.

Dear Miss Wariya. Chankham

As you submitted the research protocol on "Depression literacy among family caregivers of older adults: A qualitative approach", project code 064/2564 to The Human Research Ethics Committee of Thammasat University (Science), (HREC-TUSc) for consideration

The HREC-TUSc examined and approved to affirm the human research ethics for your research project. We are therefore attaching the Certificate of Approval of your research projects. When the time period of 1 year counted from the approval date, the principle investigator will have to submit a progress report to the office of HREC-TUSc, Room No. 110, Piyachart Building, 1st Floor, Thammasat University Rangsit Campus.

We would like to inform you about this and ask you to proceed in accordance with these regulations. Thank you very much.

(Assoc. Prof. Jinda Wangboonskul, Ph.D.)
Chairman of the Human Research Ethics Committee of Thammasat University (Science).

SOP03_01(Eng)

The Human Research Ethics Committee of Thammasat University (Science), (HREC-TUSc) Room No. 110, Piyachart Building, 1st Floor, Thammasat University Rangsit Campus, Prathumthani 12121, Thailand, Tel: 0-2986-9213 ext.7358 E-mail: ecsctu3@Staff.tu.ac.th

COA No. 077/2564

Certificate of Approval

Project No. : 064/2564
Title of Project : Depression literacy among family caregivers of older adults: A qualitative approach
Principle Investigator : Miss Wariya. Chankham
Place of Proposed Study/Institution: Faculty of Nursing, Thammasart University

The Human Research Ethics Committee of Thammasat University (Science), Thailand, has approved the above study project in accordance with the compliance to the Declaration of Helsinki, the Belmont report, CIOMS guidelines and the International practice (ICH-GCP).

Signature:……..… Signature: ……

(Assoc. Prof. Jinda Wangboonskul, Ph.D.)
Chairman of the Human Research Ethics Committee of Thammasat University (Science).

(Assoc. Prof.Laksana Laokiat, Ph.D.)
Secretary of of the Human Research Ethics Committee of Thammasat University (Science).

Date of Approval: 2 August 2021 **Approval Expire date:** 1 August 2022
Progressing Report Due: 2 July 2022

The approval documents including
1) Research proposal
2) Patient/Participant Information Sheet and Informed Consent Form
3) Principal Investigator's Curriculum Vitae
4) Semi structure Question of Depression literacy and management of depression in Elderly among Family caregivers'
5) The demographic sheet

The example of semi-structured questions:

3.5.2.1 The knowledge and perceived factors

1) Main question

- From the experiences and your own understanding, how do you describe the disease and its symptoms observed while taking care an older adult member with depressive disorder?
- What is the meaning of the disease in your own understanding?

Specific question

- What are the physical symptoms thoughts, memory, emotions, and behaviors of the elderly who suffer from depression according to their perceptions?

2) The main issue

- What illness is caused by this depression?
- What factors do you think caused your _____'s depression?

Specific question

- Why do you think that ?

3) Main question

- What else do you think makes older adult depressed, or trigger depression?

Specific question

- What do you think it is?

4)Main question

- How do you know while the older adult has depressive symptoms or depressed?
- Could you briefly explain the depressive symptoms you have noticed in your _____ at home?

Specific question

- When older adults have depressive symptoms, What the symptoms do you observe?

- What are the symptoms that change?

3.5.2.2 The attitude toward caring for depression

1) Main question

- I would like to hear about your feeling about caring for depression of your_____

Specific question

- How do you feel?
- What do you think ?
- When the older adult has depressive symptom, who do you call for help and why?
- Do you know about any hospital or agency's resources for depression relief? Where?
- Do you need or not need for help in caring for an older adult with depression?
- If you need for help, who or what agency do you think you would ask for help? Why?

3.5.2.3 The caring for older people with depression

1) Main question

- When the older adult in the family is depressed, what do you do? Or how do you manage?
- I would like to hear about what strategies or methods you take care
- of your_____?

Specific question

- Why did you do that?
- What do you think about caring for older people with depression?
- How do you feel about the way (strategies) you manage your care?

3.5.2.4 The knowledge and perceived factors

1) Main question

- From the experiences and own understanding, how do you describe the disease and its symptoms observed while taking care an elderly member with drepression?
- What is the meaning of the disease in your own understanding?

Specific question

- What are physical symptoms, cognition, thinking, memory, mood, behavior?

2) Main question

- What the illness is caused by this depression?
- What factors do you think to cause your _____'s depression?

Specific question

- Why do you think that ?

3) Main question

- What else do you think makes elderly depressed, or trigger depression?

Specific question

- What do you think it is?

4) Main question

- How do you know if the elderly has depressive symptoms or depressed?
- Could you briefly explain the depressive symptoms you have noticed in your _____ at home?

Specific question

- When elderly have depressive symptoms, What the symptoms do you observe?
- What are the symptoms that change?
-

3.5.2.5 The attitude toward caring for depression

1) Main question

- I would like to hear about your attitude toward caring for depression of your_____

Specific question

- How do you feel?
- What do you think ?
- When the elderly has depressive symptom, who do you call for help and why ?
- If you haven't asked for help yet, who or what agency do you think you would ask for help? Why?
- Do you know about any hospital or agency's resources for depression relief? Where?
- How do you need help caring for the elderly with depression? From anyone or any where?

3.5.2.6 The caring for older people with depression

1) Main question

- When the elderly in the family is depressed, what do you do? Or how do you manage?
- I would like to hear about what strategies or methods you take to care for the depression of your_____?

Specific question

- Why did you do that?
- What do you think about caring for older people with depression?
- How do you feel about the way (strategies) you manage your care?

BIOGRAPHY

Name	Wariya Chankham
Educational Attainment	Academic Year 1998: Bachelor of Nursing Science Prachomklao College of Nursing, Phetchaburi Academic Year 2005: Master of Nursing Science Chulalongkorn University

Publication

Chankham, W., Soonthornchaiya, R., Othaganont,P. and Wang, JJ. (2023). Attitudes of Caregivers of Older Thai Adults with Major Depression: A Qualitative Study. Pacific Rim International Journal of Nursing Research, 27(3), 485–499. Retrieved from https://he02.tci-thaijo.org/index.php/PRIJNR/article/view/261344